TESTIMONY

OF THE

ILLINOIS STATE MEDICAL SOCIETY

BEFORE THE

ILLINOIS HEALTH BENEFITS EXCHANGE

LEGISLATIVE STUDY COMMITTEE

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The Illinois State Medical Society would like to take this opportunity to comment on the State of Illinois current activity with respect to the establishment of a Illinois Health Benefits Exchange consistent with the federal Patient Protection and Affordable Care Act (ACA).

A health benefits exchange has the potential to be a valuable method for obtaining health insurance for a large number of Illinois citizens. Given the importance of the exchange, the overriding goal of the exchange should be to foster fair competition among health plans so that individuals have a wide range of options that fit their individual preferences based on consistent information that allows plan comparison.

Governance

ISMS prefers either establishing the exchange within an existing state agency or as a public-private board as opposed to a wholly independent entity. A public private entity would give the exchange flexibility while allowing the state to retain oversight. Regardless of the specific governance structure, it is imperative that practicing physicians be explicitly included in governance structure and governing board along with broad representation of other key stakeholders.

Scope of the Exchange

ISMS believes that the exchange should be open to all qualified plans that meet the ACA criteria as well as the additional exchange transparency requirements discussed below. The exchange should focus on developing the tools to allow consumers to make informed choices rather than directly negotiating prices with health plans. If the exchange is negotiating prices and other issues, patient choice may suffer as certain plans would not be offered on the exchange. An open exchange might encourage new entrants in the concentrated Illinois market, and having the exchange attempt to become a purchaser would only impede such a development.

Qualified Health Plans

The exchange's primary objective should be to maximize health plan choice and provide meaningful information on health plan options so individuals and families can make an informed decision. ISMS believes that patients should have access to a health benefit plan that includes catastrophic coverage as well as preventive services, appropriate screening, primary care, immunizations, and prescription drug coverage. It is our position that individuals should determine what coverage best suits one's individual needs and, therefore, the coverage parameters such as first dollar coverage, deductibles, and the preferred setting for services, etc., could vary according to individual needs and preferences. As a result, the exchange should not restrict the plans offered through the exchange and instead should promote a diverse offering.

We are hopeful that the federal government will allow sufficient flexibility for its criteria for what constitutes a qualified health plan and it will allow the exchange to offer a wide range of plans, including policies that make consumers more cost conscious. Currently many patients pay little or nothing for the health care services they receive and do not know – let alone care – about the costs of their treatment or the various settings in which such care can be rendered. Policies

should be structured to include transparent payment schedules and a combination of deductible, coinsurance, and copayments in order to make patients conscious of the costs of the health care services they are seeking.

Allowing individuals to choose from a variety of plans will have other benefits a well. The exchange has the potential to provide greater choice and transparency than what many individuals currently experience. For individuals receiving employer sponsored insurance, they are limited to the plan selected by their employer. Therefore when physicians and their patients have difficulty receiving approval for treatment the patient has little influence with the health plan because the employer is the customer, not the patient. While the exchange will initially apply only to individuals and small employers, it may serve as a model to empower individual patients to hold plans responsible for their service to patients as opposed to meeting the needs of employers. We see this unresponsiveness especially with plans that choose not to contract with some hospital based physicians. The plan will cite a hospital as in-network and patients only find out when they receive hospital based care that the network is a charade with groups of specialist physicians are not a part of the network. Transparency and competition will allow patients to review health plan practices and to make informed choices regarding which plans best meet their needs.

Exchange Financing

When the exchange becomes self supporting in 2015, ISMS believes that the current Illinois Comprehensive Health Insurance Plan (ICHIP) assessment process should serve as a financing model for the exchange. An assessment on the health plans would be appropriate as the health plans would in effect be paying for a service to market and sell their plans via an online marketplace. The health plans would pay a fee for each plan sold through the exchange just like they currently pay brokers.

ISMS opposes any physician assessment to finance the exchange. Proponents of physician taxes have argued that since more of their patients will have health insurance coverage due to health care reform, physicians will experience a "windfall" of revenue. Such thinking is misguided because there is no assurance that physicians will experience higher net income, and this is especially true when patients obtain Medicaid coverage that sometimes does not even cover the costs of providing care. It is more likely that the health plans will see increased business and benefit in other ways such as by having the exchange perform some of the functions currently performed by health plans such as collecting premiums and distributing information about their plans. Therefore, physicians should not be the funding source for an exchange.

Physician Participation

The vast majority of Illinois physicians contract with several health care plans, but all too often physicians face take it or leave it contracts where health plans refuse to negotiate. Because of the negotiating imbalance between health plans and physicians, often times the only recourse a physician has is to not sign the contract. Therefore, we believe that it will be imperative that physicians maintain their freedom to contract with health plans. Physicians should not have their participation in a health plan offered via the exchange tied to participation in the other plans

offered via the exchange. The ISMS would strongly oppose any requirements for participation in all qualified health plans or Medicaid as unduly restricting a physician's freedom to practice as it would totally eliminate what little ability physicians currently have to negotiate fair contracts with health plans.

Quality of Care Standards

Some exchange proponents see the exchange as an opportunity to impose quality guidelines, best practices, comparative effectiveness research, and other mechanisms on physicians all in the name of quality improvement. The ISMS cautions against the exchange becoming involved in such programs. While the exchange can provide the opportunity to improve the health care provided to patients, ISMS is concerned that "quality measures" often can be used as nothing more than cost containment mechanisms. If the exchange does become involved in regulating quality it will be imperative that health insurer performance standards should also be developed. ISMS believes that the following non inclusive criteria developed by the AMA should be considered in evaluating the quality of a health plan:

- Practicing physicians, physician organizations, and consumers are involved in the development, evaluation and refinement of the program measures (e.g. AMA Physician Consortium for Quality Improvement (PCPI) physician measures).[1]
- The measures shall be representative of the full range of services typically provided by health insurance issuers, including preventive services.
- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers.
- An analysis of health insurance issuer performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed.
- Performance data used to compare performance among health insurance issuers shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status.
- Health insurance issuer performance data that are self-reported by health insurance issuers shall be verified through external audits.
- The methods and measures used to evaluate health insurance issuer performance shall be disclosed to health insurance issuers, physicians and other health care providers, and the public.

