

**State of Illinois  
Department of Public Health  
Adequate Health Care Task Force**

**Updated Coverage Expansion Model  
(Modified 7<sup>th</sup> Hybrid Model)**

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Draft and Preliminary**



**NAVIGANT**  
CONSULTING

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## SECTION I: OVERVIEW

The 2004 Illinois General Assembly, under Governor Blagojevich, enacted the Health Care Justice Act, which established the Adequate Health Care Task Force (“Task Force”) and charged it with developing a policy strategy to ensure that all Illinois residents have access to affordable quality health care starting in 2007. According to the Act:

*“...on any given day an estimated 1.8 million Illinoisans are without health insurance and, according to a March 2003 Robert Wood Johnson study, nearly 30 percent of the non-elderly Illinois population (3,122,000) during all or a large part of 2001 or 2002 were uninsured; a growing number of Illinoisans are under-insured, the consumer’s share of the cost of health insurance growing and coverage in benefit packages is decreasing...”*

Pursuant to the Health Care Justice Act, the Illinois Department of Public Health engaged Navigant Consulting, Inc. (Navigant Consulting) to assist the Task Force in developing an overall strategy for providing affordable, quality health care to all Illinois state residents, in accordance with the Health Care Justice Act. Navigant Consulting’s team includes Mathematica Policy Research, Inc. (MPR) and Milliman, Inc. and we refer to this team in the remainder of this document as the “Consulting Team”.

### **Development of the Health Care Coverage Expansion Model**

In May 2006, the Task Force selected five proposals for the Consulting Team to evaluate and requested that the Consulting Team develop a sixth proposal for the Task Force’s consideration – a hybrid model – which would combine features from the five proposals that would address the Task Force’s interests and objectives and rely on best practices and innovations from other states’ approaches.

The Consulting Team presented the evaluation of the five proposals and the sixth hybrid model at the July 25, 2006 Task Force meeting. Subsequently:

- The Task Force requested that the Consulting Team created a seventh model that included modifications to the previous hybrid model to reflect “high” and “moderate” consensus items; Task Force members identified and ranked these consensus items by vote during the August 15, 2006 Task Force meeting. These consensus items are included as Appendix B.
- The Consulting Team presented the seventh model to the Task Force on September 26, 2006. Reflecting the different approaches that could be used to achieve the Health Care Justice Act’s goals and the Task Force’s consensus items, the revised model included both a voluntary and a mandatory approach to coverage, and two options for implementation of the premium

assistance component, one which relied solely on the private market (Option A) and one which relied on a public/private market combination (Option B).

- The Steering Committee provided instructions to the Consulting Team for further modifications to the 7<sup>th</sup> hybrid model that reflected the discussions at the September 26 meeting and a series of meetings of eight subgroups.

The coverage expansion approach described here reflects the changes requested by the subgroups and approved by the Steering Committee.

### **Features of the Model**

Under the proposed model, individuals will be required to obtain health care coverage and those under 400 percent of the federal poverty level (FPL) will have subsidized coverage options available to them. It is expected that all employers will contribute to the health care costs of their workers. Employers may meet this obligation either by providing a voluntary health insurance plan or by paying an amount to the state that is scaled to wages. Changes to insurance regulations are designed to spread risk, stabilize premiums and reduce administrative costs for all Illinoisans. Implicit in the proposed model is the recognition that the substantial funding is required to accomplish the Act's goals.

The main goals of the proposed health care coverage expansion model are to:

- Comply with the Health Care Justice Act
- Preserve the current employer-based coverage system with its employer contributions and benefits of personal income tax and Federal Insurance Contributions Act (FICA) exemptions
- Require personal financial responsibility for health care
- Encourage cost-effective, high quality care
- Minimize administrative spending on health care
- Spread the cost of coverage broadly across workers, employers and taxpayers
- Minimize new State costs through the adoption of policies to promote cost-effectiveness, require an employer contribution to coverage and optimize the use of Federal matching funds

The main features of the model are:

- The current State Children's Health Insurance Program (SCHIP) and Medicaid benefit packages will be maintained.
- A comprehensive, standard benefit package ("Comprehensive Standard Plan") will be available on a guaranteed-issue basis to all individuals and small groups. Under Option A, carriers will be required to offer the Comprehensive Standard Plan in the small group and non-group market if they offer products in those markets; under Option B, a State self-insured plan will provide this package in the small group and non-group markets and carriers may voluntarily offer the package on a guaranteed-issue basis. The State self-insured plan will use Medicaid providers and pay 105 percent of Medicaid rates. The Task Force has not yet recommended the Option that will be included in the final proposal. Given the Steering Committee's October 17, 2006 decision to increase payments for Medicaid providers to 100 percent of costs for current and future public program expansions (with consideration of upper payment limit rules and regulations that apply to various provider groups), the Task Force may want to reconsider whether payment to providers under the self-insured plan in Option B should be set at 105 percent of Medicaid rates as originally proposed.
- All Illinois residents, including undocumented immigrants and non-residents enrolled in Illinois colleges and universities, must obtain qualified health insurance coverage or pay a penalty.
- Public coverage will be expanded to cover additional low-income parents, childless adults with very low incomes and specific disabled populations.
- Employers will be expected to contribute to health insurance coverage for their workers by paying a per worker assessment that will be used to partially cover the cost of the premium subsidies. Employers will receive a credit against this assessment if they provide coverage directly. While the cost estimates (Section X) include an estimate of one potential assessment structure (described in Appendix C), this model does not include a specific recommendation as to the extent of the employer assessment and the specific conditions under which an employer will receive a credit against the assessment.
- Small employers with a majority of low-wage workers are encouraged to offer coverage by allowing them to contribute as little as 50 percent of the cost of single coverage when offering the Comprehensive Standard Plan. Workers with incomes under 400 percent of FPL will be eligible for premium

subsidies to help cover the remaining premium. These employers must enroll at least 75 percent of full-time workers who otherwise do not have evidence of coverage and establish a Section 125 plan, which allows employees to contribute to premiums on a pre-tax basis.

