Office of Consumer Information and Insurance Oversight

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

State of Illinois – Quarter 4 Report

Date: October 31, 2011

State: Illinois

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

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Project Summary

The State of Illinois continued to make substantial progress toward planning and establishment activities surrounding a State Health Benefits Exchange during the fourth quarter of the Grant period. After working closely with consultants to prepare key Exchange-related findings for public consumption, the State received and published final reports from its Needs Assessment and Background Research consultants. The Needs Assessment report, completed by Health Management Associates (HMA) and Wakely Consulting, provides background information on the federal law, analyzes the State's needs in setting up an Exchange, addresses mandatory Exchange services and functions, projects Exchange start-up and operating costs, and provides insights on policy decisions the State will need to make in designing its Exchange, coordinating it with the Illinois insurance market, and integrating it with existing Illinois public programs. A separate report, prepared by HMA and CSG Government Solutions (CSG), provides the State with information necessary to establish an Integrated Eligibility System (IES). The Background Research report, completed by Deloitte LLP (Deloitte), provides information on the State's health insurance market. The report includes projections for coverage through 2020 and analyzes the impact of the Exchange, Medicaid expansion, and other reforms contained in the Affordable Care Act (ACA). As the following sections describe in detail, the State has already begun implementing many of the recommendations contained in the reports.

The Illinois General Assembly also took measurable steps towards State Exchange implementation during the fourth quarter. In passing SB 1555 in May 2011, the General Assembly created a Legislative Study Committee (LSC) staffed by the Commission on Government Forecasting and Accountability (COGFA) to produce recommendations for the establishment of an Exchange. Members were appointed to the LSC and began holding hearings in August. Over the course of five separate public hearings, the LSC heard testimony from State officials in the Departments of Insurance and Health and Family Services as well as the Illinois Comprehensive Health Insurance Program (State High-Risk Pool) and Office of Health Information Technology. A broad variety of stakeholder groups provided testimony to the LSC as well. Members of the LSC and COGFA produced a draft report of their findings, and one of the committee's Co-Chairpersons, Representative Frank Mautino, introduced legislation to establish an Exchange during the General Assembly's Fall Veto Session.

An intergovernmental working group formed to address eligibility, verification, and enrollment requirements related to the ACA continued to meet during the fourth quarter. The Eligibility Modernization Oversight Group (EMOG) adopted a specific charter and established 5 workgroups—Policy Definition, Business Processes, Technical, User Experience and Change Management. The workgroups are heavily involved in preparation and procurement activities related to the development of the Integrated Eligibility System. A separate interagency team was heavily involved in the Enroll 2014 UX project to design a front-end portal for Exchange customers.

Finally, the State was informed by the federal government during the fourth quarter that its Level 1 Exchange Establishment Grant and its Planning Advanced Planning Document (PAPD) were approved by CCIIO and CMS, respectively.

Core Areas

• *Background Research*

To wrap up the final milestones of the Background Research report work, Deloitte staff presented a midterm report to DOI and HFS staff in July 2011. Deloitte their findings of their targeted population survey to inform the report as it relates to consumer barriers in the marketplace to accessing affordable coverage and explore some of the qualitative aspects of the underinsured. This survey builds upon secondary data describing characteristics of the insured and uninsured in Illinois. The data is based off of information such as age and gender, race, employment status, and barriers to coverage. Following this report, the State worked collaboratively with the vendors to prepare the report for easy consumption by the general public. The final report was presented to DOI, HFS, and the legislature's office in September of 2011 (see *Appendix A*).

Over the course of the last three months, the State also completed its initial Needs Assessment report, in partnership with HMA and subcontractors Wakely Consulting and CSG. This report includes the costs, staffing implications, and infrastructure needs associated with an Exchange, long-term financing options for the Exchange, and options for the State to transition its existing public health program eligibility systems to the level of functionality required under the ACA. The report went into considerable detail on important operational issues, ranging from options for the State Governance structure, actuarial impacts of reforms, analysis of educational and outreach options for the State, and an example five-year administrative and operating budget, including job descriptions and salaries for key staff. Financial projections were illustrated for high, low and moderate enrollment scenarios for 2014 and 2015, providing the State maximum flexibility for different implementation scenarios.

Both reports used insurance company data provided to the Department using the Director of Insurance's targeted market examination authority. In doing so, the Department required a legal review of all reports prior to publication to ensure no information publicized violated the confidentiality requirements of that exam. The final presentation of the HMA report was delivered on September 13, 2011, to DOI, HFS, the Governor's office and other key departments. Wakely consultants presented some of their findings before the Legislative Study Committee for their review. For details about their presentation, please see the "Regulatory or Policy Actions" section of this report. The report was posted online for the public (see *Appendix B*).

• *Stakeholder Involvement*

The Legislative Study Committee (LSC) process initiated by the passage of SB 1555 permitted yet another opportunity for a diverse set of stakeholders to offer opinions directly to legislators in open public forums. Stakeholders provided testimony at three of the LSC's five public hearings. Groups that chose to testify included providers, unions, medical and policy associations, business interest groups as well as independent businesses, carriers, agents and brokers, insurance industry groups, and civic and civil rights organizations. Testimony covered a broad variety of

issues related to the Exchange, including governance structure, governing board composition, financing mechanisms, and operating models. A full list of stakeholder groups testifying before the LSC is attached (see *Appendix C).*

Stakeholder representatives played a prominent role on the State's Enroll UX 2014 project team. In the fourth quarter, Kathy Chan, Associate Director of the IL Maternal and Child Health Coalition, traveled to San Francisco for the project's Design Conference with State officials from the Departments of Insurance, Healthcare and Family Services, and Human Services. If the Enroll UX 2014 Project does move forward to expand its scope to the Small Business Health Options Program (SHOP) Exchange, Illinois intends to make additional opportunities available to Illinois stakeholders outside of government.

- *Program Integration*

Officials from across State government continue to work in close cooperation to successfully integrate the different public health care programs, as mandated by the ACA. The intergovernmental working group to address Integrated Eligibility System (IES, what we initially called the EVE process) continues to meet on a weekly basis. The interagency group, jointly chaired by Mike Koetting (Medicaid) and Kate Gross (Department of Insurance), has named itself the Eligibility Modernization Oversight Group (EMOG), has adopted a specific charter, and established 5 workgroups—Policy Definition, Business Processes, Technical, User Experience and Change Management. Chairs and co-chairs have been named and include all the impacted agencies. In addition, regular meeting with the Illinois Health Information Exchange have begun. (In mid-October, the HIE announced the awarding of a contract for its core system developer. Several components of its development—particularly the patient, provider and plan directories—will be integrated with the IES and the HIX operating system.)

In early September, HHS-CMS approved the APD submitted on July 1, enabling the State to receive 90% match of the Medicaid portion of the IES expenditures. That approval dovetailed with the receipt of the Exchange grant, which is contributing to the overall cost of the IES based on the allocation formula approved as part of both the APD and the Grant submission.

- *Resources & Capabilities*

As noted above, on September 16, 2011, the State received the final Needs Assessment report from HMA and Wakely. The report provided a comprehensive picture of the resources and capabilities necessary for the implementation and operation of an Exchange through 2015. Key findings from the report are described below.

- Start-up costs for the Exchange from 2011 through 2013 are projected at $92.3 million. Operating costs for 2014 are projected to be between $32.1 million and $46.7 million (depending on enrollment). For 2015, costs are expected to increase along with enrollment to $57.4 million to $88.6 million. As participation in the exchange increases the operational costs will decrease due to fixed costs being spread out over a larger membership base. It is anticipated that the operating costs in 2014, on a per-member per-

month basis, will be approximately $10.47-$16.83. A decrease in 2015 is expected, with costs between $8.92 and $13.47.

- A model staffing chart has been created and received from the HMA team. The report includes all necessary full time employees that will be utilized by the Exchange. Included in the report are annual salaries of these titled positions from 2011 – 2013.

- Mandatory operational needs of an Exchange have been established. These needs include: Exchange design, organizational structure and governance, resources and capabilities needed, education and outreach, IT needs assessment, and mandatory regulatory functions.

- Outsourcing is the most viable IT option for the Exchange. As noted in the Wakely report a systems integrator will coordinate the design and development of an outsourced Exchange solution or series of integrated solutions. Contracting out a call center is the most feasible option for the Exchange. Allowing an outside vendor to develop and operate the call center under one contract allows the state to gain valuable knowledge and experience from the vendor.

- It will be necessary to implement the new eligibility system in two phases. The first will bring the State into full compliance with CMS standards and will be complete by 2013. The second will include a complete replacement of legacy enrollment, case management, and benefits processing functions. These efforts are not feasible in the timeframe established for HIX implementation but will be adapted as the second phase by 2015.

- *Governance*

SB 1555, passed in the third quarter, created a Legislative Study Committee (LSC) to produce recommendations regarding the establishment and implementation of an Exchange, including Exchange governance. While LSC did not produce a specific recommendation for governance, one of its Co-Chairpersons, Representative Frank Mautino, introduced an amendment to SB 1313 on October 26, 2011. The amendment calls for the establishment of an Exchange as a quasigovernmental agency, governed by a board of four ex-officio, non-voting members, including the Director of Insurance, the Director of Healthcare and Family Services, the Director of Human Services, the Director of Public Health; two voting members appointed by the Attorney General, including an attorney with experience with public programs such as Medicaid and an Attorney with experience working for the Attorney General's Health Care Bureau; and seven voting members appointed by the Governor, including a consumer representative, a small employer representative, an employee of a small business, a certified health actuary or health economist, an organized labor representative, an individual who qualifies for Medicaid, and one community based provider. SB 1313 is currently assigned to the House Insurance Committee. The Department hopes that SB 1313 or other Exchange legislation passes during the General Assembly's Fall Veto Session, which ends November 10, 2011.

- *Finance*

The Needs Assessment report produced by HMA and Wakely provided estimates for the operating expenses necessary both during the start-up phase (2011-2013) and first two years of Exchange operation (2014 and 2015). Start-up costs for the Exchange from 2011 through 2013 are projected at $92.3 million. Operating costs for 2014 are projected to be between $32.1 million and $46.7 million (depending on enrollment). For 2015, costs are expected to increase along with enrollment to $57.4 million to $88.6 million. These costs are broken down in detail within the report, with cost estimates for several expense categories and Exchange functions, including eligibility determination and enrollment, the Exchange website, customer service, premium billing, IT infrastructure, marketing and advertising, consulting and professional services, employee salary and benefits, general and administrative expenses, facility costs and related expenses, the appeals program, and the navigator program. The report also included estimates of Exchange enrollment, and used these projections to calculate the amount of an assessment on a per-member per-month basis, anticipated to range from $10.47 to $16.83 in 2014 and $8.92 and $13.47 in 2015. Obviously, the exact amount of such an assessment would rise and fall along with Exchange enrollment.

The State hopes the General Assembly will pass legislation enabling the Exchange to become fully self-financing by the January 1, 2015, deadline. Legislation to that effect (SB 1313) is currently assigned to the House Insurance Committee.

- *Technical Infrastructure*

The three major activities of the last quarter in this sphere have been:

- Assimilating the results of the Needs Assessment
  The technology portion of the Needs Assessment was received at the very end of June and has guided ongoing discussion. Illinois is proceeding to develop a new IES, presumably in a two-phase approach. The first phase will create a front end portal (we are heavily involved in UX 2014 activity to guide that development), including connections to the Federal hub, to determine eligibility for Medicaid expansion and the HIX effective in 2013. The second phase will replace the fully depreciated underlying eligibility system for Illinois.

- Procurement activities for the Integrated Eligibility System (IES)
  The first effort was to procure a vendor to assist in the development of the IAPD and the RFP that will procure the DDI vendor for the IES. (A contract was signed with CSG—who did the initial technology Needs Assessment—in mid-October.) The second is to establish, via contract, a PMO to manage the DDI. (Hopefully, that RFP will be posted before the end of October, with an award anticipated in early January.)

- Recruitment of key staff for the IES and the HIX operating system
  HFS has recruited a Senior Policy Advisor to assist with the IES. Gabriela Moroney was hired under contract in early October. She was previously Illinois Director for Real Benefits, an ambitious program to create an integrated eligibility application for several Illinois health and welfare programs. DOI has been recruiting for a Project Manager for the HIX operating system. Several promising candidates were interviewed in September.

- *Business Operations*

The Needs Assessment report provided an in-depth analysis of the business operations and mandatory Exchange functions required by the ACA. Based on this information, the State's Exchange planning team has reorganized its policy planning into five general categories – Consumer Assistance, Plan Management, Eligibility, Enrollment, and Financial Management – and has assigned Staff leads to each of these five policy areas. Staff leads have the responsibility to reexamine all requirements for Exchange business operations (among other activities) and ensure each are captured and incorporated into the technical planning process of at least one policy area. Each ACA requirement that necessitates State action or a policy decision—such as charging an entity with certification, recertification, and decertification of health plans—is included as a milestone with a next step being that each of these individual areas will be assigned a more detailed work plan. As reported in previous quarters, DOI continues to lead responsibility for Exchange operations tasks while HFS has assumed responsibility for those related to program integration. In relation to the newly identified policy areas, DOI will maintain a primary role in defining consumer assistance, plan management, enrollment and financial management, while HFS will continue to lead eligibility.

The addition of newly hired staff has enabled the State to make progress on policy planning and development. In the last month, four new staff were identified to join the Exchange planning team, and the State is in the final stages of interviewing for its Exchange IT Project Manager. The State submitted information to CCIIO on October 28 notifying of the staff additions.

Finally, the State renewed its contract with HMA and Wakely Consulting to continue to assist the State in identification and development of specific work plans on several areas that affect business operations. This is work outlined and approved as part of the State's Level 1 Implementation grant and will be detailed in those quarterly reports going forward.

Regulatory or Policy Actions

In the third quarter, the Illinois General Assembly passed legislation (SB 1555) declaring Illinois would establish a state-operated Exchange. SB 1555 also formed a Legislative Study Committee (LSC) staffed by the Commission on Government Forecasting and Accountability (COGFA) to produce recommendations for the establishment of an Exchange. Members were appointed to the LSC and began holding hearings during the fourth quarter. The chairs of the committee were selected from each party caucus in the House and Senate, and included Senator William Haine (Democrat), Senator Bill Brady (Republican), Representative Frank Mautino (Democrat), and Representative JoAnn Osmond (Republican).

The LSC conducted four public hearings throughout the fourth quarter. The first hearing, held August 24, 2011, featured testimony from Kate Gross of DOI and Michael Koetting of HFS on the minimum federal requirements for establishment of an Exchange as well as for application for an HHS Level Two Exchange Establishment Grant. Ms. Gross and Jon Kingsdale of Wakely Consulting Group testified about potential policy goals for an Exchange as well as the timeline for measures necessary to stand up an Exchange by fall 2013. Finally, Ms. Gross, officials from

the Illinois Comprehensive Health Insurance Program, and Laura Zarembra, Director of the Office of Health Information Technology, testified regarding potential governance options for the Exchange.

At the second hearing, held August 30, 2011, interest groups were given the opportunity to provide testimony on issues related to the Exchange. Groups participating represented a broad spectrum of stakeholders, including providers, unions, medical and policy associations, and business interest groups as well as independent businesses. At a third hearing, on September 15, 2011, the Committee heard from carriers, agents and brokers, industry groups, and the Illinois Public Interest Research Group. Stakeholder comments addressed a diverse array of Exchange issues, including governance structure, governing board composition, financing mechanisms, and operating models. A full list of stakeholder groups testifying before the LSC is attached (see *Appendix C).*

A fourth hearing was conducted on September 21, 2011, and included testimony from civic organizations, including state and local branches of the League of Women Voters and the NAACP, about the effect of an Exchange on their constituent communities. Ms. Gross, Mr. Kingsdale, and Patrick Holland of Wakely Consulting Group briefed the Committee on the findings in the Needs Assessment report.

Several legislative developments have occurred since the end of the fourth quarter. On October 6, 2011, the LSC held a final meeting to discuss a draft report produced by COGFA and General Assembly Member staff. The report drew on testimony from previous hearings as well as questions submitted to DOI, HFS, and other State agencies. Changes based off committee member feedback were included in a final report, to be issued in the near future. The draft report included a description of required Exchange functions, but did not produce recommendations on specific policy options. On October 26, Rep. Mautino introduced an Amendment to SB 1313 (see *Appendix D*) containing Exchange establishment language. The bill has not advanced out of the House Insurance Committee, though the Department is hopeful that SB 1313 or other Exchange legislation will pass during the General Assembly's Fall Veto Session, which ends November 10, 2011.

Barriers, Lessons Learned, and Recommendations to the Program

As of the writing of this report, the State's most significant barrier to progress is the lack of legislation creating a governing body and financing mechanism for the Exchange. Without such legislation, the State will remain unable to apply for Level 2 Establishment Grant funding. The State remains hopeful that legislation will pass before the November 10, 2011, end of the General Assembly's Fall Veto Session.

Technical Assistance

Illinois looks forward to being an active participant in collaborative efforts between States and the federal government, including user groups, conferences, and CALT.

Draft Exchange Budget

The Needs Assessment project completed by HMA and Wakely provided a budget for Exchange start-up and operating costs through calendar year 2015. FFY 2012, 2013, and 2014 spending is informed by the HMA/Wakely analysis. FFY 2011 spending is based on estimates of spending under the State's Exchange Planning and Level One Establishment Grants.

TOTAL	**FFY 2011**	**FFY 2012**	**FFY 2013**	**FFY 2014**
Salaries and Wages	$110,082.43	$2,448,369.74	$4,194,000.00	$6,018,516.67
FTEs	1.5	30	48	70
Fringe Benefits	$17,014.64	$527,300.26	$903,253.00	$1,296,195.33
Consultant Costs	$1,151,385.04	$3,243,722.00	$2,967,976.00	$2,148,104.00
Equipment	$1,062.33	$70,400.00	$78,900.00	$798,654.00
Supplies	$2,088.37	$0.00	$0.00	$0.00
Travel	$17,716.05	$0.00	$0.00	$0.00
Other	$7,424.20	$26,862,714.00	$45,863,586.00	$29,061,709.00
Contractual Costs	$0.00	$0.00	$0.00	$0.00
Subtotal	$1,306,773.04	$33,152,506.00	$54,007,715.00	$39,323,179.00
			PROJECT TOTAL	**$127,790,173.03**

Staffing. This budget assumes the salaries/wages and fringe benefits of both permanent and contract employees within the Department of Insurance (DOI), Department of Healthcare and Family Services (HFS), and the Department of Human Services (DHS) for both 2011 and 2012. As noted on the table, this includes 1.5 FTEs in 2011 and 30 FTEs in 2012, with 15 other existing state employees contributing on a fraction of their time to the Exchange. The costs for these years have been cost-allocated to Medicaid using the methodology described in the States' Level 1 grant application. Beginning in 2013, the States assumes some level of staffing will be necessary within existing agencies to meet the ongoing needs for the eligibility systems with public healthcare programs and the consumer assistance program within DOI. However, at this time those estimates are unknown and therefore have not been incorporated into the budget estimates. We expect to include these in future estimates. The staffing estimates included beginning in 2013 and 2014 are ONLY those working for the Illinois Exchange 100 percent of the time.

Consultant Costs. This budget assumes a varying degree of consultant costs – the estimates for 2011 are virtually all based on the Planning and Level 1 grant, while FFY 2012-2014 are based on the Needs Assessment report. The State assumes the costs provided by the consultants include

a myriad of needs associated with purchasing services primarily for auditing, legal, actuarial and independent contractors for short-term subject matter expertise.

Equipment. This includes the costs associated with IT infrastructure, including computer equipment, software licensing, servers and hosting services, and other key operational expenses associated with an Exchange.

Supplies. At this point, supplies are only considered for State staff in 2011 working on the Exchange specifically. Because "supplies" are not clearly defined in the current budget estimates provided by the States' consultants (but are rather lumped together in a "General and Administrative" category), these will have to refined going forward and re-budgeted as appropriate.

Travel. Similar to supplies, travel is only considered for State staff in 2011 working on the Exchange specifically, and is not defined as a subset of the 2012, 2013, and 2014 budgets yet. This will be refined going forward, but is currently lumped into a larger category called "General and Administrative".

Other. This category includes all of the costs associated with purchasing various aspects of the Exchange Systems Development and Support. These items, which affect specifically the systems for eligibility, verification and enrollment, the Exchange website, a customer service/call center, and premium billing, can be obtained through various different mechanisms. Since the State has not yet defined the mechanisms through which it will obtain the different pieces, they are simply categorized as other for now. This category also includes "General and Administrative" costs, such as office supplies, postage, printing, and travel, as well as "Facility and Related" costs, such as rent, utilities, furniture, etc. Finally, due to the uncertainty of how marketing and advertising will be approached by the Exchange; these items are also lumped into this category.

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Appendices

Appendix A: *Review of the Current Illinois Health Coverage Marketplace: Background Research Report* (Deloitte LLP)

Appendix B: *Illinois Exchange Strategic and Operational Needs Assessment: Final Report* (Health Management Associates and Wakely Consulting)

Appendix C: List of groups providing oral and written testimony to the Illinois Health Benefits Exchange Legislative Study Committee

Appendix D: House Amendment 002 to Senate Bill 1313 (Rep. Frank Mautino)

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Appendix A: *Review of the Current Illinois Health Coverage Marketplace: Background Research Report* (Deloitte LLP)

Deloitte.

Review of the Current Illinois Health Coverage Marketplace: Background Research Report

September 2011

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A. Executive Summary

Under the federal Affordable Care Act[1] (ACA), each state is authorized to establish a Health Benefits Exchange (Exchange) for individuals and small employers to obtain health insurance. Deloitte Consulting LLP (Deloitte Consulting) has prepared this report as background research to support the State of Illinois (the State) in the development of its Exchange.

Results from the background research are intended to inform policy and operational decisions impacting the Exchange. Specifically, the State's goals for this report were to provide information on:

- Purchasers, and potential purchasers, in the health insurance marketplace, including insured, uninsured and underinsured Illinoisans.
- The health insurance carriers in the market, including products being offered, premiums being charged, and the affordability of health insurance at different income ranges.
- Future population projections by health insurance status and source of insurance under multiple market scenarios.

This information was developed from analysis of multiple data sources, including:

- State information from the Department of Healthcare and Family Services (HFS), Department of Insurance (DOI), and Department of Public Health (DPH);
- New primary research via surveys of the Illinois population (2011 Illinois Health Insurance Survey or IHIS) and of the State's major health insurance carriers (Carrier Survey);
- Existing secondary research; and,
- Deloitte Consulting's Healthcare Reform Impact Model.

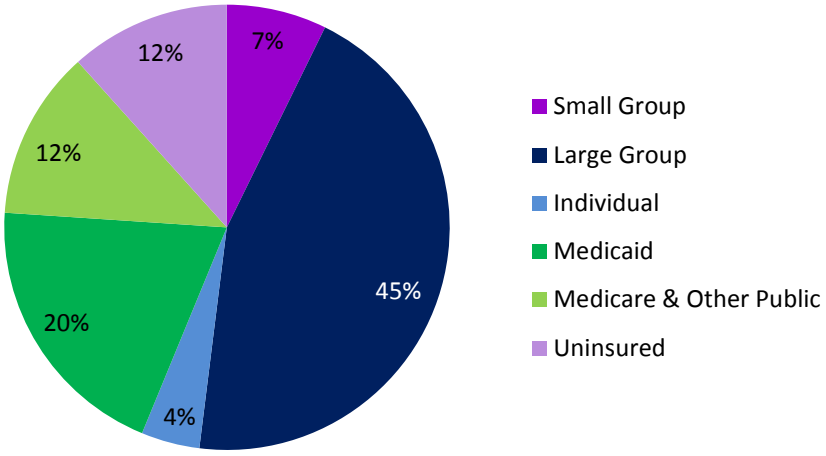
Below is a summary of major findings, organized as follows:

- Health Insurance Coverage
- Health Insurance Marketplace
- Affordability
- Market Projections

Health Insurance Coverage

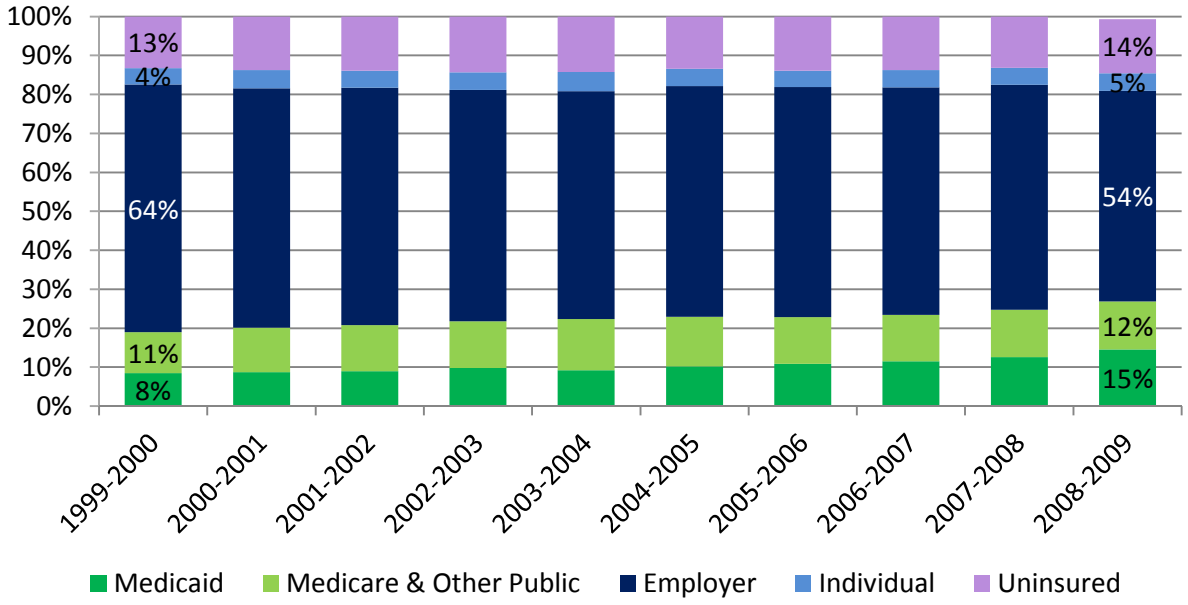
- Health Insurance Coverage – In 2011, an estimated 52% of the Illinois population is covered by employer-sponsored programs (including small group and large group plans), 4% purchase insurance in the individual market, 20% are covered by Medicaid (including All Kids, the State's program to cover all children and those dually eligible for Medicare benefits), 12% by Medicare and certain other public programs (e.g., military and veterans' programs), and 12% are uninsured. The figure below (Figure A.1) illustrates the baseline distribution of health insurance coverage.

Figure A.1: Estimated 2011 distribution of health insurance coverage across total Illinois population (Deloitte Consulting Health Reform Impact Model)[2]



- Historical Trends – Over a ten-year period ending 2008-2009, the uninsured population grew slightly (13% to 14%) as a percentage of the total State population, while the prevalence of employer coverage declined from 64% to 54% of the population, Medicaid grew from 8% to 15%, and Medicare (with other public programs) increased from 11% to 12% (Figure A.2). The growth in Medicaid was primarily due to economic conditions and specific policy expansions. In the adverse economic environment since 2009, some of these trends have accelerated, including the decline in employer sponsored coverage and the increase in Medicaid enrollment. The number of uninsured Illinoisans has declined somewhat since 2008-2009; this is attributable in large part to the growth in Medicaid enrollment.

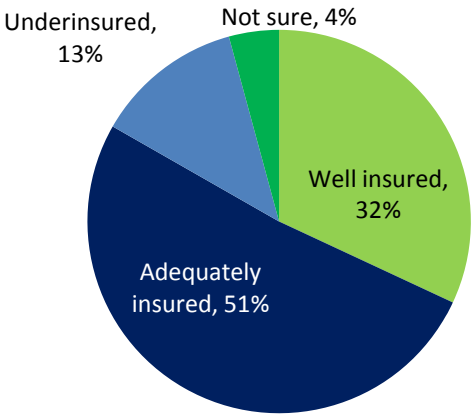
Figure A.2: Distribution of health insurance coverage across total Illinois population over the past decade, shown as two year averages (1999-2009 Urban Institute/Kaiser)[3]



- Insured and Uninsured Population Characteristics

  - Age - The young adult population (18-25 year olds) is the least likely to have health insurance (24% of young adults are uninsured)[4]. Insurance coverage prevalence increases as age increases[4].
  - Household Income - Insurance coverage increases as income increases[4]. Only 5% of persons living in households with incomes over 400% of the Federal Poverty Level (FPL) are uninsured whereas 34% of persons living in households with incomes less than 138% FPL are uninsured[4].
  - Geographic Regions – The adult (18-64) uninsurance rate ranges from 12% in the Urban Counties to 19% in the Rural Counties[4].
  - Insurance Adequacy - Of Illinoisans who are currently insured, the majority (83%) report that they are at least "adequately" insured while 13% report being underinsured. The remaining 4% are not sure (Figure A.3).

Figure A.3: Insurance adequacy in Illinois, adults age 18-64 (2011 IHIS)[4]



- Barriers to Coverage – Cost of health insurance is the most commonly reported reason for a person being uninsured (47%)[4]. The second most common reason is that health insurance is not offered by an employer (22%)[4].

Health Insurance Marketplace

- Market Concentration – The health carrier marketplace in Illinois is highly concentrated. Among the ten largest states, only Michigan has a higher degree of concentration, based on standard metrics used by the federal government for antitrust purposes (Figure A.4).

  The largest health carrier in Illinois owns a high market share, compared with leading carriers in other large states. Health Care Service Corporation (HCSC) has 49% of the statewide market share. This percentage is the second highest among the ten largest states, and compares with a median value of 25% for the leading carrier in the other nine largest states in the U.S. These market shares and concentration levels are calculated based on total health plan member counts, including all commercial (insured and self-insured), managed Medicare, and managed Medicaid members (if any).

Figure A.4: Health coverage market concentration for the top 10 most populous states based on enrollment estimates as of January 2011 in all fully and self-insured products (2011 HealthLeaders-InterStudy, 2011 HHI)[5,37]

Market Sorted by Population	Total Population	Top Carrier	Top Carrier % Share	Market Concentration
California	37,253,956	Kaiser	25%	Unconcentrated
Texas	25,145,561	HCSC	29%	Moderately Concentrated
New York	19,378,102	UnitedHealth Group	21%	Unconcentrated
Florida	18,801,310	UnitedHealth Group	22%	Unconcentrated
Illinois	12,830,632	HCSC	49%	Highly Concentrated
Pennsylvania	12,702,379	Highmark	28%	Unconcentrated
Ohio	11,536,504	WellPoint	23%	Unconcentrated
Michigan	9,883,640	BCBS of MI	51%	Highly Concentrated
Georgia	9,687,653	WellPoint	23%	Unconcentrated
North Carolina	9,535,483	BCBS of NC	38%	Moderately Concentrated

However, in no Metropolitan Statistical Area (MSA) in the State, does the market share of the area's largest carrier exceed about 56%, as shown in Figure A.5 below.

Figure A.5: Illinois health plan market concentration based on enrollment estimates as of January 2011 in all fully and self-insured products (2011 HealthLeaders-InterStudy)[5]

Market Sorted By Population	Total Population	Top Carrier	Top Carrier
Illinois	12,830,632	HCSC	49%
Chicago/Naperville/Joliet	7,883,147	HCSC	46%
Lake County–Kenosha, WI	869,888	HCSC	43%
Davenport	379,690	UnitedHealth Group	56%
Peoria	379,186	UnitedHealth Group	39%
Rockford	349,431	HCSC	44%
Champaign-Urbana	231,891	Health Alliance	53%
Springfield	210,170	HCSC	50%
Bloomington–Normal	169,572	HCSC	44%
Kankakee	113,449	HCSC	32%
Decatur	110,768	HCSC	48%
Danville	81,625	Health Alliance	37%

According to the Carrier Survey, only one carrier operates substantially statewide, having significant fully insured membership (in individual, small group, and large group markets) in nearly all counties in the State. (For this purpose, significant membership is defined as

more than 5% of the county total). Four other carriers have significant membership in between 26% and 37% of the counties across the State (as seen in Figure A.6).

Figure A.6: Geographic Coverage (% of Illinois counties covered with at least 5% market share in insured commercial market) for six top carriers in Illinois (2011 Carrier Survey) [6]

Carrier 1	Carrier 2	Carrier 3	Carrier 4	Carrier 5	Carrier 6
99%	9%	28%	26%	37%	33%

In addition to regional variations, market share concentration also varies by market segment. For example, statewide market share of the largest carrier in the individual market segment is higher than the 49% share shown above for all market segments combined[6].

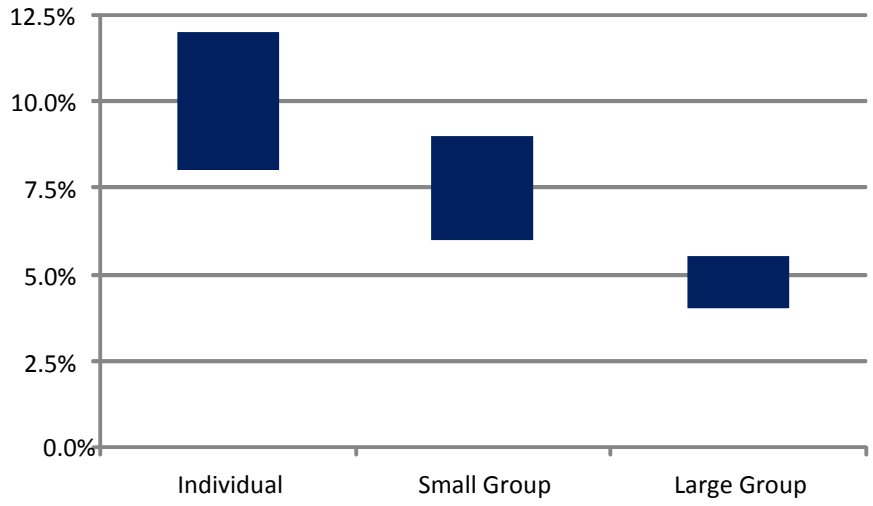
- Plan Designs – The Carrier Survey data indicates Preferred Provider Organizations (PPOs) dominate the Illinois individual and small group markets[6]. In the individual (non-group) segment of the market, 99% of reported membership is in PPOs and for the small group market, 84% of reported membership is in PPOs[6].

  The current market is characterized by a wide range of product options available to consumers and employers. Across the carriers surveyed, more than 500 distinct cost sharing combinations were observed across the items included and analyzed as part of the Carrier Survey (deductible, coinsurance, out-of-pocket (OOP) maximum, primary care provider (PCP) copays, specialist copays, inpatient copays, and emergency room (ER) copays)[6].

- Barriers to Market Competition – Illinois' insurance regulatory requirements and processes appear to be similar to those of other states[7,8,9]. Regulation does not currently appear to present any unusual barriers to competition or potential future market entry by new carriers. Other potential barriers or influences on competition are discussed in Section F.

- Agents – As of the beginning of 2011, there were over 54,000 agents licensed to sell health insurance in Illinois[10]. This represents 1 agent for every 240 persons in the State[10,11]. Agent compensation levels vary somewhat across carriers, with compensation levels declining (as a percentage of premium) as customer size increases (Figure A.7).

Figure A.7: Carrier-reported agent compensation as a percentage of premium by market (2011 Carrier Survey)[6]



In addition, there were 347 All Kids Application Agents in 2010 that helped enroll families into the All Kids and other Medicaid programs[12]. These agents are paid $50 per enrolled applicant.

Affordability

The report analyzes several measurements of affordability by comparing health care cost components to household income. Estimated premium and out-of-pocket cost sharing (OOP) costs for health insurance purchased through both the individual and small group markets are shown in Figure A.8 (as a percentage of household income, for households at 200% of FPL) and in Figure A.9 (in dollar values and as a percentage of income for households at 200% of FPL). For the purposes of this research, the State has defined an additional affordability measurement, total real out-of-pocket cost (TROOP), as the total of the estimated premium and OOP costs.

The affordability analysis in this report addresses the current market; ACA was intended to substantially improve affordability, particularly for lower income people, and it is expected that ACA provisions such as the Exchange and premium subsidies will substantially impact affordability when implemented in the future.

Note that for the small group premiums, employers typically pay a substantial portion of these costs on behalf of the employee. Federal government survey data indicate that the average employee contribution to small group health plan costs in Illinois for 2010 was $1,221 for

employee coverage, and $4,383 for family coverage[20]. However, it is reasonable to believe that employees ultimately bear much of the cost burden of these employer subsidies (in the form of lower wages than would otherwise be received).

OOP costs shown below reflect medical benefits, excluding pharmacy, and are based on in-network levels. OOP costs are substantially higher for out-of-network services.

Figure A.8: Average premium and OOP cost (excluding pharmacy) as a percent of household income at 200% FPL (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

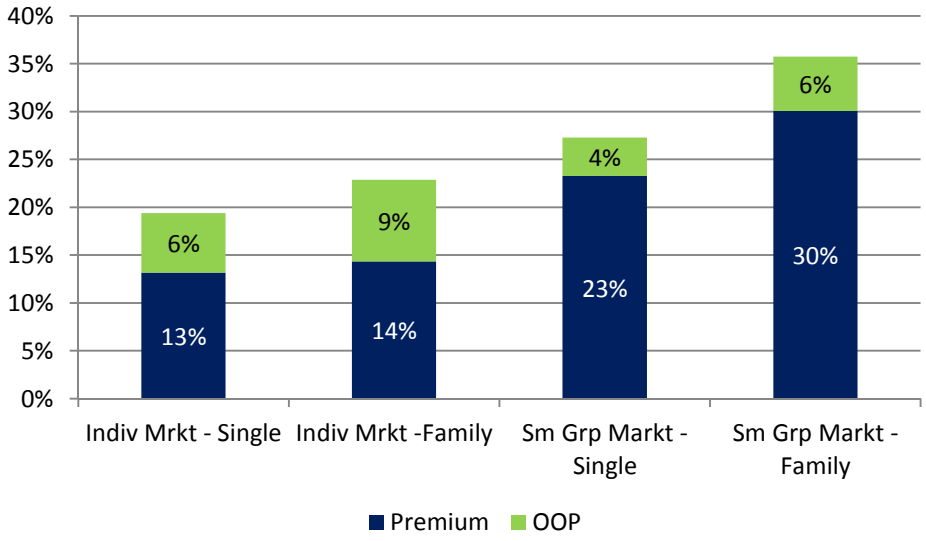


Figure A.9: Annual income, average OOP and average TROOP (excluding pharmacy) at 200% FPL (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

	Individual Market		Group Market	
	Single	Family of 4	Single	Family of 4
Annual Income	$21,660	$44,100	$21,660	$44,100
Average OOP	$1,347	$3,758	$868	$2,514
Average TROOP	$4,197	$10,088	$5,908	$15,764
Average TROOP % of Income	19%	23%	27%	36%

The differences between premium rates in the individual and small group market are due to differences in:

- benefit designs (group benefits typically pay a larger share of eligible medical expenses); this is estimated to account for 60% of the difference[13]; and
- underwriting (individual insurance underwriting often results in denial of coverage for persons in poor health) and other factors, such as member demographics and carrier administrative expenses. These factors are estimated to account for the remainder of the difference in premium rates.

- Out-of-Pocket (OOP) Costs – Figure A.8 and Figure A.9 shows the estimated average OOP costs for typical plan designs in each market. In many cases, the average OOP cost exceeds affordability thresholds specified by the State for low income individuals and families.

- Average Total Real Out-of-Pocket (TROOP) Costs – Average TROOP costs include both out-of-pocket costs and premiums for a typical plan design, and are illustrated by the total bars in Figure A.8 and the third row of Figure A.9. These costs range from 19% to 36% of household income for individuals and families at 200% FPL[13].

Market Projections

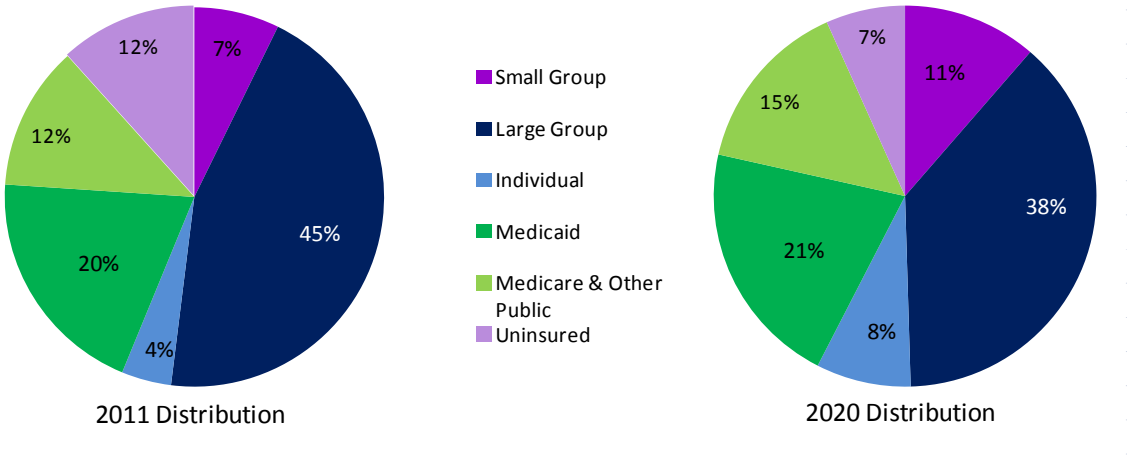
- Future Health Insurance Coverage – Health insurance coverage sources for the total population are projected to shift from 2011 to 2020 as follows (Figure A.10):

    - Small Group and Large Group Employer (including the Exchange) - declines from 52% to 49%,
    - Individual (including the Exchange) – grows from 4% to 8%,
    - Medicaid – increases significantly due to ACA eligibility expansion; but this increase is largely offset by assumed future improvement in economic conditions, resulting in net growth from 20% to 21% over the period,
    - Medicare – increases from 12% to 15%, and
    - Uninsured – declines from 12% to 7%.

  Note that persons eligible for both Medicaid and Medicare (i.e., “dual eligible”) are included in the Medicaid market in the population projections. As required by ACA, the definition of Small Group changes between 2011 and 2020. As of 2011, the Small Group market includes

employer plans with up to 50 employees while no later than 2016 the Small Group market must include employer plans with up to 100 employees. Projections reflect baseline assumptions developed with the State and summarized in Appendix D.

Figure A.10: Projected change in coverage distribution of total Illinois population (Deloitte Consulting Health Reform Impact Model)[14]



- Medicaid Enrollment – There are several factors that will tend to increase Medicaid enrollment: the expanded eligibility required under ACA, enhanced outreach by the State to eligible beneficiaries, and increased uptake of coverage by eligible Illinoisans. The "Prior Eligibles" in Figure A.11 below indicate those individuals who are currently eligible for Medicaid, prior to implementation of ACA eligibility expansion. Additional Medicaid enrollment due to ACA expanded eligibility requirements is labeled "New Eligibles" in Figure A.11 below. The dual eligible population (310,000 members in 2011) is expected to increase as the State's population ages and is included in the Medicaid numbers charted below.

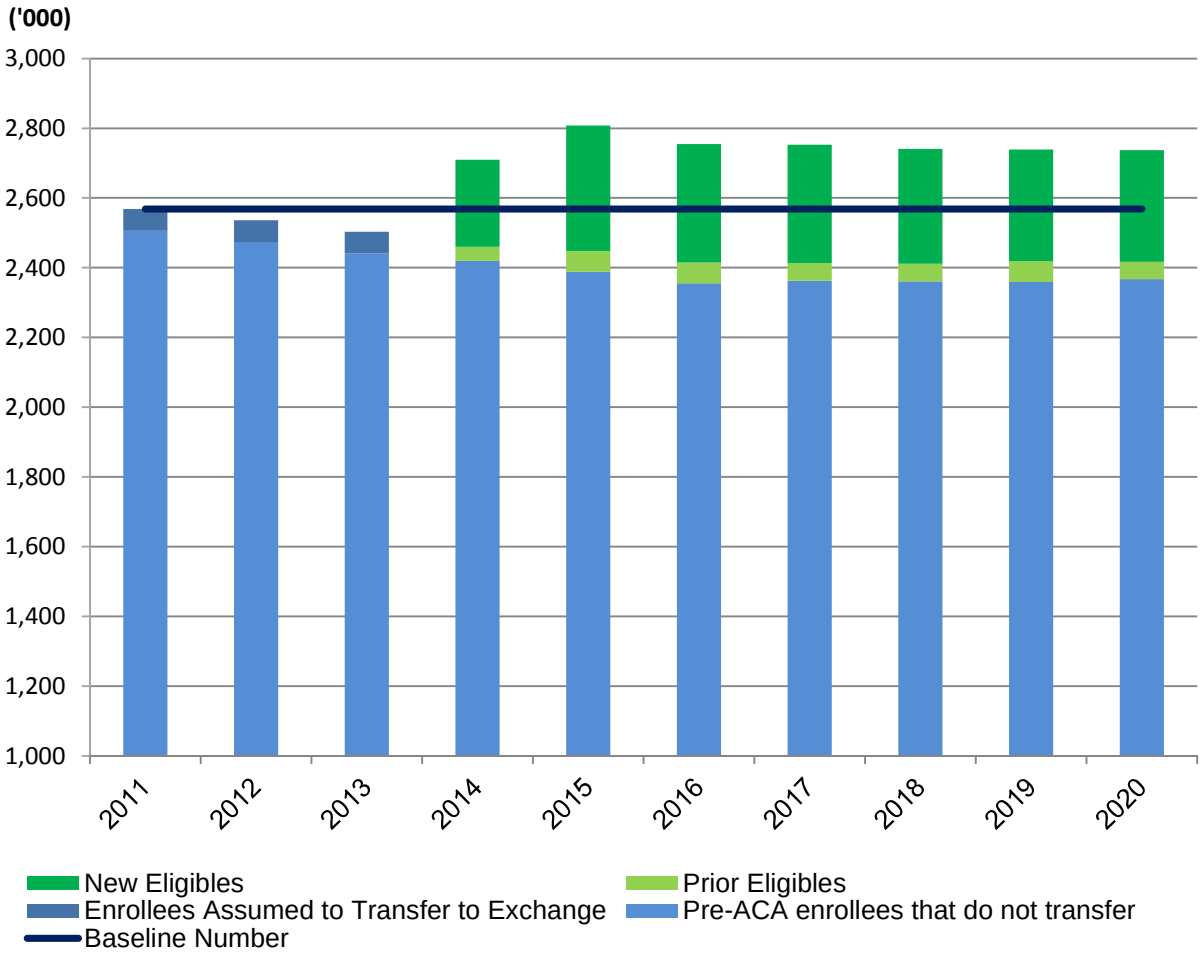
  However, Medicaid enrollment growth is offset by estimated reductions due to projected future economic recovery (future reductions in unemployment are projected, offsetting the significant increase in unemployment levels observed in recent years, and reversing the corresponding impact on Medicaid enrollment levels) as well as an assumed transfer of some persons from Medicaid and other State programs to the new Exchange (note that this transfer is an assumption regarding a policy decision the State has yet to make, and the States actual decision may differ).

  In addition to these factors, future growth of the total Medicaid population is limited to

some extent by the very high participation levels already achieved in Illinois, particularly with respect to eligible children, as determined from State enrollment data. In 2010, more than 95% of all Illinois children were estimated to have health insurance.[38]

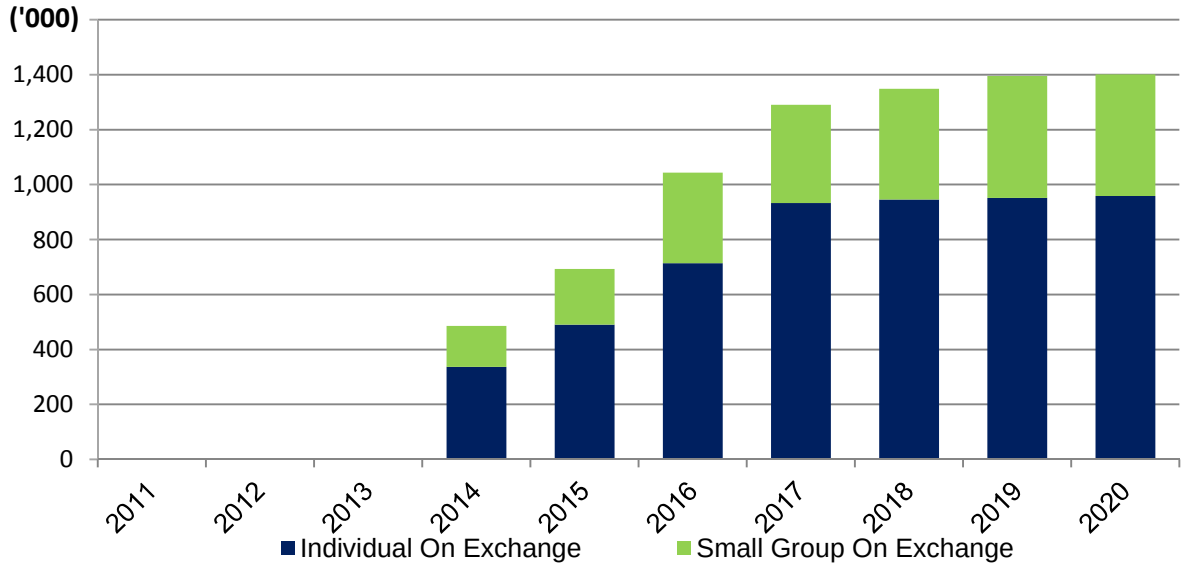
Given the uncertainty surrounding current and future economic growth in the U.S., it is important to note that all assumptions for the future of the economy incorporated in this reports projections are based on benchmarks published by the Congressional Budget Office.

Figure A.11: Projected growth in Medicaid, including Medicare dual eligibles (Deloitte Consulting Health Reform Impact Model)[14]



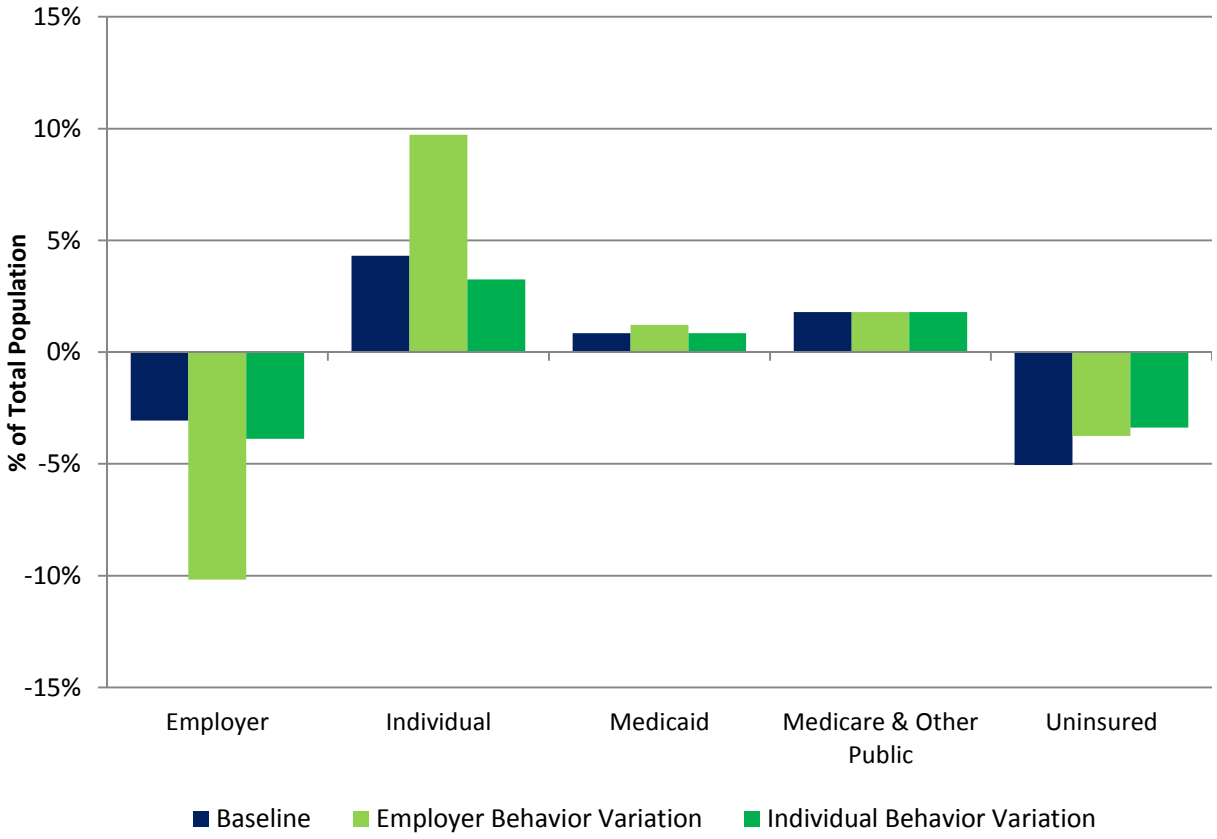
- Exchange Membership – health insurance enrollments through the Exchange are projected to ramp up over the first three years of operation. As of 2017, approximately 1.3 million people are projected to be purchasing health insurance through the Exchange (Figure A.12) as part of the individual market and the small group market (Small Business Health Options Program, or SHOP) according to the baseline assumptions.

Figure A.12: Projected exchange membership (Deloitte Consulting Health Reform Impact Model)[14]



- Multiple Scenarios – Market projections are influenced by future economic conditions, legislative and regulatory decisions, and behavior of market participants, and are therefore subject to a high degree of uncertainty. Additional scenarios were modeled to illustrate the impact of key assumptions and decisions on the future marketplace. The two additional scenarios are summarized and compared to the baseline below with the projected impacts reflected in Figure A.13:
    - Baseline Scenario - assumes ACA is implemented as written, and produces employer and individual behavior generally consistent with Congressional Budget Office projections.
    - Employer Behavior Variation - assumes a larger disruption to the existing employer-sponsored market compared to the Baseline by assuming more employers terminate or re-structure their traditional health benefits programs. The increased disruption is most pronounced in lower income industries and smaller employers. This scenario projects more uninsured and a larger individual market.
    - Individual Behavior Variation – illustrates reduced health insurance enrollment due to multiple factors, including the potential elimination of the ACA individual mandate penalty. The scenario also projects more uninsured than in the Baseline scenario.

Figure A.13: Changes in the enrollment by the year 2020, as percent of the total population – compared to 2011 (Deloitte Consulting Health Reform Impact Model)[14]



B. Project Overview and Research Methods

Overview

This report section provides background and describes the data used for the analyses. The information is summarized into the following areas:

- Background and Objectives,
- State Data Sources,
- 2011 Illinois Health Insurance Survey (IHIS),
- Carrier Survey,
- Secondary Research, and
- Market Projections.

Background and Objectives

Under the ACA, each state is authorized to establish an Exchange for individuals and small employers to obtain health insurance. Deloitte Consulting has prepared this report as background research to support the State, including DOI and other departments, in the development of its Exchange.

Results from the background research are intended to inform policy and operational decisions impacting the Exchange. Specifically, the State's goals for this report were to provide information on:

- Purchasers, and potential purchasers, in the health insurance marketplace, including insured, uninsured, and underinsured Illinoisans.
- The health insurance carriers in the market, including products being offered, premiums being charged, and the affordability of health insurance at different income ranges.
- Future population projections by health insurance status and source of insurance under multiple market scenarios.

This information was developed from analysis of multiple data sources, including:

- State information from the HFS, DOI, and DPH
- New primary research via surveys of the Illinois population (IHIS) and of the State's major health insurance carriers (Carrier Survey);
- Existing secondary research; and,
- Deloitte Consulting's Healthcare Reform Impact Model.

Findings within this report have been validated with additional sources to the extent they were reliable and available. In some cases, results obtained from different sources may be inconsistent or contradictory; this may be due to differences methodology, source data used, time periods considered, etc. In cases where differences appear significant, the data sources are disclosed and potential reasons are noted.

Certain Medicaid beneficiaries receive partial benefits (e.g. family planning services) only; data shown in this report reflect participants receiving full Medicaid benefits.

Some results have been adjusted so that rounded subtotals displayed in the report add to 100% of the total numbers.

This report documents the details and findings from the background research.

State Data Sources

a. Overview and Methodology

Data and analyses were provided by various State departments. The specific data requests are included as Appendix A of this report.

b. Data Listing

Below is a summary of the information provided by each of the State departments. Also, State websites and published reports were utilized to gather additional information and data (e.g., Illinois Comprehensive Health Insurance Plan (ICHIP) data was collected and analyzed from the ICHIP website).

Department	Summary of Data Provided	Sample Data Analyses
HFS	Recent history of Medicaid enrollment and claims experience	• Recent growth in Medicaid enrollment by aid category • Population projections starting point
	Summary of Medicaid and related program eligibility criteria	• Overview of current market • Input to population projections
	10 years of historical information on active All Kids Application Agents (AKAA)	• Agent Analysis (AKAA specific), their locations in the State and levels of activity
	State Employee Carrier Network Information	• Carrier network coverage across the State

Department	Summary of Data Provided	Sample Data Analyses
DPH	10 years of historical data from the Behavioral Risk Factor Surveillance System (BRFSS).	• Population characteristics • Validation for external data • Uninsured analysis – mental health
	Summarized Information from the all-payer State Inpatient Database.	• Regional differences in coverage distributions
	Health Maintenance Organization (HMO) Network Approval information	• Overview of current market • Regulatory Barriers to Carriers
DOI	Historical health premium volumes and policy counts for fully insured business	• Overview of current market • Validation of market share information
	Agent and broker Licensing Information	• Distribution Analysis – Access to Agents
	Compliance and regulatory requirements for establishing an insurance company or HMO in Illinois.	• Overview of current market • Regulatory Barriers to market entry for insurance carriers
	Insurance complaints information	• Overview of current market • Barriers to individuals obtaining health insurance
	Sample rate filing information	• Regulatory Barriers
	Various DOI reports	• Overview of current market • Analyses of High Risk Pool • Input into population projections

2011 Illinois Health Insurance Survey (IHIS)

a. Overview and Methodology

To describe current health insurance coverage, health care related expenditures and attitudes of residents, a population survey was designed and administered. Harris Interactive, Inc. was contracted to administer a web-based survey in June-July of 2011. An overview of the survey methodology is as follows:

- Survey was conducted in both English and Spanish. The survey questions, as well as the weighted survey results, can be found in Appendix B of this report (in English).
- Survey criteria required completion by any adult in the household who was a current resident of the State (as evaluated by the person's current zip code), over the age of 18 and under the age of 65.

- 2,051 respondents met the survey criteria and completed the survey. The respondents were tracked to ensure that a sufficient number of uninsured individuals with incomes below 200% of the FPL were included in the sample.

b. Representativeness of the Sample

The survey targeted a representative sample of Illinois residents based on several demographic characteristics, including age, gender, education, race, insured status, and income. A weighting factor was applied to each survey respondent to match the targeted population.

With over 2,000 completed responses, the survey provides results at a sufficient level of detail and statistical significance to draw conclusions about the population and health insurance market in the State.

For example, IHIS results show that 16% of the Illinois population aged 18-64 is uninsured. The margin of error for this statistic at 95% confidence is 2%. This means that there is a 95% probability that a similar survey reaching the entire population of the State would indicate the uninsured population in this age group is between 14% and 18%.

Carrier Survey

a. Overview and Methodology

The Carrier Survey requested information directly from the largest health insurance carriers in the State to provide data on the insurance market. The State issued a Data Call to these carriers under its insurance regulatory authority. There were two Data Calls – the original request for information on products, enrollment, and plan designs which was executed by Wakely Consulting Group. The addendum to the Data Call was a request for member location information which was executed by Deloitte Consulting working together with Wakely Consulting Group. The data submitted covered the following areas:

- Individual underwriting experience, providing estimates of the proportions of cases denied, approved, with exclusions, etc.
- Small Group underwriting experience, providing estimates of case distribution relative to the rating band,
- Summarized health insurance product experience, including exposure (counts of member months), claims and premium differentiated by market (individual or small group), product type (PPO, HMO, etc.), and various plan design characteristics (e.g. deductible, coinsurance, PCP copay),

- Distribution (e.g., agents/brokers) compensation information, including commission schedules, bonus definitions, and total compensation levels by market, and
- Regional exposure, providing fully insured group and member distribution by zip code for each of the fully-insured individual, small group and large group markets.

The two requests sent to carriers are included as Appendix C of this report.

b. Representativeness of the Sample

The DOI requested information from the top six carriers based on the volume of individual and fully insured small group enrollment in the State. The information represents a large subset of the Illinois marketplace, and:

- Does not include self-funded or large group business. Note that the second survey requests enrollment by zip code and market and does include insured large group business.
- Was limited to comprehensive coverage insurance plans only. In other words, it excludes products such as mini-med products.
- Requests detailed plan design information for the top 80% of each carrier's enrollment. Products with lower enrollment, but materially different cost sharing, could be omitted.
- Focuses on in-network benefit designs and on limits for single members. Out-of-network benefits were excluded. Generalizing analysis to family limits required additional assumptions outlined in the relevant sections of the report.
- Did not specifically request information on lifetime or annual limits, or specific policy exclusions, which may impact member cost sharing.
- The pharmacy information submitted by the carriers was not included in the plan design analysis or included in the out-of-pocket cost estimates developed in the report. Carriers' coverage of pharmacy appear to vary (e.g., as a separate policy, as a discounted program, or included with the medical benefits).

Secondary Research

a. Overview and Methodology

In order to provide a broader picture of the Illinois marketplace, and to validate or test findings from the primary research outlined above, the background research project considered various external resources. These include a cross-section of:

- Deloitte Consulting's Models, Databases and Publications,
- Other external datasets, and
- Market Publications.

b. Data Listing

Below is a brief summary of the key secondary research utilized (Figure B.1).

Figure B.1: Summary of secondary data research

Tool/Resource	Examples of Data Utilized
Deloitte Consulting's Models, Databases & Publications	• Deloitte Consulting's Health Reform Impact Model described further in subsequent sections of this report • Health insurance benefits modeling used to calculate the total relative cost of coverage based on specific plan designs • *Thomson Reuters MarketScan® Research Databases*, a commercial claims database capturing utilization and expenditures at the participant-level across service categories for over 2 million individuals under the age of 65 in Illinois • The Deloitte Center for Health Solutions' 2009 Survey of Healthcare Consumers
External Datasets	• U.S. Census Bureau: Current Population Survey (CPS) • U.S. Census Bureau: American Community Survey (ACS) • U.S. Census Bureau: Annual Social and Economic Supplement (ASEC) • U.S. Census Bureau: Survey of Income and Program Participants (SIPP) • U.S. Census Bureau: Small Area Health Insurance Estimates (SAHIE) • U.S. Department of Health and Human Services: Medical Expenditure Panel Survey (MEPS) • Kaiser Family Foundation(KFF)/Urban Institute: State Health Facts information

Tool/Resource	Examples of Data Utilized
Market Publications	• HealthLeaders-InterStudy: Managed Market Surveyor and Managed Market Surveyor Rx • Illinois Comprehensive Health Insurance Plan (CHIP): Illinois Comprehensive Health Insurance Plan 2009 Annual Report • America's Health Insurance Plans (AHIP): Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits • Kaiser Family Foundation (KFF): Survey of People Who Purchase Their Own Insurance • Kaiser Family Foundation (KFF) and Health Research & Educational Trust: Employer Health Benefits 2010 Annual Survey • SK&A: Nationwide Physician Specialty Report

Market Projections

a. Overview and Methodology

Deloitte Consulting's Health Reform Impact Model is an analytical tool that uses baseline demographic and cost data to project market results for multiple years under alternative future scenarios based on specific assumptions. The model projects information by state and various market segments. In general, persons having insurance coverage available from two different sources are classified based on the primary source of coverage. However, to facilitate comparison with State Medicaid data and other research, persons dually eligible for both Medicare and Medicaid are classified as Medicaid enrollees (even though Medicare generally provides primary coverage for these persons).

The model utilizes a variety of data sources (e.g., Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, U.S. Census Bureau, Kaiser Family Foundation) to develop baseline information for use in projection estimates.

Projections incorporate a variety of estimates, including assumptions pertaining to future economics, legislative outcomes, behavioral reactions, and strategic decisions. Due to the subjective nature of any future projections, results are highly uncertain, and multiple scenarios are modeled to illustrate some of the potential variation.

b. Results and their Interpretation

Results from population projections are dependent upon:

- The underlying data - As an example, Aliens Not Lawfully Present in the US cannot (by law) purchase coverage on the Exchange or receive affordability credits and this group represents a significant share of the population uninsured (approximately

300,000) and insured (approximately 200,000) in Illinois[15]. However, this is a segment of the population where data is limited and may be inaccurate.

- The assumptions used in the projections - As an example, estimates around the speed and robustness of economic recovery significantly impact public program enrollment. Estimates on when the economy will recover vary widely.

Market projections are subject to a high degree of uncertainty and should be understood in the context of the multiple assumptions and estimates used to develop the projection. This report uses a scenario-based approach to help illustrate the sensitivity of results to specific assumptions that could impact the distribution of coverage in the Illinois market.

C. Baseline Population

Overview

This report provides baseline information about the State that will be helpful to understand as results are presented throughout the report. This section is organized into the following areas:

- Age and Gender,
- Race,
- Employment Status,
- Household Income,
- Public Programs,
- Geographic Regions,
- Health Insurance Coverage, and
- Historical Trends in Coverage.

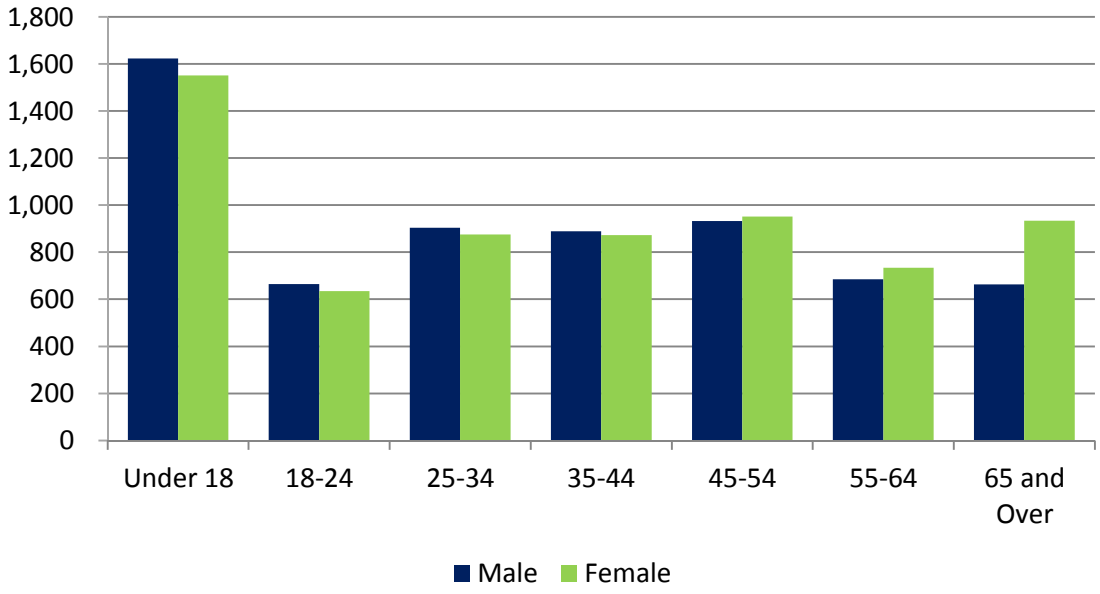
Key findings from this section include:

- As of 2009, approximately half of the Illinois working age population was employed full time, while 30% worked part time and approximately 20% did not work in the prior 12 months[11].
- As of 2009, nearly 70% of single parent households have incomes below $25,000 per year[16].
- The Chicago Suburbs/Collar Counties contain 42% of the State's population, translating to over 5 million people[11].
- According to the State Medicaid data, 28% of the population in Chicago is in the Medicaid program whereas 18% of the Chicago Suburbs/Collar Counties area is in Medicaid[17].
- As of 2011, 52% of Illinois residents obtain health insurance through employer sponsored coverage[18].
- The uninsured rate has been estimated at 12% for the entire population (2011)[2], 14% for those over 18 years old (2009)[16], and 16% for those between 18 and 64 years old (2011)[4].
- The distribution of coverage by source in Illinois has shifted over the last decade as employer sponsored coverage has declined and government sponsored coverage has grown[3].

Age and Gender

The Illinois non-elderly (under age 65) population is evenly distributed by gender. The non-elderly adult population is close to equally divided across male and female. The 65 year old and older age group population is smaller and contains more females than males (refer to Figure C.1 below).

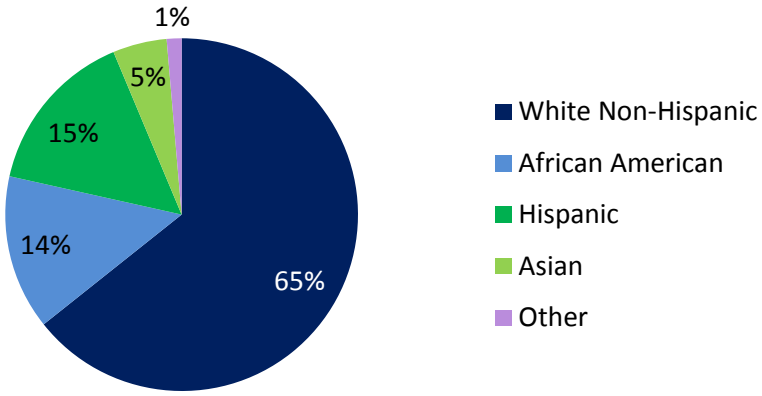
Figure C.1: Distribution of total Illinois population (in thousands) by age and gender (2009 ACS) [11]



Race

White Non-Hispanics make up the majority (65%) of the Illinois population, followed by Hispanics and African Americans. According to the 2009 ACS population study, Hispanics are 15% of the population and African Americans are 14% of the population. Note that throughout this report, the African American and Asian categories exclude Hispanic persons (who may be of any race).

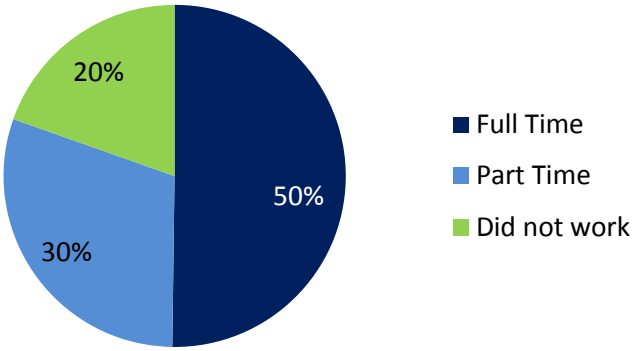
Figure C.2: Total Illinois population by race (2009 ACS) [11]



Employment Status

Approximately half of the Illinois working age population was employed full time, while 30% worked part time and 20% did not work in the prior 12 months. For purposes of the ACS survey, full time employment is defined as persons who usually worked 35 hours or more per week. Part time employment is defined based on persons who worked less than full time, year round.

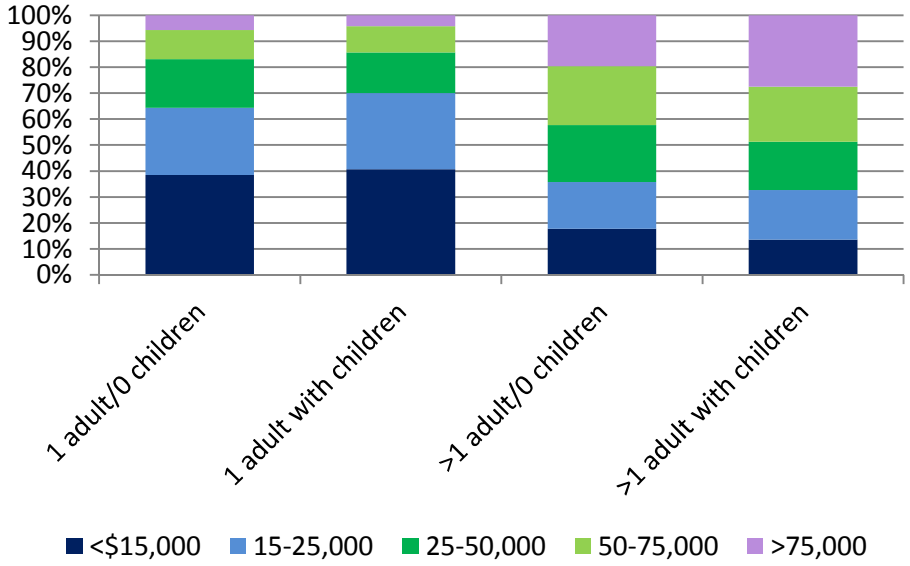
Figure C.3: Distribution of employment status (18-64) for Illinois (2009 ACS) [11]



Household Income

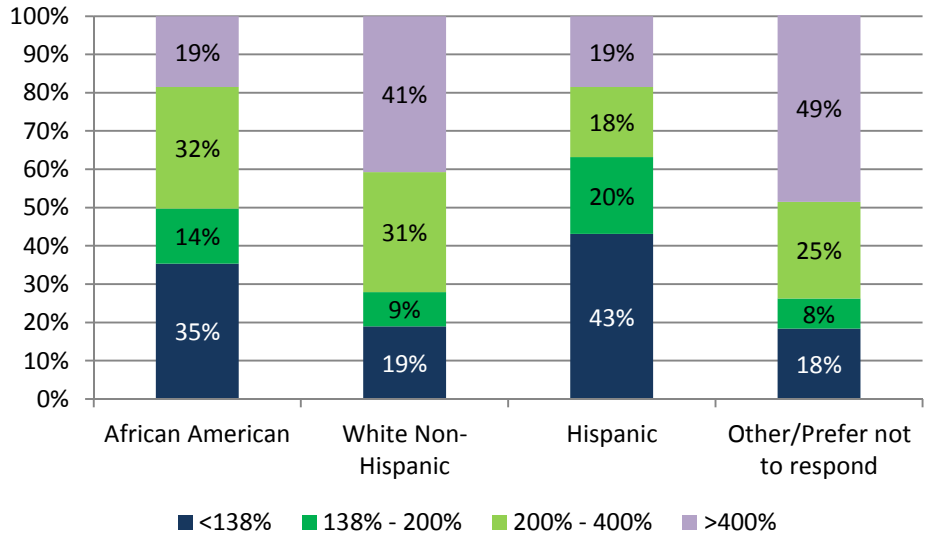
As of 2009, nearly 70% of single parent households in Illinois have household incomes of less than $25,000. In contrast, half of households with more than one adult and one or more children have incomes over $50,000 annually. The below chart (Figure C.4) summarizes the differences in household income for various household compositions.

