Grants to States for Health Insurance Premium Review – Cycle I

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State: Illinois

Project Title: Premium Review Project

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PART I

Introduction

The Illinois Department of Insurance ("the Department") has made substantial progress during Quarter 1 in implementing the rate review enhancements proposed in its application for the Health Insurance Premium Review Cycle 1 Grant ("the Grant"). The Department is utilizing the Grant to develop the infrastructure required for an effective rate review process, including new tools and procedures to collect, analyze, and publish premium information in order to educate consumers and State policymakers. Specifically, the Department is increasing actuarial and insurance analyst staffing and investing in technology necessary for increased collection and analysis of premium data; developing protocols for the collection, analysis, and publication of premium rates; and seeking legislative authority to deny unreasonable premium rates or rate increases. Coupled with an effective campaign to engage the public, the Department's proposed rate review enhancements will prove to be an important tool for consumers in Illinois' private health insurance marketplace.

Many important steps toward implementation of the enhanced rate review process are already completed or underway. Specifically, the Department is progressing through the state-mandated personnel process in order to hire two Health Actuaries, and Department staff are currently in the process of evaluating proposals submitted in response to an RFP for actuarial consulting services. In December 2010, the Department issued a bulletin outlining the process for the reporting of all rate changes, for which the Department in February launched a web-based reporting system. The Department has also worked with National Association of Insurance Commissioners (NAIC) to develop modifications to the System for Electronic Rate and Forms Filing (SERFF), with a long-term goal of merging its operations with the new reporting system. Finally, legislation authorizing the Department to review and approve premium rates was drafted and has been introduced in the Illinois General Assembly as HB 1501.

Program Implementation Status

Accomplishments to Date

The Department has categorized rate review implementation milestones into four broad objective areas: 1) efforts to facilitate the *collection* of premium rate data; 2) efforts to facilitate the *analysis* of premium rate data; 3) efforts to obtain the authority to conduct comprehensive premium rate review; and 4) the engagement and education of the public regarding premium rate findings. Below is a list of the implementation milestones achieved in each area during Quarter 1. A more detailed and narrative discussion of the work behind these milestones appears under the section "Significant Activities: Undertaken and Planned."

Objective: Effectively Collect Premium Rate Data

- Evaluated current authority to request and collect data;
- Identified comprehensive set of rate filing data elements necessary to achieve all of the goals of rate review;
- Evaluated current data collection and system capabilities through electronic reporting, and identified problems with SERFF functionality;
- Developed an interim manual process for data reporting by carriers while waiting for implementation of electronic process;
- Developed and successfully launched an electronic reporting system for carriers;
- Drafted and circulated Company Bulletins 2010-08 and 2011-02 providing instructions to insurers on the new rate filing requirements and procedures (*See Appendix A through D*); and
- Retained a new team of IT experts to assist with the development of an electronic reporting system to supplement SERFF.

Objective: Effectively Analyze Premium Data

- Evaluated current capacity to analyze individual rate filings and aggregate rate data;
- Identified additional resources and tools necessary to achieve goals of rate review;
- Developed and published Request for Proposals for Actuarial Services to assist with timely data analysis; and
- Began hiring process for two new Health Actuary II positions to assist with rate review activities.

Objective: Obtain Authority to Conduct Comprehensive Premium Rate Review

- Reviewed ACA provisions and proposed regulations related to review of unreasonable premium increases and began development of an internal process for reviewing rates;
- Drafted legislation vesting the Department with the authority to approve or deny proposed rates and rate changes, with such review meeting the criteria for an "effective rate review program" as outlined in the proposed rules at 75 FR 81004 (December 23, 2010); and
- Worked with members of the General Assembly to have the legislation introduced (See *Appendix E*).

Objective: Engage and Educate the Public on Premium Rates and Rate Review Authority

- Began planning for the establishment of a consumer advisory group that will consider issues such as premium rate increases and rate review processes from the consumer perspective;

- Conducted public education through a Premium Rate Review Educational Webinar (available on the Department's website at http://insurance.illinois.gov/webinars/);
- Began working with potential vendor regarding website and material translational services; and
- Applied for and received a Consumer Assistance Program Grant to aid in website development.

Challenges and Responses

The Department experienced a delay in filling the positions proposed in the original grant application due to certain limitations imposed by state-mandated hiring processes. Given these circumstances and subsequent related changes in the Department's permanent staffing needs, the Department is currently moving forward with the hiring of two permanent staff health actuaries (as opposed to only one), and plans on hiring one additional actuarial assistant (as opposed to three), two insurance analysts, and an assistant analyst on a temporary contract basis in March. The work previously thought to be conducted by multiple actuarial assistants will be built into the contract for actuarial services currently being finalized with an outside vendor. The Department anticipates fulfilling the Grant-related hiring in quarter two, which a variation from the original timeline where the Department initially estimated the hiring process for these positions to be completed before the end of the first quarter. These changes have been reflected in the attached SF-424A.

The Department has also attached updated budget spreadsheets and a budget narrative. These documents not only reallocate funds based on the current personnel needs of the Department, but also more accurately categorize the different expenses associated with the Grant. As new personnel are hired and new contracts are executed, the Department will supplement this report with additional information about Grant-related personnel and vendors and adjust the cost allocations as needed.

The Department has also taken significant steps to update its outdated IT systems and capabilities. The Department developed a new Web Portal enabling the electronic submission of rate filings. IT is working to resolve accessibility issues identified by some insurers. The Web Portal is necessary in the short term to supplement the data collection and analysis capabilities of the SERFF system, but this requires carriers to report through two different electronic systems. Accordingly, the Department is working with the NAIC and SERFF to address these data analysis limitations in the long-term through a single system.

Another challenge the Department has encountered is the lack of explicit statutory authority to approve or deny premium rates or rate increases. To address this problem, the Department drafted legislation that requires insurers to report detailed rate information to the Department, and provides the Department with the ability to deny proposed rates which are unreasonable, excessive, inadequate, unjustified or unfairly discriminatory.

Finally, the public hearings the Department proposed to conduct in the first quarter have been delayed to allow more time for data collection which will help to inform consumers and State policymakers involved in the hearings. Now that the new rate reporting requirements and procedures have been implemented, the Department has begun planning public hearings for the second quarter. The Department incorporated changes into its updated budget based on these new plans.

Significant Activities: Undertaken and Planned

As noted above, the Department has categorized Grant implementation milestones into four broad areas: 1) efforts to facilitate the *collection* of premium rate data; 2) efforts to facilitate the *analysis* of premium rate data; 3) efforts to obtain the authority to approve or deny premium rate increases; and 4) the engagement and education of the public regarding premium rate findings. Each of the four categories is further organized into multiple subcategories. Early milestones have already been implemented or initiated in nearly every subcategory as described below.

1. *Collection of Premium Rate Data*

A. *Data Collection Goals and Metrics*

In October and November 2010, Department staff worked to identify the data elements and actuarial documentation necessary for a thorough and adequate review of a rate filing. A list of these data elements and a description of the actuarial memorandum the Department requires was published in Company Bulletin 2010-08.

B. *Announcement of New Rate Reporting Requirements*

In November 2010, the Department informed companies, through Company Bulletin 2010-08, of the procedures and requirements for reporting information related to new rate filings.

C. *Technical Capacity for Data Collection*

Department staff evaluated the existing system capacity for data collection and consulted with the NAIC on potential modifications to SERFF that would enable the Department to transfer SERFF data into a searchable database. Although SERFF is currently unable to accommodate this capability, it has, though the NAIC, committed to work with the Department to achieve the Department's data collection goals.

To address the short-term needs of the Department, the Department executed a contract for IT services (*See Appendix F*), and together with existing permanent IT staff developed a new internal database – The Illinois Web

Portal -- through which carriers must report required rate information, in addition to reporting through SERFF. Prior to the official launch of the new rate reporting web portal, the Department tested a pilot web portal with five of Illinois' largest insurers.

D. *Staffing Capacity for Data Collection*

The Department plans to hire two insurance analysts and one assistant analyst to work with SERFF and assist the Department in the process of filing health insurance premium rate and form changes. This is now scheduled to take place during the second quarter due to unexpected delays in the hiring of new staff as discussed in the *Challenges and Responses* section above.

E. *Actual Collection of Data*

Pursuant to Company Bulletins 2010-08 and 2011-02, the Department has received 11 rate filings since December 1, 2010.

2. *Analysis of Premium Rate Data*

A. *Identifying Analytics Goals*

The Department has reviewed the HHS rule on unreasonable premium rates, and is in the process of developing a list of market trends that will help to inform the public and policymakers about the current state of Illinois' private health insurance marketplace. When this process is complete, the Department will need to determine the data necessary to calculate such trends.

B. *Technical Capacity for Data Analysis*

In December 2010, the Department evaluated its technical capacity for data analysis and determined the additional functionalities necessary to achieve the goals of rate review. In the coming months, the Department will continue to work with IT consultants to develop an electronic reporting system to conduct trend calculations for public reporting.

C. *Staffing Capacity for Data Analysis*

The Department posted its first Health Actuary II position in December 2010, and posted an announcement for a second Health Actuary II position in February 2011. Individuals filling these positions will assist with the initial evaluation of all rate filings received from carriers, including an initial evaluation of the reasonableness of a proposed rate. They will also assist the Department in a macro-analysis of Illinois' private health insurance marketplace to identify trends in premium rate increases, and the impact of

such increases on families and employers. The Department expects to complete the hiring process for these positions within the next several weeks.

On December 17, 2010, the Department issued a Request for Proposals for Actuarial Services to assist with review of premium rates flagged as "unreasonable" by the Department. The Department is now in the process of evaluating vendors, and hopes to execute a final contract within the next month.

D. *Conduct Actual Analysis*

As data is collected, and the online system is adjusted to provide all the necessary micro and macro analysis of premium rate increases and trends, the Department will conduct its analysis. After completing the analysis, the Department plans to make an annual report available to the public and state policymakers, and conduct activities to publicize its findings. In the next month, the Department will develop a format for this report and establish a process for posting the report on the Department's website and eliciting public feedback.

3. *Authority to Conduct Comprehensive Premium Rate Review*

A. *Obtain Authority to Approve or Deny Premium Rate Increases*

In December 2010, the Department drafted a bill that vests it with the authority to protect Illinois families and employers from unreasonable premium increases. The bill has been introduced in the Illinois General Assembly as HB 1501, and the Department will advocate for its passage during this legislative session.

Joe Weimholt, Assistant Director for Health Policy, has been added to the Grant's staff organizational chart as he is leading the Department's efforts to advocate for legislation to provide the Department with rate review authority. Although based in the Department's Chicago office, Joe will be the primary staff member traveling to the State capital, Springfield, for legislative business related to the rate review bill. The costs associated with this travel have been included in the modified budget documents.

Support for Departmental rate review authority was also included in the list of recommendations developed by Governor Quinn's Health Reform Implementation Council. This Council, which was established by Executive Order 10-12 in July 2010, is expected to publish its final report to the Governor in February 2011. More information on this Council is included under the "Collaborative Efforts Section."

4. *Public Engagement and Education*

A. *Public Hearings*

The Department plans to launch a series of public hearings this spring in order to educate the public and state policymakers on the important role premium review authority can play in Illinois' health insurance marketplace and accept feedback on the new rate review process proposed in HB 1501. The Department will work with legislators and stakeholders to determine the date, location, and agenda of such meetings. The Department will publicize the hearings and record them for posting on the Department's website.

B. *Interactive Website*

The Department has received a Consumer Assistance Program Grant under the Affordable Care Act and will be coordinating website improvement efforts related to both grants so as to avoid duplication. The Department will use grant dollars to develop an interactive and user-friendly website allowing consumers to, among other things, search and access all publicly available information related to premium rates and rate increases within the Illinois health insurance marketplace.

C. *Translation Services*

The Department has received a separate grant to translate all of its web pages and materials to several different languages and will contract with a vendor to accomplish this task. The funding allocated as part of this grant will supplement those efforts.

D. *Educational Webinars*

The Department has launched a series of educational webinars on different topics related to the implementation of the ACA. On February 1, 2011, the Department conducted an educational webinar entitled "Health Insurance Premium Increases in Illinois" (S*ee Appendix G*). More than 100 individuals participated in the webinar, and several submitted questions which were answered by the Director immediately after his presentation. A copy of the webinar as well as an audio file of the presentation is now posted on the Department's website. The Department expects to conduct future webinars on premium rate review.

Operational/Policy Developments/Issues

The Department has encountered obstacles related to its IT capabilities and ability to analyze premium rate data. The Department has found the SERFF system to be inadequate to meet the needs of enhanced rate review activities. As a result, the Department engaged a vendor to assist with the development of a supplemental premium

rate reporting system. The Department has also worked closely with the NAIC on upgrades to SERFF, with the ultimate goal merging the Illinois rate reporting system with SERFF.