- State-funded premium subsidies will be available for residents below 400 percent of the FPL for employer-based coverage or – if no employer offer is available – for the Comprehensive Standard Plan purchased in the non-group market.
- A number of changes to the insurance market will be implemented to further the goals of the Act and the Task Force, including a reinsurance program for Comprehensive Standard Plan products, minimum medical loss ratios of 85 percent and tighter limits on the variation in a carrier's base rates for all products, and limits on annual rate increases for the Comprehensive Standard Plan. These changes must be viewed in the context of an individual mandate environment, and as such should not be considered stand-alone recommendations.
- The State will establish and administer the *Illinois Health Education and Referral Center (IHERC)* that will operate as an enrollment broker and information clearinghouse on coverage options, premium costs, provider quality, individual health care literacy and other information to educate consumers, as well as make recommendations regarding program monitoring to avoid fraud and abuse.
- Provider payments for current and future public programs will be increased to 100 percent of costs (with consideration of upper payment limit rules and regulations that apply to various provider groups) to enhance access to health care services.
- IHERC will provide web-based information on existing provider quality efforts.
- The State will implement Long-Term Care Partnerships in Illinois to encourage the purchase of long-term care coverage.

Federal matching funds, funding from the employer assessment and individual premium contributions will fund this program along with additional state funding. The Task Force proposes that the legislature identify additional state funding using the broad-based revenue sources available to the state.

This health care expansion approach will extend coverage to an estimated 89 percent of the currently uninsured population (1.5 million out of 1.7 million uninsured), for an overall coverage rate of 98 percent of the non-elderly population. In addition to the new coverage options available to the currently uninsured population, many low-income individuals who are currently insured will also be eligible for premium assistance under the proposal.

For the first full year of program operation, approximately \$3.6 billion (Option A) or \$3.1 billion (Option B) in State funding will be needed, assuming the availability of additional federal Medicaid/SCHIP matching funds and an employer assessment totaling approximately \$1.5 billion. Increases in Medicaid provider payment rates represent an estimated \$769 million or \$1.171 billion of total State costs (Options A and B, respectively)<sup>1</sup>. Total State costs without the provider payment increase are approximately \$2.9 to \$1.9 billion (Options A and B, respectively). To the extent that the employer assessment is structured to collect less funding, the State will need to identify additional state funds.

The following sections provide additional detail regarding plan features and corresponding cost and coverage estimates.

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<sup>1</sup> Does not include funding from Illinois' recently passed provider tax program as this initiative may not be available upon or after expansion implementation. Estimate reflects increases in payments to hospitals and physicians; additional analyses would be needed to determine payment increase to achieve 100 percent of estimated costs for other providers (see Section X for additional detail). Includes payment rate increases totaling \$403 million related to the state self-insured plan in Option B.

## **SECTION II: COMPREHENSIVE BENEFIT PACKAGE AND QUALITY OF CARE**

The proposed expansion model contains provisions to provide residents with access to a full range of affordable quality health care services, as described below.

### **Comprehensive Benefit Package**

The proposed health care coverage expansion model supports access to a full range of preventive, acute and long-term care services in two main ways.

First, the proposed model will maintain the current SCHIP and Medicaid benefit packages for new public program populations. The Medicaid Benefit package will be the same for all populations (although the Deficit Reduction Act of 2005 would allow it to vary), reflecting the Health Care Justice Act's focus on access to a full range of services for all Illinoisans.

Second, a comprehensive, standard benefit package that includes all Illinois mandated benefits will be available on a guaranteed-issue basis to all individuals and small groups. If a product is guaranteed-issue, carriers that offer the product must accept all applicants if they meet the contractual terms of coverage (for example, at least minimum employee participation in a group plan). By federal law, coverage for small groups (2 – 50) is guaranteed-issue in every state, but each state determines whether individual coverage is guaranteed-issue.

The proposed Comprehensive Standard Plan will include acute care and preventive services, and long-term care benefits consistent with a typical commercial package. As such, Medicaid cost-sharing limits do not apply and long-term care benefits will not be as comprehensive as those that Medicaid provides.

### **Two Options for Purchasing the Comprehensive Standard Plan**

The proposed model contains two alternative options for making the new product available to Illinois residents. Under Option A of the proposal, all carriers must offer the Comprehensive Standard Plan in the individual or small group markets if they offer products in those markets. Under Option B, the State self-insured plan will administer and bear the risk for the guaranteed issue, comprehensive product. This plan will use the State's Medicaid provider network and pay providers at 105 percent of Medicaid rates. Carriers may voluntarily offer the package on a guarantee issue basis.

Given the Steering Committee's October 17, 2006 decision to increase payments for Medicaid providers to 100 percent of costs for current and future public program expansions (with consideration of upper payment limit rules and regulations that apply to various provider groups), the Task Force may want to reconsider if

payment to providers under the self-insured plan in Option B should be set at 105 percent of Medicaid rates as originally proposed.