Figure C.4: Distribution by household size and income for the over 18 Illinois population (2009 BRFSS) [16]



63% of the Hispanic population in Illinois currently live in households below 200% FPL while only 28% of the White Non-Hispanic population live in households below 200% FPL. On the other hand, 41% of White Non-Hispanics in Illinois are above 400% FPL while only 19% of African Americans and Hispanics in Illinois are above 400% FPL. (Figure C.5)

Figure C.5: Illinois population distribution (18-64) by race and income level (2011 IHIS)[4]



Public Programs

According to State data, approximately one in five people are on Medicaid (21% of the Illinois population). Using data provided by HFS, the below table (Figure C.6) shows the distribution of Medicaid enrollment by region and as a percentage of the region's total population. This reflects a higher percentage than the survey data provided by Urban Institute/Kaiser (shown as 15% of the Illinois population in 2008-2009). These differences are primarily due to the fact that the HFS data includes State-only sponsored programs and due to differences in survey methodology and timing (Medicaid enrollment has grown significantly in recent years). The Medicaid population is approximately 28% of the total population in Chicago, while in the Chicago Suburbs/Collar Counties Medicaid membership is only 18% of the total population.

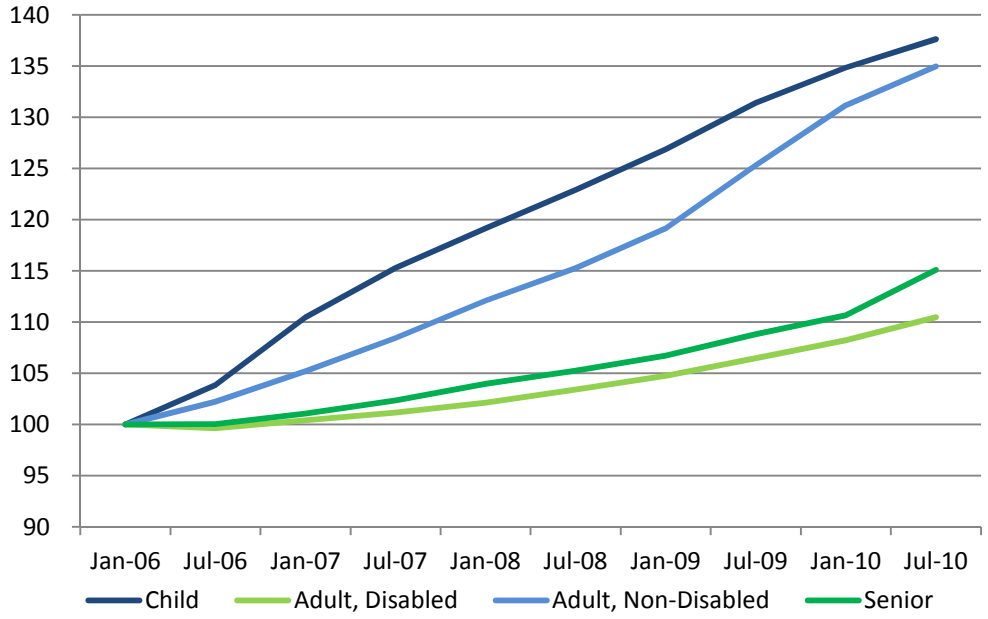
Figure C.6: Medicaid enrollment by region and percentage of total Illinois population (July 2010 HFS & 2009 ACS) [11,17]

Region	Medicaid Enrollment*	Enrollment Distribution	Enrollment as a % of the Region Population
Chicago	817,104	31%	28%
Chicago Suburbs/Collar Counties	933,576	35%	18%
North Central Counties	116,805	4%	23%
Urban Counties	365,328	14%	21%
Rural Counties	417,168	16%	20%
No Location	8,016	0%	N/A
Total	**2,657,986**	**100%**	**21%**

** Medicaid includes All Kids and Family Care Programs, as well as dual eligibles. It does not include programs that cover partial benefits.*

Medicaid enrollment has increased over the past five years, driven primarily by increases in enrollment of children and non-disabled adults. The following table (Figure C.7) shows changes in Medicaid enrollment, including enrollment in other State health insurance programs, since January 2006, as provided by HFS. Values have been normalized such that the January 2006 values are set to 100. Enrollment for children and non-disabled adults (less than or equal to 65 years old) has increased over time whereas enrollment growth for disabled adults (less than or equal to 65 years old) and seniors (those over 65 years old) has been less pronounced.

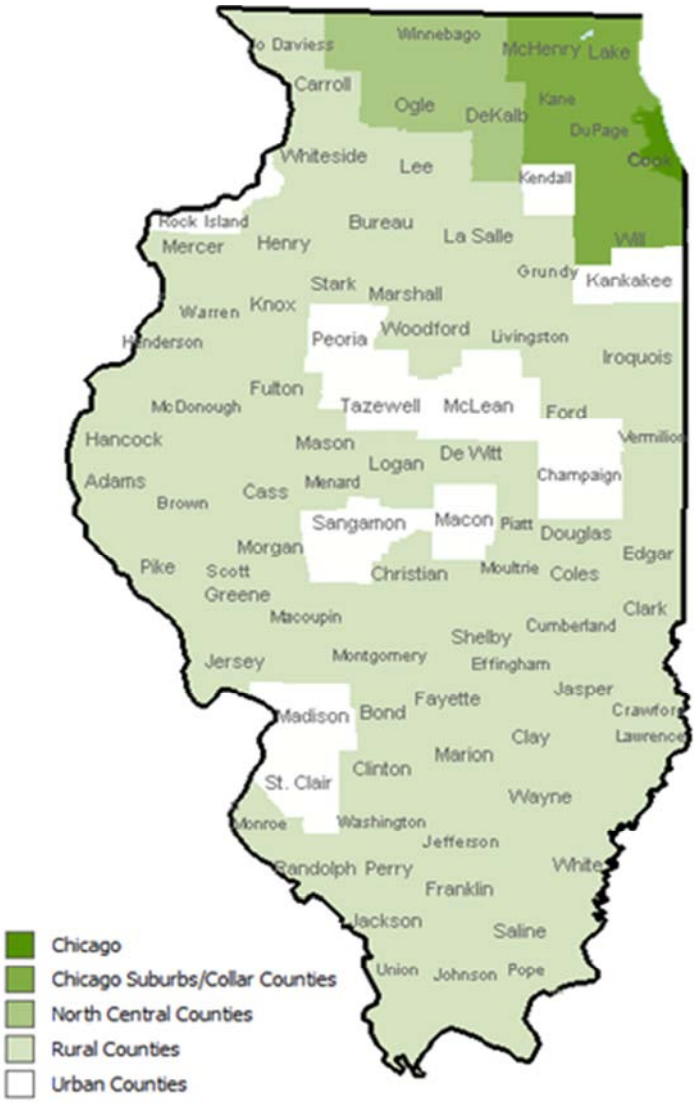
Figure C.7: Historical Medicaid enrollment based on the change from January 2006 (July 2010 HFS) [17]



Geographic Regions

Geographic breakdowns in this report are based on the IL BRFSS [16], which stratifies its survey data by Chicago, other parts of Cook County, Collar Counties, Urban Counties and Rural Counties. This report includes a separate region for the North Central region and combines non-Chicago Cook county and the Collar Counties to make up the 'Chicago Suburbs/Collar Counties' region. Geographic breakdowns in this report reflect the following five regions:

Figure C.8: Map of counties and regions (based on 2009 BRFSS)[16]



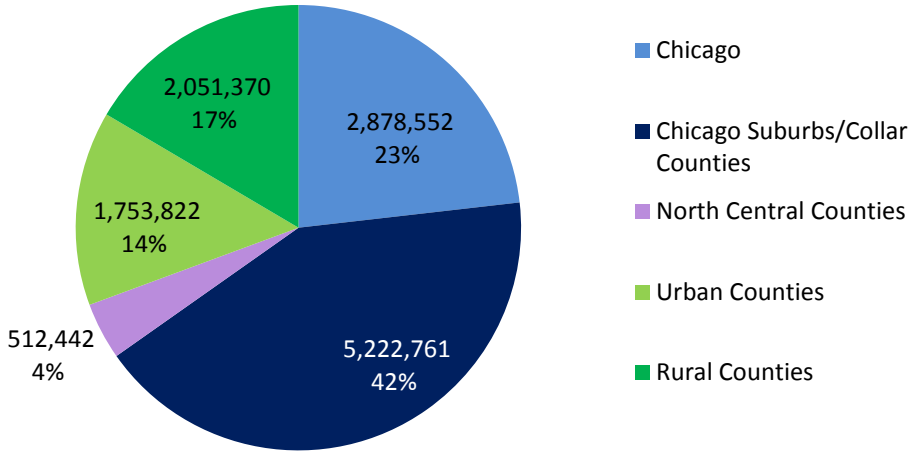
The following table depicts this same county–to-region mapping in list form.

Figure C.9: List of counties and regions (based on 2009 BRFSS)[16]

Region	Counties
Chicago	Part of Cook County- City of Chicago
Chicago Suburbs/Collar Counties	Suburban Cook County, DuPage, Kane, Lake, McHenry, Will
North Central Counties	Boone, De Kalb, Ogle, Stephenson, Winnebago
Urban Counties	Champaign, Kankakee, Kendall, Macon, Madison, Mclean, Peoria, Rock Island, Sangamon, Saint Clair, Tazewell
Rural Counties	Adams, Alexander, Bond, Brown, Bureau, Calhoun, Carrol, Cass, Christian, Clark, Clay, Clinton, Coles, Crawford, Cumberland, DeWitt, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Jo Daviess, Johnson, Knox, La Salle, Lawrence, Lee, Livingston, Logan, Macoupin, Marion, Marshall, Mason, Massac, McDonough, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Saline, Schuyler, Scott, Shelby, Stark, Union, Vermillion, Wabash, Warren, Washington, Wayne, White, Whiteside, Williamson, Woodford

The Chicago Suburbs/Collar Counties have the largest portion of the population (42%) in Illinois representing over 5 million people. The City of Chicago has 23% of the total population, which translates to approximately 2.9 million people. In contrast, the North Central Counties has about 500,000 people, representing 4% of the total population (Figure C.10).

Figure C.10: Total Illinois population by region (2009 ACS) [11]



The median income is lowest in rural areas. According to the 2005-2009 ACS data, the population in the Collar Counties have the highest median income (refer to Figure C.11).

Figure C.11: Median household income averaged by region (2005-2009 ACS) [19]

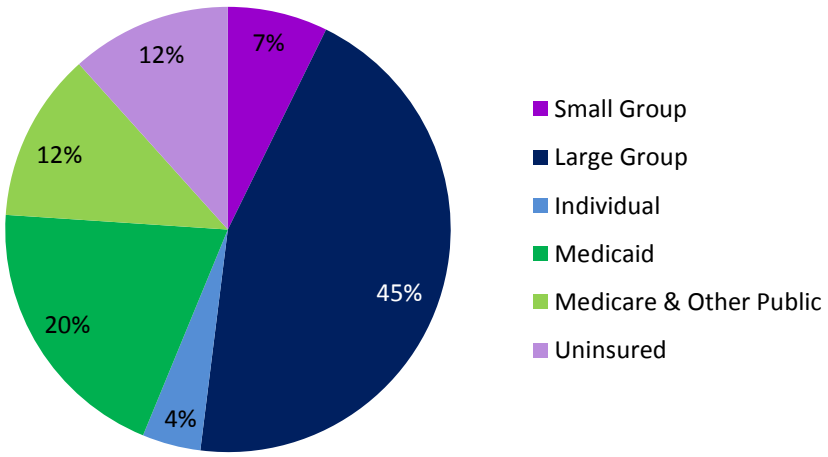
Region	2005-2009 ACS*
Collar Counties	$75,229
Cook County	$53,903
North Central Counties	$49,704
Urban Counties	$50,141
Rural Counties	$43,880
Statewide	$56,530

*Amounts shown in 2009 inflation-adjusted dollars

Health Insurance Coverage

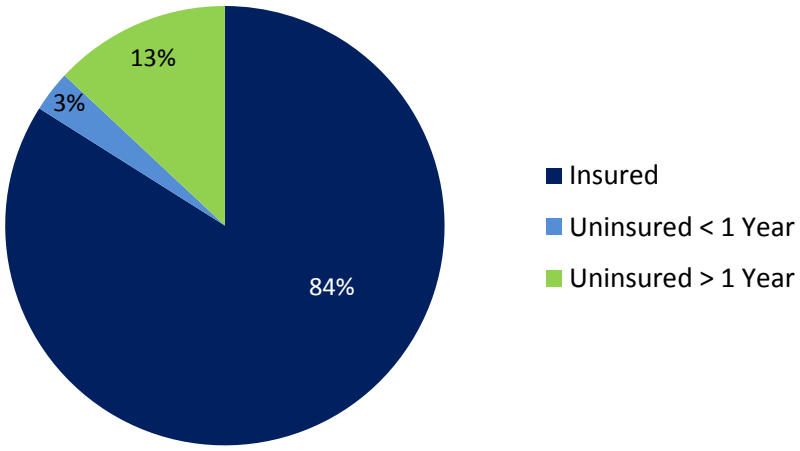
The majority (52%) of Illinois residents obtain health insurance through employer sponsored coverage. Employer sponsored coverage includes small group and large group plans, provided through insurance policies or self-funded by employers. The overall distribution of health insurance coverage in 2011 for the Illinois population is shown below in Figure C.12. Health insurance purchased through the individual market represents 4% while Medicaid covers 20% and Medicare & Other Public Programs cover 12% of the total population. The dual eligibles are included in the Medicaid enrollment. The uninsured represent 12% of the population.

Figure C.12: Estimated 2011 distribution of health insurance coverage across total Illinois population (Deloitte Consulting Health Reform Impact Model)[2]



As of 2011, IHIS results indicate that 84% of the Illinois 18-64 year old adult population is currently insured. 3% of Illinoisans in this age group are currently uninsured, but had health insurance in the past year while 13% is uninsured and has not had health insurance for at least one year (refer to Figure C.13).

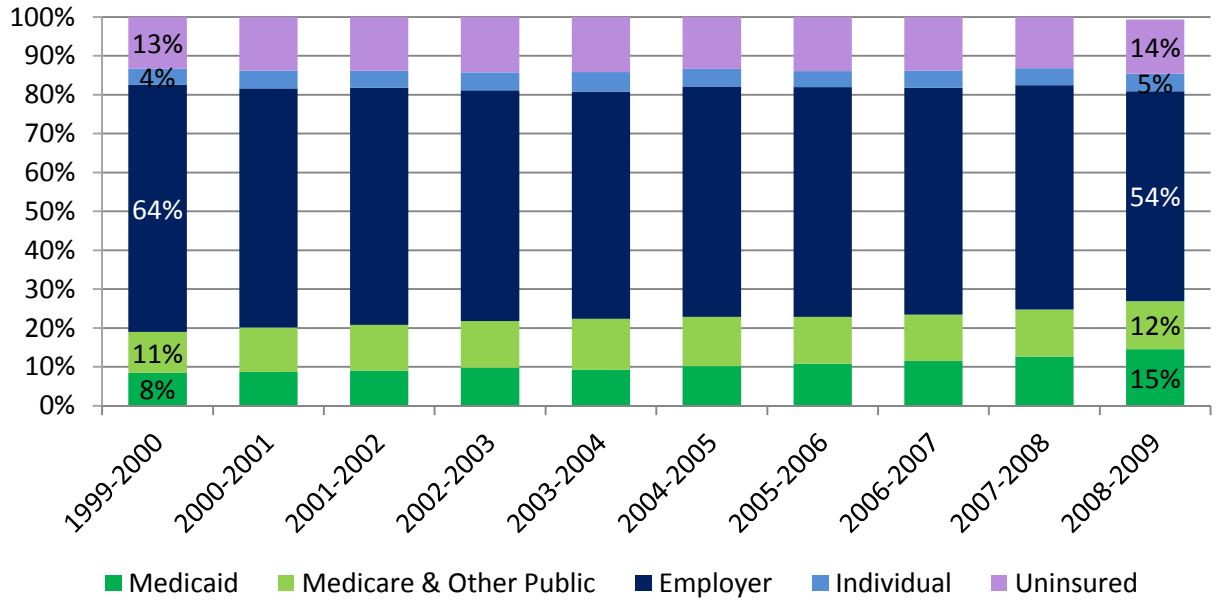
Figure C.13: Illinois (18-64) population by insured status (2011 IHIS) [4]



Historical Trends in Coverage

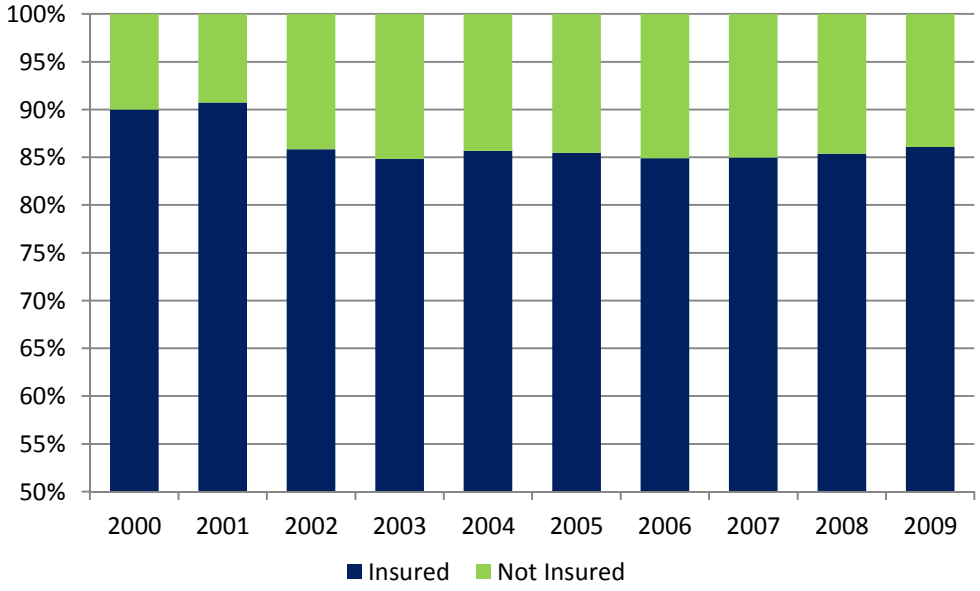
Coverage in Illinois has shifted somewhat from commercial toward government sponsorship over the last decade. By 2008-2009, Medicaid enrollment has expanded to cover 15% of the State population, largely offsetting a reduction in employer sponsored insurance. Rates of uninsured have held fairly steady over time (refer to Figure C.14 below). Dual eligibles are included in Medicaid.

Figure C.14: Distribution of health insurance coverage across total Illinois population, shown as two year averages (1999-2009 Urban Institute/Kaiser)[3]



According to the BRFSS study, nearly 90% of the Illinois adult population had insurance coverage as of 2000. By 2009, the insured rate reduced to the approximately 86%, reflecting a large increase in the number of uninsured (uninsured went from approximately 10% of the population to 14% of the population). The Urban Institute/Kaiser data above also show an increase in the uninsured rate, however the magnitude of the increase in uninsured is much larger in the BRFSS data (5 percentage point increase) versus the Urban Institute/Kaiser data (1 percentage point increase).

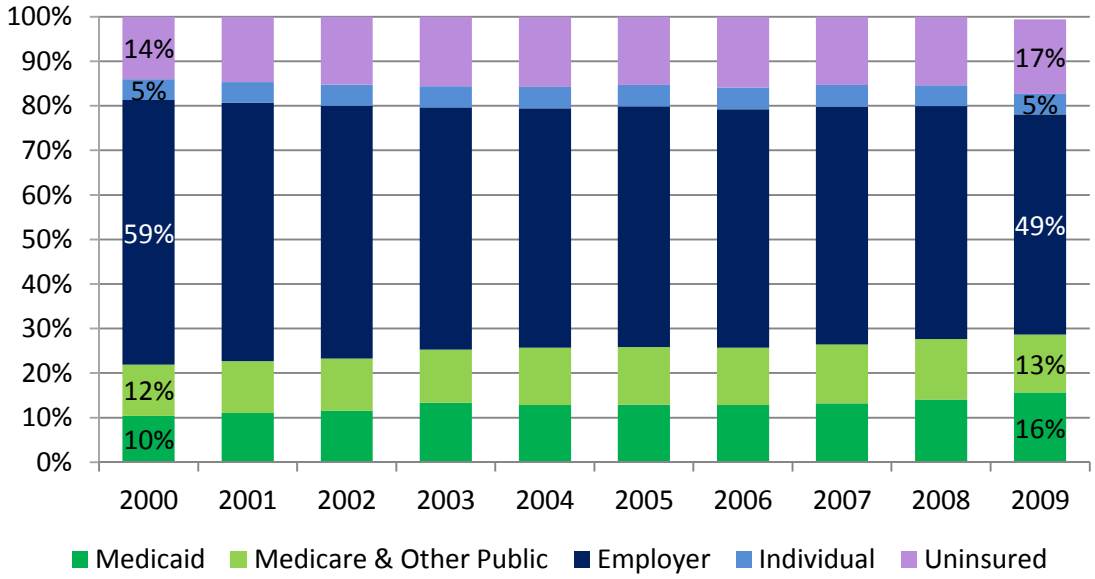
Figure C.15: Historical distribution of the over 18 population by insurance coverage across Illinois (2000-2009 BRFSS) [16]



Coverage trends for Illinois are slightly different from those for the U.S. population. Trends in the U.S. are comparable to Illinois, though somewhat different in magnitude

In Illinois, residents are more likely to access coverage through employer-based arrangements (55%) versus the U.S. (49%) as of 2009. Government sponsored insurance represents a growing share of the coverage nationwide, with Medicare enrollment growing as the population continues to age and Medicaid enrollment growing due to economic conditions and program expansions.

Figure C.16: Distribution of health insurance coverage across the U.S. (2000-2009 Urban Institute/Kaiser)[3]



D. Characteristics of the Insured and Uninsured

Overview

This section of the report describes key characteristics of the insured and uninsured populations and is organized as follows:

- Age and Gender,
- Race,
- Employment Status,
- Household Income,
- Public Programs,
- Geographic Regions,
- Barriers to Coverage for Individuals, and
- Specific Populations of Interest.

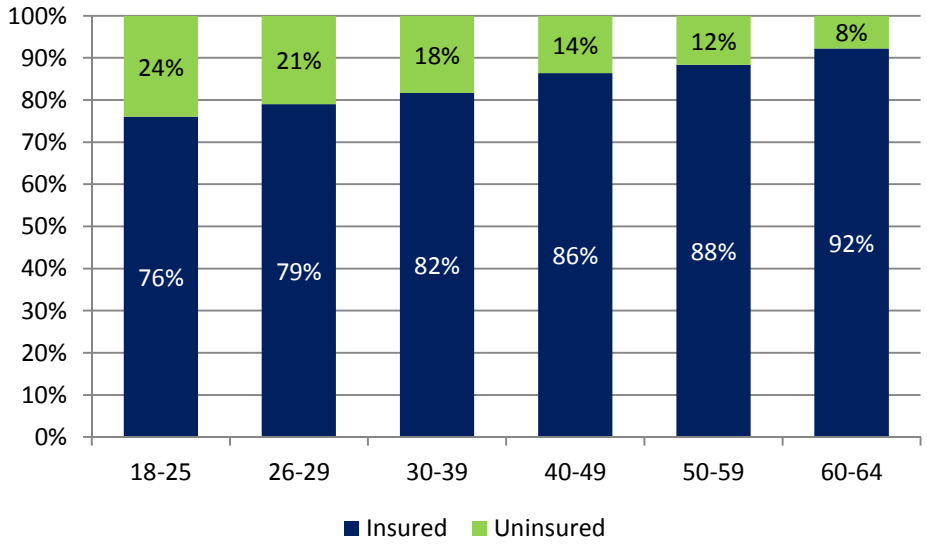
Key findings in this section include:

- The young adult population segment (18 to 25 year olds) is the most likely to be uninsured (24%) while the 60 to 64 year olds have the lowest uninsured rate (8%) among the age groups surveyed[4].
- Among the largest racial groups in Illinois, Hispanics have the highest uninsured rate (27%) with African Americans second (23%), while White Non-Hispanics have the lowest uninsured rate (13%)[4].
- As income increases, Illinoisans are increasingly likely to have health insurance coverage[4].
- Self-identified health status improves with increases in household income[16].
- Insured Illinoisans indicate that the most important factors in selecting a health plan are the cost of premiums and the out-of-pocket costs associated with doctor visits[4].
- The top two reasons reported by the uninsured for not having health insurance are:
    - insurance is too expensive,
    - insurance is not offered by an employer[4].
- The incidence of Frequent Mental Distress (FMD) is increasing over time, both in the total population and for the uninsured segment[16].

Age and Gender

Older Illinoisans are more likely to have health insurance. The young adult population segment (18 to 25 year olds) is the most likely to be uninsured (24%) while the 60 to 64 year olds have the lowest uninsured rate (8%) among the age groups surveyed.

Figure D.1: Distribution of Illinois (18-64) population by age (2011 IHIS)[4]



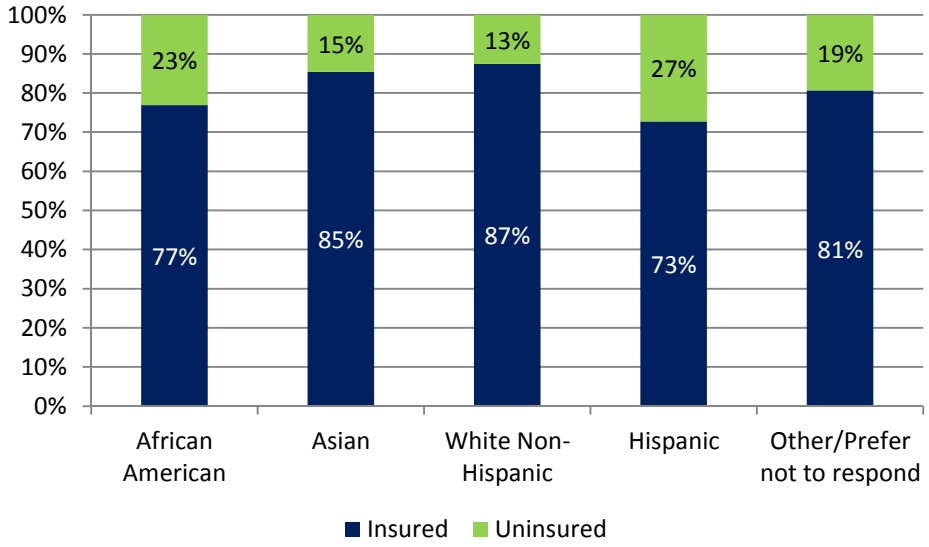
No statistically significant differences were found between the uninsured rates for males and females in Illinois. According to the IHIS, approximately the same rate of uninsurance exists for both males and females (16%)[4].

In 2010, more than 95% of all Illinois children were estimated to have health insurance. [38] According to a recent study performed by the State, nearly all children in Illinois were covered by some type of insurance.

Race

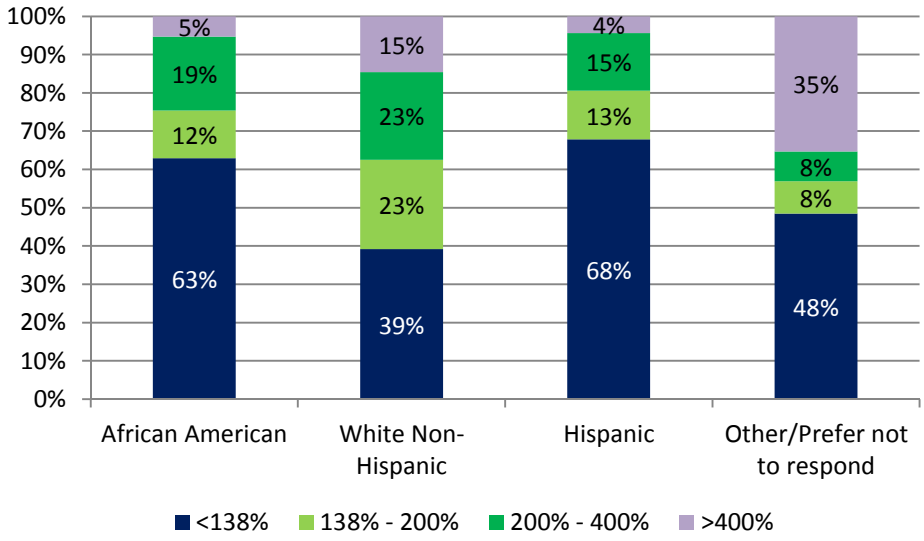
Among the largest racial groups, Hispanics in Illinois have the highest uninsured rate (27%) while White Non-Hispanics have the lowest uninsured rate (13%). According to the IHIS, 27% of Hispanics and 23% of African Americans in Illinois do not have health insurance, while only 13% of White Non-Hispanics are uninsured (Figure D.2*)*.

Figure D.2: Illinois population distribution (18-64) of race by insured status (2011 IHIS) [4]



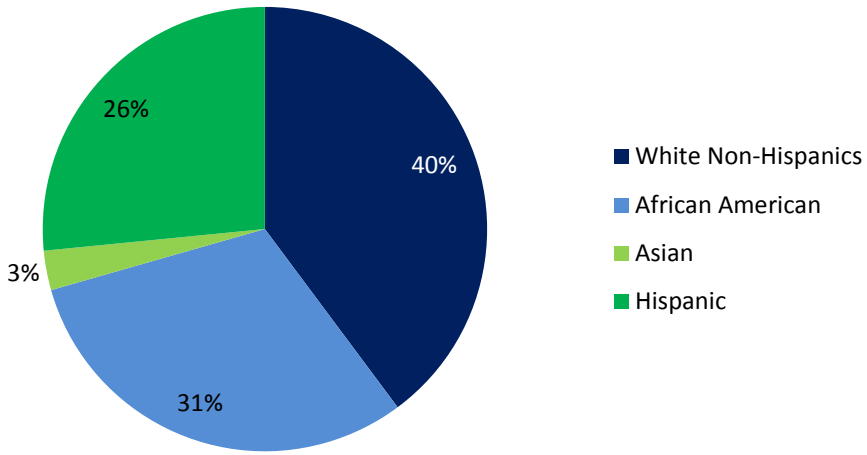
Over 75% of uninsured Hispanics and African Americans have incomes below 200% FPL. In contrast, only 62% of uninsured White Non-Hispanics live in households below 200% FPL, suggesting that this group is somewhat more often uninsured by choice, as opposed to reasons of financial constraints.

Figure D.3: Illinois uninsured (18-64) population distribution of race by income level (2011 IHIS)[4]



White Non-Hispanics make up the largest share of Medicaid enrollment, followed by African Americans and Hispanics. However, Hispanics and African Americans are disproportionately over-represented in the Medicaid population, while White Non-Hispanics are under-represented in Medicaid (as compared with their representation in the total State population).

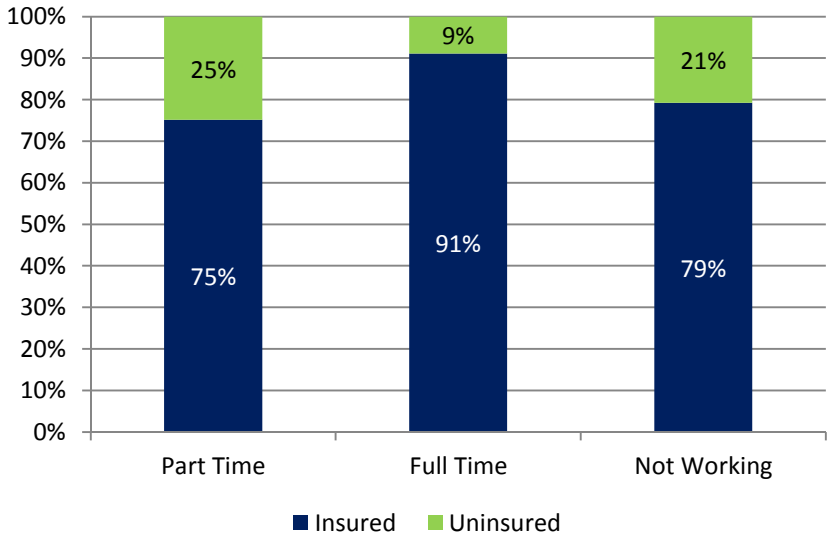
Figure D.4: Medicaid enrollment distribution across Illinois by race (July 2010 HFS)[17]



Employment Status

Per IHIS, fully employed respondents are more likely to have health insurance. Approximately 91% of the adult survey respondents working full time are insured while 75% of those working part time are insured, and 79% of those currently not working are insured. Respondents could be insured through another person's coverage (e.g., parent or spouse).

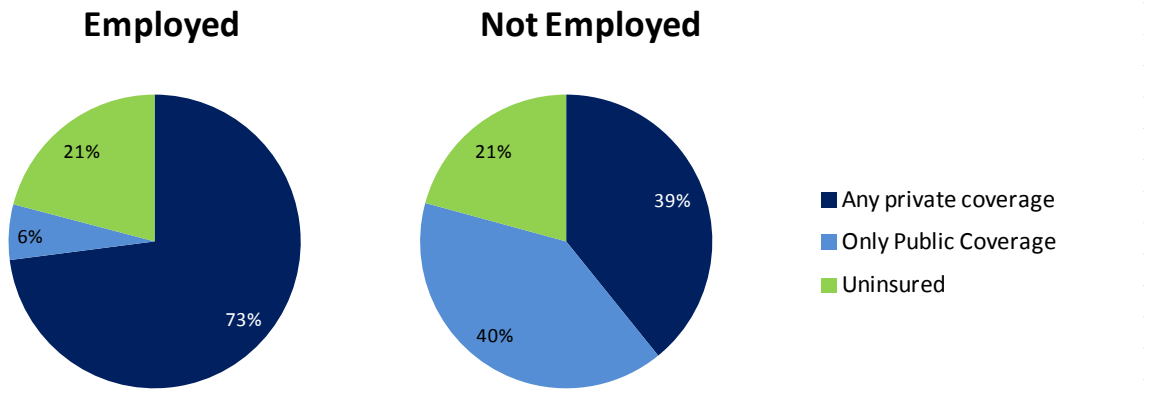
Figure D.5: Illinois population (18-64) insured status by employment status (2011 IHIS)[4]



The majority of employed persons are insured through private coverage while a large portion of those not currently working obtain health insurance through public programs. According to MEPS, persons who are currently employed are more likely to obtain health insurance through a private source (employer, individual market, etc.) than through any other source[20].

Those not currently working are significantly more likely than their employed counterparts to obtain insurance through public programs (Medicaid, Medicare, etc.) as only 6% of the employed population nationwide obtains insurance via public programs while 40% of those not currently working have public health insurance coverage[20].

Figure D.6: U.S. adult (16+) insured population's type of insurance by employment status (2010 MEPS)[20]



Most of the insured population in Illinois is working in services, education, health services, and retail industries. The service industries include business, personal, legal services, finance, insurance, real estate, technology, communication, transportation, government and public service, health services, etc. (Figure D.7).

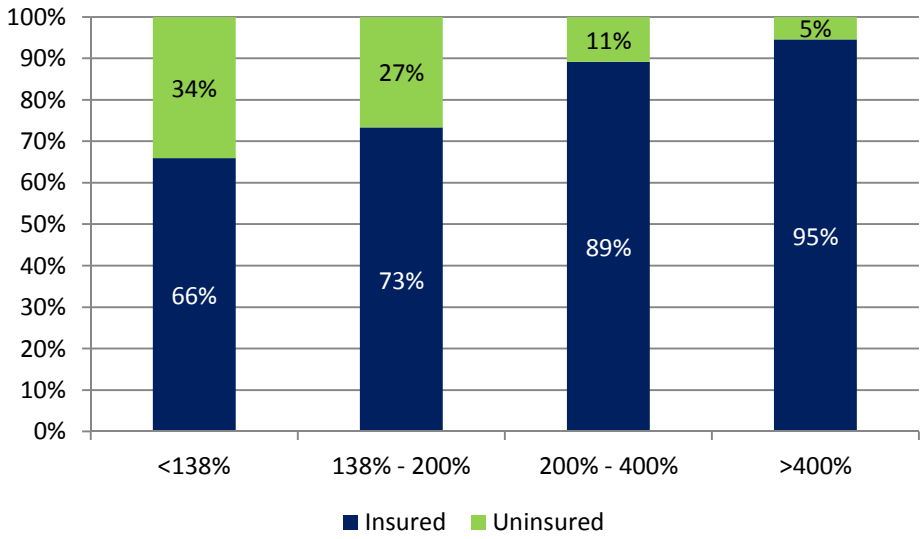
Figure D.7: Illinois insured adult (18-64) population by industry (2011 IHIS)[4]

Industry	% Population
Business services, personal services, legal services, finance, insurance, real estate, technology, communication, transportation	22%
Construction	3%
Education, social services	13%
Government, public service, military	5%
Health services	10%
Manufacturing	8%
Non-profits, religious organizations	4%
Retail, restaurant	10%
Arts, entertainment, recreation	3%
Other	22%

Household Income

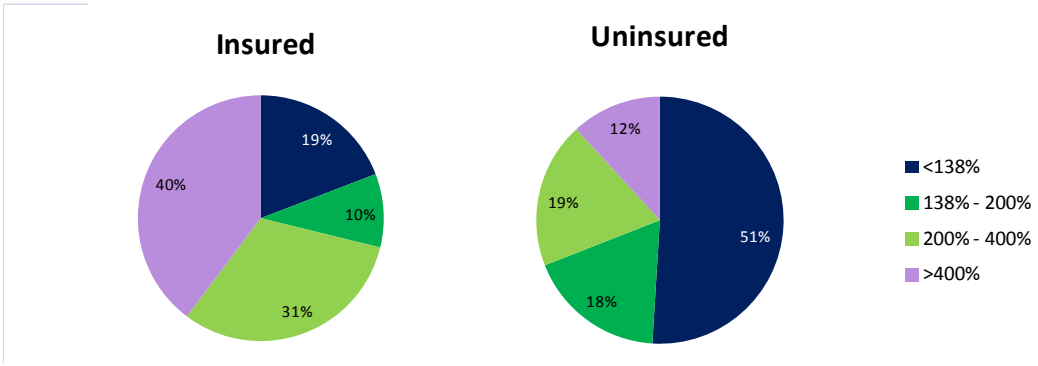
As income increases, Illinoisans are increasingly likely to have health insurance coverage. According to IHIS (Figure D.8), 34% of those having incomes below 138% FPL are uninsured, while only 5% of those above 400% are uninsured.

Figure D.8: Illinois population (18-64) by insured status and income level (2011 IHIS) [4]



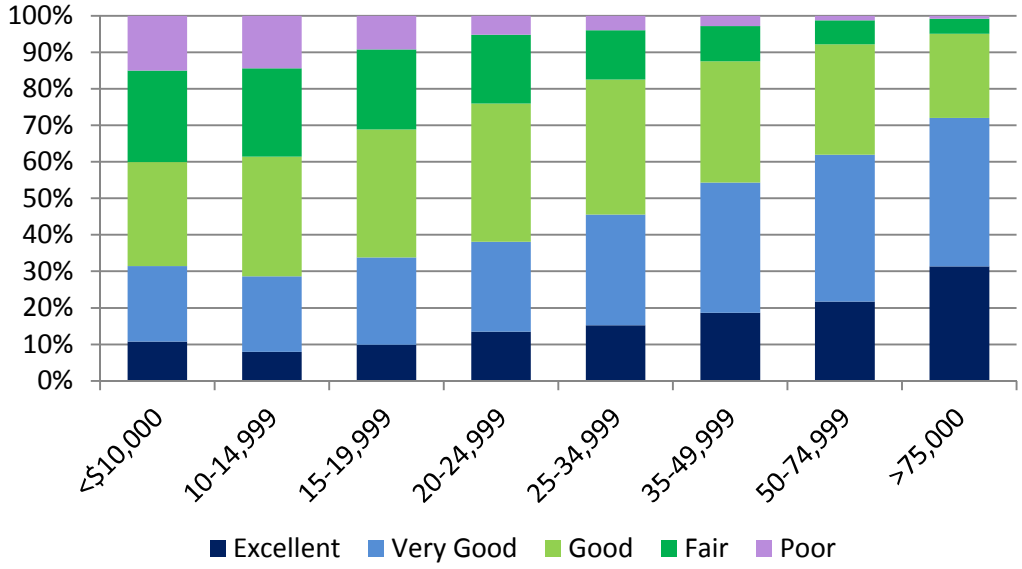
The uninsured are much more likely to be in lower income categories than insured persons. According to the IHIS, 31% of uninsured respondents have household incomes of more than 200% FPL while 71% of the insured respondents' household incomes exceed 200% FPL (Figure D.9.

Figure D.9: Illinois population (18-64) by income and insured status (2011 IHIS)[4]



Self-identified health status improves with increases in household income. According to the BRFSS results, respondents with higher income report better health status (Figure D.10).

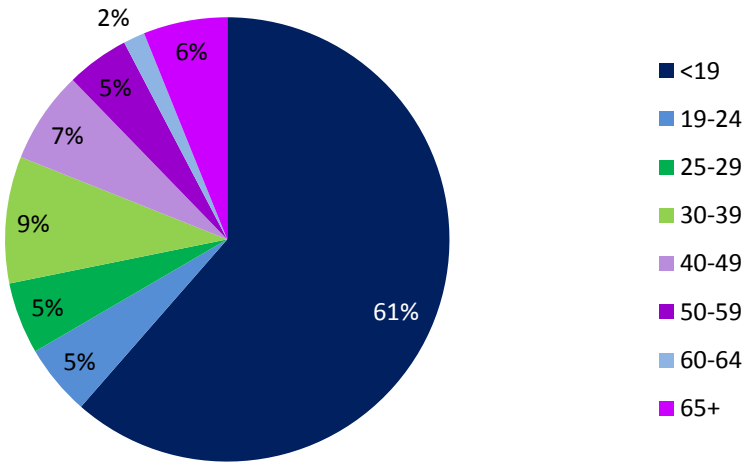
Figure D.10: Self-identified general health rating for the Illinois adult over 18 population by FPL (2009 BRFSS)[16]



Public Programs

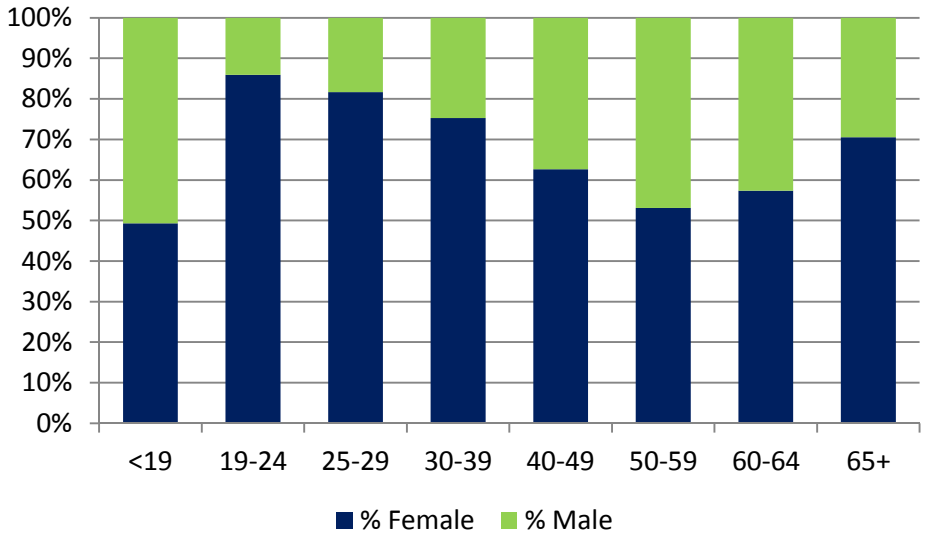
The majority of the current Illinois Medicaid enrollees are children under the age of 19. According to Medicaid enrollment data provided by HFS, 61% of the State's Medicaid enrollment is children. Included in Medicaid are the All Kids and Family Care programs and dual eligibles. The partial benefit programs have been excluded. Nearly 6% of the State's Medicaid enrollment is persons over age 65, who are typically also eligible for Medicare (i.e. dually eligible for both Medicare and Medicaid).

Figure D.11: Total Illinois Medicaid enrollment distribution by age (July 2010 HFS) [17]



The Medicaid population is dominated by females across age groups, with the exception of children. For ages older than 18, females are far more likely to be enrolled in Medicaid than males.

Figure D.12: Total Illinois Medicaid enrollment distribution by age and gender (July 2010 HFS) [17]

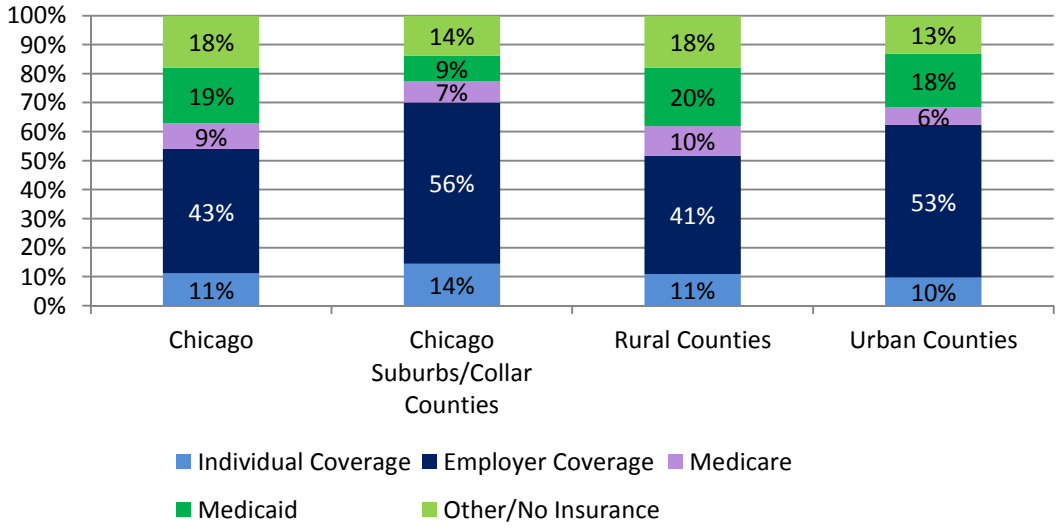


20% of the total uninsured population age 18-64 has a household member currently covered under Medicaid[4]. This statistic can be attributed largely to Medicaid-eligible children living in uninsured persons' households.

Geographic Regions

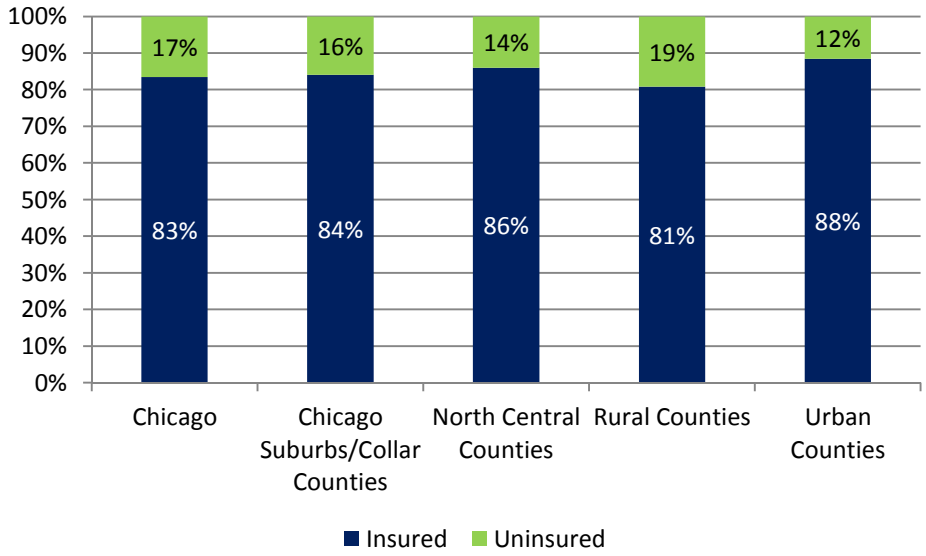
Health insurance coverage type varies by region. According to the IHIS, the Chicago Suburbs/Collar Counties' population primarily obtains insurance coverage via the employer market (56%), while far fewer obtain coverage through Medicaid (9%) or Medicare (7%). In contrast, less than half (43%) of the Chicago population obtains coverage via the employer market while 19% access insurance through Medicaid and 9% receive coverage through Medicare. (Figure D.13).

Figure D.13: Regional Illinois population by type of insurance coverage (2011 IHIS)[4]



The uninsured rates vary between 12% and 19% across geographic regions. The highest rate of uninsurance according to the IHIS is in the Rural Counties (19%) while the lowest rate of uninsurance is in the Urban Counties (12%) (Figure D.14)

Figure D.14: Regional distribution of Illinois population (18-64) by insured status (2011 IHIS)[4]



Other Considerations

a. Cost

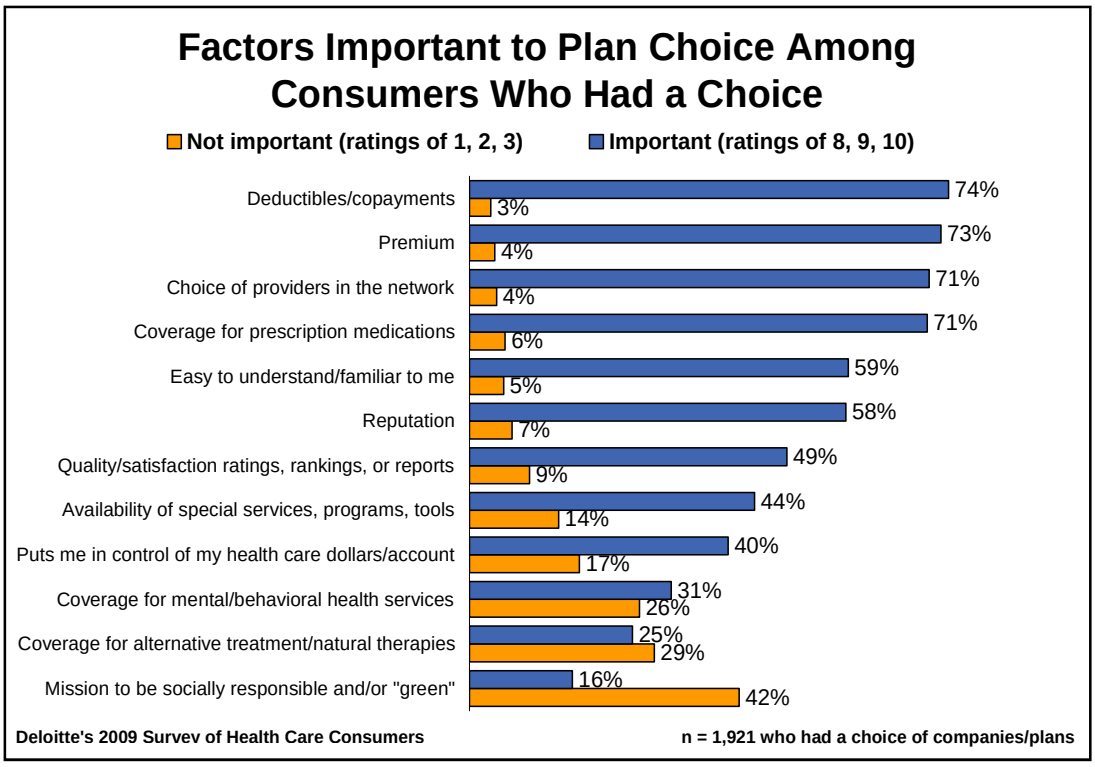
The most important factors in the selection of a health plan for the Illinois population are the cost of premium and the out-of-pocket costs associated with doctor visits. Also significant were the reputation or reliability of the health plan when it comes to paying claims, as well as having a choice of providers in the network. In the below Figure D.15, each question was rated separately as the respondent was asked to identify how important a given factor is in choosing primary health insurance. For the purposes of this question, a '1' indicates the factor is 'Not at all important' while a '5' indicates the factor is 'Extremely important'.

Figure D.15: Illinois population's (18-64) importance rating when selecting a health plan (2011 IHIS)[4]

Question	Average Rating
What I have to pay each month to buy the insurance (premium)	4.44
What I have to pay out-of-pocket when I visit a doctor (cost sharing via deductible/co-pay)	4.29
Reputation or reliability in paying claims	4.21
Choice of providers in the network	4.20
Puts me in control of my health care dollars	4.08
Easy to understand/familiar to me	4.06
Coverage for generic medications	4.05
Quality of customer service that I receive from the Insurance Company	4.04
Coverage for prescription brand name medications	3.97
Quality or satisfaction ratings, rankings, or reports of the particular plan: If you were to purchase health insurance today, how important would each of these factors be in choosing your primary health insurance?	3.82
Coverage for mental/behavioral health services	3.68
Coverage for alternative treatment approaches or natural therapies	3.52

The most important factors in selecting a health plan for the U.S. insured population include out-of-pocket costs (copays/deductible and premium), accessibility of providers in network, and coverage of prescription drugs. These same factors are at the top of the list for Illinoisans. The Deloitte Center for Health Solutions' 2009 Study of Healthcare Consumers rated each of the following categories on a ten point scale with '1' being least important and '10' being most important.

Figure D.16: U.S. important factors when selecting a health plan (2009 Study of Healthcare Consumers, Deloitte Center for Health Solutions)[21]



b. Satisfaction

Consumer satisfaction with health insurance varies across several key characteristics. Satisfaction is highest for mental health coverage, quality of medical care, and generic medication benefits.

The two most important features when selecting a health plan are the two characteristics the insured population is least satisfied with in their current insurance. Illinoisans are least satisfied with the amount they pay in premium (3.06 average rating), followed by the amount they pay for cost sharing (3.12 average rating), and amount of control they have over their health care dollars (3.13 average rating) (Figure D.17). For this topic, respondents were asked to rate how satisfied he/she is with each of the below factors for his/her current health insurance. A rating of '1' indicates the respondent is 'Not at all satisfied' while a rating of '5' is 'Extremely satisfied'

Figure D.17: Insured population (18-64) satisfaction with health plan characteristics (2011 IHIS) [4]

Health Plan Characteristic	Average Rating
Mental Health Coverage	3.72
Quality of Care	3.61
Generic Rx Coverage	3.60
Choice of Doctors	3.51
Alternative Treatment Coverage	3.50
Quality of Customer Service	3.36
Benefits & Services	3.23
Brand Rx Coverage	3.16
Easy to Understand	3.16
Control of Health Care Dollars	3.13
Cost Sharing	3.12
Premium	3.06

The most common complaint filed by health insurance consumers with the Illinois DOI was unsatisfactory claims settlement, followed closely by the denial of a claim. Claim related issues represent the top three items, amounting to over 75% of the complaints. Figure D.18 displays the number of complaints by general complaint categories over 2009 – 2011.

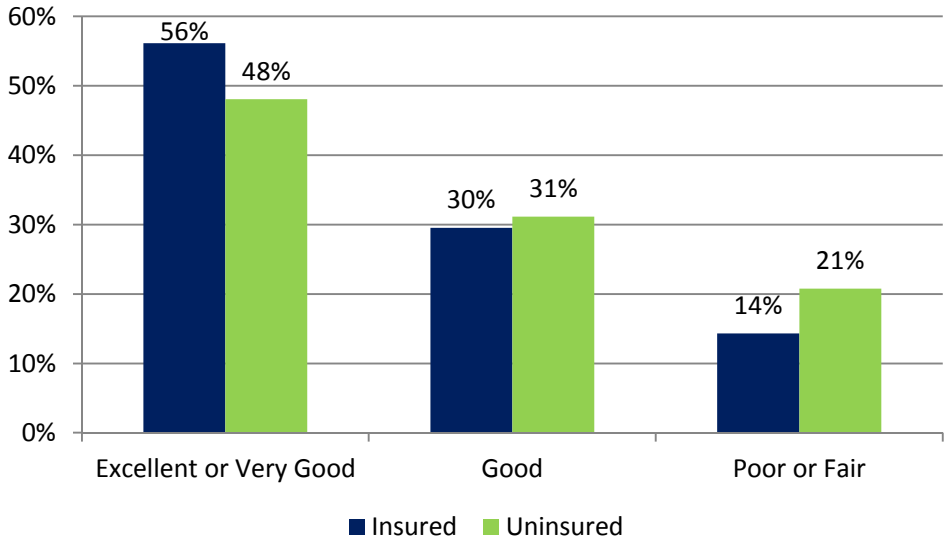
Figure D.18: Distribution of Illinois consumer complaints filed with the DOI (2009-2011 Illinois DOI) [22]

Description of Complaint	Count of Complaints 2009 - 2011	% of Complaints
Unsatisfactory Settlement	909	35%
Denial of Claim	871	33%
Claim Delay/Unpaid	245	9%
Service Delays	161	6%
Premium & Rating	143	5%
Other	94	4%
Refusal to Insure	66	3%
Provider Relations	53	2%
Post Claim Underwriting	43	2%
Cancellation	33	1%
Premium Notice/Billing Problem	13	0%
Total	**2,631**	**100%**

c. Health Status

The uninsured population in Illinois self-reports as being less healthy than those who are insured. (Figure D.19). The IHIS results are consistent with the findings shown from BRFSS.

Figure D.19: Distribution of Illinois population by general health rating and insured status for adults 18+ (2009 BRFSS) [16]



IHIS results also indicate that 37% of the uninsured have been diagnosed with a chronic condition while 52% of the insured have been diagnosed with a chronic condition[4]. However, the higher rate of diagnoses for the insured population is influenced by their insurance and better access to medical services. These findings suggest that the uninsured are somewhat less healthy, on average, than the insured. As the uninsured obtain new coverage on the Exchange in 2014 and later years, their average health status may tend to increase average health costs; however, there are a number of additional factors which will tend to exacerbate this effect (e.g. guaranteed issue requirements under ACA) or mitigate it (e.g. ACA subsidies which will motivate some healthier individuals to join the Exchange)..

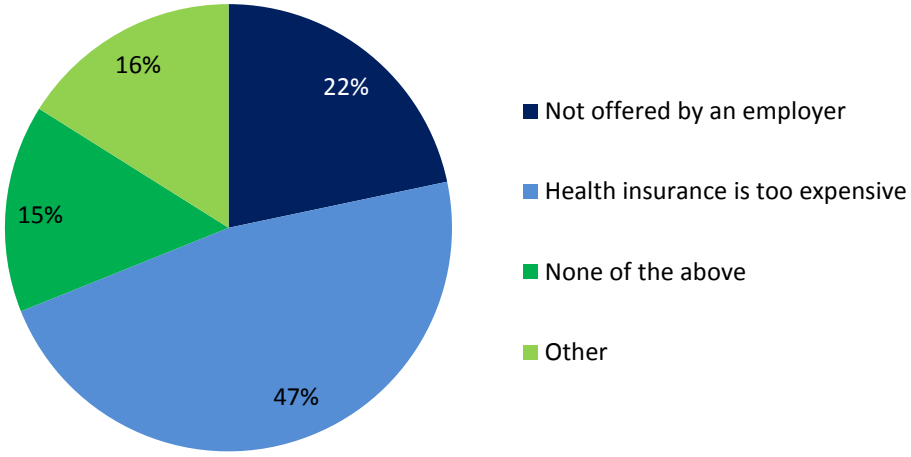
Barriers to Coverage for Individuals

Barriers to individuals purchasing and maintaining health insurance coverage are analyzed in this section, using information drawn from various research work.

a. Cost of Insurance and Employers Offering Coverage

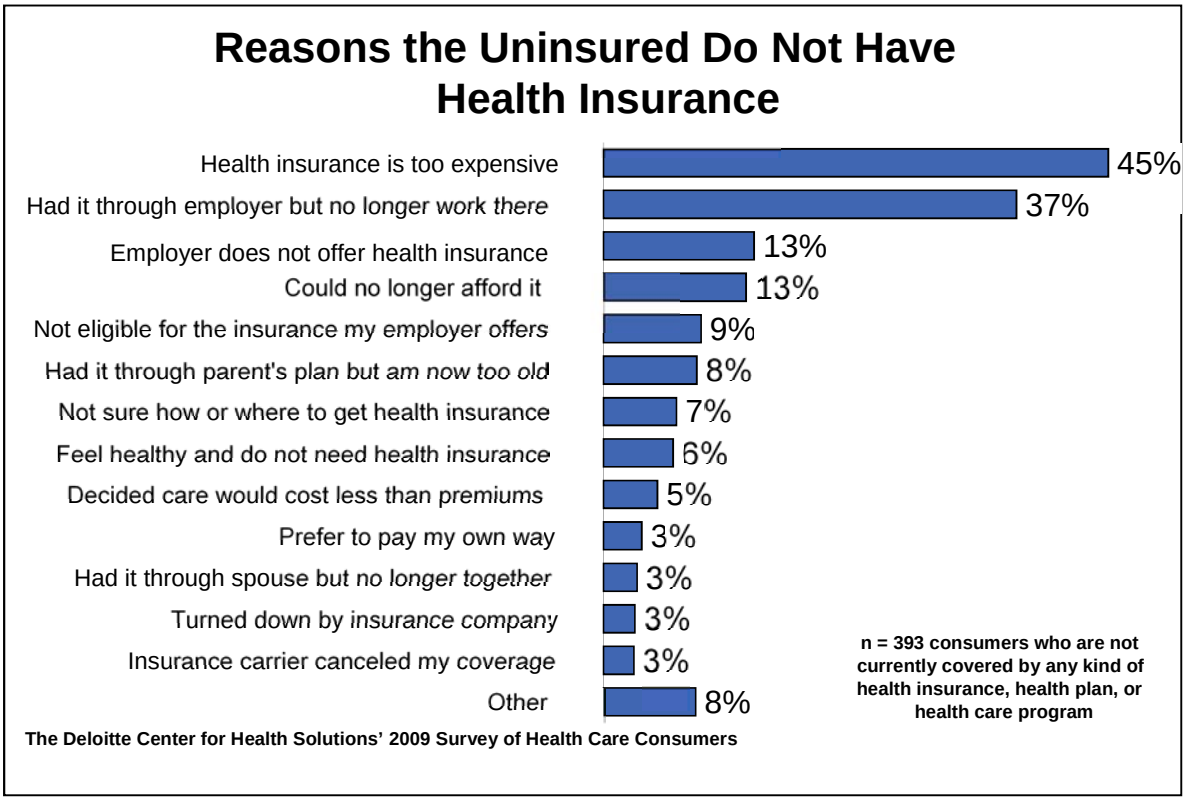
The top two reported reasons the uninsured in Illinois do not have health insurance are because insurance is too expensive and/or because it is not offered by an employer. In the IHIS, 47% of uninsured respondents answered that the reason why he/she does not currently have health insurance is because it is too expensive. The second most frequent answer given by 22% of respondents was that health insurance was not offered by an employer (Figure D.20).

Figure D.20: Illinois adult 18-64 population, reasons for being uninsured (2011 IHIS)[4]



Consistent with the Illinois IHIS, major reasons the uninsured in the U.S. do not have health insurance is because insurance is too expensive and it is not offered by an employer.

Figure D.21: Reasons the uninsured in the U.S. do not have insurance (2009 Consumer Survey, Deloitte Center for Health Solutions)[21]



b. <u>Health Status</u>

According to the Carrier Survey information, 9% of policies for the individual market (HMO and PPO) were issued with specific conditions excluded as part of the underwriting process[6].

These prior-existing conditions exclusions present barriers to coverage for people - mostly because they will not be fully covered for certain existing medical conditions (see Section E)[6]. Some people may choose not to purchase insurance if a significant health condition is excluded from the policy.

However, the State does operate several high risk pools to offer insurance to individuals that have trouble finding insurance, including the Traditional High Risk Pool that covers pre-

existing conditions[23].

c. Additional Comments

- **Age and Gender -** Older Illinoisans are more likely to have health insurance. The younger populations (18-25 year olds) have the highest rate of uninsurance[4]. This is influenced by relative income levels and employment rates, as well as differences in the perceived need for health insurance. Based on the research, there are no apparent differences between males and females in their rate of uninsurance[4].

- **Household Income** –according to the IHIS, the majority of the uninsured (69%) are under 200% FPL and as income rises, the percentage insured increases[4].

Specific Populations of Interest

The State identified two specific segments of the population for additional background research:

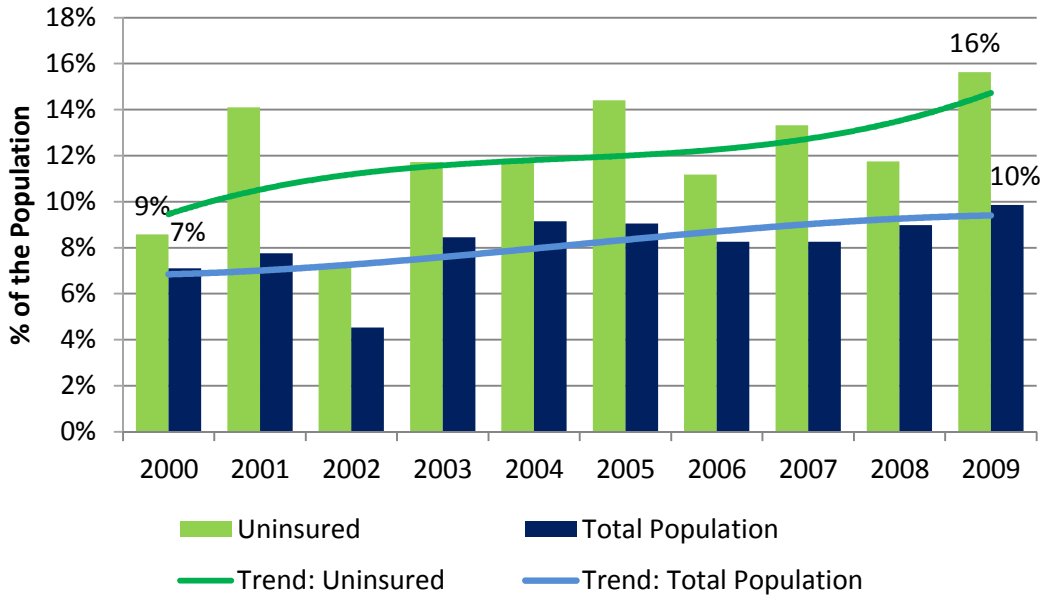
- The uninsured that suffer from mental illness and
- The ex-prisoner population.

a. Uninsured that Suffer from Mental Illness

The incidence of Frequent Mental Distress (FMD) is increasing over time, both in the total population and among the uninsured. FMD is defined as those who have 14 or more mentally unhealthy days in the last 30 days, per the Center for Disease Control[16]. BRFSS investigates this by asking respondents each year to identify the number of days their mental health was not good in the past 30 days. While the actual rate of FMD incidence has varied from year to year, the percentage of the population with FMD has generally increased over time (Figure D.22).

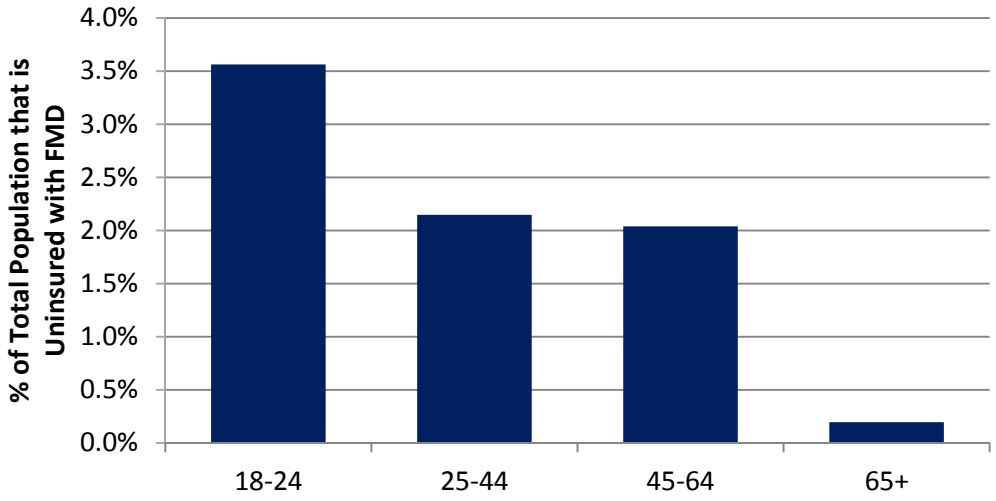
The reported increase in 2009 for the uninsured population is particularly pronounced (Figure D.23). For all periods, the incidence of FMD is higher in the uninsured than the total population.

Figure D.22: Trends in the incidence of FMD in the Illinois adult 18+ population over time (2000-2009 BRFSS)[16]



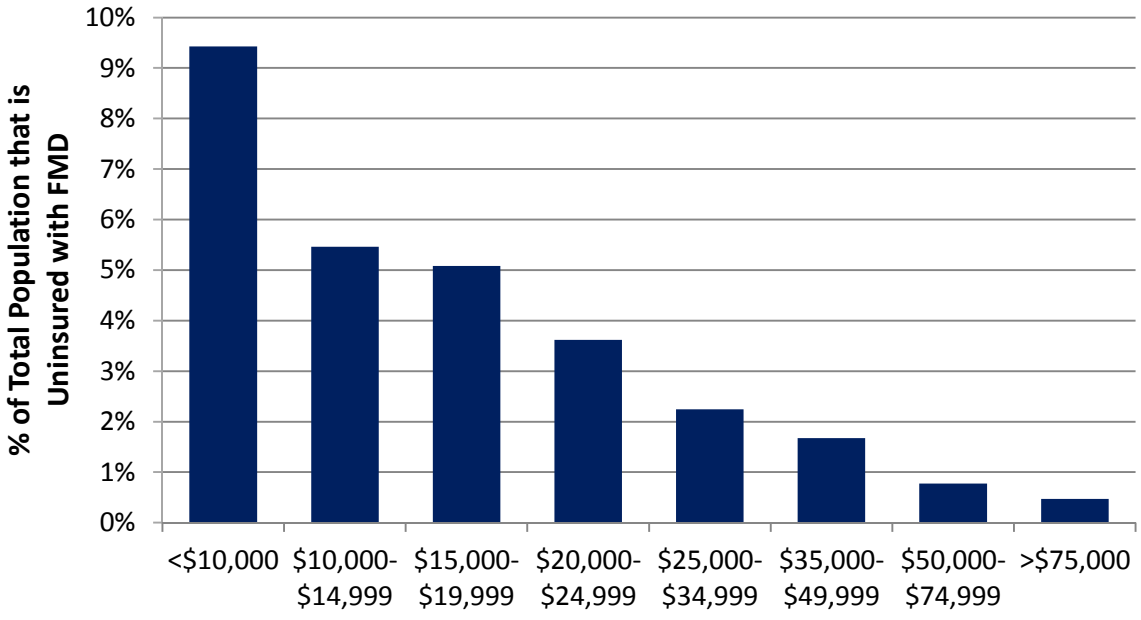
Within the uninsured population, FMD is more common at the younger ages. The incidence of FMD is higher for 18 to 24 year olds than for older age groups (Figure D.23). (Given the low level of uninsured over the age of 65 the value for that age group may not be reliable.)

Figure D.23: Differences in the incidence of FMD in the uninsured population by age group (2007-2009 BRFSS) [16]



Within the uninsured population, FMD is more prevalent at lower income levels, with incidence decreasing rapidly as income increases (Figure D.24).

Figure D.24: Incidence of FMD in the uninsured population by income level (2007-2009 BRFSS) [16]



b. Ex-Prisoner Population

The ex-prisoner population is less likely to be employed than the population as a whole. This group also tends to have depressed earnings when employed relative to the average.

- The PEW Charitable Trust found that employment was lower (indicated as average number of weeks worked) for the ex-prisoner population nationally, and that hourly wages and annual earnings reduced as well (Figure D.25).

Figure D.25: Estimated effect of incarceration on male wages, weeks worked and annual earnings predicted at age 45 (2009 The Pew Charitable Trusts)[24]

Population	Wages	Weeks worked	Annual Earnings
If not incarcerated	$16.33/hr.	48 weeks	$39,100
Post-Incarceration	$14.57/hr.	39 weeks	$23,500

- A significant proportion of ex-prisoners have been found to return to prison within a relatively short period from the time of their release. The PEW Center on the States in collaboration with the Association of State Correctional Administrators (ACSA), found three year recidivism rates of 52% for Illinois, higher than the U.S. average of 43%[25].