Additionally, as mentioned above, the Department does not have explicit statutory authority to prevent unreasonable premium rates or rate increases. The Department drafted legislation, which has since been introduced, to address this problem.

Public Access Activities

As noted under "Significant Activities Undertaken and Planned", the Department has launched a few activities focused purely on educating and engaging Illinois patients, families, and other stakeholders. As mentioned, the Department is currently in the process of planning public hearings around premium increases in Illinois. The Department has and will continue to reach out to consumer advocates and state policymakers to solicit opinions on the issue of rate review, and is assembling a advisory group composed of numerous interested parties to advise the Department on this and other issues affecting health care consumers in the Illinois private health insurance marketplace.

The Department also received a Consumer Assistance Program Grant under the Affordable Care Act and will be coordinating website efforts related to both grants so as to avoid duplication. The Department will issue a Request for Proposals and work with a vendor to develop, test, and deploy a website with a consumer satisfaction survey that can be submitted online. The website will be updated as necessary. The Department will identify appropriate insurer information for display, and will work to translate the website into several languages.

Additionally, as noted earlier, the Department has launched a series of educational webinars on different topics related to the implementation of the ACA. On February 1, 2011, the Department conducted an educational webinar entitled "Health Insurance Premium Increases in Illinois." The Department intends on planning future education webinars on the issue of premium rate review.

Collaborative Efforts

The Department was a key participant in Governor Quinn's Health Reform Implementation Council ("the Council"), with Department Director Michael T. McRaith serving as Vice Chair. In its report to the Governor, the Council recommended "enacting legislation giving the Department of Insurance the authority to approve or deny proposed health insurance rate increases." (See *Appendix H*)

As mentioned above, the Department has reached out to consumer advocacy groups to draw on their expertise and obtain support for rate review legislation. This includes collaboration with both local and national elected officials to rally support

among Illinoisans for rate review authority for the Department. An advisory group is currently in the process of formation.

The Department has also worked with the NAIC to develop modifications to SERFF, with a long-term goal of merging its operations with the new reporting system.

The Department is currently planning a series of public hearings addressing premium rates and rate review legislation. The Department will coordinate with legislators, stakeholders, and other state agencies to ensure the process is inclusive, well-organized and effective.

Lessons Learned

The Department failed to fully anticipate the limitations imposed by State-mandated personnel processes but is moving ahead in a manner consistent with the Department's ultimate goals as set forth in the Grant.

Updated Budget, Workplan, and Timeline are attached as separate documents

Enclosures/Attachments

- Appendix A: Company Bulletin 2010-08
- Appendix B: Rate Filing Actuarial Memo
- Appendix C: Experience Spreadsheet
- Appendix D: Company Bulletin 2011-02
- Appendix E: HB 1501
- Appendix F: IT Contractor Disclosure Information
- Appendix G: Rate Increases Webinar PowerPoint Presentation
- Appendix H: Illinois Health Reform Implementation Council Initial Report
- Updated SF 424A
- Updated Budget Spreadsheet
- Updated Position Estimator Tool
- Updated Budget Narrative
- Updated Workplan
- Updated Timeline
- Updated Staff Organizational Chart

PREMIUM REVIEW PROJECT TIMELINE

(*Updated February 28, 2011*)

Should the Premium Review Project proposal be accepted by the Department of Health and Human Services (HHS), the Illinois Department of Insurance ("the Department") will proceed with the following timeline for implementation of stated grant activities to enhance the current rate review process.

First Quarter (August 9, 2010 through December 2010). *This quarter will primarily be composed of going through the formal hiring process, staff training, and planning necessary to effectively execute each of the activities planned in the grant application.*

- August/September 2010. The Department anticipates the National Association of Insurance Commissioners (NAIC) will begin work immediately to modify the current System for Electronic Rate and Form Filing (SERFF) to address data collection and reporting requirements in Section A.1(c)(2) and A.1(c)(2) of the grant application. Until the Department is able to procure the Level II IT consultant, the Project Director will be working closely with NAIC over the subsequent 3 months of development to improve this technology.

- October 2010. The Department will initiate the formal process of hiring new staff dedicated to the Rate Review Enhancement Project. Illinois has a structured interview and selection process that includes bargaining contracts, executive orders and court mandates. These procedures may take 12-16 weeks.

- October 2010. The Department will begin the process of preparing for and contracting with a new IT consultant dedicated to health reform and procuring additional actuarial consulting services. The Department will submit a Request for Proposal (RFP) following the statutorily required procurement process, which requires approval from the State Chief Procurement Officer. This is estimated to take approximately 12 weeks.

- October 2010. The Department will work with industry, consumer, and community-based organizations to identify partners for the engagement and education of the public and policymakers.

- October 2010. Department senior staff will work in concert with the new health reform IT consultant to begin crafting a plan to transition the Department's existing IT infrastructure to meet the needs of improved rate review activities and consumer engagement tools.

- October/November 2010. The Department will establish a reporting protocol for major medical insurance products.

- November 2010. The Department will provide written notification to insurers of the Department's rate increase reporting protocol.

- December 2010**.** As soon as practicable, insurers in every market (individual, small group, large group, HMO) will begin reporting rate information electronically through SERFF and the IT infrastructure developed for this purpose.

- December 2010. Using the enhanced SERFF technology and the IT design plan from the consultant, the Department will begin building an enhanced IT infrastructure to report findings to consumers.

Second Quarter (January 2011 - March 2011). *This quarter will be dedicated to public hearings on rate increases, developing/testing/training staff on the new technological infrastructure necessary, and educating insurers about the IT reporting process.*

- January 2011. The Department will continue to engage and educate the public and policymakers regarding the dysfunction of the Illinois market and the need for extensive rate review authority, through mechanisms such as education webinars and other outreach to coordinate with stakeholders on expanding rate review authority for the Department. Department professionals will continue to evaluate and analyze data received in the rate review process.

- January 2010. Appropriate Department staff will commence training on updates to SERFF reporting systems and related API web services, while new technical staff continues to represent the needs of the Department as it relates to additional updates to SERFF and related API services with NAIC.

- January/February 2011. SERFF staff and our internal health reform IT consultant will train relevant staff on new rate filling technology. IT staff will work with senior rate filing staff to draft the appropriate notice and directions on the new rate filing system for insurers. New information will be made public, and posted prominently on the Department's website.

- February/March 2010. The Department will develop the administrative plan for the public hearings on proposed rate increases (with the goal of multiple hearings in Chicago and Springfield). Planning will consist of location, logistics, potential witnesses, public notification, and administrative processes.

- March 2010 – 2012. The Department expects to host public hearings on proposed rate increases.

Third Quarter (April 2011 – June 2011). *This quarter will be dedicated to evaluating implementation of and actual information reported due to the new reporting requirements, more in-depth review of rates, reporting on rates, and communication with key stakeholders during the second half of the state's legislative session.*

- April/May/June 2011. The Department will continue to hold public hearings regarding proposed rate increases. The Department will compile and publish analyses regarding rate increases, health care costs, health care utilization and benefit design.

- May/June 2011. In coordination with the efforts in the Department using the Consumer Assistance federal grant, IT staff will launch a beta version consumer interface for the rate review web site and associated tools with simulated information for feedback and refinement.

- May/June 2011**.** Reports generated from the rate review process will be made publicly available.

- May/June 2011**.** The Department will commence a public campaign to inform individuals and businesses about the information and trends apparent in the rate filing data. This may include only preliminary information, rate trends, and relevant information related to the Medical Loss Ratio data submitted to the state, NAIC, and HHS.

Fourth Quarter (July 2011 – September 30, 2011)

- July/August 2011. Any new legislation granting the Department rate review authority will be incorporated into appropriate regulation, and the Department will evaluate and begin planning for the necessary IT system updates and additional staffing needs related to any potential new authority.

Premium Rate Review Project Work Plan

(*Updated February 28, 2011*)

I. The goals of the Premium Rate Review Project are to:

1. *Expand the scope of current review processes and improve rate filing requirements.*

a) To improve the infrastructure for health insurance rate filing, review, analysis and publication, the Department of Insurance (the "Department") plans to hire additional staff, update existing technology for collecting and analyzing rate information, and impose reporting requirements on insurers.

b) In addition, the Department plans to engage and educate the public and policymakers. Outreach will be premised upon the information assembled from the rate review reporting (as well as the additional consumer-provided information described below), the analysis of that data, and further reports on consumer impact.

2. *Enhance consumer protection standards.*

a) To increase transparency and enhance both consumer and policymaker engagement, the Department will conduct public hearings on proposed unreasonable rate increases, and the effect of these increases on Illinois families and businesses. All information related to the hearings will be posted prominently on the Department's website.

b) The Department also plans to engage individuals from across the state to inform the Department on the true impact of current health insurance premium rates, to understand the statewide health care economy, utilization trends and benefit designs.

c) The Department will develop interactive tools for consumers, accessible on the Department website, which are dedicated to improving transparency and understanding of premium rate information through the use of consumer-friendly interfaces. This technology will enable individuals and businesses to search a database that will include:

- Information on the history of an insurer and previous rate increases (to the extent the State has this information);
- Functionality to permit individuals to compare rates and trends; and
- A means for a consumer to submit to the Department a standardized survey about experienced rate increases, accompanying benefit reductions, satisfaction with an insurer's rating practices, and any additional information the Director deems necessary.

II. The Department will know how many consumers it reaches by:

a) The number of attendees of the public hearings and educational events, such as webinars;

b) The number of "hits" to the website;

c) The number of consumer surveys returned; and

d) The number of policyholders impacted by a proposed rate change.

III. Preliminary actions have taken place for the Premium Rate Review Project.

The Department has publicly and privately engaged the insurance industry and emphasized the need for rate review in Illinois. The Department prepared and published a report of rate increases in the individual market dating from 2005. The Department drafted legislation for the Illinois General Assembly to adopt that would authorize the Department to approve or deny a rate increase. The Department has initiated the formal hiring process to employ necessary personnel.

IV. The Premium Rate Review Project will be conducted by the Department's actuaries and insurance analysts.

Improvement of the rate review process requires the Department to hire 3 additional actuaries (2 health actuaries and 1 actuarial assistant) to help manage increased rate reporting and analysis of rates. The Department will hire 2 additional analysts and 1 additional clerk/office coordinator to help process the higher volume of rate filings. Credentials for those employees will include the following:

- The **Health Actuaries** perform highly responsible professional actuarial work by providing counsel and advice and conducting technical research in the insurance field of life, accident and health; conducts technical actuarial determinations of insurance firms doing business in the State; develops and prepares reports and recommends appropriate actions to the chief actuary or to the department director and administrators; may supervise lower level actuaries.

- The **Health Actuary** position requires knowledge and skill equivalent to completion of four years of college, with courses in higher mathematics, such as calculus, probability and statistics. Requires four years professional experience in actuarial work in the life, accident and health field. Preferably requires the equivalent to the certificate received for the completion of necessary examinations to qualify as an Associate or Fellow of the Society of Actuaries (A.S.A. or F.S.A.) or Casualty Actuarial Society (A.C.A.S. or F.C.A.S.). Preferably requires the type and kind of experience and training necessary for membership in the American Academy of Actuaries.

- The **Actuarial Assistant** under general direction, performs actuarial analysis of statistical insurance data; researches information on various topics to prepare reports for life and/or casualty actuary; analyzes and develops reports on reserve analysis, market surveys and closed claims; reviews documents supporting the licensure of insurance companies, performs profitability studies.

- The **Actuarial Assistant** position require knowledge and skills equivalent to four years college with a major in actuarial science – **or** – four years college with coursework in mathematics, numerical analysis, calculus, probability and statistics, preferably supplemented by the equivalent to the certificate received for completion of Part I and any one of Parts 2, 3, or 4 of the examinations administered by the Society of Actuaries.

- **Insurance Analyst II** performs professional duties in specialized areas of insurance: reviewing, analyzing or auditing documents to determine compliance with regulatory and procedural standards; or reviewing or analyzing policy forms, rating plans, filing, license applications, charters and bylaws; or investigating complaints, claims and disputes.

- **Insurance Analyst II** requires knowledge and skill equivalent to completion of four years of high school. Requires one year of professional experience as would have been gained as an Insurance Analyst I. Requires either a working knowledge of either the Illinois Insurance Code, departmental rules, regulations, executive bulletins and general insurance company methods and procedures, particularly as related to life, accident and health or property and liability types of financial regulations; as related to policy evaluation, license and complaint resolution; or requires a working knowledge of the State Employees Group Insurance Act in matters pertaining to benefits, claims, privileges of participants and responsibilities of carrier.

V. The Premium Rate Review Project will take place

August 9, 2010 – September 30, 2011.

