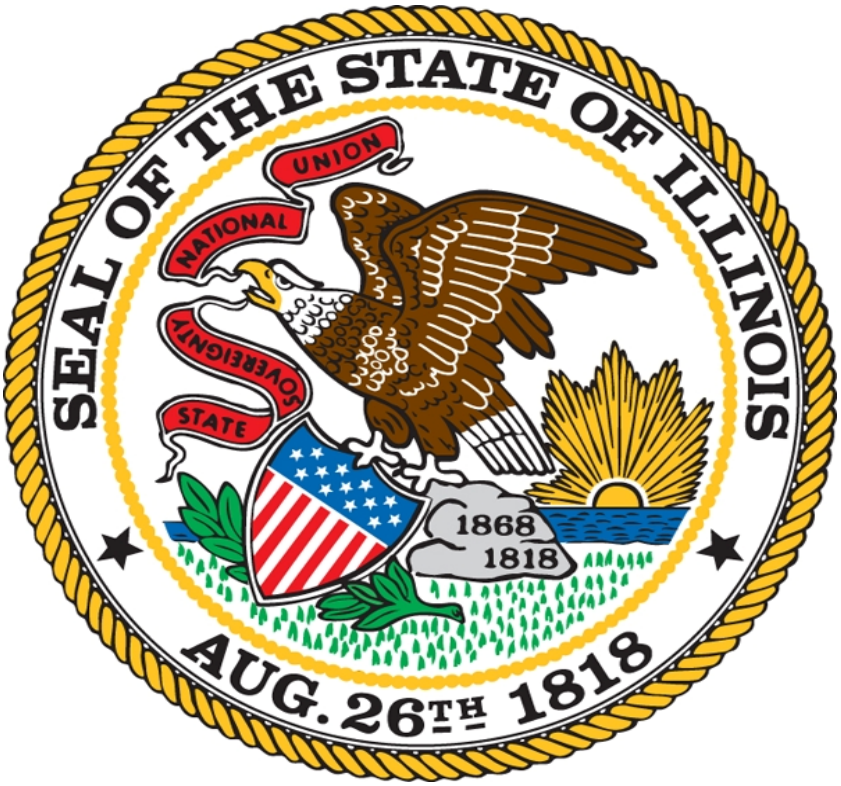
HEALTH CARE REFORM IMPLEMENTATION COUNCIL INITIAL REPORT



GOVERNOR PAT QUINN
MARCH 1, 2011

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EXECUTIVE SUMMARY

The federal Affordable Care Act (ACA) was signed into law on March 23, 2010. Several of the law's provisions started immediately, others took effect six months later, and more will begin in 2014. Already, more than 1,000 people who were denied coverage by health insurance companies because of pre-existing conditions are now insured through Illinois' federally funded high-risk pool. Children in Illinois can no longer be denied health coverage because of a pre-existing condition. More than 120,000 Illinois seniors and people with disabilities received a $250 rebate check last year to help cover the costs of prescription drugs. Health insurance companies must now cover immunizations, mammograms and other important procedures without charging the high deductibles and co-payments that once deterred consumers from important preventive measures. And, thanks to the ACA, thousands more young adults can remain covered under their parents' health insurance policies.

When fully in effect in 2014, the ACA will provide many more benefits to Illinoisans, including the ability for more than one million to obtain health insurance, many for the first time. The ACA is designed for states to implement key provisions within federal guidelines. Indeed, adding more than a million residents to public and private insurance rolls compels the state to carefully examine the adequacy, quality, efficiency and effectiveness of healthcare delivery resources, insurance oversight, and funding incentives.

In response to this challenge, on July 29, 2010, Gov. Pat Quinn issued Executive Order 10-12 establishing the Healthcare Reform Implementation Council. The purpose of the council is to recommend steps needed to improve the health of Illinois residents, by increasing access to care, reducing disparities, controlling costs and improving the affordability, quality and effectiveness of healthcare. The governor charged the council, comprised of directors of state departments responsible for elements of ACA implementation, to hear from legislators, providers, individuals and organizations throughout the state on how best to implement the ACA for the benefit of Illinois residents.

The council conducted four public meetings in Chicago, Peoria, Carbondale, and Springfield focused on the following issues: 1) establishing a health insurance exchange and related consumer protection reforms; 2) reforming Medicaid service structures and enrollment systems; 3) developing an adequate workforce; 4) incentivizing delivery systems to achieve high-quality health care; 5) identifying federal grants, pilot programs, and other non-state funding to assist with implementation of the ACA; and 6) fostering the widespread adoption of electronic medical records and participation in the Illinois Health Information Exchange. In addition, the council solicited written comments regarding a series of specific questions concerning implementation of the insurance exchange in Illinois. A fifth public meeting was held in Chicago in February for stakeholders to question and react to the initial recommendations submitted by the council on

February 3. Overall, more than 150 individuals and organizational stakeholders shared their suggestions with the council.

The council's recommendations fall into two categories: issues that the state must address immediately, and decisions that will be made after the council gathers more information from stakeholders and the federal government provides additional guidance. Foremost among the immediate recommendations is to establish a health insurance exchange for Illinois, governed by a quasi-governmental authority. Other recommendations describe its nature and scope. The council also recommends immediate action to provide Illinois consumers with the same health insurance protections contained in the ACA to assure fairness and affordability. Workforce, quality, delivery, and eligibility and enrollment reforms require further deliberation. Workgroups will be established initially on systems design, workforce, and quality improvements.

Governor Quinn expects the council to continue to oversee the state's efforts to fully implement the ACA for the full benefit of Illinois residents. The council will continue to meet publicly and lead state implementation of the health insurance exchange, important consumer protections, health care delivery and quality improvements, long term care reforms, and to secure funding from public and private sources. The council and the state agencies that comprise it have been and will continue to seek input from all interested stakeholders as it relates to the structure and enabling legislation of an Illinois health insurance exchange and implementation of the other recommendations. Future reports to the governor will be issued periodically covering progress implementing various components of the governor's executive order as they are developed.

RECOMMENDATIONS: IMMEDIATE ISSUES

A. Establish an American Health Benefits Exchange

ACA provides states with funding to plan and establish a centralized marketplace that provides individuals and small businesses with access to more affordable, comprehensive health insurance coverage options. Any state that establishes an Exchange also must establish a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in enrolling employees in qualified health plans.

By January 1, 2013, states must demonstrate progress toward implementing an Exchange, or the U.S. Secretary of Health and Human Services will implement an Exchange in that state. It must be fully operational by January 1, 2014.

It is in the best interest of employees and families in Illinois for the state to retain control of such an entity. State control will ensure that the Exchange reflects and meets the unique needs of Illinois. By ceding responsibility for the Exchange to the federal government, the state would lose significant oversight and consumer protection authority. The only authority that would remain with the state would involve health plans outside the Exchange. Such disparate oversight could result in adverse selection (attracting individuals with more medical needs), reduce insurance competition, and negatively affect insurance producers and clients. Illinois also would be ceding significant economic and employment opportunities for individuals and firms in Illinois to an entity in Washington, D.C.

Stakeholder Comments

A broad spectrum of stakeholders commented on this issue, and the council received virtually unanimous support for the state to develop an Exchange. Some patient and family advocates noted that an Illinois-specific Exchange would "provide great opportunities for input from consumers, transparency, and accountability"[1] and "enable greater coordination of benefits and eligibility rules across health coverage programs."[2] This position was further supported by health-care providers who said "Illinois will be able to create synergy with IDHFS and its programs" in a way that the federal government cannot.[3] Developing a state Exchange will protect the option for the state to "institute consumer protections that are stronger than those in the federal system."[4]

The employer community expressed strong support for a state-based Exchange, noting that "state policymakers and stakeholders [are] best positioned to design and implement an Exchange capable of adequately addressing the coverage gaps and the needs of the market that are unique

[1] Champaign County Health Care Consumers.
[2] Health and Disability Advocates.
[3] Illinois Chapter, American Academy of Pediatrics.
[4] AIDS Foundation of Chicago.

to this state."[5] Representatives of insurance producers (agents and brokers) reiterated the point, stating, "The state of Illinois knows the needs of our diverse constituency and how best to serve the population."[6] Insurers agreed "states are in the best position to implement the Exchanges."[7]

B. Establish the Exchange as a Quasi-Governmental Entity

The ACA gives states the option to establish an Exchange as a governmental agency or a nonprofit entity. This lends itself to three alternatives for the organizational structure: establish the Exchange within an existing state agency; develop an independent nonprofit entity; or create a quasi-governmental entity led by an appointed board of directors.

The third option structure is more independent from political influence than an Exchange established within an existing state government entity, and can be far more nimble in staffing, procurement and operations. By offering more competitive compensation, a quasi-governmental entity would be able to attract individuals with extensive experience both in the public and private sector, ensuring business savvy. Even with such independence, a quasi-governmental entity maintains a significant tie to the state, making it more accountable to the people and policymakers of Illinois than an independent nonprofit would be. This mechanism is not new to Illinois. Several quasi-governmental entities operate successfully, including the Governor's Office of Health Information Technology (OHIT) and the Illinois Comprehensive Health Insurance Program (ICHIP).

Should the state decide to proceed with an Illinois Exchange, as the council recommends, the organizational form of the entity should be incorporated into enabling legislation to officially establish the Exchange.

Stakeholder Comments

Most of the feedback the council received from stakeholders reflects strong support for an entity that is efficient and accountable to the public. Patient and family advocates consistently supported a model that would "maintain independence from the Department of Insurance and HFS while also maintaining good working relationships with them."[8] They also expressed support for "a high level of accountability and transparency"[9] and "ample opportunity for public input."[10] The producer community recommended against establishing any entity that would be subject to "state hiring and procurement rules," noting that such rules "will lead to high costs and

[5] Illinois Chamber of Commerce, Illinois Manufacturers Association, Illinois Retail Merchants Association, Illinois Life Insurance Council, Tooling and Manufacturing Association, and Chicagoland Chamber of Commerce.
[6] Illinois Coalition of Agents and Brokers, Illinois Association of Health Underwriters, Independent Agents of Illinois, and NAIFA Illinois.
[7] America's Health Insurance Plans.
[8] Health and Disability Advocates.
[9] Association of Community Mental Health Authorities.
[10] AARP.

a time-consuming bureaucracy."[11] Small businesses consistently voiced support for a "nimble" Exchange that is "nimble" that does not burden employers with "too much unnecessary paperwork or processes."[12]

B1. Operating Model

The council recommends initially organizing the Exchange as a "market developer" and later transitioning to a "market organizer" model once premium volume and a sufficient number of covered lives are achieved within the Exchange marketplace. This will ensure that the Exchange offers insurers strong incentives to compete, and allows individuals and small employers to benefit from Exchange-based coverage. This approach should be incorporated into the Exchange enabling legislation.