- The PEW Charitable Trust similarly found that the impact on earnings is longer term in nature and prevents upward income mobility.

Figure D.26: Percent of ex-prisoner men in the top and bottom of the earnings distribution in 2006 who were in the bottom in 1986 (2009 Pew Charitable Trusts)[24]

Population	Remain in Bottom of Earnings Distribution	Progress Upward in Earnings Distribution
Not incarcerated	33%	16%
Incarcerated	67%	2%

Soon-to-be-released prisoner population has a higher prevalence of diseases. The RAND research brief "Prisoner Reentry: What Are the Public Health Challenges?" reported that incidence for numerous diseases are higher in the soon-to-be-released prisoner population, when compared to U.S. average (Figure D.27) [26].

Figure D.27: Health status of soon-to-be-released offenders compared to the U.S. population (1996 The RAND Corporation)[26]

Category	Condition	Prevalence Relative to U.S. population
Infectious Diseases	Active Tuberculosis	4 times greater
	Hepatitis C	9 - 10 times greater
	AIDS	5 times greater
	HIV Infection	8-9 times greater
Chronic Diseases	Asthma	Higher
	Diabetes/hypertension	Lower
Mental Illness	Schizophrenia/Psychotic Disorder	3 - 5 times greater
	Bipolar Disorder	1.5 - 3 times greater
	Major Depression	Roughly equal

E. Characteristics of the Underinsured

Overview

The underinsured population is a subset of the insured population. The underinsured have health insurance, but the insurance is not considered fully adequate. The State developed several different definitions of underinsured, each of which is analyzed in this section:

- Consumers' confidence about adequacy of health insurance coverage,
- Those enrolled in a 'mini-med' policy, and
- Those who currently have a pre-existing condition that is specifically excluded from their policy.

In Section G (Assessment of Affordability of Coverage), there is further analysis relevant to the issue of underinsurance. In that section, we focus on specific cost related issues, such as:

- Estimating the out-of-pocket costs and comparing to household income to determine whether out-of-pocket costs are more than 10% of household income (more than 5% of household income for families below 200% FPL).
- Providing findings on those who have had problems paying medical bills or who have delayed care due to cost.

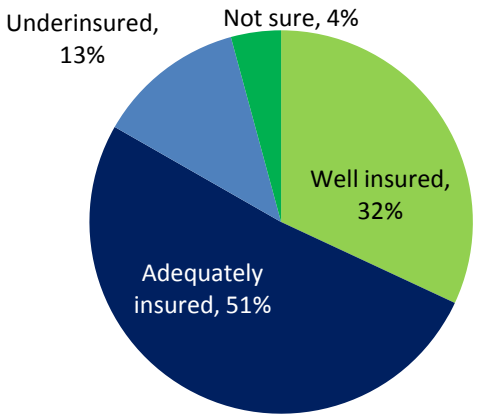
Key findings detailed in this section include:

- Approximately 13% of Illinois households self-identify as being underinsured[4].
- According to a summary from the U.S. Department of Health and Human Services (HHS), approximately 1.2% of the U.S. population is enrolled in a health plan approved for waiver of the annual limits requirements[27].
- 8.6% of the Illinois population has been denied coverage and/or had health benefits limited due to a pre-existing condition, according to the IHIS[4].

Health Insurance Adequacy

Approximately 13% of the insured Illinois population self-identifies as being underinsured. According to the 2011 IHIS, approximately half of the population feels 'well insured' with another 32% feeling 'adequately insured', for a total of 83% feeling their insurance coverage is at least adequate. A small portion of the population (4%) is not sure about their level of insurance.

Figure E.1: Illinois adult, 18-64, population distribution of insurance adequacy (2011 IHIS) [4]



Mini-Med Policies

According to a summary from the U.S. Department of Health and Human Services (HHS), approximately 1.2% of the U.S. population is enrolled in a health plan approved for waiver of the annual limits requirements[27]**.** Between now and 2014, employers and insurers must get permission (or a waiver) to continue to provide these types of limited coverage. The HHS waiver list includes employers based in Illinois, as well as employers based in other states that have Illinois employees[27].

Below is a table summarizing the waivers filed with HHS as of 1/26/2011, where employer-based plans represent 97% of all waivers (including self-insured plans, collectively-bargained plans, and health reimbursement arrangements)(Figure E.2). The remaining 3% are health insurers and state governments.

Figure E.2: Summary of waivers by coverage type in the U.S. (January 2011 U.S. HHS Listing)[27]

Source of Health Plan Coverage/Waiver Type	Number of Waivers	Percentage of All Waivers
Employment-Based Plans		
Self-Insured Employer Plans	*359*	49%
Collectively-Bargained Employer-Based Plans	*182*	25%
Health Reimbursement Arrangements (HRAs)	*171*	23%
Health Insurers	16	2%
State Governments (OH, MA, NJ, TN)	4	1%
Total Number of Waivers	**732**	**100%**

Policies with Exclusions

8.6% of the Illinois adult population, age 18-64, has been denied coverage and/or had health benefits limited due to a pre-existing condition, according to the IHIS[4]. Note that these denials and limitations occur mainly in the individual market, rather than under group plans. The percentage includes respondents who may have group or other coverage currently, but report having coverage denied or limited in the past.

The percentage of individual market policies issued with specific exclusions was 9% according to the Carrier Survey[6]. 9% of policies in the individual market were issued with specific underwriting prior-existing condition exclusions[6]. Application denials averaged 12% according to the Carrier Survey[6]. The prevalence of pre-existing conditions exclusions and denial rates vary significantly among carriers in the individual market[6].

F. Characteristics of the Health Insurance Marketplace

Overview

This section provides an overview of the health insurance marketplace in Illinois and is organized as follows:

- A description of the current market for commercial coverage including common plan designs,
- Information on the State's high risk pools,
- Identification of potential barriers to competition in the market, and
- Descriptive statistics on the distribution channels (e.g., agents, brokers) for coverage as they exist today.

Key findings in this section include:

- The Illinois health carrier market is highly concentrated among a small number of leading carriers.
- The largest carrier in the State has a market share of about 49% of total enrollment across all health plan market segments, including insured and self-insured. This is significantly higher than the market share of leading carriers in most other large states [5].
- The top two carriers in each Metropolitan Statistical Area in Illinois represent over 60% of each area's enrollment[5].
- The data indicates that PPOs dominate the fully insured individual and small group market[6].
- The market offers hundreds of products/plan designs[6].
- The top barriers to coverage are cost and availability of insurance being offered by employers[7,8,9].
- Individuals in the State-funded high risk pools represent less than 1% of the total population[23].
- Agents' total compensation measured as a percentage of premium decreases as customer size increases[6].
- As would be expected, consumers travel longer distances to access care in the more rural areas of Illinois[29]. Medicare insured members tend to travel shorter distances than persons with other types of coverage[29].

Current Carrier Marketplace

Analyzed below are several aspects of the current carrier marketplace including the carriers and their market concentrations, products and plan designs, and provider networks.

a. Carriers and Market Concentration

The health insurance marketplace in Illinois includes one carrier that is much larger than any competitor in the State. Health Care Service Corporation (HCSC) has 49% of the statewide market share (in terms of enrolled membership). This compares with a median value of 25% for the leading carrier in the other nine largest states in the U.S. The top two carriers in the State have 63% of the membership (Figure F.1). The percentage market share calculations below include membership in insured and self-insured plans, including managed Medicare and managed Medicaid (if any) for the ten states.

In comparison to the other largest states in the country, Illinois is second only to Michigan in the market share concentration achieved by the largest carrier. The 49% share shown for HCSC excludes business attributable to associated Blue Cross and Blue Shield plans based in other states, and may differ from other market share estimates for that reason. In addition, market shares vary by market segment and are also affected by differences in time periods and methodology.

The health carrier marketplace in Illinois is 'highly concentrated' based on standard metrics and thresholds used by the federal Department of Justice (DOJ) for antitrust enforcement purposes. This analysis uses the Herfindahl-Hirschman Index (HHI), a weighted average market share metric. DOJ guidelines define an unconcentrated market as one with an HHI below 1,500, a moderately concentrated market as one with an HHI between 1,500 and 2,500, and a highly concentrated market as one with an HHI above 2,500. With a statewide HHI of approximately 2,800, Illinois is somewhat above the threshold for highly concentrated markets. Michigan is also determined to be 'highly concentrated', while Texas and North Carolina are 'moderately concentrated' and the remaining large states are 'unconcentrated'.

Figure F.1: Health plan market concentration for the top 10 most populous states based on enrollment estimates as of January 2011 in all fully and self-insured products (2011 HealthLeaders-InterStudy, January 2011 HHI)[5, 37]

Market Sorted By Population	Total Population	Top Carrier	% Share		2011 Herfindahl –Hirschman Index (HHI)	
			Top Carrier	Top 2 Carriers	Index	Classification
California	37,253,956	Kaiser Foundation	25%	49%	1,455	Unconcentrated
Texas	25,145,561	HCSC	29%	47%	1,544	Moderately Concentrated
New York	19,378,102	UnitedHealth Group	21%	37%	1,056	Unconcentrated
Florida	18,801,310	UnitedHealth Group	22%	42%	1,219	Unconcentrated
Illinois	12,830,632	HCSC	49%	63%	2,795	Highly Concentrated
Pennsylvania	12,702,379	Highmark	28%	43%	1,344	Unconcentrated
Ohio	11,536,504	WellPoint	23%	39%	1,280	Unconcentrated
Michigan	9,883,640	BCBS of MI	51%	59%	2,840	Highly Concentrated
Georgia	9,687,653	WellPoint	23%	44%	1,332	Unconcentrated
North Carolina	9,535,483	BCBS of NC	38%	57%	2,104	Moderately Concentrated

In no Metropolitan Statistical Area (MSA) does the largest carrier's market share exceed approximately 56%. The largest carrier varies by region, and the largest market share in each region is most often between 40% and 50%[5] (Figure F.2).

The top two carriers represent over 60% of each MSA's enrollment (all segments, fully insured and self-insured). As shown in a study by HealthLeaders-InterStudy, HCSC has almost 50% market share and is the carrier with either the highest or second highest enrollment in most of Illinois' Metropolitan Statistical Areas (MSA) markets (Figure F.2).

Figure F.2: Illinois Insurance market concentration based on enrollment estimates as of January 2011 in all fully and self-insured products (2011 HealthLeaders-InterStudy)[5]

Market Sorted By Population	Total Population	Top Carrier	% Share	
			Top Carrier	Top 2 Carriers
Illinois	12,830,632	HCSC	49%	63%
Chicago/Naperville/Joliet	7,883,147	HCSC	46%	64%
Lake County–Kenosha, WI	869,888	HCSC	43%	65%
Davenport	379,690	UnitedHealth Group	56%	68%
Peoria	379,186	UnitedHealth Group	39%	62%
Rockford	349,431	HCSC	44%	62%
Champaign-Urbana	231,891	Health Alliance	53%	66%
Springfield	210,170	HCSC	50%	60%
Bloomington–Normal	169,572	HCSC	44%	65%
Kankakee	113,449	HCSC	32%	62%
Decatur	110,768	HCSC	48%	60%
Danville	81,625	Health Alliance	37%	65%

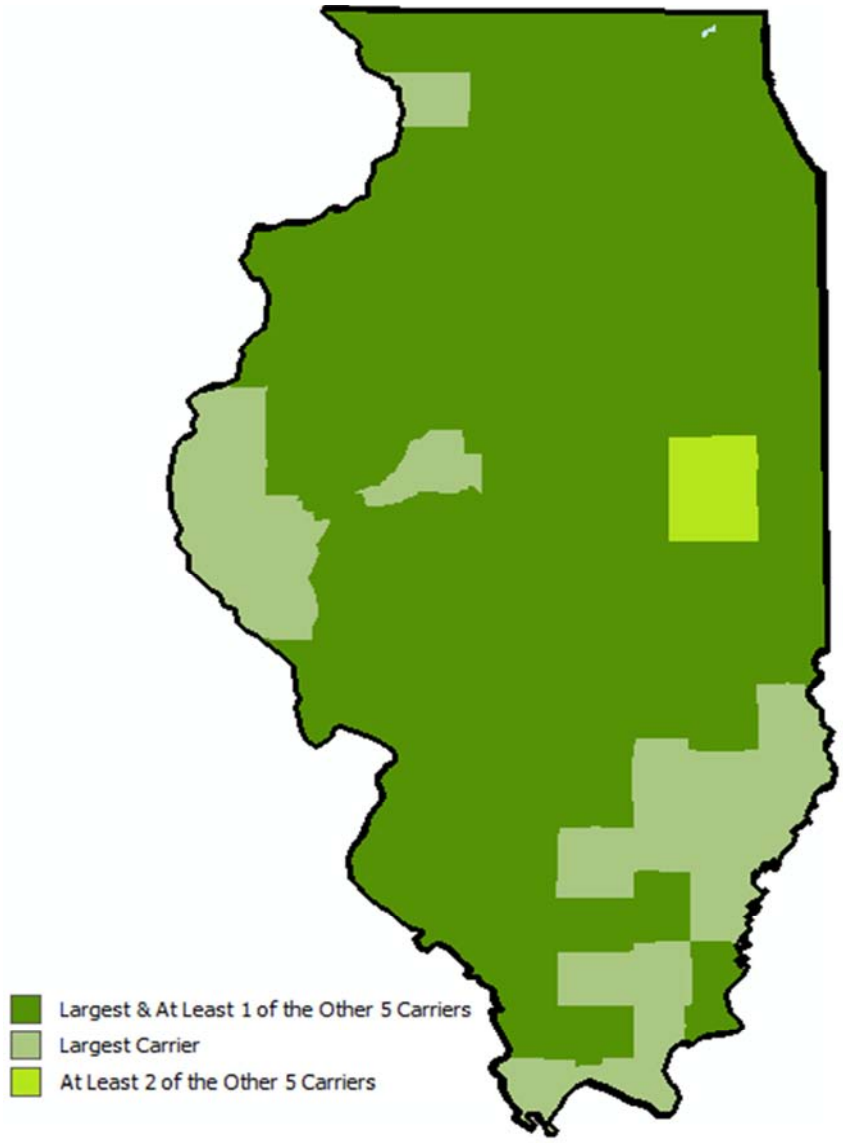
According to the Carrier Survey, only one carrier covers substantially all counties. Four other carriers cover between 26% and 37% of the counties across the State. These numbers are based on counties where each carrier has at least 5% of the fully insured commercial (individual, small group, and large group) membership (as seen in Figure F.3).

Figure F.3: Geographic coverage (% of Illinois counties covered with at least 5% market share in insured commercial market) for six top carriers in Illinois (2011 Carrier Survey) [6]

Carrier 1	Carrier 2	Carrier 3	Carrier 4	Carrier 5	Carrier 6
99%	9%	28%	26%	37%	33%

At least two carriers compete in most counties of the State. As shown in Figure F.4 below, at least two carriers compete significantly in each county. For this purpose, a significant competitor means a carrier having at least a 5% market share in the county's insured commercial enrollment (including individual, small group and large group) The light green areas represent those areas primarily covered by the top carrier (due to other carriers each covering less than 5% of the county's membership).

Figure F.4: Geographic coverage (at least 5% market share in insured commercial market) by the top 6 carriers by county (2011 Carrier Survey)[6]



There have been some recent exits from the carrier marketplace (or major market segments). The most recent Office of Consumer Health Insurance report (2009) highlighted some of these events including the largest recent market exit, Unicare, which withdrew from the commercial group and individual markets in 2009-2010, impacting 183,000 individuals[30]. Historical review of these reports indicated four market exits in 2007, one market exit in 2008, and four market exits (in addition to Unicare) in 2009[30].

b. Products and Common Plan Design

The data indicates for the top carriers, PPOs dominate the fully insured commercial market. This is especially true in the individual market where virtually all membership included in the Carrier Survey information is enrolled in PPO products (refer to Figure F.5 below).

Figure F.5: Distribution of enrollment by product type (2011 Carrier Survey)[6]

Plan Type	Small Group	Individual
PPO	84%	99%
HMO	11%	1%
Other (e.g., Point of Service)	5%	0%

The market offers over 500 different benefit designs. Across the carriers surveyed, more than 500 distinct cost sharing combinations were observed in the individual and small group commercial markets across the features included and analyzed as part of the Carrier Survey (deductible, coinsurance, out-of-pocket (OOP) maximum, PCP copays, specialist copays, inpatient copays, and emergency room (ER) copays)[6]. Note that participating carriers provided detailed information only on their top products by enrollment, representing at least 80% of enrollment for the carrier.

The most common plan designs in each of the individual and small group markets (excluding HMOs) are shown below, along with the market share of that plan design (Figures F.6 and F.7).

Figure F.6 & F.7: Top Illinois fully insured products by enrollment in the individual and small group commercial markets (none of the top plans included a hospital inpatient copay, excludes pharmacy) (2011 Carrier Survey)[6]

Individual Market						
Deductible	Coinsurance	OOP Max	ER Copay	PCP Copay	Specialist Copay	% of Total
$5,000	0%	$5,000	NA	NA	NA	6.7%
$2,500	20%	$5,500	NA	$30	$30	5.8%
$1,000	20%	$2,000	NA	$20	$20	5.2%
$1,000	20%	$4,000	NA	$30	$30	4.8%
$2,500	20%	$3,500	NA	$20	$20	4.0%
$2,500	20%	$3,500	NA	NA	NA	3.6%
$2,600	0%	$2,600	NA	NA	NA	3.5%
$1,000	20%	$2,000	NA	NA	NA	3.2%
$500	20%	$1,500	NA	$20	$20	3.0%
$500	20%	$3,500	NA	$30	$30	2.9%

Small Group Market						
Deductible	Coinsurance	OOP Max	ER Copay	PCP Copay	Specialist Copay	% of Total
$1,000	20%	$3,000	$150	$30	$50	6.5%
$2,500	0%	$5,000	NA	NA	NA	5.8%
$500	10%	$1,500	$150	$20	$40	4.5%
$2,500	0%	$2,500	NA	NA	NA	4.2%
$2,500	20%	$4,500	$150	$30	$50	3.8%
$500	20%	$2,500	$150	$30	$50	3.5%
$1,500	20%	$3,500	$150	$30	$50	3.3%
$1,000	10%	$2,000	$150	$20	$40	3.0%
$500	20%	$2,500	$150	$20	$40	2.8%
$2,500	20%	$5,000	NA	NA	NA	2.4%

Considering only the deductible, coinsurance and out-of-pocket maximum allows for grouping of like plans and produces a more consolidated view of popular plan designs. This summarized version of plan designs across non-HMO plans still show variability across the product options selected within the individual and small group markets, even when only considering the more popular options.

Figure F.8 & F.9: Deductible, coinsurance and out-of-pocket maximum combinations with more than 120,000 member months' exposure (excludes cases with copay cost sharing only; amounts shown apply to covered medical expenses other than pharmacy) (2011 Carrier Survey)[6]

Individual Market			
Deductible	Coinsurance	Out-of-Pocket Maximum	% of Total Enrollment*
$2,500	20%	$3,500	10.1%
$1,000	20%	$2,000	8.8%
$2,500	20%	$5,500	8.8%
$1,000	20%	$4,000	7.3%
$5,000	0%	$5,000	6.8%
$1,750	20%	$4,750	5.9%
$500	20%	$3,500	5.2%
$5,000	20%	$8,000	4.6%
$500	20%	$1,500	4.6%
$2,600	0%	$2,600	3.5%
$5,000	20%	$6,000	3.3%

Small Group Market			
Deductible	Coinsurance	Out-of-Pocket	% of Total Enrollment*
$1,000	20%	$3,000	10.1%
$500	20%	$2,500	7.6%
$500	10%	$1,500	7.2%
$2,500	0%	$5,000	5.8%
$2,500	0%	$2,500	5.4%
$1,500	20%	$3,500	4.9%
$2,500	20%	$4,500	4.8%
$1,000	10%	$2,000	3.8%
$250	10%	$1,250	3.1%
$2,500	20%	$5,000	2.4%

**Member Months reflect only cases where detailed plan design information was provided*

c. Provider Networks

According to SK&A's Nationwide Physician Specialty Report, there were over 32,000 physicians in Illinois as of June 2011, representing roughly one physician per 400 people in the population. This proportion for Illinois is in line with the United States in total. The 10 most prevalent specialties are listed in the table below (Figure F.10).

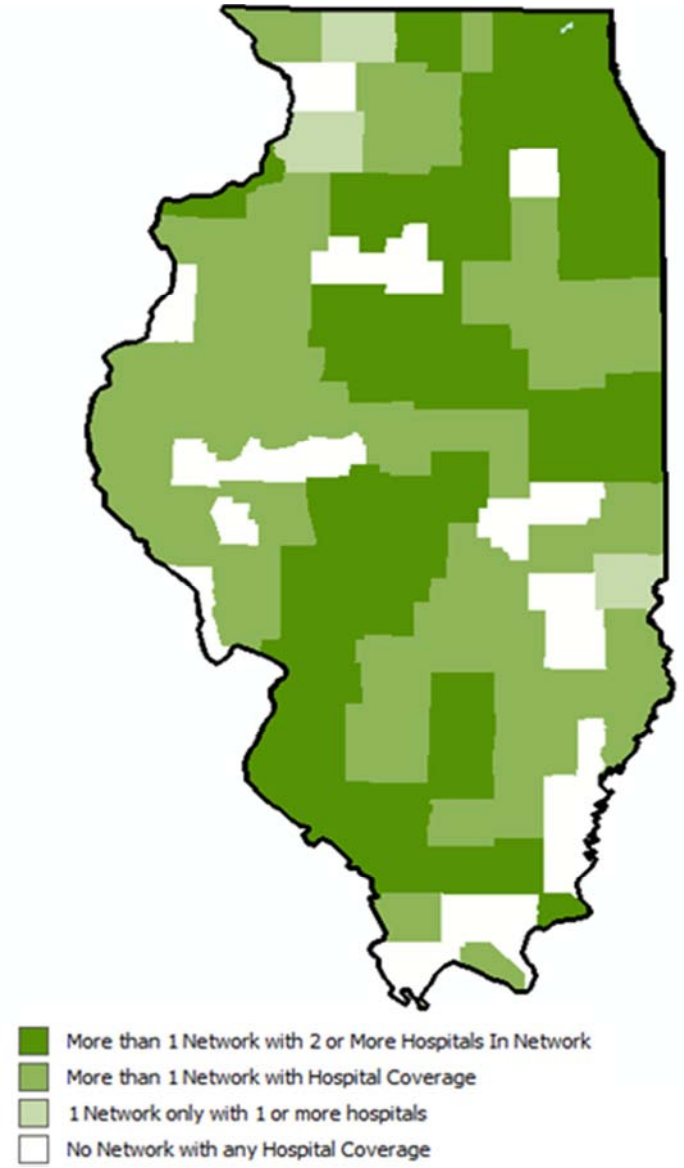
Figure F.10: Top 10 physician specialties in Illinois (2011 SK&A)[31]

Physician Type	Count
Family Practitioner	4,052
Internist	3,607
Pediatrician	2,079
Obstetrician/ Gynecologist	1,836
Orthopedic Surgeon	1,414
Cardiovascular Disease	1,301
Ophthalmologist	1,301
Psychiatrist	1,196
Podiatrist	1,090
Diagnostic Radiologist	1,016

Another way to view coverage access is to analyze the level of choice (i.e., number of options) within health plan networks.

Within their chosen provider network, the majority of State employees are able to select from two or more hospitals. Information from carriers offering to provide health insurance coverage to the State employee population was utilized to review network coverage across the State. From this information, it was clear that the majority of residents had options to select between multiple networks each of which would offer access to more than one hospital within their county.

Figure F.11: Distribution of provider networks by hospital choices available (2009 State Employee Bid)[28]



As expected, consumers travel longer distances to access care in the more rural areas of Illinois. However, even in rural areas, average travel distances are generally reasonable. Using the State's All Payer Discharge database, we analyzed distances consumers traveled for inpatient services, approximated as the distance between the patient home zip code and the provider zip code for each discharge on record. In the more rural areas, consumers had to travel close to 20 miles on average for an inpatient service compared to approximately 5 miles in Chicago (Figure F.12). Those with Medicare insurance consistently traveled the shortest distance compared to others in the all payer data base (Figure F.13).

Figure F.12: Estimated average distance traveled for inpatient care (2010 State Discharge Data)[29]

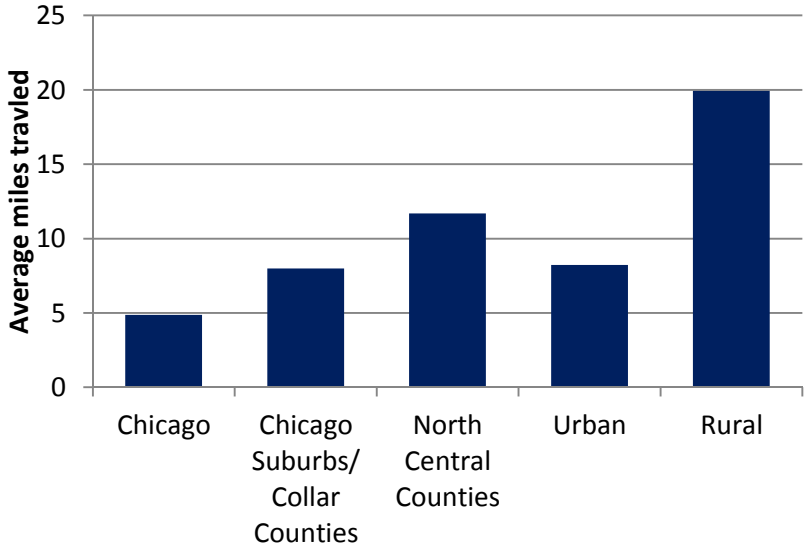
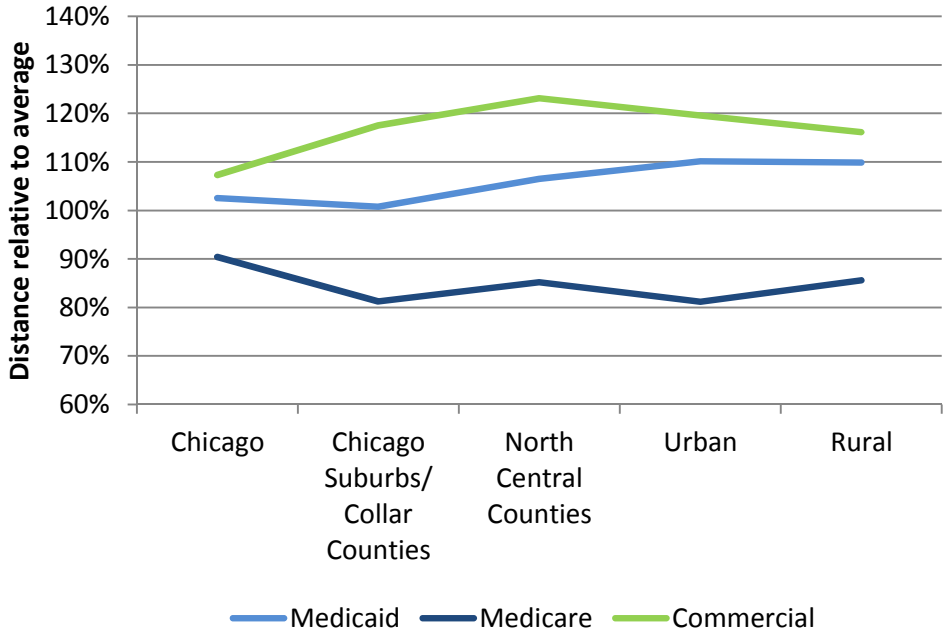
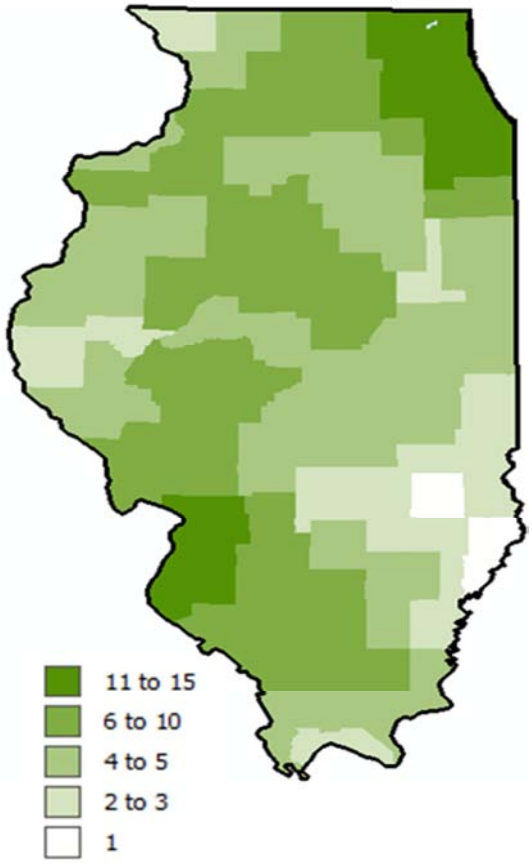


Figure F.13: Inpatient relative distance compared to all payers average distance by region (2010 State Discharge Data)[29]



Currently there are HMOs approved in all counties in Illinois with wider selections available in the more populous areas of the State. There are a number of HMOs approved for business across the State. In Figure F.14 below, the map depicts the number of approved HMOs in each county per data provided by DPH.

Figure F.14: Prevalence of approved HMOs by county (April 2011 DPH)[32]



High Risk Pools

Illinois has three high risk pools currently in place to provide coverage for higher cost individuals. Illinois' Comprehensive Health Insurance Plan (ICHIP) includes three high risk pools, including the Federally-funded Pre-existing Condition Insurance Plan established in September 2010 as part of ACA. This plan had 1,357 enrollees as of May 31, 2011[33]. In addition, there are two other State-funded high risk pools:

- The Traditional Pool for those unable to obtain coverage due to a pre-existing medical condition (2009 Enrollment of 4,565 individuals, and an enrollment cap of 5,950 individuals[23]) and
- The HIPAA pool for those losing access to group coverage (2009 Enrollment of 11,520 individuals[23]).

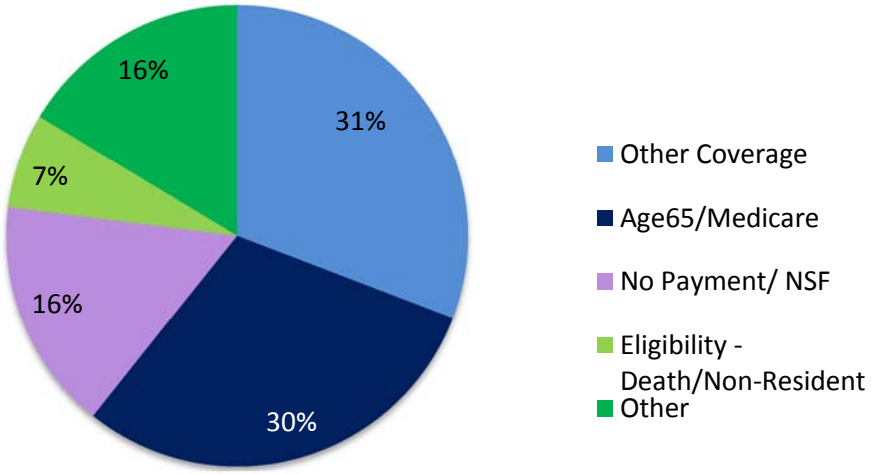
The individuals in the State-funded high risk pools represent less than 1% of the total population. The geographic distribution of high risk pool members is relatively similar to the population distribution of the overall State. The Chicago Suburbs/Collar Counties do have a higher concentration of those in the high risk pools, as seen from the higher observed penetration rates for Lake and DuPage Counties.

Figure F.15: High risk pool enrollment (under 65) as a percentage of the Illinois population by county (2009 ICHIP) [23,11]

County	Enrollment	Percentage of Population
Cook	6,202	0.19%
DuPage	1,778	0.31%
Lake	1,574	0.37%
Will	743	0.18%
Kane	596	0.20%
McHenry	466	0.24%
Winnebago	431	0.24%
Peoria	226	0.21%
Sangamon	204	0.17%
All Other counties	3,865	0.17%
Total	16,085	0.21%

Individuals tend to leave the high risk pools when access to other coverage becomes available. 61% of the documented reasons for terminating from the high risk pool are transfers to other coverage and turning 65 (presumably to transfer to Medicare). While transfers produce the majority of terminations, 16% of individuals terminate specifically for cost or affordability reasons (Figure F.16).

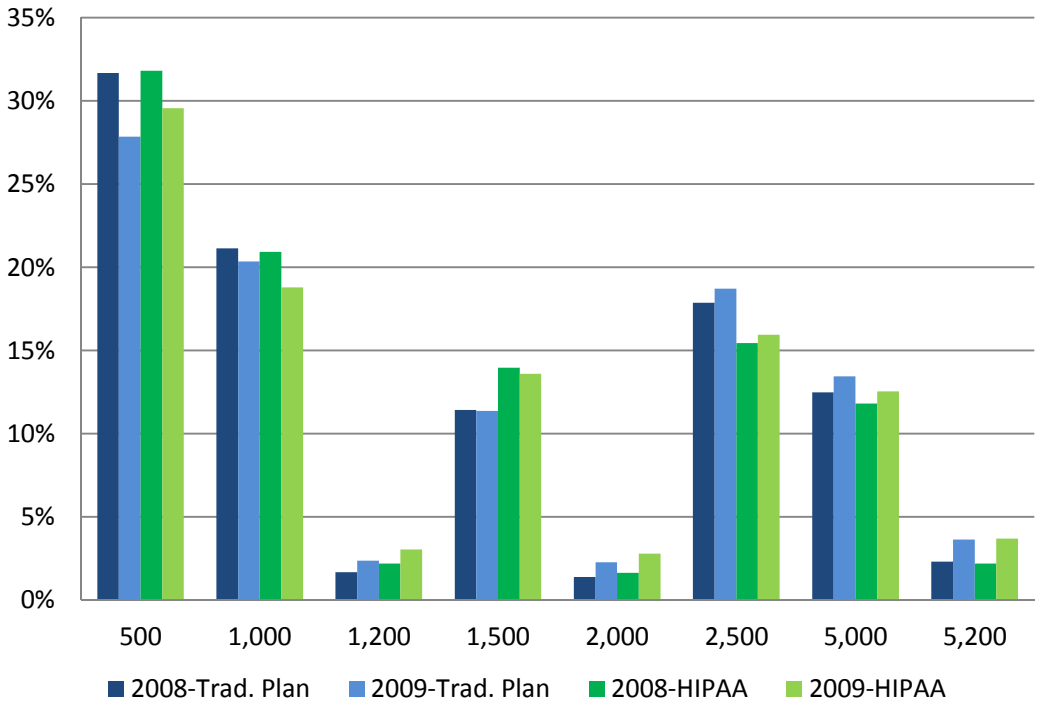
Figure F.16: Distribution of reasons for leaving a high risk pool (2009 ICHIP Annual Report) [23]



The selected cost sharing in the high-risk pool plans closely resembles the cost sharing in the small group market. The observed cost sharing in the State-paid High Risk Pools was compared to the common plan designs from the Carrier Survey information.

- The median deductible for the high risk pool in 2009 was $1,200 with a median out-of-pocket maximum of $2,700[23], only slightly higher than the $1,000 and $2,500 levels found for small group deductibles[6] and out-of-pocket maximums, respectively.
- The following charts provide additional detail on the distribution of coverage by deductible (the deductible amount is included in the out-of-pocket maximum). Although $500 is the most popular deductible option, there is also significant membership at the $2,500 and even $5,000 deductible levels. The information also indicates a slight shift in 2009 toward higher deductibles.

Figure F.17: Distributions by traditional & HIPAA plans by deductible over time (2008 & 2009 Illinois Comprehensive Health Insurance Plan Annual Report)[23]



Barriers to Entry for Additional Carriers

In general, it does not appear that Illinois presents unusual regulatory barriers to market entry for carriers. Although Illinois does exhibit somewhat greater market concentration (measured by market share of the largest carrier) than other large states, all of the major national carriers have a presence in Illinois, and several have substantial market shares in regions of the State. Following are a review of the regulatory environment and comments on other issues relevant to market entry and competition.

a. Regulatory Framework

Based on information provided by the DOI and DPH, which oversee the insurer and HMO markets, we did not find evidence that the Illinois regulatory environment is a major hurdle to the entry of new carriers in the marketplace. Below is a summary of the major components of the regulatory framework considered and their potential impact on new entrants.

The insurance licensing and HMO approval process is not excessively or unusually burdensome to market entrants/participants. These processes do not appear to be overly burdensome when compared to other states[7]. Furthermore, Representatives of the DOI indicated that the vast majority of license applications are approved, with most exceptions being cases where foundational requirements (e.g. required capital or audited financial statements) had not been met.

The product approval and rate review processes do not significantly limit the attractiveness of the Illinois market. The DOI website provided the process of the product approval and rate review[34, 35]. The requirements imposed (e.g., Health Insurance Portability and Accountability Act (HIPAA) requirements, reviews for compliance with mandated benefits) do not appear to limit the relative attractiveness of Illinois as a market for new entrants. Illinois, like other states, is strengthening its rate review process in accordance with the requirements of ACA, which requires states to enhance the review of rate increases (especially those deemed to be unreasonable) and improve documentation and communication of the rate review process.

Consumer protections, rating and underwriting restrictions are generally consistent with the majority of other states. Illinois has introduced a number of regulations to limit the ability of carriers to select and rate for risk or limit their exposure to pre-existing conditions. These regulations tend to be consistent with the regulatory approaches in most other states[8,9]. Some specific examples include:

- Pre-existing conditions[8,9] - The Illinois small group market applies a 6 month look-back (similar to 46 other states as of January 2011) and a 12 month maximum exclusion period (which is aligned with 36 other states and is the longest of all states). In the individual market, Illinois has a 24 month look-back period (longer than 28 other states) and a 24 month exclusion period (longer than 31 other states). The longer the time period, the more opportunity the carrier has to control its risk.
- Rate differentiation[8,9] - In the small group market, Illinois allows for rating bands with deviations of up to 25% from the manual rate, which means premiums can be reduced or increased by up to 25% to allow for variations in health status. As of January 2011, 35 other states apply rate bands in the small group market while 11 states applying more stringent adjusted community rating rules where no additional rate modification is allowed for health status. In the individual market, Illinois does not restrict rating, giving carriers more flexibility to vary premiums.
- Groups of one[8,9] - Illinois does not allow group insurance for employers having only one employee. This is consistent with the practice in 37 other states, and allows carriers to assess the risk for these policies under individual market rating rules.

Other regulatory requirements align well with majority practice. Based on National Association of Insurance Commissioner (NAIC) documentation of health insurance regulation, Illinois tends to be consistent with national market practices in terms of documentation requirements, capital and surplus requirements, public records, etc[7]. Costs related to additional fees, taxes levied and benefit mandates (e.g. Annual Statement filing fee, Certificate of Authority Renewal Fee, Financial Regulation Fee, Fire Marshal's Tax), likely have limited bottom-line impact on carrier financials and would not significantly impact the entry of new carriers into the market.

b. Other Considerations

In addition to regulatory barriers, other market characteristics may impact the willingness of new carriers to enter the market or existing competition.

Market concentration among a few incumbents may deter new entrants and decrease competition in certain geographic areas. The market is mature with Health Care Service Corporation (HCSC) being the dominant market player in the State[6].

Network discounts significantly impact product pricing. The largest existing market players have the ability to exert more influence in provider negotiations, because of their market power. This is typically most evident in the largest MSA markets. Differences in provider discounts directly impact pricing to the consumer. In a price-competitive market any pricing

disadvantage may prove to be a significant barrier to the entry of new market participants and impact competition in the State.

Key attributes include brand value, credibility and community presence of the existing carriers in the market. The largest market players have brand awareness and consumer loyalty due to their presence in the market and active community involvement. Overcoming this hurdle is a significant challenge for a new market participant, especially if this company does not yet have a good presence in the large group self-insured market or another health care related market.

Establishing distribution systems in the agent channel could present a hurdle to a new market entrant, increasing the risk of investment in the new market. Compensation for agents frequently includes bonuses determined by total enrollment with a carrier and retention of those individuals and groups. Persuading agents to put this compensation at risk (by moving enrollees to the new carrier) would require additional investment by the new carrier. Moreover, agents may also expect to see a history of good service, before moving significant parts of their block to a newer carrier, leading to longer investment periods for the new carrier.

Investment costs to develop a new market may reduce potential return on investment and deter new carriers. Entering a new market requires significant investments. These include marketing and administrative investments to set up a new carrier or new market presence, premium commissions required to attract agents to the new carrier, and the risk of anti-selection as agents may initially place poorly performing groups with the new carrier. These costs can be significant, especially in early years, and can deter new carriers.

New Minimum Medical Loss Ratio (MLR) requirements under ACA impact start-up carriers disproportionately. The new minimum loss ratio requirements limit the amount an insurer can spend on non-medical costs as a percentage of premium – once the limit is exceeded a rebate becomes payable to the policyholders. In initial years, especially in the individual market, policies tend to have lower medical costs which result in the carrier having more margin from which to fund business development costs and overhead. Under the new ACA regulations, the fixed expenses and market development costs will have to be funded from capital, as high non-medical costs paid from premium would trigger rebates to members, thus increasing the investment required to develop a new market.

Agents

The term 'agent' is used throughout this report to define those selling health insurance, through a brokerage agency, consulting firm or employed by an insurer In Illinois. All Kids Application Agents provide assistance to enrollees in some of the State supported programs for families, including the All Kids program that covers children throughout the State. The DOI licenses and regulates agents and HFS licenses and regulates the AKAAs.

a. Agents

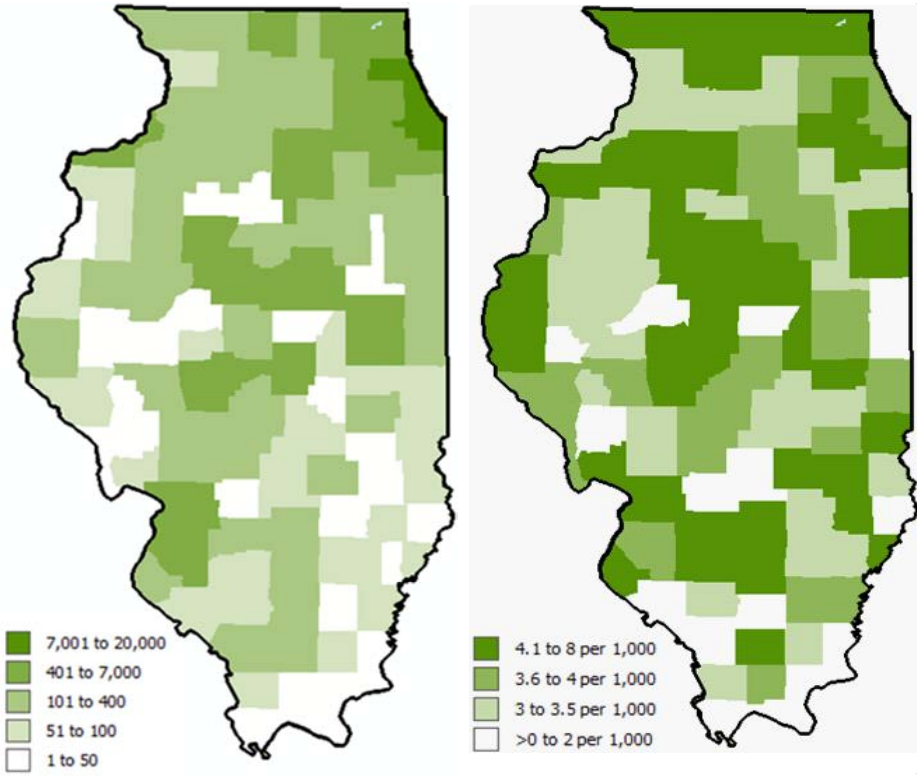
As of the beginning of 2011, there were over 54,000 agents licensed to sell health insurance in Illinois. Almost all agents licensed to sell health insurance are also accredited to sell other types of insurance, such as casualty, fire, and life insurance (Figure F.18).

Figure F.18: Number of health insurance agents by number of license lines (2011 DOI)[10]

	Health Only	2 Lines	3 Lines	4 or More Lines	Total
Number of Agents	517	15,267	12,904	25,952	54,640
% of Health Agents	1%	28%	24%	47%	100%

As would be expected, most of the agents live in urban areas where the concentration of people is high. The map on the left below (Figure F.19) shows the distribution of agents across the State. After adjusting for the population size, the map on the right below shows the concentration of agents per 1,000 people.

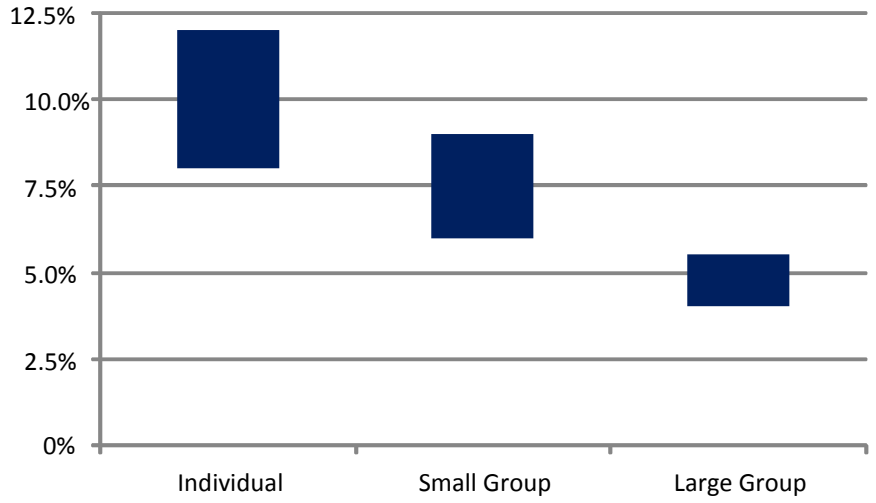
Figure F.19: Health insurance agents by county (left map) and agents per 1,000 persons (right map) (2010 DOI)[10]



Agents typically receive both commissions and bonuses as part of their compensation package[6]. Commission structures and bonus levels vary depending on whether the agent is selling health insurance to individuals, small employer groups, or large employer groups. Compensation includes both commissions and bonuses.

While agent compensation levels vary across carriers, compensation, measured as a percentage of premium, decreases as customer size increases. In Figure F.20, the range of compensation paid by market size is illustrated; demonstrating the higher percentage of premium paid for smaller policies and lower percentage of premium for larger policies. Also shown is the larger range of compensation for the smaller policies as compared to a tighter range of compensation for the larger policies. These compensation levels include both commissions and bonuses as reported through the Carrier Survey.

Figure F.20: Carrier-reported agent compensation as a percentage of premium by market (2011 Carrier Survey)[6]



Commission levels for the individual market are consistently based on premiums, but amount and structure of commissions vary across carriers[6]. All carriers indicated that commissions are structured as a percentage of premium. This means that a 10% commission on a $200 monthly premium per enrolled member results in $20 in commission per month. Additional information on the commissions for the individual market includes:

- The majority of carriers (four of six surveyed) indicated higher first year commissions of 10% to 20% of premium, compared to renewal commissions of 4% to 10% of premium[6]. Some carriers vary the level of first year commissions based on the overall enrollment of the producer[6].

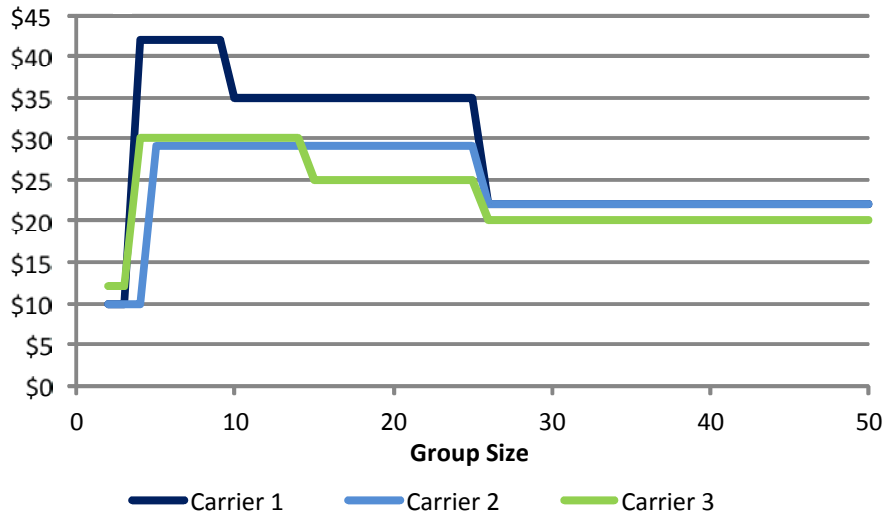
- Recent changes in commission levels varied across carriers (with some increases and some decreases)[6].

Small group market commission structures are changing from a percentage of premium basis to a fixed dollar amount per enrolled employee. The Carrier Survey information shows that two thirds of the carriers now pay commissions based on a fixed dollar amount per enrolled employee while the other third of the carriers pay a percentage of premium[6]. Additional insights on commission in the small group market include**:**

- All but one of the surveyed carriers indicated flat commissions over time of the policy, meaning there are no increased commissions for the first year[6].

- Commissions vary by employer group size, where the smallest employer groups (typically those having fewer than 5 employees) have the lowest commission fees and the next group size (e.g., 5 to 10 employees) has the highest commission fees on a per enrolled employee basis. Thereafter the commission fee reduces as employer group size increases. The figure below demonstrates these relationships for three of the carriers (Figure F.21).

Figure F.21: Carrier-reported agent commission by group size (2011 Carrier Survey)[6]



In the large group market, commission levels lower as the employer group size increases. For example, one carrier stated that commissions for employer group sizes between 101 and 250 employees were 2% of premium while for an employer group size of 251 to 500 employees, the commissions were 1% of premium[6].

A number of carriers have transitioned to enrollment-based commissions for the 51-99 group sizes, with premium-based commissions being most prevalent thereafter[6]. For example, some carriers offer a commission of $15 per enrolled employee (with no additional payment related to enrolled dependents) for group sizes of 51-99 and offer 1.25% of premium for group sizes over 100 employees[6].

Bonuses in the small group and large group markets are based on a combination of retaining business and enrolling new business[6].

b. All Kids Application Agents

AKAAs have been successful at enrolling individuals into coverage, but the volume of enrollment has decreased in recent periods[12]. All Kids application agents (AKAAs) are authorized to support the enrollment of individuals into multiple State administered programs including All Kids, FamilyCare and Moms & Babies.

The AKAAs are "community-based organizations, including faith-based organizations, day care centers, local governments, unions, medical providers and licensed insurance agents. Most, but not all, AKAAs receive a $50 Technical Assistance Payment (TAP) for each complete application that results in new coverage"[12].

The volume of new enrollments has decreased over time most likely due to two external factors, namely lower numbers of eligible children yet to be enrolled in the program, and the introduction of a web-based enrollment option[12]. The table below shows the total number of agents, the total number of applications processed, and the resulting average number of applications submitted per agent per year.

Figure F.22: AKAAs enrollment activity over time (HFS 2002-2010)[12]

	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total AKAAs	449	461	476	474	496	507	449	403	347
Total Enrollments	37,934	42,915	41,194	40,799	43,040	37,808	32,433	27,156	22,869
Average Enrollments per AKAA	84	93	87	86	87	75	72	67	66

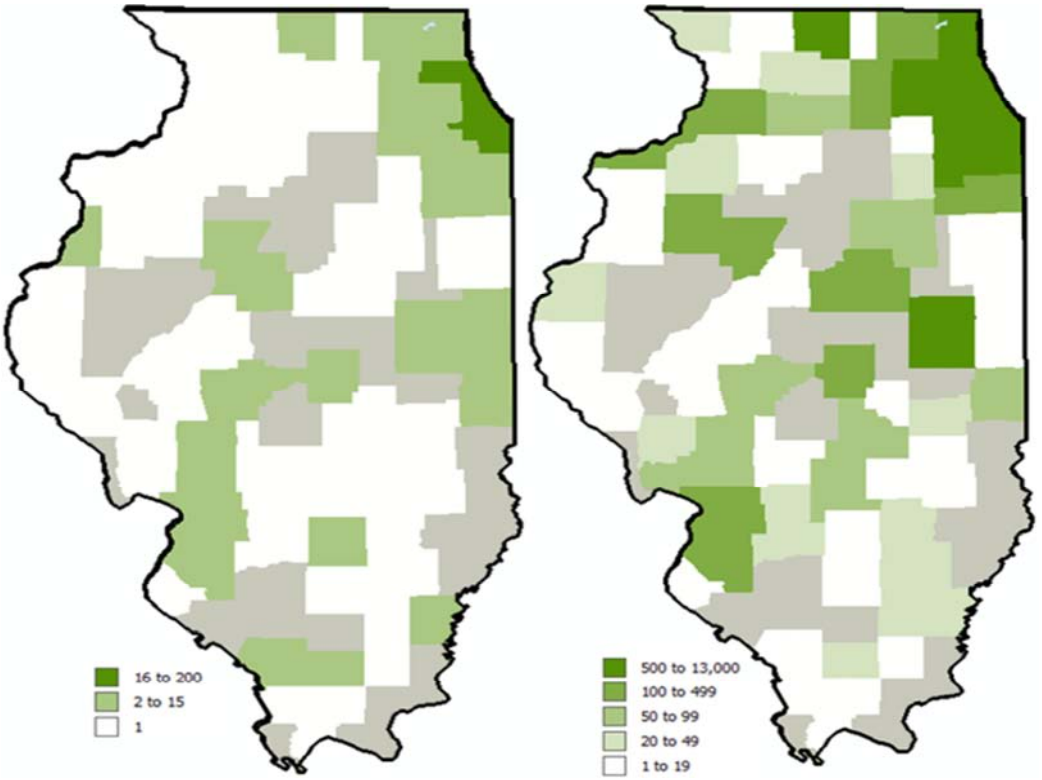
A small number of AKAAs represent a large proportion of the membership enrolled. The table below (Figure F.23) shows that fewer than 20% of AKAAs have consistently enrolled over 100 applicants per year (17% of the agents enrolled over 100 of the applicants in 2010). Over half of the AKAAs enroll fewer than 25 applicants over the last 9 years.

Figure F.23: Distribution of AKAAs processing enrollments (HFS 2002-2010)[12]

	2002	2003	2004	2005	2006	2007	2008	2009	2010
1 To 24 Enrollments	59%	57%	57%	57%	59%	60%	59%	58%	56%
25 To 99 Enrollments	24%	24%	24%	24%	23%	21%	23%	24%	27%
Over 100 Enrollments	17%	19%	19%	19%	18%	19%	18%	18%	17%

The active AKAAs are distributed across the State, but access may still be limited in some areas. The map below shows the distribution both of AKAAs and AKAA enrollments across the State for 2010. There are some areas of the State where the distribution of AKAAs (Figure F.24) is less than proportional to the enrollments (Figure F.22 & F.23).

Figure F.24: Number of AKAAs (map on left) and approved All Kids enrollments (map on right) (HFS 2010)[12]



G. Assessment of Affordability of Coverage

Overview

One of the main items identified as a barrier to health insurance coverage for individuals is cost. This section provides additional information regarding how health care costs relate to income and impact other financial decisions within the household. Different measures identified by the State are considered:

- Average premium as a percentage of income,
- Average out-of-pocket spending as compared to a pre-determined percentage of income,
- The sum of premium and cost sharing, and
- Consumers' confidence in their ability to pay for health care costs.

The key findings from this section include:

- Average monthly premiums in Illinois in 2010 were $208 per member for the individual market and $365 per member for the small group market[6].
- According to State-defined affordability thresholds, , the average out-of-pocket costs for the individual market were determined to be unaffordable based on the threshold specified by the State for the low income population segments (less than 200% FPL). Average out-of-pocket costs for the higher income population segments were determined to be affordable based on the threshold[13].
- According to State-defined affordability thresholds, , the average out-of-pocket costs for the small group market were estimated to be affordable for the low income singles but unaffordable for the families. The estimated out-of-pocket costs for the higher income singles and families were deemed affordable[13].
- A single person with income at 200% FPL is estimated to spend 19% of household income to cover the premium and estimated out-of-pocket costs for a policy purchased in the individual market[13].
- A family of four with income at 200% FPL is estimated to spend 23% of their household income to cover the premium and estimated out-of-pocket costs for a policy purchased in the individual market[13].
- The higher Illinoisans' incomes are, the more confident they are that they will be able to pay for their families' medical costs[4].
- 28% of the Illinois population delayed visiting the doctor because of cost in the past 12 months[4].

Premium Levels Compared to Income

2010 average monthly premiums were $208 for the individual market and $365 for the small group market. Based on the Carrier Survey data, the average premium per member (across individual purchasers and family purchasers) is:

- $208 per month (approximately $2,500 annually)[6] in the individual market and
- $365 per month (approximately $4,375 annually)[6] in the small group (fully insured) market.

The differences between premiums in the individual and small group market are due to differences in:

- benefit designs (group benefits typically pay a larger share of eligible medical expenses); this is estimated to account for 60% of the difference[13]; and
- underwriting (individual insurance underwriting often results in denial of coverage for persons in poor health) and other factors, such as member demographics and carrier administrative expenses. These factors are estimated to account for the remainder of the difference in premium rates.

Annual premium estimates for individuals and families were developed using estimated single to family ratio and family size values. These estimates are shown in Figure G.1 below.

Figure G.1: Estimated average annual premiums (2011 Carrier Survey)[6]

	Single	Family
Small Group Market	$5,040	$13,250
Individual Market	$2,850	$6,330

Note that the single premiums are higher than the per member premiums from the Carrier Survey because persons with single coverage are generally adults, not children.

Average premium as a percentage of income ranges widely across income levels. Expressing each of these premiums as a percentage of income at different income levels provides a measurement of affordability. Note no adjustments are included for any potential difference in premium levels by income. In each of the tables below the columns highlighted in blue represent sections on the income curve where the populations are considered low income (i.e. 200% of FPL). Family premiums were compared against income for a family of four. The last row of each of these tables (Figure G.2) contains the estimated premium as a percentage of income.

Figure G.2: Average annual premium levels in the individual and fully insured small group market relative to income (2011 Carrier Survey)[6]

Individual Market	Premium:		$2,850
Single	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent	$21,660	$32,490	$43,320
Premium % of Income	13%	9%	7%
Individual Market	**Premium:**		**$6,330**
Family of 4	**Income Level**		
% of FPL (Family of 4)	200%	300%	400%
Annual $ Income Equivalent (Family of 4)	$44,100	$66,150	$88,200
Premium % of Income	14%	10%	7%

Small Group Market	Premium:		$5,040
Single	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent	$21,660	$32,490	$43,320
Premium as % of Income	23%	16%	12%
Small Group Market	**Premium:**		**$13,250**
Family of 4	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent (Family of 4)	$44,100	$66,150	$88,200
Premium % of Income	30%	20%	15%

There are approximately 515,000 members in the individual market and 900,000 members in the small group market for 2011 in Illinois[2].

When interpreting the small group numbers, note that the impact of the premium is shared by employers who make contributions to the cost of coverage. Survey data from MEPS indicate that the average employee contribution to small group health plan costs in Illinois for 2010 was $1,221 for employee coverage, and $4,383 for family coverage[20]. In addition, even the portion of premium that is subsidized by employers impacts worker affordability, since money spent on health insurance is not available to spend on employee wages.

High Out-of-Pocket Spending

In the individual market, average out-of-pocket costs for the low income population exceed the specified affordability threshold. Average out-of-pocket costs for the higher income populations are below the threshold. Out-of-pocket (OOP) costs related to deductibles, copayments, and coinsurance were defined as unaffordable if these costs are higher than 5% for low income individuals or 10% for higher income individuals. For this purpose, low income is defined as income at or below 200% of FPL and is highlighted in blue below (Figure G.4). Out-of-pocket expenditures were estimated based on the following common plan design for the Illinois individual market (Figure G.3). The plan design was then applied to a representative MarketScan® data base in order to estimate average OOP costs.

Figure G.3: Typical Illinois individual plan design (2011 Carrier Survey)[6]

Individual Market Plan Design
• $2,500 Deductible • $3,500 OOP max • 20% coinsurance • $21 PCP Copay • $34 Specialist Copay • No ER copay – included in coinsurance • Family OOP Limit Capped at 2 x Single • No pharmacy costs included • Only in-network benefits valued

Comparing the affordability threshold of 5% or 10% (row 3 of each table), to the Average OOP % of Income (row 4 of each table), shows that the costs are above the threshold for the lower income population. In no instance did income levels above 200% of FPL result in an average out-of-pocket cost of more than 10% of income.

Figure G.4: Average out-of-pocket expenditure (excluding pharmacy) relative to income levels in the individual market (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

Individual Market	Average OOP:		$1,347
Single	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent	$21,660	$32,490	$43,320
Affordability Threshold	5%	10%	10%
Average OOP % of Income	6%	4%	3%

Individual Market	Average OOP:		$3,758
Family of 4	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent (Family of 4)	$44,100	$66,150	$88,200
Affordability Threshold	5%	10%	10%
Average OOP % of Income	9%	6%	4%

Average out-of-pocket costs are estimated to be unaffordable for the low income population segments according to the specified affordability threshold. Average out-of-pocket costs for the higher income population segments were deemed affordable. As shown in Figure G.6 below, the small group market had results similar to the individual market. As in the individual market analysis, a typical plan design (Figure G.5) specific to the small group market was established based on common plan designs found in the Carrier Survey. The plan design was then applied to a representative MarketScan® data base in order to estimate average OOP costs.

Figure G.5: Typical Illinois small group plan design (2011 Carrier Survey)[6]

Small Group Market Plan Design
• $1,000 Deductible • $2,500 OOP max • 10% coinsurance • $22 PCP Copay • $34 Specialist Copay • $150 ER Copay • Family OOP Limit Capped at 2 x Single • No pharmacy costs included • Only in-network benefits valued

Figure G.6: Average out-of-pocket expenditure (excluding pharmacy) relative to income levels in the small group market (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

Group Market	Average OOP:		$868
Single	Income Level		
% of FPL	200%	300%	400%
Annual Income	$21,660	$32,490	$43,320
Affordability Threshold	5%	10%	10%
Average OOP % of Income	4%	3%	2%

Group Market	Average OOP:		$2,514
Family of 4	Income Level		
% of FPL	200%	300%	400%
Annual Income	$44,100	$66,150	$88,200
Affordability Threshold	5%	10%	10%
Average OOP % of Income	6%	4%	3%

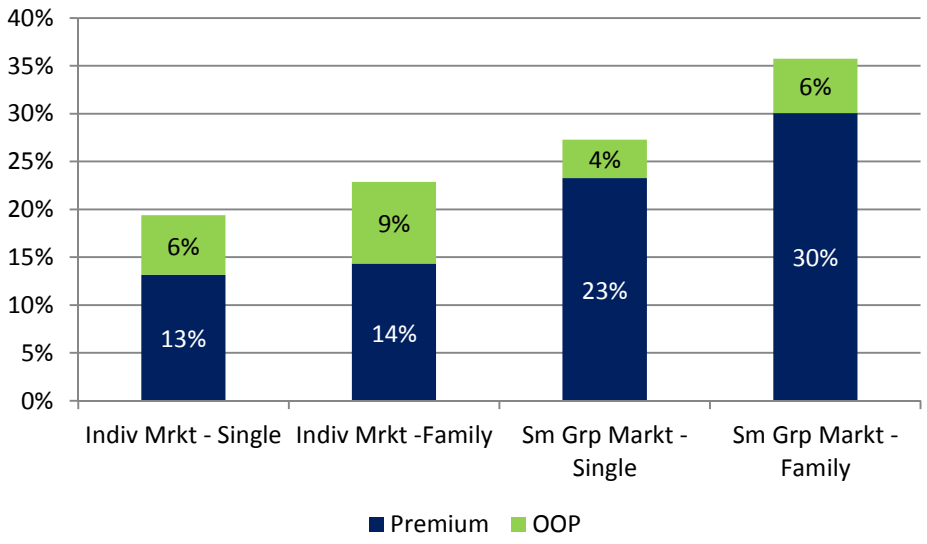
Average Total Real Out-of-Pocket (TROOP) Costs

For purposes of this research, the State defined TROOP as the sum of premiums and out-of-pocket cost sharing, representative of the total cost of health care. Using the premiums and out-of-pocket costs calculated above, affordability was analyzed for a household at 200% FPL (Figure G.7).

- A single person with income at 200% FPL is estimated to spend 19% of household income to cover the premium and average out-of-pocket costs for a policy purchased in the individual market.
- A family of four with income at 200% FPL is estimated to spend 23% of household income to cover the premium and average out-of-pocket costs for a policy purchased in the individual market.

Estimated costs for policies purchased through small employers are also shown in the figure below and have not been adjusted for the portion of the premium that may be subsidized by the employer.

Figure G.7: Average premium levels and estimated OOP (excluding pharmacy) in the individual and fully insured small group market relative to 200% FPL (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]



Average TROOP costs range widely across markets, policy types and level of claims costs. The below table (Figure G.8) provides a summary of the range (i.e., various percentiles) of the possible out-of-pocket costs, including the premium. The range of costs illustrated is large; ranging from $6,330 to $13,820 for family coverage purchased in the individual market (last row).

These expected cost ranges are for the same typical plan design described in the previous section. In practice, the TROOP will vary even more across individuals, as similar claims levels across different plan designs may result in significantly different TROOP exposure.

The average (or mean) TROOP values are provided in the last column.

Figure G.8: Distribution of potential TROOP expenditure (excluding pharmacy) at different claims levels based on modified MarketScan® experience and average plan design (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

Estimated TROOP $	Percentile on the TROOP distribution					Mean
	5th	25th	50th	75th	95th	
Small Group Market: Single	$5,040	$5,160	$5,710	$6,390	$7,670	$5,908
Small Group Market: Family	$13,250	$14,450	$15,490	$16,880	$18,950	$15,764
Individual Market: Single	$2,850	$2,960	$3,580	$5,560	$6,540	$4,197
Individual Market: Family	$6,330	$7,720	$9,860	$12,560	$13,810	$10,088

In addition, table (Figure G.9) summarizes annual income and average OOP and TROOP costs by individual and small group market and percentage of FPL. TROOP costs consume a substantial portion of total household income (as shown in the last row of each table), particularly for lower income levels and family households. As stated above, the premium estimates have not been adjusted to reflect employer subsidies.

Figure G.9: Annual income, average OOP and average TROOP (excluding pharmacy) by income level (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

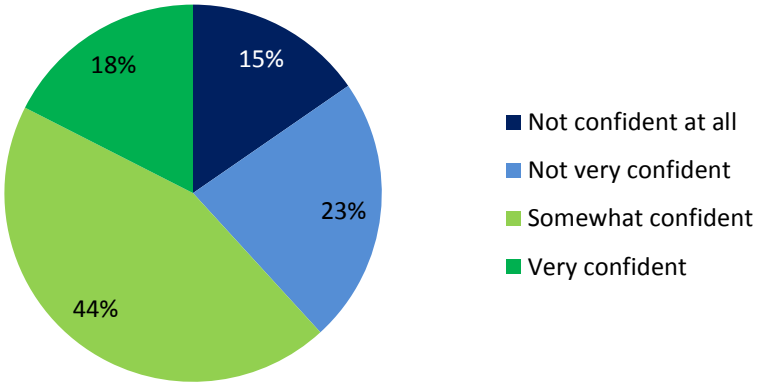
	Individual Market					
	Single			Family of 4		
% of FPL	200%	300%	400%	200%	300%	400%
Annual Income	$21,660	$32,490	$43,320	$44,100	$66,150	$88,200
Average OOP	$1,347	$1,347	$1,347	$3,758	$3,758	$3,758
Average TROOP	$4,197	$4,197	$4,197	$10,088	$10,088	$10,088
Average TROOP % of Income	19%	13%	10%	23%	15%	11%

	Group Market					
	Single			Family of 4		
% of FPL	200%	300%	400%	200%	300%	400%
Annual Income	$21,660	$32,490	$43,320	$44,100	$66,150	$88,200
Average OOP	$868	$868	$868	$2,514	$2,514	$2,514
Average TROOP	$5,908	$5,908	$5,908	$15,764	$15,764	$15,764
Average TROOP % of Income	27%	18%	14%	36%	24%	18%

Consumer Confidence in Affordability

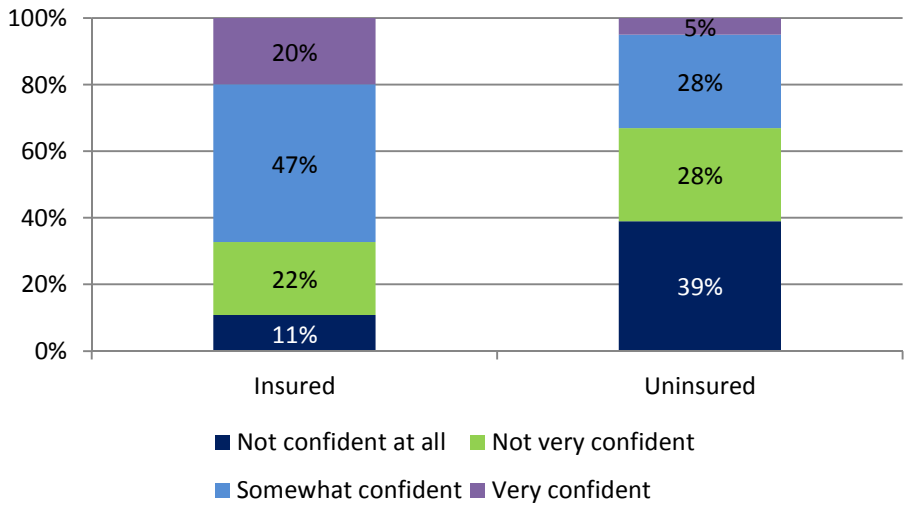
Most (62%) Illinoisans are at least 'somewhat confident' in their ability to pay the medical expenses their family incurs. This question was asked in IHIS of all survey respondents, regardless of whether they are insured.

Figure G.10: Illinois population by confidence in ability to pay medical expenses (2011 IHIS)[4]



Approximately one-third of the uninsured are at least somewhat confident that they will be able to pay for their families' medical costs . As would be anticipated, the IHIS finds that the amount of confidence a respondent has in his/her ability to pay for medical expenses is far higher for those with insurance than it is for those without insurance (Figure G.11).

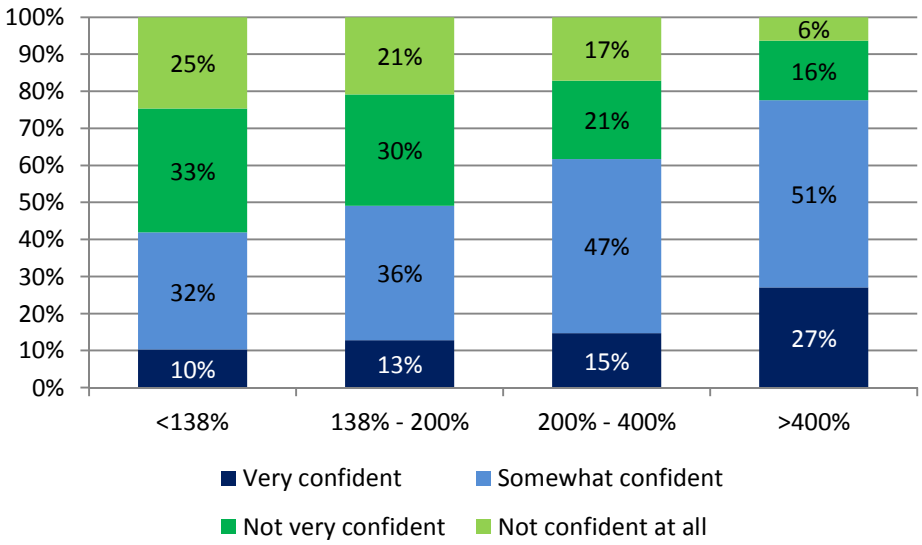
Figure G.11: Illinois population's financial confidence to pay medical expenses by insured status (2011 IHIS)[4]



The higher Illinoisans' incomes are, the more confident they are that they will be able to pay for their families' medical costs. According to the IHIS, the amount of confidence a respondent has in his ability to pay for medical expenses is far higher for those above 400%

FPL than it is for those below 138% FPL (Figure G.12). Even among Illinoisans over 400% FPL, approximately 27% are "very confident" on this issue.

Figure G.12: Illinois population's financial confidence to pay medical expenses by income (2011 IHIS)[4]



28% of the Illinois population delayed visiting the doctor in the last 12 months because of cost. Also, 15% of respondents had serious problems paying or were unable to pay medical bills and 15% had to choose between paying for health care or prescriptions and paying for other essential needs (such as rent, mortgage, utilities). Respondents could answer multiple times (Figure G.13).

Figure G.13: Illinois population's restrictions to healthcare access (2011 IHIS)[4]

Action	% Respondents
Delayed visiting a doctor or other provider due to the cost	28%
Had serious problems paying or were unable to pay medical bills	15%
Had to choose between paying for health care or prescriptions and paying for other essential needs (such as rent, mortgage, utilities)	15%
Ran up credit card or other debt your household is still paying off due to medical costs	10%
Delayed visiting a doctor because I didn't know where to find one and/or the doctor I could find was too far away	7%
Delayed visiting a doctor due to a current disability or physically difficulties getting to the office	5%
None of these	60%

H. Projected Population

Approach and Assumptions

The Deloitte Consulting Health Reform Impact model was used to produce State-level projections of coverage patterns in future years under multiple scenarios. The model projects the future population counts by coverage type considering:

- The current population in Illinois and breakdowns by demographic category and income,
- Observed current (pre-reform) market participant behaviors and coverage distribution,
- Assumptions on how the population will grow and change over time, and
- Assumptions on how behaviors and coverage will change due to the introduction of ACA.