Under both options, premiums will vary by age and location but not by health status or any other factor. In the non-group market, the Comprehensive Standard Plan is the only product eligible for premium assistance (for individuals without an employer offer of coverage).

Appendix B provides a summary of the benefit plan used to model the costs of this benefit package as an example of a typical comprehensive commercial package of benefits that could be used to implement this expansion.

### **Quality of Care**

Components of the coverage expansion proposal will support the ability of the healthcare system to maintain and improve the quality of health care:

- IHERC (the administrative entity that will be charged with the oversight of the coverage expansion) will offer a website providing “one-stop shopping” links to provider quality of care initiatives.
- IHERC will convene a panel of experts to develop quality initiatives and advise IHERC on quality improvement.
- Comprehensive Standard Plan products will be able to prohibit payment for services related to “never events.” Before this policy is implemented, the Task Force recommends further discussion and consideration of “never events” to avoid penalizing providers for events that are not within their control.

**[Note to Task Force: Potentially consider expanding this provision to all insurance plans]**

- The General Assembly should direct the Illinois Department of Public Health to advocate, review and implement standards for digital exchange from the American Health Information Community and the Office of the National Health Care Coordination on Health Care Technology Information. This collaboration will push forward the State’s goal of e-prescribing by 2011.

### SECTION III: INDIVIDUAL MANDATE

The individual mandate will require that all Illinois residents<sup>2</sup>, including undocumented immigrants and non-residents enrolled in Illinois colleges and universities, have qualified health coverage. Children will be included in this mandate and parents will be responsible for ensuring compliance with the mandate on their behalf. For purposes of the mandate, qualified health coverage is defined as:

- Public coverage (Medicare, Medicaid, SCHIP, Illinois Comprehensive Health Insurance Plan (ICHIP), Tricare or other military health coverage and state-only funded programs)
- Employer-sponsored coverage or non-group coverage

To facilitate compliance with the mandate, a new comprehensive insurance product will be offered on a guaranteed-issue basis with premium assistance for those under 400 percent of FPL.

Residents who fail to comply with the mandate will pay a penalty that the State will assess through the State income tax system. Residents and non-resident students must have qualified coverage to enroll in Illinois colleges and universities. The State may allow exemptions from the mandate based on hardship.

The penalty will be based on a percentage of gross income; residents with no income tax filing obligations will not be subject to the penalty. The dollar amount of the penalty will vary. Under Option A, the maximum penalty per uninsured person will be 115 percent of the lowest cost Comprehensive Standard Plan offered in the non-group market by the three largest carriers in the individual's geographic area (for specific age and gender). Under Option B, the maximum penalty will be 115 percent of the average premium for the state self-insured plan (for a specific age, gender and geographic location).

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<sup>2</sup> Except members of Native American tribes.

## **SECTION IV: PUBLIC PROGRAM EXPANSIONS**

The health care coverage expansion model will expand Medicaid and SCHIP for low-income parents and specific disabled populations and provide public coverage for low-income childless adults, as described below.

### **Medicaid Expansions for Selected Disabled Populations**

In this proposed model, the State will expand Medicaid coverage to the following disabled populations as follows:

- Aid to the Aged, Blind and Disabled (AABD) program –Expand income eligibility from 100 percent to 300 percent of the FPL for the blind and disabled.
- Health Benefits to Workers with Disabilities (HBWD) –Increase income eligibility from 200 percent of FPL to 350 percent of FPL and remove asset and spousal deeming barriers. It will also expand Medicaid coverage to former enrollees of the HBWD Program.
- Children with disabilities up to 300 percent of the FPL –Implement a Medicaid buy-in.
- Individuals deemed “probably eligible for SSI” – Reinstated the Interim Assistance Program. This program will allow interim SSI recipients to receive necessary medical coverage by helping them provide evidence to prove eligibility for SSI, thus entitling them to Medicaid.

### **State Children’s Health Insurance Program (SCHIP)**

The State will expand SCHIP coverage for parents from 185 percent of the FPL to 200 percent of the FPL. Because Illinois has already committed all of its federal SCHIP funding to existing coverage, this expansion assumes that the State will make lower-income parents who currently receive coverage through SCHIP eligible for Medicaid by disregarding a certain amount of income from the Medicaid eligibility calculation. The State will then use the “freed up” SCHIP allotment to cover parents from 185 to 200 percent of the FPL.

The expansion to additional low-income parents will require a modification to the State’s current 1115 federal waiver. The State will also either identify savings in the current Medicaid population to maintain budget neutrality (requirement of 1115 federal waiver) or make the low-income parents eligible for Medicaid through a State Plan Amendment, creating a new Medicaid eligibility category. Both approaches will require

approval by the Centers for Medicare and Medicaid Services to ensure continued availability of federal matching funds for the expansion population.

### **New Public Coverage Option for Childless Adults**

The State will cover childless adults and parents ineligible for FamilyCare under 100 percent of the FPL using the Medicaid administrative structure and provider network to provide this benefit. Program costs, however, will not be matched by federal funds. While some states have covered childless adults through Medicaid by identifying savings in their Medicaid programs to expand coverage, Illinois is already using this approach to cover all children in Illinois.

### **Provider Payment Increases**

Provider payments for current public programs for current and expansion public program populations will be paid at 100 percent of provider costs and in a timely manner, with consideration of upper payment limit rules and regulations that apply to various provider groups. Section X describes how this payment increase was modeled for the cost estimates.