The ACA does not prescribe how the Exchange should operate within a state's existing marketplace. In determining an operating model, the state can choose to allow all health insurers that meet minimum federal requirements to belong to the Exchange ("market organizer" model), or set more stringent criteria to ensure quality and facilitate competition ("market developer" model). In the market developer model, the Exchange negotiates with insurers and requires them to compete on price and quality to gain access to the Exchange marketplace.

The market organizer model may offer too many choices for consumers, who could find the process overwhelming. The market developer model could increase competition, thus reducing the price of premiums or increasing the quality of service or benefits for consumers. On the other hand, if the requirements to enter the Exchange are too strict, it could fail to offer consumers sufficient options, resulting in a marketplace that is neither competitive nor appealing to individuals or businesses. The challenge is to balance the benefits of a competitive marketplace with one that is consumer-friendly.

Stakeholder Comments

Stakeholder groups expressed wide disagreement about the operating model of the Exchange. Family and patient advocates ardently supported the "market developer" model, saying "insurers should have to meet some quality standard to be included in the Exchange."[13] Virtually every consumer representative requested that the Exchange use "its authority to only offer plans that enhance value, consumer protection and affordability."[14] Moreover, some commenters requested that the state incorporate rules to "decertify plans that … impose unreasonable premium increases."[15]

[11] Illinois Coalition of Agents and Brokers, Illinois Association of Health Underwriters, Independent Agents of Illinois, and NAIFA Illinois.
[12] National Federation of Independent Businesses.
[13] Gary Hartlieb, individual.
[14] Health Care for America Now (including 32 undersigned organizations).
[15] Sargent Shriver National Center on Poverty Law.

Insurers supported the opposite approach, requesting that the state "permit broad insurer participation in the Exchange … to allow maximum choice for consumers"[16] and "ensure an open, competitive marketplace."[17] On the issue of quality, some insurers noted that smaller players in the market may not have access to a credible amount of data, which could result in a "skewed perception of which plan is better 'quality'."[18]

B2. Single Exchange or Separate Individual Market and SHOP Exchanges
The council recommends that Illinois initially establish a single Exchange entity that sells products to both individuals and small employers. The council also recommends that the state revisit merging the individual and small group risk pools after it receives additional information and analyses of the marketplace and the potential impact of this option. At that point, the state might consider adopting stricter rating rules or other market reforms to ensure a stable health insurance marketplace.

Illinois can choose to establish a single Exchange, combining the individual and SHOP (Small Business Health Options Program) Exchange, or create two separate entities. Establishing a single Exchange can benefit consumers by eliminating the possibility of confusion between the two entities. However, an individual or family may have different health plan needs than an employer or employee. Depending on the model(s) of health coverage they purchase on the SHOP Exchange, employers would benefit if the Exchange handles the transactions associated with covering multiple employees. A single Exchange could both reduce confusion and meet the needs of small employers in simplifying health plan administration.

The state also could merge the risk pools of the individual and SHOP exchanges or maintain separate risk pools. While pooling risk could result in lower or more stable premium costs, it is unclear what the impact would be on premiums in either the individual or the small group market. The state intends to assess current market conditions in the individual and small group markets to help identify a solution that would make premiums more affordable or more stable without severely disrupting either marketplace.

Stakeholder Comments

Stakeholder groups suggested that merging the small group and individual exchanges could have the benefit of reducing administrative costs and overcoming adverse selection issues. However, the majority of groups cautioned that the state should thoroughly study the existing insurance market to assess the impact of such a merger (including factors that could potentially result in rate shock for some currently insured individuals or employers) before reaching a conclusion.[19] Patient and family advocates commented that ACA-related market reforms, particularly

[16] Aetna.
[17] Trustmark.
[18] Trustmark.
[19] Illinois Chamber of Commerce, Illinois Manufacturers Association, Illinois Retail Merchants Association, Illinois Life Insurance Council, Tooling and Manufacturing Association, and Chicagoland Chamber of Commerce.

regarding premium rating rules, could limit the premium rate disruption that might occur when the markets are combined.[20] Stakeholders advised the state to gather data and report about the potential impact on rates paid by individuals and by small employers under both a merged market and separate markets.[21]

B3. Regional or Subsidiary Exchanges

The council recommends that the state further examine the potential benefits of a regional Exchange, which may be necessary to accommodate the health care needs of Illinois residents who obtain medical care in other states.

The ACA permits states to establish regional or other interstate Exchanges, or one or more subsidiary Exchanges within a state. States are only permitted to establish subsidiary Exchanges only if each Exchange serves a geographically distinct area.

Stakeholder Comments

Stakeholders agreed that economies of scale are essential for the Exchange and that creating smaller, sub-state-level Exchanges would ultimately decrease the size of the risk pool—making the Exchange less attractive to insurers, consumers and employers.[22] Others commented that while plans within the Exchange should be allowed to develop targeted products to address delivery and other variables within specific regions of the state, the state should establish a single, statewide Exchange. The Exchange should help consumers and employers understand the choices available in geographic regions and provide detailed information on the geographic reach of each plan's provider network.

B4. Financial Sustainability

The council recommends further study to identify a long-term funding mechanism from carriers, other health care stakeholders, or both. Funding should be independent of state general revenue funds.

The ACA provides an uncapped amount of federal funding for states to establish an Exchange. However, it requires states to "ensure that such Exchange is self-sustaining beginning January 1, 2015." States can impose an assessment or user fee on carriers that participate in the Exchange. Illinois will have to decide whether to apply this fee only to plans that participate in the Exchange, or to apply the fee more broadly.

State funding through general revenues is an option states can consider but is highly unlikely in Illinois. Some share of Medicaid or SCHIP funding could be used to support enrollment through an Exchange. The state also could consider a user fee on consumers. An additional option would be to assess all health care stakeholders that benefit from broader health insurance coverage

[20] Campaign for Better Health Care.
[21] Illinois Maternal and Child Health Coalition.
[22] Sargent Shriver National Center on Poverty Law.

offered through the Exchange, including not only carriers, but also providers, pharmaceutical companies, medical supply companies, and even self-insured plans.

Stakeholder Comments

The majority of stakeholders expressed the view that the state should consider financing options that would be the least likely to increase the cost of coverage for families and employers.[23] However, little consensus exists on this topic. Multiple patient and family advocacy groups suggested that the state charge assessments or user fees to participating health plans or identify new, targeted revenues to fund the Exchange.[24] Other stakeholders urged the state to consider funding mechanisms that do not solely focus on health insurers.[25] The only general consensus among the stakeholders who provided feedback on this topic is that the state should carefully consider all options and choose the option that encourages the greatest participation in the Exchange while promoting transparency and cost-effectiveness.[26]

C. **Additional** Health Insurance Consumer Protections

The council recommends that the state incorporate ACA reforms into state law to ensure clear, consistent, and fair implementation.

The ACA establishes important new consumer protections enabling individuals, families, and small employers to secure meaningful and affordable health insurance coverage. Some of the reforms build upon existing protections found within the Illinois Insurance Code, other state laws, or related regulations. However, most introduce new protections. For example, the ACA prohibits pre-existing condition exclusions for children under age 19 and eliminates lifetime dollar limits on "essential health benefits." Illinois families and businesses must receive the full benefits and protections established by the ACA. The Illinois Health Insurance Portability and Accountability Act, passed by the Illinois General Assembly after enactment of the federal HIPAA law, can serve as one model for incorporating federal reforms into state law.

Stakeholder Comments

Testimony received during the council's September 22, 2010, hearing in Chicago highlighted some of the many problems and abuses that the ACA reforms were designed to address. Stephanie Altman, advocate and legal counsel with Health and Disability Advocates, told the story of two clients who struggled to find affordable health insurance for themselves or their loved ones due to the presence of a pre-existing condition. In one case, health insurance was "rescinded" after an individual had a stroke, leaving the family liable for tens of thousands of dollars in unexpected medical bills.

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[23] Health and Disability Advocates, and Illinois Maternal and Child Health Coalition.
[24] Community Behavioral Healthcare Association, Access to Care, Campaign for Better Health Care, Sargent Shriver National Center on Poverty Law, and Kelly A. Martin, RN, MSN, FNP (individual).
[25] Illinois Coalition of Agents and Brokers.
[26] NAIFA Illinois, AARP, Illinois PIRG, and Illinois Maternal and Child Health Coalition.

Sarah Lieberman Weisz testified about her family's personal struggles to obtain affordable health insurance. She said that very few options are available to self-employed individuals and described how difficult, confusing, and fear-inducing it can be to shop for health insurance on the individual market in Illinois, even for informed and educated consumers.

C1. Internal Appeals and External Review

The council recommends enacting legislation that brings Illinois law into compliance with ACA standards governing internal appeals and external review processes, to avoid federal preemption of state law.

The ACA establishes new protections to ensure that all individuals have the right to appeal an insurance company's decision to deny needed medical care. Effective July 1, 2010, all Illinois residents covered by an individual or group health insurance policy have the right to an internal appeal and an independent, external review of denied health insurance claims. The ACA reforms expand upon the appeal rights currently available to Illinois residents.

C2. Minimum Medical Loss Ratio Requirements

The council recommends enacting legislation to adopt and incorporate the ACA minimum medical loss ratio requirements into state law, given the importance of these provisions to Illinois families and businesses seeking enhanced value from the purchase of health insurance.

