



## **The Woodrow Wilson School Graduate Policy Workshop**

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# **Laying the Groundwork for a Post-Partnership Health Insurance Marketplace in Illinois**

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## List of Acronyms

<b>ABE</b>	Illinois Application for Benefits Eligibility	<b>HFS</b>	Illinois Department of Healthcare and Family Services
<b>ACA</b>	Patient Protection & Affordable Care Act	<b>HHS</b>	U.S. Department of Health and Human Services
<b>ACF</b>	Administration for Children and Families	<b>HICA</b>	Health Insurance Claims Assessment
<b>ACS</b>	American Community Survey	<b>HIX</b>	Health Insurance Exchange
<b>APD</b>	Advance Planning Document	<b>IAPD</b>	Implementation Advance Planning Document
<b>APTC</b>	Advance Premium Tax Credit	<b>ICHIP</b>	Illinois Comprehensive Health Insurance Plan
<b>BAFO</b>	Best and Final Offer	<b>IES</b>	Integrated Eligibility System
<b>BHP</b>	Basic Health Plan	<b>IPA</b>	In-Person Assister
<b>CCIO</b>	Center for Consumer Information and Insurance Oversight	<b>IT</b>	Information Technology
<b>CFR</b>	Code of Federal Regulations	<b>IV&amp;V</b>	Independent Verification and Validation
<b>CHIP</b>	Children’s Health Insurance Program	<b>M&amp;O</b>	Maintenance & Operations
<b>CMS</b>	Centers for Medicare and Medicaid Services	<b>MAGI</b>	Modified Adjusted Gross Income
<b>CRM</b>	Customer Relationship Management	<b>MCO</b>	Managed Care Organization
<b>CSR</b>	Cost Sharing Reduction	<b>OEP</b>	Open Enrollment Period
<b>DD&amp;I</b>	Design, Development, & Implementation	<b>OHIT</b>	Illinois Office of Health Information Technology
<b>DOI</b>	Illinois Department of Insurance	<b>OMB</b>	U.S. Office of Management and Budget
<b>DPH</b>	Illinois Department of Public Health	<b>QHP</b>	Qualified Health Plan
<b>E&amp;E</b>	Eligibility & Enrollment	<b>RFI</b>	Request for Information
<b>EMOG</b>	Eligibility Modernization Oversight Group	<b>RMS</b>	Random Moment Study
<b>ERISA</b>	Employee Retirement Income Security Act	<b>SBM</b>	State-based Marketplace
<b>FFM</b>	Federally-facilitated Marketplace	<b>SDLC</b>	Systems Development Life Cycle
<b>FNS</b>	Food and Nutrition Service	<b>SHADAC</b>	State Health Access Data Assistance Center
<b>FPL</b>	Federal Poverty Level	<b>SNAP</b>	Supplemental Nutrition Assistance Program
<b>GOMB</b>	Governor’s Office of Management & Budget	<b>TANF</b>	Temporary Assistance for Needy Families
<b>HCRIC</b>	Health Care Reform Implementation Council	<b>UIC</b>	University of Illinois at Chicago
		<b>USDA</b>	U.S. Department of Agriculture





## Executive Summary

The Patient Protection & Affordable Care Act (ACA) is a joint federal-state initiative, designed to expand health insurance coverage, control costs, and improve the healthcare delivery system. The ACA established Affordable Insurance Exchanges (later re-named “Marketplaces”) to provide individuals and small businesses health insurance coverage beginning in January 2014. In the years leading up to the current Open Enrollment Period (OEP), states chose to operate either as a State-based Marketplace (SBM), or as a Federally-facilitated Marketplace (FFM) run by the U.S. Department of Health and Human Services (HHS). Several states, Illinois included, opted to pursue the hybrid Partnership Marketplace model, which enabled them to assume primary responsibility for carrying out activities related to plan management and/or consumer assistance and outreach, while reserving operation of the eligibility and enrollment system to the Federal government.

It is not clear whether Federal funds for Marketplace operations will be available to states in 2015 and beyond, and as a result, HHS has indicated that the Partnership model as it currently exists will be phased out by 2015.<sup>i</sup> This leaves Illinois at a significant decision point: the State will either default to the FFM model, or it will pass legislation to transition into an SBM, as was the State’s original intention.

As part of a required policy workshop, graduate students from the Woodrow Wilson School of Public and International Affairs at Princeton University approached the Marketplace team—*Get Covered Illinois*—about providing analysis and recommendations to consider as they prepare for a transition out of the Partnership Marketplace model and for the remainder of the first year of ACA implementation. This report is a culmination of these efforts.

The authors address consumer assistance and Marketplace funding considerations for both the FFM and SBM options, but focus primarily on the SBM model, as a transition into an SBM would result in far more opportunities for the State to consider and pursue. The topics covered were selected in response to the *Get Covered Illinois* team’s expressed interests, as well as to the authors’ determinations of what information could be most useful to the State in this transition period.

The report opens with a preface that provides an overview of several challenges related to consumer assistance and funding that Illinois will need to address should it default to an FFM. The rest of the report is divided into two sections focused on considerations for the SBM model: one with several sub-topics related to consumer assistance and outreach, and the other with several sub-topics related to funding. Though the sections are certainly related to one another, they are designed to be considered independently of each other as well. Each sub-topic section provides background information, delineates key issues to consider, and provides issue-specific recommendations.

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<sup>i</sup> Note that this report reflects the current (January 2014) status of the Federal government’s ACA implementation policies, which are subject to change.

## Consolidated Key Points & Recommendations

Illinois has instituted a robust consumer assistance program for the first year of ACA implementation, and we recommend that the State continue with a well-funded program in future years and under new Marketplace models.

### Part I: Considerations for Consumer Assistance & Outreach in a State-based Marketplace

#### Health Insurance Literacy

1. Insurance literacy is a prevalent concern for Illinois' insurance consumers. *Get Covered Illinois* should consider **insurance literacy a barrier to coverage that is just as important** as policy affordability or insurance carrier supply.
2. *Get Covered Illinois* should use Navigators to not only inform consumers about plans, but also to **build consumers' trust in the Marketplace** as an objective resource for insurance information.
3. *Get Covered Illinois* should use policy and technical sorting mechanisms to **filter consumer plan options** and therefore empower consumers to make better purchases.

#### Health System Literacy

1. **Deficient health system literacy among the newly insured** of Illinois and its implications on future healthcare utilization and costs should be a key consideration of the *Get Covered Illinois* team.
2. *Get Covered Illinois* should **expand the role of Navigators from enrollment assisters to health system educators** to help transition the newly insured to more efficient use of the health system.
3. The *Get Covered Illinois* website should include **educational modules for consumers containing health system information focusing** on establishment of primary care, use of preventive services, and explanations of the financial responsibilities of health insurance.

#### Medicaid Churn

1. **Churn should remain a key focus** for the *Get Covered Illinois* and Medicaid teams.
2. *Get Covered Illinois* should provide an **in-depth supplementary training module** to Navigators about churn and the full complexities of individuals transitioning in and out of different coverage.
3. The *Get Covered Illinois* website landing page could include a **link for individuals who have recently experienced a change in income or family size** to easily get help.
4. Consumers would benefit from **FAQs that include information on income or family size changes, changes in eligibility, and transitioning** between Medicaid and the Marketplace on the *Get Covered Illinois* website.

### *Continuing Education and Professional Pathways for Navigators*

1. The *Get Covered Illinois* team should pursue creating a **healthcare certificate program** that is linked with its Navigator training program. A Navigator certificate program could **greatly benefit current Navigators**, as almost 30 percent of them do not hold any **higher education credentials**. This could also significantly **boost an individual's wages**, as studies show that individuals with healthcare certificates working in the healthcare field experience a 35 percent wage premium.
2. **The University of Illinois at Chicago (UIC) and Illinois community colleges** already offer healthcare certificates— *Get Covered Illinois* should consider partnering with these kinds of institutions to create online courses geared towards Navigators with little college experience.

### *Marketing for Spring 2014 and Beyond*

1. The *Get Covered Illinois* team should **utilize SHADAC and any other available data and analysis** to determine which demographic populations in which geographic areas are uninsured and then **refine marketing strategies** to better reach those groups.
2. The *Get Covered Illinois* team should consider whether and how to **market to the “special enrollment period”** eligible population in between OEP dates.
3. The *Get Covered Illinois* marketing team should **profile real-life stories** of those who have benefitted from the ACA. Advertising efforts beyond the first OEP should continue to simultaneously educate Illinoisans about their health insurance options and also illustrate how the reform is improving people's health.
4. The *Get Covered Illinois* team should develop a strategy for **ensuring re-enrollment** as well as first-time enrollment during the second OEP that begins Nov. 15, 2014.

### *Evaluation of Consumer Assistance*

1. If Illinois transitions to an SBM, it should consider **building capacity into its new web system** so that Navigators can **report and track consumer assistance and enrollment** in that same system. This system would create a **Customer Relationship Management tool** to help Navigators track consumers they are assisting, and help the *Get Covered Illinois* team monitor the performance of Navigators and evaluate its consumer assistance program.
2. In addition to the valuable information and soft metrics that *Get Covered Illinois* is currently collecting, it should consider collecting **more demographic information** on consumers that Navigators are assisting.
3. The ongoing **webinars** for lead Navigator organizations provide a good opportunity for **peer-to-peer sharing of promising practices** around consumer assistance.

## Part II: Considerations for Funding a State-based Marketplace

### *Sustainable Funding for a Future State Health Insurance Marketplace*

1. Illinois should **take full advantage of Federal grant opportunities**, as any additional grant money reduces the burden left for the State to bear. **The available Federal funding should be used to finance the startup costs of an SBM**, leaving the lower recurring costs for the State.
2. Illinois should include an **outside funding source** not currently included in its already-stretched budget.
3. We recommend either a **Health Insurance Claims Assessment (HICA)**, modeled on Michigan's legislation, or a similarly **broad-based assessment on premiums**. For the stability of the funding source and the incentives to sell on the Marketplace, Illinois should create a **single assessment rate for all plans**, both on and off the Marketplace, in a HICA or a premium assessment.
4. Illinois should consider the **sale of advertising on the SBM website** to support partial funding of the SBM.

### *Funding Consumer Assistance and Marketing*

1. Illinois should focus on **first-year 2014 budget numbers** from other SBMs for planning its own SBM budget.
2. Illinois should **adequately invest in consumer assistance and outreach** in 2016.
3. Illinois should retain enough **flexibility** with its user fee and budget to make vital changes based on enrollment patterns, such as not reaching enough consumers in 2014 and 2015 as expected or hoped.
4. Illinois should apply for continued **financial assistance for start-up and operational costs** of its Marketplace.

### *Cost Allocation*

1. Illinois should adopt a cost allocation methodology that **maximizes Medicaid reimbursement**.
2. Illinois should act as quickly as possible to transition to an SBM and **take advantage of time-limited enhanced funding opportunities**.
3. Illinois' cost allocation plan should be **comprehensive**, including activities beyond IT, and **forward-looking**, emphasizing long-term savings—even those that require short-term costs.
4. Illinois should establish a formal **cross-agency process** to collaboratively (1) identify opportunities Medicaid reimbursement and (2) transfer, to the HFS budget, the State matching funds necessary to draw down savings.
5. Illinois should **keep up the good work**: few states have received as much Medicaid funding for ACA implementation; the challenge will be to maintain it.

## Preface: Considerations for a Federally-facilitated Marketplace

The vast majority of this report is designed to surface key questions, challenges, and opportunities for Illinois should the State move to a State-based Marketplace once the Partnership model is phased out. However, before analyzing SBM-specific considerations, we first begin with an overview of some of the relevant challenges should Illinois instead default to a Federally-facilitated Marketplace. Though we believe that such a move would limit Illinois' ability to serve its citizens and is a far inferior option to an SBM, because it is a distinct possibility we wish nevertheless to briefly touch on a few key considerations.

### Comparison States

Whichever path lies ahead, Illinois will have peer comparison states facing similar situations. Five other states have also expanded Medicaid while thus far operating under the Partnership model: Arkansas, Delaware, Iowa, Michigan, and West Virginia.<sup>ii</sup>

Another four states that have expanded Medicaid have already been operating within the FFM, providing a source of learning for what Illinois could expect should it default to FFM status. These states are Arizona, New Jersey, North Dakota, and Ohio.<sup>1</sup>

### Key Limitations of the FFM

**1. States' unique needs might go unmet.** Early on, industry experts predicted most states would choose to run their own Marketplaces. Administration officials hoped for the same.<sup>2</sup> Instead, as we have seen, a majority of states opted against SBMs and defaulted to the FFM or entered into Partnership arrangements with the Federal government, placing strain on key agencies and necessitating more funds than anticipated. If all current Partnerships ultimately default to an FFM, the Federal government would be responsible for facilitating Marketplaces on behalf of 34 states. With such volume, it will be exceedingly difficult for HHS to tailor Marketplaces to meet each state's unique insurance market needs.<sup>3</sup>

**2. The future of consumer assistance is uncertain.** HHS has indicated that the number of Navigators it can support in each state will be dependent on the continued availability of grant and training funds in the Federal budget.<sup>4</sup> Additionally, should any Partnership states move to an FFM, there will be more states seeking such funding from a pool of resources that may remain constant, or even decline. Currently, FFM states receive much less funding for consumer assistance, resulting in fewer Navigators in FFM states relative to SBM states.<sup>5</sup>

For instance, Ohio—an FFM state with a very similar population size to Illinois—has only been able to invest a tenth the amount that Illinois has (\$3 million vs. \$30 million) into in-person assisters.<sup>iii</sup> As Table 1 shows, the only states that have been able to invest in consumer assistance programs at similar levels to Illinois have been SBM states like New York (\$27 million) and Maryland (\$24 million).<sup>iv</sup> Further, Navigators in FFM states are only required to complete the Federal

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<sup>ii</sup> Note, however, that Michigan's status as a Partnership state does not begin until April 1, 2014.

<sup>iii</sup> Throughout the report, we will use the terms "Navigator" and "in-person assister" interchangeably. The term "Navigator" refers to both Navigators and In-Person Counselors.

<sup>iv</sup> However, it should be noted that Illinois is not investing more than any other state in consumer assistance. That distinction would appear to go to California, for which figures were not yet fully available at the time of

training, meaning that Illinois might lose the robust, state-specific assister training program with which it supplements the Federal curriculum.

**Table 1: Consumer Assistance Funding Across Selected States**

State	Marketplace Status	Total Public Navigator/IPA Funding	State Population (2013 Estimate)
Illinois	Partnership	\$30,000,000	12,830,632
Arkansas	Partnership	\$17,775,305	2,959,373
Michigan	Partnership	\$2,541,888	9,895,622
Ohio	FFM	\$3,043,858	11,570,808
New Jersey	FFM	\$2,020,407	8,899,339
New York	SBM	\$27,000,000	19,651,127
Maryland	SBM	\$24,000,000	5,928,814

Sources: Kaiser Family Foundation and U.S. Census Bureau

**3. Illinoisans will pay higher fees.** HHS has proposed funding the FFM via a 3.5 percent user fee to be levied on the premiums of all insurance plans sold on the Federal Marketplace. This is a smaller revenue pool than is open to states that operate their own SBMs, since states “can assess user fees on all policies sold in the state, not just those sold through the Exchange.”<sup>6</sup> Importantly, as the size of a state revenue base increases, the per-member cost of the state’s Marketplace decreases. Thus, at a fixed rate of 3.5 percent across the FFM universe, a large state like Illinois would likely subsidize the operations of Federally-run Marketplaces in smaller states. As we show in this report, if Illinois authorized a statewide premium assessment, the user fee could be quite a bit lower, saving Illinois families hundreds of dollars each year relative to under an FFM. (See Part II for more detailed discussion.)

**Key Points**

If the State transitions to an FFM, funding for consumer assistance programs will almost certainly be dramatically reduced for Illinois. In that event, the *Get Covered Illinois* team should encourage Illinoisans to take full advantage of consumer assistance while Partnership-level services exist. We also recommend that *Get Covered Illinois* communicate with its current Navigator and In-Person Assister grant recipients as early as possible so that consumer assistance organizations and those they serve have time to prepare for a new model with much lower funding levels. Additionally, the State should communicate with and learn from peer states in Partnership models (potentially Arkansas, Delaware, Iowa, Michigan, and/or West Virginia). The experience of Medicaid expansion states that have already operated within the FFM—Arizona, New Jersey, North Dakota, and Ohio—could also be a source of learning.

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the publication of the Kaiser report cited here. However, the California Endowment alone has already granted \$29 million for consumer assistance in California, above and beyond any government funding.