## SECTION V: EMPLOYER COVERAGE AND RELATED SMALL GROUP MARKET CHANGES

The health care coverage expansion model emphasizes the need to maximize and support employer participation in health care coverage through:

- Premium assistance for individuals under 400 percent of the FPL that must be used for employer coverage if available; this assistance is more generous in the group market than in the non-group market
- Modest incentives for low-wage, small employers to begin offering coverage
- Small group insurance market changes that spread risks broadly and stabilize premiums
- Employer assessments to establish a baseline level of employer commitment to health care coverage for their workers.

These model features are described below.

### **Premium Assistance for Workers and their Dependents Under 400 percent of the FPL**

Individuals under 400 percent of the FPL who have an offer of employer coverage will be eligible to receive state-funded premium assistance. Premium assistance in the group market will be structured so that the net premium will generally not exceed four percent of family income if all family members are enrolled. This assistance will not include point-of-service cost-sharing which – depending on the level of cost-sharing – may continue to present barriers to care for low-income individuals. Section IX provides additional discussion of this issue.

### **Support for Small, Low-Wage Employers**

Small, low-wage employers may provide the Comprehensive Standard Plan (under Option A) or the State self-insured plan (under Option B) using contribution and enrollment levels that will be less than the levels typically required by insurers. Specifically, small low-wage employers may contribute as little as 50 percent of the cost of single coverage when they offer the Standard Comprehensive product, and no contribution will be required for dependents<sup>3</sup>. However, these employers must:

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<sup>3</sup> The structure of the employer assessment will have to be coordinated with the below-market contribution provision that is being offered to small, low-wage employers in the proposed coverage approach. Small, low-wage employers who cover their workers under that model provision should not be subject to an assessment.

- Enroll at least 75 percent of full-time workers who otherwise do not have evidence of qualified coverage<sup>4</sup>
- Establish a Section 125 plan, which allows employees to contribute to premiums on a pre-tax

The administrative body that will oversee the health care coverage expansion, the Illinois Health Education and Referral Center (IHERC), will provide information on its website for small employers regarding small group products available in Illinois.

### **Small Group Insurance Market Changes**

The proposed model includes specific small group insurance market changes that are intended to spread risks broadly and stabilize premiums in the small group market, as follows:

- Carriers must file small group rates for State review and approval
- For approval, small group rates must reflect a minimum medical loss ratio of 85 percent
- Rates for each product will not vary by more than 130 percent of a carrier's base rate, accounting for all rating factors a carrier may use except geography
- To increase the predictability of future rates increases for guaranteed issue Comprehensive Standard Plan products only, the annual rate increases for this product will not exceed 115 percent of the medical cost trend across each carrier's entire book of small group business.
- Carriers must permit the lower contribution requirement and participation requirements for firms meeting the small, low-wage criteria and offering the comprehensive standard plan to their employees. As already discussed, reinsurance for this product will be available on a voluntary basis.

The Task Force recommends that the General Assembly fund further analyses of these changes to more precisely determine their impact on the insurance market and individuals seeking coverage (Section IX provides additional detail regarding the recommended studies).

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<sup>4</sup> Qualified coverage will include employer group coverage, Medicaid, Medicare or coverage under any other Federal program that finances comprehensive health care services for the worker.

Carrier obligations with regard to the new comprehensive product will vary between Options A and B. Specifically:

- *Option A:* Carriers operating in the small group markets must offer the Standard Comprehensive Plan on a guaranteed-issue basis. Each carrier will set premiums based on the experience for all groups of 2 to 50 enrolled in its Standard Comprehensive Plan product.
- *Option B:* Carriers operating in the small group markets may voluntarily offer a guaranteed issue Standard Comprehensive Plan. If offered, the carrier will set premiums based on the experience for all groups of 2 to 50 enrolled in its Comprehensive Standard Plan product.

To support the small group market, the State will develop and operate a reinsurance program to voluntarily reinsure the guaranteed-issue comprehensive small group and individual products. Like the National Association of Insurance Commissioners' (NAIC) model reinsurance program:

- Insurers must pay a \$5,000 deductible for all individuals, employees or dependents ceded to the reinsurance program, after which the reinsurance program will pay all claims.
- All carriers writing either individual or group coverage in Illinois, as well as other licensed third-party administrators of health benefits plans in the State, will contribute to pool losses (net of reinsurance premiums paid) in proportion to their medical claims paid, including risk and non-risk business.

In addition, similar (but not identical) to the Connecticut and New Hampshire reinsurance programs, premiums will be capped at 400 percent of each carrier's base rate, respectively, for non-group guaranteed-issue products and the Standard Comprehensive Plan for small groups.<sup>5</sup>

### **Employer Assessment**

To place employers on a more equal footing regarding their role in the funding of healthcare, the proposed model requires a minimum level of employer effort that will be required of all employers. Sometimes referred to as "pay-or-play," employers will pay an assessment to the State, with potential assessment exemptions and phase-ins for small employers. Employers will receive a credit against this assessment if they provide at least a minimum level of coverage. The State will use the revenue collected through

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<sup>5</sup>The intent of this provision is to encourage insurers to cede approximately five percent of covered lives to the reinsurance program to help stabilize premiums in the guaranteed-issue product.

the assessment to fund premium assistance for low-income individuals and other state activities associated with the proposed model.