The ACA requires insurance companies to spend a minimum percentage of premium dollars on providing health care to policyholders (known as a "medical loss ratio"). The ACA requires minimum medical loss ratios of 85 percent in the large group market and 80 percent in the individual and small group (50 employees or fewer) markets. Insurers that do not meet the applicable minimum medical loss ratio within a given plan year will be required to issue rebates to policyholders. They also will be required to report detailed loss ratio data to regulators and make the information publicly available.

C3. Premium Rate Review

The council recommends enacting legislation giving the Department of Insurance the authority to approve or deny proposed health insurance rate increases.

The ACA includes provisions to provide consumers and regulators with more information about health insurance premium increases. However, it does not provide any new authority for state or federal regulators to prevent insurance companies from imposing unreasonable premium increases. The Department of Insurance's rate authority is limited to assuring that the rates charged by the health insurer are not so low as to jeopardize their solvency. As a result, health insurance premiums in the individual market in Illinois have increased, imposing a severe burden on Illinois businesses and families.

The ACA establishes a process for state and federal regulators to review unreasonable premium increases. Insurers are required to submit the justification for a premium increase prior to implementing it, and to post this information on company websites.

Illinois already has taken steps to increase oversight of health insurance rate increases. The Department of Insurance was awarded a $1 million federal grant to enhance its rate review capacity. This grant will fund upgrades to technical infrastructure and enhanced information for consumers and policymakers. Without action by the state legislature, however, Illinois families and businesses will still be vulnerable to unreasonable premium increases.

Stakeholder Comments

In testimony before the council on September 22, 2010, one advocate "[urged] the Quinn administration to provide the Department of Insurance with broad and strong powers … to review all proposed rate increases by the industry, and ultimately, through a public process, either deny, agree, or readjust these rate increases to protect small businesses and working families throughout our state."[27] In response to the initial recommendations, one stakeholder recommended that Illinois should exceed the ACA's minimum medical loss ration and that the state should "raise that loss ration to 90% in the large group market and to 85% in the individual and small group markets."[28]

Others expressed support for rate review authority in response to the "Key Issues for Public Comment" document published by the council: "Illinois must take legislative action to increase their authority to review, approve and recalibrate premium rates."[29] "Legislation should be passed and signed as quickly as possible to grant the Department review power so that it can adequately enforce the provisions reform offers."[30]

C4. Health Care Cooperative Program (CO-OPs)

The council recommends that Illinois law be amended as necessary to remove barriers and facilitate formation of nonprofit member corporations eligible for federal funding under the ACA.

The ACA appropriated $6 billion in federal funding to facilitate creating nonprofit, member-run health insurance companies. The program, intended to provide additional coverage options for individuals and small employers, is known as the Consumer Operated and Oriented Plans (CO-OP) Program. To qualify for federal funding, an entity must be organized under state law as a nonprofit, member corporation and must meet other criteria established by the ACA. Given the highly concentrated nature of Illinois' health insurance market, the council believes Illinois

[27] Jim Duffet, Campaign for Better Health Care.
[28] Access Living.
[29] Health Care for America Now Coalition.
[30] AIDS Foundation of Chicago.

businesses, in particular, would benefit from new market participants, especially the nonprofit, member-owned corporations envisioned by the ACA.

C5. Mental Health Parity
The council recommends enacting state legislation to bring Illinois law into compliance with the Mental Health Parity and Addiction Equity Act (MPHAEA) and the Mental Health Parity Act (MHPA), which will enable the Department of Insurance to assure consistency with these federal laws.

In 2008, President George W. Bush signed into law the Wellstone-Domenici MHPAEA, which provides equivalent coverage for mental health or substance use disorders and other medical or surgical conditions.

The MHPAEA applies to group health insurance policies and HMO plans covering 51 or more employees. It builds upon the Mental Health Parity Act of 1996, which prohibited annual or lifetime limits for the treatment of mental health or substance use disorders that are less favorable than those applied to medical and surgical benefits.

Health insurance policies issued in Illinois are also required to cover treatment of certain mental health disorders pursuant to several state laws. Some provisions of these state laws conflict with, and are preempted by, the requirements of the MHPAEA or the MHPA. This recommendation will assure that plans sold outside the Exchange contain the same protections as plans sold on the Exchange.

D. Eligibility Verification and Enrollment (EVE) in Coverage
The council recommends that the state:

- **Establish an interagency project management team to ensure that state departments meet key deadlines;**
- **Allocate sufficient resources to departments engaged in ACA implementation to meet the October 1, 2013, deadline to begin enrollment in the Exchange;**
- **Ensure that development of the EVE system is consistent with state efforts to coordinate enrollment in other government programs;**
- **Capture as much federal funding as possible and budget sufficient state funds to acquire the necessary technology.**

The state will face a major challenge enrolling people into the various programs anticipated as part of the ACA. The best current estimate of the number of uninsured in Illinois is about 1.5 million. Of these, the council estimates:

- Between 500,000 and 800,000 people will be added to Medicaid;
- Between 200,000 and 300,000 people will purchase subsidized coverage through the Exchange;

- Between 300,000 and 600,000 people will remain uninsured.

Additionally, the council anticipates that another one million Illinois citizens who are currently insured will get private insurance through the Exchange, much of it with federal subsidy. The ACA requires people to be able to access Medicaid, Children's Health Insurance Program (in Illinois, All Kids) and private insurance through the Exchange.

Recent legislation in Illinois requires HFS and sister human service departments to prepare an IT plan that anticipates how the EVE system for Medicaid will be upgraded, including preparing for the additional volume and other requirements associated with ACA.

The existing Medicaid enrollment system uses an IT infrastructure that is more than 30 years old. The system is not suitable for effectively serving the current population, let alone handling a significant increase. Moreover, the reduction in caseworker numbers has led to decreased service levels and delays in processing applications. The federal government has acknowledged the policy and technical issues and has agreed to make significant resources available.

Stakeholder Comments

There were few specifics from stakeholders, either at the hearings or in subsequent submissions. Stakeholders acknowledged the importance of streamlining enrollment. For example:

> The success of the Exchange will depend greatly on its ability to establish a streamlined enrollment and eligibility system that is seamlessly linked to the Medicaid programs. The Exchange should apply policies that will facilitate the development of a “no wrong door” enrollment system, including aligning, to the greatest extent possible, Medicaid rules and verification requirements … Illinois should also make sure that if a consumer applies for Medicaid, but does not qualify, he or she is immediately connected to the Exchange and can access its subsidies. Whatever door a consumer enters through, they should quickly and easily receive the appropriate coverage. In fact, the Exchange is required to identify individuals who are eligible for Medicaid and ensure that they are enrolled without having to submit additional information or paperwork. The Exchange and Medicaid should facilitate electronic applications that minimize the need for paper documentation. Interim assistance should be readily available in cases where eligibility cannot immediately be determined. The reconciliation requirements of ACA should be interpreted so as not to defeat the purpose of providing assistance to those who need it. Illinois Exchange should have as its goal to ensure the continued enrollment of eligible individuals and families for tax credits or public programs,

> rather than holding individuals responsible for continually having to work at maintaining their own eligibility.[31]
>
> Coordinated eligibility and enrollment efforts between Medicaid, CHIP and Exchanges will help promote continuity and stability for consumers, and this will in turn help streamline the process of eligibility and enrollment. An essential function of the Exchange will be the ability to take an individual or household and based on their Modified Adjusted Gross Income, direct the person to the program and subsidy for which they qualify. A challenge in achieving the goal of seamless coordination will be the fact that people's incomes and/or circumstances may change.[32]
>
> Since the Exchange is charged with determining if applicants are eligible for Medicaid, CHIP, other public coverage programs as well as new premium and cost-sharing subsidies for private coverage, it will need to develop a system capable of performing this task. This will require collaboration among state agencies operating public coverage programs, as well as with HHS and Treasury. We don't underestimate the challenge that this presents, but hope that it may lead to some creative thinking that can simplify some existing eligibility and enrollment procedures and practices…. It is important that consumers are able to easily compare options to a clear standard and receive help through hot lines and community-based "navigators."[33]

Several stakeholders recommended thinking systematically about various enrollment obstacles that might arise (e.g. language difficulties, physical disabilities, lack of computer access) and making explicit plans to address them. A few noted the difficulties of the current system and suggested this might be a good opportunity to upgrade the entire system. Some suggested that it would be useful to have "navigators" or other people to help—similar to the All Kids application agents. (The Illinois Hospital Association noted, no doubt correctly, that many people will first come to grips with their ability to get health insurance while in a hospital and suggested there be some organized effort to enlist navigators within hospitals.) Only one commenter mentioned outsourcing, suggesting a potential vendor.

[31] Sargent Shriver National Center on Poverty Law.
[32] United Health Group.
[33] AARP.

RECOMMENDATIONS: OTHER CRITICAL ISSUES AND NEXT STEPS

A. Additional Adjustments to the Health Insurance Marketplace

A1. Participation in Exchange

The council recommends further study whether the definition of "small employer" should be increased from 50 to 100 employees and whether larger employers should be allowed to participate in the Exchange.

The ACA requires that states establish SHOP Exchanges through which "qualified employers" can offer health insurance to their employees. While the ACA defines "qualified employers" as those with up to 100 employees, it allows a state to limit Exchange participation prior to 2016 to employers with 50 or fewer employees, to accommodate states such as Illinois that currently define small employers as those with 50 or fewer employees. In 2016, all states must allow employers with up to 100 employees to participate in the Exchange; and beginning in 2017, states can choose to include employer groups of 100 or more.

Experts generally advise that Exchanges should enroll as many participants as possible since insufficient enrollment has been the primary obstacle for earlier state-based Exchanges. While expanding the number of employers who are eligible to participate in the Exchange may seem to be an obvious strategy for increasing participation, rapid expansion could make the Exchange vulnerable to adverse selection, which leads to higher premiums. This threat is particularly acute when participation is expanded to large employers, since they are not required to provide the minimum benefits mandated for plans in the Exchange. Employers with more sick or at-risk workers may choose to purchase through the Exchange, while others with healthier populations may not.