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# Part I: Considerations for Consumer Assistance & Outreach in a State-based Marketplace

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## Introduction to Part I

The following sections focus on topics relevant to consumer assistance and outreach under a State-based Marketplace. We begin by discussing how the role of Navigators can expand to address health insurance and health system literacy, as well as to assist consumers moving between Medicaid and the Marketplace. We also provide a case for developing career pathways for Navigators, preparing them for other health-related professions in the future. We end by discussing possible next steps for marketing and for evaluating the State's consumer assistance programs.

## Health Insurance Literacy

Health insurance consumers have a difficult time evaluating and understanding insurance policies. This prevents them from purchasing the optimal coverage based on their needs or from purchasing insurance coverage at all. An SBM allows Illinois to leverage in-person assisters to enhance consumers' understanding of insurance policies and alleviate the cognitive obstacles that prevent them from making the best insurance policy purchases. Ultimately, user-friendly adaptations made to an SBM's consumer interface will result in a trustworthy and accessible third party to offer insurance policies and achieve the goal of expanding healthcare coverage.

### Insurance Literacy: Understanding the Problem

The American Institute for Research defines insurance literacy as “the capacity to find and evaluate information about health plans, select the best plan given financial and health circumstances, and use the plan once enrolled.”<sup>7</sup> Insurance literacy research is a relatively new field derived from efforts to understand financial literacy, yet the difficulties associated with purchasing the right insurance policy are evident: purchasing insurance is a complicated and emotional process. Advocates for improving insurance literacy therefore work to simplify the emotional and cognitive task of buying insurance.

Insurance literacy is difficult to quantify, but research shows that many Americans are not confident they know how to purchase the appropriate insurance policy for themselves. A 2010 study by the National Association of Insurance Commissioners underscores the degree to which Americans are uneducated regarding insurance decisions. In that study, 86 percent of respondents did not understand terms used in the healthcare reform debate, and collectively, respondents were unable to correctly answer 60 percent of the questions presented in an insurance literacy exam.<sup>8</sup> A December 2013 study from Consumer Reports shows that one-third of consumers are more confused about the new healthcare law since the beginning of open enrollment. Further, 90 percent of survey respondents stated that their mistrust of information sources has contributed to their confusion.<sup>9</sup>

Educational materials like glossaries or co-insurance payment calculators are helpful tools to improve insurance literacy but fall short of resolving the problem. Consumers faced with decisional anxiety will often take shortcuts to make their purchase and skip the tools provided to choose a better plan.<sup>10</sup>

Consumers will reject insurance information if it does not come from a trusted source, which is a significant obstacle for making better-informed purchases.<sup>11</sup> All consumers—insurance literate and not—share concern that not all policy information provided by insurers is reliable. Focus-group

research indicates that consumers view insurance carriers as “tricky” and believe that important information is often buried in fine print. The complex language in health insurance policies, which are typically written at a tenth-grade reading level, magnifies this problem.<sup>12</sup>

Additionally, uninsured consumers do not always understand the value of coverage for unexpected medical costs.<sup>13</sup> Consumers show a preference for insuring against small costs while eschewing coverage for catastrophic expenses. They also choose policies with lower deductibles without calculating the price and risk tradeoffs for those policies, and they show uneven variability in deductible choice across plan types.<sup>14</sup>

The cognitive costs and barriers to choosing a plan are increased when too many choices are offered.<sup>15</sup> Without guidance to relieve the cognitive burden of choosing insurance, consumers are reluctant to sort through plan information to select their insurance policy. Helping consumers overburdened with options may be one of the most important ways the Marketplace can use design features to improve overwhelmed consumers’ ability to complete insurance purchases.<sup>16</sup>

### The Reward for Insurance Literacy

Poor insurance literacy threatens health outcomes and incomes for Illinois consumers. Consumers who choose the wrong policy for their circumstances will either overspend for coverage or expose themselves to unacceptable financial risk, given their health status. Those who purchase the right plan will profit from the benefits of insurance coverage, such as better preventative care, reduced mortality, and higher wages associated with better health.<sup>17</sup>

Increased insurance literacy also relaxes regulators’ burdens. If consumers could make better insurance choices, then regulators could allow insurance providers more flexibility to innovate and diversify policy designs with less concern for predatory or unfair practices, since regulators would be better able to rely on well-informed consumers to advocate for themselves. Better insurance literacy would also reduce administrative burdens for regulators and insurers that address the concerns of dissatisfied consumers who do not understand their policies. Insurance illiteracy, then, has significant effects on consumers’ health as well as the ability of the insurance market to perform optimally.

### Federal Changes to Improve Insurance Literacy

The ACA advances the progress of design decisions that facilitate consumer selection, but ultimately these improvements are incomplete solutions to insurance literacy concerns. The following are two examples of positive steps already included in the ACA.

**1. Coverage examples help consumers assess their insurance needs.** Many consumers misunderstand the importance of insurance to cover expected and unexpected costs.<sup>18</sup> The ACA requires every insurance plan’s Summary of Benefits and Coverage to provide “coverage examples,” or a description of how the plan would cover two common medical situations. This helps consumers to determine the right type of plan that best suits their health and financial circumstances, but they still have to combine various insurance concepts to understand what is covered. Consumers sensitive to premium prices may still not understand that they may spend more in out-of-pocket costs. Therefore, robust funding for in-person assistance provided by SBMs will be critical in helping individual consumers better assess their health insurance needs.

**2. New tools help consumers compare plans.** The Federal Marketplace provides consumers with two new tools to help them compare similar plans. The first tool groups plans in tiers by actuarial value:

catastrophic, bronze, silver, gold and platinum tiers. Filtering by actuarial tiers helps consumers identify plans to compare with one another, but it cannot help consumers determine which plan is better for controlling costs, or which offers better quality care.<sup>19</sup>

Consumer comparisons are also facilitated by the ACA's mandate for a standardized Summary of Benefits and Coverage, which requires a consistent, accessible presentation of benefit features across plans. These changes enable consumers to make “apples-to-apples” comparisons of multiple plans, instead of basing their decisions on cost alone.<sup>20</sup>

### **Addressing Insurance Literacy with a State-based Marketplace**

States running an SBM have more leverage to address insurance illiteracy because they can deploy Navigators to targeted communities, enable consumer trust by providing a more responsive alternative to the Federal website, and develop better ways to help consumers sort and compare insurance plans.

**1. Navigators can serve as a trusted third-party.** Illinois has developed a robust training curriculum for Navigators, who facilitate a trusting relationship between consumers and the Marketplace. An SBM with the opportunity to uniquely structure its consumer assistance program can further enhance these efforts to build trust and credibility in the Marketplace, mitigating the trust obstacles that hinder enrollment.

**2. An SBM can provide a more responsive Marketplace portal.** The Federal Marketplace has recently received much negative press, which threatens consumers' trust in it as an information resource.<sup>21</sup> Consumers reject untrustworthy insurance information resources, meaning complications from the FFM might induce consumers to seek plans outside of the Marketplace, or to forego insurance altogether. If this negative association persists, an SBM might leverage better trust with consumers due to its separation from the Federal website.

**3. Limiting plans in the Marketplace helps consumers.** There is robust evidence from behavioral economics,<sup>22</sup> state-based plans,<sup>23</sup> and similar international examples<sup>24</sup> that limiting plan options enhances enrollment. Though more options within the Marketplace may contain more “best” choices for consumers, the overwhelming number of plans increases the likelihood the consumer will pick a worse plan, or no plan at all.

A State has the authority to limit plans offered in the Marketplace through its Department of Insurance, and as an SBM, it also has the opportunity to limit the number of insurance plans presented to consumers when they search for plans, using advanced filtering software that narrows consumer options to a manageable number.

## Limiting Plan Options: The Massachusetts Example

Massachusetts Health Connector manages two health insurance marketplaces, Commonwealth Care and Commonwealth Choice, which facilitate plan selection in subsidized and individual marketplaces, respectively. Commonwealth Choice also facilitates a marketplace for small businesses to purchase insurance called Business Express.<sup>25</sup>

The Massachusetts marketplaces understand the health insurance market from an unconventional angle: instead of opening competition to improve quality and reduce prices, Massachusetts determined that health insurance market forces need consumer supports and regulation to operate effectively.<sup>26</sup>

The Connector has benefitted from selective contracting in the subsidized insurance market to limit plans and reduce premium rates with great success: premium rate growth is below five percent since 2007, less than half the national average.<sup>27</sup>

The Connector has less market power to negotiate prices in the individual market, but it has added value in other ways. The Connector has facilitated consumer choice by offering moderate cost-sharing standardization of plans, limiting the number of plans offered, and providing a Seal of Approval to help consumers select plans they can trust and shop on overall plan value.

### Key Points & Recommendations

The following recommendations summarize this section and are provided for Illinois to effectively leverage consumer assistance and outreach within a State-based Marketplace to address insurance literacy obstacles:

- ☑ Insurance literacy is a prevalent concern for Illinois' insurance consumers. *Get Covered Illinois* should consider **insurance literacy a barrier to coverage that is just as important** as policy affordability or insurance carrier supply.
- ☑ *Get Covered Illinois* should use Navigators to not only inform consumers about plans, but also to **build consumers' trust in the Marketplace** as an objective resource for insurance information.
- ☑ *Get Covered Illinois* should use policy and technical sorting mechanisms to **filter consumer plan options** and therefore empower consumers to make better purchases.

## Health System Literacy

Success of the Affordable Care Act throughout the nation is measured not just by increased insurance coverage and the protection from financial risk that insurance provides; rather, the ultimate goal of the ACA is to improve the health of the population in a financially and operationally efficient manner. In order to achieve this goal, the newly insured must use the health system in an efficient way. However, because chronic uninsurance acts as a *de facto* barrier to accessing healthcare services, the majority of the newly insured have had little experience efficiently interacting with the health system. This results in a poor understanding of how the healthcare system works and how it should be used, a concept known as “health system literacy.” With many financial barriers to accessing the health system now removed by the ACA, an unanticipated problem arises for the newly insured: learning to navigate the complex and often confusing health system efficiently. In order to do this successfully, the newly insured need not only health insurance, but increased health system literacy as well.

The implications of deficient health system literacy extend from the personal level (individuals not receiving appropriate healthcare services) to the systemic level (increases in the overall cost of healthcare and inappropriate use of resources). All stakeholders in the healthcare system—from individual consumers to providers and payers, including both private insurance companies and state-funded public systems such as Medicaid—thus have a key interest in ensuring that the newly insured population approaches the health system with knowledge of how to use it appropriately. Empowering consumers to use the health system and take advantage of their insurance benefits will lead to consumer satisfaction with health insurance, a higher value for health insurance, and greater re-enrollment rates in the future—all driving the “culture of coverage” that the state seeks to create.

### Health System Literacy

Health system literacy refers to the knowledge and skills that allow a person to be an informed healthcare consumer and to navigate the healthcare system effectively. These skills allow consumers to choose healthcare providers; understand their health plan benefits; and know their responsibilities as patients, such as scheduling and showing up to appointments and being compliant with their plan of care as recommended by their healthcare providers. Part of this knowledge involves understanding when and where to seek healthcare services under different circumstances, such as what constitutes appropriate emergency care, the importance of pursuing preventive care, and understanding options for elective services.

Additionally, health system literate consumers understand and fulfill the financial responsibilities associated with their health insurance, such as premiums, co-pays, co-insurance, and deductibles. Part of the purpose of these cost-sharing devices is to incentivize certain health behaviors, such as seeking preventive services, and to disincentivize others, such as avoidable emergency room visits. However, these incentives will only be effective if consumers are aware of them and accordingly adjust their behavior. Meanwhile, awareness of the additional out-of-pocket costs associated with healthcare services can also prevent “sticker shock” at point-of-service. Informed healthcare consumers also know how to seek information and whom to ask, whether their health insurance carrier or their healthcare providers.

## Deficient Health Literacy Among the Uninsured & Newly Insured

Americans' level of health system literacy is uneven and incomplete. This is even more true of people with a history of chronic uninsurance. Uninsured people interact with the health system much differently than people with health insurance. In general, they pursue less preventive healthcare and instead rely on emergency and inpatient care, which are both less cost-effective and produce worse health outcomes. Uninsured people also have fewer visits to medical doctors and dentists compared with their insured counterparts. Only 24 percent of uninsured individuals visit a medical provider at least once per year, compared to 75 percent of those with insurance.<sup>28</sup> Even fewer—only 11 percent—receive routine medical checkups while uninsured. They are also less likely to use prescription medications, to have a regular clinic or provider, and to receive routine preventive care such as cancer screenings.<sup>29</sup> Additionally, uninsured children have lower immunization rates.<sup>30</sup> All of these factors contribute to the uninsured having worse health outcomes, which eventually leads to increased health expenditures.

This decreased utilization, however, does not correlate with apparent need, as nearly half of the uninsured population has a chronic condition. In Illinois, the self-reported health status for uninsured people is lower than that for the insured population.<sup>31,32</sup> Specifically, the incidence of mental illness is higher in the uninsured of Illinois (16 percent) than in the insured (10 percent),<sup>33</sup> and uninsured people are also more likely to smoke.<sup>34</sup> The Centers for Disease Control reports that adults without health insurance are more likely to forego needed healthcare because of cost compared to those who are continuously insured. This is especially true of individuals with diagnosed chronic conditions.<sup>35</sup> With their chronic conditions poorly managed, these individuals are especially prone to needing inpatient medical treatment. Because uninsured people are more likely to delay seeking care, they present to medical facilities in more advanced stages of disease and tend to have worse outcomes.<sup>36</sup>

The combination of less utilization and higher need for healthcare creates a problem of pent-up demand for healthcare services when individuals gain health insurance for the first time.<sup>37,38</sup> The financial barriers to accessing the health system are removed with the attainment of health insurance; however, this does not translate to a change in healthcare behaviors by the newly insured. In fact, many newly insured people continue to use the health system inefficiently even after they obtain health insurance.

Overall, newly insured people tend to use the emergency room 1.4 times as frequently as when they were uninsured, while those new to Medicaid have an even higher rate (1.69 times).<sup>39</sup> Furthermore, new Medicaid beneficiaries continue to use emergency rooms both for conditions better suited for primary care management and at times when regular doctors offices are open, leading healthcare costs to soar 25-35 percent higher per person than expected.<sup>40</sup> Meanwhile, the newly insured continue to have fewer outpatient office visits and use preventive services less than people who have maintained continuous insurance. This discrepancy is especially evident in minority populations.<sup>41</sup> This evidence shows that health insurance alone is not sufficient to achieve the dual goals of better health outcomes and cost control.

The implications of this pent-up demand may be significant for Illinois, as an unprecedented number of individuals are expected to gain new health insurance during the initial enrollment period of the ACA. As many as 814,000 individuals are likely to obtain new health insurance, with the majority—510,000—enrolling in Medicaid.<sup>42</sup> Thus, healthcare expenditures for this population may be higher than initially anticipated. Additionally, pent-up demand may add pressure to the already-stressed

delivery side, especially in areas around Chicago where the majority of newly insured will reside.<sup>43</sup> For individuals enrolling in private insurance plans for the first time, higher expenditures after enrollment may result in higher-than-expected premium increases for the following year of coverage. Thus, once they become insured, it is crucial that the population of newly insured be directed to more efficient uses of healthcare resources than when they were uninsured.

### Employing Navigators to Improve Health Literacy among the Newly Insured

Improving the health literacy of the newly insured will be a multi-step process. A person who becomes newly insured under the ACA should know that the first step in accessing the healthcare system is to establish care with a primary care provider. This requires knowing which providers are included in their plan's network, as well as which providers are accepting new patients into their practices. The newly insured with previously diagnosed chronic conditions may also need to seek specialty providers in the same manner. Likewise, the newly insured need to find out which pharmacies and labs are included in their plan's network.

Navigators have great potential for helping the newly insured population make this transition successfully and improve their health system literacy. Navigators are well positioned to meet this need for several reasons:

- ❖ Navigators have already made personal contact and established relationships with many among the newly insured population. They have established themselves as unbiased and trustworthy sources of information.
- ❖ Navigators have an understanding of health insurance and have a demonstrated interest in assisting newly insured people in achieving the goals of the ACA.
- ❖ Navigators interact with newly insured people at an ideal time: when consumers are most interested in understanding their benefits and learning how to use them.
- ❖ As the end of the first OEP approaches in late March 2014, Navigators will have the opportunity to transition their efforts from enrollment toward other activities necessary to implementation of the ACA.