Premium Review Project Budget Narrative

(*Updated February 28, 2011*)

Overall Budget

The Illinois Department of Insurance (DOI) budget for the current fiscal year totals $40,137,400. Projected annual revenue collected in FY10 is $359,200,677 (this amount includes the taxes collected and transferred to the General Revenue Fund).

Current rate review budget for Illinois' FY 2011

The current budget for premium rate review is $80,481. The total includes 1 full-time Insurance Analyst II plus employee benefits which is a cost of $75, 381. Additional employee costs total $5,100. This position does not require travel. (Please see attached spreadsheet for more detail).

Estimated Budget for Premium Review Cycle I

To enhance the current rate review process and to improve consumer protection standards, the Department estimates a total cost of $1,000,000. An itemization of the costs is below.

Personnel

The submitted proposal requires 6 additional staff which includes 2 health actuaries, 1 actuarial assistant, 2 insurance analysts and 1 clerk/office coordinator. Total estimated cost for salaries is $369,192.00. Attached is an itemization of personnel and fringe benefit costs in a modified position estimator spreadsheet.

Fringe Benefits

The cost of fringe benefits, including group insurance, social security, and retirement for the two additional permanent staff is $92,977.00.

Travel

Though new staff will not travel, existing staff will travel under the grant to perform activities related to advancing legislation, and coordinating with Springfield staff and other stakeholders across the state. Joe Weimholt, Assistant Director for Health Policy, will be traveling to Springfield during the legislative session to advocate for the Department's legislation to establish rate review authority. The Department has allocated $3000 for the cost of travel, including mileage (408 miles roundtrip at the federal rate of 51 cents per mile, or $208),

hotel ($70/night plus taxes), and Per Diem ($27 per full day). This will cover the cost of one staff traveling 1-2 times per month to Springfield during the General Assembly's spring session.

Equipment

For the two new permanent employees and four additional contracted staff funded by this grant, the Department anticipates an average cost of $1000 per employee for equipment for the year. This comes to a total of $6000, and includes computers, printers, calculators, staplers, and other similar equipment.

Supplies

For the two new permanent employees and four additional contracted staff funded by this grant, the Department anticipates an average cost of $500 per employee for supplies for the year, for a total of $3000. Supplies (also referred to as "commodities") include paper, pencils, pens, ink cartridges, filing folders, binders, and other similar materials.

Contractual Services

New Employee Contractual Services

For the two new permanent employees and four additional contracted staff funded by this grant, the Department estimates an average cost of $1000 per employee for various contractual services for the year, for a total of $6000. These contractual services are a standard cost built into the cost of hiring new employees, and include services ranging from renting offsite storage for servers, to repairs and maintenance of IT and other electronic equipment.

IT Services
Illinois intends to develop a new analytic data system to report rate increases to consumers. Improvement to the current IT infrastructure requires funding for a Level II IT consultant to design and build rate review software and convert to web-based system for consumer use.

IT development would consist of 2 6-month contracts for web development. Each contract will require the expertise of a Level II IT consultant. The average rate of a Level II IT consultant is currently $99 per hour. Each 6-month contract consists of 1,000 hours of work, for a total of $198,000.

Actuarial Services
Illinois will contract with an actuarial firm assist the Department in analyzing premium rate increases flagged as being potentially "unreasonable", and assisting the Department in filling any gaps in their new process. At an estimated cost of

$250 per hour estimate for 1,095 hours of work (6 months), the Department estimates this activity will cost $272,978 for one six month contract.

"Other" Category Spending

New Employee Electronic Data Processing (EDP)

For the two new permanent employees and four additional contracted staff funded by this grant, the State estimates an average cost of $2,000 per employee for electronic data processing services for the year. This comes to a total of $12,000. These services are a standard cost built into the cost of hiring new employees, and include services such as rental of data processing equipment and facilities.

New Employee Telecom

For the three new employees funded by this grant, the State estimates an average cost of $600 per employee for various telecom services for the year. This comes to a total of $3,600. These services are a standard cost built into the cost of hiring new employees, and include services such as local and long distance calling, phone rentals, and blackberry contracts.

IT Upgrades

The Department will upgrade the current SERFF system at a cost of $18,808. The cost estimate covers the expenses associated with modifying SERFF to address data collection and reporting requirements, such as:

- State options to indicate premium review grant participation;
- Company profile changes to incorporate company type;
- State-maintained indicator for rate filing requests meeting the HHS threshold for 'unreasonable';
- Addition of field to indicate product types;
- Company-maintained product information including product name, HHS id, and product status that will allow the companies to track products and apply them to filings;
- A new set of fields added to the Rate/Rule schedule items to provide HIPR data on a policy form basis;
- Changes to the State API to accommodate retrieval of the data elements added above and to allow for updates of appropriate data elements via the State API.

Public Hearings

The Department will conduct public hearings regarding premium rates and increases. The goal is to hear the "real" impact of rate increases on individuals, families and small businesses. The Department estimates the cost of the public

hearings to be $1,000. This estimate is based on evaluation of unspecified expenses for print materials, newspaper notices, rental of conference space and miscellaneous expenses (*i.e.,* projectors, screens). *The Department intends to use public meeting space such as public libraries or universities, which may have nominal rental fees.*

Consumer Education and Outreach

The Department will engage and educate the public and policymakers regarding health insurance premiums, health care costs, utilization and benefit design. The Department estimates the cost of this effort will be $1,500. The estimate includes the cost of media notifications, printing and postage.

Translation Services

In an effort to provide appropriate services to all Illinois consumers, the Department will translate web-based databases, documents, reports and charts to Spanish, Polish and Korean. In addition, the Department will translate documents, reports and charts into other languages identified in the last census. A detailed description of language services is attached. The Department estimates the cost of these services to be $11,945.

Proposed Total Budget for Premium Review Cycle I

(Updated February 28, 2011)

Category	Item		Amount
Personnel			
Salaries			$ 369,192.00
	1 Actuarial Assistant		$ 57,996.00
	2 Insurance Analysts		$ 99,984.00
	1 Clerk/Office Coordinator		$ 42,966.00
	Health Actuary II		$ 84,123.00
	Health Actuary II		$ 84,123.00
Fringe Benefits (for new permanent staff)			$ 92,977.00
	Social Security		$ 12,872.00
	Retirement		$ 50,905.00
	Group Insurance		$ 29,200.00
Travel			$ 3,000.00
	New Staff		$ -
	Existing Staff		$ 3,000.00
Equipment			$ 6,000.00
	Computers, calculators, etc.		
Supplies			$ 3,000.00
	Paper, pens, pencils, etc.		
		SUBTOTAL	**$ 474,169.00**
Contractual Services			
New Employee Contractual Services			$ 6,000.00
	Storage, additional IT consulting services for existing systems		
IT Consulting Team			$ 198,000.00
	$99/hour for 2000 hours of work (1 year)		
Actuarial Consulting Services			$ 272,978.00
	$250/hour estimate for 1,095 hours of work (6 months)		
		SUBTOTAL	**$ 476,978.00**
"Other"			
Electronic Data Process (EDP)			$ 12,000.00
	IT Support staff		
Telecom			$ 3,600.00
	Local and longdistance calls, phone rental, phone purchases		
IT Upgrades			$ 18,808.00
	Upgrade to current SERFF system		
Public Hearings			$ 1,000.00
	Regional public hearings estimated cost includes cost of media notifications/print materials		
Consumer Education and Outreach			$ 1,500.00
	Estimated cost includes printing, postage, and telecommunications		
Translation Services			$ 11,945.00
	Translation of the database, documents, reports and charts		
		SUBTOTAL	**$ 48,853.00**
		Total	**$ 1,000,000.00**

Position Estimator: Proposed Budget for Additional Staff

(Updated February 28, 2011)

Title	Monthly Rate	Salary	Retirement	Social Security	Group Insurance	PS& R Total
			0.30253	0.0765		
Office Associate	$ 3,583	$ 42,996				$ 42,996
Ins. Analyst II	$ 4,166	$ 49,992				$ 49,992
Ins. Analyst II	$ 4,166	$ 49,992				$ 49,992
Actuarial Asst.	$ 4,833	$ 57,996				$ 57,996
Actuary II	$ 7,011	$ 84,132	$ 25,452	$ 6,436	$ 14,500	$ 130,521
Actuary II	$ 7,011	$ 84,132	$ 25,452	$ 6,436	$ 14,500	$ 130,521
	$ -	$ -	$ -	$ -	$ -	$ -
7	$ 30,770	**$ 369,240**	**$ 50,905**	**$ 12,872**	**$ 29,000**	**$ 462,017**

Salaries are based on the Step 4 for AFSCME, and AVG of range for MC

Average Additional Costs/Per Employee

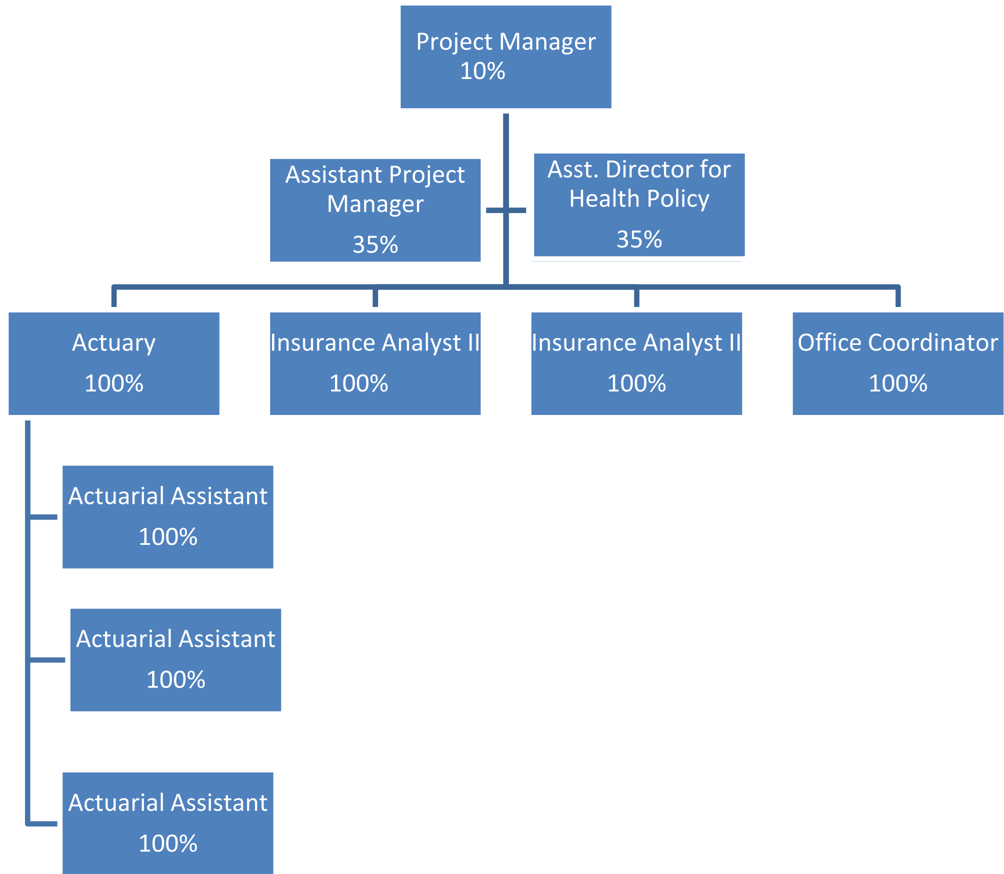
Please note that Travel will be adjusted per title (for example an office associate will have $0.00 for travel.)

		Based on HC	Other	NEW other Ops Total
1200-Contractual	$ 1,000.00	$ 6,000.00		**$ 6,000.00**
1290-Travel	$ -	$ -		**$ -**
1300-Commodities	$ 500.00	$ 3,000.00		**$ 3,000.00**
1500-Equipment	$ 1,000.00	$ 6,000.00		**$ 6,000.00**
1600-EDP	$ 2,000.00	$ 12,000.00		**$ 12,000.00**
1700-Telecom	$ 600.00	$ 3,600.00		**$ 3,600.00**
	$ 5,100.00	$ 30,600.00	$ -	**$ 30,600.00**

Total $
$ 492,617

Premium Review Project Organizational Chart

(Updated February 29, 2011)



List of Appendices

Appendix A: Company Bulletin 2010-08

Appendix B: Rate Filing Actuarial Memo

Appendix C: Experience Spreadsheet

Appendix D: Company Bulletin 2011-02

Appendix E: HB 1501

Appendix F: IT Contractor Disclosure Information

Appendix G: Rate Increases Webinar PowerPoint Presentation

Appendix H: Illinois Health Reform Implementation Council Initial Report

Illinois Department of Insurance

PAT QUINN
Governor

MICHAEL T. McRAITH
Director

TO: ALL COMPANIES AUTHORIZED TO WRITE HEALTH INSURANCE IN ILLINOIS

FROM: MICHAEL T. MCRAITH MTM

DATE: NOVEMBER 1, 2010

RE: COMPANY BULLETIN 2010–08

REQUIRED SUBMISSION AND APPROVAL OF ACTUARIAL MEMORANDUM AND JUSTIFICATION REVIEW STANDARDS FOR NEW AND RENEWAL HEALTH RATES

Under Section 2794 of the Public Health Service Act (PHS Act), added by Section 1003 of the Federal Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, the Secretary of the Department of Health and Human Services (HHS) and the States are required to establish a premium reporting and review process. PPACA further requires all health insurance issuers (issuers) to disclose and justify an unreasonable premium increase prior to the use of the increase.