Stakeholder Comments

The foremost priority of the Exchange is to create a stable market inside the Exchange to allow for affordable and quality plans that deliver fairly priced coverage for families and employers. However, comments from stakeholders regarding the best strategy for promoting a stable market indicate the diversity of perspectives represented. The employer advocacy groups recommended that Illinois take a cautious approach to expanding the group size limit in order to preserve stability and choice in the market. The employer coalition suggested that the Exchange initially limit eligibility to 50 employees or fewer and then consider expanding eligibility later.[34] The Illinois chapter of the National Federal of Independent Businesses (NFIB) also would like to see an initial limitation on eligibility for the SHOP Exchange to those employers with 50 or fewer employees. NFIB recognizes that small employers have different needs than larger ones, and that

[34] Illinois Chamber of Commerce, Illinois Manufacturers Association, Illinois Retail Merchants Association, Illinois Life Insurance Council, Tooling and Manufacturing Association, and Chicagoland Chamber of Commerce.

broadening access too soon, before the Exchange is fully developed and working properly, could limit its success.[35]

Several family and patient advocate groups recommended a scheduled phase-in for expanding Exchange participation to employers with 100 employees by 2016.[36] However, the organizations further cautioned against opening the Exchange to large employers as it could result in adverse selection.[37]

A2. Dual Market and Regulatory Parity

The council recommends that Illinois initially establish a "dual market" system and pursue legislation to foster regulatory parity between the Exchange and non-Exchange markets.

The ACA gives broad discretion to states to set rules about the Exchange's role in state insurance markets. States can choose to require that all individual health insurance coverage be sold solely on the Exchange, folding the external market into the Exchange; or both markets could continue to exist ("dual market") under rules that prohibit insurers from discouraging participation in the Exchange. States may also employ a hybrid of these options, such as permitting supplemental or secondary coverage to be sold in an external market but requiring that all major medical coverage be sold only in the Exchange.

The advantage of operating the Exchange as the sole market for individual and small group insurance is that the Exchange would be able to exert more influence on the cost and quality of health care. However, there are drawbacks. An insurance carrier that did not meet the Exchange's standards for participation would effectively be kept out of the state's entire health insurance market. This could cause disruption for individuals and businesses that are happy with their current coverage.

Stakeholder Comments

Based on comments received, stakeholders are divided on the question of whether the Exchange should supplant or supplement the state's existing individual and small group insurance markets. Many groups commented that while the Exchange will provide a tremendous opportunity to improve access to affordable coverage for small employers and individuals, eliminating the outside health insurance market would run counter to the very same principle.[38]

Several other stakeholder groups said that the simplicity of a single marketplace would increase access to insurance, and that Illinois should eliminate the external market and adopt a model that requires offering all individual insurance plans through the Exchange. These groups commented that such a model would provide the state and the public with numerous benefits, including:

[35] National Federation of Independent Businesses.
[36] Illinois Maternal and Child Health Care Coalition.
[37] Campaign for Better Health Care.
[38] Illinois Chamber of Commerce, Illinois Manufacturers Association, Illinois Retail Merchants Association, Illinois Life insurance Council, Tooling and Manufacturing Association, and Chicagoland Chamber of Commerce.

- Simplify the selection process for consumers;
- Eliminate the concern about adverse selection;
- Allow the state to easily standardize benefit designs, quality metrics, marketing regulations, and other marketplace rules;
- Maximize the size of the risk pool; and
- Enhance the public perception of the Exchange by eliminating the idea that the Exchange offers only "bare bones" plans while the best coverage is only available in the external market.

The general sentiment among a majority of stakeholders is that, should Illinois decide to establish the Exchange as a dual market, it will only be as strong as the rules that govern it and the manner in which they are enforced. The Campaign for Better Health Care (CBHC) recommended that the state require plans outside the Exchange to comply with the same regulations imposed on plans within it. While most of the ACA-related requirements for insurers apply to those both inside and outside the Exchange, the ACA imposes a number of additional requirements on health plans certified to participate within the Exchange that may not apply to nonparticipating plans. CBHC advises that these requirements be applied generally to plans outside the Exchange to protect against the risk of adverse selection. Most importantly, the same marketing, benefit design and plan-pricing provisions should apply both within and outside the Exchange to deter non-Exchange plans from marketing plans or structuring benefits to attract better risk.[39] Many patient and family advocate groups recommended that Illinois pass legislation that prohibits insurers from selling only catastrophic (bronze) coverage outside the Exchange.

A3. Risk Adjustment, Reinsurance, and Risk Corridors
The council recommends obtaining the statutory authority to implement federal risk adjustment measures.

The ACA provides for three risk spreading or risk mitigation programs to begin in 2014. The states will administer the risk adjustment and reinsurance programs, while HHS will establish and operate the risk corridor program. The state risk adjustment program will provide a mechanism for assessing a charge on plans that incur lower-than-average risk and providing payments to those with higher-than-average risk. According to HHS, federal rules in 2011 will outline risk adjustment methods.[40] HHS will provide further guidance in subsequent regulations. The federal rules will apply risk adjustment consistently to all plans in the individual and small group markets, both inside and outside of Exchanges.

The transitional reinsurance program is intended to stabilize premiums in the individual market during the first three years of operation of an Exchange, when the risk of adverse selection is

[39] Campaign for Better Health Care.
[40] "Initial Guidance to States on Exchanges" (November 10, 2010), HHS Office of Consumer Information and Insurance Oversight, available online at http://www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html.

greatest. Although administered at the state level, the program will be federally funded and based on federal standards.

The risk corridor program established by the ACA is meant to spread risk more evenly among health plans by projecting target health claims for each plan, and then providing payments to those that exceed these health claims by more than 103 percent. The program will apply to individual and small-group products offered through the Exchange, and is based on the risk corridors used in Medicare Part D. Like the reinsurance program, the risk corridor program will be in effect during the three years beginning January 1, 2014.

Stakeholder Comments

The majority of stakeholders encouraged the state to employ a risk adjustment system that takes into account diagnoses as well as income, language barriers, and other barriers for the populations covered through the Exchange. Stakeholders commented that a comprehensive set of risk adjustments and reinsurance measures could redefine the incentives inside the Exchange—creating a marketplace in which plans have the incentive to cover and improve care for individuals with high needs, rather than to avoid covering sick individuals. Furthermore, patient and family advocacy groups recommended that, due to the dynamic nature of risk selection, the state's enabling legislation should require the Exchange to actively monitor the insurance market for signs of adverse selection, so the state can rapidly adjust its risk selection approach.[41]

The Association for Community Affiliated Plans noted that enrollees disproportionately receive health-care services through community health centers, and encouraged the state to take provider networks into account when constructing its risk adjustment system.

A4. Benefit Mandates

The council recommends waiting for further guidance from HHS before deciding whether to require benefits beyond the "essential benefits" defined by HHS.

Exchanges will offer a choice of qualified health plans that vary in coverage levels but provide a package of "essential health benefits," which HHS will define based on the scope of benefits offered by a typical employer plan. Essential health benefits must include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Some of Illinois' existing benefit mandates may not be included in the definition of "essential health benefits." The ACA allows states to require qualified health plans offered in the Exchange to provide benefits in addition to the "essential health benefits." However, states must pay for

[41] Campaign for Better Health Care.

any portion of subsidized coverage that is attributed to the cost of those additional benefits. The state could consider funding these mandates separate from the Exchange.

Stakeholder Comments

Numerous stakeholders expressed their concern about the scope of benefits covered under the "essential benefits" definition. Delta Dental, for example, noted that Illinois may require benefits in addition to the "essential benefits," and recommended that oral health services—especially pediatric oral health services—be a component of any statewide benefit mandate. Various other provider and patient and family advocacy groups reiterated the need for strong mandated coverage.

A5. Basic Health Plan

The council recommends waiting for further guidance from HHS before deciding whether to establish a Basic Health Plan and what it should include.

The ACA allows states to contract for a coverage program for individuals and families with incomes between 133 percent and 200 percent of the poverty line. The state would receive federal funds to operate this Basic Health Plan equal to 95 percent of the cost of the premium, plus cost-sharing subsidies that would have gone to providing coverage for this group in the Exchange.

Because the Basic Health Plan would be operated under the same rules as Medicaid, the state would be able to maintain continuity of care across Medicaid and non-Medicaid programs. If properly designed, a Basic Health Plan could provide more affordable and comprehensive coverage than the Exchange. In addition, a state could provide Medicaid, CHIP, and Basic Health Plan coverage for working families, allowing them to keep the same medical providers if their income changes.

Stakeholder Comments

The majority of patient and family advocacy groups encouraged the state to explore the most appropriate approach to establish a Basic Health Plan program to ease the transitions and gaps in coverage between Medicaid and non-Medicaid programs, including the subsidized coverage offered in the Exchange. In general, comments reflected the view that an Illinois Basic Health Plan would likely be a more affordable and comprehensive option for individuals and families than commercial insurance offered through the Exchange.[42] The state could also design the Basic Health Plan to allow parents and children to be covered under the same plan so that a family could enroll in "family coverage," or at least have coverage that includes the same provider network and/or cost-sharing system for children (who are covered by Medicaid or CHIP) and parents (who are ineligible for Medicaid but meet the eligibility requirements for a Basic Health

[42] AIDS Foundation of Chicago, Sargent Shriver National Center on Poverty Law, and Campaign for Better Health Care.

Plan). Such plans might be easier for families to understand and use, which would improve access to health care.

B. Consumer Issues and the Exchange

B1. Consumer Outreach

The council recommends that the state continue to engage employers, consumers, and insurers to develop an aggressive and culturally sensitive outreach plan that reflects Illinois' demographic and geographic diversity and the myriad health care needs of Illinois families and employers.

The ACA requires that the Exchange operate a toll-free customer assistance hotline; maintain a website that allows customers to compare qualified health plans; and establish a network of "Navigators" to raise awareness of the Exchange, provide information, and assist individuals and small employers in choosing and enrolling in qualified health plans.

Although individual premium subsidies and small business tax credits will be available only for plans purchased through the Exchange, participation is voluntary. Successful implementation of the Exchange will necessitate a strong outreach and education component to attract sufficient participants to ensure its stability.