Due to these factors, there is great opportunity for the role of Navigators to evolve and expand to meet the emerging needs of the newly insured population as implementation of the ACA proceeds, including improving the health system literacy of the newly insured. The expanded responsibilities of the Navigators in educating the newly insured about the health system could be based on a model that has proven useful in healthcare previously, that of a "health system liaison." This role was first used to help patients newly diagnosed with cancer navigate the complicated experience from diagnosis through treatment. The role has been adopted by more comprehensive health systems and has resulted in more patient-centered medical care, better continuity of care, lower healthcare expenditures, and more efficient use of healthcare resources.<sup>44,45,46</sup> Expanding the consumer assistance role of Navigators to educate the newly insured about the health system would be possible under an SBM if Illinois commits to sufficient consumer assistance funding levels (as detailed in Part II). These sources of funding, however, are unlikely to be available under an FFM, based on other large states' 2014 FFM experiences.

The specific role of Navigators in health system literacy education could be appropriate for both an individual and population level. With their existing knowledge of health insurance plans, Navigators could help link newly insured individuals to providers covered by their new health plans. This establishment of primary care would create an important first step toward more efficient use of healthcare services. Additionally, Navigators could help explain specific plan benefits that may be relevant to individuals, and could also help clarify the often confusing financial responsibilities associated with health insurance, such as co-pays and other out-of-pocket expenses. Lastly, for more complicated questions related to issues such as claims processing, Navigators could direct newly insured individuals to the correct contact from their health insurance provider. This expanded role of Navigators would require additional training than what is currently required. Additionally, in order to assess impact and appropriate implementation of the program, specific outcome measures would need to be established and monitored.

Using their existing networks and experience in organizing stakeholder meetings, Navigator organizations could reach large numbers of people through health system literacy education sessions designed for newly insured people. These events could provide instruction on universally relevant topics of the health system. Information material and educational modules provided at these sessions should also be available on the *Get Covered Illinois* website.

### Suggested Health System Literacy Educational Topics

- ❖ Best methods for establishing care with and interacting with healthcare providers and their offices
- ❖ How to recognize high-quality healthcare and how to be an informed healthcare consumer
- ❖ The organization of the healthcare system: defining which venues to use for different healthcare services and emphasizing the importance of preventative and primary care

#### Key Points & Recommendations

The following recommendations summarize this section and are provided for Illinois to effectively leverage its consumer assistance and outreach program to improve health system literacy among the newly insured:

- ☑ **Deficient health system literacy among the newly insured** of Illinois and its implications on future healthcare utilization and costs should be a key consideration of the *Get Covered Illinois* team.
- ☑ *Get Covered Illinois* should **expand the role of Navigators from enrollment assisters to health system educators** to help transition the newly insured to more efficient use of the health system.
- ☑ The *Get Covered Illinois* website should include **educational modules for consumers containing health system information focusing** on establishment of a primary care home, use of preventive services, and explanations of the financial responsibilities of health insurance.



## Medicaid Churn

In the new world of the Affordable Care Act, “churn” refers to the movement of low-income individuals and families between the Marketplace and Medicaid. Prior to the ACA, research showed that 43 percent of newly enrolled adults in Medicaid experienced a disruption in Medicaid coverage within one year.<sup>47</sup> Under the ACA, the scope of churn is increased further because of the greater number of people covered by health insurance and the multiple subsidy systems created. On the basis of their income, individuals qualify for Medicaid, qualify for subsidies on the Marketplace, or buy coverage without subsidies on or off the Marketplace. Over the course of the year, income fluctuations and changes in family size and composition affect eligibility.<sup>48</sup> Even a slight change in income or household composition—such as a small change in the number of work hours, a marriage, or a grown child leaving the home—can trigger changes in eligibility.<sup>49</sup>

### The Consequences of Churn

The ACA is designed for all Americans to have health insurance, but churn can result in disrupted care or even loss of coverage. When individuals lose their Medicaid eligibility, they should be able to easily transition to purchasing affordable coverage on the Marketplace. But, administrative complications associated with that process or frequent churning between Medicaid and the Marketplace may result in people ceasing to sign up for health insurance. Many people at risk for churning have incomes low enough to exempt them from the Federal insurance mandate, and if they become tired of signing up for different coverage systems, they may stop signing up for health insurance altogether and face no penalty.<sup>50</sup>

Even if people re-enroll, they may face disruptions in coverage between different health systems. Research shows that insurance coverage disruptions have negative healthcare consequences. Coverage gaps lead to skipping or delaying needed medical care, leaving prescriptions unfilled, higher use of emergency rooms for preventable health conditions, greater onset of health problems that could have been managed with ambulatory care, and a greater risk of falling into medical debt.<sup>51,52</sup> For those who do transition to new coverage, they may have different provider networks, benefits, premium levels, and cost-sharing responsibilities and may not understand the details of their new plans.

Churn also results in increased costs for the State.<sup>53</sup> Medicaid expenditures may increase if patients skip needed care and are sicker when they re-enroll in the program. A recent analysis found that continuity of coverage leads to lower average monthly costs for Medicaid. The average monthly cost was \$345 for adults enrolled in Medicaid for 12 months of the year, compared to \$597 for adults who were enrolled for just one month.<sup>54</sup> The frequent re-enrollment of individuals into both Medicaid and the Marketplace also leads to higher administrative costs for the State. Additionally, income changes are more common among younger, more educated, and white adults—who typically are healthier and are thus important to be enrolled in the Marketplace for a favorable risk pool in Illinois.<sup>55</sup>

### Anticipated Churn in Illinois

Benjamin Sommers and Sara Rosenbaum used national survey data to estimate churn prevalence under the Affordable Care Act.<sup>v</sup> At a national level, they estimate that 50 percent of all adults with

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<sup>v</sup> Sommers and Rosenbaum use the Survey of Income and Program Participation, with a primary sample from 2004 that covers 2004 to 2008.

family incomes below 200 percent of the Federal Poverty Level (FPL) will experience a shift in eligibility from Medicaid to the Marketplace, or from the Marketplace to Medicaid, within one year. Within four years, 38 percent of the adults in the sample will have experienced at least four eligibility changes.

Exact projections for the expected number of Illinoisans expected to experience churn under the ACA are not available. However, extrapolating Sommers' and Rosenbaum's findings to Illinois and using estimates on the number of uninsured adults in Illinois who will enter the insurance market, roughly 162,678 individuals in Illinois will churn in and out of Medicaid and the Marketplace at least four times by the year 2018.<sup>vi</sup> These high numbers of individuals affected and of churn episodes represent significant costs for Illinois and negative health consequences for individuals.

### Options to Mitigate Churn Under the Affordable Care Act

States have many strategies available to reduce the number of people who are affected by churn.<sup>vii</sup> Some of these options require states to actively assert authority over the plans that participate in the Marketplace—therefore, only states with a State-based Marketplace can implement those. Accordingly, if Illinois becomes a Federally-facilitated Marketplace in the future, it will have fewer options to address churn.

When coverage began on January 1, 2014, churn will have started occurring almost immediately. For states that are experimenting with innovative strategies for churn, they will begin to find out whether these strategies are showing promising results by early spring. Illinois should track these developments in order to learn lessons to use in the future. In particular, Illinois should look at Nevada and Maryland. Nevada is aligning its Medicaid and private plans by requiring all Medicaid managed care organizations (MCOs) to offer a transition plan in the Marketplace. This transition plan option will be available on the Marketplace only for Medicaid enrollees who have lost their Medicaid eligibility. Maryland has adopted strict rules requiring continuity of care when people transition between types of plans. For example, health plans must allow new enrollees within a specified course of treatment to receive care from out-of-network providers for 90 days.

### Consumer Assistance and Churn in Illinois

Robust consumer assistance plays a critical role in addressing churn and explaining this difficult and ongoing issue to consumers. So far in Illinois, consumer assisters have primarily focused on enrollment, but as the state begins preparing for the close of the first OEP and ramping up for the second OEP, churn should be a primary focus.

Well-trained Navigators and well-designed websites and call centers can provide important guidance to consumers facing eligibility transitions. Consumer assisters can:

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<sup>vi</sup> We used uninsured population statistics from SHADAC's 2011 data center and 2013 state population data from World Population Statistics. We assumed that 25 percent of uninsured adults in Illinois would enter the insurance market.

<sup>vii</sup> The Illinois Exchange Strategic and Operational Needs Assessment identifies a few of these options for consideration in Illinois: requiring or incentivizing Medicaid managed care organizations to participate in the Marketplace and offering a Basic Health Plan (BHP) to families with incomes between 133 and 200 percent of the FPL. Other policy options include offering a Medicaid bridge plan in the Marketplace, premium assistance, reducing the amount of paperwork necessary to retain coverage during eligibility transitions, and 12-month continuous eligibility for Medicaid.

- ❖ Help individuals understand the requirement to report interim income and household size changes.<sup>56</sup>
- ❖ Help individuals recognize that they must enroll in the Marketplace within 30 days of a triggering event that makes them no longer Medicaid-eligible.
- ❖ Show consumers where to go for help, who to contact when there is a change in their eligibility, and how to fill out complex paperwork.
- ❖ Aid consumers in enrolling outside of the OEPs.
- ❖ Help consumers understand that households are calculated differently in the Marketplace than for Medicaid.<sup>57</sup>

Additionally, consumers should be able to easily find information about the effects of income and family changes that might affect their eligibility when they visit the *Get Covered Illinois* website. Currently, the website does not provide easily accessible FAQs or fact sheets with information about income or family composition changes and the resulting effects on eligibility.

Sufficient funding to train consumer assisters and to provide broad consumer assistance is key to successful consumer assistance for churn. Under the current Partnership Marketplace, Illinois has the resources necessary to train Navigators and provide this broad consumer assistance, but the Partnership model will be phased out. Under an SBM, Illinois would be able to support a robust consumer assistance program through fees (see Part II for a detailed discussion about funding options for an SBM). However, as an FFM, Illinois would have much less autonomy with and funding for its consumer assistance program, as discussed in the Preface.

If Illinois transitions to an SBM, it will also need to consider churn as it builds its IT system in order to facilitate smooth transitions for consumers between Medicaid and the Marketplace. The system must be user-friendly for consumer assisters and individuals to quickly find information, report changes, and enroll in coverage. The back-end of the system also needs to easily adjust to reported changes and determine program eligibility.

### Key Points & Recommendations

The following recommendations summarize this section and are provided for Illinois to effectively leverage its consumer assistance program to mitigate the effects of churn:

- Churn should remain a key focus** for the *Get Covered Illinois* and Medicaid teams.
- Get Covered Illinois* should provide an **in-depth supplementary training module** to Navigators about churn and the full complexities of individuals transitioning in and out of different coverage.
- The *Get Covered Illinois* website landing page could include a **link for individuals who have recently experienced a change in income or family size** to easily get help.
- Consumers would benefit from **FAQs that include information on income or family size changes, changes in eligibility, and transitioning** between Medicaid and the Marketplace on the *Get Covered Illinois* website.

## Continuing Education and Professional Pathways for Navigators

Illinois has one of the most robust Navigator training programs in the country. In addition to required Federal training, Navigators in Illinois must complete two days of in-person training and one day of online training conducted by Illinois' training partners at the University of Illinois at Chicago (UIC). Navigators also receive continuing education to supplement these initial training sessions and are updated with policy changes through webinars created by UIC and the *Get Covered Illinois* team.

During the 2013-2014 OEP, Navigators have been assisting individuals and families through the Marketplace application process, helping consumers choose and enroll in a health insurance plan that suits their needs. Navigators have also participated in community outreach events that raise awareness about the importance of getting health coverage.

Navigator duties are likely to shift in 2014 from focusing on health insurance enrollment and public outreach to helping Illinoisans retain and utilize their insurance. As discussed in the previous sections, trainings and continuing education webinar sessions will need to change their focus in order to help Navigators learn the new skills and updated policy information associated with this shift. In conjunction with these changes, Illinois should pursue partnerships with educational institutions to create a college-level certificate program in a health-related field that takes advantage of Navigators' robust training sessions and on-the-job experience. This certificate could be used to start or supplement higher education opportunities in Illinois, provide Navigators who have limited college experience with significant wage premiums, and prepare current Navigators for other health-related professions in the future.

Though this section will be focused on the need for a certificate geared towards Navigators with limited college experience, most of the Illinois Navigators already have at least some sort of postsecondary credential, and many have a Bachelor's degree.<sup>58</sup> Creating two Navigator certificate programs—one for those with some college experience and the other for those who already have a four-year degree—can increase higher education opportunities for all Illinois Navigators. Although there is no clear career path for individuals from the Navigator program, a certificate program could help set Navigators with college degrees on a trajectory towards a wide variety of professions, such as community health worker, patient navigator, and even health insurance broker. There is no reason Illinois should limit itself to creating only one type of Navigator certificate program, as many of the current Navigators have different educational backgrounds and interests.

### The Demand for a Highly Educated Workforce

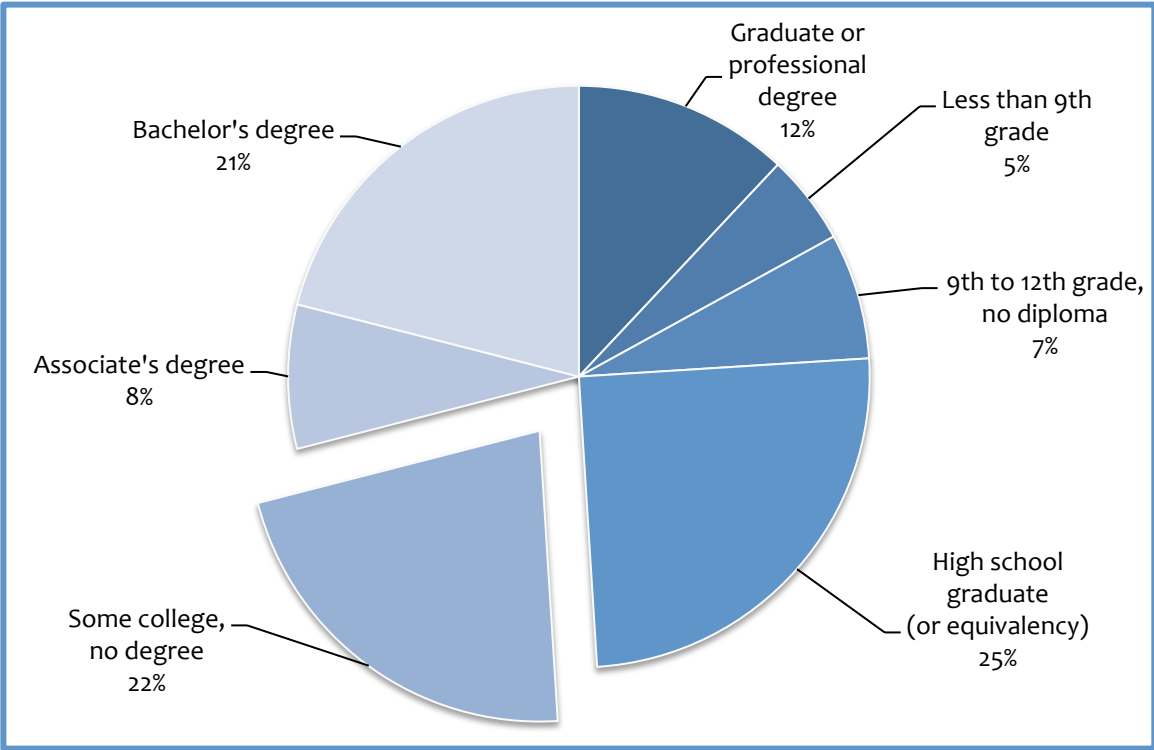
As of November 2013, Illinois has an estimated unemployment rate of 8.7 percent, meaning that approximately 567,500 Illinoisans are currently unemployed.<sup>59</sup> However, this high unemployment rate does not necessarily mean that there will be a lack of jobs available to Illinois residents in the future. According to the Lumina Foundation, there will be over 2 million job vacancies in Illinois that will need to be filled between now and 2018, with the vast majority, 1.3 million, requiring postsecondary qualifications.<sup>60</sup> By 2018, 64 percent of jobs in Illinois will require some form of postsecondary education.<sup>61</sup>

To help fill these job vacancies that require postsecondary education, Illinois should prioritize and invest in higher education for a more educated, competitive workforce. This investment in higher education can help lower the high unemployment rate in the state and provide higher wages for individuals seeking to earn a higher education credential.