The goals of the employer assessment are:

- Place employers on a more equal footing with regard to their financial commitment to health care
- Provide transition support for very small employers in the form of delayed implementation of the assessment.
- Discourage erosion of traditional employer support for health care coverage.

The proposed health care coverage expansion model described here does not specify the extent of the employer assessment and the specific conditions under which an employer will receive a credit against the assessment. For purposes of the cost and coverage estimates provided in this report and for demonstration purposes only, a potential employer assessment structure is used that initially applies to employers with 25 or more employees and expands to employers with 10 or more employees in the third year of the program). As described in more detail in Appendix C, this sample assessment requires employers to contribute at least 4.8 percent of payroll for their Illinois workers (subject to a cap).

Given the far-reaching implications of the employer assessment on employers in Illinois, the final determination of the parameters for the assessment is identified as another area for further study (see Section IX). Such study should address a wide variety of issues, including:

- Employer incentives to drop or not offer coverage, based on the amount of the assessment
- Whether or not the assessment should reward employers who provide coverage for dependents
- Amount of an assessment as compared to the cost of providing coverage to an employee
- Administrative burden of complying with the assessment
- Impact of the assessment on all employers' finances and, in particular, small employers
- Impact of the assessment on the state's ability to retain employers

To inform decisions regarding the employer assessment, the Task Force also recommends that the General Assembly also fund an analysis to quantify the number of uninsured individuals that are estimated to be covered by this proposal by income level, employer size (under or over 25 employees) and their source of coverage and financing (i.e., premium assistance, new public program or other). Additional studies may also be useful in determining the impact of various employer assessment approaches.

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## **SECTION VI: NON-GROUP MARKET CHANGES**

To facilitate compliance with the individual mandate, individuals will have access to at least one guaranteed-issue insurance product in the non-group market (the Comprehensive Standard Plan). Individuals who do not have an employer offer of coverage and have incomes under 400 percent of FPL will be able to use state-subsidized premium assistance to purchase this coverage in the non-group market (i.e., individual market) if they do not have an offer of coverage from their employer. Insurance market changes will also spread risk and stabilize premium levels in the non-group market.

### **Premium Assistance for Selected Coverage**

If employer-sponsored coverage is not available, individuals under 400 percent of the FPL may apply their premium assistance to Comprehensive Standard Plan coverage in the non-group market. Under Option A, this assistance will be applied only to the guaranteed-issue Comprehensive Standard Plan products available in the non-group market. Under Option B, this assistance will be applied only to the State's self-insurance plan or guarantee issue standard plans voluntarily offered by insurance carriers. Premium assistance in the non-group market will be structured so that the net premium if all family members are enrolled will generally not exceed six percent of family income.

The percentage of income used to determine premium subsidies is higher in the non-group market as compared to the small group market (six percent and four percent, respectively). This differential is intended to encourage the provision of employer-sponsored coverage by making it more valuable to the employees than the coverage they can purchase in the non-group market.

Individuals offered only the guaranteed-issue product(s) of any carrier, or offered a guaranteed-issue product at a higher premium than available in the state's high-risk pool (ICHIP), will be eligible for ICHIP.

Similar to premium assistance for employer-sponsored insurance, the premium assistance in the non-group market will not cover point-of-service cost-sharing which, depending on the final plan design selected for the Comprehensive Standard Plan, may continue to present challenges to access to care for low-income individuals. Section IX provides additional discussion of this issue.

## Non-Group Insurance Market Changes

The model includes specific non-group insurance market changes that are intended to spread risks broadly and stabilize the premium costs, specifically:

- Carriers must file rates for State review and approval.
- For approval, non-group rates for all non-group products must reflect a minimum medical loss ratio of 85 percent.
- Rates for any product cannot vary by more than 130 percent of a carrier's base rate for that product, accounting for all rating factors a carrier may use except geography.

To encourage broad pooling of risk and increase the predictability of future rates increases for the guaranteed-issue, comprehensive product, the annual rate increases for the guaranteed-issue, comprehensive product cannot exceed 115 percent of the medical cost trend across each carrier's entire book of non-group business.

Additional insurance market changes vary according to Option A and B, specifically:

- *Option A:* Carriers operating in the non-group market must offer a guaranteed-issue Comprehensive Standard Plan, and will use the following two separate risk pools, both of which will be adjusted only for age and geographic location:

- Individuals eligible for subsidies
- Individuals ineligible for subsidies

The creation of two separate risk pools is intended to target the premium assistance to the actual costs of the subsidized individual.

- *Option B:* Carriers operating in the non-group group market may voluntarily offer a guaranteed issue Comprehensive Standard Plan. If offered, this product is subject to the pooling restrictions of Option A. Individuals eligible for premium assistance will be able to apply their premium assistance to either the State's self-insured plan or a commercial carrier's guaranteed issue Comprehensive Standard Plan.

To support the non-group market, the State will develop and operate a reinsurance program to voluntarily reinsure guaranteed-issue comprehensive non-group products.

Individuals offered only the guaranteed-issue product(s) of any carrier, or offered a guaranteed-issue product at a higher premium than available in the state's high-risk pool (ICHIP), will continue to be eligible for ICHIP.

The Task Force recommends that the General Assembly fund further analyses of these changes to more precisely determine the impact on the insurance market and individuals seeking coverage. (Section IX provides additional detail regarding proposed studies).