The key assumptions and data sources used in the projections are outlined in Appendix D, as approved and finalized by the State.

The key findings from this section include:

- Illinois is aging, with a decreasing proportion of the population projected to be of working age, and a growing proportion of those eligible for Medicare[14].
- The distribution of the population by FPL band stays relatively constant in the future[14].
- Medicaid is expected to remain relatively flat in terms of enrollment —despite some economic recovery—as eligibility expands under ACA, people currently eligible enter the program, and some members are assumed to shift to the Exchange[14].
- Income distribution of the uninsured population changes as the major changes due to ACA are reflected[14].
- There are large shifts in health insurance coverage over the 2014-2016 time period. Sensitivity is reflected in the modeling of different scenarios reflecting different assumptions of market behavior[14].
- The Exchange is projected to become the dominant marketplace for individual health insurance, reflecting over 1 million people in 2017. Another 357,000 people are estimated to be part of the SHOP in the same year[14].

Market Projection Results

In this section, summary projection results are shown, with a discussion of the drivers of the results.

a. Definition of the Baseline Scenarios and Alternatives

Results from projections are sensitive to assumptions. To gauge these sensitivities and to better understand potential drivers of future coverage, the State considered two alternatives to the Baseline. These scenarios are described below and contrasted with the Baseline in Figure H.1.

- Baseline - assumes ACA is implemented as written, and produces employer and individual behavior generally consistent with the Congressional Budget Office projections.
- Employer Behavior Variation - assumes a larger disruption to the existing employer-sponsored market compared to the Baseline by assuming more employers drop coverage. The scenario projects more uninsured and a larger individual market.
- Individual Behavior Variation - illustrates less pronounced reactions of individual market participants compared to the Baseline by assuming individuals are less likely to purchase coverage. This scenario projects less enrollment and more uninsured, primarily due to the absence of an individual mandate.

Figure H.1: Employer behavior variation scenario of the population projections (Deloitte Consulting Health Reform Impact Model)[14]

Assumptions (EEs = Employees)	Reduction in Coverage Offered	
	Baseline	Employer Behavior Variation
Employers >100 EEs	5%	15%
Employers with 51-99 EEs	7.5%	25%
Employers with <=50 EEs	10%	35%
Income Bias in Reduction	No bias	2:1 reduction for low vs. high income industries

Figure H.2: Individual behavior variation scenario of the population projections (Deloitte Consulting Health Reform Impact Model)[14]

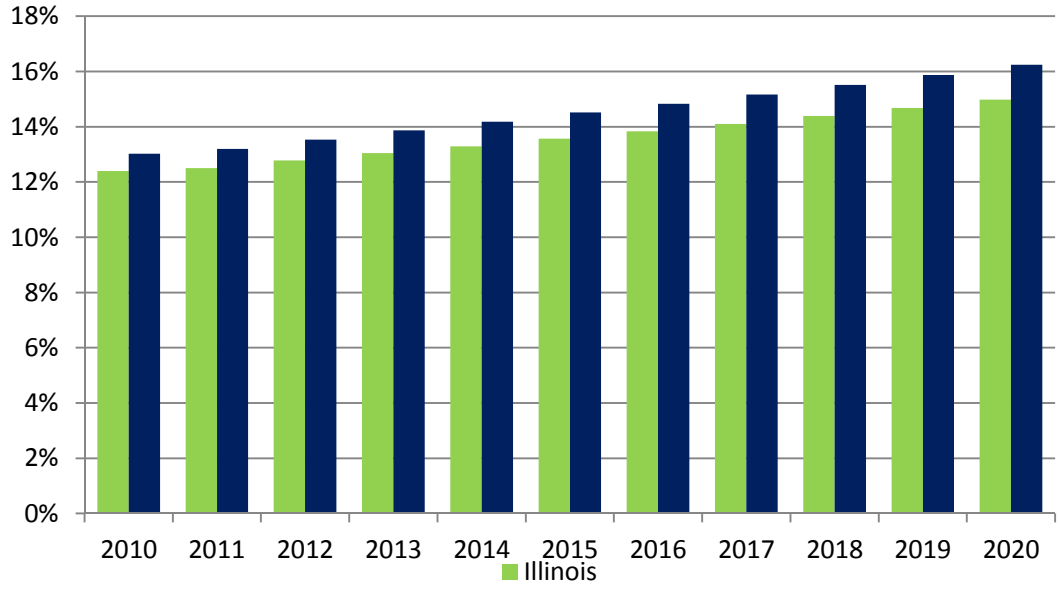
Assumptions	Baseline	Individual Behavior Variation
Cost Sensitivity	Model standard by income	50% of model standard
Impact of Individual Mandate	Model standard for compliance with mandate	Reduced enrollment reflecting elimination of the ACA individual mandate penalty
Individual market Maximum Take-Up	Model standard by income	Consistent with adult Medicaid take-up

b. Changes in the Age and Income Distributions

The type of coverage that people access is driven, among other things, by age (e.g. Medicare is predominantly for over 65 year olds, All Kids is for under 19 year olds) and income level (e.g. Medicaid eligibility thresholds). Independent of the provisions in ACA, this will continue to be the case.

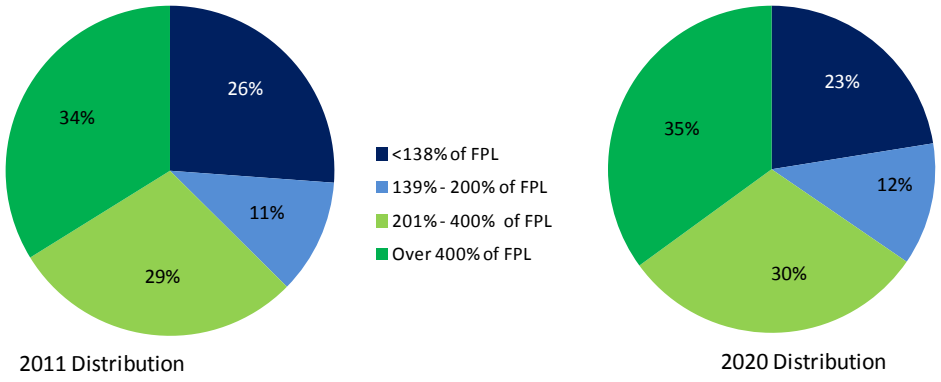
Illinois is aging, with a decreasing proportion of the population projected to be of working age, and a growing proportion eligible for Medicare. Based on U.S. Census projections, the share of the population over the age of 65 is anticipated to grow by approximately 20% (from approximately 12.5% to 15% of the population) over the next decade. This mimics the aging projected for the U.S. population in aggregate (Figure H.3).

Figure H.3: Growing elderly share of the Illinois and U.S. populations (Deloitte Health Reform Impact Model)[14]



The distribution of the population by income band changes most significantly in the <138% FPL category. Those that have incomes under 138% of FPL are estimated to be 26% of the population today, and 23% in 2020. As shown in Figure H.4, the distribution of the population by income band for the other categories stays relatively constant when comparing estimates in 2011 to 2020.

Figure H.4: Change in income distribution over the projection period due to modeled economic recovery (Deloitte Consulting Health Reform Impact Model)[14]



c. Changes in Public Programs

Medicaid is expected to have a net growth in enrollment as eligibility expands under ACA and people currently eligible enter the program. However, the impact of these effects will be partially offset by assumed economic growth and an assumed shift of enrollment from Medicaid to the Exchange.

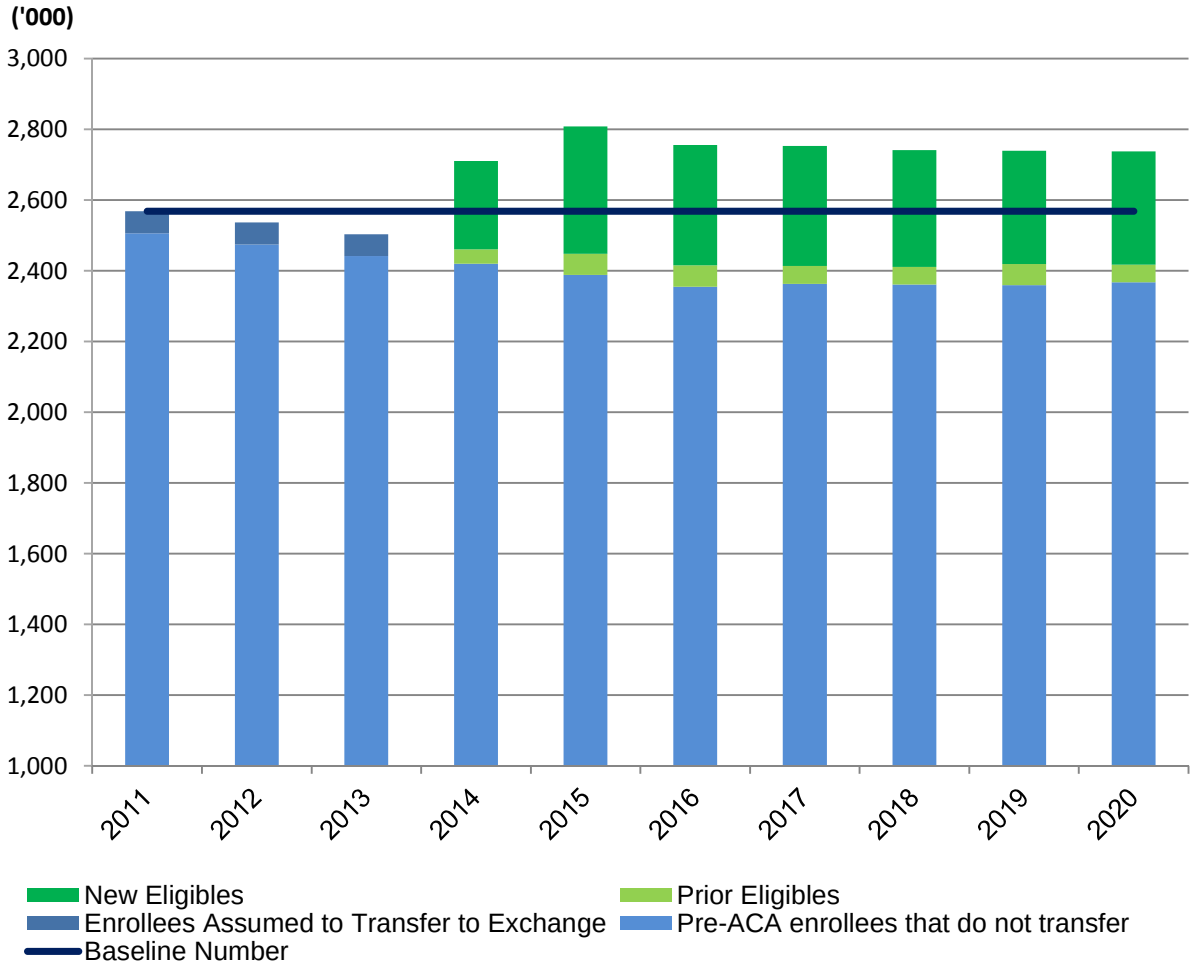
Under the Baseline scenario, the change in Public Program (e.g., Medicare, Medicaid) enrollment is projected as follows:

- Medicare enrollment is projected to grow in line with the growth in the over age 65 year old population. The dual eligible population (310,000 members in 2011) is included in the Medicaid market for consistency with other data.
- Medicaid enrollment is projected to grow due to enhanced outreach and uptake of coverage - independent of changes in the eligibility. The "Prior Eligibles" in Figure H.5 below indicate those individuals who are currently eligible for Medicaid, prior to implementation of ACA eligibility expansion. Additional Medicaid enrollment due to ACA expanded eligibility requirements is labeled as "New Eligibles" in Figure H.5 below.

This growth is offset by projected reductions in enrollment from the baseline due to the projected economic recovery (reduced unemployment and real wage growth) as well as an assumed transfer of 62,000 Medicaid adults and those covered through State programs to the Exchange (referenced below as "Enrollees Assumed to Transfer to Exchange). The impacts of these offsets to the starting estimates are shown in the Figure H.5 below.

Given the uncertainty surrounding current and future economic growth in the U.S., it is important to note that all assumptions for the future of the economy incorporated in this reports projections are based on benchmarks published in 2010 by the Congressional Budget Office.[14]

Figure H.5: Growth in Medicaid projections* (Deloitte Consulting Health Reform Impact Model)[14]

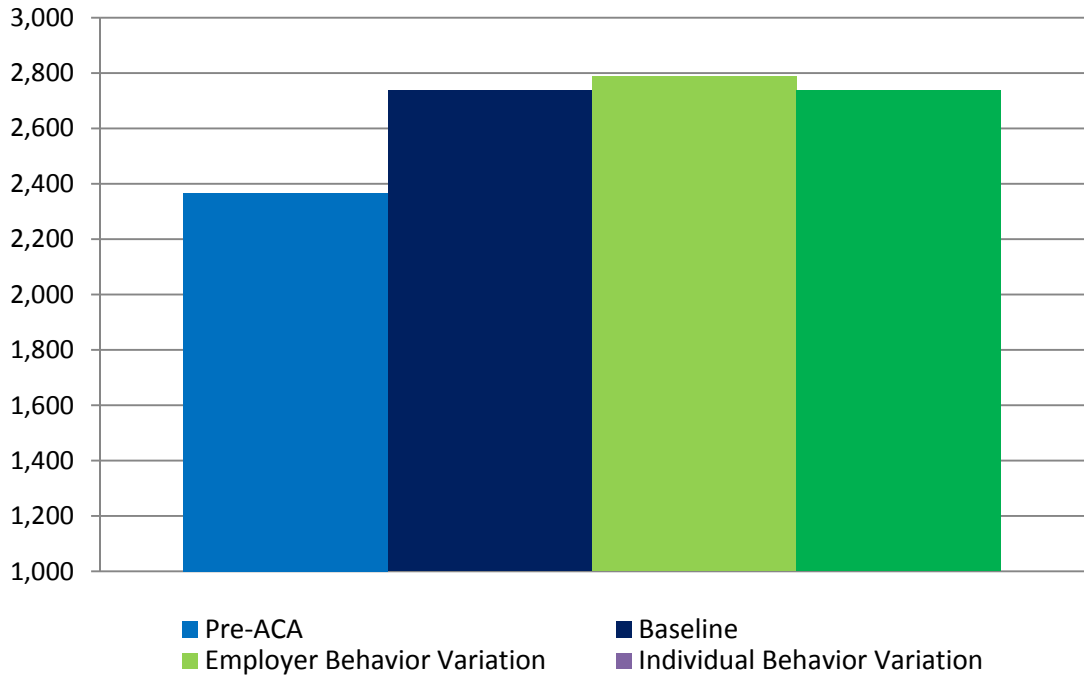


*Medicare dual eligibles are included in Medicaid projections

Comparing results across the different scenarios, the projected Medicaid enrollment is fairly stable, with minor changes only in the Employer Behavior Variation. Where employers exit the health insurance benefits market in higher numbers, modest increases are reflected in Medicaid as some working families in lower income households losing employer sponsored coverage are projected to enroll in Medicaid.

The comparison of 2020 Medicaid enrollment across the three scenarios is shown below. These scenarios did not impact Medicare projected enrollment.

Figure H.6: 2020 Medicaid projected enrollment under alternate scenarios, in (000's) (Deloitte Consulting Health Reform Impact Model)[14]

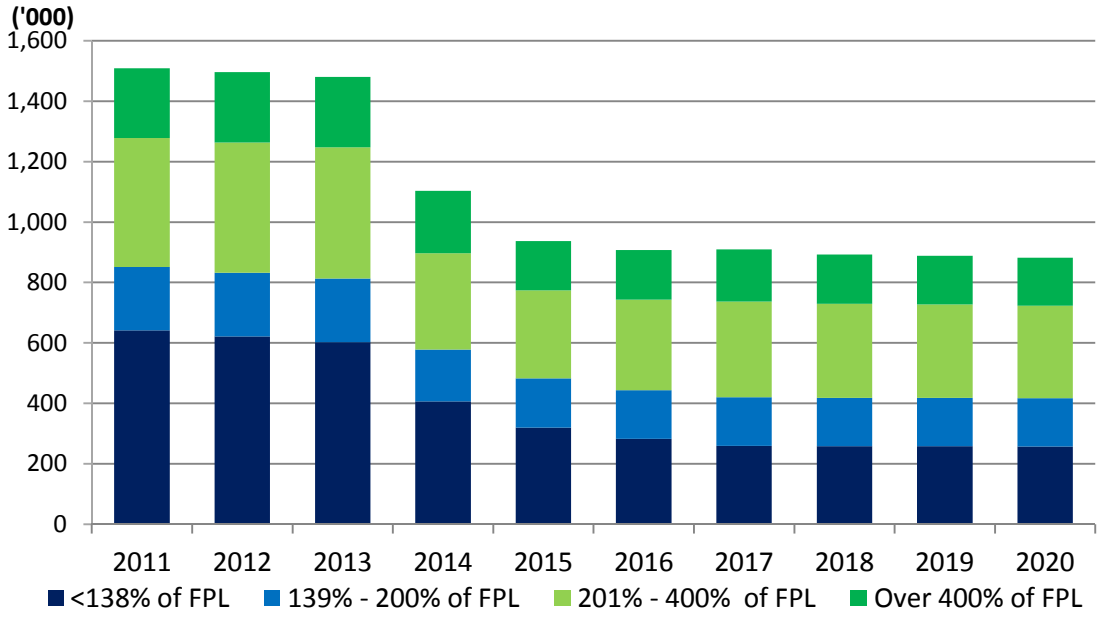


d. Changes in Uninsured

Income distribution of the uninsured population changes as the major provisions of ACA take effect. The uninsured population in Illinois is projected to decline across all income levels under the Baseline scenario assumptions (Figure H.7). These reductions are due to changes affecting people at the various income levels:

- At the lower income levels, this is mostly from the Medicaid expansion under ACA,
- At intermediate income levels this is mostly due to the ACA premium subsidies, and
- At the top income levels the individual mandate is the major driver for increased coverage levels projected.

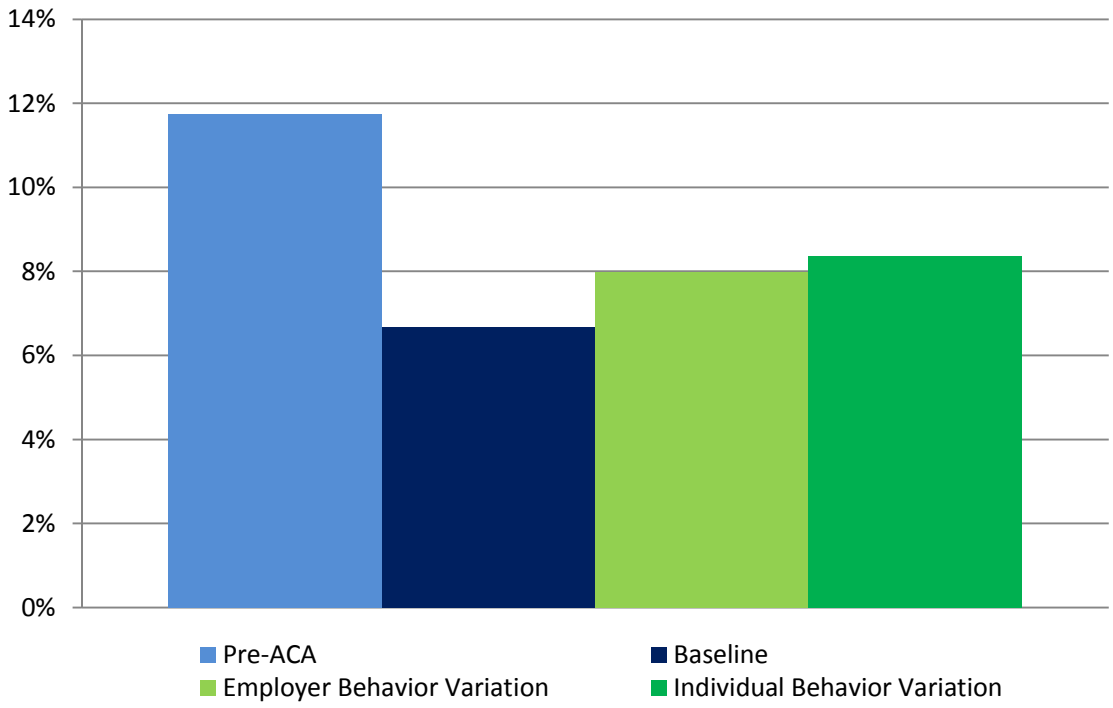
Figure H.7: Projected changes in the income distribution of the uninsured over time (Deloitte Consulting Health Reform Impact Model)[14]



The Employer Behavior Variation Scenario and Individual Behavior Variation Scenario both yield smaller reductions in the uninsured population. In comparing the alternative scenario results to the Baseline results, the uninsured population levels have (Figure H.8):

- Increased in the Employer Behavior Variation Scenario, where employers exit the market in higher numbers – as some working families go without coverage upon losing employer subsidies for coverage.
- Increased in the Individual Behavior Variation Scenarios as reduced take-up rates are projected from reduced compliance with the ACA individual mandate and reduced cost sensitivity (which reduces the impacts of subsidies and penalties).

Figure H.8: 2020 uninsured population as a percentage of total State population under alternate scenarios (Deloitte Consulting Health Reform Impact Model)[14]

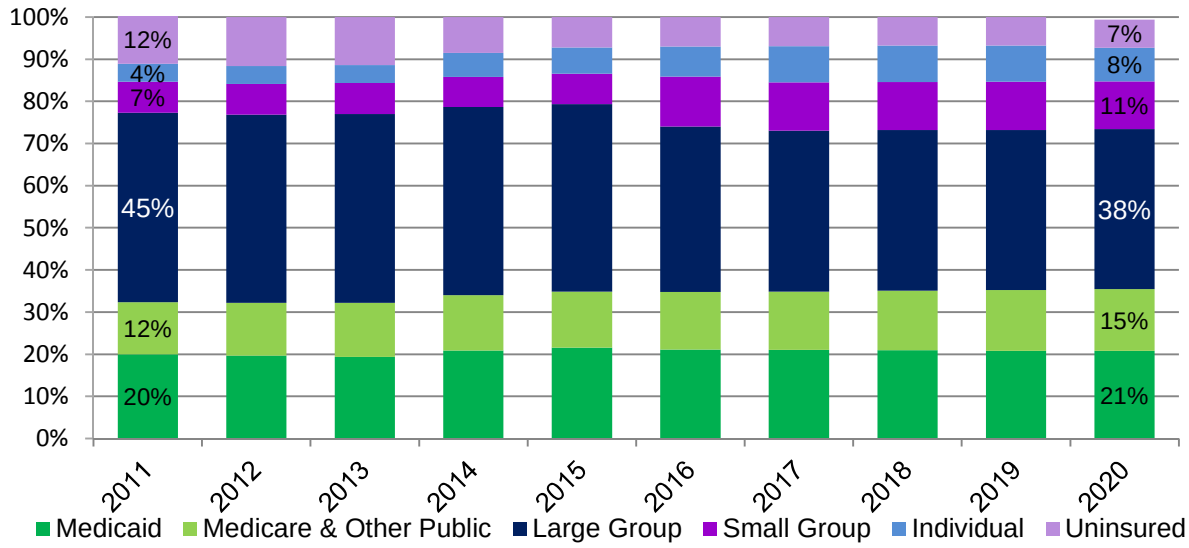


e. Composition of the market

Large shifts in coverage over the 2014-2016 time period. There are many shifts in coverage sources anticipated between 2011 and 2020 as shown in the Figures H.9 and H.10-H.14 below, in total and by income band. The primary shifts projected in the Baseline include:

- Shift from employer sponsored insurance, individual market and uninsured to Medicaid with the expansion of Medicaid eligibility and enhanced outreach/take-up rates of coverage.
- Shift from Medicaid to individual and employer sponsored coverage as economic conditions improve.
- Shift from employer sponsored insurance to the individual market and uninsured as some employers exit the market.
- Shifts from fully insured to self-insured employer sponsored insurance as employers are projected to react to additional taxation of the fully insured market and more restrictive rating requirements.
- Shift from uninsured to individual market as premium and cost sharing subsidies and the individual mandate take effect.

Figure H.9: Projected changes in coverage distribution over time (Deloitte Consulting Health Reform Impact Model)[14]



The small group market is assumed to be defined as up to 50 employees through 2015, then in 2016 the definition of small group will be expanded to include groups up to 100 employees.

Figure H.10: Change in coverage distribution over time for the total Illinois population (Deloitte Consulting Health Reform Impact Model)[14]

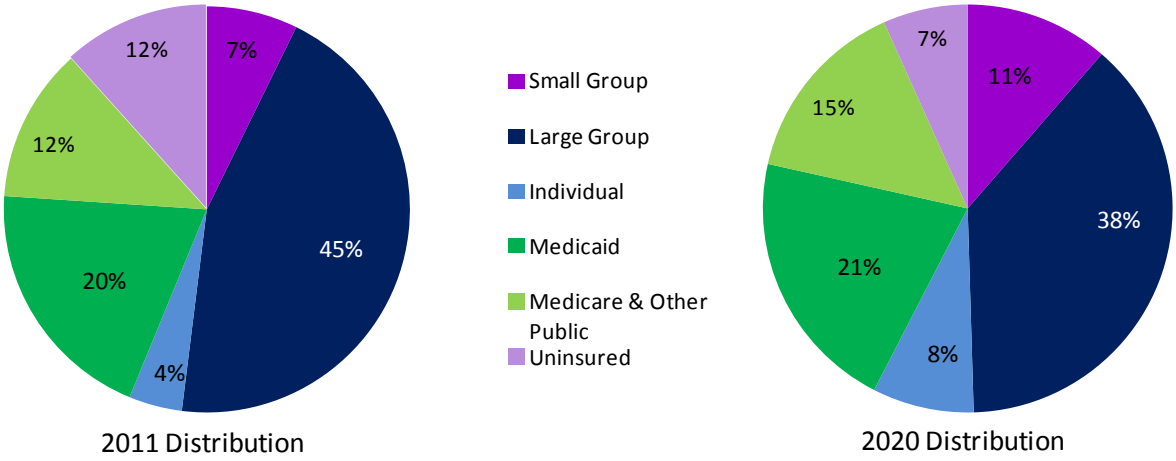


Figure H.11: Change in coverage distribution over time for the Illinois population below 138% of FPL (Deloitte Consulting Health Reform Impact Model)[14]

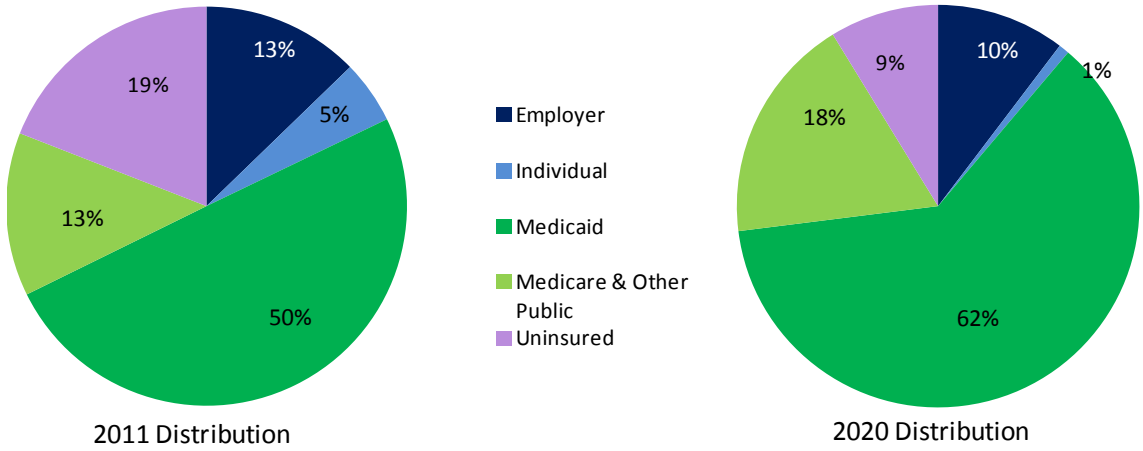


Figure H.12: Change in coverage distribution for the total Illinois population 139-200% of FPL (Deloitte Consulting Health Reform Impact Model)[14]

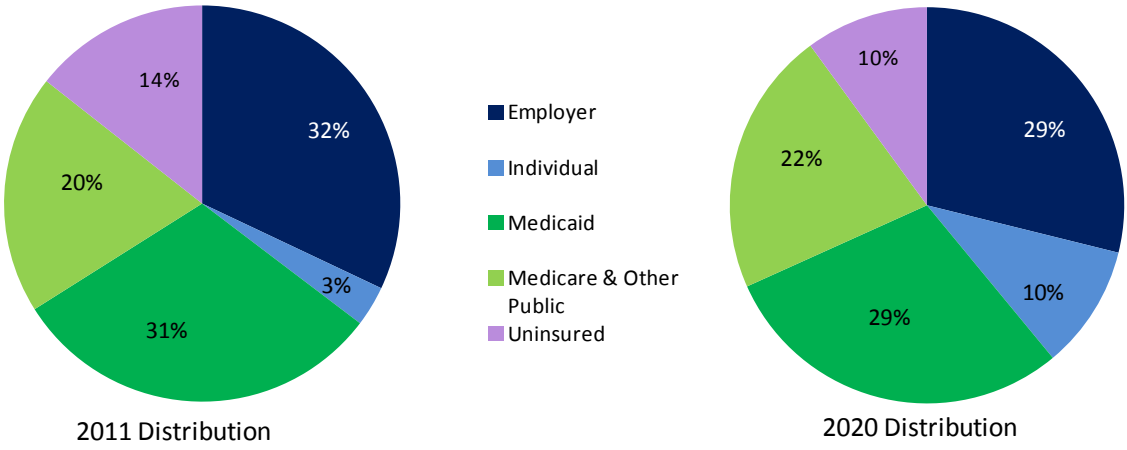


Figure H.13: Change in coverage distribution for the total Illinois population 201-400% of FPL (Deloitte Consulting Health Reform Impact Model)[14]

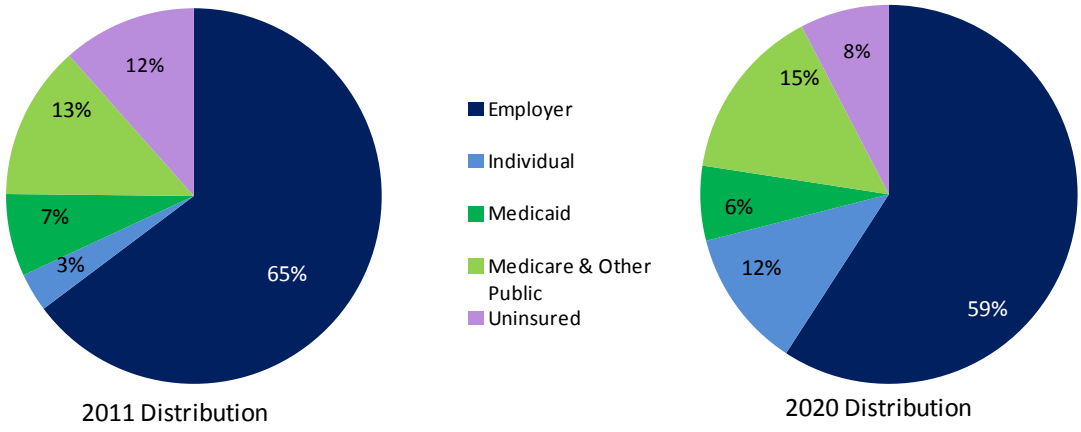
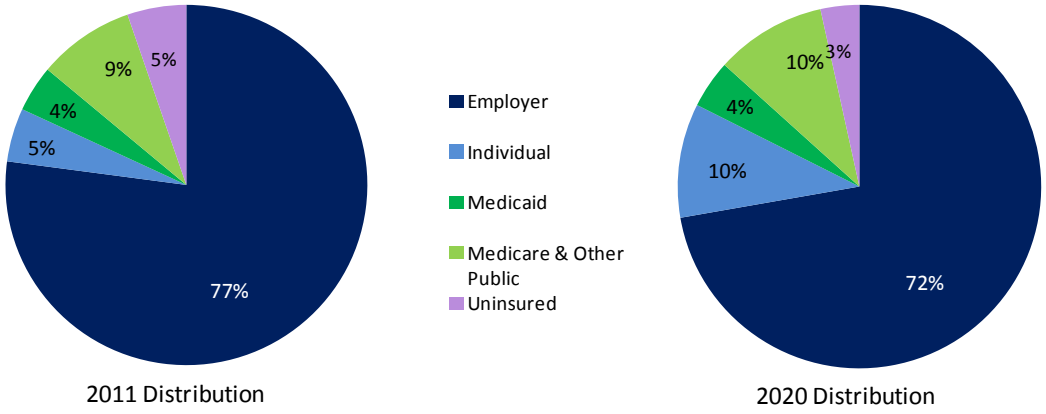


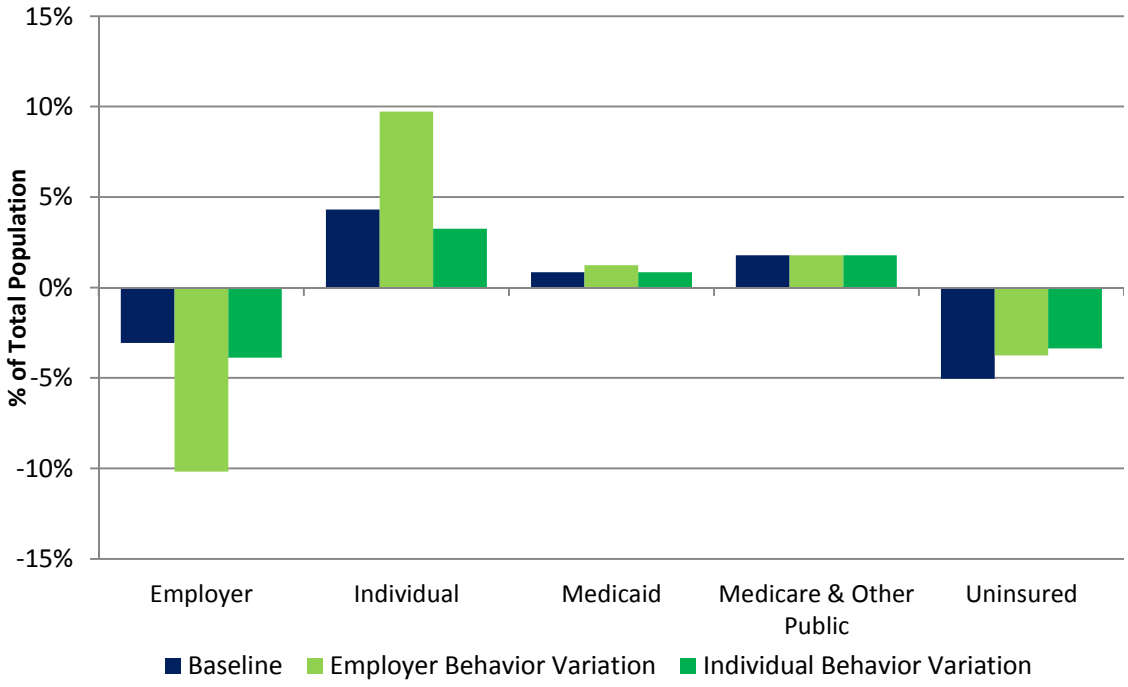
Figure H.14: Change in coverage distribution for the total Illinois population over 400% of FPL (Deloitte Consulting Health Reform Impact Model)[14]



Comparing across the different scenarios illustrates the sensitivity of results to market participant behavior. The Baseline scenario assumes behavior largely as anticipated when reform was introduced. This is contrasted to the other two scenarios as follows (Figure H.15):

- The Employer Behavior Variation Scenario - projects greater uninsured and a larger individual market if employers exit the market in larger numbers.
- The Individual Behavior Variation Scenario - projects reduced enrollment in coverage (especially individual coverage) and a resultant increase in the uninsured. This could happen if the individual mandate is weakened or eliminated or if, for whatever reasons, individual take-up rate is materially lower than assumed.

Figure H.15: Changes in coverage components as percentage of the total population as of 2020 (Deloitte Consulting Health Reform Impact Model)[14]

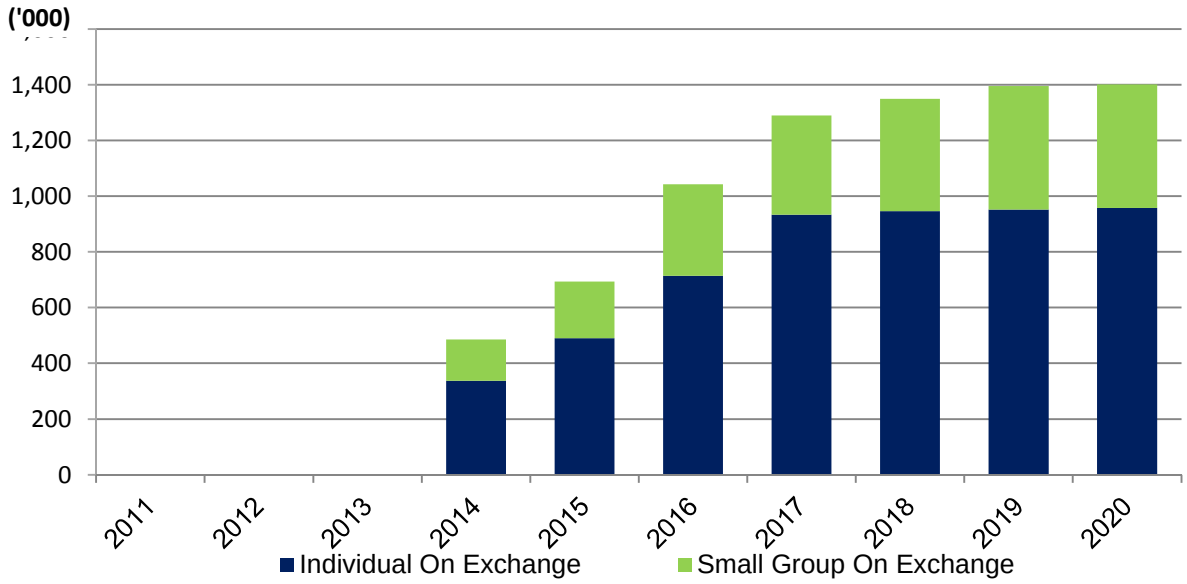


The Exchange is projected to become the dominant marketplace for individual health insurance. In the various projections, a strong Exchange is assumed. In other words, the projections assume that the large majority of those eligible for premium subsidies will purchase coverage through the Exchange (Figure H.16).

The small employer exchange, or Small Business Health Options Program (SHOP), is estimated to grow to approximately 357,000 members by 2017. The modeling also assumes that the Exchange will provide a viable alternative marketplace for those above 400% of FPL and that a majority share of this population will also purchase coverage through the Exchange.

The off-Exchange marketplace is assumed to continue to exist, mainly as a market where higher-income individuals as well as Aliens Not Lawfully Present in the U.S. can purchase coverage.

Figure H.16: Projected Exchange membership (Deloitte Consulting Health Reform Impact Model)[14]



Appendix A: Data Requests Submitted to State Agencies

Illinois Department of Insurance

1. Agent and Broker Data

Summary:

This data request pertains to the agent and broker database maintained by the DOI.

Agent and Broker Data	
Field	Comments
Unique Identifier	This field should be a unique identifier for each agent. Using name is ok, but a simple numbering convention (1,2,3, etc.) is also reasonable.
Zip Code	IL zip codes
Line of Insurance (LOI) License	This field should list the license held by the agent. If licenses are within the data as a code or are non-descriptive, please provide a data dictionary with a description of the license.

2. Historical Insurer & HMO Premium

Summary:

The following data request pertains to Annual Statement data that could be used to show changes over time in the health insurance market.

Historical Insurer & HMO Premium
Request
Please provide an updated version of the sample report, [Sample Data.pdf], for both insurers and HMOs and include all 10 years of available data. If possible, please provide these historical premium exhibits split between individual product premium and group product premium. This level of granularity may not be available from all Statutory annual statements, but we do believe it is captured in Orange Blanks (Life & Health).
Additional Notes: The DOI ultimately provided historical premium for companies filing Life blanks with the NAIC for the 5 year period ending in 2010. We relied on a vendor data set for historical premium from Health blank filers for the 10 year period ending in 2010.

3. Complaint Database

Summary:

The following data request pertains to the complaint database maintained by the DOI.

Complaint Database	
Field	Comments
Year Complaint Submitted	Data should include, if possible, historical complaints for the most recent 5 years.
Year Complaint Resolved	This data item may not be available in some or all cases. Please ignore if not available.
Regional Field	If a field capturing the location of the party registering the complaint, for example zip code, is available please include.
Gender	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Race/Ethnicity	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Age of Insured Person	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Marital Status	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Sources of Income	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Number of Persons in Household	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Job Status	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Spouse Job Status	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Relationship Close Code	Based on the sample code files provided

Complaint Database	
Field	Comments
Coverage Code	Based on the sample code files provided
Reason Code	Based on the sample code files provided
Contributing Factors	Based on the sample code files provided
Against Close Code	Based on the sample code files provided
Disposition Code	Based on the sample code files provided
Count of Complaints	Based on the sample code files provided

Illinois Department of Public Health

1. Behavioral Risk Factor Surveillance System

Summary: This data request pertains to the Illinois Behavioral Risk Factor Surveillance System.

Illinois Behavioral Risk Factor Surveillance System	
Field	Comments
Year	Please include survey results from 2000 to 2009.
Zip Code	If available, please delineate by zip code.
County	
Area	Based on the survey, possible values are Chicago, Suburban Cook County, Collar Counties, Urban Counties, Rural Counties
Age Group	Based on the survey topic - Demographics
Sex of Respondents	Based on the survey topic - Demographics
Race	Based on the survey topic - Demographics
Hispanic or Latino	Based on the survey topic - Demographics
Income Level	Based on the survey topic - Demographics
Education Level	Based on the survey topic - Demographics
Household Type	Based on the survey topic - Demographics
Have a Health Plan	Based on the survey topic - Health Care Utilization
Have Primary Care Provider	Based on the survey topic - Health Care Utilization
Avoided Doctor Due to Cost	Based on the survey topic - Health Care Utilization
Last Routine Checkup	Based on the survey topic - Health Care Utilization
General Health	Based on the survey topic - Health Status
Days Mental Health Not Good	Based on the survey topic - Health Status
Days Physical Health Not Good	Based on the survey topic - Health Status
Days Health Kept from Doing Usual Activities	Based on the survey topic - Health Status
Get Social / Emotional Support	Based on the survey topic - Quality of Life/Disability
How Satisfied You are with Your Life	Based on the survey topic - Quality of Life/Disability
Unweighted Count	Unweighted count is the number of actual survey

Illinois Behavioral Risk Factor Surveillance System	
Field	Comments
	respondents stratified by the above fields. Note: This field was not specifically provided. Rather it could be obtained by counting the number of rows with a desired stratification of the above fields.
Weighted Count	Weighted count is the count of respondents extrapolated to the population as a whole, stratified by the above fields.

Illinois Department of Healthcare and Family Services

1. Medical Data Warehouse

Summary: The following data request pertains to the medical data warehouse and various enrollment and claims experience data.

Medical Warehouse Database		
Field	Comments	Additional Notes
Zip Code		
Year	Year of enrollment from 2001 to 2010	2006 - 2010 provided; 2010 claims adjudicated through June 3, 2011 and are incomplete.
4 + 1 Category	Per our phone discussion, the categories for members are 1)Children 2)Adults, non-disability (19-64) 3)Adults with disabilities (19-64) 4)Elderly, 65+ and 5) Partial benefits	Enrollment Codes were linked to additional table below to determine if full or partial benefits and if disabled.
Medicaid Program or Category of Aid	This field should show specific Medicaid programs. We would expect to see field values consistent with those provided by Megan Moore in the file [SUMMARY OF MEDICAL ELIGIBILITY GROUPS 05.2011(1.0).docx], column "Program Name". For example, "Family Care", "All Kids Assist", "All Kids Share", etc....	Enrollment Code descriptions were provided from linking code provided on main file to additional table below.
Age	<18, 18-25, 26-29, 30-39, 40-49, 50-59, 60-64, 65+	
Gender	Male/Female	
Race	White, African, Asian, Hispanic, Other	D=did not respond, M=multi
Employment Status	Employed Yes/No, or Full time/Part time, if known	Not available
Count of Unique Members	This field should show a count of the number of members stratified by the previous fields. Specifically, the number of members enrolled for a	Members counted as of Jan 1 and July 1 each year.

Medical Warehouse Database		
Field	Comments	Additional Notes
	given year, demographic characteristics, 4+1 Category and Medicaid Program.	
Member Months	This field should show the total number of member months stratified by the previous fields. Specifically, the number of members enrolled for a given year, demographic characteristics, 4+1 Category and Medicaid Program.	Not provided
Gross Claim Cost	This field should show the total cost stratified by the previous fields. This includes both the costs paid by the Program and cost sharing by the individual	Not available as copays are not tracked.
Net Claim Cost	This field should show the total cost stratified by the previous fields. This includes both the costs paid by the Program and cost sharing by the individual	Net paid provided. These are costs allocated to an individual person for an individual health event. Bulk payments are not included.

Additional Medicaid Programs Data			
Enrollment (Detail Report Group) Code	**Enrollment Detail Report Group Description**	**Benefits Type Code**	**Disabled Indicator**
110	Illinois Cares Rx	Partial	N
120	Breast and Cervical Cancer (BCC)	Full	N
130	Illinois Healthy Women (IHW)	Partial	N
140	MPE - Pregnant Women	Partial	N
150	General Assistance adults	Partial	N
160	Emergency services only (excludes Labor & Delivery)	Partial	N
170	All Kids Rebate	Partial	N
180	Family Care Rebate	Partial	N
190	Chronic Renal	Partial	N
200	QMB Only	Partial	N
210	SLMB Only	Partial	N
220	QI-1 Only	Partial	N
230	Mental Health Screening Only	Partial	N
240	AABD - Age 65 years old and older	Full	Y
250	AABD - Blind/Disabled under Age 65 years	Full	Y
260	HBWD	Full	Y
270	All Kids Income <= 133%	Full	N
280	All Kids - Age 6 to 18 years old & Income	Full	N
290	All Kids - Age 6 to 18 years old & Income	Full	N
300	All Kids - income > 133% <= 150% FPL	Full	N
310	All Kids - income > 150% <= 200% FPL	Full	N

Additional Medicaid Programs Data			
Enrollment (Detail Report Group) Code	Enrollment Detail Report Group Description	Benefits Type Code	Disabled Indicator
320	All Kids - income > 200% <= 300% FPL	Full	N
330	All Kids - income > 300% <= 400% FPL	Full	N
340	All Kids - income > 400% <= 500% FPL	Full	N
350	All Kids - income > 500% <= 600% FPL	Full	N
360	All Kids - income > 600% <= 700% FPL	Full	N
370	All Kids - income > 700% <= 800% FPL	Full	N
380	All Kids - income > 800% FPL	Full	N
390	DCFS - Foster Care	Full	N
400	DCFS - Adoption Assistance	Full	N
410	DCFS - Subsidized Guardianship	Full	N
420	DJJ Non-Incarcerated Children	Full	N
425	DCFS - Other cases enrolled and administered	Full	N
430	Moms & Babies	Full	N
440	Unborn Child SPA	Full	N
450	FamilyCare Assist w cash	Full	N
460	FamilyCare Assist w/o cash	Full	N
470	FamilyCare - income <= 133% FPL	Full	N
480	FamilyCare - income > 133% <= 150% FPL	Full	N
490	FamilyCare - income > 150% <= 185% FPL	Full	N
500	FamilyCare - income > 185% <= 400% FPL -	Full	N
510	General Assistance - age <= 18 years old	Full	N
520	RRA	Full	N
530	TMA	Full	N
540	Veterans Care	Full	N
550	Warriors Assistance	Partial	N
560	Pending Asylees or Torture Victims	Full	N
570	Presumptive Eligibility	Full	N
999	Unknown	Full	N

2. All Kids Application Agents

Summary: The following data request pertains to All Kids Application Agent data (number of approved applications, location of agent).

All Kids Application Agents
Request
We note that the sample file provided shows the number of approved applications by agent for the period 4/01/2010 - 3/31/2011. If possible, please provide similar files for the prior 12 month periods, up to 10 periods as available. For example, 4/1/2009 - 3/31/2010, 4/1/2008 - 3/31/2009, 4/1/2007 - 3/31/2008, etc. In addition, we have the following questions to clarify the sample data provided. 1) Within the sample file what does "Active" mean - registered, enrolled at least one person? 2) Is the list of AKAAs provided in the sample file a truncated list? The lowest number of approved applications by an agent is 21. We would expect to see some agents with between 1 and 20 approved applications. If this is a truncated list, can you provide the complete list?
Additional notes from the State: 1) The State provided approvals for the period April 2002 through March 2011. 2) An Active AKAA is one who submitted an application during the time period of the report. AKAA activity has declined over the years, mainly due to the popularity of the web based application. Prior to the web based application, the majority of the State's applications came through AKAAs.

3. Discharge Data

Summary: The following data request pertains to the Illinois all payer hospital discharge data set.

Illinois Discharge Data - Inpatient	
Field	Comments
Year	2008, 2009, 2010
Patient Age Band	<18, 18-25, 26-29,30-34, 35-39, ….,60-64, 65+
Patient Zip code	
Provider Zip code	
Diagnosis	Primary only
Primary Payer Type	Private Insurance, Medicaid, Medicare, Self Pay, Other
Secondary Payer Type	Private Insurance, Medicaid, Medicare, Self Pay, Other
Sum of discharges	
Sum of days	

Illinois Discharge Data - Outpatient	
Field	Comments
Year	2008, 2009, 2010
Patient Age Band	<18, 18-25, 26-29,30-34, 35-39, ….,60-64, 65+
Patient Zip code	
Provider Zip code	
Diagnosis	Primary only
Primary Payer Type	Private Insurance, Medicaid, Medicare, Self Pay, Other
Secondary Payer Type	Private Insurance, Medicaid, Medicare, Self Pay, Other
Sum of Cases	

Appendix B: 2011 Illinois Health Insurance Survey Questions and Results

IHIS Questions and Weighted Results

Note to Survey Respondents: It may be beneficial to track down your health insurance card and other relevant health insurance information before beginning this survey. If you don't currently have insurance, that's OK as you will go through a related set of questions on this topic.

Q258 - COUNTRY - SHORT LIST

In which country or region do you currently reside?

Country of Residence	% Respondents
United States of America	100%

Q268 - GENDER

Are you...?

Gender	% Respondents
Male	50%
Female	50%

Q270 - YEAR OF BIRTH

In what year were you born? Please enter your response as a four-digit number (for example, 1977).

Age Bands	% Respondents
18-25	18%
26-29	9%
30-39	20%
40-49	23%
50-59	18%
60-64	12%

Q326- Concatenated zip/postal code

What is your zip code (zip codes were later grouped into geographic regions)?

Region	% Respondents
Chicago	21%
Chicago Suburbs/Collar Counties	43%
North Central Counties	5%
Rural Counties	19%
Urban Counties	12%

Q602 - Number of Adults (18 or older) live in your household

Including yourself, how many people age 18 or older live in your household? If you live in more than one household, please answer for only one of the households.

# Adults in Household	% Respondents
1	23%
2	48%
3	17%
4	8%
5	2%
6	1%
7+	1%

Q603 – Number of Children (under age 18) live in your household

How many people under the age of 18 live in your household? If you live in more than one household, please answer for only one of the households.

# Children in Household	% Respondents
0	63%
1	17%
2	13%
3	5%
4	1%
5+	1%

Q610 - Total 2010 household income

Which of the following income categories best describes your total 2010 household income before taxes (income ranges varied by household size)?

1 Person	
Less than $15,000	26%
$15,000 to $21,999	7%
$22,000 to $31,999	14%
$32,000 to $42,999	10%
$43,000 to $99,999	28%
$100,000 or more	4%
Decline to answer	11%
% Population	**19%**

5 Persons	
Less than $25,000	9%
$25,000 to $35,999	28%
$36,000 to $51,999	11%
$52,000 to $76,999	16%
$77,000 to $102,999	12%
$103,000 or more	15%
Decline to answer	9%
% Population	**6%**

2 Persons	
Less than $20,000	12%
$20,000 to $28,999	6%
$29,000 to $43,999	11%
$44,000 to $57,999	15%
$58,000 to $99,999	27%
$100,000 or more	14%
Decline to answer	15%
% Population	**30%**

6 Persons	
Less than $25,000	18%
$25,000 to $40,999	21%
$41,000 to $58,999	11%
$59,000 to $88,999	15%
$89,000 to $117,999	12%
$118,000 or more	16%
Decline to answer	7%
% Population	**5%**

3 Persons	
Less than $25,000	19%
$25,000 to $36,999	12%
$37,000 to $54,999	14%
$55,000 to $72,999	11%
$73,000 to $99,999	15%
$100,000 or more	15%
Decline to answer	14%
% Population	**19%**

7 Persons	
Less than $25,000	30%
$25,000 to $45,999	24%
$46,000 to $66,999	25%
$67,000 to $99,999	18%
$100,000 to $132,999	1%
Decline to answer	2%
% Population	**2%**

4 Persons	
Less than $30,000	19%
$30,000 to $43,999	13%
$44,000 to $65,999	15%
$66,000 to $87,999	15%
$88,000 to $99,999	10%
$100,000 or more	17%
Decline to answer	11%
% Population	**18%**

8+ Persons	
Less than $25,000	27%
$25,000 to $50,999	25%
$51,000 to $73,999	15%
$74,000 to $110,999	17%
$111,000 to $147,999	3%
$148,000 or more	7%
Decline to answer	6%
% Population	**1%**

Q625 - Health Insurance

We will now ask you some questions about health insurance. Are you currently covered by any kind of health insurance, health plan, or health care program? Please select one.

Health Insurance Status	% Respondents
Yes, I am currently covered	84%
No, I am not currently covered, but I had coverage within the past year	3%
No, I am not currently covered and have not had health insurance coverage at any time during the past year	13%

Q705 - Number of individuals

Including yourself, how many individuals in your household have the following types of coverage?

Type of coverage	Average Number of Individuals with Coverage
Purchased individual or family coverage directly from an insurance company	0.4
Obtained it through an employer (either your own or your spouse/partner's)	1.5
Enrolled in Medicare	0.2
Enrolled in Medicaid, All Kids, or other Illinois health programs	0.4
Enrolled in military health care (TRICARE, VA, CHAMP-VA)	0.1
Other source	0.1
Do not have insurance	0.3

Q711- Additional insurance

Does anyone in your household have any of the following additional types of insurance programs? Please select all that apply.

Type of coverage	Average Number of Individuals with Coverage
Long term care coverage	0.2
Dental care coverage	0.6
Vision or eye care coverage	0.5
Supplemental insurance to cover what my primary insurance/spouse's insurance does not cover (e.g., Medigap policies and other plans)	0.1
Prescription drug coverage under an additional policy I had to purchase (e.g., Medicare Part D and other policies, programs)	0.2
Not sure what additional coverage I have	0.1
Other	0.1
No Additional insurance	0.3

Q750- Insurance Plan

We will now ask you some questions regarding your insurance plan.

Thinking about the health insurance coverage you have and the medical costs you could afford to pay out of pocket, do you consider yourself to be… Please select one.

Insured Level	% Respondents
Well insured	32%
Adequately insured	51%
Underinsured	13%
Not sure	4%

Q756 - Satisfaction

Thinking of your current insurance plan, how satisfied are you with each of the following factors? Please rate each factor.

	Not at all satisfied (1)	Somewhat satisfied (2)	Satisfied (3)	Very Satisfied (4)	Extremely satisfied (5)	Does not apply (6)
What I have to pay out-of-pocket to buy the insurance (premium)	16%	22%	30%	13%	11%	8%
What I have to pay out-of-pocket when I visit a doctor (cost sharing via deductible/co-pay)	11%	22%	33%	16%	14%	4%
Benefits and services covered by your insurance policy	7%	21%	35%	21%	14%	2%
Quality of health care service you receive	2%	12%	35%	26%	23%	2%
Choice of doctors in the network	5%	13%	35%	23%	21%	3%
Coverage for prescription brand name medications	11%	19%	35%	17%	14%	4%
Coverage for generic medications	3%	13%	35%	23%	23%	3%
Coverage for alternative treatment approaches or natural therapies	13%	17%	29%	11%	7%	23%
Coverage for mental/behavioral health services	7%	14%	34%	13%	10%	22%
Puts me in control of my health care dollars	11%	22%	34%	14%	11%	8%
Easy to understand/familiar to me	7%	20%	39%	19%	13%	2%
Quality of customer service that I receive from the Insurance Company	5%	18%	40%	18%	12%	7%

Q760 – Uninsured Barriers to Coverage

Which of the following describes why you do not currently have health insurance? Please select all that apply.

Barrier to Coverage	% Respondents
I do not have access to health insurance offered by an employer	22%
I applied for health insurance but was turned down by the insurance company	5%
Health insurance is too expensive	47%
I feel healthy and do not need health insurance	6%
I do not have insurance due to religious/cultural observance	1%
I am not able to conveniently access a doctor that would be covered under any available health insurance	1%
I am not able to find a doctor who speaks my language that would be covered under any available health insurance	0.4%
I can pay the bills myself without insurance	4%
None of the above	15%

Q766 - Primary Health Insurance- Importance

If you were to purchase health insurance today, how important would each of these factors be in choosing your primary health insurance? Please rate each factor.

	Not at all important (1)	Somewhat important (2)	Important (3)	Very important (4)	Extremely important (5)	Does not apply (6)
What I have to pay each month to buy the insurance (premium)	0%	2%	15%	23%	56%	4%
What I have to pay out-of-pocket when I visit a doctor (cost sharing: deductible/co-pay)	1%	3%	17%	27%	49%	3%
Reputation or reliability in paying claims	1%	3%	21%	29%	43%	3%
Quality or satisfaction ratings, rankings, or reports of the particular plan	1%	9%	31%	28%	28%	3%
Choice of providers in the network	1%	4%	20%	27%	45%	3%
Coverage for prescription brand name medications	2%	7%	24%	28%	36%	3%
Coverage for generic medications	1%	5%	24%	28%	38%	4%

	Not at all important (1)	Somewhat important (2)	Important (3)	Very important (4)	Extremely important (5)	Does not apply (6)
Coverage for alternative treatment approaches or natural therapies	7%	16%	29%	19%	21%	8%
Coverage for mental/behavioral health services	8%	14%	28%	17%	22%	11%
Puts me in control of my health care dollars	0%	4%	26%	30%	36%	4%
Easy to understand/familiar to me	1%	4%	25%	32%	36%	2%
Quality of customer service that I receive from the Insurance Company	0%	5%	26%	31%	35%	3%

Q770- Chronic Conditions

A "chronic condition" is any disease or health problem that has lasted for 3 months or more. Examples include arthritis, diabetes, cancer, heart disease, high blood pressure, high cholesterol, asthma, allergies, back pain, depression, alcohol or drug dependence, and others. Have you been diagnosed by a doctor or other medical professional as having one or more chronic conditions? Please select one.

Chronic Condition	% Respondents
Yes	50%
No	50%

Q775 - Denied Coverage

Have you ever been denied coverage and/or had health benefits limited due to a pre-existing condition? Please select one.

Denied Coverage Due to Pre-X	% Respondents
Yes	9%
No	91%

Q780 - Poor Health

In general, would you consider any member of your family to have poor health? Please select one.

Poor Health	% Respondents
Yes	23%
No	77%

Q785 – Level of Confidence

Generally, how confident are you that you and your family have enough money to pay for the usual medical costs that you and your family require?

Level of Confidence	% Respondents
Very confident	15%
Somewhat confident	23%
Not very confident	44%
Not confident at all	18%

Q790 - Household Behavior

In the past 12 months, has your household done any of the following? Please select all that apply.

Barrier to Coverage	% Respondents
Had to choose between paying for health care or prescriptions and paying for other essential needs (such as rent, mortgage, utilities)	11%
Had serious problems paying or were unable to pay medical bills	11%
Ran up credit card or other debt your household is still paying off due to medical costs	7%
Delayed visiting a doctor or other provider due to the cost	20%
Delayed visiting a doctor due to a current disability or physically difficulties getting to the office	4%
Delayed visiting a doctor because I didn't know where to find one and/or the doctor I could find was too far away	5%
None of these	43%

Q800 - Health Insurance Premiums

Approximately how much do you pay for your household health insurance premiums, not including the health care costs you pay directly out of your own pocket? You may enter the amount you pay per month or per year. If you are not sure what this number is, please look it up in your insurance documents. Please enter just one number:

Premium Time Period	Average	Median
Average Premium Per Month	$244	$147
Average Premium Per Year	$2,455	$1,800

Q805 - Number of Adults and Children Covered by Premium

How many adults over 18 (including yourself) and how many children under 18 are covered by this premium?

Persons	Average
Average Number of Adults	1.6
Average Number of Children	0.5

Q810- Out of Pocket Costs

Even with insurance, most people have to pay additional costs for their insurance above and beyond their premiums. How much have you and your family paid for health care costs, such as co-pays, deductibles, and any other expenses not covered by your insurance, out of your own pocket in the past 12 months? Please do not include the amount you pay for health insurance premiums, since this was provided in the previous answer.

	Average	Median
Out of Pocket Spend Per Year	$1,170	$700

Q815 - Maximum Benefit

Thinking about your current insurance plan, what is the maximum amount of benefit your policy will cover for medical care per year? If you are not sure what this number is, please look it up in your insurance documents.

Maximum Benefit	% Respondents
Less than $20,000	10%
$20,000 to $99,999	12%
$100,000 to $999,999	13%
$1,000,000 to $4,999,999	12%
$5,000,000 or more	7%
Don't know	46%

Q820 – Premium afford to pay

Thinking about an insurance plan in which you could enroll in the future, approximately how much could you afford to pay for the following: Your household health insurance premiums, not including the health care costs you would pay directly out of your own pocket? You may enter the amount you could afford to pay per month or per year.

Please enter just one number:

Premium Time Period	Average	Median
Average Premium Per Month	$196	$118
Average Premium Per Year	$2,231	$1,104

Q822- Out of pocket

Thinking about an insurance plan in which you could enroll in the future, approximately how much could you afford to pay for the following: "Out of pocket" health care costs for you, such as co-pays, deductibles, and any other expenses not covered by your insurance, over 12 months? Please do not include the amount you would pay for health insurance premiums.

	Average	Median
Out of Pocket Spend Per Year	$1,085	$421

Our next series of questions is for classification purposes and will help us properly analyze responses to this survey.

Q900 - Race

Which of the following best describes your race? Please select one.

Race	% Respondents
African American	14%
Asian	2%
White Non-Hispanic	68%
Hispanic	12%
Other	1%
Prefer not to respond	3%

Q905 - Current Employment Status

What best describes your current employment status? Please select one.

Employment Status	% Respondents
Part time (<30 hours per week on average over the course of a month)	16%
Full time	46%
Not currently working	38%

Q910 - Industry

Which of the following best describes the industry in which you work? Please select one.

Industry	% Respondents
Agriculture, forestry, mining	2%
Business services, personal services, legal services, finance, insurance, real estate, technology, communication, transportation	20%
Construction	3%
Education, social services	12%
Government, public service, military	5%
Health services	10%
Manufacturing	8%
Non-profits, religious organizations	3%
Retail, restaurant	11%
Arts, entertainment, recreation	3%
Other	23%

Appendix C: Carrier Survey Data

The Carrier Survey requested information directly from the largest health insurance carriers in the State to provide data on the insurance market. The State submitted a Data Call to these carriers under its insurance regulatory authority. The Initial Carrier Survey was executed by Wakely Consulting Group and Deloitte Consulting executed the Addendum to the Carrier Survey, on behalf of the State. The following table summarizes the two data requests sent to the participating carriers, labeled Initial and Addendum.

Initial Carrier Survey Data Request	
Request	**Detailed Data Elements**
Illinois Small Group and Individual Experience for 2010 ***Note that different levels of detail were requested based on the following indicator:*** ** Data element collected for products that make up at least 80% of enrollees in the small group market and at least 80% of enrollees in the individual market for a particular carrier.* *** Data elements collected for products not captured in the 80% of enrollment in small group and individual markets.* **** Data elements collected for all products*.	Carrier*** Line of Business*** Type of Product* In-network Deductible* In-network Coinsurance* In-network Maximum Out-of-Pocket* Inpatient per admit copay* Inpatient per day copay* Emergency Room Cost-Sharing* PCP Office Visit* Specialist Office Visit Cost-Sharing* Generic Prescription Drug Cost-Sharing* Preferred Brand Prescription Drug Cost-Sharing* Non-Preferred Brand Prescription Drug Cost-Sharing* Closed or Open status as of 1/1/2011* 2010 Member Months*** 2010 Earned Premiums*** 2010 Incurred Claims net of cost sharing (paid) including incurred but not reported (IBNR)*** 2010 Incurred Claims gross of cost sharing (allowed) including IBNR**\

Initial Carrier Survey Data Request (cont.)	
Request	**Detailed Data Elements**
Illinois Individual Underwriting Experience	2010 Policies and 2010 Written (Annualized) Premium by: 2010 Applications 2010 Standard Issues 2010 Preferred Issues 2010 Sub-standard Issues 2010 Denied 2010 Non-Issued at Policyholder discretion 2010 Issued with Underwriting Condition Exclusion Current Rating Factors and Persistency at End of Year by Duration.
Illinois Small Group Underwriting Experience	By Group Size: 2010 Group Months 2010 Employee Months 2010 Member Months 2010 Earned Premium Average Health Status Adjustment Factor 2010 Earned Premium or # of Groups by Health Status Factor Adjustment
Agent Compensation	For Each Commission Schedule: Company Name NAIC Company Code State Market Product Commission Schedule Applies to What Class of Producers Date Commission Schedule First Went Into Effect Date Commission Schedule Terminated First Year Commission - % of Premium Renewal Commission - % of Premium First Year Commission - Fixed Amount Renewal Commission - Fixed Amount Incentive or Bonus Programs Total Compensation in Dollars Total Compensation - % of Premium

Addendum Carrier Survey Data Request	
Request	**Detailed Data Elements**
Illinois Fully Insured Product Exposure by Zip Code for 2010	For Each Plan: Carrier Line of Business Type of Product Group Zip Code Member Zip Code 2010 Member Months 2010 Earned Premiums

Appendix D: Projection Assumptions

Item	Definition/Description	Sources and Assumptions
Total Population		
Total Illinois Population	Population projections for years 2011-2020 (breakdowns by state, age, and income)	Age Distribution from Census Projections. Income distribution per Urban/Kaiser Family Foundation (KFF) values, derived from Census projections (CPS). www.statehealthfacts.org
Aliens Not Lawfully Present	Projections on the number of persons residing in Illinois who are Aliens not Lawfully Present in the United States, and their health insurance coverage from 2011-2020.	Baseline counts of this population group per PEW Hispanic Center. http://pewhispanic.org/unauthorized-immigration/ Current coverage levels per PEW and Center for Immigration Studies (CIS) http://www.cis.org/articles/2009/hr3200.pdf Baseline level of increase corresponds with population growth. Those with commercial coverage are assumed to retain it. Exchange and Medicaid expansion are assumed not to apply to this population group, as per ACA.
Legal/ACA		
Individual Mandate	Size, basis and timing of penalties for those without health care coverage	ACA provisions – without adjustment
Employer Pay or Play	Size, basis and timing of fees assessed on employers not providing health care coverage	ACA provisions – without adjustment
Exchange availability: Individuals	Date at which Exchange established, and subsidies etc. can be processed	Assume strong exchange beginning on Jan 1, 2014.
Exchange availability: Groups	Date at which SHOP established, and group sizes allowed over time.	Assume SHOP for groups <50 on Jan 1, 2014 Assume SHOP for groups <100 on Jan 1, 2016 No SHOP for groups > 100 in projection period

Economy		
Unemployment	Unemployment rate projections from 2011-2020 by state	Timing of employment recovery per CBO Budget Office Economic Outlook http://www.cbo.gov/ftpdocs/120xx/doc12039/01-26_FY2011Outlook.pdf Eventual unemployment level: Per Bureau of Labor Statistics http://www.bls.gov/lau/
Real Wage Growth	Year over year increase in wages, adjusted for inflation.	CBO Budget Office Economic Outlook
Commercial Coverage		
Group Coverage Offer Rates	% of those eligible to purchase coverage through their employer by group size	Compound assumptions (decreases with establishment of Exchange and Guaranteed Issue requirements, increases with Pay-or-play). Net assumption produces a gradual reduction of approximately 7% in offer rates by the year 2017.
Group Coverage Take Rates	% of those offered group coverage that accept group coverage, by group size	Increase over time as a function of the individual mandate
Group ASO Share	% of those with group coverage on self-insured plans, by group size.	Moderate increase in ASO with introduction of ACA industry fees applicable to insured business only Larger shift to ASO with community rating of larger groups when the small group market is extended up to 100 employee groups
Individual Take Rates	Individual Enrollment as % of (Individual + Uninsured)	Derived through decision modeling based on the price sensitivity, considering estimated value of subsidies, cost of penalties, underwriting and rating restrictions
Individual Market Maximum Take Rates	Maximum take rate by Income	Consistent with Adult Medicaid Take rates
Medicare		
Medicare Beneficiary Projection	Number of persons enrolled in Medicare for 2011-2020, including dual eligibles.	Increase in Medicare beneficiaries proportional to population growth for the over age 65 population.
Medicaid		
Medicaid Beneficiary Projection	Number of persons enrolled in Medicaid and All Kids over the projection period.	Changes each year due to population growth and economic factors including unemployment rates and real wage growth rate assumptions Eligibility calculated based on Illinois income distribution data from KFF

Effective Income Limit Floor	The minimum income level at which federal law requires eligibility for Medicaid	ACA without adjustment. 138% of FPL (i.e. 133% + 5% income disregard)
Shift of Membership from State Programs To Exchanges	Assumed Exchange take up from individuals on Medicaid or State Programs prior to reform	Assume that a subset of adults on Medicaid and State Programs with incomes above 138% of FPL (62K) transfer to the Exchange. This reflects an assumption of movement that may change once policy decisions are finalized.
Take Rates - Prior Eligibles	The proportion of people who enroll for Medicaid from among those already eligible prior to the implementation of ACA.	Assume that 20% of those not taking up coverage today, will do so in the future. (Excludes disabled individuals). Assume All Kids children stay on Medicaid.
Take Rates - New Eligibles	The % of people who enroll for Medicaid from among those who will be newly eligible due to ACA.	Assume that 60% take coverage (includes currently uninsured as well as current Group and Individual market enrollees) Take up Rate per Urban Institute: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf

Endnotes

Note: The following endnotes contain web links where applicable. The links in this report may have moved or been deleted after this report became final.

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

State of Illinois – Quarter 4 Report

Appendix B: *Illinois Exchange Strategic and Operational Needs Assessment: Final Report* (Health Management Associates and Wakely Consulting)

HMA

HEALTH MANAGEMENT ASSOCIATES

Illinois Exchange Strategic and Operational Needs Assessment

Final Report

SEPTEMBER 2011

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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1. Executive Summary

The Affordable Care Act (ACA) is a substantial, comprehensive reform of health care and health insurance in this country. A central element of the ACA is the creation of Health Insurance Exchanges. Exchanges are organized marketplaces for the purchase of health insurance by individuals and small businesses. Among the most challenging aspects of implementing health reform for states is planning for Exchange establishment and operation.

The ACA will substantially overhaul the individual and small-group insurance market in Illinois, require individuals to buy insurance, and incentivize employers to purchase insurance for their employees. The ACA also expands Medicaid eligibility and establishes new tax credits to subsidize the purchase of insurance for individuals who are low income but do not qualify for Medicaid. Those subsidies are only available to individuals who purchase insurance through an Exchange. There are currently 1.5 million uninsured individuals in Illinois. According to the State's most recent estimates, the reforms included in ACA will dramatically reduce the number of uninsured in the State.

The purpose of this report is to inform the process of Exchange planning in Illinois. The report provides background information on the federal law, analyzes the state's needs in setting up an Exchange, addresses mandatory Exchange services and functions, projects Exchange start-up and operating costs, and provides insights on policy decisions the state will need to make in designing its Exchange, coordinating it with the Illinois insurance market, and integrating it with existing Illinois public programs.

The process of Exchange planning involves both the Executive and Legislative branches. After passage of the ACA, Governor Pat Quinn issued an Executive Order establishing the Illinois Health Reform Implementation Council. The Council convened a series of public hearings during the latter part of 2010 and on November 15, 2010, sought public input on a series of explicit policy questions regarding the ACA implementation. The final report of the Council, titled *Health Care Reform Implementation Council: Initial Recommendations,* was made public on March 1, 2011. With the support of a federal Exchange planning grant, affected state agencies have established a variety of workgroups, commissioned this report, and conducted other background research efforts. The General Assembly, which created a Legislative Study Commission to study and provide recommendations on Exchange enabling legislation, also plays a crucial role in Exchange planning in Illinois. Overall the state of Illinois is deeply engaged in ACA implementation planning.