**Higher Education Attainment in Illinois**

There is sufficient need in Illinois for higher education attainment that can have a meaningful impact on individual wages. Figure 1 illustrates that 41 percent of adults ages 25 to 64 in Illinois have at least a two-year college degree, and 37 percent of adults have only a high school education or less.<sup>62</sup> If Illinois wants to meet near future job demands, it must invest in creating higher education opportunities for adults who have limited college experience.<sup>63</sup>

**Figure 1: Levels of Education for Illinois, Ages 25-64**



Source: Lumina Foundation

One key demographic that has high potential for pursuing higher education is the 22 percent of Illinoisans that have some college experience but do not have a degree. This population is of special interest because it has shown at least some dedication to achieving a type of post-secondary credential and, at over 1.5 million individuals, its large population can constitute a significant portion of a future, highly skilled workforce.<sup>64</sup>

This section of the population with some college experience also constitutes a significant portion of the more than 1,600 Navigators currently working in Illinois.<sup>65</sup> Of these Navigators, 20 percent, or roughly 320 individuals, have some college or trade school experience, while another 9 percent, or roughly 150 individuals, have a high school diploma or GED as their highest level of education.<sup>66</sup> Thus, approximately 470 current Navigators could obtain higher education credentials for the first time if they were presented with education opportunities geared specifically towards their skill and experience levels.

## Certificates and Their Role in Higher Education

According to a recent study by the Georgetown Center on Education and the Workforce, “certificates are recognition of completion of a course of study based on a specific field, usually associated with a limited set of occupations.”<sup>67</sup> Certificates differ from industry-based certifications and licenses in that they are earned through classroom learning, usually at a two-year public institution of higher education or in a private, for-profit college, in programs that range from less than one year in length to two or four years.<sup>68</sup> Due to this emphasis on classroom learning and varying lengths of certificate programs, certificates are similar to a college degree.

In contrast, industry-based certifications are usually obtained by passing a test, going through some type of apprenticeship, or completing government or company-sponsored training.<sup>69</sup> These types of certifications do not need to be associated with any classroom learning and the final tests for proficiency can be taken in a variety of places.<sup>70</sup>

The current training of Navigators most resembles these types of industry-based certifications. Although Navigators must undergo a rigorous in-person training facilitated by UIC faculty and administrators in addition to the online Federal training, this is not the equivalent of the amount of classroom time required to obtain a certificate. Even the short-term certificates usually require several months of classroom time.

Nevertheless, certificates hold a great deal of potential for increasing an individual’s wages in future employment. On average, individuals who report a certificate as their highest level of education earn the same amount of income as people who report having some college experience, though certificates are most beneficial when the individual pursues occupations in the field in which he or she earned the certificate.<sup>71</sup> In fact, the Georgetown Center on Education and Workforce has found that individuals with certificates, working within their certificate field, can earn up to 37 percent more than people with only a high school education, and are within 4 percent of the earnings of workers with an Associate’s degree.<sup>72</sup> If an individual with a healthcare certificate goes on to work in the same field, he or she should expect to see an in-field earnings premium of about 35 percent more than people with only a high school education.<sup>73</sup> Thus, it is of critical importance that any new certificate designed for Navigators closely aligns with jobs in demand by the healthcare industry.

Certificate holders are more likely to be black or Latino, and considering that blacks and Latinos constitute 19 and 25 percent, respectively, of all Navigators in Illinois, these demographic groups could greatly benefit from the creation of a Navigator certificate program.<sup>74</sup> Blacks, in particular, obtain certificates at higher rates than other racial and ethnic groups. Approximately 18 percent of blacks earn a certificate as their highest education level.<sup>75</sup> Similarly, Latinos obtain certificates at higher rates on average than most other demographic groups.

Considering that almost 30 percent of the Navigators in Illinois do not have any higher education credentials, almost 45 percent of Navigators in Illinois are black or Latino, and that healthcare certificate holders working in the healthcare field can receive a 35 percent earnings premium, Navigators in Illinois could greatly benefit from a certificate geared towards them.

## The Navigator Program as a Health-Related Certificate

The Navigator program in Illinois has the potential to provide Illinoisans with an opportunity to obtain a health-related higher education credential in a field where there is great need for well-trained professionals. With its training emphasis on broad healthcare policies and trends and the

professional responsibilities of working directly with the community, the Navigator program could be incorporated into a certificate closely aligned with professional opportunities in the healthcare field. The Navigator training and the online learning courses could also count for credit at an Illinois community college and become incorporated into existing or new health-related certificates at community colleges around the state.

Such a certificate can be created and administered by both UIC and Illinois community colleges. While UIC already offers nine online certificate programs through its School of Public Health, these certificates are geared towards individuals who already have Bachelor's degrees and are seeking to receive credit used to apply for graduate degrees.<sup>76</sup> Nevertheless, certificates like the Basic Community Public Health Practice certificate and the Health Disparities Research certificate could possibly be tailored to tie into the Navigator program. In order to reach those individuals in the Navigator program with no higher education credential, however, UIC should consider designing the new Navigator healthcare certificate to accommodate these students. Most of the certificates currently being offered at the UIC School of Public Health require about one academic semester of course work.

With approximately 48 colleges in 39 community college districts in the Illinois Community College System, community colleges are widely dispersed throughout the state and have the capacity to reach hundreds of thousands of Illinoisans each year.<sup>77</sup> Public, two-year schools' ability to reach Illinoisans in different regions of the state should be utilized to broaden the accessibility of a Navigator certificate. Community colleges also offer a variety of health-related certificates geared towards the population that could benefit most from attaining a certificate: those with limited-college experiences. Furthermore, the City Colleges of Chicago community college system offers approximately six health-related certificates, such as the Medical Assistant and Medical Administrative programs, which could be good models for a Navigator certificate.<sup>78</sup> Most of these certificates vary in length from one to two academic semesters.

Public community colleges already provide over half of all certificates, so it would seem that public two-year schools would have more expertise in administering and granting certificates geared towards individuals with limited college experience.<sup>79</sup> Although private, for-profit schools provide 45 percent of certificates, we do not advise Illinois to seek partnerships with these institutions, as for-profit institutions are more expensive and have higher loan default rates among their students.<sup>80</sup>

Schools can take advantage of the real-world professional experience, the intensive initial training provided by UIC, and all the continuing education Navigators currently receive to create a healthcare-related certificate for Navigators. Although traditional certificate programs are usually distinguished by several months of classroom learning dedicated towards certificate completion, a Navigator certification program could substitute classroom learning for online instruction. Since Navigators currently receive most of their continuing education instruction through online platforms, this is a realistic proposal that could provide real gains for individuals seeking to further their higher education.

## Key Points & Recommendations

The following recommendations summarize this section and are provided for Illinois to lay the groundwork for creating professional pathways for Navigators:

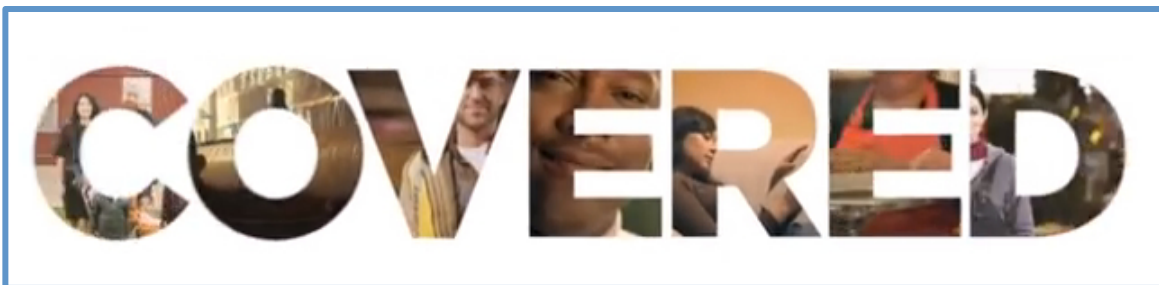
- ☑ The *Get Covered Illinois* team should pursue creating a **healthcare certificate program** that is linked with its Navigator training program. A Navigator certificate program could **greatly benefit current Navigators**, as almost 30 percent of them do not hold any **higher education credentials**. This could also significantly **boost an individual's wages**, as studies show that individuals with healthcare certificates working in the healthcare field experience a 35 percent wage premium.
- ☑ **The University of Illinois at Chicago (UIC) and Illinois community colleges** already offer healthcare certificates—*Get Covered Illinois* should consider partnering with these kinds of institutions to create online courses geared towards Navigators with little college experience.

## Marketing for Spring 2014 and Beyond

Much of the marketing groundwork that Illinois has developed during its Partnership period can be seamlessly leveraged and extended in the event it opts to transition to an SBM. Indeed, the “Get Covered Illinois” brand and message is becoming increasingly familiar via the State’s comprehensive advertising effort. Given this, Illinoisans are now well prepared for additional education and calls to action within this consistent framework, tailored to the unique enrollment challenges that will emerge over the next few years.

### The End of the First Open-Enrollment Period

The first major timeline consideration is the end of the first OEP, on March 31, 2014.<sup>81</sup> One option is to simply continue the current marketing effort right up until this date. For instance, the six ads released in mid-December 2013, as part of a \$1 million ad buy, were well conceived and targeted, especially the core “Covered” and “Cubiertos” ads. Given the recent raft of private insurance company advertising, the line that appears in the Covered ads—“*GetCoveredIllinois.gov is the official place to compare all health plans and find financial support*” (italics added)—is particularly helpful in establishing the credibility of Illinois’ Marketplace website, without resorting to more politically charged terms, such as “Obamacare.” Furthermore, emphasizing “financial support,” as the “Covered” ads do, is wise since such a message has been found to be one of the top motivators for getting the crucial population of the young uninsured to enroll.<sup>82</sup>



Source: *Get Covered Illinois* advertisement, 2013



Another option is to analyze new data on where the uninsured reside in order to target late-February and early-March marketing efforts. For instance, using the American Community Survey (ACS), the State Health Access Data Assistance Center (SHADAC) prepared for New York zip code level analysis regarding rates of uninsurance. SHADAC should be able to provide such analysis for Illinois as early as February 2014, providing new data points for a late-OEP adjustment of marketing strategy.

Crucially, since SHADAC's zip code analysis aligns with the U.S. Census Bureau's census block level data, Illinois could gain awareness of which demographic groups (by neighborhood, income, age, and race, in particular) are historically uninsured and likely proving the most difficult to enroll. With such data, advertising efforts could be directed toward such groups via more targeted messaging, media-placement, and ad-buy strategies, both in the final run-up to March 31 and beyond.

### **Between 2014 and 2015 Open-Enrollment Periods**

From April 1, 2014 until November 14, 2014, Illinoisans will only be able to purchase individual insurance through the Marketplace if they are Medicaid eligible or experience a “qualifying life event” making them eligible during the “special enrollment period.” Such qualifying life events include “moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby).”<sup>83</sup> Thus, one key question is whether or not to develop marketing efforts specifically oriented towards Medicaid eligibles and these special enrollment populations—and how to do so without confusing and frustrating Illinoisans who are not eligible to enroll during this period.

Regardless of what Illinois decides to do regarding marketing to those eligible outside of OEPs, further educational efforts targeted to broader uninsured populations in the period between the OEPs is recommended. Marketing efforts have already attempted to build public support for the state Marketplace in particular (and, by extension, the Affordable Care Act), with ads such as “James” and “One Thing,” which both highlight how healthcare reform is changing lives for the better. Once the previously uninsured get covered and then, as a result, receive medical care, there will be an opportunity to profile real-life stories of those who have benefitted from the law. Ideally, advertising efforts will continue to simultaneously educate Illinoisans about their health insurance options and also illustrate how the reform is improving people's health.

Even if Illinois decides to go nearly “dark” in its marketing efforts between enrollment periods, resources can be devoted to evaluation of the first round of marketing efforts. In particular, exchange and Medicaid enrollment data may help Illinois learn: Which populations enrolled at what rates? How does this compare to initial goals set by the state and by the federal government? What populations need to be better motivated and assisted to enroll in order to achieve a more balanced risk pool and the success of the Marketplace? Additionally, data collected in the course of evaluating consumer assistance efforts should also be integrated into such analysis (please see the following section for more detail on this point) for the most effective coordination of “ground” and “air” efforts.

## Key Points & Recommendations

The following recommendations are provided to summarize this section and to help the *Get Covered Illinois* team plan for marketing in the months to come:

- ☑ The *Get Covered Illinois* team should **utilize SHADAC and any other available data and analysis** to determine which demographic populations in which geographic areas are uninsured and then **refine marketing strategies** to better reach those groups.
- ☑ The *Get Covered Illinois* team should consider whether and how to **market to the “special enrollment period”** eligible population in between OEP dates.
- ☑ The *Get Covered Illinois* marketing team should **profile real-life stories** of those who have benefitted from the ACA. Advertising efforts beyond the first OEP should continue to simultaneously educate Illinoisans about their health insurance options and also illustrate how the reform is improving people’s health.
- ☑ The *Get Covered Illinois* team should develop a strategy for **ensuring re-enrollment** as well as first-time enrollment during the second OEP that begins Nov. 15, 2014.

## Evaluation of Consumer Assistance

Evaluation of the consumer assistance program in Illinois is important to understand where there have been successes and what areas still need improvement. Evaluations of consumer assistance programs for Medicaid and the state Children’s Health Insurance Program (CHIP) have found that children in families who received enrollment assistance were significantly more likely to enroll in coverage, and clinics participating in consumer assistance found one-on-one enrollment assistance to be financially sustainable.<sup>84</sup>

The *Get Covered Illinois* team has instituted a thorough consumer assistance evaluation process this year. As the Marketplace team thinks about consumer assistance for next year and under different Marketplace models, it will have to make decisions about the size and scope of the consumer assistance program. Additionally, if Illinois transitions to an SBM in the future, consumers will need help enrolling, renewing, or changing their plans in the entirely new system, and lessons learned from the current consumer assistance program can help target consumer assistance to be most effective in an SBM.

### Customer Relationship Management Web Portal

Currently, Illinois has Navigators complete a weekly Metrics Reporting Form as part of the evaluation process. If the state moves to an SBM and creates its own web portal for enrollment, it will have the opportunity to build capacity into the system for Navigators to report required information directly into that same web portal through a unique access identification number. This action will create a customer relationship management (CRM) tool, will eliminate the need for a separate reporting system, and will help to streamline the process for Navigators. The Navigators could use this CRM web portal as an ongoing account management tool and would be able to easily track consumers they are assisting and the status of each application.

Additionally, the state would be better able to evaluate the performance of individual Navigators and Navigator organizations through this web system. It could track the current required performance metrics and benchmarks of Navigators (applications started and submitted with Navigator assistance) and could also track additional data points. For example, the Marketplace team would be able to create reports on the geographic distribution of applications submitted with the assistance of individual Navigators for purposes of future resource allocation decisions and would be able to analyze whether any Navigators are steering consumers toward particular plans.

This CRM web portal would also be similar to tools that insurance brokers use and may be an opportunity to engage brokers in the Marketplace. The state could consider allowing brokers to have a broker identification number to access the CRM and integrate their work with consumers into the Marketplace's web system.

### An Example of the Value of the CRM Web Portal

The CRM system would allow *Get Covered Illinois* to effectively work with two data points that it is already collecting from Navigators: Marketplace and Medicaid applications started but not yet submitted. The Marketplace team has this data, but it does not have the ability to identify those applicants and directly follow-up – instead relying on Navigators to do so. If this web portal existed, applications started but not submitted would be attached to an individual Navigator's profile, and the Marketplace team could identify the Navigators working with those consumers and direct the Navigator to follow-up. *Get Covered Illinois* would have better monitoring mechanisms and could ensure that those consumers' incomplete applications are not lost.

### Types of Information Collected

Several states, including Illinois, are using Request for Information (RFI) cards as another method to collect information about consumers. These RFI cards show the reach of the consumer assistance program and are an indicator of how successful the programs have been in disseminating information. They also show the demand for information that still exists among consumers and if Navigators are not reaching all types of consumers across the state.

Beyond the RFI cards and the current data that Navigators are reporting, *Get Covered Illinois* has the opportunity to collect additional consumer information in the future in order to evaluate and refine its consumer assistance and marketing strategy. We recognize that there is sensitivity around collecting personal information, but this data would be available for limited purposes and personal health information would not be collected. HHS's Center for Consumer Information and Insurance Oversight (CCIIO) is currently collecting many data points from SBMs to provide an overview of the applications submitted and eligibility determinations in the first years of ACA implementation. However, it remains unclear whether this level of data will be made available from the FFM to states like Illinois.

As an SBM, Illinois could benefit from collecting more individual-level data through a CRM system, and better macro level data to meet the CCIIO reporting requirements, all of which would help ensure the States' ability to effectively manage and evaluate its own consumer assistance program

and marketing efforts. Illinois could consider collecting information like what the DC Health Link is collecting, such as contact information for consumers, age, gender, race, insurance status, income, family size, and more. Navigators could also report the time required to complete each application so the Marketplace could assess whether specific types of consumers require more consumer assistance.