Consistent with Section 2794 of the PHS Act, and pursuant to the Illinois Insurance Code, this bulletin outlines the data elements and required documentation for each submission of new rate filings, rate revisions or justifications of an existing rate. Beginning December 1, 2010, all SERFF and/or CD ROM rate filings must be filed with an Excel spreadsheet providing the data required by the attached Rate Data Collection Form, along with a PDF version of that Excel spreadsheet. On or before February 1, 2011, issuers will be able to file rate filings electronically through the Department's website. Notice will be sent when the ability to file electronically new rates, rate revisions or justifications of an existing rate becomes available.

Public disclosure of information rate modification and justification used to establish such modification is required by federal law.

There are two documents which accompany this bulletin. The first is the ***Rate Filing Actuarial Memorandum and Justification Review Standards*** document. This document explains the sections and content required for each rate filing. Issuers must provide the requested documentation. The second document is the ***Rate Data Collection Form***. This form is an Excel spreadsheet which must be completed and filed through SERFF.

The filing and/or the posting of the rate information does not constitute ratification or approval of the rate filing. The rate filing will be reviewed and the issuer will be notified by the Department of any action taken.

As HHS provides further guidance, the Department will review this guidance and provide clarification to all health insurance issuers. Please direct questions regarding this bulletin to Mr. Gerald Lucht at Gerald.Lucht@illinois.gov.

320 West Washington St.
Springfield IL 62767
(217) 782-4515
insurance.illinois.gov

Rate Filing Actuarial Memorandum and Justification Review Standards

General Instructions

A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, submit all new rate filings and rate revisions. The assumptions presented shall be appropriate at the time of the filing and shall clearly identify all rating factors and methods proposed to be changed.

Each rate filing actuarial memorandum and justification shall include the following sections and content:

Section	Content
Scope and Purpose of Filing	This section shall specify whether this is a new filing, a rate revision, or a justification of an existing rate. If the filing is a rate revision, the reason for the revision shall be stated.
Requested Rate Action	The average requested rate increase or rate decrease.
Status	Indicate whether the policy form(s) that are the subject of the rate action are: a. Open – new policies are still being issued or b. Closed – no new policies are being issued.
Description of Benefits	This section shall include a brief description of the benefits provided by the policy.
Renewability Clause	This section shall identify the renewability classification of the form.
Applicability	This section shall specify whether the insurer anticipates new issues under the form or renewals only.
Morbidity	This section shall describe the morbidity basis for the form, including the source or sources used.
Mortality	This section shall state the mortality basis.
Persistency	This section shall state and describe the lapse rates used.
Expenses	This section shall include a brief description of any expense assumptions used, including, for example, per policy and percentage of premium expense for acquisition, maintenance, and commissions. These must be provided separately for each policy year.
Marketing Method	This section shall provide a brief description of the market and the marketing method.
Underwriting	This section shall provide a brief description of the extent to which this product will be underwritten, if any, and the expected impact by duration and in total, on the claim costs.
Premium Classes	This section shall state all the attributes upon which the premium rates vary.
Issue Age Range	This section shall specify the issue age range of the form. A statement shall be made as to whether the premiums are on an issue age, attained age or other basis.
Area Factors	This section shall include a brief description for any area factors used, and an explanation of any changes since the last filing. The area factors and definitions must also be displayed.
Average Annual Premium	This section shall display the average annual premium for both Illinois and the nation. If a rate adjustment is proposed, average annual premiums reflecting the Premium Schedule both before and after the proposed adjustment shall be provided.
Premium Modalization Rules	This section shall display the modalization factors and fees as applicable.

Trend Assumptions – Medical and Insurance	a. This section must describe the trend assumptions used in pricing, which assumptions must be appropriate for the specific line of business, product design, benefit configuration, and time period. b. All factors affecting the projection of future claims must be presented. c. The trend assumptions shall be presented under two categories: (I) Medical Trend: the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology. In determining medical trend from underlying data, the analysis: (A) Shall use credible data and make appropriate adjustments to claims data to isolate the effects of medical trend only; and (B) Shall not include the effects of underwriting wear-off, aging, or changes to claim costs due to changes in demographics, policy coverages, geographic distribution, or reinsurance. (II) Insurance Trend: the combined effect of underwriting wear-off, deductible leveraging, anti-selection resulting from rate increases, and discontinuance of new sales. Medical trend must be determined or assumed before insurance trend can be determined. "Underwriting wear-off" means the gradual increase from initial low expected claims which result from underwriting selection to higher expected claims for later (ultimate) durations.
Minimum Required Loss Ratio for the Form	This section shall state the minimum required loss ratio for the form.
Anticipated Loss Ratio	This section shall provide the anticipated loss ratio and the interest rate(s) used in the determination of the value. The target loss ratio for an annually rated group policy form may be reduced upon demonstration and justification of an increase in administrative costs, but not less than the minimum required standard for the policy form. When claim cost projections include the effect of medical trend, premium projections shall also include the effects of such trend.
Distribution of Business	This section shall provide the anticipated issue distribution for new policy forms and the actual in-force distribution for rate revisions. All criteria having a rating difference shall be included.
Contingency and Risk Margins	This section shall describe the contingency and risk margins anticipated for the Policy Form at the time of the filing.
Experience on the Form (Past and Future Anticipated)	This section shall display the actual experience on the form and that expected for the future and shall include: a. Past Experience: Experience from inception (or the last 3 years for annually rated group coverages) shall be displayed, although, with proper interest adjustment, the experience for calendar years more than 10 years in the past may be combined. Excluding annually rated group policy forms, earned premiums, actual incurred and expected claims experience shall also be displayed, for each policy year or issue year, within the calendar year. The following information shall be displayed : (I) Year, (II) Earned premium, (III) Paid claims, for past periods only (IV) Change in claim liability and reserve, for past periods only. These reserves shall be updated to reflect actual claim runoff as it develops. (V) Incurred claims (=(III)+(IV)), (VI) Incurred loss ratio (=(V)/(II)), b. Future periods where the projected values are based on in-force experience: (I) The experience period used as the basis for determining projected values shall be clearly indicated. (II) The projected values shall represent the experience that the actuary fully expects to occur. In order for the proposed premium schedule or rate change to be reasonable, the underlying experience used as the basis of a projection must be reflective of the experience anticipated over the rating period.

Experience on the Form (Past and Future Anticipated) – cont.	(III) Projection years shall include columns I, II, V and VI as indicated in sub-subparagraph 23.a. above. (IV) Projections shall be based on existing in-force business with no new sales assumed during the projection period. (V) A summary of the historical and projected data shall be provided for all experience columns providing the accumulated past values, future values, and lifetime values both with and without interest and with and without the proposed rate change. c. Projections for new forms or otherwise not based on experience shall: (I) Project an initial assumed cohort of new business with no new sales assumed during the projection period; and (II) Shall display columns for each policy year, anticipated premiums, claims and loss ratios and include the lifetime values both with and without interest. d. The experience exhibit shall be submitted electronically in an active Excel worksheet or workbook, i.e., not converted to a PDF or other image format. Formulas used to develop other values in the worksheet or workbook shall be included.
Lifetime Loss Ratio	This is the loss ratio determined over the rating period for annually rated groups. For other forms, the loss ratio is derived by dividing A by B where: a. A is the accumulation with interest of incurred claims from the original effective date of the policy form to the evaluation date, and the present value of future incurred claims over the entire future lifetime of the policy form; and b. B is the accumulation with interest of earned premiums from the original effective date of the policy form to the evaluation date, and the present value of future earned premiums over the entire future lifetime of the policy form. c. The evaluation date is the endpoint of the actual experience review period.
History of Rate Adjustments	This section shall list the approval dates and average percentage rate adjustments in Illinois since inception.
Number of Policyholders	This section shall report the number of Illinois policyholders/certificate holders who will be affected by the proposed rate revision, and the number of policyholders/certificate holders in-force nationwide.
Proposed Effective Date	This section shall state the proposed effective date and method of the proposed rate revision implementation.
Actuarial Certification	a. Certification by a qualified actuary that: (I) The entire rate filing is in compliance with the applicable laws and regulations of the State of Illinois and the applicable Federal statues and regulations; (II) Complies with all applicable Actuarial Standards of Practice; and b. In making the certification: (I) The actuary shall recognize that the certification is a prescribed statement of actuarial opinion. c. A qualified actuary is one who is a member of the Society of Actuaries or the American Academy of Actuaries, and who is qualified in the area of health insurance. d. If the actuary is unable to provide the certification without qualification, a detailed explanation and reason for the qualification shall be provided as part of the certification.

EXPERIENCE SPREADSHEET FORMAT

Projection Assumptions:

Rate increase effective XX/XX/XXXX:	
Claim Trend:	
Insurance Trend:	
Lapse Rate:	
Aging:	

	Calendar Year	Earned Premium	Paid Claims	Change in Claim Liability & Reserve	Incurred Claims	Loss Ratio
	INCEPTION					
	…					
	…					
	…					
	…					
PAST	2009					
FUTURE	2010			XXX		
	2011			XXX		
	…			XXX		
	…			XXX		
	…			XXX		
	…			XXX		
	…			XXX		
	…			XXX		
	END OF PROJECTION PERIOD			XXX		

Totals:		Paid Claims	Change in Claim Liability & Reserve
Totals:	Past	xxx	xxx
	Future	xxx	xxx
	Lifetime	xxx	xxx

With Interest: x.x%

Totals:		Paid Claims	Change in Claim Liability & Reserve
Totals:	Past	xxx	xxx
	Future	xxx	xxx
	Lifetime	xxx	xxx

Illinois Department of Insurance

PAT QUINN
Governor

MICHAEL T. McRAITH
Director

TO: ALL COMPANIES AUTHORIZED TO WRITE HEALTH INSURANCE IN ILLINOIS

FROM: MICHAEL T. MCRAITH MTM

DATE: FEBRUARY 1, 2011

RE: COMPANY BULLETIN 2011-02

REQUIRED SUBMISSION AND APPROVAL OF ACTUARIAL MEMORANDUM AND JUSTIFICATION REVIEW STANDARDS FOR NEW AND RENEWAL HEALTH RATES – ILLINOIS WEB PORTAL

Pursuant to Section 2794 of the Public Health Service Act, added by Section 1003 of the Federal Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, the Department of Insurance has established a premium reporting and review process.

The purpose of this bulletin is to offer health insurers assistance in meeting this requirement by clarifying affected rate filings and providing a web portal through which electronic filings and actuarial memoranda may be electronically reported. This reporting process does not replace existing requirements for the submission of these materials through SERFF. The Department of Insurance issued a previous Company Bulletin (CB 2010-08) which provided specific guidance on the required submission of the actuarial memorandum and justification review standards for new and renewal health rates:

http://insurance.illinois.gov/cb/2010/cb2010-08.pdf

The bulletin specified that the Department would establish on or before February 1, 2011, a website through which the electronic reporting of these rates and actuarial memorandum would be available. The initial Company Bulletin may be reviewed to provide guidance on the filing of the rates through SERFF and/or CD ROM.

As a reminder, public disclosure of information on rate modification and justification used to establish such modification is required by federal law.

Scope and Process

Any insurance company, health maintenance organization or health service plan authorized to offer health insurance coverage, as that term is defined in the Illinois Health Insurance Portability and Accountability Act [215 ILCS 97/1 et.seq.], must file all proposed rate increases with the Department prior to its use.

Proposed rate increases will be reviewed by the Department to determine whether such increase is: (i) excessive – unreasonably high in relation to the benefits provided and/or unsupported by substantial evidence or assumptions; (ii) unjustified – incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined; or (iii) unfairly discriminatory – differences for a particular product between insureds/members within similar risk categories, which do not reasonably correspond to differences in expected costs.

Illinois' Web Portal

Illinois' web portal is now available to electronically accept required submissions of actuarial memoranda and the justification for new and renewal health rates. Through the web portal, insurers may access and complete both the Rate Data Collection Form and the Rate Filing Actuarial Memorandum and Justification Review Standards Form.