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## VII: ADDITIONAL STRATEGIES TO INCREASE ACCESS TO CARE

The proposed health care coverage expansion includes additional strategies to increase access to care, including long-term care:

- Increase access to providers in underserved areas, by:
  - Targeting State grants for capital investments, health care workers and public health interventions to underserved areas.
  - Increasing access to providers in rural areas in conjunction with the State Rural Health Care Access Plan, and through other efforts demonstrated to improve access in rural areas, such as telemedicine and financial incentives, and medical and nursing school tuition loan forgiveness.
  - Building on two pre-existing programs – the Illinois Medical Student Scholarship Program and the Rural Medical Illinois Assistance Program – to increase the number of providers of color and providers serving underserved areas (using state-only funds and, if available, federal funds) and expanding these programs to emphasize:
    - Supporting scholarship or loan programs
    - Targeting a wide variety of health care professionals (physicians, nurses, mental health professionals, etc.)
    - Supporting faculty positions in health care education (raised as a particular concern for downstate Illinois)
    - Evaluating current “buy out” provisions<sup>6</sup> from the program to determine if they should be made more onerous; funnel money received from these provisions back into the program
- Increase home-and community-based services and reform the State’s long-term care system by:
  - The State will implement Long-Term Care Partnerships in Illinois to encourage the purchase of long-term care coverage. These Partnerships, authorized by the Deficit Reduction Act of 2005, will

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<sup>6</sup> For example, an individual receives a scholarship for medical education in return for working in an underserved area and accepts a position with a different employer who buys the individual out from the obligation.

allow the State Medicaid agency to disregard any assets or resources in an amount equal to the insurance benefit payments into a qualified long-term care insurance partnership policy, for purposes of determining eligibility for Medicaid-funded long-term care services.

- Building on the State's current activities to implement the Older Adult Services Act (OASA) by supporting the Department of Aging's efforts to develop single points of entry for the full range of available long-term care services and restructuring the Medicaid Program's nursing facility payment methodology to create incentives for nursing facilities to provide home- and community-based services.
- Offering incentives or assistance to organizations to create additional adult day care centers, community-based residential facilities and affordable housing with supportive services.
- Increasing collaboration among state agencies that are responsible for institutional and home- and community-based long-term care, including agencies that are responsible for different groups of long-term care users (e.g., elders, nonelderly adults with physical disabilities, adults with behavioral problems with children with physical or cognitive disabilities) and agencies that receive funding from different sources (e.g., Medicaid and the Administration on Aging).

## SECTION VIII: PROGRAM ADMINISTRATION

A number of state agencies will have responsibility for implementing the new coverage options. Primary responsibility will lie with a new state agency, the Illinois Health Education and Referral Center (IHERC), which will operate as an enrollment broker and information clearinghouse on coverage options, premium assistance, premium costs, provider quality, individual health care literacy and other information to educate consumers. A governing board of IHERC will have consumer, insurer and provider representatives as a means of assuring these stakeholder groups' input and participation. This public body will evaluate the coverage expansion's performance and make recommendations for improvement.

IHERC will be responsible for the implementation of new coverage options. This responsibility will include:

- Establishing a premium assistance schedule and oversee premium assistance payments to health insurance carriers.
- Working with carriers to understand issues related to premium assistance payments, including the need to promptly notify IHERC about disenrollment of individuals.
- Assisting with eligibility determinations for and enrollment in the State's premium assistance program
- Providing price comparisons of different insurance carriers' offerings of the Comprehensive Benefit Package in the non-group and small group markets.
- Providing information via the web and telephone regarding consumer coverage options –e.g., providing information to individuals regarding the individual mandate and individuals' specific public and private options for obtaining coverage and the price of that coverage. This information would be specific to an individual or family income level and other characteristics that could determine their coverage options. As part of this effort, IHERC's webpage will include an interactive health insurance and medical assistance decision tree, which will help explain the different coverage options for Illinois residents and their costs.<sup>7</sup>
- Providing price and benefit comparisons of the long-term care policies that carriers offer.

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<sup>7</sup> IHERC could build on the Division of Insurance's Ombudsman and/or the Medicaid Program's Primary Care Case Management enrollment broker as models.

- Providing links to The Department of Public Health’s Consumer Guide to Health Care and other websites associated with quality initiatives (see the discussion on quality improvement below).
- Monitoring and reporting on uncompensated care through existing reporting mechanisms to determine the impacts of coverage initiatives.
- Publishing and updating insurance carriers’ standardized product description and the base rate for each product.
- Reviewing state products, and making recommendations for adoption of proven technologies to identify and address fraud and abuse.
- Reporting on the commercial market’s best practices regarding fraud and abuse and make recommendations for public program fraud and abuse policies.

In addition to IHERC, the Division of Insurance and the Division of Revenue will have responsibilities related to the implementation of the health care coverage expansion. For example, the Division of Insurance will:

- Monitor compliance with medical loss ratio requirements for carriers who offer coverage in the small group or non-group.
- Monitor rates charged by these carriers to ensure that savings are passed through to purchasers of these policies (in conjunction with IHERC).
- Collect information on insurance carriers’ standardized product description and the base rate for each product.
- Under Option A, monitor insurance carriers’ compliance with the requirement to offer the Comprehensive Standard Plan on a guaranteed-issue basis to separate risk pools and provide applicants information about this product.

The Department of Revenue will:

- Determine compliance with tax penalties for the individual mandate and employer assessment.
- Coordinate with IHERC regarding tax penalties and the employer assessment.