Exchange Planning and the Challenges of the ACA Timeline

A primary consideration and constraint in planning for Exchange implementation is timing. Exchanges begin operating under new ACA rules on January 1, 2014. To begin providing coverage options on that date, Exchanges need to be operational for an initial open enrollment period beginning October 1, 2013. Substantial development, generally funded by the federal government, and careful testing of new IT infrastructure needs to be completed satisfactorily before the initial enrollment period. State Exchange plans must be submitted for federal approval in the fall of 2012 for approval by the Secretary of Health and Human Services (HHS) by January 1, 2013. Many of the policy decisions about how the Illinois

Exchange will operate in relation to the larger insurance market and how the Exchange will integrate with the state's existing Medicaid program are necessary well in advance of 2013. Finally, requirements for Exchange operations, most notably the need to integrate eligibility and enrollment systems with existing state Medicaid enrollment, necessitate action now to allow time for design, procurement, development, and deployment steps that must be taken before implementation.

We emphasize timing at the outset because it helps bring into sharp focus the issues faced by Illinois and every other state considering establishing an Exchange. We also emphasize two related points. First, the challenge of compressed timeframes impacts not only state government planners but also health insurance carriers that wish to be qualified to offer Exchange plans; they will have to undertake significant operational preparations. Second, preparations for ACA implementation are well underway in Illinois, with senior-level state staff organized, coordinated, and engaged in the day-to-day decisions needed to support the planning effort. However, final decisions on the myriad options confronting Illinois will be impossible without an established Exchange organization with an accountable governance structure. Given the priority placed on Exchange planning in Illinois, legislative action to establish an Exchange is a crucial next step.

Potential Policy Goals of an Exchange

An important initial consideration for Illinois is to consider the goals that it seeks to prioritize in implementing an Exchange in the state. Informed by Illinois planning efforts to date, this report identifies potential policy goals for an Exchange and discusses methods to ensure that those goals are met. We recommend an early discussion about potential goals among decision-makers in Illinois to arrive at common understandings of priorities and of the trade-offs inherent in the setting of those priorities. On August 24, 2012 the Legislative Study Committee discussed potential goals of an Exchange with the support of a presentation drawn largely from the material in section 4.1 of this report.

Mandatory Exchange Decisions and Functions

Initial projections are that the Illinois Exchange will enroll 486,000 individuals in 2014, the first year of operation. Of that total, 149,000 will enroll in the Small Business Health Options Program, or SHOP Exchange, and 337,000 as individual purchasers. Of the individual purchasers, 73% will receive some form of premium or cost-sharing tax credit. As the Exchange becomes well-established, enrollment is projected to grow, particularly over the first few years of operation. By 2016, the Illinois Exchange is projected to serve over 1 million customers.

Exchange enrollees will include: individuals without insurance and certain individuals in state programs today (many of whom will have access to subsidized coverage through the Exchange), people who purchase nongroup insurance today and will use the new Exchange market to purchase insurance, and people (some insured and others currently uninsured) who work for small employers who choose to use the SHOP Exchange.

A threshold question for Illinois is whether to build its own Exchange or to defer Exchange establishment in Illinois to the federal government. This report discusses both structural and organizational models for

an Exchange that are authorized under the ACA. Given the large number of new functions Exchanges must perform and the operational complexity of these functions, Illinois should consider design and organizational approaches to the Exchange that enable prompt decision-making and provide flexibility to adapt quickly to shifting market conditions. Board decisions will be difficult because they will directly affect a wide range of stakeholders, special-interest groups, consumers, and business interests. Given the importance of ensuring the public's trust in Exchange board decisions and of insulating, to the extent practical, members from political pressures, Illinois should prioritize competence and experience in defining its board membership rather than status as a representative of an identified interest group.

Operational expectations of Exchanges are substantial. This report reviews mandatory Exchange requirements and addresses, in fourteen separate domains, whether existing state infrastructure is available or could be leveraged to serve the function for Illinois. The functions of the Exchange can be grouped into the following fourteen domains:

- Eligibility determination
- Online shopping
- Enrollment, billing, and collections
- Customer service
- Producer management
- Navigator management
- Communications and outreach
- Plan specification and qualified health plan management
- Financial management
- Risk adjustment (if done by the Exchange)
- Oversight, governance, and program evaluation
- Mandate certification and eligibility appeals
- Consumer protections
- Reporting for federal and state oversight

In general, relatively little functionality is already in place in Illinois that could be adapted or expanded to serve the Exchange – a conclusion not altogether surprising or unique to Illinois. This report recommends potential approaches to acquiring or performing mandatory Exchange functions. A number of mandatory Exchange functions will require substantial investments in information technology infrastructure. A significant element of IT development, relating to eligibility and enrollment systems, is dealt with in a separate report produced by the HMA Team. This report also recommends a series of approaches for strategically approaching purchasing options in acquiring the various IT and operational needs of Exchanges.

Education and outreach is another important function for the Exchange. We treat the function as mandatory because we believe that well-conceived enrollment strategies are a critical element of success for the Exchange. The ACA and Exchanges will substantially change how health insurance is purchased by individuals and small businesses by streamlining and simplifying the process of shopping for and purchasing health insurance. As a new distribution channel that is expected to reform the

purchase of health insurance for the individual and small-group markets, there is a natural tension between the Exchange and the role of brokers, commonly known in Illinois as producers. If producers are hostile to the Exchange and have incentives to avoid sending business to it, their actions could threaten the success of the Exchange. At the same time, producers play an important and valued role in Illinois today for individuals and small business purchasing insurance. Because defining the role and compensation level of producers in the Exchange is a complicated and potentially controversial issue, we strongly recommend working with all stakeholders, including the producer community, to develop a policy and financial model that seeks to smooth the inevitable tension between an Exchange and producers.

Illinois also has a successful education and outreach resource targeted at supporting enrollment in public programs, All Kids Application Agents. The report compares the role and functions of producers and AKAAs to a new role created in the ACA and required to be funded by Exchanges, that of Navigators. Again, our recommendation is for working closely with stakeholders to define appropriate roles—a step that is necessary to ensure successful outreach strategies that work in the unique context of Illinois.

Finally, the ACA substantially reshapes the insurance marketplace in Illinois and, in doing so, creates substantial new obligations on Illinois insurance regulators at the Department of Insurance. As part of this needs assessment, we identify specific new regulatory functions and assess the resources that will be necessary to perform the regulatory work that is essential to the successful operation of health reform.

Exchange Finances

Under the ACA, by 2015 Exchanges are required to be self-sustaining. In other words, Illinois needs to identify appropriate revenue to support its Exchange after the start-up and establishment funding currently being provided by the federal government is spent. The report includes a preliminary Exchange financial model to inform the state's planning effort.

Once operational, the per-member cost of running the Exchange, as well as the Exchange's cost as a percentage of premiums, will decline as enrollment grows. This is because the Exchange will be able to spread its fixed costs across a larger membership base.

While a range of potential revenue sources are possible, the financial model presented in this report assumes that the Exchange will be financed through an assessment on participating health carriers in order to provide a concrete illustration of potential costs and revenues. Based on the assumption that revenue is collected only from Exchange-participating plans and a range of potential enrollment scenarios, we estimate that the assessment required to finance the cost of running the Exchange, as a percent of premium, will be between 2.24% and 3.39%. We estimate that the cost of the Exchange on a per-member per-month (PMPM) basis will be between $10.47 and $16.83 in 2014 and between $8.92 and $13.47 in 2015. Both measures compare favorably with existing benchmarks. For example, in FY 2011, its fifth year of operations, the Health Connector in Massachusetts experienced PMPM expenses of $11.16. The Health Connector has employed premium assessments between 3% and 4% of premium.

Illinois may consider other revenue-raising options, including by broadening the base on which any assessment is charged to the non-Exchange health insurance market. The policy justification for a broader assessment is that the Exchange, by increasing coverage and decreasing unreimbursed care, serves a role that benefits the entire market.

Other Structural Exchange Decisions

In addition to mandatory Exchange functions, there are other decisions that Illinois could make that will have important and lasting impacts of the character and success of its Exchange.

One area concerns methods and actions Illinois can take to avoid adverse selection. Adverse selection is a general term referring to the negative consequences that result if more high-risk individuals actually enroll in insurance plans than the market or an individual health insurer anticipated. There are three general types of adverse selection, which involve selection against 1) the entire market, 2) the Exchange market as compared to the "outside" or non-Exchange market, or 3) a specific insurance carrier. The ACA contains a number of provisions intended to avoid adverse selection. Recognizing and building on those provisions of the ACA, we provide in this report specific recommendations about steps Illinois can take to avoid adverse selection.

The ACA also requires the expansion of the small-group market to employers with up to 100 employees in 2016. Until 2016, Illinois may retain its current definition of small group (up to 50 employees), or it may expand the definition to the higher level. The small-group market is served by the SHOP Exchange. Most published analysis of the issue argues for retaining the current restriction of the market, based on the concern that allowing businesses with 51-100 employees into the SHOP immediately could raise premiums because businesses with healthy workforces would choose to self-insure, while businesses with less healthy workforces would choose to take advantage of the coverage available through the SHOP. The analysis in this report finds that over 30% of the 50-100 employee size firms would need to self-insure before the SHOP would begin to be significantly impacted with increased premiums. The State should carefully consider options to prevent large groups between 50 and 100 from exiting the fully-insured marketplace (by either dropping coverage or self-insuring) to ensure that the state benefits from an early expansion of the Small Group Market.

Another option available to Illinois under the ACA is to combine its small-group and individual risk pools. In general, merging markets will equalize premiums. Based on actual historical data provided by Illinois carriers in the individual and small -group markets, we estimate that rates in the individual market would likely increase significantly, and rates in the small-group market would likely decrease minimally if the markets were merged in Illinois. It is important to emphasize that the results of our analysis are not intended to suggest that small-group premiums are expected to decrease under the ACA. The finding presented here with regard to the market merger is in isolation of other possible findings related to the ACA and should be viewed strictly in relation to if the markets were *not* merged.

Finally, we analyze and recommend against the early implementation of the substantial insurance market and consumer protection reforms that will become effective under in 2014, including the ACA's prohibition on pre-existing condition exclusions and the ACA's guaranteed issue and renewal rules. In

the circumstances, early implementation of those reforms without an individual mandate will cause pricing turmoil in the market and potential damage a larger group of currently insured than would benefit from the protections before 2014. Rather, we recommend focusing resources on careful planning to deal with the implementation challenges and market impacts of the ACA in 2014.

Medicaid and the Exchange

Efficiently integrating an Exchange with existing Illinois state programs, most particularly the Medicaid program, will be an essential element of success for the state. There are both policy and operational dimensions to the integration of the Exchange with existing state programs, and our advice is to pay close attention at all turns to how Exchange decisions and actions will affect other state programs. We also emphasize that decisions of state agencies and circumstances in the Medicaid program may equally affect the Exchange. There is currently a strong working relationship between staff in the Medicaid program and the Department of Insurance working on Exchange implementation. We strongly recommend the development of a formal structure once an Exchange is established that continues this relationship, including the involvement of senior staff involved in both operational management and agency policy-setting.

The report also addresses existing state agency operational capacity. The increased caseload attributable to the ACA, in combination with the need for enhanced program integrity measures from the 2012 Illinois Medicaid reform law, cannot be handled with existing staffing levels given existing business processes. We recommend a focus on improved business processes as a component of the overhaul of eligibility IT systems, and a close monitoring of state agency staffing needs.

Medicaid Expansion Impacts

In January 2014, the ACA expands Medicaid to cover individuals and families below 133% of the federal poverty level (FPL). Individuals above that income level (some of whom are served by state programs or Medicaid today) will have access to Exchange-based subsidized coverage. In Illinois, the Medicaid expansion will affect primarily two groups:

- Individuals with income at or below 133% FPL who do not meet categorical eligibility criteria.
- Individuals with disabilities and income at or below 133% FPL and above the current Medicaid threshold of 100% FPL.

Based on existing state enrollment and administrative data concerning growth, we project Medicaid enrollment between now and 2014 at an effective annual growth rate of 3.1%. After accounting for the eligibility changes created by the ACA, we estimate total Medicaid and Children's Health Insurance Program enrollment in FY2014 to be 3.1 million. Of that total (which covers only individuals receiving comprehensive benefits), 130,000 will be new enrollment from currently eligible individuals and 267,000 will be individuals newly-eligible under the Medicaid expansion – an important distinction because of the differential federal matching rates provided for the two groups under the ACA. We also estimate

that eligibility for 22,994 children and 39,524 non-elderly adults will be eliminated and those individuals will be eligible instead for federal subsidies through the Exchange.

Costs based on this new enrollment in Medicaid are estimated to be $224.5 million in 2014. Savings attributable to the elimination of eligibility in Illinois are estimated to be $115.1 million, for a net state cost to the state in 2014 of $109.4 million. Our analysis addresses costs and savings from changes in Medicaid eligibility standards in 2014 and is not a comprehensive analysis of the cost of health reform in Illinois. The state should analyze other potential cost savings, including reductions in state spending for uncompensated care, to understand the overall impact of the ACA on the state budget.

The Basic Health Plan

Illinois has the option of establishing a Basic Health Program (BHP) in lieu of Exchange coverage for people ineligible for Medicaid who have income at or below 200% FPL. Because the BHP allows the state flexibility in benefit design and cost sharing, it may be an opportunity to design a plan that is intended to address the needs of the low-income population and to improve continuity of care across transitions in coverage and within families who would otherwise be "split" between the Exchange and Medicaid. However, the financial structure of the BHP, which gives states 95% of what BHP enrollees would have received in subsidies on the Exchange, creates significant risk and uncertainty for Illinois. This report analyzes risks and benefits of the BHP in detail.

We also provide a financial model intended to demonstrate how the state can assess BHP financing analytically. Given substantial uncertainty across a variety of inputs to the cost and revenue model for the BHP, most especially available revenue to the state for the BHP, our model is primarily intended to provide a framework for illustrating a range of potential BHP financial scenarios.

Next Steps

Many of the policy and operational decisions faced by the state and the Illinois General Assembly are addressed in detail in this report. We provide recommendations throughout the report for areas that deserve further inquiry, additional research, or ongoing monitoring. And we emphasize, in this summary and throughout the report, that: 1) the single most challenging aspect of implementing Exchanges and ACA in Illinois is meeting required timelines to achieve the 2014 implementation date; and 2) the single most crucial step the state could take support a successful implementation is to establish, through legislative action, an Exchange with appropriate authority over and responsibility for providing direction to the state's implementation efforts.

2. Introduction

2.1 Contract Background and Approach

The State of Illinois received a planning grant from the federal government to support planning activities related to the creation and operation of health benefit Exchanges under the Affordable Care Act (ACA). Health Management Associates (HMA) was engaged by the state to provide assistance with this planning process.

The contract, through the Illinois Department of Insurance (DOI) on behalf of the state, was divided into two major related components. The first component was an "Exchange Organizational and Impact Assessment" intended to help the state identify business, organizational, and financial needs to establish an Exchange, and to assess the impact of the ACA and a state-based Exchange on the Illinois insurance market and on existing Illinois public programs. The second component involved information technology infrastructure to perform eligibility, verification, and enrollment (EVE) functions for an Exchange and for other existing Illinois health and human services programs. The EVE component was intended to review current state Information Technology (IT) systems and initiatives alongside new federal requirements, to develop options for an ACA-compliant solution, and to support the process of the state's selection of an approach that would address new federal requirements and meet state strategic goals.

HMA recruited a team of individuals and organizations to support this work. The HMA Team includes two major subcontracting firms, CSG Government Solutions (CSG) and Wakely Consulting Group (Wakely). Wakely's work has focused on the Strategic Needs Assessment, including actuarial and market analysis. CSG, an information technology firm, has focused on the EVE component of the contract. HMA has participated substantively in both components of the work and has managed the overall engagement, including a group of additional individual subcontractors.

The planning and analysis process has consisted of a range of activities and events. The HMA Team attended an executive-level briefing at the outset of the project. The contract called for a "mid-term oral report," which took place in Chicago on June 15, 2011, with state executive leadership and legislative staff. After discussions with state project leadership, that oral report took the character of a general update on the status of the Team's work combined with a detailed facilitated discussion of potential policy goals that could be served or supported as the state designs its approach to ACA and Exchange implementation. Throughout the engagement, the HMA Team has met regularly with state project leadership from DOI and the Illinois Department of Healthcare and Family Services (HFS) for the purpose of status reporting and to organize substantive discussions with appropriate state staff to inform the planning work. Research and data gathering activities conducted in preparation for this report are described more fully in the relevant sections of the report and in the supplemental EVE report.

For the EVE component, the HMA Team's engagement with Illinois state staff and agency leadership was particularly important. The goal of that work was to identify a clear set of options and to help the state select a preferred option for a major system development project affecting multiple agencies and serving multiple programs. For that reason, the HMA Team worked with state project leadership to

design and conduct a series of facilitated discussions with a planning team composed of appropriate representatives of affected agencies, departments, programs, and business operations. The group, known as the EVE Planning Group, met regularly from May to July. HMA Team members also met individually with executives in affected agencies and presented at a Medicaid Advisory Committee meeting to discuss EVE planning.

This report and the materials accompanying it comprise the final report of the planning process. In recognition of the unique and technical nature of the EVE planning process, the HMA Team has created a separate final report for that component, which is a supplement to this report.

2.2 State Exchanges and Planning

THE AFFORDABLE CARE ACT AND STATE EXCHANGE PLANNING

The ACA is a substantial, comprehensive reform of health care and health insurance in this country. The overall goals of the ACA are to:

- reform the individual and small-group health insurance market by instituting certain consumer protections, establishing limits on rate variation based on enrollee risk and other regulatory requirements, and defining basic benefit standards;
- require the purchase of insurance by individuals, enforced by tax penalties for non-purchasers;
- incentivize employers to purchase insurance using a variety of methods; and
- expand insurance coverage for lower-income individuals with subsidies, either through coverage in the Medicaid program or through Exchange-based premium and cost-sharing subsidies.

A central element of the ACA is the creation in states of Exchanges. The purpose of this report is to inform the process of Exchange planning in Illinois. That planning process includes both executive branch agencies and the legislative branch. While state agencies are appropriately directing research and doing implementation planning work, Exchanges are ultimately a creature of state law, so this report is intended to inform legislative decision-making as well as state agency planning. The report provides background information on the federal law, analyzes the state's needs in setting up an Exchange, addresses mandatory Exchange services and functions, projects Exchange start-up and operating costs, and provides insights on policy decisions the state will need to make in designing its Exchange, coordinating it with the Illinois insurance market and integrating it with existing Illinois public programs.

HEALTH INSURANCE EXCHANGES

As envisioned in the ACA, the Health Insurance Exchange will be a major mechanism for expanding health coverage. A Health Insurance Exchange is an organized marketplace for the purchase of health insurance by individuals and small businesses.

The ACA requires that an American Health Benefits Exchange be available to individual consumers of health coverage and that a Small Business Health Options Program (SHOP) Exchange be available to small groups seeking coverage. The legislation mandates that Health Insurance Exchanges be available to residents in every state either as a state-established entity, or if a state decides not to create an Exchange or does not meet Federal requirements for Exchange development, through the Federal Department of Health and Human Services (HHS). States implementing an Exchange can create a single Health Insurance Exchange serving all the residents of the state, partner with neighboring states to create a regional Exchange, or create subsidiary Exchanges serving different regions within a state.

Health Insurance Exchanges are expected to fulfill the following functions:

- Certifying qualified health plans
- Administering premium tax credits and cost sharing
- Providing assistance to consumers for the purchase of health coverage
- Creating and maintaining a website designed to assist consumers to assess their eligibility and enroll in health insurance
- Coordinating Exchange eligibility and enrollment with Medicaid and the Children's Health Insurance program

The ACA requires Health Insurance Exchanges to be available to consumers seeking individual and small-group coverage by January 1, 2014. The legislation also authorizes the provision of federal premium and cost sharing subsidies to individuals with incomes between 133% and 400% of the Federal Poverty Level (FPL). These subsidies will be available only for coverage purchased through a Health Insurance Exchange.

PLANNING EFFORTS IN ILLINOIS

After passage of the ACA, Governor Pat Quinn issued an Executive Order establishing the Illinois Health Reform Implementation Council. The Council, composed of representatives of the state agencies affected by the ACA, convened a series of public hearings during the latter part of 2010 and on November 15, 2010, sought public input on a series of explicit policy questions regarding the ACA implementation. Informed by that public comment, a second draft report was produced by the council in February 2011. The final report of the Council, titled *Health Care Reform Implementation Council: Initial Recommendations,* was made public on March 1, 2011.

We mention the Council's report here because it has been an important guide to our efforts, but also because it represents a significant undertaking to begin organized planning for health reform implementation. However, the work of the Council is far from the only implementation planning activity underway in Illinois.

In May 2011, the Illinois General Assembly passed, and in July 2011 Governor Quinn signed into law SB 1555, the Illinois Health Benefits Exchange Law (Public Act 97-0142). The law created a 12-member Legislative Study Committee to conduct a study regarding the implementation and establishment of an Illinois Exchange. The Committee is directed to address: 1) governance and structure of the Exchange;

2) financial sustainability of the Exchange; and 3) stakeholder engagement, including ongoing legislative oversight of the Exchange. The Committee will report its findings to the General Assembly and Governor by September 30, 2011.

Finally, it is important to recognize that Illinois state staff in multiple agencies are deeply engaged in the Exchange planning effort and are dedicating significant time and resources to planning for health reform implementation. Our hope is that this report will support the ongoing efforts in Illinois by the Quinn Administration and the General Assembly.

2.3 The Federal Environment

EXCHANGE PLANNING CORE AREAS

In federal guidance concerning Exchange planning and establishment funding, the Center for Consumer Information and Insurance Oversight (CCIIO) of the United States Department of Health and Human Services (HHS) has defined 11 Exchange planning core areas. Federal oversight of planning and implementation work will generally be organized by those core areas. Exchange planning and establishment core areas are in the table below.

Table 1: Exchange Planning and Establishment Core Areas

Exchange Planning and Establishment Core Areas
1. Background Research
2. Stakeholder Consultation
3. Legislative and Regulatory Action
4. Governance
5. Program Integration
6. Exchange IT Systems
7. Financial Management
8. Oversight and Program Integrity
9. Health Insurance Market Reforms
10. Providing Assistance to Individuals and Small Businesses, Coverage Appeals and Complaints.
11. Business Operations of an Exchange

Throughout Exchange development until 2015, these core areas will be the areas about which states are obligated to report progress and on which states will be judged in seeking additional federal funding support.

No organizational structure can avoid the fact that Exchange planning decisions about policy, financing, and operations are deeply interwoven and overlapping. For example, strategic decisions about Exchange priorities (discussed in section 4.2.2) influence potential information technology solutions (section 4.2.4 and a separate EVE report). Exchange costs (section 4.3) are influenced by decisions about Exchange (and other state agency) operational processes and approaches (sections 4.5 and 4.6). By identifying core areas at the outset we do not intend to imply that planning and development should proceed

within core area "silos." In fact, to develop a successful Exchange in Illinois, state planners will need to integrate these areas in a comprehensive effort to meet the aggressive timelines required by the ACA.

FEDERAL FUNDING FOR EXCHANGE PLANNING

Costs associated with state efforts to design and implement a Health Insurance Exchange through December 31, 2014, will be fully funded by the federal government. In September 2010, the federal government made $1.0 million Exchange planning grants to all states that applied for the purpose of supporting state planning efforts. These funds were to be utilized by states on early background research and Exchange design tasks.

In January, 2011, the Federal Office of Consumer Information and Insurance Oversight (now the Center for Consumer Information and Insurance Oversight [CCIIO]) issued a Federal funding announcement, describing the structure of federal financial support for Health Insurance Exchange establishment activities. Funding is available through two related grant mechanisms:

- **Level One Establishment Grants:** These funds are available to states that have already received Exchange Planning grants. States will enter into a cooperative agreement with the federal government in Exchange for one year of Exchange establishment funding. Eligible states must demonstrate progress in Exchange planning.
- **Level Two Establishment Grants:** These funds are available to states that received Exchange planning grants and met specified federal criteria. Funding is available to support all Exchange establishment costs incurred by a state until December 31, 2014. States must demonstrate the following to qualify for Level Two Establishment grant funds:
    - Legal authority to establish and operate an Exchange that complies with Federal requirements
    - Identified self-sustaining financing mechanism
    - Establishment of an Exchange governance structure
    - Submission of a complete Exchange budget through 2014
    - Submission of a plan outlining anticipated state efforts to combat waste, fraud, and abuse
    - Submission of a plan outlining anticipated state efforts to provide customer assistance to individuals and small groups purchasing coverage through the Exchange

Application deadlines for Level One Establishment grants are established on a quarterly basis up until December 2011. Illinois submitted a Level One application on June 30, 2011. On August 12, 2011, HHS announced grant awards for the June 30 grant cycle and awarded Illinois $5,128,454 to support additional and ongoing planning efforts.

States may apply for more than one Level One grant. Application deadlines for Level Two Establishment grants are established on a quarterly basis up until June 2012.

3. Current Environment in Illinois and Background Research

The State of Illinois has a proud history of public program coverage initiatives to improve access to health care for the uninsured. In particular, in 2006, Illinois expanded its All Kids program for children to include coverage for all uninsured children, regardless of income, health status or citizenship status. Along with that coverage expansion, Illinois simplified enrollment processes for children and prioritized education and outreach to support enrollment of uninsured children. That experience and the infrastructure created by it will prove invaluable to the state as it embarks on implementation of the ACA. Today, the Illinois Medicaid program covers over 2.7 million individuals with comprehensive benefits. The impact of the ACA's Medicaid expansion in Illinois is dealt with in detail in this report.

The Illinois private insurance market is robust and relatively stable. Both the individual and small-group market will be significantly affected by the new underwriting and rating rules and other consumer protection requirements in the ACA.

There are over 1.5 million people without insurance coverage in Illinois. The number of uninsured in Illinois will drop dramatically as a result of the ACA. As Illinois prepares for potential implementation of an Exchange under the ACA, a description of the current state of insurance coverage and of the uninsured population is critical background information.

Concurrently with the HMA engagement, DOI contracted with a separate vendor to provide background research to inform Exchange planning. The outcome of that contract is a report on the current state of health insurance coverage in Illinois and the existing health insurance marketplace, including demographic analysis of the uninsured, underinsured, and insured populations, an assessment of barriers to coverage and insurance enrollment, including affordability, and a ten-year projection of Illinois coverage trends in public and private insurance.

The HMA Team has worked closely with the background research vendor, Deloitte LLC ("Deloitte"), to define responsibilities, coordinate approaches and share expertise. In substantial part, this report includes the Deloitte model's projections of Exchange enrollment in Illinois beginning in 2014. In areas that rely on these projections, this report adopts the Deloitte projections and defines ranges, of higher and lower Exchange enrollment, as appropriate to support the analysis. After discussions with the state, in one area this report provides an alternative methodology and analysis of a specific component of the research. The assessment of the cost of the Medicaid program expansion contained in section 4.5.1 requires estimates of both the number of uninsured and of the growth between now and 2014 of the uninsured and of the current Medicaid program. The Deloitte modeling approach required estimates of those same factors among many others, including economic and behavioral variables involving the effect of the ACA on the private insurance market.

The HMA Team developed a methodology focused solely on the impact of the ACA on Medicaid and other state programs. The approach is less robust and comprehensive than the Deloitte modeling approach, but more focused on using existing state administrative data to make projections about current state programs. Therefore, the analysis of Medicaid costs in section 4.5.1 presents alternative Medicaid growth projections. Taken together, the state could view these alternatives, which lead to

different projections of Medicaid growth and Medicaid costs under the ACA, as an upper and lower bound projection for planning purposes.

4. Impact Assessment and Operational Needs of an Exchange

This section of the report, and the supplemental report concerning eligibility and enrollment IT system options, constitutes the bulk of the HMA Team's research and analysis. Section 4.1 reviews potential goals that can be served by an Exchange. Section 4.2 involves the mandatory activities of an Exchange, including required policy decisions and practical operational needs involved in Exchange and ACA implementation. Section 4.3 addresses long-term financial sustainability of an Exchange. Section 4.4 reviews certain optional considerations for an Exchange and how it relates structurally to the Illinois insurance market. Sections 4.5 and 4.6 address a range of topics concerning the interactions between Medicaid, other state programs, and the Exchange.

Establishing an Exchange in Illinois is a significant undertaking. This section of the report is meant to help define the challenges Illinois faces and provide guidance on the choices that Illinois must make. It is worth emphasizing that the Illinois Exchange will have a very large customer base. Projections from the Deloitte model adopted in this report estimate Exchange enrollment of 486,000 in 2014, the first year of operation. As the Exchange is established and becomes better known, enrollment is expected to grow, particularly over the first few years of operation. By 2016, the Illinois Exchange is projected to serve over 1 million customers.

Exchange enrollees will include: individuals without insurance and certain individuals in state programs today (many of whom will have access to subsidized coverage through the Exchange), people who purchase nongroup insurance today and will use the new Exchange market to purchase insurance, and people (some insured and others currently uninsured) who work for small employers who choose to use the SHOP Exchange. Those projections are summarized below.

Table 2: Projected Exchange Enrollment in Illinois, 2014 (in thousands)

Projected Exchange Enrollment in Illinois, 2014 (in thousands)	
Total Individual Exchange	337
Subsidy Eligible - <200% of FPL	106
Subsidy Eligible - 200%-399% of FPL	141
Not Subsidy Eligible	90
Small Group – SHOP	149
Total Projected SHOP and Individual Exchange Enrollment	486

4.1 Potential Policy Goals for the Illinois Exchange

This section reviews potential policy goals that could be prioritized by an Exchange.

In light of Illinois' ongoing Exchange planning process, we identify seven *potential* policy goals for Illinois' Exchange and discuss how an Exchange might advance these goals. There are challenges and trade-offs to pursuing each of these goals, which we discuss in each section below. As planning moves forward, Illinois should assess and prioritize Exchange policy goals. Developing a clear vision of the key policy goals for Illinois' Exchange can help guide decision-making around the many policy and operational issues that will need to be addressed in setting up the Exchange.

1. CREATE AN ATTRACTIVE, ACCESSIBLE, AND EASY-TO-USE WEBSITE FOR INDIVIDUALS AND THEIR FAMILIES TO COMPARE AND PURCHASE COMPREHENSIVE HEALTH INSURANCE COVERAGE

Private health insurance contracts are long and complicated and the products are highly variable. As a result, many people have difficulty comparing the value of various options, including small business owners when they are selecting coverage for their employees. An attractive and easy-to-use website can serve as a gateway to the Exchange and can greatly improve purchasers' ability to compare and shop for value in health insurance. Standardization of benefits can facilitate comparison shopping; the ACA will promote such comparison by defining the "essential health benefits" all plans must offer and by defining four standardized benefit plans that include all of the essential health benefits but differ by the amount of consumer cost sharing. Exchanges can further standardize plan offerings to simplify comparison shopping, for example, by specifying precisely how the four cost-sharing levels will be structured in terms of co-pay, deductibles, etc.

Although standardization makes it easier for consumers to compare plan value and thereby promotes competition among health plans, if the plans offering coverage outside the Exchange are trying to differentiate themselves by offering not only the required standardized plans but a larger variety of benefits structures, the Exchange might be at a competitive disadvantage. The experience of the Massachusetts Health Connector indicates that this is an issue that requires careful monitoring. The Connector began with a broad array of options designed by each carrier and, over time, standardized plans across carriers around the most popular designs (measured by sales volume).

2. USE ADVANCED CUTTING-EDGE TECHNOLOGY TO DETERMINE ELIGIBILITY FOR INDIVIDUAL TAX CREDITS AND ENROLL QUALIFIED APPLICANTS IN THE EXPANDED MEDICAID PROGRAM

The ACA requires a "no wrong door" eligibility process. This means that the Exchange and other "portals," such as Medicaid offices, are expected to direct an applicant to the right program, in real time, and on the first encounter. To do this, the Exchange will need advanced, cutting-edge technology to make timely and accurate eligibility determinations based on data provided by the applicant and matched against several external data sources—a real challenge, to be sure.

In addition to the ACA operational requirement, both the Exchange and the state have financial incentives to perform eligibility determinations quickly and effectively. Those households and small employers who are eligible for tax credits can access subsidies only through the Exchange, and they will likely represent the core of Exchange enrollment. Because the tax credit is paid by the federal government and is available only through the Exchange, these enrollees are "free" to the state and are highly likely to buy from the Exchange. Since Exchanges are scalable entities with relatively fixed costs, higher enrollments serve to reduce per enrollee administrative costs and are consistent with the mission of an Exchange to cover people.

3. DEVELOP A PROGRAM TO ENGAGE INDIVIDUAL CONSUMERS AND HELP THEM NAVIGATE THEIR INSURANCE OPTIONS

The Exchange should identify the impediments that could make it difficult for people in various target markets to enroll. People should find the process both easy and comfortable. Consumer-friendly, simplified comparison shopping tools are part of the solution. So are Navigators, a new educational resource created through Exchanges by the ACA, and producers, both of whom can first find potential enrollees and then talk them through their options and the application process. The state will also need to decide how best to use Navigators and producers to help enrollees with their purchase. Both decisions have policy implications that will need to be thoughtfully evaluated by the Exchange.

4. ENCOURAGE THE WIDEST POSSIBLE PURCHASE OF HEALTH INSURANCE COVERAGE

There are close to 1.5 million uninsured individuals in Illinois. Some will be added to Medicaid under health reform, others will receive subsidized coverage through the Exchange, and a significant number will remain uninsured. Although ACA requires nearly everyone to acquire coverage, it is likely that some people will not understand the requirement and will remain uncovered unless efforts are made to inform them and provide easily accessible paths for them to acquire coverage. This is part of the task of the Exchange. To effectively expand coverage in Illinois, the Exchange will need robust outreach and enrollment efforts, a broadly defined mass marketing campaign, an understanding of the needs and wants of both the currently uninsured and insured populations, and a convenient and user-friendly insurance "store" with multiple points of access (via web, telephone, and perhaps walk-in locations and clinical sites).

One potential obstacle to a focus on reaching some elements of the currently uninsured population is that the Exchange may be seen as a resource primarily for lower-income, subsidized people. De-stigmatizing premium subsidies and promoting small business-tax credits should be objectives within any marketing program, advertising campaign, or outreach effort. The Exchange will need to carefully balance the objectives of expanding access among the currently uninsured and appealing to a broader swath of the overall insurance market. One example of such an approach: In Massachusetts, the Red Sox partnered with the Health Connector to promote coverage availability. Sporting teams often transcend income, age, linguistic and cultural barriers in their ability to touch otherwise divergent populations.

5. FOSTER A COMPETITIVE HEALTH INSURANCE MARKETPLACE FOR MORE AFFORDABLE COVERAGE FOR INDIVIDUALS AND THEIR FAMILIES

One of the objectives that Exchanges are designed to achieve is more effective competition among health plans. Achieving that objective requires presenting prospective buyers with easily understood comparisons of plan benefits, prices, network availability, and quality—something like a healthcare Travelocity. Consumers like choice, particularly when presented in a visually appealing way, but it must be meaningful choice that does not overwhelm the uninitiated. Beyond such basics, the Exchange can actively promote competition by encouraging new plans to compete in the non-group and small-group markets. As a single point of access to a large population of insurance buyers, the Exchange can reduce the barriers to entry for new health plans, including Medicaid Managed Care organizations (MCOs) that wish to continue serving their enrollees as they migrate into eligibility for tax credits.

6. CREATE SYSTEMS THAT SUSTAIN CONTINUITY OF CARE FOR LOWER-INCOME POPULATIONS WHOSE INCOME AND ELIGIBILITY FOR MEDICAID AND PRIVATE INSURANCE LIKELY WILL CHANGE FREQUENTLY

The Exchange should anticipate both churning (frequent transitions between coverage programs as a result of income and family size changes) and a need to sustain safety-net providers. As to churning, some degree of movement between plans is inescapable, and Illinois should anticipate the need to transition enrollees smoothly between programs. To mitigate disruptions in coverage that can otherwise result from churning, some states may require or incentivize Medicaid MCOs to participate in the Exchange so that an individual who moves between a Medicaid program and an Exchange subsidy would not need to switch health plans (or providers) each time there is a change in eligibility.

Another possible solution to this challenge is for the state to consider offering a Basic Health Plan (BHP) to individuals and families with incomes between 133% and 200% FPL. As the ACA requires that the BHP be operated under the same rules as Medicaid, the state would be able to assure continuity of care across Medicaid and non-Medicaid programs. As noted by the Council, a properly designed BHP could provide more affordable and comprehensive coverage than commercial plans offered in the Exchange. Additionally, the state could provide Medicaid, All Kids, and BHP coverage for working families, thereby allowing them to keep the same medical providers if their income changes.

With respect to this potential goal, the HMA Team's scope of work calls for a specific discussion of methods to prevent churning and of the BHP. That discussion is in section 4.5.

7. PROVIDE SMALL BUSINESSES WITH COST-EFFECTIVE AND EASY-TO-ACCESS COMPREHENSIVE HEALTH INSURANCE COVERAGE OPTIONS

Any state that establishes an Exchange must also establish a Small Business Health Options Program or SHOP Exchange to help small businesses provide health insurance for their enrollees. Understandably, small businesses are primarily seeking rate relief. Meeting this expectation will be a challenge because there is nothing inherent in the Exchange structure that will immediately reduce costs, and any such unreasonable expectations will need to be managed. Nonetheless, the SHOP Exchange can serve small business and their employees by offering employee choice of health plans, including lower-cost select

network plans. In designing a SHOP Exchange, the state should understand small employer needs and respond to these needs by persuasively marketing what the SHOP can offer owners and their employees. A well-constructed SHOP could: improve price stability for employers and employees; expand employer and employee choice by providing varied benefit levels, provider networks and carriers; and offer administrative savings to small businesses that do not have access to benefit administrators that perform SHOP-like functions.

OTHER GOAL-SETTING CONSIDERATIONS

Further dialogue with the state's leadership will be required to decide what is feasible for Illinois and which goals to prioritize. For example, many policymakers see health reform as an opportunity to transform the delivery of medical care to achieve the ultimate goals of reducing costs, ensuring access, and improving quality. They aim for payment reform and development of coordinated care models, such as Accountable Care Organizations (ACOs), to encourage clinical integration. Reforming health care to this extent would present major hurdles, and overcoming them would require a significant, sustained commitment from the state's political leadership. Only the state can determine if reforming health care delivery is a realistic goal for Illinois, either now or at some point in the future. Similarly, the state should prioritize the goals outlined above.

4.2 Mandatory Operational Needs of an Exchange

4.2.1 Exchange Design, Organizational Structure and Governance

Section 4.2.1 addresses threshold design questions and reviews Illinois' options for Exchange organizational and governance structure.

THRESHOLD EXCHANGE DESIGN OPTIONS

The ACA requires that states create an "American Health Benefits Exchange" for individuals and a "Small Business Health Options (SHOP) Exchange" for companies with 100 or fewer employees. Alternatively, states may let the federal government establish and administer Exchanges for their state. Thus, *the first key decision that a state must make is whether to build its own Exchange or let the federal government's model be used in their state.* Clearly this is a threshold question for every state to address.

Given that the Illinois General Assembly has indicated its intent to establish an Illinois Exchange by virtue of the passage of SB 1555, and the Council's initial recommendations that the state should establish its own Exchange, this report does not address in detail the implications of Illinois deciding not to establish and Exchange. Operating a state-based Exchange preserves state self-determination on a range of issues, including how the Exchange will relate to the external markets and to the state Medicaid program. However, concerning planning efforts for a federal Exchange, two points are worth emphasizing.

First, the character of a federal Exchange is unknown, and proposed federal rules shed very little light on how a federal Exchange will relate to a state. It is clear that relying on a federal Exchange would mean that Illinois would surrender control over a wide range of policy issues and a significant component of its insurance market. To the extent that the state identifies or prioritizes any of the potential policy goals of an Exchange (discussed in detail in section 4.1), deferring Exchange operations to the federal government would make it difficult to achieve a state's "own" goals. Second, state obligations under the ACA are significant irrespective of whether the state is operating an Exchange or not. For example, Illinois will need to do the work necessary to ensure a systematic relationship between its Medicaid eligibility and enrollment system and the Exchange, whether the Illinois Exchange is state-based or federally run. Similarly, Illinois insurance regulators will need to wrestle with risk-adjustment methodologies across individual and small-group markets and will need to understand how the Exchange market relates to the "outside" or remaining Illinois individual and small-group markets. This will be a different challenge if there is a federal Exchange, but it will be no less important and no less complicated. More generally, close coordination between the Exchange and existing state functions, including most obviously insurance oversight at DOI and Medicaid operational and policy issues, will be essential whether or not Illinois runs its own Exchange. While implementation planning pressures (and associated funding) would be lessened by a decision to opt for a federal Exchange, Illinois would still have significant responsibilities, related to operations, policy and finance, to perform to implement the law.

States may form multi-state Exchanges with other states. States may also allow more than one Exchange to operate within the state, as long as each "subsidiary" Exchange serves a distinct geographic area. It is important to note that a statewide Exchange could be designed with regional dimensions. For example, Illinois could establish regional rating areas, specifying regions for the purpose of qualifying health plans, and defining coherent regions through which to arrange for specified Exchange functions like outreach, consumer assistance, and services for small businesses obtaining coverage for their employees. These regions could be, in effect, "sub-units" of the statewide Exchange.

While the ACA requires that Exchanges be established to serve the individual and small-employer market, some states will determine that operating a combined Exchange is more efficient and manageable. Although ACA is not explicit about the parameters of a combined individual and SHOP Exchange, we believe there is considerable flexibility for a single Exchange to differentiate as appropriate between the individual and small-business markets, including by providing differential services and establishing different requirements depending on the market. Illinois could form one Exchange with separate risk pools for individuals and employees of small businesses.

ORGANIZATIONAL STRUCTURE FOR A STATE-BASED EXCHANGE

In terms of organizational structure, Illinois can establish an Exchange in an existing state government agency or establish a quasi-governmental or nonprofit organization to manage and operate the Exchange. Most states that have addressed this question have set up some form of a separate Exchange organization, almost always with an independent governing board. To operate an Exchange, Illinois

needs an entity that is capable of interacting with the commercial insurance market, providing services to consumers and insurance purchasers, and coordinating with existing state agencies and programs.

The structure of that entity is clearly an important question, but we recommend focusing not on form but rather on substance—that is, by reflecting on the basic purpose of an Exchange. In initial guidance to states considering establishing Exchanges, the Secretary of HHS gave this definition to Exchanges:

> A mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers.[1]

Consistent with this general description of an Exchange as a marketplace for consumers, Exchanges are expected to be a distribution channel for commercial insurance for both individuals and small businesses, to work with small employers to aid them in offering coverage, and to interact with health plans that participate on the Exchange to ensure compliance with state and federal standards for reporting, marketing, and plan benefit design. These functions are deeply connected to the existing state-regulated commercial health insurance markets.

The ACA also obligates Exchanges to perform a variety of functions that are intertwined with other existing state programs. Exchanges will determine eligibility for federal tax subsidies that will be available to lower-income people buying through the Exchange. This function must be closely coordinated with the Medicaid eligibility and enrollment processes. Moreover, over time many individuals will move between the Exchange-based subsidized market and the Medicaid and Title XXI CHIP programs. Other functions of the Exchange, such as determining exemptions from the individual mandate, are more like traditional government functions than commercial activities, but they require less integration with existing state programs.

One final point concerning the timeline for implementing the ACA is worth emphasizing. Given the large number of new functions Exchanges must perform and the operational complexity of these functions, state implementation will proceed under extremely challenging time constraints and in an evolving regulatory environment. As a result, implementation structures that promote informed and transparent public input and prompt decision-making and provide flexibility to adapt quickly to shifting market conditions will be essential.

With those general observations as a background, this section addresses the advantages and disadvantages of the options relating to organization structure of an Exchange in the table below.

[1] Letter from Secretary Kathleen Sebelius, "Initial Guidance to States on Exchanges," November 18, 2010.

Table 3: Organizational Options

	Advantages	Disadvantages
State Agency	May allow some shared infrastructure. Direct ability to coordinate with other state agencies.	Restricted to state procurement practices. Restricted to state hiring practices including freezes. Decision-making and operations may be politicized. Financial resources of exchange could be entangled with annual legislative appropriation processes.
New State Agency	Single focus, avoids conflicting priorities and objectives within agency. Could include governing board.	Requires start-up of human and other resources. May not be influential with other agencies whose cooperation is required.
Existing Agency in State Government	Enables use of existing staff and skills, administrative systems and procedures.	New objectives may overwhelm or conflict with existing functions or objectives of host agency. Existing objectives may be prioritized over new Exchange mission objectives.
New Quasi-Governmental Authority or Independent Public Agency	Less politicized. Flexibility to use or not use state procurement and personnel rules for any or all purchasing or hiring. Maintains public accountability.	May be difficult to obtain cooperation of Medicaid and other state agencies. May be less transparent.
New Nonprofit Organization	Less politicized. More flexible in hiring and procurement practices. More independent and flexible.	No access to government purchasing or hiring advantages or processes. Less public accountability and transparency. Little ability to influence or gain coordination of state agencies

GOVERNANCE CONSIDERATIONS

An important element of Exchange structure is the makeup of an Exchange governing body. We assume for the purposes of this section that Illinois intends to establish an independent, appointed governing board to support its Exchange. Unless the Exchange is established in an existing state agency, Illinois will be required to establish such a board.

An important initial point is that whatever governing structure Illinois prefers needs to be defined in enabling legislation. As discussed more fully earlier in this report, a formal governance structure is one essential component of Exchange enabling authority that is required for the state to access implementation (Level Two) grants from HHS.

There will be federal standards that must be met in defining a governing board. Proposed rules issued on July 11, 2011, set those standards, which are excerpted below. Note that these are draft proposed

rules, and HHS requested public comments on a number of issues affecting governing board standards, so the state should monitor these rules as they are finalized.

> ***42 CRF §155.110 Entities eligible to carry out Exchange functions***
>
> ***(c)*** *Governing board structure. If the Exchange is an independent State agency or a nonprofit entity established by the State, the State must ensure that the Exchange has in place a clearly-defined governing board that:*
>
> 1) *Is administered under a formal, publicly-adopted operating charter or by-laws;*
> 2) *Holds regular public governing board meetings that are announced in advance;*
> 3) *Represents consumer interests by ensuring that overall governing board membership is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and*
> 4) *Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.*

In general, the regulations give states significant discretion in structuring an independent agency or non-profit governing or oversight board. The rule does not specifically prohibit certain categories of board members, although a state could decide to do so. It does require that the board "represents consumer interests" by not having a majority of voting members "with a conflict of interest." The examples provided in the rules are representatives of insurers or agent/brokers. The board must also have a majority of voting members with relevant experience in health benefits administration or other health care or health policy fields. An Exchange board must operate under a formal structure with public board meetings, by-laws, conflict of interest and financial disclosure standards.

The SHOP Exchange may have independent governance and administrative structures from the Exchange that manages the individual market aspect of the Exchange, or SHOP and individual market Exchange may share common governance and administration. In the case that both the individual and SHOP Exchanges are combined under one governance and administrative structure, the structure must have "adequate resources to assist individuals and small employers."

Assuming the basic parameters of the proposed rule remains intact, the federal government establishes two basic standards – that the board represents consumer interests and that the board has individuals with relevant expertise. Illinois can decide who appoints board members and can establish appropriate terms. Federal standards are generally consistent with our recommendation that Illinois prioritize competence and experience in defining its board membership rather than status as a representative of an identified interest group. The HMA Team's observations about the makeup of an Exchange board, and a review of similar state structures, are included in section 4.4.2.

4.2.2 Resources and Capabilities Needed for the Illinois Exchange

> ***In this section, we profile the functional requirements of an Exchange, including those of a Small Business Health Options Program or SHOP Exchange. As part of this needs assessment, we outline the capabilities and resources essential to operating the Exchange.***

The purpose of this section is to identify resources necessary to run an Exchange and the HMA Team's assessment of whether Illinois has those resources today or needs to acquire them. Where Illinois may already have capabilities or resources in place that might be repurposed or otherwise utilized for the Exchange, we note this. Finally, when Exchange needs cannot be met through existing assets, we offer recommendations on various approaches to either "build or buy new" the required functionalities to make an Exchange operational in time for open enrollment activities to commence in the late fall of 2013.

We found relatively little functionality already in place that could be adapted or expanded to serve the Exchange—a conclusion not altogether surprising or unique to Illinois. These initial findings were confirmed in interviews with senior staff in Illinois. We also reviewed documents identified by interviewees as being of particular importance or relevance. For example, the State of Illinois Framework Vision helps summarize why Illinois is not currently well positioned to look to existing resources and capabilities for the Exchange. This document suggests that Illinois has already thoughtfully evaluated its infrastructure and, independent of any consideration to Exchange development, has found it in significant need of broad based re-engineering to support existing social service programs.

Accordingly, Illinois will likely need to "buy or build new" many of the functional requirements of an Exchange. Sourcing suggestions are made throughout this section, and the state should expect to see additional "turnkey solutions" hit the market in the months ahead as vendors rush to fill various similar voids across many state governments.

Requirements for operating an Exchange come from ACA statutory requirements, regulatory requirements based on guidance issued to date by federal regulators, and operational requirements dictated by the functions needed for an Exchange to carry out its operations. The functions of the Exchange can be grouped into fourteen domains:

- Eligibility determination
- Online shopping
- Enrollment, billing, and collections
- Customer service
- Producer management
- Navigator management
- Communications and outreach
- Plan specification and qualified health plan (QHP) management

- Financial management
- Risk adjustment (if done by the Exchange)
- Oversight, governance, and program evaluation
- Mandate certification and eligibility appeals
- Consumer protections
- Reporting for federal and state oversight

In addition, efforts to prevent fraud, waste, and abuse—both in terms of built-in systemic controls and in terms of evaluation and retrospective review systems—should be built into all processes and functions.

We will discuss each of the domains in turn and elaborate on the requirements of the Exchange in each of these domains. Table 4 shows the functional requirements of an Exchange, including their relationship to the core areas defined by CCIIO for the federal Exchange grant application process.

Table 4: Exchange Functional Requirements by Domain

Domain	CCIIO Core Area	Functions
Eligibility determination	**Business operations**	Determine eligibility for Exchange subsidies, Medicaid, CHIP and other state and local programs, in real time for most shoppers Confirm eligibility, premium and cost-sharing subsidy levels and mechanism for appeals Establish system for updating information and re-determining eligibility
Online shopping	**Business operations**	Provide standardized information on QHPs Establish website to inform shoppers about eligibility criteria for Medicaid, Exchange subsidies and other state and local programs Provide cost calculator and display costs to SHOP employees Provide information about enrollee satisfaction Establish process for "grabbing" rates from carriers Create decision support tools for consumers
Enrollment, billing, and collections	**Business operations**	Enroll qualified individuals and families in QHPs Confirm plan selection, enrollment date, premium subsidy level, monthly enrollee premium (subsidized or unsubsidized), dollar flows, effective date of coverage, and fulfillment of enrollment process/materials by carrier Enable automated data exchange between enrollment and billing systems Generate bill Process electronic funds transfer (EFT) or credit card payment Generate receipts Establish open enrollment periods Provide notification and management of annual renewals Enable employer shopping, employee census management,

Domain	CCIIO Core Area	Functions
		and secure employee access to website Establish systems for making mid-year adds/deletes, administering COBRA coverage Establish uniform policies across carriers for enrollment, billing cycle, collection, late payment and termination for non-payment
Customer service	**Providing assistance to individuals and small businesses, coverage appeals, and complaints**	Design customer service protocols (automated and in manuals) Provide customer tracking tools and database management Establish telephone hotline, in-person support and web-based support Hire and train customer service staff Establish peak-period tele-customer spillover capacity Design flexible Interactive Voice Response (IVR) system
Producer management	**Business operations**	Train and certify producers Establish advisory council Establish dedicated portal with account self-management Calculate and pay commissions
Navigator management	**Business operations**	Train and certify navigators Establish advisory council Establish dedicated portal for Navigators Provide telephonic customer service support Oversee contract performance
Communications and outreach	**Business operations** **Stakeholder consultation**	 Perform marketing/sales functions Consult with stakeholders
Plan specification and QHP management	**Business operations**	Design benefits and plans Design QHP contracting/purchasing process Research customer needs, wants Rate QHPs on quality and value Update QHP premium rates Reconcile billings/collections monthly with QHPs (and Treasury)
Financial management	**Financial management**	Perform accounting functions with annual report to secretary Coordinate payments between feds/state/plans/enrollees Publish costs of licensing, regulatory fees, and other costs of Exchange Manage vendors and contracts Perform collections and disbursements Generate reports Develop/install general ledger Coordinate audits
Risk adjustment	**Financial**	Implement risk corridors for QHPs (2014-2016)

Domain	CCIIO Core Area	Functions
	management	Implement reinsurance program (2014-2016) Implement risk adjustment (permanent)
Oversight, governance, program evaluation	**Governance** **Program Integration** **Oversight and program integrity**	Select staff and executive leadership Establish Board Coordinate with other state agencies Evaluate Exchange
Mandate certification and eligibility appeals	**Providing assistance to individuals and small businesses, coverage appeals, and complaints**	Receive and process appeals of eligibility decisions Certify exemptions from mandate Notify employers when employees access Exchange subsidies
Consumer Protections	**Providing assistance to individuals and small businesses, coverage appeals, and complaints**	Monitor QHPs pricing and underwriting Design reporting system to track buying patterns, enrollee satisfaction and problems Coordinate with DOI on host of licensure and market oversight issues Establish formalized connection to Office of Consumer Health Insurance within DOI Address consumer complaints re QHPs
Reporting for Federal and State Oversight	**Oversight and program integrity, applications and notices**	Demonstrate to HHS capability to manage finances soundly Publish annual financial audit; respond state and federal audits as required Submit the required annual accounting report to HHS

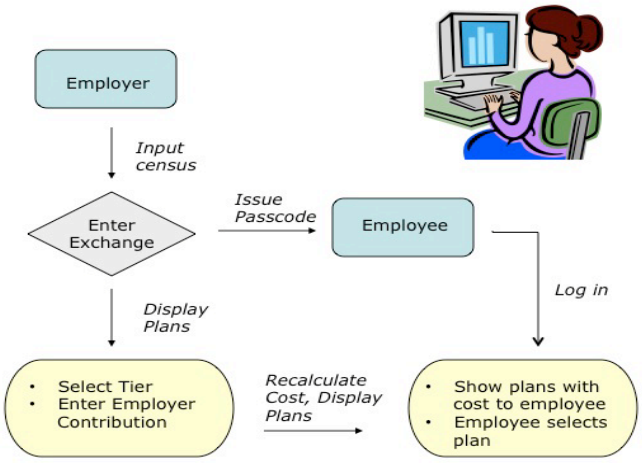
A. ELIGIBILITY DETERMINATION

This critical functional area for Exchange planning is dealt with comprehensively in the separate report regarding information technology infrastructure to perform Eligibility, Verification and Enrollment (EVE) functions.

B. ONLINE SHOPPING

Exchanges are required to establish a website that provides standardized comparative information on qualified health plans (QHPs). The Exchange must provide a cost calculator that calculates the cost of coverage after the application of a premium or cost-sharing tax credit. This means that the Exchange must have an interface for accepting rates from carriers. The Internet portal must also provide information about enrollee satisfaction. In addition, the Exchange should provide decision support tools to help consumers choose a plan. While not explicitly described in ACA, SHOP Exchanges will need to display for employees the coverage tier selected by their employer and the employee's cost of plans in that tier, taking into account the employer contribution (see Figure 1).

Figure 1: Schematic of SHOP Exchange



With regard to on-line shopping, Illinois does not have significant resources to draw on. The All Kids program offers an engaging, well designed website, but as the program offers only one benefit design, no "shopping" or comparison tools are featured. One Exchange-friendly feature is that the entire web site can be accessed in Spanish. The Illinois Comprehensive Health Insurance Plan (ICHIP), the high-risk pool program, also offers a website to enrollees, but the only Exchange-applicable feature on the site is a premium rate calculator with multiple variables. The calculator was developed in house by IT staff.

Illinois can buy on-line shopping functionality with decision support tools from a number of sources. There are several private-sector Exchanges and vendors with shopping tools for both non-group and small-group markets, as well as newly developed products which can demonstrate capabilities and customization options. Choice Administrators, eHealth, and Connecture are only a few of the many vendors that currently operate online Exchanges that could be utilized by Illinois. Plan rating resources include the National Committee for Quality Assurance and the Utilization Review Accreditation Commission. In our experience, buying a customized on-line shopping resource is likely to be more economical and faster than building one from scratch, so long as there are competing vendors in the private sector with plenty of experience, repeatable processes, and a business model that allows them to profit by serving the state Exchange.

C. ENROLLMENT, BILLING, AND COLLECTIONS

As stated earlier, the HMA Team has produced a separate report that is a needs assessment for state Eligibility, Verification, and Enrollment (EVE) functions. We limit discussion in this section to billing and collections systems, which may or may not be integrated with enrollment functions both in terms of systems and vendors.

As a primary consideration, there should be automated data exchange between the eligibility, enrollment, and billing systems, so that consumers do not need to re-enter or re-transmit basic

information at each step. The Exchange will need to generate bills, process electronic funds transfer and/or credit card payments, and generate receipts, all with appropriate security protocols in place. Uniform policies should be established across carriers for enrollment, billing cycles, collections, late payments, and termination for non-payment.

The Illinois State Treasurer's Office currently utilizes the E-Pay system for more than 650 local governments and state agencies, and the All Kids programs uses it to allow enrollees to make on line payments. E-Pay is a self-service electronic payment program allowing payments to be made at any time online, by phone or over the counter. The system accepts Visa, MasterCard and E-checks, and users do not incur any additional charge for making payments on the secure site. An open issue is whether a credit card fee applies and, if so, what is the cost and who pays? This system may be compatible for some Exchange needs.

Outside of this payment resource, the Exchange will need to pursue either a buy or build approach for billing and collections. The level of complexity in the billing and collections funds flow are very different for the individual Exchange relative to the SHOP Exchange, so Illinois will need to be aware of such differences as they begin the assessment. For example, billing individuals is a straightforward one-to-one relationship, but in the SHOP Exchange, billing will be a many-to-many reconciliation due to the employee choice model required by the law. The Exchange will need a system sophisticated enough to aggregate employer payments, report amounts due to multiple carriers, bundle the payments by carrier across multiple employers, and reconcile the payments due to the carrier across multiple employers. Buy may be the preferred option, as billing and collection systems exist, either independently or in connection with existing private Exchanges. A considerable amount of customization, however, will be required for tracking/billing multiple sources and flows of premiums, such as those between U.S. Treasury and carriers, individuals and either the Exchange or carriers, and employers and the Exchange. Alternatively, billing and collection capabilities can be built by the state, albeit probably not as cost effectively or as quickly as buying and customizing an "off the shelf" system.

D. CUSTOMER SERVICE

Exchanges are required to provide a toll-free telephone hotline for consumer assistance in addition to the website described. The ACA also directs the Secretary to establish an appeals process for eligibility determinations. Exchanges should consider the need for customer service to respond to individual, employer, and producer queries and any difficulties with website functionality or navigation, as well as problems in transmission of enrollment and premium information to plans.

To operate a customer service call center, the Exchange will need customer service protocols (automated and in manuals) and customer inquiry tracking tools and databases. Telephone and in-person staff will need to be hired and trained. In developing customer service support, the Exchange should consider accessibility of the Exchange to people whose primary language is not English and to people with disabilities, including the deaf and hearing impaired. Thus, the call center will need to be staffed with personnel fluent in Spanish and the other most commonly spoken non-English languages. To assist callers with less frequently spoken languages, the call center protocols and technology could accommodate "warm" telephone transfers to personnel in the Department of Insurance (DOI) where

existing staff can aid Polish, Korean, Japanese, Urdu, Hindi, and Bengali speaking consumers or to a translation assistance phone line. TTY/TTD services will need to be provided for hearing impaired callers.

Overall, Illinois appears to have limited experience with the multi-faceted customer service functions that will be necessary under the Exchange. While each state benefit program operates some type of customer service center, there is not a centralized resource that could be readily scaled up to take on the additional workload or interdependencies that will be generated by the Exchange. This conclusion is echoed by the Framework Vision findings. While Illinois can choose to build a tech-savvy call center, this too can be readily bought in the marketplace, generally more economically and faster than one can be built. Call centers are standardized, commoditized functions. Exchange and eligibility determination vendors, such as HP/EDS, Dell Perot, and Deloitte, are likely to offer call center options, or one can be contracted separately, in which case the vendor list is virtually endless. Moreover, external call centers generally have peak-volume back-up capacity, multiple sites from which to balance weather-related down times, and other features that a state would be hard-pressed to build on its own.

E. PRODUCER MANAGEMENT

However Illinois decides to utilize producers in marketing their Exchange, producers will need training and certification, a dedicated portal to access Exchange services, and dedicated producer service support. In addition, the Exchange will need to calculate and may need to pay producer commissions depending on the financial model employed by the Exchange (see subsequent discussion regarding the role of producers in the Exchange). Moreover, the producers will have suggestions and demands for the Exchange and will want formal channels of communication. The Exchange should consider establishing a Producer Advisory Council, much as carriers often do, to solicit their input and to explain policy and policy changes. This council should include recognized leaders among the producers, distributed by geography.

The producer support and oversight process is a complicated one. The Exchange does some things that producers traditionally do, such as set forth plan options for buyers and provide comparative information. Producers typically work for and are paid by carriers as “producers,” but this model may not fit the Illinois Exchange. The ACA defines roles and compensation for “Navigators” (through grants) that do not fit traditional producer compensation schemes, and yet there is substantial overlap between the roles of producers and Navigators. Working with producers will be crucial to the success of the Exchange, and deciding how best to do so will require further exploration by the state. To be sure, understanding producers’ roles and relationships with carriers is a skill set not readily available outside the world of producers and carriers.

However the producer role is defined, this function is critical, especially for the SHOP Exchange, and the Exchange would be well served by hiring someone with strong carrier and producer relations experience to manage the function under the Chief Sales and Marketing Officer for the Exchange. Alternatively, the Exchange may want to outsource the producer function to one or more General Agencies (GA), much like carriers in Illinois do themselves. The GA system serves as a single point of contact between a carrier and the producer, and it provides the producer with information and support needed to sell new business and retain existing contracts. Typical GA services to the producer include: prospecting and

marketing plan assistance; product, policy, procedural and sales training; online quotes; and problem solving for claim, billing, and enrollment issues. General agencies in Illinois active in the small group and non-group markets include Midwest Insurance Brokerage Services, EBRM, Flexible Benefit Service Corp and Resource Brokerage. GAs are gearing up to work closely with Exchanges, and the state may be well served by outsourcing this function to an agency demonstrating strong producer support services, advanced technological capabilities, flexibility, and importantly, strong existing relationships with the producer community.

F. NAVIGATOR MANAGEMENT

The ACA creates a Navigator program to help with education and outreach efforts for the Exchange. Navigators perform outreach, especially to hard-to-reach populations, provide information on reform to low-income populations, many of whom will qualify for Medicaid and CHIP/All Kids, rather than tax credits in the Exchange, and help clients through a sometimes daunting eligibility determination process. Effectively, Navigators are the field sales force for the non-group, subsidized market, which is likely to be the largest market segment for the Exchange. Exchanges will need to contract with Navigators and provide training as needed. A dedicated portal for Navigators may also be helpful, along with dedicated Navigator service support. The Exchange needs to encourage Navigators to pursue a broad range of outreach and educational services on health reform, and it needs to measure and provide oversight of Navigator performance, including productivity metrics. This requires classic return-on-investment (ROI) analyses. An essential tool for doing this will be a Navigator Management Information System (MIS) or Customer Relationship Management (CRM) tool, such as any carrier would deploy for its own sales force in business-to-consumer marketing. Potential vendors might include Salesforce.com, HealthPlanCRM, and Health Plan Sales Solution for Microsoft Dynamics CRM. The Exchange may want to consider measuring such productivity standards as sales leads generated, success rate in reaching leads, closing ratios, ability of Navigators to generate their own leads, enrollments per dollar spent on Navigators, and problem cases and re-work.

While the ACA defines a whole new role for "Navigators," many states, including Illinois, have experience working with application facilitators and consumer advocates who play related roles with respect to Medicaid and CHIP/All Kids. For example, in Illinois, the Exchange may benefit from the experience of All Kids and their All Kids Application Agents (AKAA) program. Community-based organizations, medical providers of any kind in good standing with HFS, and others are permitted to enroll as AKAAs. AKAAs receive reports on results of applications submitted and ongoing updates on the application process. For compensation, most AKAAs are eligible to receive Technical Assistance Payments (TAPs) of $50 for each completed application that results in new coverage. See Section 4.2.2 for more discussion of Navigators and AKAAs.

Illinois has an additional resource that might be useful to the Exchange, that being a network of almost 100 DHS Family Community Resource Centers (FCRCs) across the state, offices that can be thought of as "one stop" centers for medical assistance, food stamps, and job services. FCRCs do not have available staff time to devote to the Exchange. Nonetheless, the acquired expertise of staff in education and outreach to low-income populations should not be overlooked when Illinois develops a Navigator

approach for the Exchange. Similarly, the breadth and depth of the DHS office network also offers the Exchange extensive physical reach into literally every county in Illinois, as well as into most communities. The Exchange may be well served by attempting to harness the collective presence of state agencies, offices, and employees when attempting to "connect" with the uninsured along any of the touch points that occur when residents interact with state government for any reason. However, one innovation that might be considered is placing "online" kiosks in select local offices. Such consumer-friendly technology, placed in strategic locations, could capitalize on existing office space in local communities where lower-income individuals and families are already comfortable seeking assistance. In addition to online access to the Exchange website, the kiosk could be outfitted with toll free telephone service to allow the enrollee to contact a centralized Exchange customer service center.

G. COMMUNICATIONS AND OUTREACH

The Illinois Exchange will need communications and outreach programs to explain the role of the Exchange to Illinois residents, especially to hard-to-reach population segments. The SHOP Exchange will need to conduct outreach to small-group employers and employees, producers, and agents. In addition, the ACA specifies that Exchanges must consult with stakeholders, including representatives of small businesses and self-employed individuals.

The initial communication challenge will be publicizing the existence and purpose of the Exchange, as part of wider health reform, and making it as approachable as possible. This effort may be conceived in three parts: (1) outreach to lower-income, subsidy-eligible uninsured individuals, (2) outreach to small employers, especially those who are eligible for tax credits, and (3) broader marketing to full-pay customers. Much of the art in conceiving and executing this outreach will be in using various channels and methods of communication for both purposes. For example, lack of insurance among adults correlates with youth and lower income, and messages can be readily targeted at both segments. Nevertheless, a major thrust of outreach and education will be along the traditional lines used by Medicaid, and these elements of the campaign should be closely coordinated with HFS and its outreach efforts.

As for more conventional marketing, shopping for health insurance is not a "feel good" experience. It is a "grudge buy" and not something that the young and healthy in particular are eager to do. It is a major outlay, ranging from $3,000 to $15,000 per year, yet it carries great significance if the enrollee becomes sick or injured. Therefore, effective communications to a large population of potential Exchange customers is a critical function, and both the marketing message and venues must be selected with the limited attention span and low interest of the reluctant health insurance shopper in mind.

To conduct large scale communication and outreach campaigns leading up to the launch of the Exchange, with all the accompanying new rules and opportunities for coverage, the Exchange may want to sponsor a multi-media marketing mix featuring mass media including social media, paid advertising, creative private/public partnering, mass mailings, signage, press releases, public relations, media relations, website promotion, digital marketing, and outreach through legislators' district offices. For more targeted marketing over time (to small employers and households) a different mix of tools will probably be more cost-effective and appropriate. In particular, social media and digital marketing to

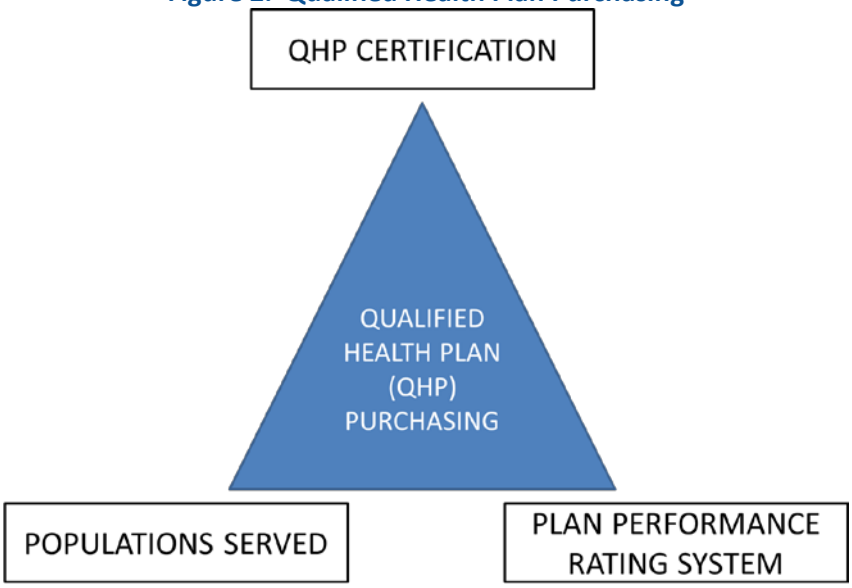
households and the producer channel for small business can be utilized but on a smaller scale with more focused messaging. The Illinois Office of Communication and Information (IOCI) may be able to help the Exchange think through some options. But given the newness and particular challenges of Exchange marketing and communications, the Exchange may be better served by tapping private-sector resources with more advanced relevant skill sets. The Exchange will want to solicit competing proposals for a PR/marketing firm to develop and execute campaigns under the direction of the Chief Sales and Marketing Officer for the Exchange, a key management position. The process of soliciting and reviewing proposals is a good way to educate the entire Exchange management team about marketing options.

H. PLAN SPECIFICATION AND QHP MANAGEMENT

The ACA requires Exchanges to certify, recertify, and de-certify plans as Qualified Health Plans (QHPs), based on standards that are established, in part, by the federal government. The SHOP Exchange will need to solicit bids and negotiate contracts with health plans to offer plans through the Exchange website. While the ACA is not specific on this point, Exchanges should also consider whether they wish to standardize benefits beyond the actuarial tiers specified in the ACA (for example, by limiting the cost-sharing options plans can use), and how selective they plan to be in the contracting process. The ACA also directs Exchanges to require health plans to submit justifications of premium increases. While not explicitly an Exchange function, there will need to be close coordination between the Exchange and the state regulatory agency responsible for such issues. An open question of considerable significance is the extent to which a state's SHOP Exchange will want to coordinate certification of QHPs with its nongroup Exchange if the two are organized separately.

Unlike several other Exchange functions, QHP management cannot be outsourced; rather, it must be built and continually managed as an Exchange core competency. Whether it chooses a "passive" or "aggressive" purchasing approach or somewhere in between, Illinois should develop an explicit purchasing strategy based on their policy goals. The Exchange has three major levers to influence the market: the QHP certification process, target populations to offer and enroll, and plan performance rating criteria. The Exchange must use these levers strategically to create carrier interest and achieve the goals of their procurement process.

Figure 2: Qualified Health Plan Purchasing

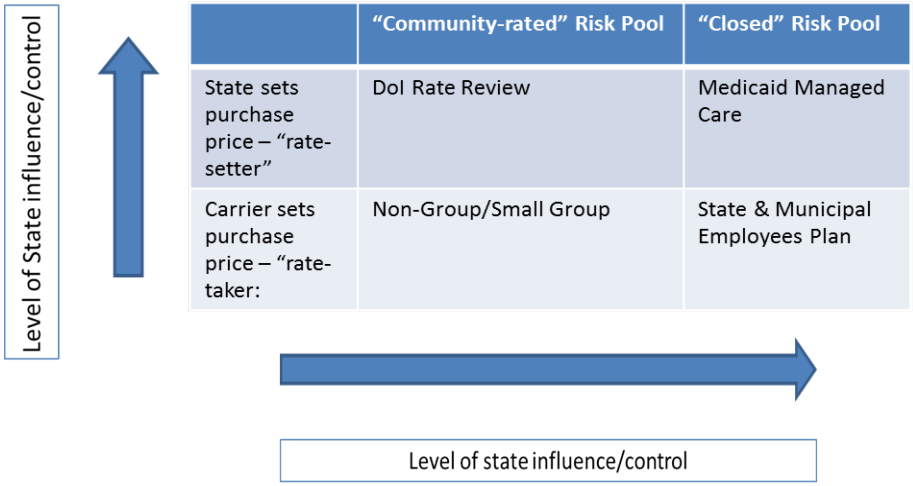


There are at least four target populations to include: subsidized and unsubsidized elements within both the non-group and small group. Illinois might further consider expanding the overall market to include Medicaid (current and newly eligible) and All Kids enrollees, state and municipal employees and potentially other state programs. The greater the Exchange's market size, the greater the leverage. The Exchange will need to assess how each population currently purchases health insurance.

The Exchange will need to determine whether they wish to pursue a "rate-setter" or "rate-taker" strategy. In concept, under a "rate-setter" strategy, the state sets the purchase price, whereas a "rate-taker" approach has the carrier setting the purchase price. The chart below demonstrates the level of influence or control the Exchange can exert, and provides general examples of typical activities or markets that represent those levels.

Figure 3: Qualified Health Plan Procurement

QHP Procurement Strategy



The plan performance rating system is a significant lever. For example, it can be utilized to advance policy objectives (i.e., rankings can be developed for metrics such as the number of primary care office visits or customer service levels). The plan rating strategy can be more influential if extended to other populations (such as Medicaid). In any event, performance rating attributes should be built into QHP specifications, and QHPs with high scores can receive preferred placement on the website, special indicators, or be selectively awarded contracts.