You can go to https://insurance.illinois.gov/Applications/HealthRateReview/ to submit your rate data and rate filing actuarial memorandum and justification review standards. In order to use the web portal, you must first register your company with the Department. If you did not receive an email concerning the availability of the Department's Web Portal or receive specific instructions containing a verification code required to complete the registration, please submit such a request through DOI.HealthRateReview@illinois.gov.

Once you have registered, an email containing your temporary password will be sent to the provided email address. You may then use your registered email address and temporary password to log into the website to submit your data.

The Department will modify the directions in this bulletin if further guidance from the Department of Health and Human Services renders such modification necessary. Please direct questions regarding the Rate Data Collection Form and the Rate Filing Actuarial Memorandum and Justification Review Standards Form to Mr. Gerald Lucht at DOI.HealthRateReview@illinois.gov.

For technical questions regarding the electronic filing of the Rate Data Collection Form and the Rate Filing Actuarial Memorandum and Justification Review Standards Form, please contact DOI.Webmaster@illinois.gov.

320 West Washington St.
Springfield, Illinois 62767-0001
(217) 782-4515
http://insurance.illinois.gov

HB1501

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB1501

by Rep. Greg Harris

SYNOPSIS AS INTRODUCED:

215 ILCS 5/355	from Ch. 73, par. 967
215 ILCS 5/355.01 new	
215 ILCS 5/367	from Ch. 73, par. 979
215 ILCS 125/2-11.1 new	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2

Amends the Illinois Insurance Code. Sets forth provisions concerning the filing of premium rates with respect to health insurance coverage offered by a health insurance issuer and premium rate changes. Provides that in addition to filing premium rates, a company shall notify the Director of Insurance whenever a policy form has been closed for sale. Sets forth provisions concerning health insurance premium rates and prior approval of the Director. Contains provisions concerning appeal and requests for actuarial reasoning and data. Makes changes to the provision concerning group accident and health insurance. Amends the Health Maintenance Organization Act. Sets forth provisions concerning premium rates and filing and prior approval. Requires that the schedule of base rates for a group or individual contract or evidence of coverage to be used in conjunction with the contract or evidence of coverage be filed with the Director. Further amends the Act to comport with the provisions of the Illinois Insurance Code concerning health insurance premium rates and prior approval. Effective on January 1, 2012.

LRB097 08008 RPM 48129 b

A BILL FOR

1 AN ACT concerning insurance.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 1. This Act may be cited as the Health Insurance
5 Rate Fairness and Affordability Act.

6 Section 5. The Illinois Insurance Code is amended by
7 changing Sections 355 and 367 and by adding Section 355.01 as
8 follows:

9 (215 ILCS 5/355) (from Ch. 73, par. 967)
10 Sec. 355. Accident and health policies-Provisions.)
11 (a) No individual or group policy of insurance against loss
12 or damage from the sickness, or from the bodily injury or death
13 of the insured by accident shall be issued or delivered to any
14 person in this State until a copy of the form thereof and of
15 the classification of risks and the premium rates pertaining
16 thereto have been filed with the Director; nor shall it be so
17 issued or delivered until the Director shall have approved such
18 policy pursuant to the provisions of Section 143. If the
19 Director disapproves the policy form he shall make a written
20 decision stating the respects in which such form does not
21 comply with the requirements of law and shall deliver a copy
22 thereof to the company and it shall be unlawful thereafter for

1 any such company to issue any policy in such form.
2 (b) With respect to health insurance coverage offered by a
3 health insurance issuer, a filing of premium rates pursuant to
4 subsection (a) of this Section shall not be complete unless it
5 contains all information necessary to justify the premium rate
6 and such other information as the Director may require to
7 determine the rate's compliance with Section 355.01 of this
8 Code. Each rate filing must also include a certification by a
9 qualified actuary that to the best of the actuary's knowledge
10 and judgment the rate filing is in compliance with applicable
11 laws and regulations and that the benefits are reasonable in
12 relation to premiums.
13 (c) With respect to premium rate changes, the filing under
14 subsection (a) of this Section shall clearly indicate the
15 percentage change from the previously filed rate and the
16 percentage change from the rate that was in effect 12 months
17 prior to the proposed effective date of such rate.
18 (d) In addition to filing premium rates, a company shall
19 notify the Director whenever a policy form subject to this
20 Section has been closed for sale.
21 (e) As used in this Section, the terms "health insurance
22 coverage" and "health insurance issuer" have the meanings given
23 those terms in the Illinois Health Insurance Portability and
24 Accountability Act.
25 (Source: P.A. 79-777.)

1 (215 ILCS 5/355.01 new)
2 Sec. 355.01. Health insurance premium rates; prior
3 approval.
4 (a) With respect to health insurance coverage offered by a
5 health insurance issuer, no such policy, plan, or contract
6 shall be issued or delivered to any person in this State until
7 the classification of risks and the premium rates pertaining
8 thereto have been approved by the Director under this Section.
9 Any subsequent addition to or change in premium rates shall
10 also be subject to the Director's approval under this Section.
11 In all cases the Director shall approve or disapprove a premium
12 rate within 60 days after submission unless the Director
13 extends by not more than an additional 60 days the period
14 within which the Director shall approve or disapprove such
15 premium rate by giving written notice to the health insurance
16 issuer of the extension before expiration of the initial 60-day
17 period.
18 (b) The Director shall disapprove a premium rate under this
19 Section if:
20 (1) the benefits provided are not reasonable in
21 relation to the premium charged; or
22 (2) the proposed premium rate is excessive,
23 inadequate, unjustified, or unfairly discriminatory.
24 The party proposing a rate has the burden of proving by
25 clear and convincing evidence that the rate does not violate
26 this Section.

1 (c) With respect to premium rate changes, the Director's
2 review of a proposed rate change shall include an examination
3 of the factors set forth in regulation promulgated by the
4 Secretary of the U.S. Department of Health and Human Services
5 pursuant to Section 2794 of the Public Health Service Act, as
6 added by the Patient Protection and Affordable Care Act (Pub.
7 L. 111-148), for the purpose of determining whether a State has
8 an effective rate review program.
9 (d) The Director shall notify a health insurance issuer in
10 writing of the approval or disapproval of a premium rate under
11 this Section, and the notice shall be posted on the
12 Department's website. If the Director disapproves the premium
13 rate, then the written notice shall clearly state the respects
14 in which the premium rate does not comply with the requirements
15 of law and it shall be unlawful thereafter for any such health
16 insurance issuer to use the premium rate. The written notice of
17 disapproval shall also advise the health insurance issuer of
18 the right to a hearing under subsection (f) of this Section.
19 (e) With respect to a rate change approved under this
20 Section, the rate change shall take effect no sooner than 30
21 days after the written approval is mailed by the Director. The
22 rate change shall be stayed if within the 30-day period a
23 written request for a hearing is filed with the Director under
24 subsection (f) of this Section. A health insurance issuer shall
25 notify in writing all policyholders to which such rate change
26 applies at least 30 days prior to the effective date of the

1 rate change. The written notice shall also advise the
2 policyholders of the right to a hearing under subsection (d) of
3 this Section.
4 (f) A health insurance issuer may appeal a decision by the
5 Director under this Section by making a written request for a
6 hearing before the Director within 30 days after receiving the
7 written notice under subsections (d) or (g) of this Section.
8 One percent or 25 of the covered lives (whichever is greater)
9 to which such rate change applies may appeal a decision by the
10 Director under this Section by submitting a written request to
11 the Department for a hearing before the Director within 30 days
12 after the Department posts public notice under subsection (d)
13 of this Section.
14 (g) The Director may request actuarial reasons and data, as
15 well as other information, needed to determine if a previously
16 approved rate continues to satisfy the requirements of this
17 Section. The Director may withdraw approval of any rate that
18 has been previously approved on any of the grounds stated in
19 subsection (b) of this Section. The Director shall notify a
20 health insurance issuer in writing of the withdrawal of
21 approval. The written notice shall clearly state the respects
22 in which the premium rate ceases to comply with the
23 requirements of law and shall advise the health insurance
24 issuer of the right to a hearing under subsection (f) of this
25 Section. The written withdrawal of approval shall take effect
26 30 days after the date of mailing but shall be stayed if within

1 the 30-day period a written request for hearing is filed with
2 the Director under subsection (f) of this Section.
3 (h) As used in this Section, the terms "health insurance
4 coverage" and "health insurance issuer" have the meanings given
5 those terms in the Illinois Health Insurance Portability and
6 Accountability Act.

7 (215 ILCS 5/367) (from Ch. 73, par. 979)
8 Sec. 367. Group accident and health insurance.
9 (1) Group accident and health insurance is hereby declared
10 to be that form of accident and health insurance covering not
11 less than 2 employees, members, or employees of members,
12 written under a master policy issued to any governmental
13 corporation, unit, agency or department thereof, or to any
14 corporation, copartnership, individual employer, or to any
15 association upon application of an executive officer or trustee
16 of such association having a constitution or bylaws and formed
17 in good faith for purposes other than that of obtaining
18 insurance, where officers, members, employees, employees of
19 members or classes or department thereof, may be insured for
20 their individual benefit. In addition a group accident and
21 health policy may be written to insure any group which may be
22 insured under a group life insurance policy. The term
23 "employees" shall include the officers, managers and employees
24 of subsidiary or affiliated corporations, and the individual
25 proprietors, partners and employees of affiliated individuals

and firms, when the business of such subsidiary or affiliated corporations, firms or individuals, is controlled by a common employer through stock ownership, contract or otherwise.

(2) Any insurance company authorized to write accident and health insurance in this State shall have power to issue group accident and health policies. No policy of group accident and health insurance may be issued or delivered in this State unless a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto shall have been filed with the department and approved by it in accordance with Section 355 and Section 355.01, and it contains in substance those provisions contained in Sections 357.1 through 357.30 as may be applicable to group accident and health insurance and the following provisions:

(a) A provision that the policy, the application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees, members or employees of members insured shall constitute the entire contract between the parties, and that all statements made by the employer, or the executive officer or trustee, or by the individual employees, members or employees of members shall (in the absence of fraud) be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in a written application.

1 (b) A provision that the insurer will issue to the
2 employer, or to the executive officer or trustee of the
3 association, for delivery to the employee, member or
4 employee of a member, who is insured under such policy, an
5 individual certificate setting forth a statement as to the
6 insurance protection to which he is entitled and to whom
7 payable.
8 (c) A provision that to the group or class thereof
9 originally insured shall be added from time to time all new
10 employees of the employer, members of the association or
11 employees of members eligible to and applying for insurance
12 in such group or class.
13 (3) Anything in this code to the contrary notwithstanding,
14 any group accident and health policy may provide that all or
15 any portion of any indemnities provided by any such policy on
16 account of hospital, nursing, medical or surgical services,
17 may, at the insurer's option, be paid directly to the hospital
18 or person rendering such services; but the policy may not
19 require that the service be rendered by a particular hospital
20 or person. Payment so made shall discharge the insurer's
21 obligation with respect to the amount of insurance so paid.
22 Nothing in this subsection (3) shall prohibit an insurer from
23 providing incentives for insureds to utilize the services of a
24 particular hospital or person.
25 (4) Special group policies may be issued to school
26 districts providing medical or hospital service, or both, for

1 pupils of the district injured while participating in any
2 athletic activity under the jurisdiction of or sponsored or
3 controlled by the district or the authorities of any school
4 thereof. The provisions of this Section governing the issuance
5 of group accident and health insurance shall, insofar as
6 applicable, control the issuance of such policies issued to
7 schools.

8 (5) No policy of group accident and health insurance may be
9 issued or delivered in this State unless it provides that upon
10 the death of the insured employee or group member the
11 dependents' coverage, if any, continues for a period of at
12 least 90 days subject to any other policy provisions relating
13 to termination of dependents' coverage.

14 (6) No group hospital policy covering miscellaneous
15 hospital expenses issued or delivered in this State shall
16 contain any exception or exclusion from coverage which would
17 preclude the payment of expenses incurred for the processing
18 and administration of blood and its components.

19 (7) No policy of group accident and health insurance,
20 delivered in this State more than 120 days after the effective
21 day of the Section, which provides inpatient hospital coverage
22 for sicknesses shall exclude from such coverage the treatment
23 of alcoholism. This subsection shall not apply to a policy
24 which covers only specified sicknesses.