IHERC is not intended to replace or duplicate existing state agencies or their functions. Upon implementation, it will be necessary to review the functions of different state agencies (i.e., Division of Insurance and the Office of Consumer Health Insurance) to determine how to effectively coordinate activities of existing State agencies.

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## SECTION IX: IMPORTANT INTERACTIONS BETWEEN PROGRAM FEATURES AND AREAS FOR FUTURE STUDY

The proposed health care coverage expansion model is comprehensive, involving all sectors of the healthcare industry. The Task Force understands that there are many details in the implementation of this model that must be worked out to avoid unintended consequences, support the robust provider and insurance markets, contain costs and provide individuals with access to quality health care.

This section describes some of the program features where additional stakeholder discussions would be beneficial. In addition, the Task Force has recommended that the General Assembly fund additional analyses to support some of these discussions. Specifically:

- *Subsidization of Cost-Sharing:* The proposal includes subsidies of premium costs in the individual or small group market for individuals under 400 percent of the federal poverty level. These subsidies do not cover point-of-service cost-sharing such as copayments, which can vary widely across employers and in the non-group market. Because cost-sharing can be a barrier to access to care, especially for low-income individuals, it is important to further consider cost-sharing levels under the expansion approach. While very low-income populations will likely be eligible for public coverage (i.e., low-income parents up to 200 percent of the FPL and childless adults up to 100 percent of the FPL), there may be individuals under 400 percent of the FPL who face prohibitive cost-sharing levels. Additional analyses are needed to determine the impact on access to care if cost-sharing subsidies are not available for low-income populations.
- *Ability of Low-Income Individuals with Employer Offers of Coverage to Use Premium Assistance in the Non-Group Market:* The proposal specifies that individuals under 400 percent of the FPL must apply their premium assistance to an employer offer of coverage, if available. If an employer offer of coverage is not available, the individual may use the premium subsidy to purchase the Comprehensive Standard Plan in the non-group market. Although the Comprehensive Standard Plan is modeled after a typical commercial plan, it is likely that there will be some employers whose benefit packages are less comprehensive and, thus, less appealing to individuals (especially if an individual requires extensive healthcare services).

Requiring individuals to first use their employer offers of coverage, if available, is designed to sustain and promote employer-sponsored coverage, but very limited employer benefit packages may not provide the level of access intended by the Health Care Justice Act. One approach to resolve this

issue is to allow individuals under 400 percent of the FPL with employer offers of coverage to use their premium assistance in the non-group market if their employer's benefit package does not meet a minimum standard. Such a "safety valve," if not set at appropriate levels, however, could encourage employers to reduce the level of coverage so that employees purchase coverage elsewhere.

- *Future Study for Employer Assessment Policy:* As mentioned in Section V, the Task Force recommends additional study of the employer assessment. One analysis recommended for funding would quantify the number of uninsured individuals who are estimated to be covered by this proposal by income level, employer size (under or over 25 employees) and source of coverage and financing (i.e., premium assistance, public program expansion or other). Additional studies may also be useful in determining the impact of various employer assessment approaches.
- *Further Study of Proposed Group and Non-Group Insurance Market Changes:* Group and non-group insurance market changes designed to spread risk and stabilize premiums are key elements of the proposal. The Task Force recommends that the General Assembly fund studies of the potential impact of these insurance market changes to inform the deliberations surrounding this proposed approach. For example, the Task Force recommends that the General Assembly fund the following studies:
  - Comparative analysis of Illinois market and markets in other states that have regulations similar to the ones proposed for Illinois. This analysis would include NAIC data and would specifically examine carrier entry and exit from the market, as well as detail on insurer size and market trends.
  - Detailed analysis of the impact of the proposed regulations using Illinois carriers' enrollment and premium information. This would entail a "data call" from the state to obtain the information from a sample of large and small carriers in Illinois.
  - Analysis of multiple years of National Association of Insurance Commissioners (NAIC) information for the State of Illinois to understand the stability of the medical loss ratios observed in 2001-2005 in both the individual and small group markets. This analysis would include a review of the companies' financial information reported to NAIC to consider their administrative cost, surplus, and profitability during those years.

## SECTION X: COVERAGE AND COST ESTIMATES

This section presents the detailed cost and coverage estimates for the updated health coverage expansion model. Exhibits X-1 and X-2 at the end of this Section provide overall cost and coverage figures, and cost estimates for each component of the proposed coverage expansion.

As modeled, this health care expansion approach will extend coverage to an estimated 89 percent of the currently uninsured population (1.5 million out of 1.7 million uninsured), for an overall coverage rate of 98 percent of the non-elderly population. Additional detail on coverage of the uninsured is provided in Exhibit X-3 at the end of this section.

As can be seen in Exhibit X-2, enrollment in new public program options accounts for 23 percent of the uninsured. Another 20 percent of the uninsured enroll in public programs under existing eligibility rules reflecting the impact of the individual mandate. Workers selecting employer-based options represent 8 percent of the uninsured. Thirty-two percent of the uninsured do not have an employer or public program option available to them and are projected to enroll in subsidized non-group coverage. Finally, an estimated 17 percent of the uninsured have incomes that exceed 400 percent of FPL and do not qualify for subsidies but are projected to enroll in coverage to comply with the mandate.

A significant portion of the premium assistance will cover individuals who are currently purchasing coverage as everyone is mandated to obtain coverage and targeting premium assistance to currently uninsured is no longer a relevant concept. The largest single group receiving premium assistance under the program are workers under 400 percent of FPL currently taking employer-based coverage; the State costs for this group are low, at an annual per capita cost of \$103.