The third lever is the QHP certification process itself. The analytical process needs to begin early. The Exchange should research populations served by carriers to determine ability to utilize common carriers and networks for similar populations (i.e., Medicaid and non-group, state employees, and small group). Benefit designs for each of the populations will need to be compared, as this will inform the level of standardization question. The procurement process should include a formal Request for Proposal (RFP), bidder's conference to explain the terms of the RFP and answers to any questions, the development of scoring criteria for the RFP responses and a "selection committee" to review and score RFP responses. Realistically, the Exchange should also plan for more frequent procurements during the beginning of operations.

I. FINANCIAL MANAGEMENT

An Exchange must account for all activities, receipts, and expenditures and provide an annual report to the HHS Secretary. An Exchange will be subject to audits and investigations. In addition to strong accounting and financial management reporting systems, Exchanges will need to be self-sustaining beginning in 2015, which means they will need to assess and collect an administrative fee. SHOP Exchanges will need to coordinate payments from employers to plans, producers, and vendors. Exchanges are required by the ACA to publish the costs of licensing, regulatory fees, and any other payments required by the Exchange. Exchanges will need data warehousing functions to manage these financial functions and be able to generate reports and receipts. Outsourcing and vendor-management

functions will also be needed. Periodically, the Exchange will need to reconcile billing and collections with QHPs and possibly the Treasury as well.

The Exchange will need to hire a Chief Financial Officer (CFO) as soon as the Executive Director is in place. The CFO should establish a financial management structure and begin hiring experienced accountant and audit staff that can assist with the development or purchase of accounting and financial reporting systems and take such basic first steps as setting up a general ledger, obtaining a Tax ID number, and establishing the corporation with the IRS and appropriate state authorities, and developing the necessary banking relationships to operate the Exchange. To meet the short-term needs of the Exchange, a simple off-the-shelf software program such as QuickBooks Pro will suffice. These programs are easy to install and learn and will provide the necessary functionality to allow the Exchange to reflect basic cash, receivable, and payable transactions.

Longer term, the Exchange should perform a more comprehensive assessment of its needs relative to accounting software. Given the expected enrollment in the Exchange, the need to manage multiple revenue streams such as carrier assessments, federal and state grants, and member premiums, it is likely that the Exchange will quickly outgrow a basic accounting package. The core functions of business accounting software include: a general ledger, accounts receivable, accounts payable, and a payroll and reporting module. One of the key decisions points in this area for the Exchange will be whether to purchase and implement an expensive enterprise resource planning (ERP) system that generally has a large collection of extra features and functionality, and corresponding complexity in installation and use, or, a more modest software package commonly in use by small business. Software packages offering more extensive capabilities include Sage Simply Accounting, NetSuite, Sage Peachtree, and CMS Professional (Cougar Mountain). QuickBooks has more powerful software called Premier and also has an ERP solution.

J. RISK ADJUSTMENT

The ACA creates three kinds of risk-adjustment programs: a temporary reinsurance program that assesses fees on all carriers and makes payments to individual plans enrolling high-risk individuals; a temporary risk corridor program for qualified health plans in the individual and small-group markets; and a risk-adjustment program for issuers offering plans in the individual and small-group markets. While it is not clear if these functions will be carried out by the Exchange or by another state entity, at a minimum, the Exchange will need to be able to coordinate closely with these programs. While further guidance from CMS is needed to more thoroughly address the needs of this domain, Illinois should tentatively plan on hiring technical consultants for advice on risk adjustment, and possibly external vendors who specialize in risk adjustment and who can work with the state on all three kinds of risk-adjustment programs. In our opinion, such external expertise will be needed, as there do not seem to be existing capabilities within state government that match the substantial level of expertise and claims collection, data cleansing, manipulation, and analysis required to do the comprehensive risk adjustment as currently envisioned under the ACA. This area will doubtless need to be revisited as federal guidance and standards are made more explicit.

K. OVERSIGHT, GOVERNANCE, AND PROGRAM EVALUATION

Staffing the Exchange with key management personnel will be one of the first critical tasks to initiate once the Exchange and governance structure is authorized. To assist the state in selecting qualified individuals for these positions, suggested qualifications and educational requirements are provided in ten job descriptions in Appendix A for the following key positions: Executive Director, Chief Financial Officer, Chief Information Officer, Chief Sales and Marketing Officer, Chief Operating Officer, Chief Communication Officer and Director of Public Education and Government Affairs, Deputy Director, Director of Human Resources, Director of Non-Group or Individual Plans, and Appeals Unit Manager.

The Exchange will be governed by a board, and Exchange staff will need to manage board relations so that the board is fully informed, works effectively, and maintains confidence and trust in the staff. Public board meetings often attract media coverage, so Exchange governance communicates a lot about the Exchange and reform more broadly. Coordination between the Exchange and other state agencies will also be important to assure effective implementation of health reform across the various involved state agencies. For example, in Massachusetts, the heads of Medicaid and the Department of Insurance were members of the Exchange board to help ensure coordination between the three entities. In addition to the financial oversight and reporting described above, Exchanges should develop multi-year strategic plans, annual operating plans, fraud detection procedures, and program evaluation tools to track performance over time, including take-up and enrollment levels of the target markets and consumer satisfaction. Exchanges should also monitor for unintended consequences such as crowd-out (reduced private insurance as a result of public insurance expansions) in the employer market or adverse selection.

Exchanges are expected to help buyers without purchasing power, specifically individuals and small employers, by creating meaningful choices and simplifying the distribution of insurance. Bylaws should further establish transparent rules consistent with state and federal requirements.

If an Exchange is to function like a private business and enroll members, it should have access to the business expertise it needs. In order to ensure the Exchange is viewed as trusted and independent by Exchange consumers it should be insulated from political influence and prevent even the appearance of any conflicts of interest. If it is to achieve policy objectives through tax-financed subsidies and some degree of regulation, it also must be publicly accountable. In short, the Exchange needs to be run like a publicly held corporation – goals must be set, metrics must be established and measured, and results should be regularly and publically reported to the governing board of directors, which is ultimately accountable for the stewardship of public funds and trust.

In our review of the Illinois Comprehensive Health Insurance Program (ICHIP) program, a possible model for Exchange governance consideration was identified. Both the Board composition and plan of operation (including articles, bylaws and operating rules) provided for in the ICHIP enabling legislation (215 ILCS 105/1 from Chapter 73, paragraph 1301) may be worthy of further study as they may well provide a suitable architectural home (with modifications as necessary) for the Exchange.

L. MANDATE CERTIFICATION AND ELIGIBILITY APPEALS

The ACA assigns the Exchange responsibility for certifying exemptions from the ACA requirement that all individuals have health insurance. While the Secretary of HHS is to establish an appeals process for eligibility determinations, it is likely that the Exchange will need to be able to implement this process. The Exchange will also need to be able to notify employers when an employee qualifies for subsidized coverage through the Exchange, thus potentially triggering an employer penalty. Carrying out these politically sensitive tasks efficiently, effectively, and with considerable flexibility will be necessary to maintain and build public support for the Exchange and health reform.

To carry out these activities, the Exchange will need to develop requirements for systems and program operations that include: accepting requests for exemptions, protocols for reviewing and adjudicating requests and notifying all concerned parties of outcomes, including HHS. Functionality related to adjudicating grievances and hearing appeals already exists at different levels in various state agencies, including the Attorney General's office, the Department of Insurance, ICHIP, and the Medicaid program. The Exchange can and should build this capability internally, borrowing techniques and expertise from sister state agencies. Within the Exchange, the functionality can reside either under the General Counsel or in Operations/Customer Service, but wherever it is located, the other department should have strong input.

M. CONSUMER PROTECTIONS

The ACA requires Exchanges to carry out a number of consumer protection functions. For example, Exchanges are directed to require health plans that seek to become QHPs to submit justifications for any premium increases. The statute directs Exchanges to collect and disclose information from plans seeking to be QHPs, including financial disclosures, data on enrollment and disenrollment, and data on denied claims. Exchanges are also required to post information about enrollee satisfaction on their websites.

Additional operational requirements include developing a reporting system to track buying patterns, enrollee satisfaction, and problems; developing a rating system for QHPs; coordinating with the appropriate Illinois agency(s) on a host of licensure and market oversight issues; updating and monitoring QHP premium rates and underwriting; and addressing consumer complaints regarding QHPs. Beyond statutory requirements, each state Exchange will no doubt exercise some discretion in deciding how proactive or interventionist it will be on consumer protections.

In Illinois, several units within the Department of Insurance (DOI) already provide consumer protection and education programs, as well as complaint intake, research, and resolution for consumers. Two of these units, the Office of Consumer Health Insurance (OCHI) and the Life, Accident and Health Complaint Unit (LAH) have been in place for years and have acquired consumer advocacy expertise with a cross-cultural, multilingual workforce that the Exchange would be hard pressed to either replicate quickly on its own or outsource to an external vendor. OCHI also manages the Uninsured Ombudsman Program, which educates uninsured Illinois residents about health insurance options and benefits and their rights under state and federal laws, clearly an area of expertise closely aligned with the mission of the Exchange. Other units within DOI provide additional consumer assistance and protections for the

citizens of Illinois. For example, the Managed Care unit oversees MCO registrations, compliance, and departmental relations with carriers; the Producer Regulatory Unit oversees producer licensing, communication and education, and complaint management; and the Department oversees carrier rate filings under the recently expanded Premium Review Project. The Exchange could formally tap into this multi-dimensional expertise through an intra-governmental subcontracting arrangement between the Exchange and the Department of Insurance. This type of synergistic arrangement is likely to be both cost effective and expeditious and would optimize the use of existing state government resources for the benefit of the Exchange.

N. REPORTING FOR FEDERAL AND STATE OVERSIGHT

Managing funds is perhaps the most critical function performed by the Exchange, and a robust management structure must be put in place at the outset to ensure the Exchange is fully meeting its fiduciary obligations. The financial management of the Exchange is twofold: it must meet the administrative and financial needs of the entity itself (ensuring the Exchange has sufficient resources to pay staff, rent, and vendors), and it must provide the appropriate controls and reporting capabilities to manage state and federal funds. Taking the time to establish strong policies and procedures with respect to the management of funds at the outset will be critical to managing the rapid growth of funds under the custody of the Exchange. An important element to financial control will be ensuring that the Exchange has sufficient analytical and reporting capabilities to track and report on the funds under its control, including the ability to respond to required federal- and state-level audits and operational reviews, as well as publish all revenue, receivables, and expenditures consistent with state and federal reporting requirements.

As a hybrid public and private organization, the Exchange should look to existing government agencies for internal control models and reporting systems to evaluate. However, with the level of public scrutiny, transparency, and the number of federal and state audits the Exchange is likely to be subject to, looking to the private market for additional examples and models of best practices will be required. Regulations such as the U.S. Federal Sentencing Guidelines for Organizations of 2005, and the U.S. Sarbanes-Oxley Act of 2002, as well as professional organizations such as the Institute of Certified Public Accountants (AICPA) and the Association of Certified Fraud Examiners (ACFE), are good resources for information and guidance.

CONCLUSION

As suggested in the previous sections, there are some capabilities that already exist in Illinois state agencies that could serve the needs of the Illinois Exchange. Any analysis of whether and how best to utilize such existing resources is complicated by the difficulties of "stitching together" functions and agencies that were formed for, and are driven by, different purposes. The Exchange will be carrying out a novel set of functions, in some ways more typical of a commercial carrier than a governmental entity. Not only is it difficult to "re-purpose" existing resources and skills in one part of state government—which may already be in short supply to meet the host agency's own needs—but doing so across numerous agencies would hugely complicate start-up challenges and effective ongoing management of the Exchange.

Therefore, unless an existing agency resource is critical to the Exchange, otherwise hard to obtain, and exceptionally well developed in the agency, we recommend not laboring to find a way to incorporate it into the Illinois Exchange operations. For example, the consumer protection units within the DOI are a good example of exceptionally well developed expertise that should be leveraged by the Exchange. There are other examples of professional experience and subject matter expertise that can and should be tapped to benefit the Exchange. One way to do so might be to establish an Advisory Board of existing state talent that can be called upon by Exchange staff on an as-needed basis. Such an informal network of "in house" consultants recognizes the valuable contributions that existing employees can make to the Exchange but does not reassign any staff away from existing needs.

Even if existing resources were maximally leveraged, however, Illinois still would have significant needs in most of the functional domains. Much of the systems infrastructure (customer service, premium billing and collections, the enrollment web site) and some of the expertise can be purchased; other functions must be developed in house, perhaps with the help of external consultants and professionals. In particular, contracting with QHPs and promoting the Exchange to target population segments are central to the Exchange's mission and success. Procurement and vendor oversight will also need to be core competencies.

4.2.3 Education and Outreach

This section describes potential approaches to the education and outreach functions that the Exchange must perform.

ROLE OF PRODUCERS IN THE ILLINOIS EXCHANGE

A particularly important organizational and business issue for Exchanges concerns the role of brokers or agents, also known in Illinois as producers. This section addresses that issue and supports a general analysis with a specific discussion of a similar role that All Kids application agents perform in Illinois. It is expected that the concepts and issues identified in this paper will be further researched, evaluated, and assessed as Illinois transitions from the planning to the establishment phase of its health insurance Exchange.

Producers play an important role for consumers. In the highly fragmented, complicated, and confusing landscape that is the health insurance market today, producers can help bring order to the disorder of evaluating options and purchasing health insurance for individuals and small businesses. Producers provide a number of value-added services to individuals and small businesses—including providing health plan comparisons, explaining benefits and cost sharing provisions, and assisting with the application and enrollment process. Many individuals and small businesses rely on producers to provide health insurance options and assist in the purchasing process. This is evidenced by the sheer number of

licensed producers in Illinois today: 77,135 resident producers and 93,292 non-resident producers[2]. Many health insurance carriers in Illinois rely on producers, as well as the General Agency system, to reach individuals and small employers, a market dynamic confirmed in our phone interviews with the six health plans having the greatest overall market presence.

Producers often act as a trusted advisor for individuals and small business and can assume the additional role of a human resource function for small business owners. Producers assist the small business owner in explaining insurance options to employees, provide information on cost sharing provisions and availability of certain health care providers, assist in completing the required health plan paperwork for employer and employees, explain insurance laws and generally ensure that the entire purchasing process, beginning with plan comparisons through paying the first month's premium, is performed smoothly and efficiently.

The ACA and health insurance Exchanges are expected to substantially change how health insurance is purchased by individuals and small businesses by streamlining and simplifying the research and purchase function through the use of state-of-the-art technology, benefit standardization, and transparency. Yet, because of the prominent role of the producers in the current Illinois market, it is still important to analyze and assess the future role of the producers in an Exchange environment.

The ACA assigns a specific role to "Navigators," who perform functions similar to those now performed by producers. They are expected to play an important role in the new health insurance market post-2013. Section 1311 of the ACA defines Navigators as "Community and consumer-focused nonprofit groups; trade, industry, professional associations; commercial fishing industry organizations; ranching and farming organizations; chambers of commerce; unions; partners of the Small Business Administration; licensed insurance agents and brokers."

The role of the Navigator, as specified under ACA, is not too dissimilar to the role played by Medicaid outreach workers and state healthcare advocacy groups. More specifically, the duties of Navigators are expected to include activities such as:

a. Conduct public education activities to raise awareness of the availability of qualified health plans.

b. Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402.

c. Facilitate enrollment in qualified health plans.

[2] Non-resident producers are licensed in their home state and afforded reciprocity in Illinois as part of their non-resident licensing application.

d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or determination under such plan or coverage.

e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

Understandably, producers are concerned about how the Navigator program will affect their role and about whether Navigators are being afforded an unfair competitive advantage in assisting prospective Exchange enrollees. Therefore, one of the first issues for the Illinois Exchange to consider will be defining the role of producers relative to that of its Navigator program. Although under ACA a broker/producer can be a Navigator, there are some practical differences in the role of each. For example:

a. Navigators are required to be funded from the operations of the Exchange, while producer commissions are paid by health plans, employers, or consumers.

b. Navigators are not allowed to receive compensation, either directly or indirectly from health insurance issuers, for enrolling individuals or employers in a health plan.

c. Producers are required to have state licenses, while any certification or licensure requirement for Navigators is to be decided by Illinois.

Using establishment grant funding, Illinois will need to perform market research and involve relevant stakeholders to help answer important questions about Navigators and producers such as the following: (i) How should each of these roles be defined? (ii) What are fair and reasonable compensation levels for each? (iii) Should there be licensure or certification criteria for Navigators, and if so, what should they be? (iv) How will the effectiveness of producers and Navigators be measured or evaluated? (v) Should roles and compensation for Navigators and producers be different for the individual market and small-group markets?

As a new distribution channel that is expected to reform the purchase of health insurance for the individual and small-group markets, there is a natural tension between the Exchange and the producer community in Illinois. Therefore, it will be important for the policy-making process to engage all of the key stakeholders to determine the best course of action for Illinois. More specifically, Illinois will need to engage in stakeholder meetings with individual health insurance consumers, employer purchasers, producers, health care advocacy groups, and health plans. The goal of such meetings will be to address the questions noted above but also discuss how the Navigator program can best serve the target market segments, whether there are natural but different market segments for Navigators and producers to serve, and what value Navigators and producers can bring to each stakeholder.

FINANCING CONSIDERATIONS

One of the more difficult finance issues that will confront the Illinois Exchange, in addition to the questions of whether and how they should continue to use producers, is how to compensate producers at reasonable commission rates while maintaining a low administrative cost structure. Whether to have commission parity inside and outside the Exchange will be an important policy decision. If the Exchange pays commissions below outside market rates, producers have an obvious incentive to write business, or "steer" prospective enrollees, outside the Exchange. A counter-balancing element is that individual enrollees and small businesses that are eligible for premium tax credits or cost sharing assistance cannot receive these subsidies unless they purchase coverage through the Exchange. However, for higher-income people not eligible for subsidies, a producer can in good conscience encourage purchase of coverage outside the Exchange, thereby causing the Exchange to lose business share.

A secondary concern is that the Exchange could become susceptible to "street underwriting" in which producers direct higher-risk enrollees to the Exchange and send healthier enrollees to carriers outside the Exchange, where commission levels are greater. The result would be adverse selection and higher cost in the Exchange compared to the outside market. Such activities by producers allegedly undermined the success of previous Exchanges, including PacAdvantage in California in 2006.[3] The ACA includes three risk-adjustment provisions to mitigate the occurrence of risk selection occurring against the Exchange. Although such provisions should provide the Exchange with some level of protection, risk-adjustment methodologies are imperfect.

The fact is that past experience suggests that if producers are hostile to the Exchange and have incentives to avoid sending business to it, their actions could threaten the success of the Exchange.

The level of compensation to be paid to producers by the Exchange will need to be carefully evaluated and assessed in the context of prevailing market norms in Illinois, expected enrollment take-up in the Exchange, and the revenue-generation options available to the Exchange. The chart below summarizes our findings regarding commission payment based on calls to six health insurance carriers made in May and June of 2011:

Table 5: Producer Commission Averages

Producer Commission Averages (expressed as a percent of premium)			
Market Segment	Average	Low	High
Small Group	6.0%	5.0%	6.8%
Non-Group	8.6%	7.4%	11.0%

In addition to this policy question of how much to pay producers, a number of other payment methodology issues will need to be carefully considered. For example:

[3] SHOPping Around: Setting up State Health Care Exchanges for Small Businesses: A Roadmap. Terry Gardiner and Isabel Perera July 2011. Center for American Progress

a. If the Exchange decides to pay producers, should the payment methodology be on a percent of premium or a fixed per member per month (PMPM) basis? Historically, producer payments have been largely based on a percentage of premiums. Recently a number of commercial carriers, as well as the two state-based Exchanges currently operating, Massachusetts and Utah, are paying producers on a fixed PMPM basis. Medicare Advantage health plans also pay a fixed fee. The rationale is that premium-based commissions provide producers with incentives to enroll individuals and employers in more expensive insurance policies. A fixed-dollar amount removes this incentive.

   Also, percent-of-premium payments reward producers from one year to the next, not on the basis of greater productivity or better service, but on the annual increase in the cost of health care. Such built in "pay raises" are not sustainable over time and merely serve to escalate premium costs needlessly.

b. Should commissions be greater in the first year than in renewal years? The logic to this practice is that the level of effort in an initial sale is much greater than renewals, justifying a higher level of reimbursement to cover the producer's incremental expense. Additionally, this methodology could provide an incentive to write the business through the Exchange. Such a policy may increase producer interest and could be financially palatable to the Exchange, especially if renewal commissions are substantially lower. But this policy could encourage churning within the Exchange, could raise the concern of Qualified Health Plans (QHPs) regarding selection bias, notwithstanding the implementation of risk adjustment, and might generally be perceived as unsatisfactory customer service for Exchange enrollees. An alternative payment methodology for consideration, and one that is currently in use in Medicare Advantage, is to pay a higher rate of commission the *first time* a resident enrolls in a QHP through the Exchange but not if the enrollee then changes to another QHP offered through the Exchange.

c. There are two primary approaches the Exchange could use in structuring producer commissions: (i) make the producer fee an explicit add-on to the premium quote, with the Exchange acting as a pass-through for payment from the enrollee to the producer, or (ii) include the producer fee in the premium quote without separately identifying it. Under the second approach, which is currently used by the Massachusetts Health Connector, the producer fee is a component of the total premium quote and is not visible to the enrollee. Assuming the Exchange generates revenue through an assessment on QHPs for enrollment through the Exchange, the Exchange includes the producer commission as part of the total assessment and pays producer from this revenue stream. This approach has the effect of making the Exchange assessment higher than it would otherwise need to be and removes the transparency of the transaction. In the first approach, the producer payment is being made directly by the insured, which has the benefit of full transparency regarding the cost of commission. However, it is a significant change in the way producers are paid in Illinois today. This type of model is currently employed by the Utah state Exchange.

Defining the role and compensation level of producers in the Exchange is a complicated and potentially controversial issue. What is clear from historical experience is that working with all stakeholders to develop a policy and financial model that seeks to smooth the inevitable tension between an Exchange and producers is in everyone's best interest. The financial advantages accruing to those who are eligible for subsidies only if they enroll through the Exchange (including those who move back and forth from Medicaid and the Exchange) are likely to offset any incentive that producers have to steer people to the outside market if the commission is higher there. But this effect does not apply to the small-group market. Although Illinois may benefit from reviewing the decisions of other states as they design roles, commission levels, and payment methodologies for producers, Illinois will most likely need to develop an approach that is uniquely informed by the local norms of its markets.

ALL KIDS APPLICATION AGENT PROGRAM

For more than twelve years, the Illinois All Kids (previously KidCare) Application Agent initiative has been very successful in promoting state health coverage programs to children and parents and in enrolling eligible families into these programs. All Kids Application Agents (AKAAs) are community organizations such as clinics, hospitals, other health providers, day care centers, religious organizations, schools, insurance agents and others that help parents, children, and pregnant women enroll in coverage through All Kids and FamilyCare. AKAAs are responsible for:

- identifying potentially eligible individuals and families;
- explaining program eligibility, benefits, cost-sharing, etc.;
- assisting applicants in completing an application, accurately answering all applications questions and gathering all required verification documents;
- submitting the complete application to the state electronically or by mail;
- complying with all confidentiality requirements; and
- following all other AKAA rules.

The state assures that AKAAs understand their duties and are knowledgeable about program provisions. Entities interested in becoming AKAAs submit a request on official letterhead to HFS. The request describes the organization, its regular duties, and how these duties put staff in a good position to encounter families likely to be eligible for All Kids or FamilyCare. HFS staff reviews the request, determines whether the entity can be approved as an AKAA, and sends an enrollment packet to approved entities. The packet contains an AKAA agreement for the entity to review, sign, and submit to HFS for the HFS Director to sign.

With an AKAA agreement signed by the community organization and HFS, the organization's staff attends AKAA training provided in English and Spanish. As part of training, AKAA staff receives an 83-page AKAA manual that explains in detail topics such as: AKAA procedures; AKAA payment requirements; benefits and cost-sharing for each program; eligibility requirements for each program;

service delivery options, including fee-for-service with primary care case management and managed care organizations; rules regarding what date coverage begins; eligibility rules for unique family circumstances; enrollee reporting requirements; how coverage is maintained by DHS and HFS staff; tips for successful applications; the renewal process; etc. In addition, the state maintains ongoing communications with AKAAs through a website and periodic AKAA updates.

AKAAs help families complete an application that is nearly identical to the application families can submit on their own. However, the AKAA application includes a checklist for the AKAA to complete to assure that they have completed all duties, answered all questions, and gathered all required verification documents. The checklist also includes a spot where the AKAA indicates organization name, staff name, and AKAA number. It is this checklist that indicates to state staff that the application came from an AKAA. If the checklist is complete, the application requires no follow-up, and if at least one individual from a family not already enrolled in state coverage is newly approved for All Kids or FamilyCare, the AKAA will receive a $50 Technical Assistance Payment (TAP) for submission of a successful application. State provisions prohibit AKAAs from submitting multiple applications for individuals in the same family and other attempts to fraudulently earn TAP payments. Each AKAA also receives monthly data reports indicating the number of applications approved and eligible for TAP, the number approved and ineligible for TAP with the reason TAP was denied, the number of applications denied, etc.

COMPARISON OF AKAAS AND NAVIGATORS

ACA requires state health insurance Exchanges to award grants to Navigators, organizations that will perform some of the same duties that AKAAs perform. Although Navigators are similar to AKAAs, some ACA provisions vary from AKAA policies. The following table compares ACA Navigator provisions with AKAA policies.

Table 6: Comparing Navigator and AKAA Provisions

	Navigator Provisions in ACA	AKAA Provisions in AKAA Manual
Types of Entities	Entities that have existing relationships or could establish relationships with employers and employees; consumers, including uninsured and underinsured persons; and self-employed individuals likely to be eligible to enroll in the Exchange. Must include entities from at least two of the following categories: trade, industry and professional associations; community and consumer-focused non-profit groups; commercial fishing industry organizations, ranching, and farming organizations; chambers of commerce; unions; Small Business Administration resource partners; other licensed insurance agents and producers; and, other entities that can perform Navigator duties and meet standards set by the Secretary, including but not limited to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies. Navigators may not be health insurance issuers or receive direct or indirect consideration from insurers in connection with enrollment.	Community based organizations, including faith-based organizations, day care centers, local governments, unions, medical providers and licensed insurance agents. AKAAs include multiple social services organizations that provide outreach and application assistance to individuals in languages such as Chinese, Korean, Japanese, Arabic, Polish, Urdu, etc. Other AKAAs frequently work with individuals who are homeless and those with mental illness and addictions.
Duties	• Perform public education duties to raise awareness about qualified health plans. • Provide fair and impartial information about enrollment in qualified health plans following standards to be set by the Secretary of HHS. • Facilitate qualified health plan enrollment. • Provide referrals to appropriate entities for enrollees with grievances, complaints, or questions. • Provide culturally and linguistically appropriate information.	• Identify potentially eligible families (including use of a worksheet to identify the programs for which individuals may qualify). • Assist applicants in completing the application including getting all verification documents, answering all application questions and having applicants authorize the application. • Submit the completed application online or by mail. • Comply with confidentiality requirements. • Notify HFS of changes in organization or staff information.
Funding	Exchanges will provide grants to Navigators from Exchange operational funds. (Federal funds and enrollee cost sharing, no state dollars.)	AKAAs receive a $50 Technical Assistance Payment (TAP) for each complete application that results in a new enrollment for a family not already covered by one of the programs. (50% federal, 50% state funds)

The July proposed rules provided some further guidance on Navigators. However, additional standards are likely to be forthcoming, given the extent of the areas for which HHS is seeking comment. Specifically, HHS is seeking comment on several topics including:

- whether HHS should propose additional conflict-of-interest provisions for entities receiving Navigator grant funds;
- whether additional conflict-of-interest provisions are required to address the potential conflict of agents and brokers (producers) being allowed to receive compensation for enrolling individuals, small employers, and large employers in non-QHPs while receiving Navigator grant funds;
- whether at least one of the two eligible entities to receive Navigator grant funds should be a community or consumer-focused nonprofit organization or whether Navigator grantees should be required to represent a broad cross-section of stakeholders;
- potential standards for state Exchanges to use when making Navigator grant awards and ways to ensure the information made available by Navigators is fair, accurate, and impartial;
- further specificity on standards for Navigators when providing information to populations such as those with limited English proficiency and individuals with disabilities; and
- requiring Exchanges to commence the Navigator program no later than the first day of the initial open enrollment period.

Additional questions not related to these areas for further comment that may be answered in future guidance include the following questions:

- What is involved in the Navigator duty to "*facilitate enrollment*"?
- Can Navigator grants be structured to in a way to pay Navigators based on "new" approved applications they facilitated?
- Despite references to "qualified health plans," are Navigators expected to work only with individuals and families likely to be eligible for Exchange qualified health plans? Or do ACA provisions for well-integrated Medicaid and Exchange eligibility and enrollment systems require that Navigators work with individuals or families eligible for Medicaid and CHIP too?
- What will be the enrollment and training requirements?

ROLE OF AKAAS IN OUTREACH AND EDUCATION INITIATIVES

A recent report[4] on the state's All Kids website indicates that AKAAs have a 92% approval rate. This is an impressive measure of the contribution that AKAAs make in streamlining the application process for families. AKAAs also reduce workloads for DHS local office and HFS All Kids Unit staff by increasing the number of complete applications that do not require staff to request additional information. Combined with a well-integrated, easy-to-use EVE system, AKAAs can assist the state in handling the increased volume of applications that will be submitted when Medicaid eligibility is expanded to 133% of FPL for U.S. citizen and qualified immigrant non-elderly individuals on January 1, 2014.

Illinois' AKAA program could be the foundation on which the Exchange Navigator program is built as an integrated outreach and application assistance strategy for Medicaid and the Exchange. Unless federal guidance regarding Navigators would contradict this, the state could expand the AKAA program to incorporate additional types of entities included in the ACA as potential Navigators. It is likely that only a few of the currently enrolled AKAAs, such as insurance agents paid by insurers, would be prohibited from being Exchange Navigators. Since the state has designed an effective system for enrolling, contracting with, training, and paying application agents and this system has been successful in providing linguistically and culturally appropriate application assistance in the community with high application approval rates, lessons learned from the AKAA effort should be integrated with and applied to application assistance for Exchange eligible persons.

Illinois structures payments to AKAAs in a way that rewards entities for providing assistance that results in coverage for a new family that is not already enrolled in state health benefits coverage. This is the ultimate goal of outreach programs, to get people covered. Many outreach programs are successful in promoting a program and making the general public more aware of the program but do not result in more people with coverage. If federal guidance will permit, the state should consider a Navigator program that rewards the submission of complete, approved applications. Not all the families AKAAs work with complete the application process or provide needed verification documents. The AKAA may submit applications for four or five families before one of the applications is approved and a TAP payment earned. After 2014, it will be more likely that the low-income uninsured individuals or families that a Navigator works with will qualify for either Medicaid or subsidized Exchange coverage. Thus the proportion of completed and approved applications should be higher than what AKAAs experience today. For this reason, despite the fact that AKAAs may request an increase in the TAP amount, it may be fair to consider the current $50 payment for an approved application an appropriate amount for the work Navigators will do to assist individuals and families in applying for Medicaid and the Exchange.

[4] Source Allkids.com/assets/042611.pdf

4.2.4 Exchange IT Needs Assessment

> ***This section addresses the information technology functions of an Exchange specifically, with a focus on opportunities and strategies for developing, purchasing, and acquiring systems and infrastructure to serve those functions.***

This section addresses Exchange information technology needs and potential solutions in Illinois for the Exchange. The HMA team has conducted an information technology needs assessment for Illinois to supplement the Exchange planning needs assessment in section 4.2. We excluded from the assessment the important Exchange functions that will be addressed by the Eligibility, Verification, and Enrollment needs assessment, which is provided in a separate report.

Similar to the review of Exchange business functions, we find little information technology in place in Illinois that can or should be adapted or expanded to serve the IT needs of the Exchange. This is an entirely expected conclusion, since Exchanges will be expected to perform new functions that are not commonly state agency activities (with the exception of eligibility and enrollment functions). Given that, and after discussions with state project managers, our team has taken an operational and strategic business approach to this task rather than a technical one. This section describes emerging federal requirements, discusses the options to acquire technology that meets the requirements, and provides some information about what selected other states are planning. It also addresses some special considerations for the SHOP Exchange. This section is guided by three focusing questions:

1. How is the federal government supporting Exchange IT acquisition?
2. What does Illinois need to acquire to run an Exchange?
3. What are Illinois' options to acquire what it needs?

There is necessarily significant overlap between the business functions of an Exchange described in section 4.2.2 and the functions addressed here. Information technology is simply a business tool, so it is always difficult to address the two components separately. Moreover, while we leave a fuller analysis of eligibility, verification, and enrollment functions to a separate and more detailed report, when reviewing options for acquiring IT functionality, there are important practical and operational reasons to consider all of the IT functions of an Exchange, including EVE functions. We stress these overlapping considerations not to complicate matters or to try to explain away the organizational structure of an exceedingly large and complex final report. Rather, we believe that the most important of the business issues that the state of Illinois needs to grapple with is how, practically and strategically, it should go about purchasing and acquiring IT functions. This would be a challenging effort in any environment, but given the constrained timeframes of the ACA, it is even more important that potential approaches and implications are considered in advance of deploying a purchasing strategy.

THE FEDERAL ENVIRONMENT AND EXCHANGE IT NEEDS

Recognizing the challenges confronted by states planning and establishing Exchanges, the federal government is engaged in an ongoing process of defining IT standards for Exchanges in detail. CMS and CCIIO are also providing significant funding for states to become compliant, including enhanced funding for certain required Medicaid eligibility system updates. The federal government is also building a data hub that state eligibility systems can access to verify of income, citizenship status, and other applicant information.

In addition to providing federal funding, distributing detailed guidance for accessing funding, and creating certain core functions for states to utilize, HHS has also recognized that assistance in the development and acquisition of technology is an important support for states establishing Exchanges. HHS has provided large grants to six Early Innovator states for Exchange IT development with a goal of disseminating the best practices and creating avenues for states to adopt models to their particular circumstances. CMS is also planning to establish "Learning Collaboratives" to help disseminate ideas and share best practices during Exchange implementation in the states.

It is important to note that, to receive federal funding to support systems-development efforts, states have to demonstrate that they have conducted "due diligence" in reviewing the system models being developed by "Early Innovator" states. States will be required to justify a decision not to use these models. We discuss Early Innovators and the prospects for Illinois later in this section. States also have to show how they will integrate the eligibility-determination functions between the Exchange and existing state agencies. On that score, as described in our separate EVE report, Illinois has a strong process underway.

KEY IT NEEDS OF THE EXCHANGE

The federal government has provided some initial draft guidance on structuring the information technology solutions that are needed to meet Exchange business requirements (*CMS Exchange Reference Architecture: Foundation Guidance,* draft v.0.99, March 2011). This guidance identifies six core business areas for Exchanges:

1. Eligibility and Enrollment
2. Plan Management
3. Financial Management
4. Customer Service
5. Communications
6. Oversight

Additional details, in the form of functional and technical requirements, have been or will be provided in relation to each of these core business areas. The detailed guidance is intended to provide the technical framework for Exchanges to use as they develop their IT solutions. Illinois should monitor closely the ongoing guidance associated with this framework.

Nevertheless, in terms of the Exchange's need to sensibly and strategically acquire IT, not every core business area requires significant IT support. In our view, there are five primary IT systems or services

that the Exchange needs to develop, purchase, or acquire. They are listed below, and generally conform, as noted, to five of the functional domains laid out in section 4.2.2:

- Eligibility determination — Section 4.2.2 (a)
- Web Portal — Section 4.2.2 (b) (Online shopping)
- Enrollment, billing, and collections — Section 4.2.2 (c)
- Customer service — Section 4.2.2 (d)
- Financial management — Section 4.2.2 (i)

Before discussing acquisition strategies, we make a few observations.

THE EXCHANGE WEB PORTAL

In this section of the report we use the term "web portal" to describe the online shopping function that the Exchange must build, for two reasons.

First, the development of a robust website is a hallmark of a successful state Exchange. Illinois should not shortchange this investment and should contemplate it at the initial planning stages as providing more than merely a shopping experience. Compared to the complex challenges and expense of updating existing eligibility systems, the state can spend relatively fewer dollars and realize large consumer rewards for this investment.

Second, using the term "web portal" emphasizes the important point that the website could (and in some cases must) be integrated with a range of Exchange functions. The point is important because it has purchasing implications. Illinois may want to purchase web portal functionality as a part of the Integrated Eligibility System (IES) described in the separate EVE report. Or Illinois could purchase website functionality from the same vendor that provides customer service functions to support the online shopping experience. The ACA also requires Exchanges to provide an "electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions." The need to have this important tool on the website crystallizes how core functions of the Exchange are expected to be integrated and presented in an accessible way to the consumer.

PREMIUM BILLING, COLLECTIONS, AND ADVANCE PAYMENT OF TAX CREDITS

Federal regulations on Exchanges are expected to address the options for states to manage the premium billing and collections from Exchange participants. As noted in section 4.2 (c), premium billing is significantly more complicated for SHOP Exchange customers than for individual purchasers. However, for individuals who qualify for premium tax credits, the Exchange will have to execute an advance-payment process that is complex and must be closely integrated with the eligibility-determination system. If Illinois opts to have health insurance carriers collect premiums, the Exchange will nevertheless have to develop or acquire an IT system that is capable of tracking the administration of the advance payments of Exchange subsidies to eligible enrollees, a core function for Exchanges.

SHOP EXCHANGE CONSIDERATIONS

The ACA requires every state that operates an Exchange to establish a SHOP Exchange. The SHOP Exchange is supposed to facilitate the purchase of coverage in qualified health plans for the employees of small-business employers that choose to purchase through the Exchange. Beginning on 1/1/2014, Small Business Health Care Tax Credits will be available only through the Exchange. There are forthcoming federal rules that will provide a framework for SHOP Exchanges, including options for how employers can provide contributions toward employee coverage that meet standards for small-business tax credits.

At a minimum, Illinois needs to consider the extra functionality that will be needed on the Exchange website for small businesses, which includes web enrollment for small businesses and their employees and a producer connection to the web for completing enrollments. In addition, Illinois will need to ensure that there is specialized attention for small businesses through its Exchange call center, particularly if the individual and SHOP Exchanges are combined.

ACQUISITION STRATEGIES

There are a number of approaches that Illinois can take to acquire its Exchange operating systems, from designing and building its own system to fully outsourcing a solution. Based on its own initial analysis, Illinois has largely decided not to attempt to build its own Exchange operating system or to modify any of its existing systems to address the Exchange's business needs. Instead, Illinois has proposed hiring a systems integrator to coordinate the design and development of an outsourced Exchange solution or series of integrated solutions.

As a result, we focus on outsourcing options. The first consideration is which phases to outsource: design, development, and/or ongoing operations. There may be different answers, depending on the business function (e.g., web portal vs. call center).

The next consideration is whether to outsource to one vendor or to multiple vendors. There are pros and cons to each approach. If the state outsources the work to one vendor, for a "turnkey" or full solution approach, a key risk is that the state has put "all of its eggs in one basket," and the vendor's failure would be hard to mitigate. If the state outsources components to multiple vendors (taking a modular approach, similar to the Minnesota RFP example discussed below), the state would need a strong system integrator to coordinate the components.

The grid below presents a logical framework for analyzing these needs and a sample approach for selected business functions. This grid is only for illustrative purposes. It is intended not to propose a specific approach but rather to illustrate how to apply a structured framework to represent the purchasing options that Illinois has.

Table 7: Business Function Purchasing Options

Business Functions→ Phases:	Web Portal	Call Center	Premium Billing	Financial Management: Accounting Systems
Design	Enrollment UX 2014 Project	Vendor C (Turnkey for all phases)	Federal framework + System Integrator	Commercial Off The Shelf (COTS) vendor
Development	Vendor A	Vendor C	Vendor D	COTS vendor
Ongoing Operations	Vendor B	Vendor C	Vendor D	In-house

Vendors will doubtless convey an ability to provide multiple functions across all phases. As noted above, a vendor that develops the IES or EVE function (which is not included on the illustration above, but could be) may be capable of designing, developing, and even providing ongoing operations for other business functions. There are, conceptually, a virtually endless variety of scenarios that fit the pieces of this puzzle together. That does not mean that every variety is a good idea.

CONSIDERATIONS FOR IMPLEMENTATION OF EACH OPTION AND ONGOING OPERATIONS

There are some core considerations that Illinois should take into account in designing its acquisition approach, including:

- The availability of qualified staff resources.
- The availability of proven vendor solutions.
- The complexity of the project, particularly in areas that need to integrate with the IES project, such as premium billing.
- The degree of uniqueness that Illinois would like to have in the design of its Exchange web portal and operating systems (as compared to other states).
- The operation of state procurement rules that apply to the Exchange on particular scenarios (how many business functions can be bundled into one procurement?) and in general (how administratively cumbersome is the process, and timely?).

PROCUREMENT LEVERAGE

Illinois may be concerned about how to maximize its leverage during any Exchange IT procurement process since so many states will be competing for the same services. While this is admittedly a challenge, Illinois has a couple of options. States that issue RFPs early, while vendors are still "hungry," will get better prices and may get more seasoned vendor staff. The state may also consider methods to make the project attractive to vendors by committing to a longer timeframe or providing financial incentives for performance.

Another approach would be to add scale by participating in a multi-state IT infrastructure procurement. While there are real (and difficult-to-quantify) transaction costs to an approach that includes other states, it is difficult to ignore that every state that is establishing an Exchange is purchasing similar, if not identical, functionality.

LEVERAGING OTHER EXTERNAL RESOURCES

Illinois is participating in a user design collaborative through the California Healthcare Foundation whose goal is to design the consumer interface for the Exchange web portal. This project provides an excellent opportunity for Illinois to incorporate best practices for consumers into its Exchange design, without committing significant resources and potentially doing so early enough to be useful. A key factor will be the timing of the project's results and therefore the ability to incorporate the design into any RFP that Illinois issues. The project appears to hold promise for the potential of collaboration among a number of participating states as well.

FEDERAL RESOURCES

The Early Innovator grant program designed by CCIIO is intended to provide states with access to development support and ultimately established, approved solutions. We see significant timing concerns with the concept, because, as described below, most Early Innovator states are now in the early phases of design and development. While the prospect is appealing, relying on not-yet developed systems for the Exchange, given the time constraints of Exchange planning, is a high-risk strategy—at least until practical outcomes become more clear. More generally, we think the state should expect ongoing developments from CCIIO about potential methods or solutions for IT infrastructure that are supported by the federal government. We recommend monitoring development with the Early Innovator states as well as other approaches that are offered by CCIIO. Obviously, much more detail will be needed to assess whether any such approach presents a viable option for Illinois.

CONSIDERATIONS FOR A SYSTEM INTEGRATION VENDOR

Procuring a system integration vendor to help manage the Exchange IT development is a good idea, especially in light of scarcity in staff resources at the state level, but a vendor does not substitute for the need for strong state oversight of the project. In addition, the system integration will need to happen across the overall health reform project, including the Integrated Eligibility System. In particular, we think that a system integrator can play a vital role in helping to manage the implementation of the Exchange's customer support center, which has many key interdependencies with other aspects of Exchange implementation. Finally, it is crucial that a system integrator or project management role coordinates very closely with the non-technical aspects of Exchange implementation.

CONCLUDING OBSERVATIONS AND RECOMMENDATIONS

Call Center: It makes sense to combine the development and operation phases of the call center into one contract. It gives the vendor the right incentives to do a good job on the development phase since they have to operate the results. To address both the need to give vendors incentives to bid on Illinois' work, combined with the desire to minimize procurement process time, a good option for the state to pursue for its call center and premium billing solutions (combined or separate) is a relatively short initial contract term (3 years) with potential extensions. The initial length of the contract, combined with the possibility of extensions, is enough to make the project worth the vendors' investment of resources, but it also gives the state the flexibility to exit if the vendor's performance is substandard. During that period, the Exchange will gain an identity and a great deal of experience and will learn from other states.

This will put the state in a position to better know what it wants and therefore refine its future procurement requests.

Web Portal: The website development and ongoing operations (such as hosting the site) are very different functions and can be easily split across vendors. Alternatively, the web portal can be designed in such a way that updates could be done by in-house Exchange staff.

Combined Contracts: Bundling the web portal and call center development is possible, but the state would need to be sure that vendors truly have strengths in each area. Often, vendors have a comparative advantage in one area; it is best if the state can play to their respective strengths. The state should be cautious when reviewing vendors who are subcontracting a great deal of the work—the state should get assurances that the teams have worked together before, and the state needs to ensure that the lead vendor is truly accountable for the results and has the capacity and expertise to step in if the subcontractor fails.

WHAT OTHER STATES ARE DOING

HMA is monitoring what other states are doing in terms of acquisition of Exchange technical systems that would have applicability to Illinois. Many, but not all, of the states are Early Innovator grantees.

MINNESOTA

Minnesota is not an Early Innovator grantee, but it is one of the first states to be issuing a technical RFP. Minnesota recently issued an RFP for Health Benefit Exchange Technical Infrastructure prototypes, most of which are related to the Exchange's web portal functions. The state has taken a creative approach to managing technology planning in a deeply uncertain environment. Vendors are being asked to respond to a two-phased approach, in which they first share their prototype ideas and then receive funding to develop the prototypes more fully. The prototypes are meant to be stand-alone modules that can also be connected into a fully integrated solution.

The modules identified are as follows:

- Individual Eligibility and Exemption
- Individual Enrollment
- Small Employer Eligibility and Enrollment
- Health Benefit Plan and Navigator/Broker Certification and Display
- Provider Display
- Fund Aggregation and Payment
- Account Administration
- Mobile Application or Accessibility.

If the prototypes are accepted, the vendors are not guaranteed the funding to fully implement the prototypes. Minnesota declares that any implementation is contingent upon future federal funding and that it may implement a solution brought by another state or build an expanded solution from other state agencies.

OREGON

Oregon received $48 million in Early Innovator grant funding and plans to use the funds to create a modular, reusable IT solution with commercially available, off-the-shelf software. The Exchange development is being linked to Oregon's "Self Sufficiency Modernization" effort, which is a major overhaul of its eligibility systems used in Medicaid and cash assistance programs. The state plans to issue an RFP for a system integrator for this project.

MARYLAND

The Maryland Department of Health and Mental Hygiene has modified its Early Innovator work plan. The state noted in its quarterly planning grant report that it had ended the contract of a software developer for assistance in creating the Exchange. The state reports a revision to their work plan to accomplish the following:

- A review of current technical infrastructure currently available.
- A review of Federal standards for minimum function of an Exchange.
- A comprehensive GAP analysis.

The report notes that the state is not ready to contract with a vendor for IT Exchange development until it has a clearer understanding of current Federal Exchange requirements.

Maryland further noted that it has merged Exchange development activities into planned IT eligibility and enrollment projects. It is our understanding that one reason for the modification of the original Early Innovator proposal was to incorporate the needs of the human services system—also an issue of particular interest to Illinois. Maryland plans on issuing a Request for Information (RFI) to assess technical capabilities available in the private sector for "back office" IT functions of the Exchange, including premium billing.

MASSACHUSETTS/NEW ENGLAND

Massachusetts is the lead state in a consortium of New England states that are looking to build upon the Exchange infrastructure that Massachusetts has already implemented. They are seeking to create a flexible IT framework for Exchanges that can be used by other states. We recommend monitoring the activities of the consortium closely, since the core functionality is further ahead of most states, and the lead state shares with Illinois a similar commitment to implementing health reform. The project is underway with an initial focus on assessing whether the current Exchange IT components comport with the ACA rules and whether they will be reusable for other states.

NEW YORK

New York is proposing to use its Early Innovator grant funds to build from its new MMIS system and develop its Exchange products. The state is expected to release an RFP for this work soon. The original grant proposal had envisioned using the vendor who completed the new MMIS to also complete the Exchange work. Adding the RFP process will lengthen the timetable, which makes it less feasible for Illinois to leverage New York's results in a relevant timeframe. Also, the project may be too state-specific or too focused on that state's MMIS to be usable for Illinois.

WASHINGTON

While not an Early Innovator grantee, Washington is one of the states that have passed Exchange legislation. Washington is taking a two-phased approach for the development of its Exchange IT system. The first is to build the foundational architecture of the Exchange, and the second is to build the actual Exchange business functions, such as eligibility and enrollment.

WISCONSIN

Wisconsin is a federal Early Innovator grantee and received an award of over $37 million to build out its proposed website for all subsidized and non-subsidized health care programs. It is worth reviewing the core functionality, which has been deployed in a number of states and subsequently developed to accommodate the requirements of the ACA, closely.

4.2.5 Mandatory Regulatory Functions

This section addresses certain mandatory regulatory functions required under the ACA, primarily concerning insurance market regulation.

As central as the Illinois Exchange will be to health reform implementation in Illinois, it is important to emphasize that there are other key provisions of the ACA that do not apply only to Exchange plans or Exchange purchasers. The law substantially reshapes the insurance marketplace in Illinois and in doing so creates substantial new obligations on Illinois insurance regulators at DOI. While Exchanges are intended to help organize, facilitate, and simplify choices for consumers, the broader market reforms regulate rating, underwriting, and marketing rules to protect consumers and to rationalize competition in the market. A particularly important regulatory activity, premium rate reviews, must be performed by DOI and the Illinois Exchange is required to consider rate increases and the DOI rate review process in certifying Exchange plans. Given the new mandatory regulatory activities that the state will need to perform, this section is intended to summarize the regulatory resources outside of the Exchange that will be needed in Illinois.

- Staff and resources to administer and monitor risk adjustment, reinsurance, and risk corridor programs.

The ACA establishes three distinct risk-sharing programs that will be largely state-administered. Risk corridors apply to all qualified health plans. Reinsurance relates to the individual market, and risk adjustment will take place across the individual and small-group markets. As noted earlier in this section, Illinois should plan on hiring technical consultants for advice on risk adjustment and possibly external vendors who specialize in risk adjustment and who can work with the state on all three kinds of risk-sharing programs. External expertise will be needed, as well as skilled resources to manage that work within DOI. In particular, risk adjustment will require a substantial level of expertise and claims collection, data cleansing, manipulation, and analysis. In addition, all three risk-sharing programs will need to be closely monitored by DOI as a part of its existing examination and oversight functions.

- Resources to enhance consumer assistance and external review functions.

The ACA required the establishment of Consumer Assistance Programs (in Illinois, housed at DOI) and the institution of new standards that govern the processes insurers need to have in place for internal appeals and external review of grievances. These provisions create new obligations on DOI for which the state has accessed federal grant money. Even so, as Exchanges are implemented, new public outreach and enrollment strategies and pathways will be devised, and DOI will need to devote time and resources to ensure that it is aware of Exchange strategies and that its consumer assistance work is well-coordinated with that of the Exchange.

- Staff and resources to perform rate reviews and monitor minimum loss ratios.

The Illinois DOI has embraced and received federal support for a significant new regulatory activity, premium rate review. This is a significant undertaking for DOI, and one for which interaction with the Illinois Exchange will be required. The Exchange must consider a carrier's justification for premium increases in determining whether to qualify a plan for Exchange participation.

The rate-review process works in conjunction with new rules that set standards for the minimum amount of collected premiums that insurers spend on medical care, with associated monitoring obligations on DOI. The state should carefully monitor the availability of federal grant support for these activities, which are ongoing and substantial, and determine whether supplemental staff and resources are required.

- Support for other individual and group market reforms in the ACA.

ACA market reforms will involve the creation of rating and underwriting standards that are not as comprehensively enforced in Illinois as they will be when the reforms take effect. New market and pricing standards will involve state legislative changes and require ongoing regulatory action in Illinois. Finally, there is a wide range of regulatory requirements in the ACA, generally associated with its overall scheme to make insurance more standardized for consumers. These requirements, including the creation of uniform enrollment forms, standard definitions of benefits and coverage, and uniform reporting requirements are or will be the subject of NAIC-led federal standards. However, review, monitoring and enforcement will largely be a matter for states. If Illinois wants to prioritize strong and efficient enforcement of the ACA's market reforms, the state should carefully review whether existing DOI resources are adequate to perform its significantly enhanced role.

4.3 Financing the Exchange

This section estimates Exchange operating expenses, projects revenue based on a range of administrative fees and Exchange enrollment assumptions, and summarizes the detailed assumptions made in designing the model into 5-year budget projections for the Illinois Exchange.

SUMMARY

This section of the report provides a description of the estimated operating expenses that will be incurred by the Illinois Health Insurance Exchange during the five-year period from 2011 to 2015. These budget projections are intended to provide some guidance as to the type of expenses that the Exchange is likely to incur during this period, as well as to assist Illinois in determining the level of and sources for funding that will allow the Exchange to become self-sustaining by January 1, 2015, as required by the ACA. To facilitate this decision-making process, the projections described in this document estimate the actual dollar value for spending in both the start-up phase, 2011 through 2013, and for the first two years of operations, 2014 and 2015, as well as the total revenue that will be required to sustain the operations of the Exchange assuming low, moderate, and high take-up rates and membership. The major assumptions necessary to create the five-year budget projections are spelled out in the document. It is expected that such assumptions will evolve considerably, and the projections will become more refined and credible as Illinois progresses to the implementation phase and updated data becomes available, especially for key variable such as Exchange enrollment projections, premium levels, the cost of the IT design and build, and the level of outsourcing of core Exchange functions. For this draft, we have assumed a highly outsourced Exchange model.

Key Messages

The key financial modeling conclusions for Illinois to consider at this phase in their Exchange development process include the following:

1. Once operational, the cost of running the Exchange, in absolute dollars, is tied to the level of enrollment, meaning that an Exchange that serves more people will cost more in absolute dollars. However, the per-member cost of running the Exchange, as well as the Exchange's cost as a percentage of premiums, will decline as enrollment grows. This is because the Exchange will be able to spread its fixed costs across a larger membership base.

2. Although other financing options exist, the model presented below assumes that the Exchange will be financed through an assessment on participating Qualified Health Plans (QHPs). Based on a range of potential enrollment scenarios, we estimate that the assessment required to finance the cost of running the Exchange, as a percent of premium, will be between 2.24% and 3.39%. This compares favorably with existing benchmarks. For example, the assessment employed by the Health Connector in Massachusetts has historically been between 3% and 4%.

3. We estimate that the cost of the Exchange on a per-member per-month (PMPM) basis will be between $10.47 and $16.83 in 2014, and between $8.92 and $13.47 in 2015. The middle of this range is comparable to benchmark PMPM expense amounts. For example, in FY 2011, its fifth year of operations, the Health Connector in Massachusetts experienced PMPM expenses of $11.16, while performing fewer functions than the Illinois Exchange is expected to perform. PMPM costs in subsequent years are expected to be a function of enrollment, meaning that ongoing growth is expected to result in moderately lower PMPM cost levels than those seen in 2015.

4. We estimate that total start-up costs for the 2011-2013 period will be approximately $92.3 million; it is anticipated that these funds will be provided via a federal Exchange establishment grant. The majority of this cost (roughly 80%) is related to the development of Exchange IT systems. The assumptions related to this cost estimate are discussed later in this section.

For planning purposes, we have developed two high-level expense subtotals: (1) Systems Development and Support and (2) Program Operations. The Systems Development and Support subtotal represents the estimated expenses for the work required to develop and operate the Exchange's four major IT systems: (i) Eligibility Determination and Enrollment, (ii) Website, (iii) Customer Service, and (iv) Premium Billing. The Program Operations subtotal includes the remainder of the administrative expenses for operating the Exchange. Examples of items included in this category include Salary and Benefits for Exchange staff, Consulting and Professional Support, General and Administrative, Marketing and Advertising, and the estimated cost to fund the Exchange Navigator program.

For the start-up phase, fiscal years 2011 through 2013, we estimate a cumulative total expense of $92.3 million. The three years reflect only 27 months in total, as we have estimated that operations would not begin in earnest until October 2011, which is when Illinois is expected to begin receiving Level 1 Exchange establishment grant funding. The spending will be staggered such that approximately 6% will be incurred in 2011, 36% of the total by the end of 2012, and the remaining 59% of the budget in 2013. The Systems Development and Support subtotal is $75.0 million, or approximately 80% of the total, with $45.4 million estimated for the eligibility determination and enrollment system, $15.8 million for a website, $9.6 million to develop a customer service call center, and $4.1 million for a premium-billing system. The Program Operations subtotal during the start-phase is $18.9 million, with 94% of projected expenditures falling into three expense categories: (1) Facility and Related of $809,959; (2) Salary and Benefits of $8.4 million; and (3) Consulting and Professional Support of $7.0 million.

For the operating phase, beginning in 2014, we developed estimated expenses that scale based on projected enrollment in the Illinois Health Insurance Exchange. We first developed an expected baseline expense on a per-member per-month (PMPM) basis, using historical data from the Health Connector in Massachusetts, after it had moved beyond start-up. We then adjusted that experience for a larger anticipated enrollment scale in Illinois, other circumstances specific to Illinois, and functions required by the ACA. We then projected expenses for low, moderate, and high enrollment scenarios, and calibrated the necessary percentage surcharge on premiums to generate sufficient revenue to achieve approximate break-even in both 2014 and 2015. Our model also provides the ability to model slow,

moderate, or fast ramp up of membership in year 1. To employ a level of conservatism, the figures in this report assume a slow ramp-up of membership in year 1 of operations.

For enrollment, we used estimates for baseline Exchange enrollment developed by Deloitte Consulting. The estimates and the sources of data are described in greater detail later in the document. We then assumed a range of enrollment around this baseline to test the impact on Exchange costs in the event that enrollment is lower or higher than anticipated. The low scenario was developed to allow for a level of conservatism so that Illinois could evaluate the level of premium assessment necessary to achieve break-even should enrollment in the Exchange fall well below expectations, while the high scenario was developed to ensure that systems and processes are sufficiently scalable to support higher levels of enrollment.

We estimate expenses in 2014 to be approximately $16.83 PMPM in the low enrollment scenario, with a downward scale on a PMPM basis under the moderate and high enrollment scenarios, which are $12.34 and $10.47, respectively. Estimated 2014 expenses range from a low of $32.1 million to a high of $46.7 million. For 2015, the range of spending on a PMPM basis is estimated to be between $13.47 PMPM for the low scenario and $8.92 PMPM for the high scenario. The 2015 estimated range on a dollar basis is between $57.3 million for the low estimate and $88.6 million for the high estimate.

While alternative models for financing exist and are discussed below, the presumed financing structure assumed for modeling purposes is a percentage surcharge on QHPs participating in the Exchange as provided for in the ACA. The surcharge percentage required to approximate break-even during the first two years of operations (2014-2015) is estimated to be between 2.83% and 4.56% in 2014 and between 2.24% and 3.39% in 2015, depending on enrollment scenarios. The average surcharge percentage needed to approximate break even over the first two years in aggregate is estimated to be between 2.42% and 3.75%.

For modeling purposes, we have not allowed for a build-up of net assets, presuming the Exchange will target break-even performance in each year. However, our expectation is that HHS will allow for the development of some surplus while the Exchange transitions from being 100% federally funded during start-up to becoming fully self-sustaining in 2015 and will recognize that it will be prudent for the Exchange to develop moderately higher net asset totals to protect the entity's long term financial stability, supplemented with a line-of-credit or other means to raise revenue should enrollment estimates come in lower than expected, or actual expenses are higher than forecasted. 2014 will be a critical year in this regard, as the Exchange will be transitioning from grant funding for Exchange start up while beginning to generate its own revenue, and should explore options around developing a modest reserve from these revenue sources to weather future potential revenue volatility.

The estimates presented in this document are based on currently available data or, where data is incomplete, on proxy or benchmark data and will need to be refined as additional data becomes available or as material policy decisions are reached. Notwithstanding the preliminary nature of these projections, we believe that they do provide a useful baseline for the Illinois Health Insurance Exchange and state leaders in Illinois as they begin to develop their start-up and implementation planning and

prepare to initiate their request for additional Level 1 or Level 2 Exchange implementation funding from the United States Department of Health and Human Services (US HHS). Continuing to obtain establishment grants (Level 1 or Level 2) will be a critical next step for Illinois, and an initial financial blueprint should jumpstart the ongoing grant application process. The presentation of revenues, expenses, and net assets in this report is representative of a typical government financial statement preparation and does not conform with the eleven core areas identified by the Centers for Medicare and Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) funding opportunity announcement (FOA) released on January 20, 2011. Restating the expenses to conform to the FOA grant application can be performed upon request.

BACKGROUND INFORMATION

This budget projection and narrative document is derived from the Wakely Exchange Financial Implementation Model or ExFIM. The ExFIM is a proprietary model that incorporates variables unique to each state, such as total targeted market size, premium rates, contract size, and expected enrollment ramp-up; it has been developed to work at various levels of detail, depending on data availability and client preference. For example, total Exchange revenue can be based off a simple, high-level composite premium estimate for the entire Exchange population, or we can refine the revenue estimates as more detailed data become available and assumptions are refined for premium level and annual trend, take-up rates, and net enrollment through the Exchange separately for subsidized non-group and small group and for the unsubsidized non-group and small-group Exchange. Eventually, both enrollment and premiums should be projected at the actuarial levels of Platinum, Gold, Silver, Bronze, and Catastrophic. This level of premium build-up provides more precision in calibrating the assessment necessary to fund the Exchange, which can be updated for actual experience and used as a business planning tool once the Exchange is operational.

For the budget estimates contained in the document, we have made assumptions that will need to be refined working with Illinois staff. Our assumptions for certain key variables are included at the end of this report, and we have used publicly available data wherever possible. We have run only three volume-based scenarios. However, if desired, we can provide the results for a broader array of scenarios resulting from changing the key assumptions, and we can perform empirical research and analyses for the development of more refined assumptions.

BUDGET DEVELOPMENT METHODOLOGY

To develop the five-year administrative budget, this analysis is organized as follows:

1. Expense Estimates

    a. We developed different methodologies for expense estimates for the start-up phase, which we have defined as fiscal years 2011 through 2013, and for the first two years of operations, which are expected to be 2014 and 2015. The reason for this methodological difference is as follows:

i. For start-up expenses, we developed actual dollar estimates using a granular, bottom-up approach based on expected staff hiring, consultant costs, and related facility and administration expenses using our direct experience implementing the health benefit Exchange in Massachusetts, our Exchange operational and IT planning work in other states, factors unique to Illinois, and common available metrics for general and administrative costs. In translating our Massachusetts-based benchmark for Illinois-specific estimates, we have reflected (1) cost-of-living differences between Massachusetts and Illinois; (2) complexities in implementing the reform law in Massachusetts compared to provisions of the ACA; (3) available data specific to Illinois; (4) the short start-up phase in Massachusetts as compared to the longer start-up and implementation period Illinois will experience in developing the Illinois Health Insurance Exchange; and (5) the significant IT design and development that will be undertaken by Illinois as part of the implementation of the ACA.

ii. In estimating expenses for the first two years of operations, we developed a baseline per member per month (PMPM) expense estimate utilizing our experience and published data in Massachusetts. Additionally, as the size of the Exchange for the baseline data was approximately 200,000 covered lives, we have developed factors that allow the baseline PMPM to scale up or down depending on the low, moderate, or high enrollment scenarios based on the relative share of fixed and variable costs. This allows for a more refined expense estimate correlated to the size of the Exchange and allows for the assessment of cost at various assumed levels of enrollment.

iii. We have also developed the functionality to adjust expenses using estimated contract size to convert expense estimates to a per subscriber per month (PSPM) basis, which will be important in assessing the impact of utilizing insurance producers as well as any future analyses that separate out the SHOP Exchange functionality from the individual Exchange.

2. Revenue Estimates

In developing revenue estimates for the Illinois Health Insurance Exchange, we incorporated the following elements into the ExFIM model:

a. Potential total size of enrollment through the Illinois Health Insurance Exchange (the source and assumptions used to estimate enrollment are discussed in the next section, “Enrollment Estimates”)

b. Estimated Illinois Health Insurance Exchange enrollment by each of the precious metal tiers and the catastrophic plan.

c. Estimated premium levels at each of the precious metal tiers.

d. Assumed that funding would be an assessment, expressed as a percentage of total premium revenue, on Exchange-only enrollment. For a discussion of potential additional funding arrangements for the Exchange that should be considered, please refer to the section titled Alternative Exchange Funding Options further in this report.

To estimate the premium levels for each of the precious metal tiers, we used premium data provided by Illinois carriers. We received 2010 premium data from carriers accounting for approximately 85% of the small- and non-group market in Illinois, and, of that market share, the data provided represented approximately 82% of the covered lives for the carriers polled, or approximately 70% of the small- and non-group market in total. The data was provided at the product level and arrayed by relative actuarial values in five percentage point increments from greater than 50% to 90% and above. We blended this more granular information to arrive at premium averages at the precious metal tier level for both small and non-group. In some cases, minor adjustments were made to correct for data irregularities and/or small cell sizes. Finally, an annual premium inflation factor of 8% compounded was applied to project these premium values from 2010 to 2014 and 2015.

In the following Tables, the Non-Group columns combine our take-up assumptions for the individual market, existing public programs, and uninsured populations.

Table 8. Estimated Premium Level by Precious Metal Tier and Market Segment

	Estimated Premium Levels – PMPM			
	CY 2014		CY 2015	
	Non Group	Small Group	Non Group	Small Group
Platinum (90% + AV)	$ 685.93	$ 669.60	$ 740.80	$ 723.17
Gold (80% - 90% AV)	$ 454.67	$ 533.84	$ 491.05	$ 576.55
Silver (70% - 80% AV)	$ 328.46	$ 469.56	$ 354.73	$ 507.13
Bronze (60% - 70% AV)	$ 283.94	$ 453.63	$ 306.66	$ 489.92
Catastrophic (<60% AV)	$ 208.11	$ 364.61	$ 224.75	$ 393.77
Total	$ 283.02	$ 499.00	$ 305.67	$ 538.92

Table 9. Estimated Enrollment Distribution by Precious Metal Tier

	Exchange Enrollment Mix - (Moderate Enrollment Scenario)			
	CY 2014		CY 2015	
	Non Group	Small Group	Non Group	Small Group
Platinum (90% + AV)	-	745	-	1,015
Gold (80% - 90% AV)	3,370	7,450	4,890	10,150
Silver (70% - 80% AV)	304,985	110,260	442,545	150,220
Bronze (60% - 70% AV)	26,960	29,800	39,120	40,600
Catastrophic (<60% AV)	1,685	745	2,445	1,015
Total	337,000	149,000	489,000	203,000

3. Membership estimates

In order to appropriately estimate the potential range of revenue and expenses of the Illinois Health Insurance Exchange, we developed a budget model that allows for various enrollment scenarios. Our approach is based on the following variables, which can be modified as more data becomes available.

a. Total baseline estimated enrollment for the non-group and small group markets based on Deloitte population model estimates.

b. Average contract size of each market.

c. Average member duration for each market (allows for the calculation of annual subscriber months—i.e., the number of months a subscriber has been enrolled in a QHP for a given year).

d. Estimates of enrollee take up by each of the precious metal tiers (Platinum, Gold, Silver, and Bronze) and the catastrophic plan.

Table 10. Estimated Total Exchange Enrollment by Sub-Population (1,000s)

	2014			2015		
	Low	Moderate	High	Low	Moderate	High
Small Group	89	149	209	122	203	284
Non-Group	202	337	472	293	489	685
Total	**292**	**486**	**680**	**415**	**692**	**969**

Table 11. Exchange Take Up and Enrollment Scenarios by Sub-Population

	CY 2014			CY 2015		
	Low	Moderate	High	Low	Moderate	High
Market Mix:						
Non Group	69.34%	69.34%	69.34%	70.66%	70.66%	70.66%
Small Group	30.66%	30.66%	30.66%	29.34%	29.34%	29.34%
Total Enrollment	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
Members:						
Non Group	202,200	337,000	471,800	293,400	489,000	684,600
Small Group	89,400	149,000	208,600	121,800	203,000	284,200
Total Members	**291,600**	**486,000**	**680,400**	**415,200**	**692,000**	**968,800**
Subscribers:						
Non Group	124,815	208,025	291,235	181,111	301,852	422,593
Small Group	45,381	75,635	105,888	61,827	103,046	144,264
Total Subscribers	**170,196**	**283,659**	**397,123**	**242,939**	**404,898**	**566,857**
Wtd. Avg. Contract Size	**1.71**	**1.71**	**1.71**	**1.71**	**1.71**	**1.71**
Member Months:						
Non Group	1,325,792	2,209,653	3,093,515	3,008,666	5,014,443	7,020,220
Small Group	586,181	976,968	1,367,756	1,248,996	2,081,660	2,914,325
Total Member Months	**1,911,973**	**3,186,622**	**4,461,270**	**4,257,662**	**7,096,103**	**9,934,545**
Subscriber Months:						
Non Group	818,390	1,363,984	1,909,577	1,857,201	3,095,335	4,333,469
Small Group	297,554	495,923	694,292	634,008	1,056,680	1,479,353
Total Subscriber Months	**1,115,944**	**1,859,907**	**2,603,869**	**2,491,209**	**4,152,016**	**5,812,822**

EXPENSE CATEGORIES DETAIL

The table below identifies the various expense line items estimated and the key assumptions we have developed for the start-up period. As noted previously, the start-up period was developed on a dollar-basis, utilizing baseline information from our experience in standing up the Exchange in Massachusetts and our work in other states in determining the level of spending in developing an Exchange under ACA, adjusted where appropriate for circumstances unique to Illinois and our understanding of Exchange requirements under ACA relative to the baseline.

A key driver of the start-up costs of the Exchange, accounting for roughly 80% of the cost during the 2011-2013 period, is the development of the core IT systems. The cost estimates included here assume a significant new development costs, consistent both with the plan for a substantial eligibility and enrollment development project and our findings that, outside of that integrated eligibility system, little existing state infrastructure could be leveraged to perform Exchange-specific functions. Because detailed specifications have not been developed for the Illinois Exchange, we relied upon benchmark information from other states that are similar to Illinois in size and expected IT build requirements. As

greater detail becomes available about the IT needs of the Exchange, the IT development cost estimates can become more refined.

Table 12. Detailed Expense Line Items, Type of Expense, and Assumptions – Start up period:

Expense Line Item	Key Assumptions
Eligibility Determination, Verification and Enrollment	Expenses used for this report were based on a detailed IT plan for a state with comparable features to Illinois in terms of size and expected IT build and complexity and allocated based on the share of each system associated with the development of Massachusetts Exchange. IT budget assumes a leveraged model, in which acquired systems would be configured and customized to meet the needs of Illinois, combined with the leveraging of solutions from early innovator states and the federal government.
Website	Expenses used for this report were based on a detailed IT plan for a state with comparable features to Illinois in terms of size and expected IT build and complexity and allocated based on the share of each system associated with the development of Massachusetts Exchange. IT budget assumes a leveraged model, in which acquired systems would be configured and customized to meet the needs of Illinois, combined with the leveraging of solutions from early innovator states and the federal government.
Customer Service/Call Center	Expenses used for this report were based on a detailed IT plan for a state with comparable features to Illinois in terms of size and expected IT build and complexity and allocated based on the share of each system associated with the development of Massachusetts Exchange. IT budget assumes a leveraged model, in which acquired systems would be configured and customized to meet the needs of Illinois, combined with the leveraging of solutions from early innovator states and the federal government.
Premium Billing	Expenses used for this report were based on a detailed IT plan for a state with comparable features to Illinois in terms of size and expected IT build and complexity and allocated based on the share of each system associated with the development of Massachusetts Exchange. IT budget assumes a leveraged model, in which acquired systems would be configured and customized to meet the needs of Illinois, combined with the leveraging of solutions from early innovator states and the federal government.
IT Infrastructure	This represents cost primarily for general IT services required by Exchange employees, such as data hosting, computer equipment, and software licensing. In operational period, IT infrastructure also includes the need for expanded data warehousing and analytical capabilities to support risk adjustment, appeals, and reporting.
Marketing and Advertising	Represents Marketing and Advertising expense for a commercial public relations firm.
Consulting and Professional	Represents purchased services primarily for auditing function, legal, actuarial, and independent contractors for short-term subject matter expertise.

Expense Line Item	Key Assumptions
Salary and Benefits	Assumes staff ramps up to approximately 48 FTEs by 2013 at an average salary of approximately $85,000 in 2013, fringe factor of 35%, and annual inflation assumed at 3% per year. Salary and fringe estimates were based on employee salary and fringe information obtained from Illinois HFS. The Wakely staffing model divides staff into four levels – (1) Staff (2) Manager (3) Director and (4) Executive. For benchmarking purposes, the Kidcare Supervisor (salary ~ $75,000) indicated by HFS was assumed to be equivalent to the Wakely Manager level in most instances, and a range up and down was developed for Staff, Directors, and Executives. For Senior Executive salaries, we assumed that, to attract highly qualified individuals, the Exchange would provide salaries at a level higher than the state employee payroll but lower than executive leaders earn in the private insurance industry. The range for executive salaries assumed in the model is between $165,000 and $235,000. To place this salary level in context, a review of executive compensation at selected Illinois insurance carriers indicates a range of compensation at the Vice President level and above between $232,000 and $1.8 million.
General and Administrative	Represents expenses primarily for office supplies, postage, printing, travel reimbursements, dues and subscriptions, etc. Where possible, we used budget assumptions from Illinois HFS (e.g., furniture and fixtures, telecommunications).
Facility and Related	Represents Rent and Utilities for approximately 50 staff, plus conference rooms, office furniture and fixtures, and property and casualty insurance.
Appeals Program	Assumes costs for development of an appeals program are incurred during the first year of operations, 2014.