These RFI cards and the CRM portal with additional demographic information included can help to build a database of consumers that the Marketplace team can go back to at any time in the future. For example, if the Navigators reported information on the income level of consumers they assist, the Marketplace team could identify consumers at risk for churn and instruct Navigators to follow up with those consumers to see if they have had a change in eligibility and need further enrollment assistance.

### DC's Consumer Tracking Tool

The District of Columbia's Marketplace, DC Health Link, requires its Navigators to fill out a Consumer Tracking Tool for each consumer they assist. This tool is part of the DC Health Link web portal and includes demographic information on the consumer, the consumer's insurance status, the consumer's stage of engagement,<sup>viii</sup> the number of estimated contacts needed to complete the person's enrollment, the approximate amount of time it took the Navigator to help the consumer complete the application, and any notes about follow-up. The web-tracking tool has two intended uses: first, a performance metrics tool to assess Navigators; and second, a work tool for the Navigators to track clients.

As the DC Health Link makes decisions about its consumer assistance program for next year, knowing that it will have to fund any Navigators that it maintains, it will be able to use the data collected through its web portal to evaluate the usefulness of its consumer assistance program and determine its scale for next year. For example, it can compare the total enrollment numbers to the Consumer Tracking Tool to estimate how many people would not have been successfully enrolled without Navigator assistance, and it can identify the percent of consumers that enrolled with Navigator assistance.

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<sup>viii</sup> Stage 1: Asked for help with enrollment or for more information about DC Health Link; Stage 2: You have helped them set up an account on the web portal; Stage 3: Eligibility determination complete; Stage 4: Insurance enrollment complete.

### Key Points & Recommendations

The following recommendations are provided to summarize this section and to help ensure successful evaluation of Illinois' consumer assistance program:

- ☑ If Illinois transitions to an SBM, it should consider **building capacity into its new web system** so that Navigators can **report and track consumer assistance and enrollment** in that same system. This system would create a **Customer Relationship Management tool** to help Navigators track consumers they are assisting, and help the *Get Covered Illinois* team monitor the performance of Navigators and evaluate its consumer assistance program.
- ☑ In addition to the valuable information and soft metrics that *Get Covered Illinois* is currently collecting, it should consider collecting **more demographic information** on consumers that Navigators are assisting.
- ☑ The ongoing **webinars** for lead Navigator organizations provide a good opportunity for **peer-to-peer sharing of promising practices** around consumer assistance.



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## **Part II: Considerations for Funding a State-based Marketplace**

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## Introduction to Part II

The following sections focus on topics relevant to funding a State-based Marketplace. We begin by offering an analysis of options for establishing a steady source of revenue to fund the Marketplace, followed by discussing considerations for planning for the Marketplace's marketing budget in the next few years, with examples from other states. We end by reviewing cost allocation principles, processes, and practices, with recommendations for revenue maximization in Illinois.

## Sustainable Funding for a Future State-based Marketplace

In order to establish a State-based Marketplace, Illinois needs a reliable, steady source of revenue to fund it. Based on Wakely Consulting Group's 2012 estimates, the state will need \$57 to \$88 million per year to finance an SBM.<sup>85</sup> This section will analyze several funding alternatives that could be appropriate for Illinois, with a focus on maximizing the cost-savings for individuals and families across the state.

### Basic Options for Financing a State-based Marketplace

States are allowed to charge an assessment or user fee on insurance carriers, which could be applied to only carriers on the Marketplace or to a broader set of insurance carriers. If applied to a broader set of insurance carriers, it could include only fully-insured plans or all health insurance plans, including self-insured plans. The Illinois Health Care Reform Implementation Council (HCRIC) Initial Report proposed using a share of Medicaid or All Kids funding, a user fee on consumers, or an assessment on all healthcare stakeholders (including providers, pharmaceutical companies, medical supply companies, and self-insured plans) who benefit from the coverage offered in the Marketplace.<sup>86</sup>

An increased or broadened provider tax in Illinois would expand on an extremely common current approach to funding the healthcare system, though it has been criticized in recent years. In fiscal year 2013, 49 states and DC had an existing provider tax, often assessed on hospitals and frequently used to fund Medicaid.<sup>87</sup> This plan may be politically challenging in Illinois.

### Criteria for Evaluation

HCRIC's work helped identify some criteria for the State to use in selecting its financing plan: the cost of coverage for families and employers; incentives that encourage insurance carrier participation in the Marketplace; transparency; and, cost-effectiveness.<sup>88</sup> The November 2012 Wakely report suggests additional criteria: the broadness of the funding base; the impact on the market; administrative feasibility; legal and other risks; and, financial impact. These are particularly important to our considerations of the long-term sustainability of the proposed funding source. Wakely presents four funding options for Illinois, which we have reviewed carefully.<sup>89</sup>

### Four Significant Funding Proposals

**1. Assess All Health Insurance Claims.** The first proposal is to use a Health Insurance Claims Assessment (HICA), like what was signed into law in September 2011 in Michigan.<sup>90</sup> This would incorporate both self-insured and fully-insured payments into the tax base, making it a broad-based revenue source and meaning the assessment rate can be quite low. It does, however, stand some

risk of an Employee Retirement Income Security Act (ERISA) challenge. Michigan's HICA law was challenged on an ERISA basis, but the challenge was thrown out in Federal District Court.

A significant difference of this proposal compared to other states' funding mechanisms is that it applies to claims rather than to premiums. The states that plan to assess the fees on premiums have to assess at much higher rates than Wakely proposed for claims in Illinois. In Illinois, the claims assessment could be one-fifth to one-third of one percent, but premium assessments in other states (often applied only to Marketplace plans) range from two to five percent.<sup>91</sup>

California allows Qualified Health Plans (QHPs) not on the Marketplace to pay half the assessment that Marketplace plans pay, and the State charges a higher rate on small business Marketplace plans than on individual Marketplace plans. Because insurers cannot charge different rates for the same insurance plan on and off the Marketplace, the differential tax assessments will effectively be spread among the plan beneficiaries and add some administrative complexity. This makes the higher on-Marketplace assessments likely to incentivize insurers to operate only off the Marketplace. We recommend a single rate for all plans, both on and off the Marketplace, in a HICA so that carriers have no financial incentive not to offer insurance plans on the Marketplace.

**2. Assess Fully-Insured Plans Only.** The second proposal is to continue the existing assessment that is used in Illinois for the high-risk pool. Unlike the first proposal, this captures only the fully-insured premium amounts, so it has a smaller revenue base. Therefore, it must also use higher assessment rates. An important note about this proposal is that we are in the middle of a historical shift toward self-insurance by employers. As this trend continues, the pool remaining for a fully-insured premium assessment would shrink over time, leading to declining revenues for an SBM.

**3. Assess Fully-Insured Plans and Stop-Loss Premiums.** The third proposal is to expand that high-risk pool assessment to also cover stop-loss premiums. This does not significantly expand the revenue base compared to the second option, so the assessment rates would be quite similar. The additional stop-loss carriers that are not already included in state regulations would be more difficult to track down, and they represent a "very small" share of medical spending when compared to the other already included medical coverage, so we suggest this additional revenue is not worth the additional effort it would require.<sup>92</sup>

**4. Assess Marketplace QHPs Only.** Finally, Wakely proposes an assessment on all QHPs for sale on the Marketplace. This would result in a much narrower revenue base than the first proposal (the HICA), and it would create incentives for insurers to not provide coverage on the Marketplace and instead sell only in the private market. This is because insurers cannot charge different prices on and off the Marketplace for the same insurance plan, so they will prefer to sell only in the market that does not require the additional assessment.

An alternative that combines the broad base of a HICA with the assessment on premiums would be to use an assessment on premiums that covers the whole insurance market in the state. It would be based only on premium levels, which are no longer rated by health. For example, funding for Connecticut's SBM is based on a premium assessment of 1.35 percent for all premiums in the individual or small-group market, regardless of whether they sell on the Marketplace.<sup>93</sup>

### Alternatives from Other States

Other states have proposed a per-member-per-month fee on insurance carriers. This is less regressive for the sick, because it charges everyone the same fee, but it is more regressive for the poor, for whom any pass-through of the fee from the insurer represents a bigger share of their income. The fees vary widely from \$5 per-member-per-month in Nevada to \$43 in Utah (both only on Marketplace plans).<sup>94</sup> In Utah, this is in addition to an annual appropriation from the state government. This kind of annual appropriation is not a good fit for Illinois' funding needs. It seems unlikely to succeed due to other pressing budgetary concerns in Illinois, including the pension crisis. We recommend an outside funding source not currently included in Illinois' already-stretched budget.

In Maryland, the Joint Committee on Exchange Financing suggested a mix of a broad based assessment like the HICA or premium assessments and a fixed funding stream like a cigarette tax.<sup>95</sup> While cigarette use certainly correlates with health expenditures, it also tends to be a regressive tax, as poorer individuals are more likely to be smokers.<sup>96</sup> To avoid making the system more regressive, we do not recommend this kind of excise tax approach. Furthermore, the State hopes to reduce demand for cigarettes through its public health work, so this would not provide a stable source of revenue in the years to come.

An additional alternative would be to allow advertising on the SBM. Through website ad space sales, the State could raise revenue in an easy-to-administer manner that is certainly not regressive, since it is not assessed on taxpayers. Commenters have suggested evaluating the required staff time and any physical resources that will be needed to sell and/or regulate ad content and any restrictions on appropriate sources for ads sold by the State.<sup>97</sup>

Our sense is that advertising would be a straightforward way to raise some revenue, but it is unlikely to cover the full costs of the Marketplace without becoming excessive and intrusive on the Marketplace website. As a result, we focus the remainder of our analysis on larger scale revenue sources, but we are not opposed to the use of advertising as a means to partially finance an SBM.

### Progressivity of the Revenue Base

One critical concern about the implementation of a financing system for an SBM is its progressivity. The HICA, the most broadly based assessment, is the most progressive option Wakely analyzed. The alternatives based on only fully-insured plans do not include the self-insured, largely freeing the largest employers in the state from responsibility for funding the Marketplace. Large employers can be asked to contribute to funding the Marketplace because they will benefit from the increase in the total insured population, which reduces uncompensated care costs and allows hospitals to charge lower rates. Presumably, these large employers, which are more likely to be self-insured, have more disposable income and thus should be included in the tax base in order to make it more progressive, making the HICA a superior option to more narrowly based assessments.

Since HICA is assessed on claims, not premiums, this could increase the incentive for insurers to find the healthier patients who will have lower health insurance claims. However, thanks to the Affordable Care Act's other protections that ban discrimination based on pre-existing conditions, insurers are no longer able to deny coverage to applicants or to charge sicker patients more. Thus, this concern about the regressivity of a HICA assessment is unlikely to be realized.

The broad-based assessment on premiums (rather than claims) is a similarly progressive alternative because it also directly spreads the costs to consumers around the state, not just to those in the Marketplace. Since consumers on the Marketplace cannot be charged more for the same plan as those off the Marketplace, this cost-spreading would happen indirectly anyway. But the important difference in progressivity depends on whether large group insurance plans are included in the assessment. Including them would allow a lower rate on individual and small-group insurance customers by charging the large employers, who generally have more of a margin and are thus affected less by a small assessment. Including insurance plans not sold on the Marketplace explains the difference between Wakely's QHP-only assessment rate of between 2.24 and 3.39 percent in Illinois and Connecticut's actual 2014 assessment of 1.35 percent on all individual and small-group plans. Wakely estimated that using only the Illinois Comprehensive Health Insurance Plan (ICHIP) pool for assessment (the current high-risk plan), Illinois could assess at a rate of 0.34 to 0.53 percent. This suggests that Illinois could use an assessment significantly lower than Connecticut's.

### **Leveraging Other Available Funding**

Until the end of 2014, Illinois is eligible to apply for grants that will fund support, but not direct operations, of the Marketplace in Illinois past January 1, 2015. While a state is functioning as an FFM, the state's Medicaid and CHIP programs do not contribute to the costs of an FFM, including for eligibility determination for Medicaid or CHIP. They do, however, need to contribute the information needed for the FFM to make eligibility determinations.<sup>98</sup> The estimated total \$57 to \$88 million needed per year to finance an SBM is hard to compare to the direct costs of the Partnership Marketplace, since the Federal grant money has been such a large component of state spending for the Partnership Marketplace so far, and we have not yet been able to see what costs will be left to the State in the future for consumer assistance and plan management.<sup>99</sup>

Illinois has received a Federal Marketplace Planning Grant of \$1 million and three Federal Level One Establishment Grants for \$5.1 million, \$32.8 million, and \$115.8 million.<sup>100</sup> These funds are substantial and can be used for building the health reform website, conducting background research needed in order to create a functioning Marketplace, and training Navigators. Additionally, the State would be eligible for Level Two Establishment Grants were it to move forward with an SBM quickly, which would significantly reduce the start-up costs for the Marketplace. However, these Federal grants are not long-term funds and cannot be used to finance operations for an SBM after January 1, 2015. During 2014, Illinois will have the opportunity to apply for additional Level One and Level Two grants, which could fund anything related to building and planning for an SBM, including ongoing IT needs, website upgrades, and web integration with other online benefit systems. Level One grants can also be used for operations prior to January 1, 2015, including consumer assistance and marketing. We recommend taking full advantage of these grant opportunities, as any additional grant money reduces the burden left for Illinois to bear.

Much of the cost of establishing an SBM comes upfront, particularly in the creation of an IT system. Of course, any IT system will need to be maintained and staffed over time, but the costs of creation are the largest component of total costs. The available Federal funding should be used to finance the startup costs, leaving the lower recurring costs for the State.

### **Benefits of a Broad-Based Assessment for Illinois**

We do not recommend an assessment on Marketplace QHPs only; rather, we suggest a broader funding base, both for the stability of the funding source and the incentives to sell on the Marketplace. We recommend instead either the first proposal, a Health Insurance Claims

Assessment, modeled on Michigan's legislation, or a similarly broad-based assessment on premiums. A HICA requires a low assessment rate of about one-fifth to one-third of one percent of paid claims, and it is a stable source of funding. In terms of administrative ease, most insurance carriers are already licensed by the Illinois Department of Insurance and are used to working with state agencies, so this assessment could be introduced relatively easily.

Connecticut's 2014 SBM is using a broad-based premium assessment on individual and small-group plans both inside and outside of the Marketplace, so Illinois can learn from the first year of their Marketplace to estimate an appropriate assessment in the future. For 2014, Connecticut's assessment on premiums is 1.35 percent, which is much lower than the 3.5 percent charged by the FFM for all premiums sold on the Marketplace in Illinois.<sup>101</sup> Based on Wakely's estimates for the ICHIP pool of an assessment of 0.34 to 0.53 percent, Illinois could most likely use an assessment significantly lower than Connecticut's. This difference could stem from both Illinois' larger population now and the extra time to increase enrollment (until 2016, compared to Connecticut's 2014 rate). The bulk of SBMs that had made financing decisions by May 31, 2013 are based on this kind of assessment on insurance plans, rather than on an existing state assessment or a premium tax.<sup>102</sup> The premium assessment is likely to be the most administratively simple funding mechanism; premiums are easily measured and reported, and they are more predictable than claims because they are posted in advance on the Marketplace or quoted to non-Marketplace consumers.

Table 2 demonstrates the cost savings to Illinois families over the first 10 years of an SBM compared to 10 years of the 3.5 percent premium assessment in an FFM. This table provides clear evidence that a broader base for premium assessments makes a tremendous difference in cost savings to Illinois families who buy insurance on the Marketplace. The lower rate associated with assessing all individual and small-group plans on and off the Marketplace, not just QHPs on the Marketplace, saves a family of four living in Springfield an additional \$3,027.47 over the next ten years (for a total savings of \$4,364.85 compared to the FFM).<sup>ix</sup> The table also demonstrates the magnitude of cost savings available to Illinois families under either a QHP premium assessment or a premium assessment for all insurance in the state compared to the FFM. The FFM, simply put, charges much higher rates than what Illinois could charge on its own SBM, and the broader the base for the assessment, the more families will save.

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<sup>ix</sup> Assuming 8 percent annual growth in premiums.