Stakeholder Comments

Stakeholders agreed that the Exchange's consumer functions should be tailored to the needs of Illinois employers and residents. Many offered suggestions on how to maximize use of the Exchange website. Some suggested that the Exchange consumer interface include such features as interactive maps of coverage areas, special rankings for the quality of treatment for prevalent chronic diseases in regions of the state, and lists of key preventive treatments for these diseases. Patient and family advocates noted that people also need clear information comparing provider and hospital networks, customer-service user reviews, and other quality indicators (for example, whether the plan encourages providers to deliver patient-centered care, and rewards positive outcomes). Consumers also need to know what each plan offered on the Exchange is doing to keep costs under control and improve the quality of care. Multiple advocacy groups recommended that the state establish feedback mechanisms similar to those found at www.healthcare.gov, which allow users to submit feedback about the usability of the website.[43]

Stakeholders cautioned that outreach efforts should not be solely computer-based. One commenter's poll of its small business members found that one in 10 did not have access to computers.[44] The Exchange must take care not to exclude this segment of the population and to make the Exchange as consumer-friendly as possible. Other groups noted that the most successful outreach strategies utilize community-based groups to assist with hard-to-reach

[43] Illinois Maternal and Child Health Care Coalition, and Health Care for America Now.
[44] National Federation of Independent Businesses.

populations and work through existing networks, such as schools, churches, and labor unions, to reach targeted audiences. Particular efforts should be made to engage medical professionals, offices, hospitals, clinics, and providers of disability services.[45]

Finally, patient and family advocates noted that other public programs could serve as critical "connectors" to the Exchange and Medicaid/CHIP coverage. Linkages with other public programs should be automatic.[46] For example, applying for unemployment insurance should trigger a review of eligibility for health-care subsidies or public programs. When a child or adult is enrolled in a free school lunch program or SNAP, that individual should be automatically routed to Exchange coverage.

B2. Role of Navigators and Producers (Agents and Brokers)
The council recommends that the state further study this issue to identify innovative solutions that maintain the vital role of insurance producers while keeping costs affordable. Navigators and producers should receive similar or identical compensation for sales both inside and outside the Exchange.

The ACA expressly lists brokers and agents as potential Navigators, but provides that Navigators cannot receive compensation directly or indirectly from insurers. However, the ACA allows states to decide how best to use insurance agents and brokers in the Exchange. Current agents and brokers are generally knowledgeable about a range of insurance products and could be helpful for individuals and groups seeking to buy insurance through the Exchange.

The state also must also ensure that residents who purchase insurance outside of the Exchange have access to assistance – a role that has been, and could continue to be filled by agents and brokers.

Stakeholder Comments

Comments represent a variety of viewpoints. Many stakeholders envision producers serving as effective distribution channels for information in the newly designed insurance market.[47] Some groups assert that if the Exchange is designed to make it easy for individuals and small businesses to select plans, then producers are not needed. Many argue that commissions will be less justifiable after 2014 because the Exchange will simplify the consumer search and plan enrollment processes.[48]

While there is some discord regarding the future role of producers, most stakeholders agreed that Illinois has the opportunity to design a commission structure that eliminates the incentives that define the current relationship among producers, enrollees, and insurers. The current practice of

[45] Health Care for America Now.
[46] Health and Disability Advocates.
[47] Illinois Coalition of Agents and Brokers.
[48] Campaign for Better Health Care.

percentage commissions creates an incentive for producers to try to sell policies that are more expensive, and should be avoided. To that end, the Exchanges should limit brokerage commissions to a per-member, per-month rate, as the Utah Health Exchange has done, or a flat dollar amount similar to the commission structure for Medicare Advantage plans.[49] Furthermore, various stakeholders commented that commissions should be the same for renewals as for new enrollments. Paying enhanced commissions for new enrollments gives producers an incentive to "churn" enrollees from plan to plan rather than ensuring that they enroll in the most appropriate plan.

C. Healthcare and Public Health Workforce

The council recommends convening a Healthcare Workforce work group to develop an aggressive, comprehensive plan for professional and paraprofessional health care and public health worker shortages statewide, now and in the future.

The plan should address:

- Workforce shortages statewide;
- Education and training for health professionals and support personnel;
- Racial, ethnic, geographic, cultural diversity and disability status of state residents;
- Public health workforce development;
- Collaboration with the Illinois Workforce Development System, including the Illinois and local Workforce Investment Boards;
- Scope of practice laws associated with healthcare, including the medical practice act, nurse practice act, pharmacist practice act, as well as new workforce categories that may be needed to assure that providers can work to the full extent of their training and education;
- Coordinating efforts of community colleges, universities, and academic medical centers to initiate and expand workforce development programs and capture funding under the new ACA Prevention and Public Health Fund and other federal education and training funding opportunities;
- Other human resources needed to prevent disease, detect it early, and manage conditions before they become severe.

The Affordable Care Act includes a comprehensive strategy with $250 million in funding to achieve these goals by investing in new caregivers through training, new incentives to physicians for providing primary care to patients, and support for caregivers who choose to enter primary care in underserved areas.

The Association of American Medical Colleges estimates that the nation will have a shortage of approximately 21,000 primary care physicians in 2015. Without action, experts project a

[49] Campaign for Better Health Care.

continued primary care shortfall due to the needs of an aging population, decline in the number of medical students choosing primary care, and impending retirement of the Baby Boomer generation of providers. This structural shortfall occurs at a time when the ACA will significantly increase access to health care to more than one million Illinois residents.

It is critical that a highly qualified workforce exists to meet this heightened demand.

Stakeholder Comments

"Expanding Illinois health care workforce is a complex challenge requiring initiatives and solutions that address numerous points on the supply continuum, including career awareness, student preparation, educational capacity, licensure, and recruitment and retention."[50] The shortage of health care workers "impacts access to needed treatment and contributes to inadequate care and unsafe conditions."[51]

Health care workforce needs must be evaluated; indeed, "[p]ublic and private health systems must have healthcare providers in numbers and locations adequate to provide timely, appropriate services."[52] Subsequently, a career ladder to address those needs must be developed. Moreover, to assist in the cultivation of the workforce, incentive programs should be developed to "recruit and retain medical students, physicians and mid-level providers who will practice in rural, underserved and shortage areas."[53] Education and professional development of the current workforce must be fostered. Furthermore, "[w]e must continue to build diversity in all of our health careers" by increasing cultural and linguistic diversity within the health care workforce.[54] Finally, Illinoisans have a "need for a highly skilled healthcare workforce."[55] Consequently, fulfilling this need requires reviewing laws, regulations on licensure, and the scope of practice for health care professionals. Responding to the initial recommendations, a stakeholder commented that the discussion of recruiting and retaining physicians in Illinois should include "the critical need for medical liability reforms."[56]

D. Health Information Technology

The council recommends aggressive implementation of the Illinois Health Information Exchange (HIE) Strategic and Operational Plan.

Implementing the ACA offers a historic opportunity to achieve and sustain measurable improvement in the structures, processes, and outcomes of Illinois' health care system.

[50] Illinois Hospital Association, testimony by Cathy Grossi, vice president.
[51] National Alliance on Mental Illness.
[52] National Alliance on Mental Illness.
[53] Illinois Hospital Association, testimony by Cathy Grossi, vice president.
[54] Dr. Linda Samson.
[55] Dr. Linda Samson.
[56] Illinois Hospital Association, testimony by John Bomher, vice president.

The Illinois HIE plan, which aims to protect the privacy and security of identifiable health information, was approved by the federal government in December 2010. Stakeholders across the state are collaboratively developing the HIE.

The HIE focuses on:

- Promoting the adoption and meaningful use of electronic health records (EHRs);
- Developing a statewide HIE to ensure that all Illinois providers can exchange data and participate in the federal payment incentive programs;
- Ensuring that providers who wish to begin exchanging health information electronically in 2011 can do so;
- Incorporating state information systems to ensure that providers can fulfill public health and other reporting requirements directly from their EHRs, as well as access vital information, such as immunization data, directly through EHRs;
- Encouraging evidence-based care delivery;
- Prioritizing standards-based public health reporting data functions (information exchange, management, and analytics) consistent with the Quality Data Set (QDS);
- Integrating state information systems (e.g., immunization data, vital records, registries) into the HIE using federally accepted guidelines;
- Developing information systems and date sources, such as an all payer claims database, that will support Illinois' quality initiatives, delivery system innovations and payment reforms.

The use of electronic health records can give providers access to critical information that helps them deliver better care and provide patients access to their own health information so they can make better-informed choices about their health care. Standardized data also allows for accurate measurement of clinical quality and health outcomes. The Illinois HIE plan is available at www.hie.illinois.gov.

Stakeholder Comments

The Illinois Hospital Association (IHA) testified in favor of ACA incentives to improve quality and control costs, including development of accountable care organizations (ACOs), and pledged to work with member hospitals and other entities interested in implementing ACOs. The IHA urged the state to explore and implement a Medicaid ACO demonstration project and retain and expand the state's primary care case management and disease management programs to include additional populations, conditions, and providers. The IHA further advocated for consistency and standardization among federal, state, and private payers' quality incentive programs to increase the number of providers participating in them, and asked that cost savings realized from reforms be reinvested in programs to improve access to quality care. The IHA also urged the state to provide incentives for collaboration among providers and business relationships that support potential new payment mechanisms instituted under the ACA.

Physicians, hospitals, and public health officials affirmed the potential benefits of health information technology and recommended that the state continue to create incentives to encourage the use of EHRs by all clinicians. Southern Illinois Healthcare testified that the state should continue its efforts to build a comprehensive health information exchange based on national standards and consistent with the federal concept of EHR meaningful use. Support was expressed for statewide standards regarding privacy and security for health information exchange at the statewide and local levels.

The IHA testified that hospitals implementing EHRs are achieving greater effectiveness and efficiencies and that access to accurate patient information is essential to understanding processes and outcomes and to improve coordination of care among providers. The IHA encouraged the state to develop its Medicaid EHR payment incentive program plan and make payments available to providers as soon as possible. The IHA advocated continued support for the Governor's Office of Health Information Technology and stakeholder participation in health information exchange efforts. It suggested that state policy should eventually require all providers to participate in a health information exchange.