One additional expense category, applicable to the Exchange starting in 2014, merits special comment. This is the cost of Navigators. For Navigators, we used a fairly modest estimate of approximately $2.0 million to $4.0 million, which was derived, based on a baseline from a comparable program utilized in Massachusetts and increased to account for (a) the increased complexities of the ACA requirements and (b) the larger scale of population in Illinois. We assume that Navigators will shoulder a considerable responsibility for outreach, education, and enrolling the (mostly subsidized) non-group population, a function that will be supported by the Exchanges marketing and outreach expenditures.

Table 13. Navigator Program Expenses

Expense Line Item	Key Assumptions
Navigators	Developed a baseline PMPM amount utilizing the experience in Massachusetts in using consumer advocacy groups to assist the subsidized population in understanding and navigating the health care system. Adjusted baseline to account for enhanced ACA requirements and other differences unique to Illinois. The Massachusetts Exchange was one of a number of funding streams for "Navigators" in that state, so the figures represented in this budget were adjusted to reflect this difference.

ALTERNATIVE FUNDING OPTIONS FOR EXCHANGE

State-based Exchanges are expected under ACA to be self-sustaining as of January 2015, and federal grants are available to finance start-up administrative costs, including part of the first-year costs of operations (2014). On a steady-state basis, ACA legislation anticipates that state Exchanges will levy a surcharge or assessment on Qualified Health Plans (QHP's) to support the Exchange's operations. As indicated above, employing such a methodology would provide for self-sustainability, with a carrier assessment range of between 2.42% and 3.75% of premium. Please note that this level of assessment does not take into account the potential role of insurance producers and whether significant volume of enrollment is drawn from producers. As was indicated earlier, producer fees, when added to the administrative expense, could have a material impact on the overall cost as a percentage of the premium and should be considered when considering the total cost of the Exchange.

Based on the relatively large expected volume of enrollment, a relatively low carrier surcharge of this kind appears likely to provide sufficient revenue to sustain Exchange operations. However, the level of assessment that is tolerable to stakeholders in Illinois will dictate whether this surcharge alone is sufficient, and it may be prudent for Illinois to explore alternative or supplemental funding levels. In addition to the conventional funding approach of an assessment on QHP enrollment through the Exchange, there are a number of alternative funding options that can work in combination with a QHP assessment or expand the QHP assessment across a larger part of the health insurance market. The discussion that follows identifies a number of such alternatives and where additional financial modeling will be necessary.

1. Leveraging the State Medicaid Program. Some states have elected to utilize the Exchange to determine eligibility for Medicaid and other public subsidized programs. In this arrangement, the Exchange incurs a cost that can be charged to the state's Medicaid program. The Medicaid program can offset this cost utilizing its federal administrative cost match rate, thus lowering the total cost to the state of Illinois. In order to quantify the potential revenue accruing to the Exchange for providing this service, we will need to work with the appropriate state and federal personnel to develop a cost allocation methodology. The methodology will need to quantify areas such as: (a) the cost for the Exchange for determining eligibility; (b) the number of Medicaid applications processed by the Exchange; (3) the number of customer service calls

coming through the Exchange, but redirected to the Medicaid program; (4) any anticipated notifications sent to Medicaid enrollees by the Exchange; and (5) federal guidance.

In addition, by working closely with the Medicaid program, the Exchange and Medicaid program could potentially leverage scale economies such that the Exchange could assume certain additional administrative functions, minimizing redundant resources and providing for additional funding sources for the Exchange. Areas for Illinois to explore in this area include, member notifications, website integration, and call center functions.

In a similar vein, should the Exchange adopt the opposite approach of utilizing existing state eligibility determination systems, it may be able to take advantage of similar economies of scale to reduce its overall administrative cost footprint. This approach could also yield significant savings in the IT development and start-up phases by leveraging existing technology.

2. Exchange as a purchasing agent. Because the Exchange will be organizing the purchase of health insurance for a large and diverse population, the opportunity could exist to perform a similar function on behalf of other state programs such as the state employees plan and Medicaid Managed Care. Providing this service could result in a strong ongoing source of revenue for the Exchange. One of the core missions of the Exchange is to organize the purchase of health insurance for the individual and small-group markets. In performing this function, the Exchange will be developing core expertise in working with health insurance carriers, developing benefit designs, negotiating contracts, and influencing the price of insurance, all critical functions for which the entity could derive revenue from its "clients", i.e., other state agencies. This alternative source of funding has the additional promise of lowering the overall cost to the state, as the resources required of the state employee's plan or Medicaid Managed Care to support the purchasing function can be redirected to other functions, thereby lowering the administrative cost for those programs.

3. Broadening the QHP assessment. Another approach to consider is the expansion of the QHP assessment to apply to all members of a QHP, or to go even further, an assessment across all health insurance carriers whether or not they are participating in the Exchange. This may be controversial, the latter more so than the former, but should still be an option for Illinois to consider. The policy justification for a broader assessment is that the Exchange serves a role that benefits the entire market. The Exchange, by making coverage more affordable and accessible, reduces uncompensated care costs and limits the premium impact associated with unreimbursed care.

   In broadening the enrollment to be assessed, the Exchange can project with a much higher degree of certainty its funding revenue. This would be especially important during the first few years of operations, when the expense load may be heavy due to start up and the revenue yield is uncertain as the Exchange transitions from federal funding to private market funding. Broadening the assessment base to a larger number of enrollees would allow the state to garner the same revenue from a smaller assessment per enrollee.

This approach would help to dampen the desire of carriers to enroll members directly, thereby avoiding paying the Exchange assessment, and could serve to encourage Exchange participation. Finally, the ACA requires that federal and state taxes and licensing and regulatory fees be excluded from premium revenue for carriers when they calculate their medical loss ratio (MLR). As a result of this provision, carriers may be more willing to go along with a broad-based assessment.

4. Service fee on consumers. Yet another approach is to charge consumers, individuals, and small employers who are purchasing health insurance through the Exchange a modest service fee. Although not as consumer friendly as other options that are available, this has the benefit of being transparent and user-based; it is currently in use in the Utah's state-based Exchange. In some markets such as Massachusetts, small employers are charged an add-on fee in addition to the monthly premium.

5. Other. There are additional mechanisms for the Exchange to generate revenue in addition to an assessment on QHP's. For example, the Exchange could decide to extend its product line beyond health insurance and begin selling complementary products such as dental, life insurance, and long-term care insurance. Alternatively, the Exchange could sell advertising space on its website. Yet another approach could be a dedicated sin-tax such as on tobacco, which would provide for dedicated revenue stream to the Exchange. Some of these ideas could be very controversial, and our inclusion of these concepts is not an endorsement of their viability, but simply to point out that alternative sources of funding could be sought or created.

Table A – Budget Pro-Forma: Low enrollment estimates; 4.56% Administrative Fee for 2014; 3.39% for 2015.

Illinois Health Insurance Exchange
Five-Year Projections
Administrative Budget

	Start Up			*Operations*	
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Members	0	0	0	291,600	415,200
Member Months	0	0	0	1,911,973	4,257,662
Total Exchange Premiums	$ -	$ -	$ -	$ 706,093,101	$ 1,691,923,983
Operating revenues:					
QHP Administrative Fee	$ -	$ -	$ -	$ 32,197,845	$ 57,356,223
User Fees				$ -	$ -
HHS Grant Funding - Exchange Est.	$ 5,139,789	$ 33,152,506	$ 54,007,715	$ -	$ -
Total operating revenue	$ 5,139,789	$ 33,152,506	$ 54,007,715	$ 32,197,845	$ 57,356,223
Operating expenses:					
Eligibility Determination & Enrollment	$ 2,270,642	$ 15,894,495	$ 27,247,706	$ 5,712,616	$ 11,476,969
Website	$ 791,284	$ 5,538,991	$ 9,495,413	$ 1,395,448	$ 2,803,534
Customer Service	$ 481,651	$ 3,371,560	$ 5,779,817	$ 7,413,319	$ 14,893,776
Premium Billing	$ 206,422	$ 1,444,954	$ 2,477,064	$ 3,205,170	$ 6,439,368
Subtotal - Systems Dev. & Support	**$ 3,750,000**	**$ 26,250,000**	**$ 45,000,000**	**$ 17,726,553**	**$ 35,613,647**
IT Infrastructure	$ 122,700	$ 70,400	$ 78,900	$ 632,312	$ 1,270,351
Marketing & Advertising	$ 20,000	$ 80,000	$ 100,000	$ 1,831,526	$ 3,679,639
Consulting & Professional	$ 810,931	$ 3,243,722	$ 2,967,976	$ 1,700,703	$ 3,416,807
Salary & Benefits	$ 295,988	$ 2,975,670	$ 5,097,253	$ 6,790,550	$ 7,194,449
General & Administrative	$ 52,629	$ 246,166	$ 327,716	$ 352,627	$ 506,637
Facility & Related	$ 87,542	$ 286,547	$ 435,870	$ 566,901	$ 1,138,936
Appeals Program	$ -	$ -	$ -	$ 1,068,390	$ 2,146,456
Broker Commissions	$ -	$ -	$ -	$ -	$ -
Navigators	$ -	$ -	$ -	$ 1,504,468	$ 2,398,857
Subtotal - Program Operations	**$ 1,389,789**	**$ 6,902,506**	**$ 9,007,715**	**$ 14,447,476**	**$ 21,752,133**
Total Operating	**$ 5,139,789**	**$ 33,152,506**	**$ 54,007,715**	**$ 32,174,030**	**$ 57,365,780**
	6%	**36%**	**59%**		
Nonoperating revenue:					
Investment income	$ -	$ -	$ -	$ -	$ -
Total nonoperating revenue	$ -	$ -	$ -	$ -	$ -
Increase in net assets	$ -	$ (0)	$ 0	$ 23,816	$ (9,557)
Total net assets - beginning of fiscal year	$ -	$ -	$ (0)	$ 0	$ 23,816
Total net assets - end of fiscal year	$ -	$ (0)	$ 0	$ 23,816	$ 14,259

Table B - Budget Pro-Forma: Moderate enrollment estimates; 3.34% Administrative Fee for 2014; 2.59% for 2015.

Illinois Health Insurance Exchange
Five-Year Projections
Administrative Budget

	Start Up			*Operations*	
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Members	0	0	0	486,000	692,000
Member Months	0	0	0	3,186,622	7,096,103
Total Exchange Premiums	$ -	$ -	$ -	$ 1,178,602,875	$ 2,819,873,305
Operating revenues:					
QHP Administrative Fee	$ -	$ -	$ -	$ 39,323,179	$ 73,041,573
User Fees				$ -	$ -
HHS Grant Funding - Exchange Est.	$ 5,139,789	$ 33,152,506	$ 54,007,715	$ -	$ -
Total operating revenue	$ 5,139,789	$ 33,152,506	$ 54,007,715	$ 39,323,179	$ 73,041,573
Operating expenses:					
Eligibility Determination & Enrollment	$ 2,270,642	$ 15,894,495	$ 27,247,706	$ 7,215,427	$ 14,990,817
Website	$ 791,284	$ 5,538,991	$ 9,495,413	$ 1,762,547	$ 3,661,879
Customer Service	$ 481,651	$ 3,371,560	$ 5,779,817	$ 9,363,531	$ 19,453,732
Premium Billing	$ 206,422	$ 1,444,954	$ 2,477,064	$ 4,048,350	$ 8,410,878
Subtotal - Systems Dev. & Support	**$ 3,750,000**	**$ 26,250,000**	**$ 45,000,000**	**$ 22,389,856**	**$ 46,517,307**
IT Infrastructure	$ 122,700	$ 70,400	$ 78,900	$ 798,654	$ 1,659,289
Marketing & Advertising	$ 20,000	$ 80,000	$ 100,000	$ 2,313,343	$ 4,806,216
Consulting & Professional	$ 810,931	$ 3,243,722	$ 2,967,976	$ 2,148,104	$ 4,462,915
Salary & Benefits	$ 295,988	$ 2,975,670	$ 5,097,253	$ 7,314,712	$ 8,322,752
General & Administrative	$ 52,629	$ 246,166	$ 327,716	$ 392,779	$ 600,518
Facility & Related	$ 87,542	$ 286,547	$ 435,870	$ 716,035	$ 1,487,638
Appeals Program	$ -	$ -	$ -	$ 1,349,450	$ 2,803,626
Broker Commissions	$ -	$ -	$ -	$ -	$ -
Navigators	$ -	$ -	$ -	$ 1,900,246	$ 2,381,311
Subtotal - Program Operations	**$ 1,389,789**	**$ 6,902,506**	**$ 9,007,715**	**$ 16,933,323**	**$ 26,524,266**
Total Operating	**$ 5,139,789**	**$ 33,152,506**	**$ 54,007,715**	**$ 39,323,179**	**$ 73,041,573**
	6%	**36%**	**59%**		
Nonoperating revenue:					
Investment income	$ -	$ -	$ -	$ -	$ -
Total nonoperating revenue	$ -	$ -	$ -	$ -	$ -
Increase in net assets	$ -	$ (0)	$ 0	$ -	$ -
Total net assets - beginning of fiscal year	$ -	$ -	$ (0)	$ 0	$ 0
Total net assets - end of fiscal year	$ -	$ (0)	$ 0	$ 0	$ 0

Table C Budget Pro-Forma: High enrollment estimates; 2.83% Administrative Fee for 2014; 2.24% for 2015.

Illinois Health Insurance Exchange
Five-Year Projections
Administrative Budget

	Start Up			*Operations*	
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Members	0	0	0	680,400	968,800
Member Months	0	0	0	4,461,270	9,934,545
Total Exchange Premiums	$ -	$ -	$ -	$ 1,650,044,026	$ 3,947,822,627
Operating revenues:					
QHP Administrative Fee	$ -	$ -	$ -	$ 46,713,795	$ 88,595,438
User Fees				$ -	$ -
HHS Grant Funding - Exchange Est.	$ 5,139,789	$ 33,152,506	$ 54,007,715	$ -	$ -
Total operating revenue	$ 5,139,789	$ 33,152,506	$ 54,007,715	$ 46,713,795	$ 88,595,438
Operating expenses:					
Eligibility Determination & Enrollment	$ 2,270,642	$ 15,894,495	$ 27,247,706	$ 8,718,238	$ 18,504,666
Website	$ 791,284	$ 5,538,991	$ 9,495,413	$ 2,129,646	$ 4,520,224
Customer Service	$ 481,651	$ 3,371,560	$ 5,779,817	$ 11,313,744	$ 24,013,688
Premium Billing	$ 206,422	$ 1,444,954	$ 2,477,064	$ 4,891,530	$ 10,382,389
Subtotal - Systems Dev. & Support	**$ 3,750,000**	**$ 26,250,000**	**$ 45,000,000**	**$ 27,053,158**	**$ 57,420,966**
IT Infrastructure	$ 122,700	$ 70,400	$ 78,900	$ 964,996	$ 2,048,226
Marketing & Advertising	$ 20,000	$ 80,000	$ 100,000	$ 2,795,160	$ 5,932,794
Consulting & Professional	$ 810,931	$ 3,243,722	$ 2,967,976	$ 2,595,506	$ 5,509,023
Salary & Benefits	$ 295,988	$ 2,975,670	$ 5,097,253	$ 8,080,342	$ 9,062,822
General & Administrative	$ 52,629	$ 246,166	$ 327,716	$ 432,930	$ 694,399
Facility & Related	$ 87,542	$ 286,547	$ 435,870	$ 865,169	$ 1,836,341
Appeals Program	$ -	$ -	$ -	$ 1,630,510	$ 3,460,796
Broker Commissions	$ -	$ -	$ -	$ -	$ -
Navigators	$ -	$ -	$ -	$ 2,296,024	$ 2,630,071
Subtotal - Program Operations	**$ 1,389,789**	**$ 6,902,506**	**$ 9,007,715**	**$ 19,660,637**	**$ 31,174,472**
Total Operating	**$ 5,139,789**	**$ 33,152,506**	**$ 54,007,715**	**$ 46,713,795**	**$ 88,595,438**
	6%	**36%**	**59%**		
Nonoperating revenue:					
Investment income	$ -	$ -	$ -	$ -	$ -
Total nonoperating revenue	$ -	$ -	$ -	$ -	$ -
Increase in net assets	$ -	$ (0)	$ 0	$ -	$ -
Total net assets - beginning of fiscal year	$ -	$ -	$ (0)	$ 0	$ 0
Total net assets - end of fiscal year	$ -	$ (0)	$ 0	$ 0	$ 0

Table D. PMPM Cost Table Low enrollment estimates; 4.56% Administrative Fee for 2014; 3.39% for 2015

	PMPM Spending	
	FY 2014	FY 2015
Members		
Member Months		
Total Exchange Premiums	$ 369.30	$ 397.38
Operating revenues:		
QHP Administrative Fee	$ 16.84	$ 13.47
User Fees	$ -	$ -
HHS Grant Funding - Exchange Est.	$ -	$ -
Total operating revenue	$ 16.84	$ 13.47
Operating expenses:		
Eligibility Determination & Enrollment	$ 2.99	$ 2.70
Website	$ 0.73	$ 0.66
Customer Service	$ 3.88	$ 3.50
Premium Billing	$ 1.68	$ 1.51
Subtotal - Systems Dev. & Support	**$ 9.27**	**$ 8.36**
IT Infrastructure	$ 0.33	$ 0.30
Marketing & Advertising	$ 0.96	$ 0.86
Consulting & Professional	$ 0.89	$ 0.80
Salary & Benefits	$ 3.55	$ 1.69
General & Administrative	$ 0.18	$ 0.12
Facility & Related	$ 0.30	$ 0.27
Appeals Program	$ 0.56	$ 0.50
Broker Commissions	$ -	$ -
Navigators	$ 0.79	$ 0.56
Subtotal - Program Operations	**$ 7.56**	**$ 5.11**
Total Operating	**$ 16.83**	**$ 13.47**

Table E. PMPM Cost Table Moderate enrollment estimates; 3.34% Administrative Fee for 2014; 2.59% for 2015

	PMPM Spending	
	FY 2014	FY 2015
Members		
Member Months		
Total Exchange Premiums	$ 369.86	$ 397.38
Operating revenues:		
QHP Administrative Fee	$ 12.34	$ 10.29
User Fees	$ -	$ -
HHS Grant Funding - Exchange Est.	$ -	$ -
Total operating revenue	$ 12.34	$ 10.29
Operating expenses:		
Eligibility Determination & Enrollment	$ 2.26	$ 2.11
Website	$ 0.55	$ 0.52
Customer Service	$ 2.94	$ 2.74
Premium Billing	$ 1.27	$ 1.19
Subtotal - Systems Dev. & Support	**$ 7.03**	**$ 6.56**
IT Infrastructure	$ 0.25	$ 0.23
Marketing & Advertising	$ 0.73	$ 0.68
Consulting & Professional	$ 0.67	$ 0.63
Salary & Benefits	$ 2.30	$ 1.17
General & Administrative	$ 0.12	$ 0.08
Facility & Related	$ 0.22	$ 0.21
Appeals Program	$ 0.42	$ 0.40
Broker Commissions	$ -	$ -
Navigators	$ 0.60	$ 0.34
Subtotal - Program Operations	**$ 5.31**	**$ 3.74**
Total Operating	**$ 12.34**	**$ 10.29**
Nonoperating revenue:		
Investment income	$ -	$ -
Total nonoperating revenue	$ -	$ -
Increase in net assets	$ -	$ -
Total net assets - beginning of fiscal year	$ 0.00	$ 0.00
Total net assets - end of fiscal year	$ 0.00	$ 0.00

Table F. PMPM Cost Table High enrollment estimates; 2.83% Administrative Fee for 2014; 2.24% for 2015

	PMPM Spending	
	FY 2014	FY 2015
Members		
Member Months		
Total Exchange Premiums	$ 369.86	$ 397.38
Operating revenues:		
QHP Administrative Fee	$ 10.47	$ 8.92
User Fees	$ -	$ -
HHS Grant Funding - Exchange Est.	$ -	$ -
Total operating revenue	$ 10.47	$ 8.92
Operating expenses:		
Eligibility Determination & Enrollment	$ 1.95	$ 1.86
Website	$ 0.48	$ 0.46
Customer Service	$ 2.54	$ 2.42
Premium Billing	$ 1.10	$ 1.05
Subtotal - Systems Dev. & Support	**$ 6.06**	**$ 5.78**
IT Infrastructure	$ 0.22	$ 0.21
Marketing & Advertising	$ 0.63	$ 0.60
Consulting & Professional	$ 0.58	$ 0.55
Salary & Benefits	$ 1.81	$ 0.91
General & Administrative	$ 0.10	$ 0.07
Facility & Related	$ 0.19	$ 0.18
Appeals Program	$ 0.37	$ 0.35
Broker Commissions	$ -	$ -
Navigators	$ 0.51	$ 0.26
Subtotal - Program Operations	**$ 4.41**	**$ 3.14**
Total Operating	**$ 10.47**	**$ 8.92**
Nonoperating revenue:		
Investment income	$ -	$ -
Total nonoperating revenue	$ -	$ -
Increase in net assets	$ -	$ -
Total net assets - beginning of fiscal year	$ 0.00	$ 0.00
Total net assets - end of fiscal year	$ 0.00	$ 0.00

GENERAL OBSERVATIONS – FINANCE

In addition to the development of the five-year administrative budget projections, we have added below additional context for Illinois's consideration in moving forward with their forecasts and estimations. This information is supplementary to the budget analysis above and is intended to help frame certain issues experienced by the authors in standing up an Exchange model. It may be helpful to the staff of the Illinois Exchange implementation team as they begin developing the Exchange business plan, infrastructure, and grant application budgets:

1. Negotiate vendor contracts and provisions within contract terms for scalability of costs.

   Because of the number of systems that will most likely need to be developed for the Illinois Health Insurance Exchange, a major function will be procuring the services of a number of vendors. In doing so, it is important for the Exchange to dedicate resources to negotiate key legal and financial terms and to allow for ongoing vendor management and oversight once a contract has been signed. This area will be a major spending source for the Exchange and can be an area of inefficiency, misunderstandings, and excessive budget overruns. Areas where the Exchange may want to focus include negotiating financial terms that are scalable, such as on a per member or subscriber basis with floors and ceilings to protect the vendor from losses and therefore poor performance, as well as protecting the Exchange from overpayments driven by higher than expected enrollment.

2. Weigh carefully the pros and cons of augmenting Exchange staff with professional support.

   Although the use of short-term professional support staff can be costly, it will be important for the Exchange to consider the ability to support fulltime staff with knowledgeable external help, especially during the start-up phase of the Exchange. To meet the challenging timelines and find and hire personnel with the multitude of skills required of Exchange staff, the Exchange should develop a cost/benefit analysis when considering the hiring of short-term professional staff. Also, as a new entity responsible for implementing a complex law, there may be short-term resource need which can be more cost-effectively resourced by contracting for a subject matter expert short-term, rather than hiring the expertise—only to discover that yet a different set of skills is needed once the original issue has been researched and addressed.

3. Budget discipline will be a critical core competency, especially during the beginning of operations.

   The requirement of the Exchange to be a self-sustaining organization requires a high degree of fiscal responsibility and management. This is especially true if the source of revenue for the Exchange is tied to the level of enrollment in the Exchange. Key attributes of a budget model will be timely updates of both spending and enrollment projections, knitted closely with vendor negotiations and related financial terms. Developing a budget system that not only tracks actual expenses but is adept at forecasting both expenses and enrollment will allow the Exchange to

make informed decisions regarding the level of assessment, the scale and scope of vendor contracts, and the maintenance of effective cash flow to meet the ongoing business obligations.

4. Strong management reporting and financial systems.

   Closely tied to the budget discipline function noted at #3 above, the development of the Exchange infrastructure needs to include a very strong system of management and financial reporting. Often overlooked when developing a start-up organization, the ability for the Exchange to have a strong accounting system, human resource function, accounts receivable and payable, consistent contract terms and obligations, cash flow management, and a host of other functions and data needs will be critical for the Exchange to be a strong fiduciary of the state and to convey a sense of competency for market participants looking to work with the Exchange.

5. Need to carefully manage expected spending in 2014/2015 as federal funding sunsets and the Exchange is expected to be self-sustaining.

   This will be a particularly important timeframe from a financial perspective. Presumably, a significant amount of expenses will be committed to vendors by the Exchange as it rolls into operations in 2014. By year-end 2014, federal funding will cease, and it is expected that the Exchange will be generating enough revenue in 2015 to cover its operating expenses. Key areas on which the Exchange should focus include:

   a. Will US HHS allow the Exchange to develop some level of surplus during start up and the first year of operations?

   b. What is the range of enrollment estimates, and can the Exchange meet its expense obligations at the low end of the enrollment range?

   c. If enrollment is ramping up more slowly than expected, can vendor payment terms be adjusted?

   d. Can the Exchange establish a line of credit for meeting short-term cash flow issues?

Finally, it is worth reiterating that the projections in this report rest on a host of assumptions about market size, penetration rates, premium levels, consumer preferences, cost of technology, and so forth that are imperfect at this early stage but which can be refined over time, with research and experience. These assumptions will materially affect the results, and such research should be undertaken to make the model more accurate. Eventually, as the Exchange garners real experience, the model can be refined and used as a management tool. Nevertheless, we do believe that the range of administrative expenses and revenues shown here—on the order of % of premiums—is in the right ballpark.

It is important to emphasize that this model does not include funding from Exchange operating funds for the payment of producer commissions. As discussed in section 4.2.3, this is an important policy

consideration for the Illinois Exchange, and one which could significantly alter the overall financial picture of the Exchange. Producer commissions average 6% of premiums the small-group market at 8.6% in the small-group market.

This budget document also makes other assumptions about some key policy determinations, such as the level of Navigator subsidies, the surcharging of total premiums associated with Exchange enrollment (and of no other premiums or revenue sources), and the size of the "footprint" of the Exchange regarding full-time personnel. We have made these assumptions simply in order to proceed in the absence of more defined policy direction, and have attempted to "fill in the blanks" with plausible assumptions. We have no reason to believe that the Exchange will (or should) eventually make its own determinations in line with the same policy assumptions as we put into this model. Indeed, one of the future uses of this model may be to highlight and then draw out the financial implications of making some very different policy determinations than this model assumes.

START-UP STAFFING CHART

		FTEs by Calendar Year		
	Annual Salary	CY 2011	CY 2012	CY 2013
Leadership				
Sr. Executives :		**3.0**	**5.0**	**8.0**
Executive Director	$ 253,000	1	1	1
General Counsel	$ 176,000			1
Chief Financial Officer	$ 165,000	1	1	1
Chief Technologist	$ 165,000		1	1
Chief Operating Officer	$ 165,000		1	1
Chief Marketing Officer	$ 165,000			1
Chief Medical Officer	$ 220,000			1
Senior VP for Risk Adjustment	$ 165,000	1	1	1
Staff by Functional Area				
Administration		**1**	**1**	**2**
Manager	$ 50,000	1	1	1
Assistant	$ 33,000	1	2	3
Appeals		**0**	**0**	**1**
Director	$ 70,000			
Manager	$ 60,000			1
Specialist	$ 50,000			
Finance		**2**	**5**	**8**
Director	$ 85,000	**1**	**1**	**1**
Manager	$ 75,000	1	2	3
Analyst/Accountant	$ 60,000		2	4
HR		**0**	**1**	**1**
Director	$ 65,000			
Manager	$ 55,000		1	1
Specialist	$ 45,000			
IT		**3**	**5**	**5**
Director	$ 85,000	**1**	**1**	**1**
Manager	$ 75,000		2	2
Specialist/Analyst	$ 68,000	2	2	2
Legal		**0**	**1**	**2**
Asst Gen Counsel	$ 120,000			
Attorney	$ 100,000		1	2
Paralegal	$ 60,000			
Operations		**1**	**5**	**10**

		FTEs by Calendar Year		
	Annual Salary	CY 2011	CY 2012	CY 2013
Director	$ 85,000	**1**	**1**	**1**
Manager	$ 75,000		2	3
Specialist/Analyst	$ 60,000		2	6
Communications/Outreach		**1**	**2**	**3**
Director	$ 85,000	**1**	**1**	**2**
Manager	$ 75,000			
Specialist	$ 55,000		1	1
Policy		**1**	**1**	**3**
Director	$ 85,000	**1**	**1**	**1**
Manager	$ 75,000			1
Analyst	$ 60,000			1
Sales		**0**	**1**	**2**
Director	$ 85,000			
Manager	$ 75,000		1	2
Specialist	$ 55,000			
Grant Administrator		**1**	**1**	**1**
Director	$ 70,000	**1**	**1**	**1**
Manager	$ 60,500			
Specialist	$ 45,000			
		14.0	**30.0**	**48.0**

OPERATIONAL STAFFING LOAD PROJECTIONS: FTES BY FUNCTIONAL AREA FOR HIGH, LOW, AND MODERATE ENROLLMENT SCENARIOS, 2014 AND 2015

	2014			2015		
	Low	Moderate	High	Low	Moderate	High
Administrative	2	2	3	2	3	3
Appeals	5	6	6	5	6	7
Sr. Executives	9	9	9	9	9	9
Finance	11	12	14	12	14	16
Human Resources	1	1	2	1	2	2
IT	5	6	6	5	6	7
Legal	4	4	5	4	5	5
Operations	15	16	17	16	17	19
Outreach	5	6	6	5	6	7
Policy	3	3	4	3	4	4
Sales	3	4	5	3	5	6
Grant Administrator	1	1	2	1	2	2
Total	**64**	**70**	**79**	66	79	87

4.4 Other Structural Considerations for Exchanges

4.4.1 Minimizing Adverse Selection under the Affordable Care Act

> ***This section discusses adverse selection, identifies the most important provisions of the ACA that address the risk of adverse selection, and recommends approaches the state can take in Exchange planning in general to address adverse selection issues.***

The Affordable Care Act (ACA) provides for the development of an insurance marketplace (Exchange) for the purchase of health insurance for individuals and small groups. It allows for states to expand the definition of small group to 100 employees. While the ACA has a very long list of provisions affecting various aspects of the insurance market, this portion of the report is focused on methods for minimizing adverse selection in the individual and small-group marketplace. Pending regulation may materially affect the issues and recommendations presented herein.

INTRODUCTION AND OVERVIEW

Adverse selection occurs when an insurance market or an individual insurer enrolls a disproportionate share of higher-risk, less healthy people who, because of their greater need for medical services, are more costly to insure than the average person in the population as a whole. Because the entity enrolling these more costly people is forced to raise premiums to cover the higher costs, lower-risk enrollees to flee to other forms of coverage where premiums are lower. Once begun, the process can result in a downward spiral of rising premiums and lost enrollment.

Avoiding and mitigating adverse selection is essential to the success of an Exchange, in order to keep coverage affordable for residents of Illinois, particularly those without access to subsidies.

The ACA provides for states to create an Exchange, but allows for the continuation of a market outside of the new Exchange. Multiple insurance companies would be expected to participate in the Exchange and outside the Exchange. There are three general types of adverse selection that can occur.

1. Adverse Selection against the market in total ("Market Adverse Selection") occurs when a market enrolls relatively few healthier people and provides coverage for a disproportionate share of higher-risk people. The problem is exacerbated if market rules allow people to buy coverage with no penalty once they determine they need medical services. This type of adverse selection increases the average cost of insurance across the market.

2. Adverse Selection against the Exchange ("Exchange Adverse Selection") occurs when the Exchange enrolls a higher proportion of higher-risk people than insurers operating outside the Exchange. This type of adverse selection increases the average cost of insurance inside the Exchange and decreases it outside of the Exchange.

3. Adverse Selection against a given insurer ("Insurer Adverse Selection") occurs when some insurers attract a disproportionate share of higher-risk people. This type of adverse selection increases the average cost of insurance for some insurers and decreases it for others.

This section discusses the most important aspects of provisions of the ACA and of Exchange planning in general to address adverse selection issues.

It is important to understand the ACA recognizes the potential problems created by adverse selection and includes a number of crucial provisions to try to solve those problems, including requiring that everyone purchase coverage (the individual mandate) and requiring that Exchanges establish several types of risk-adjustment mechanisms. But we begin our discussion by looking at the rating and underwriting rules in Illinois, then move to a discussion of some of the ACA provisions that could cause adverse selection problems in the absence of provisions to mitigate them. We continue with an explanation of the ACA provisions to protect against adverse selection and then conclude with recommendations for Illinois.

CURRENT RATING AND UNDERWRITING RULES IN ILLINOIS

The current rating and underwriting rules in Illinois provide an important context for adverse selection issues under the ACA since underwriting and rating practices are employed to mitigate adverse selection. Current regulations in these areas are intended to provide particular consumer protections while allowing for health insurers to protect themselves against adverse selection. Regulations vary considerably by state. Illinois is generally more permissive than other states in terms of the practices insurers are allowed to employ to mitigate adverse selection.

INDIVIDUAL MARKET

Illinois currently allows individual health insurers to deny coverage to individuals with pre-existing conditions or other characteristics that the insurer deems to put them at high risk. Insurers can use a variety of methods to deny coverage including denying coverage for pre-existing conditions, attaching coverage riders, or using exclusion periods of up to 24 months. If a claim is made in the first 24 months, the insurer can review the individual's history up to 24 months prior to application to check for pre-existing conditions and refuse the claim if the condition was pre-existing.

If an individual is eligible for HIPAA and is denied coverage from an insurer, he or she is able to join the Illinois Comprehensive Health insurance Plan (ICHIP, the state's high risk pool).

There are no limits on the extent to which insurers can vary premiums based on the individual's health status or other characteristics, but coverage cannot be cancelled because of an individual's health condition. Rates can vary based upon age, health status, plan type, and family size. Renewal rates can reflect similar factors.

Illinois does not require standardized policies that must cover the same benefits but does require the inclusion of a number of state law-required policy provisions and coverage of certain benefits by all insurers under all plans, such as diabetes care and mammogram screenings.

SMALL-GROUP MARKET

Illinois currently defines small groups as employers with 2-50 employees. Insurers cannot deny coverage or cancel coverage for small groups because of health conditions of employees and dependents. Premiums can vary based on enrollees' health status, gender, age, and risk. In the individual market, carriers are not constrained to the degree of variation incorporated in rating for health status, whereas in the small group market, carriers can vary rates based solely on health status up to 25%. Allowing a limit on health status variation generally has the effect of making premiums lower for the less healthy groups and making premiums higher for the healthier groups.

To be eligible for coverage, employers must meet minimum employee participation requirements set by the insurers; if they do not, the plan can be terminated. Insurers can also require that employers contribute a minimum specified percentage of the premium.

A policy/product that is sold to one group must be available to all other small groups. The benefits must be the same, but the premiums can vary by group.

ACA PROVISIONS THAT INCREASE POTENTIAL FOR ADVERSE SELECTION

The ACA includes a number of provisions generally designed to protect consumers that, in the absence of offsetting provisions that are part of ACA, could increase the potential for adverse selection in the individual and small-group markets:

1. Rating or underwriting based on health status based is not allowed. The only factors than can be used to vary rates are age and smoking status.

2. Age rating is allowed but is limited to a ratio of three to one for adults. Therefore, the highest rate (for the oldest person) cannot be more than three times the lowest rate (for the youngest person). Actual medical cost variations are much greater – with highest-cost age/gender rate cells being six to eight times more costly than the lowest-cost age/gender cells. Therefore, limiting the rating variation to a ratio of three to one means that the youngest members will be partially subsidizing the oldest members. Any time one group of individuals subsidizes another, there is risk of adverse selection, meaning that the market prices can move upward overall if the individuals subsidizing others choose to leave the market.

3. Subsidies available for specific populations. ACA provides subsidies to lower-income and moderate-income individuals (up to 400% of the federal poverty level) to be used to purchase health coverage. As the subsidies can be used to purchase coverage only within the Exchange, there will be a higher proportion of these individuals in the Exchange. If those who are eligible for subsidies are also higher-than-average risk, Exchange Adverse Selection may occur. (Whether this will be the case generally or in Illinois is not yet clear, as income correlates with both health and age, but age correlates negatively with health status and age-rating is constricted. That is, lower-income people tend to be sicker for their age, but younger people are more likely to be low-income than their older counterparts.) As discussed elsewhere in this

section, income should be considered as a risk-adjustment variable (if permitted by federal regulation).

4. Availability of plans outside Exchange. Plans outside the Exchange may be grandfathered such that they are allowed to remain in place as long as they meet requirements for maintaining their pre-reform benefit levels, co-pays, contribution levels, and covered services. Grandfathered plans are not subject to adjusted community rating rules. These plans would not be available within the Exchange. Depending on how prevalent grandfathered plans continue to be in Illinois, those that continue to exist may drive a different balance of risk between the population covered through the Exchange and those covered outside the Exchange.

5. A smoking adjustment of up to 50% of premium is allowed. Insurance regulators should monitor the application of this adjustment closely to ensure that it is not abused to "cherry-pick" favorable risks. In addition, if the smoking adjustment is excluded from the calculation of federal subsidies, permitting carriers to increase the rates for smokers, this significantly may lead to a substantial number of low-income state residents facing premiums that are unaffordable to them. In doing so, these individuals will be exempt from the requirement to purchase health coverage, and reduce the expansion in coverage experienced by the state.

ACA PROVISIONS INTENDED TO AVOID OR MITIGATE ADVERSE SELECTION

The ACA includes key provisions intended to avoid or mitigate adverse selection:

1. Individual mandate. The ACA applies penalties if individuals who can afford to purchase coverage do not. The mandate is intended to avoid all three types of adverse selection. Because under ACA people cannot be denied coverage or charged more for poor health status, without a mandate many low-risk people would choose not to buy coverage initially, waiting until they anticipating needing expensive medical services to enroll in a plan. The result would be adverse selection: they would incur costs far in excess of the amount they contribute to the risk pool in premium payments. To the extent that the mandate prevents such behavior, it protects the market from this form of adverse selection. The penalties for failing to buy coverage are relatively small in relation to potential premiums. However, even a relatively modest penalty like that in Massachusetts has been shown to have a material effect on coverage. In fact, tax-based penalties in Massachusetts are lower than those that will be enforced under the ACA. The constitutionality of this particular provision of the ACA is being litigated in a number of courts and is likely to be decided ultimately by the Supreme Court.

2. Risk Corridor – 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 the targeted health claim levels by more than 103%. In this way, plans that have significantly worse than expected experience will have their losses lessened, and plans that have experience that is significantly better than expected will have their profits lessened. Risk corridors protect somewhat against "Insurer Adverse Selection," "Exchange

Adverse Selection," and "Market Adverse Selection." This protection extends only through 2016. Risk corridors apply to qualified health plans in the individual and small-group markets.

3. Reinsurance – Reinsurance provides protection against high-cost claims and applies to the Individual market only. Recently released proposed rules by HHS define the reinsurance program to be a more traditional approach that considers the actual costs for specific members (i.e., "Stop Loss reinsurance"). Reinsurance protects somewhat against "Insurer Adverse Selection," "Exchange Adverse Selection" and "Market Adverse Selection." However, it can be argued that reinsurance does not really protect against "Market Adverse Selection" since it is funded through assessments on the market in general. This protection extends only through 2016.

4. Risk Adjustment – The risk adjustment program is intended to 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. In this manner, plans that enroll high-risk members are likely to receive payments from plans that enroll low-risk members. Risk adjustment uses demographic characteristics and past claims history to determine the relative risk for each individual. Risk adjustment is budget neutral for the market in total. Therefore, it does not protect the market in general from adverse selection. Risk Adjustment protects against "Insurer Adverse Selection" and "Exchange Adverse Selection."

Other provisions of the ACA that are intended to avoid or mitigate adverse selection, including the following:

1. Essential benefits. The ACA requires all non-grandfathered policies in the small-group and non-group markets to cover essential benefits (to be defined in detail by HHS), which represent a relatively comprehensive list of medical services. By requiring all policies to cover most medical services, health insurers cannot offer very lean benefit plans that exclude certain services (e.g., cancer treatment) to attract healthy individuals or exclude high-cost services such as maternity coverage.

2. Common benefit designs. Under the ACA, standardized benefit plans will be designated as Bronze, Silver, Gold, or Platinum. The covered medical services will be the same in all metal tiers, but the level of cost sharing will vary by specified percentages in terms of the proportion of claims costs that are covered. Insurers participating in the Exchange must offer both a Silver and Gold plan. Similar to the essential benefits, the requirement that plans offer a similar set of plans (though they can choose to also offer the Bronze and Platinum level plans) means that one insurer will not inherently attract a different population than another insurer offering a different plan. While this provision reduces Insurer Adverse Selection within the Exchange, if similar requirements are not set up outside the Exchange, there may still be Exchange Adverse Selection occurring.

ADVERSE SELECTION RECOMMENDATIONS

This section lists specific risks and Wakely's recommendations for addressing these risks.

1. Overall Risk Mitigation

   Develop robust risk adjustment, reinsurance, and risk corridor methodologies with input from the health plans.

   Allow insurers to offer individual and small-group coverage only through the Exchange[5], or apply all of the same market rules to the Exchange and non-Exchange markets. This includes many of the provisions that are outlined by ACA as well as additional requirements that can be set up by the state including network adequacy minimums, contracting with safety net providers, and prohibitions on marketing and benefit design practices intended to avoid high-cost individuals (similar to Medicare Advantage). Having the same rules inside and outside the Exchange eliminates the potential for adverse selection between the Exchange and the external market. The regulations can be set up so that the consumers are still offered a wide array of coverage alternatives and protections.

2. Avoid Individuals Only Seeking Coverage when they are Sick

   If the individual mandate is successful, people will not be buying coverage only when they get sick. But if the mandate were to be overturned in the courts, then other protections would be necessary. Given the opportunity, individuals that are aware of upcoming health issues may choose to obtain or increase coverage specific to that condition only for the period of need. In order to mitigate this risk, the state could (*if permitted by federal law* because the mandate provision is overturned) limit opportunities for enrolling to an open enrollment period that is relatively short (one or two months). Exceptions should be allowed for life events such as birth, death, marriage, change in job, change in subsidy eligibility, and others affecting insurance coverage. The state may want to limit these exceptions to circumstances in which the individual or family had prior coverage. Another policy option that is similar and could be incorporated as an alternative would be a late enrollment penalty, such as that currently employed by the Medicare program.

   Require small employers to contribute a minimum share or amount of employees' premium for coverage purchased in the Exchange comparable to prevailing underwriting requirements of the carriers in the outside market. The more that an employer contributes toward an employee's health premium, the more likely that employee will opt for insurance. This will result in more people choosing coverage as well as broaden the risk pool so that it includes both healthy and sicker individuals. The higher the burden of premiums on members, the more likely

[5] If the Exchange is the only marketplace, undocumented immigrants would not have a marketplace to purchase insurance.

the healthiest will opt to forego coverage. (Again, this approach may not be necessary if the mandate requirement is effective.)

3. Avoid Adverse Selection for Groups of 51-100 Affecting Small-Group Risk Pool

   While this paper separately discusses this issue and indicates that increasing the small-group market to 51-100 in 2014 may not significantly increase small-group premiums, any major change in the market can produce adverse selection issues. The possible danger is the higher-risk groups in this size category would choose Exchange coverage to save on premiums, while the lower-risk groups choose other forms of coverage. Groups larger than 50 employees have more options for coverage. Because they have more people in the risk pool than smaller employers, their average risk is likely to be more representative of the entire population; their risk will be less affected by the presence of one or two very high-risk individuals. They are also not subject to the same underwriting approaches that are used with groups under 50. As a result, they can often purchase relatively inexpensive coverage outside the Exchange. Additionally, groups that believe themselves to be a lower-than-average-risk group may choose to self-insure rather than purchase insurance through the Exchange or the external market. Defining stop loss insurance in state regulations will help to avoid selection issues (see later discussion). For example, if groups are able to obtain a significant amount of stop loss insurance, it will lessen their retained risk and provides further incentive for a group to self-insure and therefore not enter the insured market. Prohibiting insurers from selling stop-loss coverage to groups of 51 to 100 employees would eliminate this problem.

   This issue extends into the "large group" (employers with 100 or more employees). Many of the same issues that are considered with the 51-100 groups are also present in the large groups, although the size of the impact can be much greater because of the size of the over-100 market.

4. Selection Against the Exchange

   Require all QHPs licensed to sell products in the individual and small-group market to offer Bronze, Silver, Gold and Platinum policies both inside and outside the Exchange. This will ensure that insurers are offering similar option packages to all members and that no insurer can opt to offer only the benefit plans that would attract better risks. The state may take this protection further and standardize benefit packages beyond what ACA requires (essentially by standardizing the cost-sharing provisions). If the state did further standardize benefits it could limit the myriad possibilities within the constraints of ACA actuarial value categories and essential benefits and make it more difficult for carriers to target healthier risks. In addition, these standardized packages could be required to be offered inside and outside the Exchange by any licensed plans participating in each or both of these markets. A state may decide to allow plans to offer only the four specific plans – both inside and outside the Exchange – without an option to offer additional plans. This would mitigate adverse selection the most. Alternatively, a state may require plans to offer the four specific plans and leave open the possibility for plans to offer additional designs (all with at least 60% actuarial value). Adverse selection would

greatly be mitigated with this approach as well, but not as much as if fewer plans – all uniform in design – were offered. The state will need to weigh concepts of minimizing adverse selection with allowing more consumer choice.

Regulations should be the same inside and outside the Exchange. Illinois currently has fairly liberal rating and underwriting regulations that allow insurers significant leeway in determining rates and in underwriting groups. The more restrictive rules of the ACA apply equally to the Exchange and to the remaining market (if any) outside the Exchange. Any additional protections or health plan requirements that apply to the Exchange should also be applied to the market outside the Exchange, and can be done at state discretion.

Require meaningful retention of risk by employers in order for those employers to be self-funded. Prohibit insurers from selling stop-loss coverage to firms below a certain size. (ERISA prohibits states from regulating employer benefits, and thus Illinois cannot require employers to be fully insured. But states can regulate insurers and the coverage they can or cannot sell.)

In the SHOP Exchange, allow employees to have choices of carriers. However, do not employ a defined contribution approach with complete choice for employees. Require the employer to define the product level (bronze, silver, gold, or platinum) and then require employees to select a plan at that level. The reason defining a product level mitigates adverse selection is that if given a prescribed contribution, healthier employees will tend to choose the lowest-level plans, and employees with more health care needs will tend to select higher level plans. As a result, the cost of higher level plans in the SHOP will, over time, become increasingly more expensive and eventually become potentially unaffordable or not in the best interest of the carriers to offer.

Employ income as risk adjustment variable. Studies have shown that a person's income can be a predictive indicator of health care claim costs. For risk adjustment to work optimally by maximizing the predictive nature of a population, a state should consider a person's income as a risk adjustment indicator when determining if a plan has greater or less risk than an average plan.

Require QHPs to "fairly and affirmatively" market plans offered on the Exchange. As discussed previously, it is important that there is consistency between plans offered in and out of the Exchange. In addition, all plans must be actively marketed or else the Exchange will face the same adverse selection as if the plans weren't offered at all.

4.4.2 Expanding Small Group Definition of 50 to 100

This section analyzes the impact of expanding the small group-market in Illinois to include groups of up to 100 employees. The current definition in Illinois includes employers with up to 50 employees.

Effective 2016, the ACA requires the small-group definition to be inclusive of all groups with up to 100 employees. However it allows the restriction of the small-group definition to 50 employees through 2015.

The majority of the documentation published to date regarding this decision recommends that States continue to restrict the definition to 50 lives until 2016. The rationale for this is risk mitigation. Businesses with 51 to 100 workers are more likely to have alternative coverage arrangements marketed to them, including "self-insured" plan arrangements, generally including some sort of stop-loss reinsurance provisions. Allowing the businesses with 51-100 into the SHOP immediately could raise premiums because of adverse selection. Businesses with healthy workforces would choose to self-insure, while businesses with less healthy workforces would choose to take advantage of the non-health-rated coverage available through the SHOP.

In addition to the adverse selection concern outlined above, some of the other considerations that will impact this decision include:

- All employer groups over size 50 will have a penalty if not offering group insurance starting in 2014.
- The loss ratios, benefit designs, and administrative charges of the large-group market compared to the small-group market. The more different these aspects are between the two markets, the greater the potential impact of expanding the definition of small groups to 100 lives.
- Relative size of the 51-100 market compared to the current small-group market under 50, as measured by the number of people covered in both markets.

All groups between 50 and 100 will have an incentive to obtain coverage starting in 2014. This will cause groups that currently do not have coverage to seek coverage. Because they will be just entering the insurance market and likely do not have a current relationship with a producer, we believe it is that they will enter the Exchange rather than using a self-insured or alternative arrangement. This fresh pool of members could have a different risk profile than the average membership for the SHOP.

The loss ratios for the large-group market are greater, causing lower premiums for larger groups compared to the small-group market. This difference in administrative cost must be considered when combining the markets.

Lastly, the size of the 51-100 group market relative to the current small-group market in Illinois is surprisingly small. Without econometric models, it is difficult to tell, but our best information based on combining state information about group sizes from the Health Research Educational Trust/Kaiser Family Foundation study as well as the average small-group sizes from the small group employer data indicate that the 51-100 group market is likely only between 25% and 50% of the under-50 small-group market (so at most it will comprise one-third of the market). Thus, any adverse selection effect that might occur as a result of including small groups with 50 to 100 employees will be limited.

Similar to the analysis done in merging the small-group and individual markets, we have examined potential outcomes of merging the group sizes fewer than 50 and between 51 and 100 employees. Where data was not available specifically for the market between 51 and 100, we assumed that the employers in this market behave similarly to the general large-group market employers.

Based on the analysis described below, the average risk of the small-group market would not be significantly affected by the addition of the group sizes 50-100. Over 30% of the 50-100 employee size firms would need to self-insure before the SHOP would be faced with the need to increase premiums.

Step 1 – Establish that the overall morbidity of the 50-100 population is similar to the under-50 population. This intuitively seems likely, and our analysis confirms that the morbidity is similar between the markets.

Table 14: Result of Expanding Small Group Definition

Step	Description	Groups size 50-100	Group size under 50
A	2010 Premium PMPM - adjusted	$371	$384
B	Morbidity Change (guarantee issue)	1.00	1.00
C	Admin and Profit	15%	20%
D	Average Actuarial Value	81%	78%
E = A*B*C/D	2010 Allowable Claims PMPM	$387	$394
F	Ave Geo	0.8678	0.8715
G	Ave Age/Gender	1.00	1.00
H	Ave Tobacco	1.00	1.00
J = E/F/G/H/I	Normalized claim cost	$446	$453
	Morbidity difference		1.01

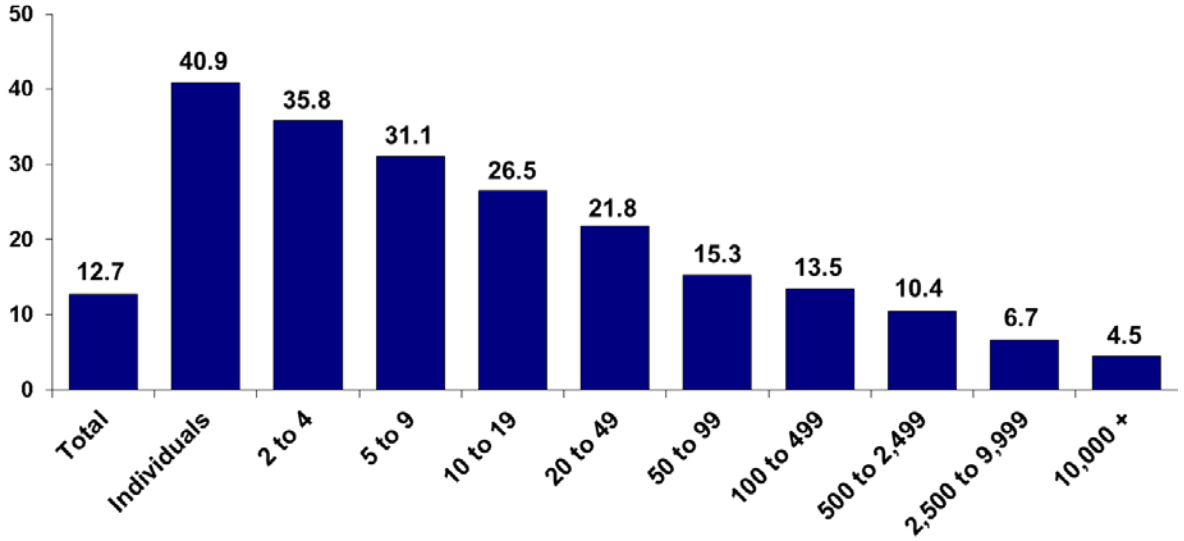
Step 2 – Compare the average premiums for the markets based on average administrative cost differences.

Table 15: Premium Difference, Expanding Small Group Definition

Step	Description	Groups size 50-100	Group size under 50
A	Normalized claim cost	$446	$453
B	Admin cost	*$56*	*$77*
C = A + B	Premium	$502	$529
	Premium Difference		1.05

Based on a study of the Lewin Group, administration costs vary significantly based on the size of the group. The figure below indicates the results of this study. For administrative cost differences, we assumed that the 50-100 group market would have 5% lower administrative fees (as a percent of premium).

Figure 4: Administrative Costs as a Percent of Premium by Employer Group Size



Source: Estimates by the Lewin group for The Commonwealth Fund Source: Commonwealth Fund Commission on a High Performance Health System

If we stop here, it would indicate that the addition of the 50-100 life groups to the market would actually reduce the premiums in the small group market. However, it is the exodus of the healthiest groups to self-funded options that remains a concern. This item is addressed in Step 3.

Step 3 – Adjust the risk level of the 50-100 life groups by removing the healthiest groups

Our approach to examine this is similar to reviewing the resulting risk of small-group leaving the market. We make two assumptions:

1. The assumed cost ratio of the highest-cost groups to the lowest-cost groups in this range is 3.2:1, which is a compression of rate range by approximately a factor of .75 relative to the small group market, and

2. The majority of the groups are at the low end of the range (similar to small groups).

Based on these assumptions, almost 30% of the groups (the healthiest groups) in the 51-100 market would need to self-insure before the increase of morbidity in the 51-100 employee groups would reach 4%. This assumption loosely ties to an HRET study that indicates that employees in self-funded groups have on average 5% less costly premiums.[6]

[6] http://ehbs.kff.org/pdf/2010/8085.pdf

Table 16: Increase in Morbidity

Percent of Members	Average Risk Factor of Small Group 2-50	Assumed Average Risk Factor of 50-100 groups [1]	Membership Leaving to Self-Insured Market	Remaining Distribution	Average Risk Score
12%	1.28	1.21	0%	17.5%	1.21
10%	1.17	1.13	0%	13.6%	1.13
18%	1.05	1.04	0%	25.6%	1.04
29%	0.94	0.96	0%	41.1%	0.96
31%	0.85	0.89	-29%	2.1%	0.89
1	1.00	1.00		100.0%	1.04
Increase in Morbidity					4%

[1] Multiplied by a compression factor of .75.

The increased morbidity with 30% of the market leaving would cause the overall premium levels in the pool to break-even, given the economics of the lower administration in the higher group sizes. Given the analysis presented above, the State should carefully consider options to prevent large groups between 50 and 100 from exiting the fully-insured marketplace (by either dropping coverage or self-insuring) to ensure that the state benefits from an early expansion of the Small Group Market. Such policy considerations are, as noted in previous sections, key for the State consider in any event, given that the market must expand beginning in 2016.

4.4.3 Illinois Health Insurance Exchange Merger Analysis

This section analyzes the ACA option that allows states to combine (or merge) the small-group and individual markets.

One of the options available to states under the Affordable Care Act (ACA) is to combine the small-group and individual (non-group) risk pools. Several states have merged the risk pools prior to the ACA laws allowing them to do so. The driving force behind merging the markets is a desire to protect and lower costs for individual policyholders who may have less negotiating power and sophistication and face higher administrative costs. From a very simple perspective, merging the markets will equalize premiums. Therefore, if premiums are lower in the small-group market prior to the merger, then small-group premiums will increase and individual premiums will decrease (and vice versa). The amount of the change in each market depends on the relative size of the markets prior to the merger. If the total market is dominated by small groups, the change to individual premiums could be substantial.

Complicating this analysis is the fact that the decision states need to make is after implementation of all of the ACA changes. These regulatory changes affect the two markets differently. In addition, the shifts

in the market due to provisions such as the individual mandate, premium and cost sharing subsidies, and others will likely be substantial.

In order to analyze the impact of merging the individual and small-group risk pools, what that means first needs to be defined. It is clear that the portion of the premium reflecting medical claims costs must be the same for everyone buying identical products in the newly merged market, but it is not clear from the ACA law or proposed rules whether rates can vary for other differences in costs between the two groups now in the merged market. Specific outstanding questions include:

1. Can rates vary to reflect differences in administrative expenses between the two markets? The costs of administering health insurance vary between the two markets for reasons such as commissions, administrative functions like enrollment and outreach, among others.

2. Can / should rates vary due to the presence of reinsurance required by the ACA in the individual market? Reinsurance effectively transfers funds from the fully insured and self-insured employer markets to the individual market.

For purposes of our analysis, we have assumed that the risk pools need to be identical but that rates can vary between the two markets for the reasons noted above.

We estimate that rates in the individual market would likely increase significantly, and rates in the small-group market would likely decrease minimally if the markets were merged. These changes are based on actual historical data provided by Illinois carriers in the individual and small-group markets (as described in the next section of this report) after adjusting that historical information for the impact of ACA reforms (guaranteed issue, adjusted community rating, etc.). Since premium rates inside and outside the Exchange need to be the same, after accounting for allowable rating characteristics, our results do not depend on the size of the health insurance Exchange or whether or not there is a market outside the Exchange. Other considerations in deciding whether to merge the markets including size and stability of the market over time, disruption to policyholders and health plans, continuity of coverage, and others.

The finding presented here with regard to the market merger is in isolation of other possible findings related to the ACA and should be viewed strictly in relation to a scenario in which the markets were not merged.

THE IMPACT OF RISK ADJUSTMENT IN A MERGED MARKET

While risk adjustment will be budget neutral across the newly merged market, it is important for carriers to understand how it will function and potential limitations in its ability to fully recognize morbidity levels across carriers. If risk adjustment does not fully capture morbidity differences, then the risk-adjustment mechanism will not fully offset the advantages or disadvantages that carriers face because they do not enroll an average-risk population. This issue is pervasive in any discussion of the limitations of risk adjustment, as similar issues exist with regard to risk differences that result from carrier-to-carrier variation in income levels of enrollees, geographic service area, network composition, and other factors.

Another important issue with respect to risk adjustment is the overlap with the reinsurance provisions of the ACA. Reinsurance will effectively limit risk for a particular person in the individual market and therefore will limit the risk of many high-cost conditions. However, that same limitation does not apply in the small-group market, which will bear the full cost of those conditions. Therefore, the calibration of risk weights for the merged market will not be entirely in sync with the application of the risk-adjustment model.

DATA RECEIVED

The analysis was based on data provided by the insurers as well as information provided by the state. This information includes but is not limited to:

- Detailed benefit plan information for plans representing at least 80% of the insurers' individual and small group books of business. The detailed information included:
    - 2010 premiums, allowed and paid claims, member months and producer commissions by benefit plan. The same data elements were also provided in aggregate for the balance of the remaining plans in the insurers' individual and small-group books of business.
    - High-level cost sharing and covered services information for each benefit plan
- Underwriting Experience, including
    - Durational factors with persistency by duration (individual)
    - 2010 application experience, including but not limited to the number of applications, number accepted (split by number of standard and nonstandard issues), denied, and number of policies with pre-existing condition exclusions (individual)
    - The average underwriting factor applied, where applicable, for policies issued to enrollees with substandard health status (individual)
    - Average underwriting factor by group size (small group)
    - Distribution of underwriting factors by group size and underwriting factor band (small group)
- Recent rate filings, where available. When rate filing information was not available, assumptions as to the insurers' rating factors were necessary.
- High risk pool experience including number of policies and historical experience
- Additional benefit design information regarding product specifications available online at carrier websites
- Earned premium and member months by member and group zip code, separated by individual, small group and large group lines of business
- Summary earned premium and incurred claims information by insurer for individual, small group and large group lines of business

The following seven insurers provided information for the analysis:

- Aetna

- Blue Cross Blue Shield of Illinois
- Coventry Health and Life
- HealthAlliance
- Humana
- PersonalCare
- United Healthcare (summary of all companies)

The inclusion of information into the analysis was based on quality of data, availability of information and significance in the Illinois market. Note that the majority of benefit plans not included in the detail, and thus not in the analysis, were closed plans.

4.4.4 Early Implementation of Consumer Protections

> ***This section addresses the possibility of implementing the insurance-related consumer protection reforms in the ACA in Illinois before 2014, when the reforms are required.***

The ACA institutes a wide range of insurance market reforms. This section addresses the advisability and potential cost of early implementation of those reforms. While certain insurance reforms in the ACA are effective before 2014, the substantial consumer protection reforms that affect the individual and small group markets take effect in 2014. These include:

- Prohibition of pre-existing condition exclusions.
- Guaranteed issue and renewal.
- Limits on waiting periods to no more than 90 days.
- Required coverage of certain qualified clinical trials.

These reforms, which concern benefits that must be available to insurance consumers, work alongside a set of rating reforms, including the institution of adjusted community rating standards and a limitation on the use of rating factors.

All of these reforms are to be implemented in 2014 alongside the requirement that individuals purchase insurance, known as the individual mandate, and the associated requirement that carriers offer plans that contain essential benefits to be defined by the Secretary of HHS. In fact, the individual mandate is essential to the operation of these reforms, since without that requirement, a relatively sicker group of purchasers would be in the insurance pool, which would cause the premium impact of the reforms to be significantly higher. We do not recommend wholesale adoption of the ACA insurance market reforms in the absence of an individual mandate. The market impact of early implementation of the insurance reforms in the ACA without early adoption of an individual mandate is likely to cause negative disruption in the market, by increasing premiums. On a purely operational level, the enforcement of an individual mandate is a significant undertaking, with very high visibility that affects every taxpayer. It would be a very difficult and costly undertaking for any state to implement that level of enforcement when taxpayers and plans will be subjected to an entirely different federal enforcement process in 2014.

It is important to note that some states may consider potential partial steps to smooth the path to the 2014 insurance reforms. Most notably, the ACA required that rate bands be limited to 3 to 1 in the individual and small-group markets. Illinois could consider slowly constricting, between now and 2014, rate bands in the small-group market or introducing rate bands in the individual market (where there are none today).

However, the impact of any such step would affect premiums for currently insured individuals and for small employers. In general, in the individual market, premium rates for sicker, older individuals would decrease and premium rates for healthier, younger individuals would increase (as will happen when the new ACA rates bands go into effect in 2014). The HMA team has not analyzed in depth the practical effect of such a step in Illinois, but there is every reason to believe that the effect of doing so on the premiums charged to currently insured individuals would be substantial, and some lower-risk people would likely drop coverage as a result.

Moreover, before 2014, the individual and small-group markets will not have implemented the risk-adjustment processes that are created in the ACA specifically to address the expected outcomes of these reforms. Those risk-adjustment processes, which will be more clearly defined in federal regulations and by states, are designed to protect insurers that enroll a disproportionate share of high-risk individuals from financial losses. We do not recommend implementing state-specific risk-adjustment or risk-sharing mechanisms before 2014, when they will be implemented by Illinois under federal rules. Certainly, preparation for implementation of the ACA's risk-sharing mechanisms will be a high-priority, high-profile, and resource-intensive activity for the state to implement even by 2014.

In sum, while the impetus for early implementation of consumer protections in Illinois is understandable, a review of the practical impact of such a policy argues strongly for waiting until 2014 and instead focusing resources on careful planning to deal with the implementation challenges and market impacts of the ACA.

4.5 Medicaid and the Exchange

This section addresses some of the dimensions of how an Exchange will relate to existing state programs. Section 4.5.1 analyzes the impact of the ACA's Medicaid expansion in Illinois. Section 4.5.2 addresses one of the often-discussed dynamics set in motion by the ACA—movement between the Exchange and Medicaid for low-income individuals, commonly referred to as the phenomenon of "churn." Section 4.5.3 analyzes the option of a Basic Health Program in Illinois. Finally, sections 4.5.4 deals with state options for early implementation of the Medicaid expansion that is required to be implemented in 2014.

Based on our team's experience and our assessment of the challenges presented by the ACA, we believe efficiently integrating an Exchange with existing Illinois state programs will be an essential element of

success for the state. While the Exchange is a new marketplace and a component of the broader commercial health insurance market, it is also deeply connected to, and will have important impacts on, the Illinois Medicaid program and on state programs generally. There are both policy and operational dimensions to the integration of an Exchange with existing state programs, and our strong advice is to pay close attention at all turns to how Exchange decisions and actions will affect other state programs.

This section concerns the ways that the implementation of the ACA and an Illinois Exchange will affect the Illinois Medicaid program. Most obviously, the ACA expands Medicaid eligibility, reforms its eligibility rules to conform to new federally set standards, and requires a streamlined eligibility determination process that must be integrated with the Exchange. In planning for Exchange implementation, current agencies in Illinois (both HFS and DHS) have to confront both the independent challenges of the Medicaid expansion and the need to forge a working relationship with a new entity. Exchanges and Medicaid are deeply integrated, both in terms of operational functions and in the sense that the law is intended to integrate public and private health insurance coverage.

This report, and the separate report concerning development of an Integrated Eligibility System (IES) to comply with the integrated eligibility requirements of the ACA, is intended to support overall Exchange planning in Illinois. In our view, one of the most important elements of that planning effort is to identify and understand the ways that Exchange implementation will affect the state Medicaid program. This introduction discusses certain areas in which resources for HFS or DHS are necessary. It is intended both to provide advice to support implementation and to illuminate the way that the Medicaid program will need to adapt to a post-reform world in which policy and operational decisions it makes affect the Exchange, and vice versa.

- Eligibility Operations Staffing Resources

A strong recommendation of the HMA Team in the context of the IES planning project is to design a Business Process Reengineering (BPR) process to identify specific options for improving business processes associated with eligibility and enrollment functions. That process should inform and complement the implementation of the IES and should also focus on staffing needs of DHS after the IES is implemented.

DHS local offices have caseworkers with large case loads and have had reductions in staff in the last few years. Earlier this year, DHS estimated that a substantial increase in the number of caseworkers would be needed to address the needs of the annual redeterminations due to the Illinois Medicaid Reform initiative. The request for additional funding for staff was not included in the FY2012 budget. In the analysis of the Medicaid expansion in this section, we project that the Medicaid program will serve over 3.1 million members after the ACA is implemented, an increase over the 2.7 million it serves today.

The increased caseload attributable to the ACA, in combination with the need for enhanced program integrity measures from the 2012 reform law, cannot be handled with existing staffing levels given existing business processes. Given the difficulty of hiring caseworkers, improvements are critical in the way the work is handled and the workload is distributed. Specific options for improving processes as the IES is designed and implemented are identified in the IES report. As the state embarks on that project,

improvements that lessen stress on staff and workloads will be a high priority. But it is an unavoidable fact that more people will apply for and become eligible for Medicaid as a result of the ACA. The state should carefully monitor current caseloads, continue to refine the initial projections provided in this report, and throughout implementation pay close attention to the needs of local offices.

This is especially true in the first years of implementation. The IES report proposes a two-stage set of changes, with a full replacement of the current system unlikely until the end of 2015 – a full two years after the ACA is implemented. The case worker demands in those two years while adding a large number of new members and maintaining two systems will surely be severe; it would be unrealistic to not expect additional administrative costs in the short-term.

- Policy and IT Resources for IES Planning

As discussed more fully in the IES report, a comprehensive overhaul of eligibility IT systems will require dedicated staff in IT units at DHS and HFS and agency staff with subject matter and policy expertise to guide development decisions. It is always challenging to devote existing resources with operational and policy responsibilities to a development project, but a lack of business and policymaking input into IES risks failure to meet the project's objectives, which are central to Exchange and ACA implementation effort. As the project is organized, HFS and DHS need to identify resources for the project and agency functions that could suffer from those resources being directed away from ongoing responsibilities. It is unlikely that federal funding will support hiring full-time permanent staff replacements for non-Exchange agencies, but Illinois should explore options for using federal Exchange grants for short-term resources that can support the ongoing operations of its agencies while the IES work is prioritized.

- Ongoing Policy and Decision-making Supports for Program Integration

For both planning and ongoing operations, HFS and DHS will have a need for resources devoted to integration with the Exchange. We also strongly recommend a formalized structure for regular communication, with the involvement of senior staff involved in both operational management and agency policy-setting. As implementation unfolds, the state, and later, the Exchange, will be contracting with vendors to provide call center services, designing a website through which individuals can apply for Medicaid or Exchange coverage, and developing approaches to the many other Exchange functions covered in this report. It will be rare that those functions will not need to be integrated with an aspect of the operational processes or technology systems managed by HFS or DHS. Early planning and engagement together will avoid inefficiencies and re-work but will be particularly challenging given the timeframes required by the ACA and the fact that the Exchange will be a new and fast-growing organization.

In addition to operational cooperation at all levels, the state needs to devote resources to identifying policy issues that are being addressed by both the Exchange and Medicaid. As discussed in this report, the Exchange will be monitoring quality of plans and assessing their provider networks for adequacy – both issues that Illinois Medicaid needs to address in its different context. If the Exchange in Illinois prioritizes outreach to low-income populations, it is important for HFS to understand the outreach strategy, possibly to enhance it and possibly to understand the operational implications.

It is also important to realize that the integration is not simply about monitoring Exchange activities. Medicaid decisions may just as easily affect the Exchange in unforeseen ways. For example, as Illinois sets its priorities for coordinated care and begins the process of contracting with risk-based organizations, the Exchange will need to assess the implications of new policies for the potential plans interested in offering coverage on the Exchange. Finally, there are financial implications to strategic decisions made by the Exchange. For example, pressure on Exchange-qualified plans to reduce premiums will translate swiftly into reduced provider reimbursements from those plans, with the predictable result that providers will resist Medicaid reductions even more aggressively (and with some justification). The important point is not that every dimension of interaction should be identified and dealt with, but rather than the state needs to recognize the deeply connected nature of the Exchange and the Medicaid program and plan ahead to address it by ensuring coordinated planning and communications structures. We recommend senior staff assigned to play this role at both the Exchange and at HFS. As noted repeatedly in this report, current planning is led by engaged and well-coordinated staff at Medicaid and DOI, so Illinois has a strong foundation on which to build this kind of formalized structure.

4.5.1 Medicaid Expansion

This section analyzes the impact of the ACA's Medicaid expansion in Illinois.

In January 2014, the ACA expands Medicaid to cover individuals and families below 133% FPL.[7] The expansion eliminates, for individuals under 65, the historical categorical eligibility standards that have made Medicaid eligibility a complex patchwork with different categories of individuals (children, individuals with disabilities, pregnant women, etc.) eligible at different income levels. In Illinois, the Medicaid expansion will affect primarily two groups:

- Individuals with income at or below 133% FPL who do not meet categorical eligibility criteria
- Individuals with disabilities and income at or below 133% FPL and above the current Medicaid threshold of 100% FPL

In this section we estimate the impact of the Medicaid expansion in Illinois.[8]

[777] The ACA establishes 133% FPL as the eligibility standard for Medicaid and also requires states to disregard 5% of income in determining eligibility. As a result the effective income standard for Medicaid is 138% FPL, but throughout this report we refer to the legal eligibility standard for the sake of simplicity and clarity.

[8] The analysis necessarily relates to the Medicaid program (42 U.S.C. Title XIX) and the Children's Health Insurance Program (Title XXI). Because Illinois operates a combined Title XIX and XXI program, and to avoid confusion with the separate Illinois Comprehensive Health Insurance Plan, we use the term Medicaid to refer to both Title XIX Medicaid and Title XXI Children's Health Insurance Program. Where necessary to differentiate between the two separate federal programs, we refer to "Title XXI", commonly known nationally as the CHIP program.

For the analysis, we used American Community Survey (ACS) census and HFS administrative data to estimate two populations for December 2013 – those enrolled in state health programs (Medicaid, Title XXI and state programs) and those who are uninsured. First, we estimate projected enrollment in state programs and Medicaid at the end of 2013 based on state enrollment data. Second, we estimate the uninsured at the end of 2013 in Illinois. Third, we allocate December 31, 2013 estimates based on new eligibility rules in 2014 to project the number of individuals who would be eligible in 2014 for state health programs, the Exchange with subsidies and the Exchange without subsidies. Finally, after assuming certain take-up rates for various 2014 populations, assumptions that we think are responsible, we estimate costs to the state of the Medicaid expansion.

This analysis is not derived from the more comprehensive modeling performed by the separate background research vendor but instead is an alternative approach to projecting Medicaid impacts. The significant difference between our analysis and that modeling is in our methodology to estimate potential growth in the Medicaid program and uninsured population between now and the end of 2013. While the Deloitte model makes assumptions about economic factors and behavioral factors that influence projected growth before ACA implementation, HMA conducted a more focused analysis derived, as described in greater detail below, from historical state enrollment and administrative data.

ESTIMATING PROGRAM PARTICIPATION FOR DECEMBER 31, 2013

To estimate the projected number of state program participants for December 31, 2013, we use April 2011 program enrollment figures from HFS as the baseline. HFS provided state program enrollment data for a 21 month period ending April, 2011. These data were detailed by more than 80 Medicaid, Title XXI and State Program comprehensive benefit eligibility categories based on age, parental status, disability status, poverty level, Medicare eligibility, etc. (See the list of eligibility categories in Appendix B.) Enrollment changes over the 21 month period varied significantly by eligibility category. As a result we used 21 month enrollment change figures for each comprehensive benefit eligibility category to estimate enrollment by category for December 2013. We then adjusted these projections to account for known policy changes. Specifically, to adjust for the impact of state Medicaid reform changes to HFS eligibility policies[9], we:

- Removed enrollment in eligibility categories for children with income over 300% FPL,
- Assumed a modest 1% reduction in growth of All Kids enrollment, which saw notably high growth during the 21 month baseline period.
- Reduced projected growth in several eligibility categories where baseline data showed significant anomalous growth during the 21 month period that appeared unsustainable going forward.