25 (8) No policy of group accident and health insurance, which
26 provides benefits for hospital or medical expenses based upon

1 the actual expenses incurred, issued or delivered in this State
2 shall contain any specific exception to coverage which would
3 preclude the payment of actual expenses incurred in the
4 examination and testing of a victim of an offense defined in
5 Sections 12-13 through 12-16 of the Criminal Code of 1961, or
6 an attempt to commit such offense, to establish that sexual
7 contact did occur or did not occur, and to establish the
8 presence or absence of sexually transmitted disease or
9 infection, and examination and treatment of injuries and trauma
10 sustained by the victim of such offense, arising out of the
11 offense. Every group policy of accident and health insurance
12 which specifically provides benefits for routine physical
13 examinations shall provide full coverage for expenses incurred
14 in the examination and testing of a victim of an offense
15 defined in Sections 12-13 through 12-16 of the Criminal Code of
16 1961, or an attempt to commit such offense, as set forth in
17 this Section. This subsection shall not apply to a policy which
18 covers hospital and medical expenses for specified illnesses
19 and injuries only.
20 (9) For purposes of enabling the recovery of State funds,
21 any insurance carrier subject to this Section shall upon
22 reasonable demand by the Department of Public Health disclose
23 the names and identities of its insureds entitled to benefits
24 under this provision to the Department of Public Health
25 whenever the Department of Public Health has determined that it
26 has paid, or is about to pay, hospital or medical expenses for

1 which an insurance carrier is liable under this Section. All
2 information received by the Department of Public Health under
3 this provision shall be held on a confidential basis and shall
4 not be subject to subpoena and shall not be made public by the
5 Department of Public Health or used for any purpose other than
6 that authorized by this Section.
7 (10) Whenever the Department of Public Health finds that it
8 has paid all or part of any hospital or medical expenses which
9 an insurance carrier is obligated to pay under this Section,
10 the Department of Public Health shall be entitled to receive
11 reimbursement for its payments from such insurance carrier
12 provided that the Department of Public Health has notified the
13 insurance carrier of its claim before the carrier has paid the
14 benefits to its insureds or the insureds' assignees.
15 (11) (a) No group hospital, medical or surgical expense
16 policy shall contain any provision whereby benefits
17 otherwise payable thereunder are subject to reduction
18 solely on account of the existence of similar benefits
19 provided under other group or group-type accident and
20 sickness insurance policies where such reduction would
21 operate to reduce total benefits payable under these
22 policies below an amount equal to 100% of total allowable
23 expenses provided under these policies.
24 (b) When dependents of insureds are covered under 2
25 policies, both of which contain coordination of benefits
26 provisions, benefits of the policy of the insured whose

1 birthday falls earlier in the year are determined before
2 those of the policy of the insured whose birthday falls
3 later in the year. Birthday, as used herein, refers only to
4 the month and day in a calendar year, not the year in which
5 the person was born. The Department of Insurance shall
6 promulgate rules defining the order of benefit
7 determination pursuant to this paragraph (b).
8 (12) Every group policy under this Section shall be subject
9 to the provisions of Sections 356g and 356n of this Code.
10 (13) No accident and health insurer providing coverage for
11 hospital or medical expenses on an expense incurred basis shall
12 deny reimbursement for an otherwise covered expense incurred
13 for any organ transplantation procedure solely on the basis
14 that such procedure is deemed experimental or investigational
15 unless supported by the determination of the Office of Health
16 Care Technology Assessment within the Agency for Health Care
17 Policy and Research within the federal Department of Health and
18 Human Services that such procedure is either experimental or
19 investigational or that there is insufficient data or
20 experience to determine whether an organ transplantation
21 procedure is clinically acceptable. If an accident and health
22 insurer has made written request, or had one made on its behalf
23 by a national organization, for determination by the Office of
24 Health Care Technology Assessment within the Agency for Health
25 Care Policy and Research within the federal Department of
26 Health and Human Services as to whether a specific organ

1 transplantation procedure is clinically acceptable and said
2 organization fails to respond to such a request within a period
3 of 90 days, the failure to act may be deemed a determination
4 that the procedure is deemed to be experimental or
5 investigational.
6 (14) Whenever a claim for benefits by an insured under a
7 dental prepayment program is denied or reduced, based on the
8 review of x-ray films, such review must be performed by a
9 dentist.
10 (Source: P.A. 91-549, eff. 8-14-99.)

11 Section 10. The Health Maintenance Organization Act is
12 amended by changing Section 5-3 and by adding Section 2-11.1 as
13 follows:

14 (215 ILCS 125/2-11.1 new)
15 Sec. 2-11.1. Premium rates; filing and prior approval.
16 (a) Notwithstanding any other provision of law, no group or
17 individual contract or evidence of coverage shall be issued or
18 delivered in this State until the schedule of base rates to be
19 used in conjunction with the contract or evidence of coverage
20 has been filed with the Director; nor shall it be issued or
21 delivered until the Director shall have approved such base
22 rates pursuant to the provisions of Section 355.01 of the
23 Illinois Insurance Code. Any subsequent addition to or change
24 in rates is also subject to this Section.

1 (b) A filing of rates under this Section shall not be
2 complete unless it contains all information necessary to
3 justify the premium rate and such other information as the
4 Director may require to determine the rate's compliance with
5 Section 355.01 of the Illinois Insurance Code. Each rate filing
6 must also include a certification by a qualified actuary that
7 to the best of the actuary's knowledge and judgment the rate
8 filing is in compliance with the applicable laws and
9 regulations of this State and that the benefits are reasonable
10 in relation to premiums.
11 (c) With respect to rate changes, the filing under this
12 Section shall clearly indicate the percentage change from the
13 previously filed rate and the percentage change from the rate
14 that was in effect 12 months prior to the proposed effective
15 date of such rate.
16 (d) In addition to filing premium rates, a health
17 maintenance organization shall notify the Director whenever a
18 plan subject to this Section has been closed for sale.

19 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)
20 Sec. 5-3. Insurance Code provisions.
21 (a) Health Maintenance Organizations shall be subject to
22 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
23 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
24 154.6, 154.7, 154.8, 155.04, 355.01, 355.2, 356g.5-1, 356m,
25 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8,

1 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15,
2 356z.17, 356z.18, 364.01, 367.2, 367.2-5, 367i, 368a, 368b,
3 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2,
4 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of
5 Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII,
6 XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.
7 (b) For purposes of the Illinois Insurance Code, except for
8 Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health
9 Maintenance Organizations in the following categories are
10 deemed to be "domestic companies":
11 (1) a corporation authorized under the Dental Service
12 Plan Act or the Voluntary Health Services Plans Act;
13 (2) a corporation organized under the laws of this
14 State; or
15 (3) a corporation organized under the laws of another
16 state, 30% or more of the enrollees of which are residents
17 of this State, except a corporation subject to
18 substantially the same requirements in its state of
19 organization as is a "domestic company" under Article VIII
20 1/2 of the Illinois Insurance Code.
21 (c) In considering the merger, consolidation, or other
22 acquisition of control of a Health Maintenance Organization
23 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
24 (1) the Director shall give primary consideration to
25 the continuation of benefits to enrollees and the financial
26 conditions of the acquired Health Maintenance Organization

after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall

1 require.
2 (d) The provisions of Article VIII 1/2 of the Illinois
3 Insurance Code and this Section 5-3 shall apply to the sale by
4 any health maintenance organization of greater than 10% of its
5 enrollee population (including without limitation the health
6 maintenance organization's right, title, and interest in and to
7 its health care certificates).
8 (e) In considering any management contract or service
9 agreement subject to Section 141.1 of the Illinois Insurance
10 Code, the Director (i) shall, in addition to the criteria
11 specified in Section 141.2 of the Illinois Insurance Code, take
12 into account the effect of the management contract or service
13 agreement on the continuation of benefits to enrollees and the
14 financial condition of the health maintenance organization to
15 be managed or serviced, and (ii) need not take into account the
16 effect of the management contract or service agreement on
17 competition.
18 (f) Except for small employer groups as defined in the
19 Small Employer Rating, Renewability and Portability Health
20 Insurance Act and except for medicare supplement policies as
21 defined in Section 363 of the Illinois Insurance Code, a Health
22 Maintenance Organization may by contract agree with a group or
23 other enrollment unit to effect refunds or charge additional
24 premiums under the following terms and conditions:
25 (i) the amount of, and other terms and conditions with
26 respect to, the refund or additional premium are set forth

1 in the group or enrollment unit contract agreed in advance
2 of the period for which a refund is to be paid or
3 additional premium is to be charged (which period shall not
4 be less than one year); and
5 (ii) the amount of the refund or additional premium
6 shall not exceed 20% of the Health Maintenance
7 Organization's profitable or unprofitable experience with
8 respect to the group or other enrollment unit for the
9 period (and, for purposes of a refund or additional
10 premium, the profitable or unprofitable experience shall
11 be calculated taking into account a pro rata share of the
12 Health Maintenance Organization's administrative and
13 marketing expenses, but shall not include any refund to be
14 made or additional premium to be paid pursuant to this
15 subsection (f)). The Health Maintenance Organization and
16 the group or enrollment unit may agree that the profitable
17 or unprofitable experience may be calculated taking into
18 account the refund period and the immediately preceding 2
19 plan years.
20 The Health Maintenance Organization shall include a
21 statement in the evidence of coverage issued to each enrollee
22 describing the possibility of a refund or additional premium,
23 and upon request of any group or enrollment unit, provide to
24 the group or enrollment unit a description of the method used
25 to calculate (1) the Health Maintenance Organization's
26 profitable experience with respect to the group or enrollment

1 unit and the resulting refund to the group or enrollment unit
2 or (2) the Health Maintenance Organization's unprofitable
3 experience with respect to the group or enrollment unit and the
4 resulting additional premium to be paid by the group or
5 enrollment unit.

6 In no event shall the Illinois Health Maintenance
7 Organization Guaranty Association be liable to pay any
8 contractual obligation of an insolvent organization to pay any
9 refund authorized under this Section.

10 (g) Rulemaking authority to implement Public Act 95-1045,
11 if any, is conditioned on the rules being adopted in accordance
12 with all provisions of the Illinois Administrative Procedure
13 Act and all rules and procedures of the Joint Committee on
14 Administrative Rules; any purported rule not so adopted, for
15 whatever reason, is unauthorized.
16 (Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07;
17 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
18 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
19 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff.
20 6-1-10; 96-1000, eff. 7-2-10.)

21 Section 99. Effective date. This Act takes effect January
22 1, 2012.

<u>Contractor Disclosure Information</u>: Information Technology Contracting Services

Name of Consultant: Terry Lindquist

Name of Company: SharePoint Business Solutions, Inc

Term of Contract: January 3, 2011-June 30, 2011

Number of Hours: 975

Rate Per Hour: $98.13/hour

Percentage of Time Dedicated to Premium Rate Review: 50 percent

Description of Services Provided: For the rate review project, Terry is developing and enhancing/maintaining the Illinois Web Portal. The development of the portal is compete, however Terry will be working on several necessary enhancements over the next several months.

Health Insurance Reform and The Affordable Care Act

Health Insurance Premium Increases and Rate Review Authority in Illinois

ILLINOIS DEPARTMENT OF INSURANCE
FEBRUARY 1, 2011

Overview of Presentation

2

- The Affordable Care Act and Federal Requirements
  - An Aside: the reason for the individual mandate.
- Rate Review in Other States
- Current Illinois Law
  - Why is health insurance different from car insurance?
- State of Illinois Actions to Date
- Questions? Please send questions to: **doi.webinars@illinois.gov**

Affordable Care Act – Health Insurance Premium Increases

- Effective upon enactment, the Affordable Care Act (ACA) establishes a process for the joint review of "unreasonable" rate increases by states and the U.S. Department of Health and Human Services (HHS). [Section 1003; PHSA Sec. 2794]
  - Beginning in 2014, this review will include premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. [Section 1003; PHSA Sec. 2794(b)(2)]
  - In addition, an Exchange must "consider" information regarding premium increases "when determining whether to make a health plan available through the Exchange." [Sec. 1311(e)(2)]

Affordable Care Act – Health Insurance Premium Increases

Proposed Regulations (45 CFR Part 154):

(Opportunity for public comment until 02/22/11)

- All insurers seeking a rate increase of 10% or more will be required to publicly disclose information justifying the rate increase.
  - States with "effective rate review programs" will determine whether the rate increase is unreasonable.
  - In states that do not have an "effective rate review program," HHS will determine propriety.
- In states without rate review authority, the proposed regulations do not prevent insurers from implementing "unreasonable" rate increases.

Rate Review in Other States

5

- In 30 other states, insurance regulators have the authority to protect consumers against unreasonable rate increases.
  - State approaches vary considerably.
    - Minnesota – prior approval by the Insurance Commissioner before a premium rate becomes effective.
    - Alaska – prior approval only in cases where the premium rate increases by 10% or more.
- Nearby states with "prior approval" authority include Indiana, Iowa, Minnesota, Tennessee, and Ohio.

