HEALTH CARE REFORM IMPLEMENTATION COUNCIL

INITIAL RECOMMENDATIONS
GOVERNOR PAT QUINN
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EXECUTIVE SUMMARY

INTRODUCTION

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

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

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

The council conducted four public meetings in Chicago, Peoria, Carbondale, and Springfield focused on the following issues: 1) establishing a health insurance exchange and related consumer protection reforms; 2) reforming Medicaid service structures and enrollment systems; 3) developing an adequate workforce; 4) incentivizing delivery systems to achieve high-quality health care; 5) identifying federal grants, pilot programs, and other non-state funding to assist with implementation of the ACA; and 6) fostering the widespread adoption of electronic medical records and participation in the Illinois Health Information Exchange. In addition, the council

solicited written comments specifically in response to a series of questions concerning implementation of the insurance exchange in Illinois. More than 150 individuals and organizational stakeholders shared their suggestions with the council.

The council's recommendations fall into two categories: issues that the state must address immediately, and decisions that will be made after the council gathers more information from stakeholders and the federal government provides additional guidance.

This document summarizes the council's initial recommendations. After another public meeting, scheduled for February 7, the council will submit the full report to the governor and begin implementation. The council will continue to advise the governor and oversee state efforts to improve protect consumers and improve access, quality and effectiveness of health care for Illinois residents.

PART ONE: RECOMMENDATIONS-IMMEDIATE ISSUES

A. Establishment of an American Health Benefits Exchange

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

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

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

B. Establishment of the Exchange as a quasi-governmental entity

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

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

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

B1: Operating Model

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

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

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

B2. Single Exchange or Separate Individual Market and SHOP Exchanges

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

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

with covering multiple employees. A single Exchange could both reduce confusion and meet the needs of small employers in simplifying health plan administration.

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

B3. Regional or Subsidiary Exchanges

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

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

B4. Financial Sustainability

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

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

State funding through general revenues is an option states can consider but is highly unlikely in Illinois. Some share of Medicaid or SCHIP funding could be used to support enrollment through an Exchange. An additional option would be to assess all healthcare stakeholders that benefit from broader health insurance coverage offered through the Exchange, including not only carriers, but also providers, pharmaceutical companies, medical supply companies, and even self-insured plans.

C. Additional Health Insurance Consumer Protections

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

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

C1. Internal Appeals and External Review

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

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

C2. Minimum Medical Loss Ratio Requirements

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

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

C3. Premium Rate Review

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

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

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

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

C4. Health Care Cooperative Program (CO-OPs)

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

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

C5. Mental Health Parity

The council recommends enacting state legislation to bring Illinois law into compliance with the Mental Health Parity and Addiction Equity Act (MPHAEA) and the Mental

Health Parity Act (MHPA), which will enable the Department of Insurance to assure consistency with these federal laws.

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

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

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

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

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

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

- Between 500,000 and 800,000 people will be added to Medicaid;
- Between 200,000 and 300,000 people will purchase subsidized coverage through the Exchange;
- Between 300,000 and 600,000 people will remain uninsured.

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

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

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

PART 2: RECOMMENDATIONS- **OTHER CRITICAL ISSUES AND NEXT STEPS**

A. Additional Adjustments to the Health Insurance Marketplace

A1. Participation in Exchange

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

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

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

A2. Dual Market and Regulatory Parity

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

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

The advantage of operating the Exchange as the sole market for individual and small group insurance is that the Exchange would be able to exert more influence on the cost and quality of

health care. However, there are drawbacks. An insurance carrier that did not meet the Exchange's standards for participation would effectively be kept out of the state's entire health insurance market. This could cause disruption for individuals and businesses that are happy with their current coverage.

A3. Risk adjustment, reinsurance, and risk corridors

The council recommends obtaining the statutory authority to implement federal risk adjustment measures.

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

The transitional reinsurance program is intended to stabilize premiums in the individual market during the first three years of operation of an Exchange, when the risk of adverse selection is greatest. Although administered at the state level, the program will be federally funded and based on federal standards.

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

A4. Benefit mandates

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

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

Some of Illinois' existing benefit mandates may not be included in the definition of "essential health benefits." The ACA allows states to require qualified health plans offered in the Exchange to provide benefits in addition to the "essential health benefits." However, states must pay for any portion of subsidized coverage that is attributed to the cost of those additional benefits. The state could consider funding these mandates separate from the Exchange.

A5. Basic Health Plan

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

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

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

B. Consumer Issues and the Exchange

B1. Consumer Outreach

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

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

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

B2. Role of Navigators and Producers (Agents and Brokers)

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

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

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

C. Healthcare and Public Health Workforce

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

The plan should address:

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

The Affordable Care Act includes a comprehensive strategy with $250 million in funding to achieve these goals by investing in new caregivers through training, new incentives to physicians

for providing primary care to patients, and support for caregivers who choose to enter primary care in underserved areas.

The Association of American Medical Colleges estimates that the nation will have a shortage of approximately 21,000 primary care physicians in 2015. Without action, experts project a continued primary care shortfall due to the needs of an aging population, decline in the number of medical students choosing primary care, and impending retirement of the Baby Boomer generation of providers. This structural shortfall occurs at a time when the ACA will significantly increase access to healthcare to more than one million Illinoisans.

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

D. Health Information Technology

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

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

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

The HIE focuses on:

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

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

E. Incentives for High-Quality Care

The council recommends establishing an Interagency work group to develop a coordinated strategy among appropriate state agencies to improve healthcare quality.

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

Multiple opportunities exist to engage consumers, providers, payers, and purchasers in coordinating and integrating quality improvement efforts across all aspects of healthcare reform. The work group should explore establishing a statewide all payer claims database, which other states are using successfully to monitor and improve quality.

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

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

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

F. Reforms to Medicaid Service Structures and Incentives

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

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

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

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

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

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

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

The current hospital rate structure was not designed with the expectation that at least a majority of clients would be served in risk-based coordinated care systems as encouraged in the ACA and mandated in recent reform legislation. The system must be revised to facilitate enrollment of Medicaid clients in coordinated care systems while building on the strength of Illinois' hospitals and medical centers throughout the state.

G. Early Medicaid expansion

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

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

However, there may be other governmental entities within Illinois for which early coverage of low-income adults would be financially beneficial. For example, when the cost of care is funded entirely through intergovernmental transfers it could be worthwhile to collect 50 percent federal matching funds on behalf of residents for whom no federal share is now available.