[1] The PCPI is a national, physician-led initiative dedicated to improving patient health and safety by: (1) identifying and developing evidence-based clinical performance measures and measurement resources that enhance quality of patient care and foster accountability; (2) promoting the implementation of effective and relevant clinical performance improvement activities; and (3) advancing the science of clinical performance measurement and improvement. The PCPI develops, tests, implements and disseminates evidence-based measures that reflect the best practices and best interest of medicine.

- Health insurance issuers being evaluated shall be provided with an adequate opportunity to review and respond to proposed health insurance issuer performance data interpretations and disclosures prior to their publication or release.
- Effective safeguards to protect against the unauthorized use or disclosure of health insurance issuer performance data shall be developed.
- The validity and reliability of health insurance issuer performance measures shall be evaluated regularly.
- Health insurance issuers do not have requirements that permit third party interference in the patient-physician relationship.
- Health insurance issuers do not sponsor tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors.
- Health insurance issuers provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.
- Health insurance issuer benefits are designed with input from patients and actively practicing physicians.
- Treatment decisions are driven by the patient and physician.

In addition, to ensure the quality of care, ISMS supports the AMA's health insurer code of conduct principles. These principles outline how to prevent some of the worst health plan abuses. These principles focus on important issues such as access to care, fair contracting and patient confidentiality, medical necessity, benefit management, administrative simplification, physician profiling, corporate integrity, and claims processing. The Health Insurer Code of Conduct Principles are attached.

Transparency of Information

The exchange will need to provide consumers with a great deal of information to assist them in making an informed choice. Information such as the composition of the provider network including accurate provider listings, and services that are included and excluded will be essential. We understand that the exchange will serve a wide range of individuals with varying levels of understanding. The exchange will not only have to present information in easy to understand language for those who may not be familiar with health insurance, but at the same time allow interested consumers to have access to more detailed information.

One of the key pieces of information that consumers will want to obtain from the exchange is details on the adequacy of the physician network. Specifically, they will want to know if a particular physician or local hospital is part of the network. It will be incumbent upon the exchange to explain what it means to be in-network and the relationship between an in-network hospital and the physicians that provide health care at the hospital. All too frequently we see health plans contract with the hospital but not contract with certain hospital based specialties.

Patients may not choose a particular physician from the hospital based specialties of radiology, pathology, emergency medicine or anesthesia but patients should know to what extent a particular health plan has contracted with physicians from these specialties at individual hospitals. Simply listing a hospital as in-network is not sufficient. Specific information on

which physicians provide care at a hospital would help individuals to determine if the health plan has sufficient physicians in the health plan's network. Providing this information would be consistent with the ACA requirement that plans report information on out-of-network policies as well as the requirements of providing adequate provider networks.

In addition to information about the network of providers, the exchange will need to develop a standardized comparison tool with a variety of health plan information. A template developed by the Texas Medical Association can serve as model. The template would require the reporting of:

- Monthly premium;
- Percent of expense paid by plan in-network;
- Percent of expense paid by plan out-of-network;
- Annual out-of-pocket cost:
- Patient total annual cost;
- Justified complaints;
- Premium to direct patient care ratio; and
- Benefit levels, including:
    - Annual deductible;
    - Annual family deductible;
    - Annual in-network deductible;
    - Annual out-of-network deductible;
    - Annual out-of-pocket maximum;
    - Office visit copayment (primary/specialist);
    - RX co-payment;
    - Emergency room visit copayment;
    - Mental health;
    - Outpatient surgery copayment; and
    - Inpatient cost sharing.

Additional information that plans should be required to disclose to patients include utilization data such as:

- Number of hospital admissions per thousand enrollees in the last year for outpatient, manageable, preventable conditions, including but not limited to community acquired bacterial pneumonia, asthma, and diabetes;
- Number of emergency department visits per thousand enrollees in the last year;
- Number of preventive services, such as immunizations, which reduce the need for later, costlier interventions;
- Percent of out-of-pocket costs incurred by enrollees for emergency department visits as a percentage of total enrollee out-of-pocket costs;
- Number of visits to out-of-network providers per thousand enrollees in the last year;
- Percent of services received from in-network providers as a percentage of total services received by enrollees; and
- Percentage of total costs for in-network and out-of-network services received by enrollees which were paid for by the health insurance issuer.

Health Disparities

The elimination of racial and ethnic disparities in health care is an issue of highest priority for the ISMS. The ISMS supports the importance of culturally effective health care in eliminating disparities and exploring ways to provide physicians with tools for improving the cultural effectiveness of their practices. The cost and coverage of interpretive services is one hurdle that has hindered physicians' ability to care for the hearing impaired and non-English speaking patients. Adequate coverage and payment for interpretive services is a solution to one health care disparity problem. Also, the streamlined enrollment process for Medicaid, CHIP, and exchange plans will help to address health care disparities by enrolling more patients and by promoting continuity of care for these patients.

In summary, ISMS requests the General Assembly to consider establishing an exchange that provides patients with meaningful information that allows them to make an informed choice. By providing patients with meaningful health plan data that will allow plan comparisons, competition will increase as will health plan accountability and service.

We look forward to working with you and other interested parties toward establishing an Illinois Health Benefits Exchange that will improve access to care for all Illinois citizens.