The Jackson County Health Department emphasized the importance of making immunization data available through the streamlined use of EHRs and HIE. Public health officials stressed that aggregated data available from EHRs and HIE will improve their ability to identify and solve public health problems in specific communities. The IHA suggested that providers should be able to submit required information to the Illinois Department of Public Health directly through their EHR systems.

The Community Behavioral Health Association of Illinois and the Illinois Association of Rehabilitation Facilities affirmed their commitment to statewide efforts to promote EHRs and health information exchange and continue addressing the challenges of sharing data and coordinating information between medical and behavioral health providers. The IHA supported efforts to include behavioral health and long-term care providers among those eligible for federal payments to adopt EHRs.

E. Incentives for High-Quality Care

The council recommends establishing a Quality work group to develop a coordinated strategy among appropriate state agencies to improve health care quality.

The Quality work group would ensure that Illinois plans are consistent with related federal health care quality strategies and federal funding opportunities intended to incentivize value-based purchasing, improve the patient's health care experience, promote transparency, and increase care coordination among multiple health care settings to improve health outcomes.

Multiple opportunities exist to engage consumers, providers, payers, and purchasers in coordinating and integrating quality improvement efforts across all aspects of health care reform.

There are several provisions within ACA (e.g., National Strategy to Improve Health Care Quality, Medicaid Quality Measurement Program) that address the five components identified by the National Academy for State Health Policy for improving health system quality and efficiency:

- Data collection, aggregation, and standardization, for performance measurement;
- Public reporting and transparency of data, to drive accountability;
- Payment reform and alignment of financial incentives, to encourage value-based purchasing;
- Consumer engagement, to drive policy change and encourage care self-management;
- Provider engagement, to drive policy change and to transform care delivery.

Aligning quality initiatives and incentives across health care payers and among multiple state agencies will reduce the administrative burden on providers, which in turn will encourage them to improve quality.

F. Reforms to Medicaid Service Structures and Incentives

Establish a System Design work group to identify options, establish priorities, and take advantage of appropriate funding opportunities under ACA to implement Medicaid program reforms and mandates.

As a result of ACA, Illinois estimates that an additional 500,000-800,000 residents will be eligible for health care coverage under the state's Medicaid program. The federal government will pay 100 percent of state costs for the newly eligible Medicaid recipients for the first four years and then reduce its contribution over time to 90 percent.

Since 1965, Medicaid has covered the state's poorest and most medically needy residents. Medicaid coverage is associated with better health compared to those with similar incomes but no health insurance. Unfortunately, decades of significant annual cost increases from higher enrollment, and increased medical and pharmaceutical costs under the state's fee-for-service reimbursement system have left the program financially unsustainable.

The numerous Medicaid challenges—from low reimbursement, to separate delivery systems for people with private insurance and those covered by Medicaid, to a lack of focus on prevention and quality—must be addressed before the influx of new covered individuals begins. Otherwise, whatever doesn't work now, still will not work—only on a larger scale.

Perhaps more importantly, the ACA creates a real sense of opportunity because of its recognition that new models are needed, along with financial incentives for states to try them. One example is the Center for Medicare and Medicaid Innovation created by HHS to coordinate with states to meet the needs of the most expensive Medicaid beneficiaries.

The ACA is insistent about the need for greater integration in delivery of care. Integration promises reduced costs and higher quality by addressing patients' needs at the earliest possible stage in the illness or disability, while reducing the chances that services are duplicated. The integration model for Medicaid's future involves teams of health professionals in different settings, connected through electronic health records, which create and implement treatment plans that meet the comprehensive needs of Medicaid clients. The requirement in the Illinois Medicaid reform legislation to serve at least half of full-time Medicaid beneficiaries in coordinated care systems reflects this priority.

New payment mechanisms also will be necessary to create adequate incentives for providers to work in teams, focus on prevention and wellness, and assure the best possible health outcomes for their patients.

The current hospital rate structure was not designed with the expectation that at least a majority of clients would be served in risk-based coordinated care systems as encouraged in the ACA and mandated in recent Medicaid reform legislation. The system must be revised to facilitate enrollment of Medicaid clients in coordinated care systems while building on the strength of Illinois' hospitals and medical centers throughout the state. The System Design work group will monitor HFS hospital payment reform efforts to assure payment systems encourage high quality, coordinated care.

Stakeholder Comments

Virtually every one of the stakeholders who addressed the issue of delivery systems at the public hearings (about one-third of all comments) or submitted written comments identified the need for greater integration of services, particularly integration of mental health and social services. A sampling of typical comments includes the following:

> All eligible individuals in Illinois should be enrolled in a health plan or program; payment for health care services should be fair and timely; include consideration for time spent on care management and coordination of care among a patient's various providers; and reward appropriate care outcomes that are delivered in a cost-effective manner…. The regulatory environment must allow clinical and financial integration of health care entities; promote health care professionals working together in teams; and provide for implementation of efficiencies that reduce cost while maintaining quality.[57]
>
> The central theme of health care reform is to significantly improve care integration between the numerous services and providers in our health system. The goal is that, with a focus on outcomes and quality rather than simply on the number of services delivered, health care costs will come down nationally and locally. In Illinois, about

[57] Illinois Hospital Association.

> 22 percent of older adults have to return to the hospital within 30 days of being discharged, often because of the gap in transitional care back home and the inability of the current system to connect the individual with necessary follow-up care in the community. Long-term care providers like CJE, in strong partnership with local hospitals, health care professionals and the state, will play a critical role in strengthening care coordination from the post-acute-care setting to home for the aging population through the implementation of health reform.[58]
>
> [The state should] move toward comprehensive case management and capitated systems … moving from behavioral health carve-outs to integrated care across all systems (acknowledging that an integrated care pilot will soon be implemented in the Chicago area)…. If health services are integrated, the funding among federal, state, and county government also has to be intertwined. Blended or braided funding forces the elimination of silos with their duplicative eligibility and other tedious administrative requirements by supporting a streamlined comprehensive service system for individuals with complex health issues and their families. Changes in practice and payment to align quality and cost and to achieve desired client and system outcomes will greatly increase the likelihood for sustainability of the newly reformed system.[59]
>
> Payment reforms will shift a great amount of cost accountability to the provider thus increasing the quality of care coordination … [they] are also a platform to reward providers financially for providing high quality healthcare while using the available resources efficiently. Shifting from a traditional fee-for-service model to pay-for-performance model across Medicaid, Medicare, etc. will ensure high quality of care irrespective of the individual's plan.[60]

However, few of the recommendations were very specific. Most used a general appeal to "integration" as an argument for participating in one of the demonstration grants authorized under the ACA that involves their kind of provider. Also, there was not much attention to the question of how any of these specific demonstrations could be "scaled up."

Only managed care organizations expressed willingness to accept risk. While accepting risk does not necessarily increase integration, capitation payments can reward integrated delivery systems that achieve savings from better primary care and lower institutional utilization.

On the other hand, several stakeholders, particularly from the hospital community, actively supported the concepts of accountable care organizations (ACOs), which are potentially risk-sharing alternatives to traditional managed care. (The Hospital Sisters Health System suggested

[58] CJE Senior Life.
[59] Association of Community Mental Health Authorities of Illinois.
[60] Infosys Technologies Ltd.

using “more incremental ingredients of care management since a fully developed ACO may be difficult to achieve in the short term—especially in rural areas where providers have only begun to coordinate care.” The organization suggested continued support for coordinating components such as care management protocols, information technology capabilities, quality/efficiency incentives, and medical homes.)

G. Early Medicaid Expansion

The council recommends that Illinois not apply for a federal waiver to expand Medicaid prior to 2014 unless the General Assembly lifts the recent moratorium on eligibility expansion.

The ACA allows states to apply for waivers to expand Medicaid prior to the 2014 official implementation date. However, recent Illinois legislation imposed a moratorium on Medicaid eligibility expansion. In addition, early expansion would be reimbursed only at the state’s current federal Medical Assistance Percentage (50 percent, after the stimulus increment expires in 2011) and state resources to expand are not available.

Stakeholder Comments

Cook County Health and Hospital System and the Sergeant Shriver National Center on Poverty Law suggested early expansion of Medicaid to increase access to health care. They pointed out that when the state’s cost of care is funded entirely through intergovernmental transfers it could be worthwhile to collect the 50 percent federal share on behalf of residents for whom no federal share is now available.

H. Grants and Sources of funding

The ACA has provided states with many opportunities to apply for grants and other funding resources to assist with implementation efforts. Not only are opportunities available for state agencies, but there are also funding opportunities for universities, community organizations, providers, community health centers, county health departments and municipalities. Funding under the Affordable Care Act is also linked to the American Recovery and Reinvestment Act, which funded states development of Health Information Exchanges to increase investment in and utilization of health information exchanges. Illinois received a grant to establish a statewide HIE and promote the adoption of EHR.

The following table lists grants from the ACA that were awarded various entities across Illinois.