**Table 2: Cost Savings to Illinois Families from Moving to an SBM, 2016-2025<sup>x</sup>**

Annual Premium Growth Rate	0.53% Premium Assessment			2.59% Premium Assessment		
	6%	8%	10%	6%	8%	10%
<b>Cook County</b>						
Single 42 Yr-Old	\$970.70	\$1,128.40	\$1,311.66	\$297.42	\$345.74	\$401.89
Family of Four	\$2,920.92	\$3,395.45	\$3,946.91	\$894.96	\$1,040.36	\$1,209.32
<b>Sangamon County</b>						
Single 42 Yr-Old	\$1,248.67	\$1,451.53	\$1,687.27	\$382.59	\$444.74	\$516.98
Family of Four	\$3,754.84	\$4,364.85	\$5,073.74	\$1,150.47	\$1,337.38	\$1,554.58
<b>Marion County</b>						
Single 42 Yr-Old	\$1,310.44	\$1,523.34	\$1,770.74	\$401.52	\$466.75	\$542.55
Family of Four	\$3,940.16	\$4,580.27	\$5,324.15	\$1,207.25	\$1,403.38	\$1,631.31

Because of the narrow base of a Marketplace QHP-only assessment, the rates would have to be much higher and were estimated between 2.24 percent and 3.39 percent in a 2012 Wakely report.<sup>103</sup> The right side of Table 2 shows the cost savings of this funding strategy compared to the FFM. These rates are about 10 times the rate charged in the paid-claims HICA system and between 5 and 10 times the rates in a system that would expand the assessments currently paid by the fully-insured into the high-risk pool funding source. The left side of the table represents the cost savings from using the current high-risk pool funding source, which Wakely estimates could use an assessment rate of 0.34 to 0.53 percent.

Additionally, the second and third Wakely proposals do not cover self-insured plans. In recent years, more and more employers have been moving toward self-insurance, meaning the Marketplace funding would be based on a shrinking tax base. This is not good for sustainability. The lower assessment on a broader base is a steadier base for revenue, and the total number of insured in the state will only grow over time, not decline like the fully-insured population.

For all these reasons, we recommend a broad assessment base of all claims or premiums paid. It is more progressive and more feasible than other proposals, and it ensures a stable funding base that will not decline over time. This is also consistent with the text of SB 34, which would have required a

<sup>x</sup> Note: In preparing these estimates, we assume that by 2016, enrollment matches previous projections (meaning that any delays in 2014 signups are made up for in 2015 and 2016 enrollment). We estimate costs for two family types: a single 42-year-old, and a family of four (ages 44, 42, 12, and 10). We take premium costs to be the second-lowest cost Silver tier plan currently available on the Marketplace, based on family size, age, and county of residence. We estimate three scenarios for annual growth in premiums: 6, 8, and 10 percent annual growth. We assume that the FFM premium assessment would be unchanged at 3.5 percent. The two SBM assessment rates of 0.53 percent and 2.59 percent come from Wakely’s estimate of expanding the current ICHIP funding source and the “Moderate Enrollment” estimate from Wakely’s 2012 report, respectively. Using data from the Society of Actuaries, we estimate that 81.1 percent of nongroup enrollment will be on the Marketplace (the average of their estimates from all states expanding Medicaid and from no states expanding Medicaid). That implies that the 3.5 percent assessment comes out to 2.84 percent and the 0.53 percent assessment comes out to 0.43 percent, after the Marketplace assessment costs are spread to the off-Marketplace nongroup plans.

revenue plan that included “annual assessments of all entities authorized in this State to transact” the general types of insurance. A premium assessment may be administratively simpler than a claims assessment, but both provide significant savings to Illinois families. Additional revenue can be raised through broker fees and advertisements in order to keep assessment rates low.

**Key Points & Recommendations**

The following recommendations summarize this section and are provided to assist Illinois in considering funding sources for an SBM that will be sufficient to cover Marketplace costs in future years:

- ☑ Illinois should **take full advantage of Federal grant opportunities**, as any additional grant money reduces the burden left for the State to bear. **The available Federal funding should be used to finance the startup costs of an SBM**, leaving the lower recurring costs for the State.
- ☑ Illinois should include an **outside funding source** not currently included in its already-stretched budget.
- ☑ We recommend either a **Health Insurance Claims Assessment (HICA)**, modeled on Michigan’s legislation, or a similarly **broad-based assessment on premiums**. For the stability of the funding source and the incentives to sell on the Marketplace, Illinois should create a **single assessment rate for all plans**, both on and off the Marketplace, in a HICA or a premium assessment.
- ☑ Illinois should consider the **sale of advertising on the SBM website** to support partial funding of the SBM.

**Funding Consumer Assistance and Marketing**

Across the country, State-based Marketplaces have allocated different proportions of their overall budgets to consumer assistance and outreach activities. To provide a window into such decisions, we have selected three states for comparison—Minnesota, New York, and Washington—due to similarities that each shares with Illinois, as well as the availability of their budget documents.<sup>xi</sup>

We chose Minnesota based on its relative proximity to Illinois. No other state in the upper Midwest is operating its own Marketplace. We believe New York to be a good comparison because of its demographic similarity. New York has 2.27 million uninsured residents to Illinois’ 1.98 million.<sup>104</sup> The two states are among the most urbanized in the country—as of

**Table 3: Size of Individual Insurance Market**

State	Size in 2011	Projected New Size
New York	776,600	1,264,000
<b>Illinois</b>	<b>602,200</b>	<b>937,00</b>
Washington	360,400	507,000
Minnesota	265,700	298,00

<sup>xi</sup> In this report, we have included the most recent budget figures that are publicly available for the three given states. Still, some projections come from 2012 and early 2013, so they may not necessarily reflect current spending realities, especially because states have continued to apply for additional funds to support SBM operations.

2010, New York's population is 87.9 percent urban, compared to Illinois at 88.5 percent urban.<sup>105</sup> Washington has relevance because it has the next highest uninsured population among SBMs (960,050).<sup>106</sup>

In 2011, as the second column of Table 3 shows, these three states' individual markets fell on both sides of Illinois in terms of enrollees.<sup>107</sup> That is also true of the populations in each state projected to be eligible for a Marketplace plan under the ACA, represented by the third column.<sup>108</sup>

Furthermore, all three comparison states are expanding their Medicaid programs under the Federal law, providing yet another important similarity to Illinois.

### Financing

Pursuant to legislation, Washington can only charge user fees to Marketplace plans.<sup>109</sup> The State's Marketplace board will ultimately determine the precise amount of the fee. Similarly, Minnesota will limit its assessment to Marketplace plans, at up to 3.5 percent of premiums.<sup>110</sup> Illinois might consider a similar ceiling on its assessments. We recommend that the *Get Covered Illinois* team work with the Legislature to place a limit of 3.5 percent—no more than the FFM can charge—on any user fee exclusive to the Marketplace.

**Table 4: Marketplace Budgets, 2014-2016**

State	Year	Total Budget
New York	2014	\$66,449,041
	2015	\$48,654,604
	2016	\$43,254,604
Minnesota	2014	\$47,600,000
	2015	\$42,800,000
	2016	\$52,800,000
Washington	2014	\$64,859,000
	2015	\$40,000,000
	2016	\$40,000,000

All three states fund consumer assistance and outreach activities in the same way: through user fee revenue generation and Medicaid cost allocation.

The three states diverge in the growth of their budgets over time. In 2014, the only year of Federal government financing of SBMs, New York's budget is substantially larger than in out years. It drops 35 percent from 2014 to 2016. Washington's projected budget also falls a great deal after the first, grant-funded year. By contrast, Minnesota reduces its budget in 2015 relative to 2014 levels, but increases it in 2016.

### Marketing

The marketing part of the budget generally includes television, radio, and online advertisements. Among the SBMs evaluated in this section, Minnesota's marketing share is smallest and New York's is highest. Washington falls in between, following the patterns of both overall state population and number of uninsured residents. In our small sample, the larger a state in 2014, the larger is its marketing budget share. This likely has to do with the expense of reaching uninsured consumers, as well as the relative cost of media markets—especially with New York City in the mix.



New York plans to allocate 20.8 percent of its grant-funded 2014 budget to marketing, rising to 31.9 percent in 2016 when the State is fully funding its operations. The relative increase is misleading, however, as the dollar amount of the annual marketing allocation remains stable, at \$13.8 million each year. The state's overall budget shrinks by over \$20 million over the course of those three years, thus leading to an increase in the proportion of the budget devoted to marketing.

**Table 5: Marketing Budgets, 2014-2016**

State	Year	Marketing	Percent of Total
New York	2014	\$13,808,310	20.8
	2015	\$13,808,310	28.4
	2016	\$13,808,310	31.9
Minnesota	2014	\$2,600,000	5.5
	2015	\$2,600,000	6.1
	2016	\$2,600,000	4.9
Washington	2014	\$8,791,000	13.6
	2015	\$0	0
	2016	\$0	0

For Minnesota, when the State is self-sustaining in 2015, marketing allocation represents 6.1 percent of the overall budget.

In mid-2013, Washington made major changes to its budget projections. In a document produced early in the year, not long before the passage of Marketplace legislation, the State projected SBM operating costs of \$51 million in 2015 and \$53.6 million in 2016.<sup>111</sup> Yet in November 2013, the Marketplace board approved budgets of only \$40 million for those two years.<sup>112</sup> Previously, the State had estimated a \$5.6 million marketing allocation for 2015 and \$4.6 million for 2016. In the most recent budget, however, the State zeroed out the marketing line item for 2015 and almost certainly 2016 as well.

One lesson to be drawn from this experience is that Illinois should ensure that its budget aligns with its needs. Washington was forced into a budget far below what it deemed operating expenses to be, which will have ramifications on its ability to reach consumers in out years.

### Consumer Assistance

The consumer assistance budget category typically includes such activities as a call center, in-person assister training, and in-person assister wages.

The 2015 consumer assistance budget shares range from 14.4 percent (Washington) to 55.9 percent (New York), with Minnesota in between. Minnesota increases its consumer assistance budget each year, whereas New York plans to keep consistent that portion of its budget from 2015 through 2019.<sup>113xii</sup>

**Table 6: Consumer Assistance Budgets, 2014-2016**

State	Year	Consumer Assistance	Percent of Total
New York	2014	\$31,800,000	47.8
	2015	\$27,200,000	55.9
	2016	\$27,200,000	62.9
Minnesota	2014	\$5,000,000	10.5
	2015	\$9,500,000	22.2
	2016	\$13,000,000	24.6
Washington	2014	\$10,805,000	16.7
	2015	\$5,776,000	14.4
	2016	\$5,776,000	14.4

<sup>xii</sup> Year 1 of New York's IPA/Navigator contracts actually runs 14 months in duration, from 8/1/2013 through 9/30/2014. That is considered the State's consumer assistance budget for year 2014, as labeled in the table.

In a budget draft from October 2012, New York made an important point: “Third Party Assistor training costs may be higher in out years because training needs to occur for in-person assistors, brokers (SHOP), and appeals.”<sup>114</sup> For Illinois, that may be especially true. Not only will the launch of SHOP require extensive training of new and existing assisters, the state may be using an entirely new system by that point.

In the following sections, we will offer perspective on Illinois’ possible transition to an SBM.

### Strategies for Illinois

Budget projections change frequently. States revisit and update old numbers when new grant applications are due, and then again after seeing how the numbers play out in reality. For these reasons, Illinois should not heavily rely on any one number from other states. What we provide in this financing section is offered as general guidance, rather than a specific model to emulate.

**1. Focus on first-year numbers.** In 2016, Illinois may be a first-year SBM—a unique position relative to most other states. In its transition to SBM by that year, Illinois will not have to engineer a full re-branding of its Marketplace, but many elements will change. Assisters, for instance, will be using a completely new system for which they will have to be trained. Education and outreach will also be necessary for consumers, who will be dealing with a new system for their renewals or starting their plan shopping from scratch. In many ways, Illinois will function like a new Marketplace. As a result, looking at the first-year budgets and experiences of other SBMs may be more helpful than their projections for 2016. In other words, Illinois in 2016 will be more like New York and Washington in 2014, or possibly 2015.

**2. Adequately fund consumer assistance and marketing.** For current SBMs, first-year 2014 budgets are largely funded by the Federal government through Establishment Grants. It might be natural to think that because Illinois will not have this luxury, it should scale back its budgetary ambitions accordingly.

However, that would be a mistake. In 2016, assuming the state authorizes an SBM in the upcoming legislative session, Illinois will need to invest heavily in start-up costs. Launching a Marketplace takes investment and effort, even if some of the foundation has already been set. Whether substantial external resources are available or not, it is important for Illinois to ensure the success of the Marketplace through appropriate funding of consumer assistance and outreach.

In September 2011, Wakely Consulting Group predicted that 337,000 Illinoisans would enroll in individual plans through the Marketplace during the first year of operations.<sup>115</sup> In all likelihood, as a result of technical problems with the Federal exchange, Illinois’ decision to allow formerly canceled plans to exist for an additional year, and other exemptions, 2014 enrollment may fall below that projection, and also below the proportional enrollment of many SBMs.

According to recent enrollment data released by HHS, 61,111 consumers in Illinois had selected a Marketplace plan by December 28. As such, the State appears unlikely to hit the Wakely prediction. Enrollment in 2015 and 2016, consequently, may be much *higher* than projected, necessitating increased funds for consumer assistance and marketing in those years. In all, Illinois will need to allocate appropriate funds during the first year of its SBM in order to reach the consumers still waiting to enroll.<sup>116</sup>

**3. Retain flexibility.** Illinois may follow the model of other states and impose a premium assessment on carriers in order to fund Marketplace operations. If Illinois passes SBM legislation in the spring of 2014, over a year and a half would pass before the launch of its own Marketplace. Enrollment in 2014 and 2015, under the Federal Partnership, could end up coming in much lower or much higher than projections. As Illinois crafts legislation in early 2014, final numbers for those two years will still be very hard to predict.

With this in mind, flexibility is paramount. Enabling the Marketplace board to set and modify the user fee would be one step the Legislature could take to ensure the Marketplace can adapt. It would allow the amount to be set for 2016 based on conditions on the ground and the continued need for consumer assistance and outreach activities.

Nevertheless, the Legislature will likely want input on the process. If necessary, we recommend that the Marketplace team allow legislators to impose a cap of 3.5 percent on the user fee. That way, any premium assessment the board sets would still come in at or below the level of a Federally-facilitated Marketplace.

Washington State provides an important lesson in funding: its second and third-year budgets are well under what the Marketplace board previously predicted spending needs to be. Illinois should utilize the aforementioned strategies to ensure that it has the flexibility to invest in its own enrollment-related activities.

**4. Apply for Level II Establishment Grants.** Illinois can and should apply to CCIIO for funds to build its SBM. In particular, we suggest looking into funding the following SBM-related items through the final round of Establishment Grants: development of consumer assistance training materials; development of any other consumer assistance materials; development of script for SBM call center; and technology updates for the call center.

### Key Points & Recommendations

The following recommendations summarize this section and are provided to assist Illinois in determining future Marketplace consumer assistance and marketing budget allocations:

- Illinois should focus on **first-year 2014 budget numbers** from other SBMs for planning its own SBM budget.
- Illinois should **adequately invest in consumer assistance and outreach** in 2016.
- Illinois should retain enough **flexibility** with its user fee and budget to make vital changes based on enrollment patterns, such as not reaching enough consumers in 2014 and 2015 as expected or hoped.
- Illinois should apply for continued **financial assistance for start-up and operational costs** of its Marketplace.

## Cost Allocation

Although insurer assessments will constitute the primary source of funding for an SBM, it is important to consider revenue options beyond user fees. The most important of these is Medicaid.<sup>xiii</sup>

For Illinois, establishing Medicaid's relationship with the Marketplace is both a necessity and an opportunity. Under longstanding Federal grant accounting rules, states are required to allocate administrative costs among benefiting programs. The ACA's "no wrong door" vision of a seamless consumer experience heightens the stakes. Integrated eligibility and enrollment processes for QHPs, advance premium tax credits (APTCs), cost sharing reductions (CSRs), and Medicaid—unified by a new common income criterion, Modified Adjusted Gross Income (MAGI)—mean that SBMs and Medicaid are inextricably linked—operationally, technologically, and financially.

These tight connections make cost allocation more challenging, but they also make it more valuable. To promote integration, HHS has provided generous enhancements to traditional Medicaid reimbursement levels. For states that capitalize on these enhancements, the Federal government can remain a major revenue source, even after Establishment Grants expire.

The larger the share of ACA implementation costs charged to Medicaid, the less is the burden that falls on state taxpayers. Despite these incentives, states vary considerably in their cost allocation methods and results. This section will review cost allocation principles, processes, and practices; discuss cost allocation methodologies; and provide recommendations for revenue maximization in Illinois.

At the outset, it is important to acknowledge that this report was produced for the *Get Covered Illinois* team. As a result, it necessarily adopts the global perspective Governor's Office staff must strive to maintain. The primary concern is how policy options affect Illinois as a whole. This orientation largely leaves aside the details of how policies may place different demands on participating state agencies and other stakeholders.