Rate Review and Premiums

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PREMIUMS V. RATE REVIEW AUTHORITY - INDIVIDUAL MARKET				
STATE	SINGLE AVERAGE MONTHLY PREMIUM (2009)	FAMILY AVERAGE MONTHLY PREMIUM (2009)	PREMIUM RANK (1 = Lowest 29 = Highest)	RATE REVIEW AUTHORITY
Iowa	$2,606	$5,609	1	Prior approval
North Carolina	$2,613	$5,120	2	Prior approval
Ohio	$2,724	$5,701	4	Prior approval
Illinois	$2,843	$6,317	8	N/A
Montana	$3,305	$5,968	23	N/A
Maine	$4,061	$7,260	26	N/A

Rate Review and Premiums

PREMIUMS V. RATE REVIEW AUTHORITY - SMALL GROUP MARKET				
STATE	SINGLE AVERAGE MONTHLY PREMIUM (2008)	FAMILY AVERAGE MONTHLY PREMIUM (2008)	PREMIUM RANK (1 = Lowest 47 = Highest)	RATE REVIEW AUTHORITY
Washington	$198	$521	1	Prior Approval
North Dakota	$250	$660	2	Prior Approval
Tennessee	$274	$724	3	Prior Approval
Oregon	$275	$726	4	Prior Approval
Illinois	$393	$1,035	37	N/A
Utah	$397	$1,046	38	N/A
Wyoming	$412	$1,087	42	N/A

Rate Review and Premiums

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PREMIUMS V. BENEFIT MANDATES - SMALL GROUP MARKET					
STATE	SINGLE AVERAGE MONTHLY PREMIUM (2008)	FAMILY AVERAGE MONTHLY PREMIUM (2008)	PREMIUM RANK (1 = Lowest 47 = Highest)	NUMBER OF MANDATES	MANDATE RANK (1 =Most 51 = Fewest)
Washington	$198	$521	1	57	5
Virginia	$313	$825	11	60	4
Illinois	$393	$1,035	37	47	19
Wyoming	$412	$1,087	42	34	33
Alaska	$504	$1,329	47	32	37

Sources:
Average Premiums: *AHIP Center for Policy & Research*
Mandates: *Council for Affordable Health Insurance*
Rate Review Authority: *NAIC Compendium of State Laws on Insurance Topics* (full cites below)

Health Insurance Premiums in Illinois

9

- Many factors influence the "average premium" paid by Illinois families. In the individual market:
  - Individuals can be denied health insurance for any reason other than "race, color, religion or national origin." (215 ILCS 5/424)
  - Individuals can be offered insurance that excludes coverage for preexisting conditions.
    - From 2007-2009, 36% of adults were denied coverage, charged a higher premium, or offered coverage excluding treatment for a preexisting condition (Commonwealth Fund Issue Brief, July 2009).
  - The actual premium an individual pays will vary depending on the person's health status, gender, age, geography, and renewal penalty.
    - Illinois law does not restrict the amount of increase attributable to any rating factor.

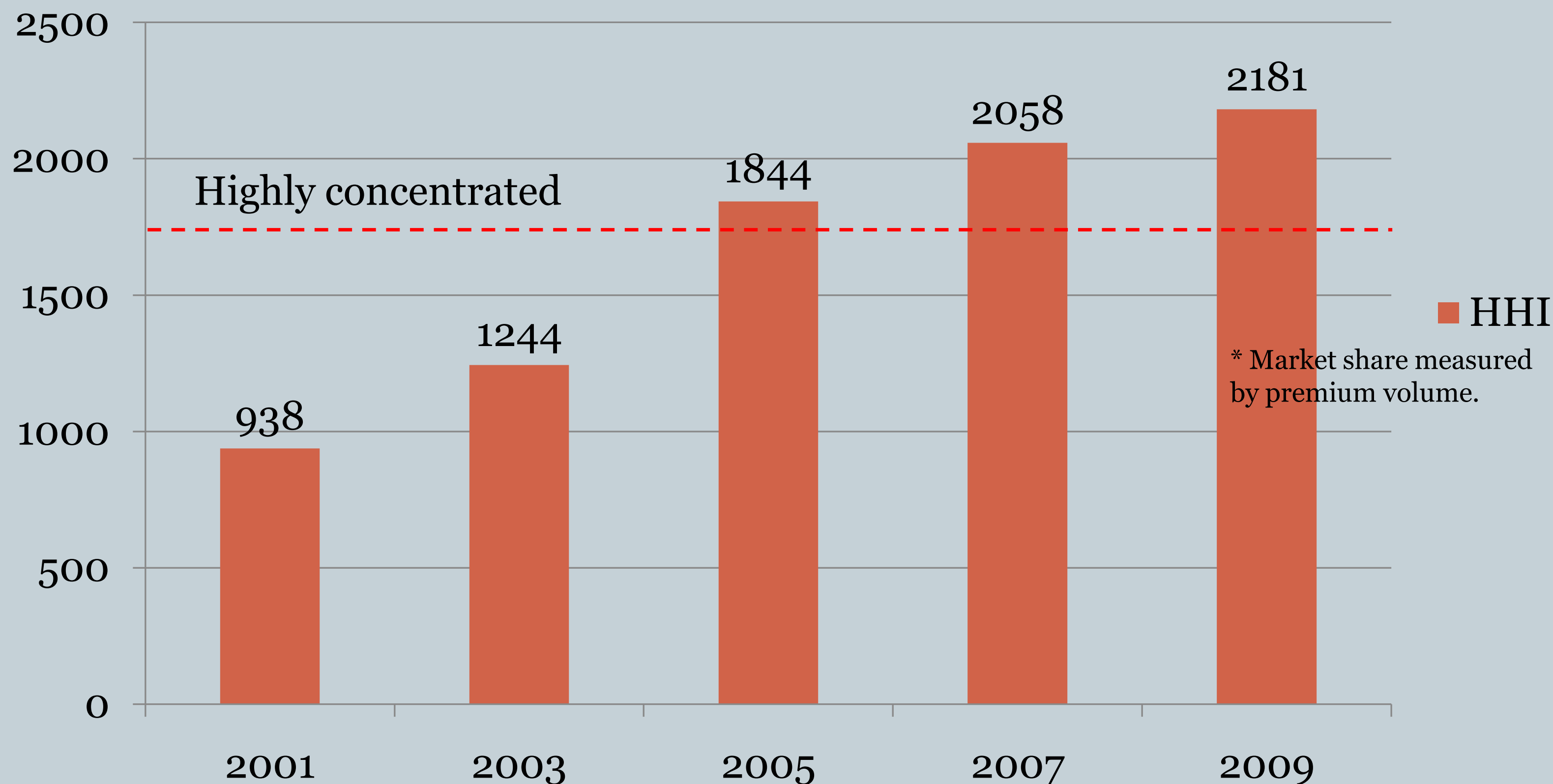
Illinois Market Concentration

10

- 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 Market Concentration

11



Current Illinois Law

12

- **Current Illinois law:**
  - In general, does not restrict health insurance premium increases.
  - Does not vest in the Department any rate review or approval authority.
    - Before enactment of the ACA, most plans were not required to even inform the Department of rate changes or rate amounts for group policies.
  - Gives small businesses (2-50 employees) nominal protection against rate increases.

Current Illinois Law

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Small Group Market (2-50 employees)

- Small Employer Health Insurance Rating Act (215 ILCS 93/1 *et seq.*):
  - "Rate bands" limit variation in premium charged to small employers based on health status of employees.
  - No limit on increase at renewal.
    - Insurers must submit annual "certification of compliance."
- Result: Small businesses remain vulnerable to onerous rate increases.

Current Illinois Law

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Individual Market

- All plans offered in the individual market must file premium rates with the Department (215 ILCS 5/355; 50 Ill. Adm. Code 5420.60)
  - Some companies offer individual coverage through association or "discretionary group" plans, and do not file rates for those plans.
- Illinois law does not limit the premiums that can be charged to any individual or the amount of any rate increase.

DOI Actions to Date

- **Individual Major Medical Health Policy Rate Filing Report**
  - Shows rate increases of up to 80% dating back to 2005—well before enactment of the ACA.
    - http://insurance.illinois.gov/reports/special_reports/IMMHPRFRG.pdf
- **Company Bulletin CB2010-08**
  - Requires insurers to submit information justifying premium rates and rate increases for all individual and group plans.
    - http://insurance.illinois.gov/cb/2010/cb2010-08.pdf
  - New electronic reporting system established, effective February 1, 2011.

DOI Actions to Date

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- **Rate Review Grant**
  - In September 2010, the Department applied for and was awarded a $1 million federal grant to enhance its rate review capacity.
    - http://insurance.illinois.gov/hiric/resources/premiumreviewapplication_full.pdf
  - As outlined in the grant application, the Department will use grant dollars for:
    - Necessary upgrades to technical infrastructure;
    - Additional staff to assist with new filings and reviews; and
    - Enhanced information for consumers and policymakers.
  - DOI will introduce legislation to repose rate approval/denial authority in the Department.
    - Rate increases must be justified, protect insurer solvency, and be fair to patients, families, and employers.

QUESTIONS or COMMENTS?

doi.webinars@illinois.gov

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ADDITIONAL FEEDBACK

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

Premiums v. Rate Regulation - Small Group Market

State	2008 Average Monthly Premium[1]			Rate Regulation[2]	Rate Review Authority[2]	Details[4]	Number of Mandates[3, 4]	Rank (1 = Most; 51=Fewest)
	Single	Family	Rank (1 = Lowest; 50=Highest)					
Washington	$198	$521	1	Adjusted community rating	Prior Approval (30 day deemer)	Small group health plan rate change (60 day deemer: Healthcare service contractor, large group & HMO large group)	57	5
North Dakota	$250	$660	2	Rate bands (13:1 or less)	Prior Approval (60 day deemer)	All health	34	33
Tennessee	$274	$724	3	Rate bands (13.1:1 - 19:1)	Prior Approval (30 day deemer)	All health except experience rated groups	41	25
Oregon	$275	$726	4	Adjusted community rating	Prior Approval	Individual and groups except groups with >25	40	28
Michigan	$280	$738	5	Rate bands (13:1 or less)	N/A	N/A	25	47
Arkansas	$283	$747	6	Rate bands (13.1:1 - 19:1)	N/A	N/A	43	24
Alabama	$296	$781	7	Adjusted community rating	N/A	File for informational purposes (Accident & Health)	21	50
South Dakota	$298	$787	8	Rate bands (13.1:1 - 19:1)	N/A	N/A	30	39
Kentucky	$301	$793	9	Rate bands (13.1:1 - 19:1)	N/A	File and use (All health)	41	25
Arizona	$305	$803	10	Rate bands (13:1 or less)	N/A	N/A	47	19
Virginia	$313	$825	11	No rating structure	N/A	File and receive acknowledgement (group health)	60	4
Missouri	$313	$826	12	Rate bands (19.1:1 - 25.1)	N/A	N/A	41	25
Iowa	$317	$835	13	Rate bands (19.1:1 - 25.1)	Prior Approval (30 day deemer, 60 days prior to effective date)	All health	26	46
Kansas	$318	$839	13	Rate bands (19.1:1 - 25.1)	N/A	File and use (Individual and group)	39	30
South Carolina	$319	$841	15	Rate bands (25.1:1 or greater)	N/A	N/A	29	41
Ohio	$320	$845	16	Rate bands (13.1:1 - 19:1)	Prior Approval (30 day deemer)	All health	29	41
Mississippi	$324	$854	17	Rate bands (13.1:1 - 19:1)	N/A	Filed for review and acknowledgment (All health)	29	41
Georgia	$330	$870	18	Rate bands (25.1:1 or greater)	NA	Information filing required for any rate increase or new program(All health)	45	21
Indiana	$333	$878	19	Rate bands (25.1:1 or greater)	N/A	File and use (30 days) (Group Health) Prior Approval (HMOs)	34	33
Pennsylvania	$337	$889	20	No rating structure	Prior Approval (45 day deemer)	All health: some groups exempt if meet reqs.	52	11
Nevada	$339	$893	21	Rate bands (25.1:1 or greater)	N/A	N/A	52	11
Montana	$340	$896	22	Rate bands (13.1:1 - 19:1)	N/A	N/A	40	28
Louisiana	$349	$919	23	Rate bands (25.1:1 or greater)	N/A	File and use (30 day deemer) (All health)	50	17
California	$349	$920	24	Rate bands (13:1 or less)	N/A	File (Individual and Group Health)	56	8
Minnesota	$353	$932	25	Rate bands (13:1 or less)	Prior Approval (60 day deemer)	All policies.	68	2
North Carolina	$355	$936	26	Rate bands (13:1 or less)	Prior approval	All Health (All individual rate revisions, medical service corp rates)	50	17
Maine	$360	$948	27	Adjusted community rating	N/A	File and use (60 days) (All health)	55	9
Oklahoma	$364	$960	28	Rate bands (19.1:1 - 25.1)	N/A	Rates filed with forms (all health)	38	31
Nebraska	$365	$963	29	Rate bands (13:1 or less)	N/A	Rate schedules filed with policy forms (all health)	32	37
District of Columbia	$366	$966	30	No rating structure	N/A	File and use (60 day review) for hospital and medical services subscriber contracts. Prior approval (90 day deemer) for health products with mental illness benefit.	28	44
Colorado	$368	$969	31	Rate bands (13:1 or less)	Prior Approval (60 day deemer)	No need for prior approval if no increase requested (file and use) (All Health)	51	15
Texas	$369	$972	32	Rate bands (25.1:1 or greater)	N/A	File and use (Accident & Health)	57	5
New Mexico	$380	$1,001	33	Rate bands (13.1:1 - 19:1)	Prior Approval (60 day notice to policy holder)	All health	57	5
Florida	$383	$1,009	34	Rate bands (13.1:1 - 19:1)	Prior Approval (30 day deemer)	All health	52	11
Connecticut	$388	$1,023	35	Adjusted community rating	Prior Approval (45 days)	HMOS	54	10
Wisconsin	$388	$1,024	36	Rate bands (25.1:1 or greater)	N/A	N/A	34	33
Illinois	$393	$1,035	37	Rate bands (25.1:1 or greater)	N/A	N/A	47	19
Utah	$397	$1,046	38	Rate bands (25.1:1 or greater)	N/A	File and use (health benefit plans)	23	49
New Jersey	$401	$1,057	39	Adjusted community rating	N/A	N/A	45	21
New York	$407	$1,072	40	Community rating	Prior Approval	Individual and group	51	15
West Virginia	$412	$1,085	41	Rate bands (13:1 or less)	Prior Approval (60 day deemer)	All health (rate filings required for new products or rate changes; rate filing shall be filed with forms)	38	31
Wyoming	$412	$1,087	42	Rate bands (25.1:1 or greater)	N/A	N/A	34	33
Maryland	$414	$1,091	43	Adjusted community rating	Prior Approval (90 days for changes)	All health	66	3
New Hampshire	$420	$1,107	44	Adjusted community rating	Prior Approval (30 day deemer)	All individual health and small employer med, hospital or surgical. File and use (30 days) all other group health.	44	23
Rhode Island	$432	$1,139	45	Adjusted community rating	Prior Approval (60 day deemer)	All health	70	1
Massachusetts	$458	$1,208	46	Adjusted community rating	N/A	Actuarial certification required (small groups)	52	11
Alaska	$504	$1,329	47	Rate bands (19.1:1 - 25:1)	Prior Approval	File and use if change is no greater than 10% (Each insurer)	32	37
Delaware	*Data not available*			Rate bands (13:1 or less)	N/A	File and use (45 days) (All health)	27	45
Hawaii	*Data not available*			No rating structure	Prior Approval: all managed care plans	Annual compliance filing: approved plans	24	48
Idaho	*Data not available*			Rate bands (19.1:1 - 25.1)	N/A	N/A	13	51
Vermont	*Data not available*			Community rating	Prior approval (30 day deemer)	All health	30	39