[9] Despite federal disapproval of two eligibility documentation changes, state Medicaid reform includes other changes that can be expected to reduce enrollment growth rates i.e. reducing All Kids upper income limit to 300% FPL, ending passive redeterminations, mandating a 60 day window for responding to requests for additional information, requiring data matches for verification purposes, etc.

As a result of this process, we estimate that 2.9 million individuals will be enrolled in comprehensive coverage through Medicaid and state programs as of December 31, 2013. As the following table shows, this is equivalent to a 3.1% annual increase over our base April 2011 enrollment numbers.

Table 17: Medicaid and State Program Enrollment (Comprehensive Benefits Only)
August 2009 and April 2011 Actual with December 2013 Projected

	Actual Aug-09	Actual Apr-11	Annual Growth	Estimate Dec-13	Annual Growth
Total	**2,548,141**	**2,702,776**	**3.6%**	**2,928,971**	**3.1%**
Children 0-18	1,574,184	1,662,066	3.3%	1,782,433	2.7%
Adults 19-64	820,085	876,368	4.1%	966,986	3.9%
Non-Elderly	**2,394,269**	**2,538,434**	**3.6%**	**2,749,419**	**3.1%**
Adults 65+	153,872	164,342	4.1%	179,552	3.5%

ESTIMATING STATE UNINSURED POPULATION AS OF DECEMBER 31, 2013

To estimate the number of uninsured Illinoisans in 2013, we started with the 2009 ACS estimates of the proportion of uninsured Illinoisans in each of three age categories (0-18 years, 19-64 years, and over 65). We then applied these proportions to the 2013 projected population estimates, which are derived from the Illinois Department of Commerce and Economic Opportunity's population projections with adjustments based on the 2010 census counts to produce the following results. These estimates exclude uninsured undocumented immigrants who are ineligible for medical assistance through ACA. This population was excluded based on a Metropolitan Chicago Information Center analysis that incorporated data from the U.S. Department of Homeland Security.

Table 18: Projected Uninsured Population in Illinois, December 2013
(Excludes undocumented immigrants)

Total	1,491,662
Children 0-18	150,769
Adults 19-64	1,326,067
Non-Elderly	**1,476,836**
12/31/13 Uninsured 65+ Pop.	14,826

PROGRAM ELIGIBILITY IN 2014

Based on new eligibility standards under the ACA, we split our estimate of 2013 enrollment by eligibility category into three categories for 2014: Medicaid, Exchange with subsidy and Exchange without subsidy. These assumptions are summarized in Appendix B.[10]

ACA implementation will make two groups of adults 19-64 newly eligible for Medicaid in 2014.

[10] Individuals over 65 years of age and Medicare enrolled individuals of any age were not considered Exchange eligible consistent with ACA provisions. In instances where HFS enrollment data did not indicate enrollee income, approximate income distribution proportions from the current population of Illinois uninsured, based on 2009 American Community Survey data, were applied to projected 2013 enrollment numbers.

- Individuals with income between 0% and 133% FPL who are not eligible for programs that cover parents and the disabled.
- Disabled persons with income above the current Medicaid threshold of 100% FPL and at or below 133% FPL.

Most enrollees in current state insurance coverage programs will remain eligible for Medicaid after 2014. However, ACA coverage and financing rules make it likely that (assuming the state decides to eliminate coverage) certain individuals enrolled in state programs will move to the Exchange. We assume that the State will choose to:

- End 100% state funding for children with income over 200% FPL and at or below 300% FPL (23,000 estimate for December 2013) and encourage them to enroll in the federally-funded Exchange in 2014.
- Reduce FamilyCare Medicaid coverage for parents from 185% FPL to 133% FPL in 2014 and encourage these individuals (36,979 estimate for December 2013) to enroll in the federally subsidized Exchange in 2014.
- Move to the Exchange a small portion of the Breast and Cervical Cancer program enrollees, those under 65 with income over 133% FPL who are not dually eligible for Medicare (1,260 estimate for December 2013).
- End the Illinois Healthy Women (IHW) program. Women in IHW receive partial benefits and are considered uninsured in ACS numbers. IHW enrollees who are under 65 and not dually eligible for Medicare (65,000 estimate for December 2013) could become eligible for comprehensive benefits through Medicaid or the Exchange in 2014.

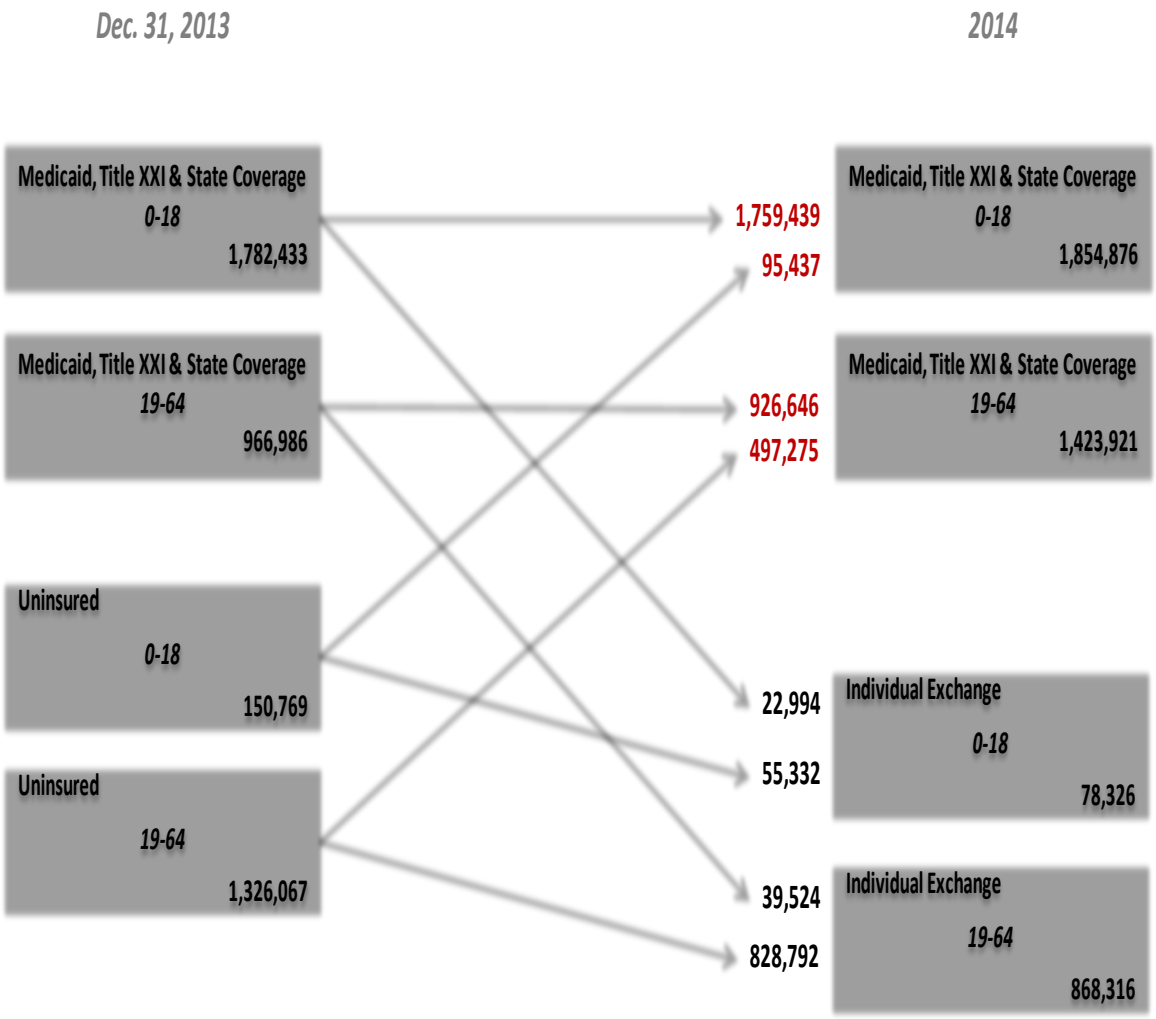
Along with currently enrolled individuals who will become Exchange eligible, a large group of currently uninsured individuals will also become eligible for the Exchange. It is estimated that 55,000 currently uninsured children with income over 200% FPL and 829,000 uninsured non-elderly adults with income over 133% FPL will be Exchange eligible in 2014.

Table 19 shows program eligibility in 2014 for those individuals who are projected to be in state programs or uninsured as of December 2013. The purpose of the table, and the following graphic, is to represent the programs that will become available to individuals who are now either served by state programs or uninsured. The rate at which these individuals actually enroll in programs available to them is addressed in a subsequent step of this analysis. In addition, this analysis is limited to the changes for the uninsured and state program enrollees. Addressed in greater detail in the separate Background Research report is the fact that currently insured individuals will also access coverage through the individual Exchange, and that employers will access coverage through the SHOP Exchange.

Table 19: 2014 Program Eligibility for State Program Enrollees and the Uninsured (Comprehensive Benefits Only)

Projected Eligibles	Projected 12/31/2013	2014 Medicaid	2014 To Exchange w/Subsidy	2014 To Exchange no Subsidy	2014 To Exchange Total	2014 Uninsured 65+
2013 State Program Enrollees	2,928,971	2,865,637	62,087	431	62,518	-
Children 0-18	1,782,433	1,759,439	22,994	-	22,994	-
Adults 19-64	966,986	926,646	39,093	431	39,524	-
Adults 65+	179,552	179,552	-	-	-	
2013 Uninsured	1,491,662	592,712	659,950	224,174	884,124	14,826
Children 0-18	150,769	95,437	39,351	15,982	55,332	
Adults 19-64	1,326,067	497,275	620,599	208,193	828,792	
Adults 65+	14,826				-	14,826

Figure 5: State Program Enrollees and Uninsured Lives; Program Eligibility in 2014 (excludes undocumented immigrants)



ESTIMATED 2014 MEDICAID ENROLLMENT UNDER THE ACA

While all the individuals represented in Table 20 are expected to be eligible for Medicaid and the Exchange in 2014, all will not enroll in coverage during the year. As with all coverage programs, 100% enrollment is unlikely to occur at any time but especially unlikely during the first year. While the individual mandate combined with multiple outreach and enrollment simplification strategies can be expected to result in higher take-up rates than traditionally seen with health benefits programs, a portion of the eligible population can be expected to enroll but not maintain coverage while others are expected not to apply for coverage at all.

For the purposes of this analysis, which is to estimate the cost of the Medicaid expansion to the state of Illinois, we assume that:

- 100% of the individuals enrolled in Medicaid or state-funded programs in 2013 will be directly enrolled in Medicaid in 2014, and
- 50% of 2013 uninsured individuals who are eligible for Medicaid in 2014 will enroll in 2014.

Table 20: Estimated 2014 Medicaid Enrollment Estimates (Comprehensive Benefits Only)

	2014 Eligible Individuals	2014 Enrollees
Total Estimated Medicaid 2014	**3,458,349**	**3,161,993**
2013 State Program Enrollees	**2,865,637**	**2,865,637**
Children 0-18 (100% take up)	1,759,439	1,759,439
Adults 19-64 (100% take up)	926,646	926,646
Adults 65+	179,552	179,552
2013 Uninsured	**592,712**	**296,356**
Children 0-18 (50% take up)	95,437	47,718
Adults 19-64 (50% take up)	497,275	248,638

MEDICAID COSTS IN 2014

Total medical spending per enrollee is the other key element in projecting 2014 costs. In order to project the cost of these new enrollees, benefit costs on a per-member per-month (PMPM) basis were projected for 2014, based on 2007-2010 actual PMPMs. The following table shows actual 2007 through 2010 PMPMs as HFS reports costs - for children, non-elderly adults with disabilities and other non-elderly adults. The three-year average percentage change in PMPMs for adults was used to project annual benefit cost changes for 2011 through 2014. For children, since 2008 saw a rare 6% reduction in the average PMPM, the two-year average percentage change for 2009 and 2010 was used. This rate of increase results in projected 2014 PMPMs of $192 for children, $1,248 for adults with disabilities and $399 for other adults. Since the 2014 new Medicaid enrollee projections are not detailed by health status, the two adult rates were blended by assuming 20% of new adult enrollees would have health needs comparable to disabled persons. This results in an average adult rate of $569 PMPM.

Table 21: Actual and Projected Per-Member Per-Month Benefit Costs 2007-2014

Actual PMPMs	2007	2008	2009	2010
XIX/XXI/St Program PMPM Benefit Costs				
Children 0-18	$173	$163	$168	$172
Adults with Disabilities 19-64	$968	$1,017	$1,065	$1,079
Other Adults 19-64	$335	$349	$356	$361
Percent Change From Prior Year				
Children 0-18		-5.8%	3.1%	2.4%
Adults with Disabilities 19-64		5.1%	4.7%	1.3%
Other Adults 19-64		4.2%	2.0%	1.4%

Note: from Illinois HFS Transparency Report extracted 4-27-11; excludes Cook, UIC, administration payments, and other agencies; for full benefit enrollees only; LTC costs excluded

Projected PMPMs	2011	2012	2013	2014
Change From Prior Year				
Children 0-18	2.7%	2.7%	2.7%	2.7%
Adults with Disabilities 19-64	3.7%	3.7%	3.7%	3.7%
Other Adults 19-64	2.5%	2.5%	2.5%	2.5%
XIX/XXI/St Program PMPM Benefit Costs				
Children 0-18	$177	$181	$186	$192
Adults with Disabilities 19-64	$1,119	$1,160	$1,203	$1,248
Other Adults 19-64	$370	$379	$389	$399
Adults 19-64 20% w/Disabilities	$520	$536	$552	$569

Federal match rates are different for individuals eligible for Medicaid under Illinois' current rules and those made newly eligible under the ACA. We assume that 80% of the new adult enrollees will be "newly eligible" and that 20% will be individuals who would be eligible under today's Medicaid rules. Given the differential matching rates for these different categories, this is an area that deserves close scrutiny and monitoring. The state's liability could be greater if the number of "previously eligible" individuals is higher than this projection, and less if the number of newly eligible" individuals is higher.

Federal support for Title XXI will increase in 2016, but that new matching rate is not relevant to the 2014 costs projected here. We use the most conservative FFP rate for children because the HMA Team has not had access to data necessary to estimate differential or blended matching rates for the combined Medicaid-Title XIX population. Thus, the 50% FFP rate for children in 2014 is understated because it does not factor in new Title XIX children for whom FFP is 65%.

As shown in Table 22, the benefit costs of the new 296,356 2014 Medicaid enrollees in our scenario were calculated using the projected 2014 PMPMs. We project 2014 benefit costs for new enrollees in comprehensive Medicaid, on an annualized basis, would total $1.8 billion. Net of federal financial participation (FFP) new state costs for Medicaid enrollment would be $224 million.

Table 22: Projected 2014 Benefit Costs for New Medicaid Enrollees (Comprehensive Benefits Only)

Total	2014 New Enrollees Previously Eligible	2014 New Enrollees Newly Eligible in 2014	Projected 2014 PMPM Costs	Annualized Costs	FFP Rate	Net State Annualized Costs
296,356				$ 1,806,459,977		$224,513,897
Children 0-18	47,718		$ 191.52	$ 109,669,748	50%	$ 54,834,874
Adults 19-64 (20% of new enrollees)	49,728		$ 568.69	$339,358,046	50%	$169,679,023
Adults 19-64 (80% of new enrollees)		198,910	$ 568.69	$1,357,432,183	100%	- -

OFFSETTING COSTS FROM PROGRAM ELIMINATIONS

If Illinois eliminates FamilyCare Medicaid coverage in 2014 for parents above 133% FPL, these individuals would move from a 50% federal match program to a 100% federally funded program. This would eliminate the state's share of costs for an estimated 36,979 persons in 2014. Assuming $399 PMPM average costs in 2014 for these parents, this would reduce state costs by $88 million in 2014.

In addition, we anticipate that an estimated 22,994 All Kids enrollees as of December 31, 2013 who have income between 200 and 300% FPL will move to the Exchange in 2014. Coverage for this population, for which the state would be receiving federal match in 2014, could be eliminated because it is not subject to maintenance of effort requirements. Assuming average benefit costs of $191.52 PMPM, state spending would be reduced annually by $26.4 million.

Factoring in all of these cost changes, Illinois Medicaid and state program spending is estimated to increase by $109.4 million, net of federal match.

2014 net cost of newly eligible Medicaid and Title XIX enrollees	**$224.5 million**
2014 savings from reducing FamilyCare eligibility from 185% to 133%	($88.7 million)
2014 savings of reducing All Kids eligibility from 300% to 200%	($26.4 million)
Total 2014 Spending	**$109.4 million**

State costs are likely to increase in subsequent years, as enrollment (from both currently and newly eligible populations) ramps up over time. It is important to emphasize that there are potential other savings associated with ACA implementation that are not analyzed here. We have not quantified potential reductions in state spending for uncompensated care that would reduce overall state costs. Using state-specific enrollment and cost data, the state should analyze potential cost savings as it makes decisions about ACA-driven changes to eligibility standards and uncompensated care arrangements to understand the overall impact of the ACA on the state's budget. Finally, this analysis does not include administrative costs associated with the Medicaid expansion.

4.5.2 Options to Mitigate Churn Between Programs

This section addresses one of the often-discussed dynamics set in motion by the ACA—movement between the Exchange and Medicaid for low-income individuals, commonly referred to as the phenomenon of "churn."

While the ACA is intended to, and will, expand health insurance coverage and streamline eligibility and enrollment processes for low-income individuals, there are risks inherent in the structural design of the law that creates Exchange-based subsidies administered separately from the Medicaid program. Specifically, maintaining continuity of coverage for individuals whose income fluctuates above and below 133% FPL (the cutoff between Medicaid and Exchanges) will be challenging.

This section focuses on ways to minimize program turnover and particularly administrative "churn." The term "churn" refers generally to movement in and out of income-based programs. That movement may be caused by changes in income and access to employer-sponsored insurance. It may also be a result of paperwork and administrative requirements of the public program, for example, the need to complete paperwork for a regular redetermination of eligibility.

Maintaining continuity of coverage has been a longstanding issue in the Medicaid and CHIP programs, because of enrollees' ongoing changes in eligibility status. Continuity of coverage is important for managing care and improving population health; there are numerous studies that show the relationship between loss of access to health insurance and people delaying or forgoing necessary health care.

But current research indicates that the challenge could be even greater under the ACA, because income fluctuations are much more likely in families at or near the breakpoint between Medicaid and Exchange-based subsidies (133% FPL).[11]

[11] See "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Benjamin D. Sommers and Sara Rosenbaum, *Health Affairs*, February, 2011 (finding that 50% of all adults with family incomes below 200% of FPL will have a change in income within one year that will move them from Medicaid to a health insurance Exchange subsidy or the reverse), and "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," Pamela Farley Short, Deborah R. Graefe, and

With that context, we discuss here several possible ways that Illinois could mitigate the churn issue when implementing health reform. Although some of these approaches are derived from historical approaches to preventing turnover in Medicaid and CHIP, we focus on opportunities presented by, and relevant to, the implementation of the ACA. We also note that some of the historical approaches, particularly those involving managed care organizations, may not be relevant to Illinois today, but we provide them knowing that the state is designing an initiative to implement coordinated care in certain parts of the state.

1. The Basic Health Plan

The Basic Health Plan (BHP) is an important potential option because it is focused on the low-income individuals who are most likely to experience income changes. In addition, the BHP may provide those individuals with a closer-to-Medicaid health insurance alternative to the Exchange that could be more affordable and reduce otherwise-likely barriers to individuals moving from Medicaid to the Exchange. States may design a BHP to reduce the cost sharing requirements for people below 200% of FPL (a population that may struggle with the affordability of the Exchange plans, even with subsidies). A recent Commonwealth Fund study suggests that most low-income people will be able to afford Exchange plans with the subsidies but will be challenged if they face high out-of-pocket costs. The potential design and funding of the BHP could reduce the "cost-sharing cliff" between Medicaid and the Exchange. Another potential advantage of the BHP in terms of reducing churn is that it could be served by the same Medicaid managed care organizations (MCOs) that serve the Medicaid program (see discussion of the role of MCOs below).

There are other potential advantages to implementing a BHP as well as potential disadvantages. These are more fully discussed in section 4.4.5.

2. Administrative Approaches to Managing Eligibility

There are a number of approaches Illinois could take to improve its eligibility policies and processes in ways that will minimize unnecessary program churn. A comprehensive Medicaid reform law signed by Governor Quinn in January of this year creates a range of obligations associated with redeterminations and program integrity in Medicaid, which we recognize and do not mean to pass judgment on. However, connected to the implementation of the ACA will be federal regulations that set standards for a streamlined Medicaid eligibility process and which may affect state options on the scale and timing of redeterminations. Given those two factors, we mention two traditional approaches to minimizing churn that the state may consider as it implements the state law and monitors developments on the federal level.

Cathy Schoen, The Commonwealth Fund, November 2003 (finding that 68% of people with incomes under 200% of FPL became uninsured over a four year period, whereas only 15% of people with incomes above 400% of FPL did).

a. Annual eligibility redeterminations

Illinois could allow for continuous eligibility of Medicaid or Exchange subsidy coverage for 12 months. A presumption of coverage is what the ACA envisions, but detailed federal guidance on eligibility rules has not yet been issued. Continuous eligibility is obviously a challenging prospect in a tight fiscal environment. On the other hand, as noted, there is research that demonstrates real administrative and programmatic costs to excessive churn, including higher administrative processing costs and potentially longer-term health costs due to delays in or forgoing needed care—even temporary lapses in coverage can cause delays in needed care.

b. Streamline eligibility processes

The ACA calls for streamlined and simplified eligibility processes, for both the initial application and in transitions or redeterminations of eligibility. Requirements of the ACA include:

- A "no wrong door" approach to the intake of applications for eligibility.
- A simplified process that is the same for all subsidized health programs.
- The use of federal databases for income and other verifications, rather than requiring additional paperwork.

The implementation of these requirements in Illinois, discussed in detail in the separate report on eligibility and enrollment systems, is among the more complex endeavors for state Exchange planners. For the purposes of this section, the point is simply that the improvements that Illinois will be making, in compliance with federal rules, could be monitored in actual application and operation to assess how successfully the changes are avoiding unnecessary eligibility changes.

Finally, an administrative approach that relates to the specific interaction between Medicaid and the Exchange after 2014 is worth mentioning.

c. Allow for Medicaid coverage to extend until Exchange coverage starts

The Exchange is likely to have enrollment policies that are more similar to the commercial market than Medicaid. Medicaid enrollees who lose their eligibility for Medicaid may have to wait until the first of the next month to enroll in Exchange coverage. (At least some Medicaid enrollees are accustomed to retroactive eligibility, which will not be available through the Exchange.) Illinois could consider allowing people to remain on Medicaid until their Exchange coverage begins.

3. Requirements for Health Plans

There is a fair amount of evidence that Managed Care Organizations (MCOs) can be effective partners with states to help mitigate administrative churn. MCOs can be engaged to help members with renewing eligibility in a timely way, through the use of such techniques as outreach, phone calls, and partnering with health care providers to inform patients. Assisting with certain mechanics of the program, such as obtaining updated addresses from enrollees and providing their renewal dates well in advance, are other ways in which the state can partner with its managed care partners to minimize

churn. As Illinois embarks on its coordinated care initiative, it may wish to consider how to include as a part of that initiative obligations and expectations that will support a goal to reduce administrative dislocations caused by churn.

Depending on that initiative and how it forms, it is worth noting as well that there are approaches the Exchange could take that would make it more likely that individuals moving between Medicaid and the Exchange could remain in their own plan. Without knowing the character of and standards for coordinated care plans, we do not suggest particular options for consideration. However, conceptually a state interested in smoothing a transition between Medicaid and the Exchange could require or incentivize Medicaid insurance plans to participate on the Exchange, in order to make it more likely that individuals will be able to retain health plan and clinical relationships as they move between the programs.

4. Consumer Assistance

Finally, there are numerous ways that Illinois can offer consumers assistance in navigating the post-health reform world of subsidized health insurance coverage. Through a vigorous outreach and education campaign, Illinois can let consumers know what their options are and where they can go for help. This campaign should include the use of advocacy organizations and other community-based groups. A robust call center with a well-trained staff, combined with an easy-to-use website, can help consumers. And finally, the Exchange can seek funding for Navigators and target their work to focus on populations at high risk for churning.

4.5.3 Impacts of Developing a Basic Health Program

This section analyzes the option of a Basic Health Program in Illinois.

BACKGROUND

Section 1331 of the ACA gives states the option of establishing a Basic Health Program (BHP) in lieu of Exchange coverage for people ineligible for Medicaid who have income at or below 200% FPL. The eligible population includes legal immigrants who, because they have less than five years of U.S. residency, are ineligible for Medicaid. This section describes the BHP and the potential differences between it and the Exchange, suggests--on the basis of Wakely analysis--an approach to evaluating the feasibility of a BHP in Illinois, and discusses considerations and potential next steps for Illinois as it considers whether to develop a BHP.

ELEMENTS OF THE BHP

The BHP allows states to set different premiums and cost-sharing and provide different benefits to low-income enrollees than the enrollee would pay for Exchange-based subsidized coverage. The state can also offer additional benefits, within federal guidelines.

The ACA allows states to set premiums at levels lower (but not higher) than what a BHP enrollee would have paid on the Exchange. Similarly, other cost-sharing under the BHP may not exceed cost sharing under an Exchange platinum plan for persons with income at or below 150% FPL and under a gold plan for those with income above 150% FPL. In Illinois, Medicaid and FamilyCare premium and cost sharing amounts are significantly lower than Exchange amounts enrollees will pay, even with Exchange premium and cost-sharing subsidies.

BHP plans must cover at least all “essential health benefits” to be defined by the Secretary of HHS later this year. A state can provide additional benefits. Illinois Medicaid includes services that the essential benefit package will likely not include, such as: other practitioners care (podiatrists, chiropractors, audiologists, optometrists, etc.), long term care and community-based long term care, hospice care, transportation, home health, and early intervention services. While, as discussed elsewhere in this document, it is possible to make plausible surmises about the general nature of "essential health benefits", until these are finally determined, it will be very difficult to fully understand the implications of implementing a BHP.

States must use a competitive process to select and negotiate with one or more BHP health plans. Health plans can be licensed HMOs, licensed health insurers, or networks of health care providers that offer managed care systems or attributes of managed care. Health benefit plans that contract with states to provide BHP coverage must maintain a medical loss ratio of at least 85%.

Generally speaking, observers see the flexibility available in the BHP as an opportunity to design a plan that is intended to address the needs of the low-income population. First, benefit design flexibility allows the BHP to be more affordable to the consumer and provide benefits not available on the commercial Exchange market. Second, in a state that utilizes Medicaid delivery systems or health plans, the BHP could improve continuity of care across transitions in coverage due to income changes and within families who would otherwise be “split” between the Exchange and Medicaid.

This flexibility for states comes with trade-offs and risks. Most importantly, the financial structure of the BHP creates significant risk and uncertainty for Illinois. The basic arrangement, analyzed in detail below, is that states will receive 95% of what BHP enrollees would have received in subsidies on the Exchange. The state is at risk for any spending above that amount. The 95% -- really a form of block grant to the state – is based on the second-lowest cost Silver level plan on the Exchange. This construct creates an immediately apparent conundrum: the lower the premiums are on the Exchange, the less money the state receives for its BHP. A state that wants to prioritize achieving lower cost premium options on the Exchange, through contracting strategies or by incentivizing limited-network plans, is simultaneously lowering its BHP allotment. Moreover, even if Illinois did not care to actively lower prices on the Exchange, the actual price of the second-lowest cost Silver plan, essential to planning for a BHP, is the subject of uncertainty and potential volatility. Finally, it is not clear how the federal government will estimate what it would otherwise have spent on the BHP population, including whether and how it will take into account year-end reconciliation amounts for individuals whose income goes up over the course of the year. More details on BHP administration are expected later this year.

Table 23 summarizes some of the opportunities and challenges presented by the BHP. As noted below, we strongly recommend this as an area for further inquiry, and close monitoring of federal developments.

Table 233: Basic Health Plan Opportunities and Challenges

BHP Opportunities	BHP Challenges
• Could simplify coverage for families by keeping parents and children on similar, coordinated programs • Could mitigate problems from movement between Medicaid and the Exchange at 133% FPL • Could build on Illinois' history of covering similar populations • Could reduce out-of-pocket costs from Exchange levels • Could present an affordable alternative for very low-income legal immigrants who have been in the U.S. for less than five years	• Uncertainty of Exchange premium amounts makes financial modeling difficult • Movement between in and out of Medicaid/BHP would still occur at 200% FPL • Potential for drawing individuals from the Exchange which could change remaining risk pool in Exchange and modify Exchange costs and revenues • State capacity and infrastructure needed to administer a BHP may be constrained • Medicaid plans, provider networks and provider rates may not be sufficient to assure adequate access • Health status of BHP population is uncertain which makes financial viability of BHP uncertain

PRELIMINARY FINANCIAL RESULTS

This section outlines an approach to analyzing and evaluating a BHP option that could be implemented in Illinois beginning in 2014. It is important to note that the results presented are only illustrative because there are so many uncertainties regarding final regulations and how private insurers and consumers will react to numerous components of healthcare reform that become effective in 2014. The purpose of the analysis is to provide a framework for modeling cash flows under a BHP and to begin the process of estimating the key components that drive those cash flows.

The basic financial structure cash flows of the program break down as follows:

Revenue

- 95% of any premium subsidies the federal government would have paid for BHP enrollees had they been enrolled in the State Exchange. The premium subsidy in the Exchange is based on the second lowest Silver plan rate.

- 100% of enrollee cost sharing subsidies the federal government would have paid had they been enrolled in the State Exchange

Costs

- Medical costs for minimum essential benefits

- Offsets for member cost sharing up to a maximum actuarial value of 10% for 133% to 150% of FL, and 20% for 151%-200% of FPL.
- Offsets for member premiums up to a maximum percent of income (varying by income level)
- Administrative costs incurred by the State, or inherent in private carrier's capitation rates

Any surplus must be held in a State trust fund and be used for future benefits, cost sharing reductions, or premium reductions.

PROJECTED CASH FLOWS FOR AN ILLINOIS BHP

Using publicly available demographic data in Illinois, medical cost information from other state programs, and information provided by the State of Illinois, we projected potential CY2014 BHP cash flows under several different scenarios. Descriptions of our process and key assumptions are in the Method and Assumptions section, below.

One of the most important assumptions in our modeling is the estimate of the premium for the second lowest cost Silver Exchange premium, which drives all of the revenues. In the model, in order to capture a range of scenarios, we utilize a range of potential premiums ranging from $261 to $392 PMPM.

We estimate that the BHP will result in a range of about ($493) million to $482 million in net cash flows in CY2014. Table 24 below shows the revenue and expenses associated with these estimates.

Table 244: Illinois BHP Cash Flows by Component and Scenario
CY2014, Amounts in Millions

Component	Very Favorable	Favorable	Neutral	Unfavorable	Very Unfavorable
Enrollment	286,000	286,000	286,000	249,000	212,000
Revenue					
Exchange Premium Credits	$830	$728	$627	$455	$312
Exchange Cost Sharing Subsidy	$288	$264	$240	$188	$142
Total	$1,119	$992	$867	$642	$454
Basic Health Program Costs					
Allowed Cost	$1,010	$1,136	$1,262	$1,251	$1,214
Member Cost Sharing	$0	$0	$0	$0	$0
Member Premium	($485)	($485)	($485)	($421)	($358)
Administrative Costs	$112	$124	$130	$112	$91
Total	$637	$776	$908	$942	$947
Surplus (Deficit)	**$482**	**$217**	**($41)**	**($300)**	**($493)**

Many other scenarios are possible, including ones that produce a surplus or (deficit) outside the range shown in Table 24. Each of the scenarios shown in the table (other than "Neutral") are based on

combinations of all favorable or all unfavorable results for certain key variables for purposes of capturing a range of scenarios. We believe it is more likely that only some variables will be more favorable while others will be less favorable than our Neutral scenario.[12]

The assumptions by key variable in Table 24 are summarized below in Table 25.

Table 255: Illinois BHP Assumptions by Scenario

Scenario	2nd Silver PMPM	BHP Med Costs PMPM	Administrative Expense %	Employer-Sponsored Take-Up Rate
Very Favorable	$392	$272	10.0%	25%
Favorable	$359	$306	12.5%	25%
Neutral	$327	$341	15.0%	25%
Unfavorable	$294	$375	17.5%	13%
Very Unfavorable	$261	$409	20.0%	0%

Please note that these assumptions are not a comprehensive set of all possibilities. Rather, these were the assumptions we believe will have the biggest impact on results.

This model is intended to demonstrate how the state can assess the BHP financial arrangement analytically. As the programmatic characteristics of a BHP are more clearly defined, we recommend ongoing analysis of the potential BHP population, its risk profile, and potential revenues to the BHP.

NEXT STEPS

As noted at the beginning of this Section, there are many unknowns in the BHP model we have presented. We believe it will be important to continue to refine and improve the assumptions that drive the projected financial results of the BHP and the overall decision to implement a BHP or not. The reader should carefully review the "Methods and Assumptions" section, in Appendix C. In particular, the development of expected medical costs involves several steps with assumptions that should be thoroughly understood before making decisions based on this analysis.

We suggest a number of important considerations that should be closely reviewed as the state evaluates the results presented here and considers the issues surrounding the BHP as it continues with Exchange implementation planning.

[12] The BHP model requires detailed background on the previous source of coverage of BHP-eligible individuals. In other words, cost assumptions in the model are directly related to the source of coverage (i.e., Medicaid, small group, individual market coverage) a BHP enrollee had prior to 2014. During development of our model, we did not have access to that degree of supporting documentation from Deloitte. More importantly, the existence of a BHP would change a range of assumptions and behaviors that would affect actual enrollment in the BHP population, as compared to enrollment in Exchange coverage. Therefore, enrollment assumptions made concerning BHP enrollment are not derived directly from the Deloitte report. Our method for estimating enrollment, and for other components of the analysis, is described in detail in Appendix C.

- We have not modeled or addressed how the Illinois Health Insurance Exchange will be impacted by the BHP. In general we believe that the subset of individuals between 133% and 200% FPL who do not enroll in the BHP will be slightly healthier than those in the BHP. The BHP and Exchange populations are unquestionably linked and we recommend further analysis of the interaction between these two programs, and how a BHP could affect the risk pool in the Exchange.

- There is considerable uncertainty in what the second-lowest Silver premium will be in the Illinois Exchange, and this is a very sensitive variable in determining the overall outcome. We have shown scenarios up to a +/- 20% change in our mid-point estimate; however the rate depends on many factors and could vary beyond this range.

- The relationship of Illinois Medicaid to the BHP in terms of management and operations is an important factor to explore. And the absence of a robust Medicaid managed care program in Illinois raises issues: under what circumstances would the federal government approve the current Medicaid provider network as an adequate BHP delivery system? Is the current network sufficient to ensure access to care for current enrollees, the Medicaid expansion population, and the BHP?

4.5.4 Early Medicaid Expansion

This section deals with the option of early implementation of the Medicaid expansion that is required to be implemented in 2014

Section 2001 of the ACA expands Medicaid eligibility, effective January 1, 2014, to individuals with incomes below 133% of FPL and sets enhanced federal matching rates (starting at 100% from 2014-2016, declining to 90% by 2020) for the costs of the expansion. The same section also authorizes states to implement the expansion earlier than January 1, 2014. An early expansion may be approved by means of a state plan amendment—for Medicaid, a relatively simple process—but the state is required to bear the cost of the early expansion at its prevailing federal medical assistance percentage rate, not the enhanced rates that begin in 2014.

The State of Illinois, like many states, has experienced a precipitous drop in revenue since the recession in 2009. The state's budget situation, while resolved with a final budget for FY2012, remains very challenging. Moreover, the Medicaid program is implementing the Medicaid reform bill that passed earlier this year (H.B. 5420) during FY12. In the context of necessary preparations that HFS and DHS need to make to prepare for health reform implementation and the 2014 expansion, the law will undoubtedly present a challenge to HFS infrastructure and resources. Given these circumstances we have not spent significant time analyzing the cost impact of a choice to implement the ACA early Medicaid expansion.

It deserves mention, however, that waiting until the January 1, 2014 implementation date also creates operational challenges. There are a significant number of individuals who are currently receiving state benefits and will qualify for Medicaid on January 1, 2014. The state may wish to consider approaches that could ease the administrative difficulties (a flood of applications, calls, and enrollments) that could result from a "big bang" implementation.

One consideration is that draft federal regulations set an initial enrollment period beginning October 1, 2013. Without question, the state will necessarily need to have its enrollment systems set up and operable by the time open enrollment begins. While it is difficult at this stage of planning to suggest a particular action or even to propose a set of options, the point is that the state may consider approaches that allow it to receive applications and process them in advance of the January 2014 coverage date so that eligibility begins right away on January 1. Once the potential operational mechanics of such an approach are more clearly defined, the state certainly will need to analyze what we expect will be a trade-off between complicating an already-complex implementation plan before 2014, on one hand, and relative administrative ease on and after January 1, on the other. Notably, there is not a state programmatic cost element to be factored into this equation, since the Medicaid expansion in 2014 will be fully funded by the federal government.

4.6 Other State Programs and the Exchange

This section addresses how full ACA implementation in 2014 and the reduced uninsurance rates that will follow will impact state programs beyond those administered by HFS.

Programs other than Medicaid that serve primarily uninsured persons will see a reduction in eligible individuals. Other programs may see an increase in applicants and enrollees as the Exchange brings more Illinoisans into contact with state programs. Some of the programs likely to be impacted by the Exchange are discussed in the following sections.

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Just over 4,000 uninsured individuals with AIDS or HIV and incomes at or below 500% of FPL[13] receive HIV/AIDS prescription benefits of up to $2,000 a month (with some exceptions) through the AIDS Drug Assistance Program. Data from the May 2011 National ADAP Monitoring Project Annual Report[14] by the National Alliance of State and Territorial AIDS Directors provides Illinois ADAP enrollment statistics for June 2010.

[13] As of July 1, 2011, the Illinois ADAP program will be limited to qualifying individuals with income below 300% FPL.

[14] http://www.nastad.org/Files/020035_2011%20NASTAD%20National%20ADAP%20Monitoring%20Project%20Annual%20Report.pdf

- There were a total of 5,919 ADAP enrollees.
- Enrollees were almost entirely adults, with 95% over 25 and 5% between 13 and 24.
- Most enrollees were low-income individuals. 85% have income at or below 133% of FPL, 8% between 133% and 200% of FPL, 6% between 200% and 400% of FPL, and 1% over 400% of FPL.
- Annual program spending of $55 million is supported by federal funds, drug manufacturer rebates, and $20 million of state funds.

As a requirement of ADAP eligibility, enrollees are not eligible for Medicaid. Many low-income ADAP enrollees are likely to be ineligible for Medicaid as a result of not being disabled and not being a parent, categorical qualifications for Medicaid that will be eliminated for individuals below 133% FPL in 2014. As highlighted above, the vast majority of enrollees are in the Medicaid income range. Others are likely ineligible for Medicaid because of citizenship or immigration status. It is not clear how many enrollees are non-citizens ineligible for Medicaid, so it is difficult to estimate the fiscal impact of the ACA on the Illinois ADAP program. Assuming conservatively that 25% of the ADAP population, or 1,480 enrollees, were ineligible non-citizens, 3,773 enrollees would be eligible for Medicaid in 2014. Another 621 individuals would be eligible for subsidized Exchange coverage.

A 75% reduction in state ADAP funds would save the state $15 million.

Separately from the Medicaid expansion providing full Medicaid coverage for current ADAP enrollees, the ACA presents a variety of opportunities for states to address the needs of individuals living with HIV. These options are outlined in a State Medicaid Director's Letter issued June 6, 2011.

ILLINOIS COMPREHENSIVE HEALTH INSURANCE PLAN

The Illinois Comprehensive Health Insurance Plan (ICHIP) has two parts—a high-risk pool for those considered to be "uninsurable," those who cannot purchase private insurance because of their health status, and the HIPAA (including Trade Adjustment Act) pool. According to the FY2012 Illinois State Budget Book, FY10 ICHIP enrollment totaled 16,904, with 4,568 in the traditional high-risk pool and 12,336 in the HIPAA-CHIP pool. In FY12 ICHIP is supported by $54.5 million in carrier assessment and $24.6 million in state general fund dollars. As with the federally funded Illinois Pre-Existing Condition Insurance Plan (IPXP) in the Department of Insurance, the need for the ICHIP pools will end with full implementation of ACA provisions such as guaranteed issue and the individual mandate on January 1, 2014, with enrollees moving from ICHIP to Medicaid or the Exchange.

GROUP INSURANCE

Illinois Group Insurance is the state's self-insurance program that provides health insurance and other benefits to state and university employees, retirees, annuitants, and their dependents. There are four Group Insurance programs—the State Employee Insurance and Benefits Program, the College Insurance

Program, Teachers Retirement Insurance Program, and the Local Government Health Plan. According to a report by the Illinois Commission on Government Forecasting and Accountability,[15] the State Employee Insurance and Benefits Program had 351,566 participants in March 2011. Of these, 118,856 are in the Quality Care Health Plan, an indemnity plan, and 232,710 are in managed care plans. FY11 estimated premium costs per participant (employee contributions and state funds) are $6,339 for enrollees on the state's indemnity plan and $5,567 for managed care enrollees. Of these amounts, $5,596 and $4,913 respectively are paid for by state funds; the remainder is covered by employee contributions.

As the state receives more information on the potential costs of coverage on the Exchange in our Final Report and on the essential health benefits that will be required to be offered under the ACA, the state will be able to more fully compare existing state insurance programs for employees to the coverage available on the Exchange.

NON-HEALTH PROGRAMS

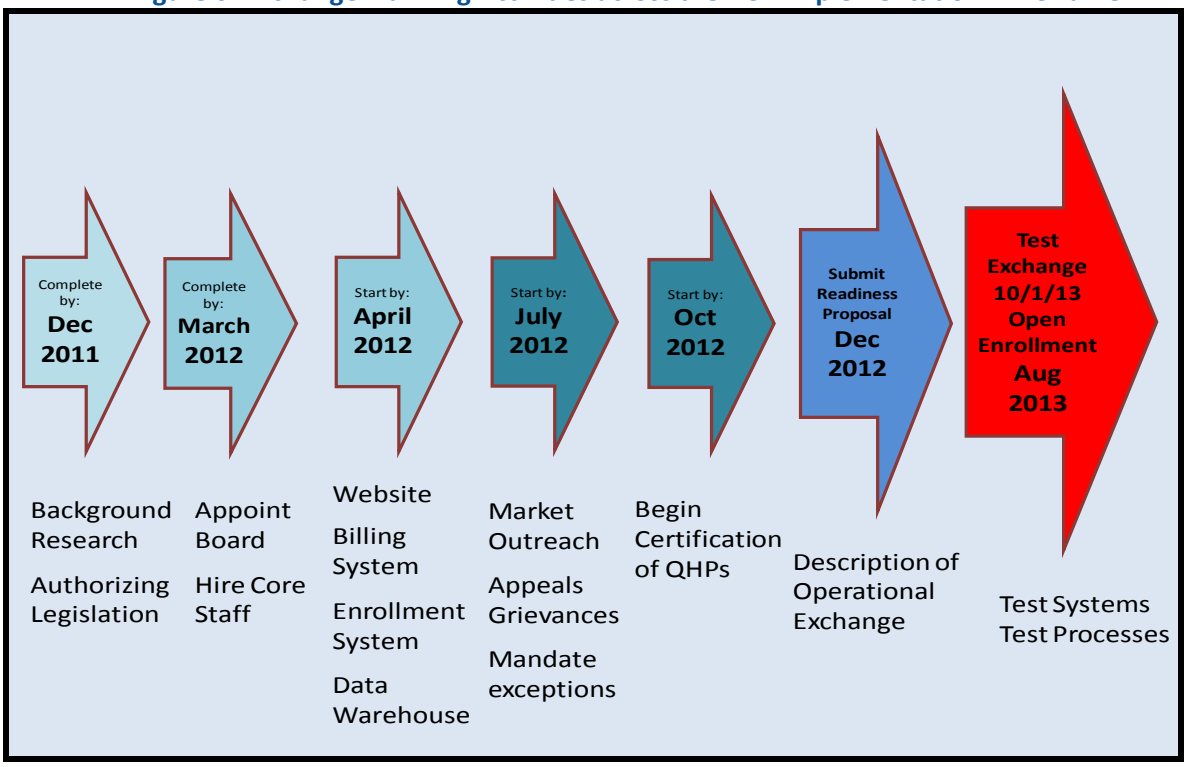
TANF, SNAP, job training, and other state programs providing assistance to individuals may experience increased enrollment as a result of the ACA implementation. First, individuals who have always been eligible for state programs but have not applied may be compelled to apply by the individual mandate and may find that they have eligibility for additional programs beyond Medicaid or the Exchange. It is difficult to estimate the extent to which this will occur and the related cost impact. Second, the development of a new and improved IES system in Illinois may similarly influence take-up rates in the state's non-health programs.

[15] March 2011 Fiscal Year 2012 Liabilities of the State Employees' Group Health Insurance Program report.

5. Next Steps

The work of the HMA Team over the course of this engagement has covered a wide range of issues, and this public report contains an enormous amount of material. As has been noted repeatedly throughout this report, the primary challenge facing Illinois is meeting the very demanding timelines confronting every state planning for health reform implementation. The figure below graphically represents aspects of Exchange planning along a timeline.

Figure 6: Exchange Planning Activities across the ACA Implementation Timeframe



The activities organized by date in the figure above refer to areas discussed in varied detail in this report. The graphic is not meant to substitute for a sophisticated project planning effort. It is included to emphasize an immediate and critical point: the most essential step in planning now is to form, through legislative action, an Exchange with appropriate authority over and responsibility for providing direction to the implementation effort.

The federal government, in the context of Exchange establishment funding expectations, has indicated that mid-2012 is a critical milestone for enabling legislation. We think that passage of legislation establishing an Exchange entity, governance structure, and a self-sustaining financing mechanism in 2011 is vastly more preferable and more likely to lead to success. Illinois can coordinate significant planning efforts (and in fact is doing so now). But true progress and concrete steps like hiring and contracting can occur only after an Exchange is established, along with a Board structure and full-time staff with ultimate accountability for success.

Many of the policy and operational decisions faced by the state of Illinois are addressed in detail in this report. We have recommended where appropriate throughout this report areas that warrant additional background research, data collection, or ongoing monitoring of federal regulations. We also recommend that the state set up formalized planning structures that will be capable of supporting an implementation effort of the scale described in this report. Finally, we recommend close collaboration with legislative leadership and with the many stakeholders that will be affected by Exchange establishment in Illinois.

6. Appendices

A. Sample Job Description Outlines
B. Program participation assumptions for 2014 by age and coverage program
C. Basic Health Plan Method and Assumptions

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Appendix C: List of groups providing oral and written testimony to the Illinois Health Benefits Exchange Legislative Study Committee

Health Insurance Exchange Study Committee Presenters

Illinois Department of Healthcare and Family Services – Mike Koetting
Illinois Department of Insurance – Kate Gross
Wakley Consulting Group – Jon Kingsdale
Illinois Comprehensive Health Insurance Plan (CHIP) – Mindy Kolaz, Bob Wagner, Howard Bolnick
Illinois Office of Health Information Technology – Laura Zaremba
Illinois State Medical Society – Jim Tierney
Illinois Hospital Association – Bill McAndrew
Illinois State Dental Society – Dave Marsh
Campaign for Better Health Care – Jim Duffett
Champaign County Healthcare Consumers – Jen Tayabji
Salud/Latino Health – Patricia Canessa
United Food and Commercial Workers – Gene Mechanic
AARP – Mary Patton
American Cancer Society – Healther Eagleton
Citizen Action Illinois – DeLane Adams
Sargent Shriver National Center on Poverty Law – Margaret Stapleton
National Federation of Independent Business – Kimi Clarke-Maisch
Illinois Chamber of Commerce – Jay Shattuck and Laura Minzer
Aircraft Gear Company – Jim Knutson
Illinois Academy of Family Physicians (Written testimony only)
Illinois Maternal and Child Health Coalition (Written testimony only)
SEIU Healthcare (Written testimony only)
Illinois Primary Health Care Association (Written testimony only)
Coalition of Insurance Agents and Brokers – Phil Lackman, Mike Wojcik, Greg Smith, Jeff Taylor
Crossroads Coalition Community – Patrick Fox, Moriel McClerklin, Mike Wojcik
Illinois Life Insurance Council – Larry Barry
Aetna – Elena Butkus, Geoff Sandler
Illinois Public Interest Research Group – Brian Imus
Blue Cross/Blue Shield – Mike Brady
Meridian Health Plan – Michael Murphy and Michael Stines
Delta Dental (Written testimony only)
Health Alliance (Written testimony only)
Illinois Main Street Alliance – David Borris
Black Women for Reproductive Justice – Toni Leonard
Champaign County Black Chamber of Commerce – Reverend Zenial Bogan and Roger Abinader
NAACP/Champaign County Branch – Patricia Avery
League of Women Voters of Illinois – Janet Craft

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Appendix D: House Amendment 002 to Senate Bill 1313 (Rep. Frank Mautino)

Rep. Frank J. Mautino

Filed: 10/26/2011

AMENDMENT TO SENATE BILL 1313

AMENDMENT NO. _____. Amend Senate Bill 1313 by replacing everything after the enacting clause with the following:

"Section 5. The State Employee Health Savings Account Law is amended by changing Sections 10-5 and 10-10 as follows:

(5 ILCS 377/10-5)

Sec. 10-5. Definitions. As used in this Law:

(a) "Deductible" means the total deductible of a high deductible health plan for an eligible individual and all the dependents of that eligible individual for a calendar year.

(b) "Dependent" means a dependent as defined in Section 3 of the State Employee Group Insurance Act of 1971, provided that any dependent age 26 or above, as defined under that Section, is eligible to be claimed by the eligible individual as a tax dependent under Section 152(a) of the Internal Revenue Code of 1986 ~~an eligible individual's spouse or child, as~~

~~defined in Section 152 of the Internal Revenue Code of 1986~~. "Dependent" also includes a party to or the child of a party to a civil union, as defined under Section 10 of the Illinois Religious Freedom Protection and Civil Union Act, provided that the party to, or the child of a party to, the civil union is eligible to be claimed by the eligible individual as a tax dependent under Section 152(a) of the Internal Revenue Code of 1986.

(c) "Eligible individual" means an employee, as defined in Section 3 of the State Employees Group Insurance Act of 1971, who contributes to health savings accounts on the employees' behalf, who:

(1) is covered by a high deductible health plan individually or with dependents; ~~and~~

(2) is not covered under any health plan that is not a high deductible health plan, except for:

(i) coverage for accidents;

(ii) workers' compensation insurance;

(iii) insurance for a specified disease or illness;

(iv) insurance paying a fixed amount per day per hospitalization; and

(v) tort liabilities; ~~and~~

(3) establishes a health savings account or on whose behalf the health savings account is established; ~~.~~

(4) is not entitled to Medicare; and

(5) cannot be claimed as a dependent on another person's tax return.

(d) "Employer" means a State agency, department, or other entity that employs an eligible individual.

(e) "Health savings account" or "account" means a trust or custodial account established under a State program exclusively to pay the qualified medical expenses of an eligible individual, or his or her dependents, that meets all of the following requirements:

(1) Except in the case of a rollover contribution, no contribution may be accepted:

(A) unless it is in cash; or

(B) to the extent that the contribution, when added to the previous contributions to the Account for the calendar year, exceeds the ~~lesser of (i) 100% of the eligible individual's deductible or (ii) the~~ contribution level set for that year by the Internal Revenue Service.

(2) The trustee or custodian is a bank, an insurance company, or another person approved by the Director of Insurance.

(3) No part of the trust assets shall be invested in life insurance contracts.

(4) The assets of the account shall not be commingled with other property except as allowed for under Individual Retirement Accounts.

(5) Eligible individual's interest in the account is nonforfeitable.

(f) "Health savings account program" or "program" means a program that includes all of the following:

(1) Participation ~~The purchase~~ by an eligible individual in an employer-sponsored ~~or by an employer of a~~ high deductible health plan.

(2) The contribution into a health savings account by an eligible individual or on behalf of an employee or by his or her employer. The total annual contribution may not exceed the amount ~~of the deductible or the amounts~~ listed in sub-item (B) of item (1) of subsection (e) ~~(f)~~ of this Section.

(g) "High deductible" means:

(1) In the case of self-only coverage, an annual deductible that is not less than the level set by the Internal Revenue Service and that, when added to the other annual out-of-pocket expenses required to be paid under the plan for covered benefits, does not exceed the maximum level set by the Internal Revenue Service ~~$5,000~~; and

(2) In the case of family coverage, an annual deductible of not less than the level set by the Internal Revenue Service and that, when added to the other annual out-of-pocket expenses required to be paid under the plan for covered benefits, does not exceed the maximum level set by the Internal Revenue Service ~~$10,000~~.

A plan shall not fail to be treated as a high deductible plan by reason of a failure to have a deductible for preventive care or, in the case of network plans, for having out-of-pocket expenses that exceed these limits on an annual deductible for services that are provided outside the network.

(h) "High deductible health plan" means ~~a~~ health coverage ~~policy, certificate, or contract~~ that provides for payments for covered benefits that exceed the high deductible.

(i) "Qualified medical expense" means an expense paid by the eligible individual for medical care described in Section 213(d) of the Internal Revenue Code of 1986.

(Source: P.A. 97-142, eff. 7-14-11.)

(5 ILCS 377/10-10)

Sec. 10-10. Application; authorized contributions.

(a) Beginning in calendar ~~taxable~~ year 2012 ~~2011~~, each employer shall make available to each eligible individual a health savings account program, if that individual chooses to enroll in the program except that, for an employer who provides coverage pursuant to any one or more of subsections (i) through (n) of Section 10 of the State Employee Group Insurance Act, that employer may make available a health savings account program. An employer who makes a health savings account program available shall annually deposit an amount equal to one-third of the annual deductible ~~$2,750 annually~~ into an eligible individual's health savings account. Unused funds in a health

savings account shall become the property of the account holder at the end of a taxable year.

(b) Beginning in calendar ~~taxable~~ year 2012 ~~2011~~, an eligible individual may deposit contributions into a health savings account in accordance with the restrictions set forth in subsection (e) of Section 10-5. ~~The amount of deposit may not exceed the amount of the deductible for the policy.~~

(Source: P.A. 97-142, eff. 7-14-11.)

Section 10. The Illinois Insurance Code is amended by adding Section 500-123 as follows:

(215 ILCS 5/500-123 new)

Sec. 500-123. Consulting. A producer shall be prohibited from selling, soliciting, or negotiating insurance or limited lines insurance after the producer or an employee or contractor of the producer has been hired by the purchaser or prospective purchaser within the previous 5 years as a consultant concerning the insurance or limited lines insurance being sold, solicited, or negotiated. For the purposes of this Section, "producer" means an insurance producer, limited line producer, or temporary insurance producer.

Section 15. The Illinois Health Benefits Exchange Law is amended by adding Sections 5-4, 5-8, 5-11, 5-12, 5-13, 5-14, and 5-18 and by changing Section 5-10 as follows:

(215 ILCS 122/5-4 new)

Sec. 5-4. Definitions. For purposes of this Law:

"Board" means the Illinois Health Benefits Exchange Board established pursuant to this Law.

"Director" means the Director of Insurance.

"Essential health benefits" has the meaning provided under Section 1302(b) of the Federal Act.

"Exchange" means the Illinois Health Benefits Exchange established by this Law and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

"Executive Director" means the Executive Director of the Illinois Health Benefits Exchange.

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

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

(a) coverage for accident only or disability income insurance or any combination thereof;

(b) coverage issued as a supplement to liability

insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics; or

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

"Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a non-profit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

"Individual Exchange" means the exchange marketplace established by this Law through which qualified individuals may obtain coverage through an individual market qualified health plan.

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

"Qualified employee" means an eligible individual employed by a qualified employer who has been offered health insurance coverage by that qualified employer through the SHOP on the Exchange.

"Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans or qualified dental plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed.

"Qualified health plan" or "QHP" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the Federal Act.

"Qualified health plan issuer" or "QHP issuer" means a health insurance issuer that offers a health plan that the Exchange has certified as a qualified health plan.

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

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

(2) resides in this State;

(3) at the time of enrollment, is not incarcerated,

other than incarceration pending the disposition of charges; and

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

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

"SHOP Exchange" means the Small Business Health Options Program established under this Law through which a qualified employer can provide small group qualified health plans to its qualified employees.

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. Beginning January 1, 2016, the definition of a "small employer" shall mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

(215 ILCS 122/5-8 new)

Sec. 5-8. Exchange Board. There is created the Illinois Health Benefits Exchange Board. The purpose of the Board is to administer the State health benefits exchange created pursuant to this Law and to conduct such other business as may further the administration of the State health benefits exchange. The Exchange shall operate subject to the supervision and control of the Board. The Exchange is created as a quasigovernmental agency and as such is not a State agency.

(215 ILCS 122/5-10)

Sec. 5-10. Exchange functions. On or before January 1, 2014, in compliance with paragraph (4) of subdivision (d) of Section 1311 of the federal Patient Protection and Affordable Care Act, the Exchange shall, at a minimum, do all of the following to implement Section 1311 of the federal Patient Protection and Affordable Care Act:

(1) Make qualified health plans available to qualified individuals and qualified employers.

(2) Implement procedures for the certification, recertification, and decertification, consistent with guidelines established by the U.S. Secretary of Health and Human Services, of health plans as qualified health plans. The Board shall require health plans seeking certification as qualified health plans to do all of the following:

(A) Submit a justification for any premium increase prior to the implementation of the increase.

The plans shall prominently post that information on their Internet web sites. The Board shall take this information, and the information and the recommendations provided to the Board by the Department of Insurance or the Department of Managed Health Care under paragraph (1) of subdivision (b) of Section 2794 of the federal Public Health Service Act, into consideration when determining whether to make the health plan available through the Exchange. The Board shall take into account any excess of premium growth outside the Exchange as compared to the rate of that growth inside the Exchange, including information reported by the Department of Insurance and the Department of Managed Health Care.

(B) Make available to the public and submit to the Board, the U.S. Secretary of Health and Human Services, and the Department of Insurance or the Department of Public Health, as applicable, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

(v) Data on the number of claims that are denied.

(vi) Data on rating practices.

(vii) Information on cost sharing and payments with respect to any out-of-network coverage.

(viii) Information on enrollee and participant rights under Title I of the federal Patient Protection and Affordable Care Act.

(ix) Other information as determined appropriate by the U.S. Secretary of Health and Human Services.

The information required under this paragraph (b) shall be provided in plain language, as defined in subparagraph (B) of paragraph (3) of subdivision (e) of Section 1311 of the federal Patient Protection and Affordable Care Act.

(C) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including, but not limited to, deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet web site and through other means for individuals without access to the Internet.

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

(4) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans.

(5) With respect to each qualified health plan offered through the Exchange, do both of the following:

(A) assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the U.S. Secretary of Health and Human Services; and

(B) determine each qualified health plan's level of coverage in accordance with regulations adopted by the Secretary under paragraph (A) of subdivision (2) of Section 1302(d) of the federal Patient Protection and Affordable Care Act and any additional regulations adopted by the Exchange under this Law.

(6) Utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Service Act.

(7) Inform individuals of eligibility requirements for the Medicaid program, the Covering ALL KIDS Health Insurance Program, or any applicable State or local public program and, if through screening of the application by the Exchange the Exchange determines that an individual is eligible for any such program, enroll that individual in

the program.

(8) Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost sharing reduction under Section 1402 of the federal Patient Protection and Affordable Care Act.

(9) Grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by that Section because of either of the following:

(A) There is no affordable qualified health plan available through the Exchange or the individual's employer covering the individual.

(B) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty.

(10) Transfer to the Secretary of the Treasury all of the following:

(A) a list of the individuals who are issued a certification, including the name and taxpayer identification number of each individual;

(B) the name and taxpayer identification number of each individual who was an employee of an employer but

who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because:

(i) the employer did not provide the minimum essential coverage or the employer provided the minimum essential coverage but it was determined under item (C) of paragraph (2) of subdivision (c) of Section 36B of the Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(ii) the name and taxpayer identification number of each individual who notifies the Exchange under paragraph (4) of subdivision (b) of Section 1411 of the federal Patient Protection and Affordable Care Act that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year, and the effective date of such cessation;

(11) Provide to each employer the name of each employee of the employer described in subdivision (i) of Section 1311 of the federal Patient Protection and Affordable Care Act who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(12) Perform duties required of, or delegated to, the

Exchange by the U.S. Secretary of Health and Human Services or the Secretary of the Treasury related to the following:

(A) Determining eligibility for premium tax credits, reduced cost sharing, or individual responsibility exemptions.

(B) Establishing procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

(C) Arranging for collection of contributions from participating employers and individuals.

(D) Arranging for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

(E) Establishing criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

(F) Establishing criteria for exclusion of vendors.

(G) Developing and implementing a plan for promoting public awareness of and participation in the program.

(H) Evaluating options for employer participation which may conform with common insurance practices.

(I) Providing for initial, annual, and special enrollment periods, in accordance with guidelines adopted by the Secretary under paragraph (6) of subdivision (c) of Section 1311 of the federal Patient Protection and Affordable Care Act.

(13) Establish the Navigator Program in accordance with subdivision (i) of Section 1311 of the federal Patient Protection and Affordable Care Act. The Exchange shall award grants to certain entities to do the following:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans.

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the federal Patient Protection and Affordable Care Act.

(C) Facilitate enrollment in qualified health plans.

(D) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the federal Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding his

or her health plan, coverage, or a determination under that plan or coverage.

(E) Refer individuals with a grievance, complaint, or question regarding a plan, a plan's coverage, or a determination under a plan's coverage to a customer relations unit established by the Exchange.

(F) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(14) Establish the Small Business Health Options Program, separate from the activities of the Board related to the individual market, to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small employer market in a manner consistent with paragraph (2) of subdivision (a) of Section 1312 of the Federal Act. ~~(a) The Illinois Health Benefits Exchange shall meet the core functions identified by Section 1311 of the Patient Protection and Affordable Care Act and subsequent federal guidance and regulations.~~

~~(b) In order to meet the deadline of October 1, 2013 established by federal law to have operational a State exchange, the Department of Insurance and the Commission on Governmental Forecasting and Accountability is authorized to apply for, accept, receive, and use as appropriate for and on behalf of the State any grant money provided by the federal~~

~~government and to share federal grant funding with, give support to, and coordinate with other agencies of the State and federal government or third parties as determined by the Governor.~~

(Source: P.A. 97-142, eff. 7-14-11.)

(215 ILCS 122/5-11 new)

Sec. 5-11. Exchange powers. The Exchange shall have the power to do the following acts.

(1) Have perpetual successions as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business.

(2) Adopt an official seal and alter the same at pleasure.

(3) Maintain an office in the State at such place or places as it may designate.

(4) Employ such assistants, agents, managers, and other employees as may be necessary or desirable.

(5) Acquire, lease, purchase, own, manage, hold, and dispose of real and personal property.

(6) Receive and accept, from any source, aid or contributions, including money, property, labor, and other things of value.

(7) Charge assessments or user fees to generate funding necessary to support the operations of the Exchange.

(8) Exclude plans that fail to deliver robust consumer

protections, quality care, and reasonable costs, particularly if the plan has a history of unreasonable rate increases.

(9) Procure insurance against loss in connection with its property and other assets in such amounts and from such insurers as it deems desirable.

(10) Invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the U.S. of America or the State and in obligations that are legal investments for savings banks in the State.

(11) Issue bonds, bond anticipation notes, and other obligations of the Exchange for any of its corporate purposes, and to fund or refund the same and provide for the rights of the holders thereof, and to secure the same by pledge of revenues, notes, and mortgages of others.

(12) Borrow money for the purpose of obtaining working capital.

(13) Account for and audit funds of the Exchange and any recipients of funds from the Exchange.

(14) Make and enter into any contract or agreement necessary or incidental to the performance of its duties and execution of its powers (copies of all contracts of the Exchange shall be maintained by the Exchange as public records, subject to the proprietary rights of any party to the contract).

(15) To the extent permitted under its contract with

other persons, consent to any termination, modification, forgiveness, or other change of agreement of any kind to which the Exchange is a party.

(16) Award grants to Navigators (applications for grants from the Exchange shall be made on a form prescribed by the Board).

(17) Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the Exchange, provided individuals and employers have an adequate number and selection of choices.

(18) Sue and be sued, plead and be impleaded.

(19) Adopt regular procedures that are not in conflict with other provisions of the general statutes, for exercising the power of the Exchange.

(20) Apply for federal grants to cover the cost associated with setting up the Exchange.

(21) Do all acts and things necessary and convenient to carry out the purposes of the Exchange, provided such acts or things shall not conflict with the provisions of the federal Patient Protection and Affordable Care Act, regulations adopted there under, or federal guidance issued pursuant to the federal Patient Protection and Affordable Care Act.

(215 ILCS 122/5-12 new)

Sec. 5-12. Composition of the Board.

(a) The Exchange shall be governed by a Board of Directors comprised as follows:

(1) Four ex officio, non-voting members to include:

(A) the Director of Insurance or his or her designee with expertise in insurance regulation;

(B) the Director of Healthcare and Family Services or his or her designee;

(C) the Director of Human Services or his or her designee; and

(D) the Director of Public Health or his or her designee.

(2) Two members appointed by the Attorney General to include:

(A) one attorney with experience with public programs such as Medicaid; and

(B) one attorney with experience working with the Attorney General's Health Care Bureau.

(3) Seven members appointed by the Governor with the advice and confirmation of the Senate pursuant to subsection (b) of this Section to include:

(A) one consumer representative;

(B) one small employer representative;

(C) one employee representative of a small employer in this State;

(D) one certified health actuary or health economist;

(E) one representative of the organized labor community in this State;

(F) one individual who qualifies for Medicaid under current or expanded Medicaid eligibility rules; and

(G) one community-based provider that mainly serves vulnerable individuals living under 200% of the federal poverty level.

The Governor shall make the appointments so as to reflect no less than proportional representation of the minority racial composition of the State.

(b) All appointments of members to the Board shall be subject to the advice and consent of the Senate pursuant to this Section. Appointments by the Governor pursuant to paragraph (3) of subsection (a) of this Section shall require the advice and consent of a 2/3 vote of the members elected to the Senate.

The Senate shall confirm or reject appointments within 30 session days or 60 calendar days after they are submitted by the Governor, whichever occurs first. Except in the case of appointments to fill vacancies, the confirmation time period specified in this Section shall not commence until all appointments required to be made in that year have been submitted by the Governor.

(215 ILCS 122/5-13 new)

Sec. 5-13. Terms of Board members.

(a) Initial members shall be appointed to the Board as follows: 4 members to serve one year, and until their successors are appointed and qualified; 4 members to serve 2 years, and until their successors are appointed and qualified; 6 members to serve 3 years, and until their successors are appointed and qualified; and 3 members to serve 4 years, and until their successors are appointed and qualified. As terms of initial members expire, their successors shall be appointed for terms to expire the first day in July 4 years thereafter, and until their successors are appointed and qualified. Any member is eligible for reappointment. A vacancy on the Board shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(b) The Board shall elect a chairperson and a vice chairperson on an annual basis.

(c) Appointed Board members may not designate a representative to perform in their absence their respective duties. Meetings of the Board shall be held at such times as shall be specified in the bylaws adopted by the Board and at such other time or times as the chairperson deems necessary. All meetings of the Board shall be conducted in accordance with the Open Meetings Act. The Board must afford an opportunity for public comment at each of its meetings.

(d) Any Board member who fails to attend more than 50% of all meetings held during any calendar year shall be deemed to

have resigned from the Board.

(e) A majority of members appointed shall constitute a quorum for the transaction of any business or the exercise of any power of the Exchange.

(f) For the transaction of any business or the exercise of any power of the Exchange, the Exchange may act by a majority of the Board members present at any meeting at which a quorum is in attendance. No vacancy in the membership of the Board shall impair the right of the Board members to exercise all the rights and perform all the duties of the Board. Any action taken by the Board may be authorized by resolution approved by a majority of the Board members present at any regular or special meeting, which resolution shall take effect immediately unless otherwise provided in the resolution.

(g) Board members are entitled to receive, from funds of the Board, reimbursement for per diem and travel expenses. No other compensation is authorized.

(h) There is no liability on the part of, and no cause of action shall arise against, any member of the Board or its employees or agents for any action taken by them in the performance of their powers and duties under this Law.

(i) No Board member shall, for one year after the end of the member's service on the Board, accept employment with any health carrier that offers a qualified health benefit plan through the Exchange.

(j) The Board may exercise all powers granted to it

necessary to carry out the purposes of this Section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this Section.

(k) A member of the Board or of the staff of the Exchange shall not be employed by or be affiliated with a health care provider, a health care facility, a medical clinic, or an insurer, with the exception of health care providers not receiving compensation for rendering services as a provider who do not have an ownership interest in a professional health care practice.

(l) The Board shall hire an Executive Director to organize, administer, and manage the operations of the Exchange. The Executive Director shall be responsible for the selection of such other staff as may be authorized by the Board's operating budget as adopted by the Board. The Executive Director shall be exempt from civil service and shall serve at the pleasure of the Board.

(m) No employee of the Exchange shall be a member of the Board or an employee of a trade association of (i) insurers, (ii) insurance producers or brokers, (iii) health care providers, or (iv) health care facilities or health or medical clinics while serving on the Board or on the staff of the Exchange.

(n) No employee of the Exchange shall, for one year after terminating employment with the Exchange, accept employment with any health carrier that offers a qualified health benefit plan through the Exchange.

(o) Any employee of the Exchange who sells, solicits, or negotiates insurance or will sell, solicit, or negotiate insurance to individuals and small employers shall be licensed not later than one year after such employee begins employment with the Exchange.

(p) The Exchange has the authority to enter into an agreement with an eligible entity to carry out responsibilities of the Exchange.

(q) The Board may establish advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

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

(1) any source of income provided to, received by, or promised to a member within 12 months prior to the time

when a decision is made; or

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

(s) The Board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the Board and carrying out the purposes of this Section. The bylaws shall do the following:

(1) specify procedures for selection of officers and qualifications for reappointment, provided that no Board member shall serve more than 9 consecutive years;

(2) require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program; and

(3) specify policies and procedures regarding conflicts of interest; the policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

(215 ILCS 122/5-14 new)

Sec. 5-14. Illinois Health Benefits Exchange Legislative Oversight Committee.

(a) There is created an Illinois Health Benefits Exchange Legislative Oversight Committee within the Commission on Government Forecasting and Accountability to provide

accountability for the Illinois Health Benefits Exchange and to ensure that Exchange operations and functions align with the goals and duties outlined by this Law. The Committee shall also be responsible for providing policy recommendations to ensure that the Exchange aligns with the Federal Act, amendments to the Federal Act, and regulations promulgated pursuant to the Federal Act.

(b) Members of the Legislative Oversight Committee shall be appointed as follows: 3 members of the Senate shall be appointed by the President of the Senate; 3 members of the Senate shall be appointed by the Minority Leader of the Senate; 3 members of the House of Representatives shall be appointed by the Speaker of the House of Representatives; and 3 members of the House of Representatives shall be appointed by the Minority Leader of the House of Representatives. Each legislative leader shall select one member to serve as co-chair of the Committee.

(c) Members of the Legislative Oversight Committee shall be appointed within 30 days after the effective date of this amendatory Act of the 97th General Assembly. The co-chairs shall convene the first meeting of the Committee no later than 45 days after the effective date of this Law.

(d) The Executive Director of the Exchange must provide updates to the Legislative Oversight Committee in person about the Exchange's progress every quarter for the first 2 years beginning at the start of employment on the Exchange.

(215 ILCS 122/5-18 new)

Sec. 5-18. Illinois Health Benefit Exchange Fund. There is hereby created as a special fund outside of the State treasury the Illinois Health Benefit Exchange Fund to be used, subject to appropriation, exclusively by the Exchange to provide funding for the operation and administration of the Exchange in carrying out the purposes authorized in this Law. The Fund shall consist of the following:

(1) any user fees or other assessment collected by the Exchange;

(2) income from investments made on behalf of the Fund;

(3) interest on deposits or investments of money in the Fund;

(4) money collected by the Board as a result of legal or other action taken by the Board on behalf of the Exchange or the Fund;

(5) money donated to the Fund;

(6) money awarded to the Fund through grants; and

(7) any other money from any other source accepted for the benefit of the Fund.

Any investment earnings of the Fund shall be credited to the Fund. No part of the Fund may revert or be credited to the General Revenue Fund or any special fund in the State Treasury. A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.

Section 90. The State Finance Act is amended by adding Section 5.809 as follows:

(30 ILCS 105/5.809 new)

Sec. 5.809. The Illinois Health Benefit Exchange Fund.

(215 ILCS 122/5-15 rep.)

(215 ILCS 122/5-20 rep.)

Section 95. The Illinois Health Benefits Exchange Law is amended by repealing Sections 5-15 and 5-20.

Section 97. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

Section 99. Effective date. This Act takes effect upon becoming law.".