In the realm of cost allocation, however, distributional impacts come to the forefront. Although maximizing Medicaid reimbursement will improve the Illinois budget bottom line, accomplishing this objective may require shifting resources between agencies. In what follows, we adopt a simple rule: you get what you pay for. Agencies required to contribute more to the State's cost allocation plan must be given the resources required to perform their mission—a mission that collectively leaves all agencies better off.

### Where Illinois Stands

The first step to optimizing cost allocation is to understand what exactly is being cost allocated. As has become well known in the months since health reform's national launch in October 2013, ACA implementation is mostly about information technology. The largest costs—by a wide margin—are those associated with building and maintaining the integrated web portals and eligibility systems through which consumers shop for, purchase, and use health insurance.

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<sup>xiii</sup> Unless otherwise noted, references to Medicaid in this section are assumed to encompass CHIP.

Illinois is no exception. At the time of Illinois' third Level 1 Establishment Grant submission (March 2013), the cumulative direct costs of ACA implementation, assuming an SBM, were estimated to be \$211.6 million through March 2014. Of this, the vast majority—\$129.4 million—is for systems development, to be paid to the consultant teams with which the State has contracts to build and implement ACA IT. By comparison, only \$2.8 million is for State Marketplace staff.<sup>117</sup>

But several aspects of ACA IT implementation also make Illinois distinct among states—and these distinctions have implications for cost allocation. Illinois is a state in transition. Although it is a Partnership state for 2014, ACA implementation has proceeded under the assumption that the State will become an SBM, pending the approval of the State Legislature. Partially as a result of uncertain transition timelines, IT systems development has followed a dual-track process, splitting ACA implementation into two projects: the Integrated Eligibility System (IES) and the Health Insurance Exchange (HIX).<sup>118</sup>

The two system approach also serves a second purpose. It accommodates the administrative complexity of creating systems that affect several State agencies, notably the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), the Department of Insurance (DOI), the Department of Public Health (DPH), the Office of Health Information Technology (OHIT), and the Governor's Office of Management and Budget (GOMB), as well as the *Get Covered Illinois* Marketplace team. To ensure the interests and expertise of all affected agencies are reflected in the final product, HCRIC chartered the Eligibility Modernization Oversight Group (EMOG) in the summer of 2011 to oversee the two-track ACA IT process.

In the first track, HFS signed a five-year, \$114.9 million contract with Deloitte to build and maintain the Integrated Eligibility System in September 2012.<sup>119</sup> Based on the Michigan Bridges system, IES is designed to determine eligibility for all health insurance programs in Illinois, as well as for the Temporary Assistance for Needy Families (TANF) program and the Supplemental Nutrition Assistance Program (SNAP). HFS Deputy Director Michael Koetting oversees the project.

As initial enrollment under the ACA began in Fall 2013, ABE (Application for Benefits Eligibility), IES' public facing portal, was operational, as were MAGI-based eligibility determinations for the medical programs. A landing page, branded "Get Covered Illinois," directed consumers between ABE and the Federal Marketplace based on a simple screening tool. For other human services programs, workarounds relying on legacy systems remained.

The second track consists of the development of the Health Insurance Exchange, which, as integrated with IES, will constitute Illinois' SBM. The DOI's procurement of a systems integrator for HIX has reached the best and final offer (BAFO) stage and will be completed pending the Legislature's approval of the Marketplace legislation. Marketplace IT Project Manager Tom Simonds is responsible for overseeing HIX development.

The unique qualities that characterize Illinois as a Partnership state in transition—in particular, the two-track approach to systems development—means that cost allocation in Illinois has a time-varying dimension not present in most other states. As we discuss below, the State's focus to-date has been on IES, which is more heavily weighted to Medicaid than is HIX. But to adequately appreciate the challenges and opportunities Illinois faces going forward, we first need to understand how cost allocation works.

### Cost Allocation Rules & Principles

The taxonomy of state health and human services is complicated. Divisions among departments are, to some extent, arbitrary. Clients' complex needs do not fit into neat buckets. Staff responsibilities cut across programs, constituencies, and funding streams. This commingling of resources creates considerable budgeting and financing challenges.

“Cost allocation” refers to the procedures through which states identify, measure, and distribute expenses among programs for purposes of claiming Federal reimbursement.<sup>120</sup> Per Subpart E of 45 CFR Part 95, each state is required to maintain an HHS-approved public assistance cost allocation plan that describes, in narrative fashion, the methodology the state uses to distribute expenses among Medicaid, TANF, SNAP, child welfare, and other all other state social service programs, whether or not Federally funded.

Cost allocation plans must conform to the accounting standards set forth in U.S. Office of Management and Budget (OMB) Circular A-87, which establishes cost determination principles for Federal awards. The basic threshold for reimbursement is that costs be “necessary and reasonable” for “proper and efficient” program performance and adequately documented. Costs meeting this standard that are directly attributable to one program are to be charged exclusively to that program. Shared costs must be apportioned among programs on a “reasonable and consistent” basis in proportion to benefits received.

Once costs are suitably assigned, states submit claims to the relevant Federal administering entities (which are generally the Administration for Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS) within HHS, and the Food and Nutrition Service (FNS) within the Department of Agriculture (USDA)) and are reimbursed at statutory rates. For Medicaid, the administering entity is CMS, and the reimbursement rate is typically 50 percent.

So long as states comply with these broad Federal requirements, they have considerable discretion to determine the precise methodology used to reasonably and consistently identify and measure the extent to which participating programs benefit from various activities and associated expenses.

### Advanced Planning Document Process

As noted, implementation of the ACA is largely an information technology endeavor. States and the Federal government are required to create streamlined web portals where consumers can compare and shop for plans, maintain accounts, and apply for coverage.

But the even more fundamental IT challenge is what goes on behind the scenes. Underlying these public-facing websites are sophisticated eligibility and enrollment systems, which must accept applications (whether electronic, paper, or telephone); assess whether consumers qualify for Marketplace plans, Medicaid, or subsidies; verify the veracity of submissions; and allow coverage to begin or be revised.

These systems must also facilitate the full range of operating activities for which Marketplaces are responsible, including plan management (QHP evaluation, plan certification, rate review, and compliance monitoring); financial management (billing, premium collection, subsidy disbursement, and Marketplace payroll and accounting); consumer assistance; reporting; and communications between consumers, employers, insurers, and officials. In most cases, functionality of this magnitude entails not only developing new systems, but also building interfaces with existing ones.<sup>121</sup>

So far as cost allocation is concerned, systems development adds an additional wrinkle. Unlike general administrative expenses, IT projects require prior Federal approval before costs can be incurred. The means through which states secure approval and the Federal financial participation that goes along with it is the Advance Planning Document (APD) process.

As spelled out in Subpart F of 45 CFR Part 95 (which was substantially updated October 28, 2010) and associated Federal guidance, the APD process is designed to provide a formal framework for conceptualizing and evaluating health and human services IT investments, with the goal of improving project management, mitigating risks, and ensuring the prudent use of financial resources.<sup>122</sup> States submit applications to the Federal oversight of all impacted programs—again, typically ACF, CMS, and FNS. ACF’s Office of Administration coordinates reviews, which are statutorily required to be completed in 60 days. However, CMS has set a goal of responding to state ACA-related submissions within 30 days.

At the core of the APD process is the Implementation APD (IAPD).<sup>xiv</sup> IAPDs request Federal funding for the most expensive part of IT projects: system design, development, and implementation (DD&I). In addition to stating needs and objectives, assessing feasibility, and outlining a project management plan with resource requirements and timelines, IAPDs must include a proposed budget and cost allocation plan. IAPD cost allocation must follow the same principles as state public assistance cost allocation plans and should generally comport with the methodology specified therein. System components exclusive to one program must be attributed entirely to that program. Shared costs must be apportioned among programs in proportion to benefits received or effort expended.

### Enhancements

The tight linkages between SBMs and Medicaid necessarily imply that resources invested in one will also benefit the other. Such shared costs are exactly the sort required to be cost allocated.

Typically, CMS reimburses suitably assigned Medicaid administrative expenses at a 50 percent rate. However, given the ACA’s emphasis on creating integrated state health insurance markets encompassing both public and private programs—and the associated scale efficiencies this alignment implies—HHS has implemented two enhancements to the traditional matching rate. These enhancements are designed to enable and encourage states to make prudent investments in system and process upgrades.

**1. 90/10 Enhanced Funding for Medicaid Eligibility and Enrollment Systems.** The ACA substantially altered the Medicaid eligibility landscape. Consumers applying for coverage in state marketplaces are jointly assessed for QHPs, Medicaid, and subsidies according to a new uniform national standard, MAGI. In states like Illinois that have opted for Medicaid expansion, all persons under 65 years of age with MAGI below 138 percent of the FPL are eligible for Medicaid. Recognizing that such changes, while initially burdensome, imply long-term administrative economies of scale, CMS issued a final rule in April 2011 (42 CFR Part 433) making available 90 percent Federal reimbursement for Medicaid eligibility and enrollment (E&E) systems DD&I. Maintenance and operations (M&O) of such systems also receive an enhanced match, at a 75 percent rate. Several aspects of the enhanced match merit further discussion.<sup>123</sup>

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<sup>xiv</sup> States may also request planning funds through Planning APDs (PAPDs), operational funds through Operations APDs (OAPDs), and revise submissions through APD Updates (APD-Ups).

- ❖ To receive enhanced matching, an approved APD must be in place and the systems to be developed must comply with the requirements described in the final rule, the most important of which are the “Seven Conditions and Standards” for Medicaid technology investments.<sup>124</sup> The seven standards emphasize flexibility, standardization, accessibility, security, performance, interoperability, reporting, and leveraging reuse. At a minimum, new Medicaid systems must be able to exchange data with the Marketplace and Federal agencies and support a single, streamlined, MAGI-based insurance application.
- ❖ Enhanced matching also applies to systems upgrades for traditional eligibility groups and is not tied to expansion populations.
- ❖ 90/10 development reimbursement is available only for costs incurred for goods and services rendered by December 31, 2015. In 2016, the DD&I match reverts to its regular 50 percent rate.
- ❖ 75/25 reimbursement for E&E operations is available in perpetuity. States can begin claiming reimbursement once systems become operational and an operations APD is approved.
- ❖ Qualifying M&O costs include not only hardware and software maintenance and associated equipment and supplies, but also facility costs (such as rent and utilities) and staff time spent on eligibility determination and enrollment activities. In broad strokes, the characteristic that identifies a personnel cost as qualifying for enhanced funding is the tightness of its link to technical operations or eligibility determination. Staff working on multiple assignments must be cost allocated. The same applies to shared facilities.
  - Staff functions typically *eligible* for 75 percent reimbursement include: application submission and editing; eligibility determination and verification; eligibility-related case management and customer service, including call centers; and IT operations.
  - Functions typically *ineligible* for enhanced matching include: outreach and marketing; policy research; training; consumer education; and general program management. Navigators and other assisters are not eligible for enhanced funding unless they work either directly for, or under contract with, the state Medicaid agency and have the authority to make eligibility determinations. Level of care assessments for long-term care are also ineligible.

**2. Human Services Program Exception.** Recognizing that technology investments made by Medicaid to conform with the ACA can also benefit other human services programs, HHS and the USDA sought and received OMB approval for a specific, time-limited exception to regular A-87 cost allocation rules. Under the human services exception, DD&I of “enterprise-wide” assets furthering a common eligibility framework for Federally-funded human services programs, including TANF and SNAP, need not be cost allocated so long as the costs would have been incurred anyway by Medicaid. In other words, the full cost of such development can receive the enhanced 90 percent Medicaid match. As a result, states have an incentive to create integrated eligibility systems, which are likely to promote administrative efficiencies and improve customer service while minimizing taxpayer expenditures. As with the 90/10 match, several key considerations apply.<sup>125</sup>

- ❖ Any incremental costs incurred to address the distinct needs of other human services programs, expanding services or capacity beyond functionality in common with the health



programs, must be charged entirely to the benefitting programs. Staff from other state programs must be meaningfully involved in the project.

- ❖ As with the 90/10 funding, this exception is available only for costs incurred through December 31, 2015.
- ❖ The exception does not apply to M&O costs, which must be allocated according to usual A-87 standards.
- ❖ States are encouraged to phase projects so that non-core system extensions do not cause ACA implementation to miss key deadlines. Proposals likely to cause such delays are unlikely to be approved.
- ❖ Among the business process and technical services HHS anticipates will be core functions of Medicaid and the Marketplace E&E systems—and thus prime candidates for repurposing—are: client portals, user interfaces, business rules engines, data warehouses, data exchanges, enterprise architecture and infrastructure, document imaging, case management, communication, privacy and security, and reporting and analytics.
- ❖ As with the 90/10 enhancement, costs are to be allocated between Medicaid and the Marketplace, using a methodology in an approved APD. Partnership states transitioning to SBMs are to follow the same cost allocation principles as SBM states. Establishment Grants can fund the Marketplace share. FFM states, as well as Partnership states without the intent to transition, cannot use Establishment funds for functions solely related to Medicaid. However, these states are still eligible for the human services exception. In no case can Establishment Grants be used as the state Medicaid matching share.

To speed the APD process so that projects can meet tight ACA deadlines, CMS also created an expedited ADP checklist and template to simplify and streamline submissions and approvals.<sup>126</sup> If states intend to include common E&E needs of other human services programs, they must supplement their submission with a detailed narrative discussing which programs will be included, how the project will be phased, and which staff will be involved.

### Cost Allocation Methodologies

As noted previously, a cost allocation plan for ACA implementation must reasonably and consistently apportion expenses among programs in proportion to benefits received. States have considerable flexibility to determine the procedure used to measure benefits, so long as the calculation is transparent, fair, and evidence-based. These choices can have profound implications for resulting reimbursements. Broadly speaking, state cost allocation methodologies fall into four categories.<sup>127</sup>

**1. Caseload:** Perhaps the simplest approach to distributing system costs is to count the number of users. States employing the caseload method use population projections for Medicaid and Marketplace enrollees and divide costs proportionally.

- ❖ These estimates can be subject to considerable uncertainty. Opting for this approach requires deciding what assumptions are reasonable and what timeframe should be used, as early enrollments are likely to differ from the insurance market's steady state.
- ❖ With regard to Medicaid projections, it is important to account for existing Medicaid beneficiaries, who will also become system users as their cases come up for recertification. A related challenge is accounting for churn—the movement of people into and out of

Medicaid as their circumstances change. (See Part II for a more detailed discussion of churn in Illinois.)

- ❖ Both New York’s and Colorado’s cost allocation plans rely upon simple projections of the relative shares of SBM and Medicaid users. Nevada uses 2016 population projections.

**2. Technical:** A second popular cost allocation method focuses on the technical side of systems development. Programs are charged for the system features they use. Typically, this approach relies upon the detailed business process requirements documents produced early in the systems development life cycle (SDLC). System functions and their sub-functions—often down to a highly specific level of detail—are divided amongst the programs that utilize them. Programs are assumed to benefit in proportion to the number of system features they demand. A more nuanced version of this approach first identifies cost per functional area, then divides function costs by program use for each function separately.

- ❖ Though the technical approach has an “objectivity” advantage, in the sense that it is based on hard facts rather than projections, simple counts of system functions may misrepresent the intensity with which features are used. Adopting a technical approach requires consideration of ways in which business functions should be weighted and aggregated.
- ❖ A further limitation is that this approach uses a strictly technical measure to distribute costs, such as staff time, that may not be technology-based.
- ❖ California apportions costs based on a simple count of system requirements by program.
- ❖ Rhode Island also allocates costs across functional components, but differentiates between project phases, the first of which deals with Medicaid and the Marketplace, and the second of which focuses on Medicaid and other human services programs.

**3. Resource:** The resource-based methodology falls somewhere between the first two. Rather than attempting to calculate the number of users or number of features attributable to a program, the resource approach looks at the interaction between users and usage to determine the demands each program’s population places on the overall system. One way to measure such demands is to examine the share of staff time spent on each program: random moment study (RMS) is a commonplace technique many states use to allocate administrative expenses. Alternatively, or in conjunction, states can use the reporting capabilities of newly established IT systems to track transactions. Massachusetts, for instance, allocated its DD&I costs by apportioning its system into 19 work orders, then dividing costs according to the amount of work necessary for each program.

- ❖ Though this approach is attractive in that it deals with actual, as opposed to hypothetical, system use, it is likely the most complicated to implement.
- ❖ Further, its accuracy and representativeness depend upon the assumption of insurance market equilibrium—that is, consumer mixes and usage patterns that are relatively consistent over time. The early years of the ACA are likely to be a time of flux. As a result, this method is perhaps better viewed as a long-term standard.

**4. Hybrid:** Many states mix the three main cost allocation methodologies to varying degrees. Some use multiple approaches to supplement each other, while others employ different methods at

various stages of system implementation. Still others take a hierarchical approach—using one methodology for a high level division of costs and a second for more detailed refinements.