[1] AHIP CENTER FOR POLICY & RESEARCH, SMALL GROUP HEALTH INSURANCE IN 2008: A Comprehensive Survey of Premiums, Product Choices and Benefits - P. 9 (Mar. 2009), *available at* http://www.ahipresearch.org/pdfs/smallgroupsurvey.pdf.
[2] NAIC COMPENDIUM OF STATE LAWS ON INSURANCE TOPICS: FILING REQUIREMENTS HEALTH INSURANCE FORMS AND RATES (2009).
[3] VICTORIA C. BUNCE & JP WIESKE, COUNCIL FOR AFFORDABLE HEALTH INSURANCE, HEALTH INSURANCE MANDATES IN THE STATES (2009), available at http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf.
[4] A mandate is a requirement that health insurance policies provide coverage for a certain benefit or category of benefits, thereby spreading the costs for needed medical treatment across all policy holders.
[5] NAIC & THE CENTER FOR INSURANCE POLICY & RESEARCH, HEALTH INSURANCE RATE REGULATION, *available at* http://naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf (last visited Apr. 16, 2010).
[6] *Id.*

Premiums v. Regulation - Individual Market

State	Average Annual Premium 2009[1]			Average Annual Premium 2006-2007[2]			Rate Regulation[6]	Rate Review Authority[3]	Details[7]	Number of Mandates[4,5]	Rank (1 = Most; 50=Fewest)
	Single	Family	Rank (1 = Lowest; 50=Highest)	Single	Family	Rank (1 = Lowest; 50=Highest)					
Wisconsin	*Data not available*			$1,254	$3,087	1	No rating structure	N/A	File and use (30 days) (Individual health)	34	33
Oregon	*Data not available*			$1,297	$4,627	2	Adjusted community rating	Prior Approval	Individual Health	40	28
Utah	*Data not available*			$1,574	$3,259	3	Rating bands	N/A	File and use (Individual Health)	23	49
Michigan	*Data not available*			$1,878	$4,118	4	No rating structure	N/A	File and Use (Individual Health)	25	47
Idaho	*Data not available*			$2,006	$4,501	5	Rating bands	N/A	File and use, certification required (Individual Health)	13	51
Washington				$2,015	*Data not available*	6	Adjusted community rating	N/A	File and use (informational only) (Individual health)	57	5
Arkansas	*Data not available*			$2,153	$4,891	7	No rating structure	Prior approval (30 day deemer)	Individual Health	43	24
Iowa	$2,606	$5,609	1	$2,202	$4,477	8	No rating structure	Prior approval (30 day deemer; 60 days prior to effective	All Health	26	46
Alabama	*Data not available*			$2,208	$4,601	9	No rating structure	N/A	File for informational purposes (Accident & Health)	21	50
Maryland	*Data not available*			$2,208	$5,055	10	No rating structure	Prior approval (90 days for changes)	All Health	66	3
Tennessee	$3,150	$5,957	15	$2,221	$4,804	11	No rating structure	Prior approval (30 day deemer)	All Health	41	25
North Dakota	*Data not available*			$2,316	$4,715	12	Rating bands	Prior approval (60 day deemer)	All Health	34	33
Delaware				$2,346	*Data not available*	13	No rating structure	N/A	File and use (45 days) (All Health)	28	44
Virginia	$3,229	$6,383	21	$2,359	$4,763	14	No rating structure	Prior approval	Individual Health	60	4
Kansas	$2,615	$5,529	3	$2,363	$5,011	15	No rating structure	N/A	File and use (Individual and Group Health)	39	30
Georgia	$3,228	$7,408	20	$2,419	$4,668	16	No rating structure	N/A	Information filling required for any rate increase or new program (All Health)	45	21
Minnesota	$2,978	$7,013	14	$2,424	$5,508	17	Rating bands	Prior approval (60 day deemer)	All policies.	68	2
Oklahoma	$3,220	$5,947	19	$2,435	$4,406	18	No rating structure	N/A	Rates filed with form. (All Health)	38	31
Mississippi	*Data not available*			$2,489	$5,015	19	No rating structure	N/A	File for review and acknowledgement (All Health)	29	41
Ohio	$2,724	$5,701	4	$2,498	$5,303	20	No rating structure	Prior approval (40 day deemer)	All Health	29	41
Illinois	$2,843	$6,317	8	$2,499	$5,438	21	No rating structure	N/A	Rate filing must be submitted with policy form (Individual Health)	47	19
Indiana	$2,930	$6,236	10	$2,504	$5,302	22	No rating structure	Prior approval (30 day deemer)	Individual Health	34	33
Nebraska	$2,950	$5,979	12	$2,505	$5,037	23	No rating structure	N/A	Rate schedules must be filed with policy forms	32	37
Missouri	$2,725	$5,657	5	$2,518	$5,535	24	No rating structure	N/A	N/A	41	25
Colorado	$2,777	$5,939	7	$2,537	$5,446	25	No rating structure	Prior Approval (60 day deemer)	File and use if no increase requested (All Health)	51	15
Kentucky	$2,740	$5,980	6	$2,537	$5,517	26	Rating bands	N/A	File and use (All Health)	41	25
West Virginia	*Data not available*			$2,540	$5,097	27	Rating bands	Prior approval (60 day deemer)	Rate fillings required for new products or rate changes; rate filings filed with forms (All health)	38	31
California	$2,943	$6,567	11	$2,565	$5,884	28	No rating structure	N/A	File (Individual & Group Health)	56	8
Arizona	$2,961	$5,292	13	$2,591	$4,598	29	No rating structure	N/A	Filed for review (HCSO and group health forms are not filed) (Individual Health)	47	19
Wyoming	*Data not available*			$2,688	$5,391	30	No rating structure	N/A	N/A	34	33
Texas	$3,208	$6,459	18	$2,782	$5,501	31	No rating structure	N/A	File and use (Individual Health)	57	5
Montana	$3,305	$5,968	23	$2,866	$5,683	32	No rating structure	N/A	N/A	40	28
South Dakota	*Data not available*			$2,914	$6,585	33	Rating bands	N/A	File and use (30 day deemer) (Individual Health)	30	39
Florida	$3,191	$6,527	16	$2,949	$4,282	34	No rating structure	Prior approval (30 day deemer)	All Health	52	11
South Carolina	$3,204	$6,128	17	$2,981	$5,346	35	No rating structure	Prior approval (90 day deemer)	Individual Health	29	41
North Carolina	$2,613	$5,120	2	$3,080	$7,125	36	No rating structure	Prior approval	All individual rate revisions (All Health)	50	17
Nevada	$3,276	$6,119	22	$3,118	$5,665	37	Rating bands	N/A	File and use (Individual Health)	52	11
Connecticut	$3,503	$8,477	25	$3,326	$7,749	38	No rating structure	Prior Approval (30 day deemer)	Individual Health	54	10
New Mexico				$3,362	*Data not available*	39	Rating bands	Prior approval (60 day notice to policy holder)	All Health	57	5
New Hampshire	$3,427	$7,672	24	$3,368	$7,105	40	Rating bands	Prior approval (30 day deemer)	All individual health and small employer med, hospital or surgical. File and use (30 days) all other group health.	44	23
Louisiana	*Data not available*			$3,377	$7,171	41	No rating structure	N/A	File and use (30 day deemer) (All Health)	50	17
Maine	$4,061	$7,260	26	$3,686	$6,951	42	Adjusted community rating	N/A	N/A	55	9
Pennsylvania	$2,873	$6,381	9	$3,949	$6,535	43	No rating structure	Prior approval (45 day deemer)	All Health	52	11
Rhode Island	$4,779	$11,107	27	$4,412	$10,062	44	Rating bands	Prior approval (60 day deemer)	All Health	70	1
New York	$6,630	$13,296	29	$4,734	$12,254	45	Pure community rating	Prior Approval	Individual Health	51	15
New Jersey	*Data not available*			$5,326	$10,398	46	Adjusted community rating	Prior approval (60 day deemer. Resubmission - 30 day deemer)	Individual Health	45	21
Mass.	$5,143	$13,288	28	$8,537	$16,897	47	Adjusted community rating	Prior approval	Non-group	52	11
Alaska				*Data not available*			No rating structure	Prior approval	File and use if change is no greater than 10% (each insurer)	32	37
District of Columbia				*Data not available*			No rating structure	Prior approval (30 day deemer)	Individual Accident and Sickness	27	45
Hawaii				*Data not available*			No rating structure	Prior approval: all managed care plans	Annual compliance filing: approved plans	24	48
Vermont				*Data not available*			Adjusted community rating	Prior approval (30 day deemer)	All Health	30	39

[1] AHIP CENTER FOR POLICY & RESEARCH, INDIVIDUAL HEALTH INSURANCE 2009: A Comprehensive Survey of Premiums, Availability, and Benefits - p. 6 (Oct. 2009), *available at* http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.
[2] AHIP CENTER FOR POLICY & RESEARCH, INDIVIDUAL HEALTH INSURANCE 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits - p. 8-9 (Dec. 2007), *available at* http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.
3 NAIC COMPENDIUM OF STATE LAWS ON INSURANCE TOPICS: FILING REQUIREMENTS HEALTH INSURANCE FORMS AND RATES (2009).
[4] VICTORIA C. BUNCE & JP WIESKE, COUNCIL FOR AFFORDABLE HEALTH INSURANCE, HEALTH INSURANCE MANDATES IN THE STATES (2009), available at http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf.
[5] A mandate is a requirement that health insurance policies provide coverage for a certain benefit or category of benefits, thereby spreading the costs for needed medical treatment across all policyholders.
[6] NAIC COMPENDIUM OF STATE LAWS ON INSURANCE TOPICS: FILING REQUIREMENTS HEALTH INSURANCE FORMS AND RATES (2009).
[7] *Id.*

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.