Grant Name	Recipient	Amount	Type/Agency
Seniors, individuals with disabilities, and caregivers better understand and navigate their health and long-term care options	Illinois Department on Aging	$1,499,253	Aging
Maternal, Infant, and Early Childhood Home Visiting Program	Illinois	$3,135,997	DHS
Communities Putting Prevention to Work Community Initiative	Children's Memorial Hospital: City of Chicago	$5,800,000	DPH/Prevention
State Health Professional Grants: Totals	Illinois Total	$4,493,481	
	Chicago Department of Health: CDC Local HIV Prevention Programs Grant	$927,321	DPH/Prevention
	Chicago: CDC Expanded HIV Testing Grant	$145,567	DPH/Prevention
	Illinois: CDC Expanded HIV Testing Grant	$145,567	DPH/Prevention
	Chicago: CDC Surveillance Grant	$16,941	DPH/Prevention
	Illinois: CDC Surveillance Grant	$72,489	DPH/Prevention
	Illinois Department of Health: CDC Tobacco Quitlines Grant	$116,426	DPH/Prevention
	City of Chicago: CDC Epidemiology and Laboratory Capacity/Emerging Infections Program Grant	$267,314	DPH/Prevention

	Illinois State Department of Public Health: CDC Epidemiology and Laboratory Capacity/Emerging Infections Program Grant	$666,815	DPH/Prevention
	Chicago Center for Health Systems Development: CDC Obesity Biometrics Grant	$1,216,915	DPH/Prevention
	Heritage Behavioral Health Center, Inc.	$496,863	Behavioral Health
	Trilogy, Inc.	$421,263	Behavioral Health
Public Health Systems and Infrastructure	Illinois State Department of Public Health	$400,000	
Public Health and Prevention Fund Workforce Grants	Illinois total	$7,675,358.00	
	University of Illinois at Chicago: Advanced Nursing Education Expansion	$1,425,600.00	Workforce
	University of Illinois at Chicago: Nurse Managed Health Clinics	$1,499,995.00	Workforce
	Swedish Covenant Hospital, Chicago: Primary Care Residency Expansion	$960,000.00	Workforce

	University of Illinois at Chicago: Primary Care Residency Expansion	$1,920,000.00	Workforce
	Southern Illinois University: Primary Care Residency Expansion	$1,869,763.00	Workforce
Health Profession Opportunity Grants: Totals	Illinois total	$2,588,501.00	
	Will County, Joliet: Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals	$1,080,000	Workforce
	Southland Health Care Forum, Inc.: Chicago Heights. Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals	$1,505,501	Workforce
Family-to-Family Health Information Center Grant Awards	The ARC of Illinois	$95,700	Workforce
Community Health Centers; operation, expansion and construction	Illinois total	$45,639,496.00	Children w/disabilities;HCBS

	Southern Illinois Healthcare Foundation, Sauget	$10,324,862.00	DPH/infrastructure for existing health centers
	The Board of Trustees of the University of Illinois	$12,000,000.00	DPH/infrastructure for existing health centers
	Christian Community Health Center, Chicago	$4,608,006.00	DPH/infrastructure for existing health centers
	Beloved Community Family Wellness Center, Chicago	$2,229,815.00	DPH/infrastructure for existing health centers
	Near North Health Service Corporation, Chicago	$4,000,000.00	DPH/infrastructure for existing health centers
	Chicago Family Health Center	$6,257,249.00	DPH/infrastructure for existing health centers
	Henderson County Rural Health Center, Inc., Oquawka	$1,067,669.00	DPH/infrastructure for existing health centers
	Community Health and Emergency Services, Inc., Carbondale	$5,151,895	DPH/infrastructure for existing health centers
Grants to Help States Crack Down on Unreasonable Health Insurance Premium Hikes	Illinois Department of Insurance	$1,000,000	DOI
Health Insurance Exchanges: State Planning and Establishment Grants	Illinois Department of Insurance	$1,000,000	DOI/HFS
Consumer Assistance Grants	Illinois Department of Insurance	$1,454,594	DOI

Illinois Pre-Existing Condition Insurance	Illinois Department of Insurance	$196,000,000	
FY2010 Personal Responsibility Education Program (PREP)	Illinois Department of Human Services	$2,231,758	DOI
Nurse Managed Health Clinics (T-56)	University of Illinois at Chicago	$1,499,995	DHS/Prevention
Advanced Nursing Education Expansion (T-57)	University of Illinois at Chicago	$1,425,600	Workforce
Community Health Center Cooperative Agreement	Illinois Primary Care Association Springfield, Illinois	$116,895	Workforce Community Health Centers- Technology, Workforce, Expansion
Electronic health Records Efforts	Governor's Office of Health Information Technology	$18,800,000 (from ARRA)	OHIT
Total as of 01/03/11		$294,856,331	

H1. Future funding opportunities

There are many potential future funding opportunities under the ACA. The state is monitoring the announcements by federal agencies of funding availability. Recently, the Chicago Community Trust and the Community Memorial Foundation were awarded a matching grant by Grantwriters in Health that will provide assistance to state agency personnel applying for grant opportunities under the ACA.

The council intends to pursue the following opportunities to the extent state resources are available to implement and administer them, whether the grants require state matching funds, and what level of future commitment by the state is required. The following include some opportunities the state intends to pursue of which are currently announced and will be announced in the future:

- CDFA 93.525 -- State Establishment Grants for the Affordable Care Act (ACA)'s Exchanges; first opportunity to apply in May 2011, and quarterly thereafter

- Community Based Care Transition Program, Demonstration project; The Community Based Care Transitions Program (CCTP) goals are; to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program. The demonstration will be conducted under the authority of section 3026 of the ACA.
- Prevention and Public Health Fund; $500 million was awarded to states (Illinois awards are listed above) last year from this and an additional $750 million will be available in the following areas this year: community prevention, clinical prevention, public health infrastructure and research and tracking.

I. Work Group Plans

The Council will establish work groups to implement the recommendations. The work groups, led by Council agency staff, will prepare detailed plans to assure timely implementation of recommendations that require continued interagency and public participation.

1. **System Design**

   The council recommends establishing a System Design work group to identify options, establish priorities, and take advantage of appropriate funding under ACA to implement Medicaid program reforms and mandates. The System design work group will be led and managed by HFS. It will include representatives from various stakeholder groups including: providers, advocacy organizations and members of the General Assembly.

   The System Design work group will convene by April 1, 2011. It will hold public meetings, and develop a set of criteria for evaluating options and then apply those criteria to various new models. The work group will issue a report by October 1, 2011.

2. **Healthcare Workforce**

   The council recommends convening a Healthcare Workforce work group to develop an aggressive, comprehensive plan to professional and paraprofessional healthcare and public health worker shortages statewide, now and in the future. The Healthcare Workforce work group will convene by April 1, 2011. It will hold public meetings and issue its' plan by October 1, 2011.

   The council recommends this work group be a subcommittee of the State Health Improvement Plan (SHIP) Implementation Council. Utilizing the existing structure of the SHIP Implementation Council, will allow for a multi-disciplinary approach to addressing health care workforce issues. The SHIP plan clearly addresses the broad concerns regarding health care workforce needs and provides a framework to develop analysis and a specific statewide workforce development plan.

The Healthcare Workforce work group will be co-chaired by the Department of Public Health and the Department of Commerce and Economic Opportunity and will also include representatives from the following state agencies and offices: Office of the Governor, Department of Public Health, Department of Commerce and Economic Opportunity, Department of Professional Regulation, Board of Health, Departments of Insurance, Employment Security, Health Care and Family Services, Board of Education, Community College Board and Board of Higher Education. Additionally, public representatives should be health care workforce experts, including representatives of practicing physicians, nurses, and dentists, and allied health professionals; State and local health professions organizations, schools of medicine and osteopathy, nursing, dental, allied health, and public health; public and private teaching hospitals; health insurers, business; and labor, and consumers.

3. **Quality**

The council recommends establishing an interagency work group to develop a coordinated strategy among appropriate state agencies to improve healthcare quality. The Quality work group will include representatives from relevant state agencies such as: HFS, DHS, IDPH, and Aging. The work group will hold public meetings, and engage the following stakeholder groups: consumers, providers, payers, and purchasers. The work group will convene by April 1, 2011 and issue a report by October 2, 2011.

APPENDIX 1: COUNCIL PROCESS

On July 29, 2010, Governor Pat Quinn established the Health Care Reform Council to help the state implement the health care reforms contained in the federal Affordable Care Act (ACA). He appointed his Senior Health Policy Advisor, Michael Gelder, as Chair of the Council, and Julie Hamos, Director of the Department of Healthcare and Family Services, and Michael McRaith, Director of the Department of Insurance, as Co-Chairs of the Council. The remaining Council members are the Directors of the relevant state agencies.

A. Public Meetings

The Council held four public meetings during which it heard more than 15 hours of testimony from more than fifty witnesses from key stakeholder groups including: consumers, public health departments, small business owners, professional associations, insurers, employers, healthcare advocacy organizations, government representatives, medical professionals.

1. First Public Meeting

At the first meeting, held on September 22, 2010, in the Thompson Center in Chicago, each of the representatives from the agencies on the Council explained the role of their department in implementing the various sections of the ACA. The following people testified:

- Stephanie Altman, Health and Disability Advocates
- Courtney Hedderman, AARP
- Sarah Leiberman Weisz, ICHIP participant/consumer
- Jim Duffett, Campaign for Better Health Care
- Sheri Hokin, Hokin Sternberg Insurance Services
- David Borris, Hel's Kitchen Catering
- Claire Gregoire, KAMDEN Strategy Group, Inc.
- Lori Cowdrey, Health Alliance
- Bill Berenson, Aetna
- Michael Brady, Blue Cross Blue Shield
- John Bomher, Illinois Hospital Association
- Margaret Davis, Action Now
- Margaret Stapleton, Sergeant Shriver Center National Center on Poverty Law
- Margie Schaps, Health and Medicine Policy Research Group
- Dr. Niva Lubin-Johnson, physician
- Janine Lewis, Illinois Maternal and Child Health Coalition
- Nelson Saltman, Legal Assistance Foundation
- Single-payer Coalition

2. Second Public Meeting

The second public meeting was held on October 5, 2011, at Illinois Central College in Peoria. The topic of the meeting was developing an adequate health care workforce. The following people testified:

- Linda Roberts, Illinois Department of Financial and Professional Regulation
- Teresa Garate, Illinois Department of Public Health
- Sure Clark, on behalf of the Illinois Nurses Association, Illinois Society of Advanced Practice Nursing and Illinois Association of Nurse Anesthetists
- Cathy Grossi, Illinois Hospital Association
- Dr. Asim Jadder, Illinois Academy of Family Physicians
- Farrell Davies, Heartland Community Health Center
- Greg Chance, Peoria County Health Department
- Carol Weissman-Acord, National Association of Social Workers, Illinois Chapter
- Dr. Linda Swanson, Governors State University
- Jennifer Mouchine, Chicago Jobs Council
- Elissa Bassler, Illinois Public Health Institute
- Carol Stagg, nurse
- Chris Wade, consumer
- Linda Pendergast, nurse and Methodist College of Nursing
- Jill Hayden, Illinois Primary Health Care Association

3. Third Public Meeting

The third public meeting was held on October 22, 2010, at the Dunn-Richmond Economic Development Center in Carbondale. The topics of the meeting were incentivizing delivery systems to assure high quality care and achieve desired outcomes, and fostering the widespread adoption of electronic medical records and participation in the Illinois Health Information Exchange. The following people testified:

- Howard Peters, Illinois Hospital Association
- Rex Budde, Southern Illinois Healthcare
- Dave Holland, Southern Illinois Healthcare
- Miriam Link-Mullison, Jackson County Health Department
- Kim Sanders, SIU Center for Rural Health and Social Service Development
- Patsy Jensen, Shawnee Health Alliance
- Dr. Dennon Davis, Illinois Academy of Family Physicians
- Dr. Marci Moore-Connelley, SIU School of Medicine/Illinois Foundation for Quality Health Care

4. Fourth Public Meeting

The fourth public meeting was held on November 16th, 2010, at the Howlett Building in Springfield. The topic of the meeting was reforming Medicaid service structure and enrollment systems. The following people testified:

- Janine Lewis, Illinois Maternal and Child Health Colaition
- Heather O'Donnell, CJE Senior Life
- Mike O'Donnell, East Central Illinois Area Agency on Aging
- Tyler McHaley, Springfield Area Disability Activists
- Tony Paulauski, The Arc of Illinois
- Frank Anselmo, Community Behavioral Health Association
- Cherryl Ramirez, Association of Community Mental Health Authorities
- Dee Ann Ryan, Vermilion County Mental Health Board
- Marilyn Martin, Access Living
- Andrea Kovach, Sergeant Shriver Center National Center on Poverty Law
- Gina Guillemette, Heartland Alliance for Human Needs and Human Rights
- Peter Palanca, Treatment Alternatives for Safer Communities, Inc.
- John Bomher, Illinois Hospital Association
- George Hovanec, Children's Memorial Hospital
- Dr. Janet Albers, Illinois Academy of Family Physicians
- Dr. Steve Malkin, Illinois State Medical Society
- Jill Hayden, Illinois Primary Health Care Association
- Deila Davis, Access Community Health Network
- Dr. Genevieve Thomas, Awakened Alternatives, Inc.
- Gail Ripka, Illinois Homecare and Hospice Council
- Maria Shabanova, MAXIMUS, Inc.
- Benjamin Schoen, Meridian Health Plan
- Dr. Margaret Kirkegaard, Illinois Health Connect Automated Health Systems
- Dr. Scott Wooley, Illinois Optometric
- John Peller, AIDS Foundation of Chicago
- Thomas Merryweather, consumer

5. Fifth Public Meeting

The fifth public meeting was held on February 9th, 2011, as the James R. Thompson Center in Chicago. The topic of the meeting was to hear public feedback on the Council's initial recommendations. The following people testified:

- John Bomher, Illinois Hospital Association
- Meryl Sosa, Illinois Psychiatrists Society

- Marilyn Martin, Access Living
- Emily Junge, Doctor's Council, SEIU
- Mary Feely, Illinois Podiatric Medical Association

B. Website and Written Comments

The Council also created a website (www.healthcarereform.illinois.gov) to improve communication with the public. The website was used to communicate information on how the ACA impacts Illinoisans' and to provide consumers a centralized portal to subsequent state agency website that provides more detailed information about the ACA.

The website was also used to post documents related to the public meetings including the meeting agendas, minutes and copies of written testimony. At each public meeting, Council members conducted a brief slide presentation about the ACA and its' impact in Illinois as well as more detailed information about the meeting's topics. These presentations were also available on the website. The website also offered a comment section designed to allow members of the public to offer their opinion and recommendations to the Council to help in its work. To date, the Council has received more than 70 comments on the website. They have ranged from inquiries about individual health plans, to suggestions on the functions of a Health Benefits Exchange, to opinions of advocacy organization about efficiencies and improvements that could be made to Medicaid enrollment, to asking the Council to examine different delivery system models such as Accountable Care Organizations (ACO's).

APPENDIX 2: COUNCIL AGENCIES

GOVERNOR'S OFFICE

Michael Gelder

Amy Lulich

Jennifer Koehler

Jessica Bruskin

GOVERNOR'S OFFICE OF HEALTH INFORMATION TECHNOLOGY

Laura Zaremba

GOVERNOR'S OFFICE OF MANAGEMENT AND BUDGET

David Vaught

John Frigo

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

Julie Hamos

Michael Koetting

DEPARTMENT OF INSURANCE

Michael McRaith

Kate Gross

Jennifer Jordan

Joe Weimholt

Ted Whalen

DEPARTMENT OF HUMAN SERVICES

Michelle Saddler

Grace Hong-Duffin

Grace Hou

DEPARTMENT OF PUBLIC HEALTH

Dr. Damon Arnold

Dr. Teresa Garate

David Carvalho

Leticia Reyes

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

James Sledge

Janice Bonneville

DEPARTMENT OF AGING

Charles Johnson

Paul Stepusin

APPENDIX 3: TIMELINE

Action	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	All 2012	Dec-13	Jan-13	Jan-14
Quality work group convenes		x												
Quality work group issies initial report								x						
Workforce work group convenes		x												
Workforce work group issues initial report								x						
System Design work group convenes		x												
System Design work group issue initial report								x						
Consultants for EVE begin work	x													
Consultants issue final report				x										
Write and approve RFP for Exchange (after enabling legislation passes)														
RFP for Exchange posted						x								
Design, build and test Exchange system														
Begin Medicaid and Exchange redetermination and enrollment												x		
HHS determination if State Exchange is operable													x	
Exchange officially up and running														x

APPENDIX 4: EXECUTIVE ORDER

EXECUTIVE ORDER CREATING THE ILLINOIS HEALTH REFORM IMPLEMENTATION COUNCIL

WHEREAS, 1.8 million Illinoisans do not have private or public health insurance coverage; and

WHEREAS, the Patient Protection and Affordable Care Act was enacted by the Congress of the United States and signed into law by the President of the United States on March 23, 2010 and the Health Care and Education Reconciliation Act (hereinafter collectively referred to as the "Affordable Care Act") was enacted by the Congress of the United States and signed into law by the President of the United States on March 30, 2010; and

WHEREAS, the Affordable Care Act relies on state governments to implement comprehensive health insurance reforms that will improve the accountability of health insurance companies, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans; and

WHEREAS, one objective of the Affordable Care Act is to provide affordable health care coverage for families; and

WHEREAS, another objective of the Affordable Care Act is to stabilize the cost of health care coverage provided by employers to employees; and

WHEREAS, the Affordable Care Act strengthens Medicare benefits by lowering prescription drug costs for those in the Part D 'Donut Hole,' enhancing chronic care, and offering free preventive care; and

WHEREAS, the Affordable Care Act will impact families and children, individuals, people with disabilities, seniors, young adults, and small and large businesses throughout Illinois; and

WHEREAS, effective coordination among State of Illinois executive branch agencies and the General Assembly regarding implementation of the Affordable Care Act will ensure that the people of Illinois receive immediate and full access to all health care coverage, insurance protections, expanded access to care and federal subsidies to ensure affordability; and

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, pursuant to the supreme executive authority vested in me by Article V of the Illinois Constitution, do hereby order as follows:

I. CREATION

There is hereby created The Illinois Health Care Reform Implementation Council (hereinafter "Council") having the duties and powers set forth herein. Members of the Council shall be appointed by the Governor and shall include the following individuals or their designees:

a. A designee of the Office of the Governor
b. Director of the Department of Healthcare and Family Services
c. Director of the Department of Insurance
d. Director of the Department of Public Health
e. Director of the Department on Aging
f. Secretary of the Department of Human Services
g. Director of the Office of Health Information Technology
h. Director of Central Management Services
i. Director of the Governor's Office of Management and Budget
j. Director of the Department of Labor
k. Secretary of the Department of Financial and Professional Regulation

The designee for the Office of Governor shall serve as the Chair of the Council and the Directors of the Department of Insurance and the Department of Healthcare and Family Services shall serve as the Vice-Chairs. Administrative support to the Council shall be provided by the agencies appointed to the Council. The Council may access donations of labor, services, or other things of value from any public or private agency or person.

II. PURPOSE

The purpose of the Council is to recommend to the Governor what changes should be initially implemented to ensure the State is improving the health of residents by increasing access to health care, reducing disparities, controlling costs, and improving the affordability, quality and effectiveness of health care consistent with the Affordable Care Act. The Council shall make recommendations on, but not be limited to, opportunities and responsibilities in the Affordable Care Act for states to:

a. establish a health insurance exchange and related consumer protection reforms; and
b. reform Medicaid service structures and enrollment systems; and
c. develop an adequate workforce; and
d. incentivize delivery systems to assure high quality health care and achieve desired outcomes; and
e. identify federal grants, pilot programs, and other non-state funding sources to assist with implementation of the Affordable Care Act; and
f. foster the widespread adoption of electronic medical records and participation in the Illinois Health Information Exchange.

III. FUNCTION

a. In carrying out responsibilities, the Council shall hold public meetings in regions across the State for the purpose of informing the public about the opportunities and responsibilities under the Affordable Care Act, soliciting recommendations for the implementation of the six areas listed above, and reporting on those recommendations. Members of the General Assembly shall be invited to attend and participate in each informational session.
b. On or before December 31, 2010, the Council shall make initial recommendations to the Governor.

c. Following December 31, 2010, the Council shall periodically report to the Governor on the implementation of the recommendations developed to assure maximum benefit to Illinois residents pursuant to the Affordable Care Act.

IV. TRANSPARENCY

In addition to any other applicable laws, rules, or regulations, all aspects of The Illinois Health Care Reform Implementation Council shall be governed by the Freedom of Information Act, 5 ILCS 140/1 et. seq, and the Open Meetings Act, 5 ILCS 120/1 et seq. This section shall not be construed so as to preclude other statutes from applying to the Council or its activities.

V. SAVINGS CLAUSE

Nothing in this Executive Order shall be construed to contravene any state or federal law.

VI. SEVERABILTIY

If any provision of this Executive Order is found invalid by a court of competent jurisdiction, the remaining provisions shall remain in full force and effect.

VII. EFFECTIVE DATE

This Executive Order shall be take effective upon filing with the Secretary of State immediately upon its execution.

Pat Quinn
Governor

Issued by the Governor: July 30, 2010
Filed with the Secretary of State: July 30, 2010