- ❖ Minnesota first divides its system into discrete modules, and then within each module projects the user population.
- ❖ Similarly, Oregon and Washington determine system cost and relative program use by function, then within each function weight program shares by projected user populations.
- ❖ Connecticut’s plan also displays a variation of this theme, first summing system components by function, then attributing functional components to Medicaid, the Marketplace, or both. For shared components, splits are based on projected populations.
- ❖ For M&O costs, Massachusetts uses a caseload approach to allocate system resource costs and a technical approach to allocate system support costs.

Of course, all cost allocation methodologies are estimates and subject to revision when better data becomes available. CMS has directed states to submit APD updates as project scopes are revised, as systems go online and subsequent upgrades are released and as actual enrollment numbers come in.

From a state budget perspective, the most important aspect of cost allocation is the degree of Federal reimbursement it achieves. Among the ten states whose ACA cost allocation methodologies we reviewed, there was surprisingly little variation in either method or results. In general, Medicaid reimbursement ranged from 17 percent in California to 42 percent in Minnesota. The two states with higher reimbursement are exceptions rather than rules. Unlike the other states, Massachusetts’ reported 60/79 percent reimbursement levels pertain to M&O, not development, complicating comparisons. Similarly, Rhode Island achieved 83 percent reimbursement in its second phase. However, this phase deals only with Medicaid and other human services programs, not the Marketplace, so higher reimbursement would be expected. Again, a comparison is misleading. In summary, it appears states have been able to charge about a third of ACA systems development costs to Medicaid.

**Table 7: Medicaid Cost Allocation Methods & Results**

State	Methodology	Medicaid Share
New York	Caseload	30%
Colorado	Caseload	33%
Nevada	Caseload	35%
California	Technical	17%
Rhode Island	Technical	36% (phase 1); 83% (phase 2)
Massachusetts	Hybrid	DD&I: unavailable M&O: 79% (resource); 60% (support)
Minnesota	Hybrid	42%
Oregon	Hybrid	30%
Washington	Hybrid	32%
Connecticut	Hybrid	30%
Illinois	Technical	75%

## Cost Allocation Considerations

Taken together, Federal regulations, enhanced funding opportunities, and lessons from other states suggest several key considerations should guide Illinois' ACA cost allocation strategy.

**1. Comply with Federal standards.** Regardless of the methodology chosen, Illinois' cost allocation plan must be reasonable, consistent, and based on verifiable data.

**2. Use cost allocation strategically to maximize Medicaid reimbursement.** This principle is not unique to ACA implementation. Maximizing Federal funding is good budgeting. Regardless of the ultimate form the health insurance market takes in Illinois, deep budget challenges will remain for the foreseeable future. Using cost allocation to expand Medicaid reimbursement to the extent allowable under Federal rules will reduce the demands on other revenue sources, freeing resources for other critical government functions.

**3. Act quickly to capitalize on enhanced funding opportunities.** Time is of the essence. Both the 90/10 DD&I match and the human services exception expire December 31, 2015. The sooner the State acts to develop an SBM—and the more other human services programs are integrated with it—the greater will be State savings and efficiencies. Better still, the operational advantages of integrated human services E&E systems extend beyond the dollars saved through cost allocation.

**4. Invest in long-term benefits.** In the near-term, cost allocating development to Medicaid represents a cost to the state. Even at 90 percent, Medicaid reimbursement is less generous than the 100 percent funding provided by Marketplace Establishment Grants. This cost should be seen as a down payment; Establishment Grants will expire. When they do, states will bear the full cost of Marketplace operations while Medicaid reimbursement for E&E will remain at 75 percent. For activities outside E&E, the traditional 50 percent Medicaid match will apply. Although development is more costly than annual maintenance, maintenance will continue indefinitely. In the long-run, cumulative operational savings due to Medicaid will easily exceed upfront development costs.<sup>xv</sup> Prudent planning thus suggests maximizing the share of costs allocated to Medicaid.<sup>xvi</sup>

**5. Incorporate the full range of costs.** While the focus of ACA implementation is understandably on IT systems development, it is important to remember cost allocation does not apply strictly to computers. All costs, including personnel, facilities, and call centers, can and should be cost allocated to maximize reimbursement. Equally important, Illinois must not neglect regular Medicaid administrative reimbursement. Just because a particular feature or activity doesn't qualify for enhanced funding doesn't mean it is ineligible for a match. Traditional 50 percent Federal participation is better than nothing. Marketplace functions reasonably shared with Medicaid should be allocated and claimed accordingly—especially once the Establishment Grants expire. Finally, once the initial hurdles are cleared, Illinois should consider incorporating other human services programs—such as childcare or child welfare—into the E&E framework created under the ACA,

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<sup>xv</sup> All that is required to break even is for 75 percent of cumulative maintenance costs to reach 10 percent of total development costs.

<sup>xvi</sup> It is conceivable that a state could pursue a strategy of maximizing Establishment Grant funding for DD&I, then update its cost allocation plan to maximize Medicaid when the system became operational. However, such an approach is of dubious credibility and would be likely be scrutinized by Federal oversights, if not rejected outright.

particularly while enhanced funding remains available. Doing so expands efficiencies that shared E&E systems make possible and creates additional savings.

**6. Consider the implications of marketplace governance.** How the SBM is organized and staffed has implications for Medicaid claiming. The tighter the integration between the Marketplace and HFS is, the greater the opportunities to draw down Medicaid matching funds will be, as activities carried out under the auspices of the designated state Medicaid agency are generally privy to more advantageous claiming standards.<sup>xvii</sup>

**7. Make prudent choices about State matching funds.** Although Federal funding for ACA implementation is plentiful, the State must still pay its share. Determining which revenue sources will fund the State share can have important budgetary implications. Though governmental accounting rules constrain these choices, flexibility remains. Using operating revenues from the General Fund may have the lowest total cost but will squeeze other budget items. Newly designated revenue streams can avoid this trade-off while increasing transparency. On the other hand, ACA implementation is a long-term investment that may be appropriate for capital financing—so long as the bonding costs are reasonable.

### Cost Allocation in Illinois

#### *Where is Illinois Today?*

So what does cost allocation for Illinois' ACA implementation look like? With HIX in a holding pattern, the focus of cost allocation to date has been IES. As described in the State's Establishment Grant submissions and in IAPDs for IES, the first of which was approved March 26, 2012, Illinois has adopted a technical cost allocation methodology, apportioning IES' approximately 700 functional elements among benefiting programs. Based on these calculations, 74.5 percent of IES costs were allocated to Medicaid and 19.1 percent to the SBM, with the remaining 6.4 percent attributed exclusively to TANF and SNAP and split evenly between them.<sup>128</sup>

The level of Medicaid reimbursement for IES—subsidizing fully three-quarters of development—is considerably higher than the norm we observed in the other states we reviewed. This is primarily attributable to two factors.

First, Illinois already had an integrated, albeit outdated, eligibility system for Medicaid, TANF, and SNAP. As a result, upgrading Medicaid systems to comply with the ACA necessarily required upgrading TANF and SNAP as well if the State's human services apparatus was to remain functional. From a claiming perspective, this is an advantage, enabling Illinois to emphasize both the human services cost allocation exception and the enhanced 90/10 Medicaid match in its planning. Where possible, ACA-related development is framed as a Medicaid requirement, with benefits to TANF, SNAP, and, to a lesser degree, HIX accruing incidentally and without increasing project scope beyond that which was already demanded by Medicaid.<sup>129</sup> Because system features necessary for Medicaid need not be allocated to other programs, this has the effect of increasing Medicaid reimbursement.

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<sup>xvii</sup> Although HFS is the designated State Medicaid agency, and thus bears primary responsibility for the administration of Medical Assistance Programs, DHS—the agency charged with overseeing Illinois welfare and social service programs—assists in processing Medicaid applications.

The second reason for impressive Medicaid claiming is less unambiguously positive. In both project management and public presentation, Illinois has deliberately divided ACA implementation into two distinct projects, IES and HIX. Partly, this is an operational necessity, as proceeding with HIX development is contingent upon the Legislature approving the Marketplace legislation. The State could not afford to delay IES as the political process unfolds.<sup>130</sup>

Nevertheless, separating the projects has implications for cost allocation, not all of which are ideal. On one hand, IES reimbursement is likely higher than it would be in a consolidated project. At the same time, however, project segregation has the practical effect of framing HIX as independent from Medicaid. In fact, as of the State's Level 1, Phase 3 application, HIX was not cost allocated to Medicaid at all. Therein lies the danger: overemphasis of project silos can impair claiming opportunities.

Given that IES and HIX will be intimately integrated, both in terms of user experience and HIX's reliance on IES' rules engine, it is conceivable that what is currently framed as SBM-specific will also benefit Medicaid, making it appropriate for cost allocation. Aspects of HIX that appear particularly appropriate for Medicaid reimbursement include: eligibility and verification functions, user portals, and account management (including security and privacy). Both Medicaid and Marketplace users will interact with these system functions in a similar fashion. Similarly, underlying technical components, such as systems architecture, data stores, and information exchange interfaces, are ripe for cost allocation, as both IES and HIX will rely upon them. The same applies to testing and training: Illinois must be sure IES and HIX work together seamlessly and that State staff understand how to use the system as a whole. Finally, while HIX and IES are expected to have their own call centers and appeals processes, the two will have a significant degree of overlap, suggesting additional claiming opportunities.<sup>131</sup>

On the other hand, several features of HIX will be confined mostly or entirely to the Marketplace. These features are not appropriate for Medicaid claiming. Plan management, which consists of the processes through which DOI evaluates, certifies, monitors, and renews QHPs offered by insurers, is one prime example. Another is financial management, which will entail calculating, billing, collecting, and disbursing premiums and subsidies. Much of consumer assistance is also likely to be specific to the Marketplace—and to the extent that it is, the Marketplace alone must pay for it.

#### *Where Does Illinois Go from Here?*

At this stage, the fate of health reform in Illinois is unclear. As both IES and HIX progress (or fail to), Medicaid's relative cost share will also evolve. Although Illinois' current cost allocation formula maximizes Medicaid reimbursement at a level exceeding most other states, the State must be diligent going forward to ensure a favorable balance remains. Different considerations will apply depending on whether Illinois transitions to an SBM or becomes an FFM.

An SBM is expected to be less costly to Illinois taxpayers than an FFM. However, the long-term financial sustainability of an SBM depends on Illinois' ability to generate revenues. To the extent these revenues can come from Federal Medicaid reimbursement, Illinois Marketplace participants and taxpayers will see even greater savings. In this manner, Medicaid maximization can smooth the transition to SBM self-sufficiency.<sup>xviii</sup> But the smoothing benefits extend beyond relieving the

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<sup>xviii</sup> Assuming Marketplace legislation passes during the 2014 legislative session, Illinois' will be an SBM beginning in in 2016. Under the ACA, SBM operations are required to be self-sustaining by January 1, 2015, but

demands on other funding sources. Medicaid can also be a more predictable financing mechanism, adding funding stability during the Marketplace's uncertain early years. At the same time, cost allocation during development may allow Illinois to set aside some Establishment funds to create an operating reserve, which can further reduce growing pains.

As an SBM, the main cost allocation challenge will be maintaining elevated Medicaid reimbursement as the focus shifts to HIX. From a cost allocation perspective, it is essential to frame IES-HIX as a single project and claim Medicaid aggressively where functions or user experiences are shared. In particular, the State should bear in mind that all Medicaid recipients—not just the newly eligible—will eventually be processed by the IES-HIX system. Along similar lines, it is important to account for churn, which suggests simple point-in-time counts of Marketplace users will *understate* the share of Medicaid beneficiaries, as a non-trivial subset of Illinoisans will cycle between private and public coverage during the course of a year. Medicaid recipients may also use the system more intensively.

One way to stabilize current Medicaid reimbursement is to incorporate caseload projections in the cost allocation methodology. The reason is straightforward. By 2017, Illinois' current Medicaid caseload of three million is expected to grow by about half a million, while some 1.4 million Illinoisans are expected to obtain Marketplace coverage.<sup>132</sup> Although these projections are subject to demographic, economic, and insurance market uncertainty, a simple caseload share calculation (3.5 million divided by 4.9 million) suggests there are empirical justifications for Medicaid to retain a significant portion of overall implementation costs as HIX proceeds—perhaps even near its current three-quarters level. When it comes to cost allocation, complexity can be a good thing, as overly simplistic rules of thumb—such as splitting costs 50/50 between Medicaid and the Marketplace—are prone to leave revenue on the table, if they are approved by HHS at all.

But it is also possible Illinois will revert to an FFM. While Marketplace legislation is pending, the State should continue to leverage Establishment Grant revenue for systems development. If Marketplace legislation ultimately fails to pass, the State must revise its cost allocation methodology by removing the Marketplace share—which will also have the beneficial effect of maximizing Medicaid reimbursement for operations.

#### *The Importance of Cross Agency Collaboration*

Successful implementation of the ACA requires the close cooperation of the Governor's Office, HFS, DHS, and DOI, as well as other affected State entities. With regard to cost allocation, this can become a sensitive issue.

Medicaid comes with a match. While Illinois as a whole benefits from increased Medicaid cost allocation, the demands on the Medicaid budget become larger. 75/25 operating funding is a great deal for the State, but the 25 must come from somewhere. As the State Medicaid agency, this somewhere is likely to be HFS. Consequently, HFS' budget should be enlarged commensurately. State matching funds necessary to draw down Federal reimbursement should be calculated and added to the HFS budget on a regular basis. Doing so not only ensures HFS is not unfairly forced to self-fund a cross-agency benefit, but it also reflects, in a tangible way, the services HFS is providing

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development costs remain eligible for Establishment Grant funding. The deadline for Establishment Grant applications is October 15, 2014. Level One Establishment Grants are available for one year from the date of award. Level Two Establishment Grants are available for three years from the date of award.

for the other players in Illinois ACA implementation. The more Medicaid takes on costs, the more it should be compensated.

Of course, such funding “increases” to HFS are in reality a cost savings to the State; by shifting more spending to HFS, Illinois as a whole is spending less than it otherwise would on health reform. The situation is not unlike a “buy one, get one half off” deal at the movie theater. One party initially pays more to achieve collective savings; when the second reimburses the first, both share in the benefits. By treating Medicaid as the foundation upon which HIX will be built, Illinois maximizes its chances for long-term savings. Doing so fairly and effectively requires the State agencies involved to communicate and work together.

### Key Points & Recommendations

The foregoing discussion makes clear that, while cost allocation can be a complex and technical endeavor, Illinois has thus far done an exemplary job of maximizing Federal reimbursement for ACA implementation. However, challenges remain—particularly given the uncertainty surrounding Legislative approval of a State-based Marketplace. The following recommendations provide a checklist of key cost allocation principles the State should bear in mind as it confronts these challenges.

- ☑ Illinois should adopt a cost allocation methodology that **maximizes Medicaid reimbursement**.
- ☑ Illinois should act as quickly as possible to transition to an SBM and **take advantage of time-limited enhanced funding opportunities**.
- ☑ Illinois’ cost allocation plan should be **comprehensive**, including activities beyond IT, and **forward-looking**, emphasizing long-term savings—even those that require short-term costs.
- ☑ Illinois should establish a formal **cross-agency process** to collaboratively (1) identify opportunities Medicaid reimbursement and (2) transfer, to the HFS budget, the State matching funds necessary to draw down savings.
- ☑ Illinois should **keep up the good work**: few states have received as much Medicaid funding for ACA implementation; the challenge will be to maintain it.



## Conclusion

The *Get Covered Illinois* team has built a solid foundation for a future State-based Marketplace—we applaud their tireless efforts and congratulate them on the progress they have made in this first year of open enrollment. We have prepared this report with the hope that it will help *Get Covered Illinois* in their transition to a State-based Marketplace, assuming Illinois enacts the legislation needed to do so.

We encourage the *Get Covered Illinois* team to further expand the role of Navigators to improve consumers' insurance and health systems literacy and to assist consumers churning between Medicaid and the Marketplace. We also recommend establishing health-related certification programs in partnership with local higher education institutions for Navigators who wish to build a career in this field. The marketing needs of the State's Marketplace will change with time; we have provided an outline of these changes for the next few years. We have also provided ideas for further enhancing the State's evaluation measures with its increased autonomy as an SBM.

As for funding a new SBM, we encourage the State to take full advantage of all Federal grant opportunities and recommend enacting a broad-based assessment on premiums, with a single assessment rate for all plans. We discuss the need for continued and robust funding for consumer assistance and marketing, and urge the State to take steps to maximize revenue gained through relevant cost allocation processes and practices.



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