For the first full year of program operation, approximately \$3.6 billion (Option A) or \$3.1 billion (Option B) in State funding will be needed, assuming the availability of additional federal Medicaid/SCHIP matching funds and an employer assessment totaling approximately \$1.5 billion. Increases in Medicaid provider payment rates represent an estimated \$769 million or \$1.171 billion of total State costs (Options A and B, respectively)<sup>8</sup>. Total State costs without the provider payment increase are approximately \$2.9 to \$1.9 billion (Options A and B, respectively). Under Option B, providers are paid the increased Medicaid rates plus five percent; these increases

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<sup>8</sup> Does not include funding from Illinois' recently passed provider tax program as this initiative may not be available upon or after expansion implementation. Estimate reflects increases in payments to hospitals and physicians; additional analyses would be needed to determine payment increase to achieve 100 percent of estimated costs for other providers. Includes payment rate increases totaling \$403 million related to the state self-insured plan in Option B.

represent \$403 million in State funding<sup>9</sup>. To the extent that the employer assessment is structured to collect less funding, the State will need to identify additional state funds.

### **Estimation Methodology**

The results presented in this section use a population-based simulation model and do not include implementation costs. Our modeling approach assumes that the proposal is fully implemented in 2007. All estimates are for residents age 0-64 to remove the impact of near universal Medicare coverage among the population age 65 or older.

The estimation approach accounts for differences in benefit design, contractual allowances from providers, administrative costs and availability of federal funds in the simulation of each of the proposal components. In keeping with previous tables of model results, each proposal component is modeled separately. When individuals are eligible for more than one coverage option, potential duplication of individuals between proposal components is removed in calculating overall coverage results.

The results presented here do not include any estimates of employment impacts or other potential secondary impacts. The model produces high-level cost, participation and financing estimates, considering major factors that affect cost and coverage. However, for reasons of time and available data, the model may not consider some factors that should be considered in developing more precise estimates, such as for a state appropriations estimate.

### **Base Data**

The model is based on 2000 Census data for the state of Illinois. These data provide detail on income, age, family type, employment status and immigration status.<sup>10</sup> The Census data were supplemented with information from the 2004 Current Population Survey (CPS) to impute the probability of health coverage and firm size to persons in each demographic and income category in the 2000 Census.

We adjusted all data to 2007 population and workforce projections. We adjusted estimates of Medicaid and State Children's Health Care Program (SCHIP) recipients (a population that is typically undercounted in household surveys) to match administrative data from the Illinois Department of Healthcare and Family Services (DHFS). We applied research estimates to calculate the percentage of the immigrant

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<sup>9</sup> Reflects public program payment increases for hospitals and physicians only; see prior footnote.

<sup>10</sup> To illustrate the data detail available from this approach, the Illinois sample in the Census 5 percent Public Use Micro Sample (PUMS) contains 619,232 observations for the state of Illinois while the 2004 Current Population Survey contains just 7,198 observations for Illinois.

population that is ineligible for federal match in the Medicaid and SCHIP programs because Federal matching funds are not available for this population.<sup>11</sup>

### **Actuarial Assumptions**

Actuaries from Milliman, Inc. provided the assumptions used to estimate the per capita coverage costs for four age groups: 0-18, 19-23, 24-44 and 45-64. These actuarial assumptions consisted of several factors that were used together to estimate overall cost, specifically:

- Baseline medical expense (reflecting undiscounted charges),
- Factors which adjusted for scope of covered services
- Factors which adjusted for actuarial plan value (reflecting different cost-sharing levels)
- Contractual allowances from providers
- Administrative cost rates.

Milliman Inc. developed these factors using their actuarial expertise and a proprietary model calibrated to Illinois-specific charge and utilization factors.

### **Payroll Assumptions**

The model assumes an overall estimated total state payroll of \$223 billion in 2007, estimated using data from Illinois County Business Patterns, projected forward for this analysis. See Appendix C for more detail on how this data were used to estimate an employer assessment.

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<sup>11</sup> Legal permanent residents (those with green cards) are ineligible for federal matching funds for Medicaid or SCHIP during their first five years in the U.S. In addition, undocumented immigrants and immigrants in the U.S. on a temporary basis (e.g., who have a temporary work visa or student visa) are generally ineligible for Medicaid and SCHIP. Identifying who is eligible for public programs and for federal match in household datasets is further complicated by the fact that many immigrant families are mixed status families. Nearly 1 in 10 U.S. families with children is a mixed-status family, that is, a family in which one or more parents is a noncitizen and one or more children is a citizen (Fix and Zimmerman, 1999). In addition, all pregnant women can receive a temporary Medicaid card for prenatal care, labor and delivery. All income-eligible persons, regardless of immigration status, are eligible for Medicaid coverage for emergency room care.

## Estimating Increases in Public Program Provider Payment

The model incorporated public program provider payment increases to 100 percent of estimated costs (within Federal upper payment limits), using the following approach:

- *Hospital payments:* According to estimates provided by the Department of Healthcare and Family Services, hospital services represent approximately 32 percent of total services and are paid at approximately 68 percent of estimated costs (does not include disproportionate share hospital payments or the pending provider tax assessment). As such, the Consulting Team identified 32 percent of estimated public program premium costs for the under 65 population and increased those costs by 1.4707, the amount necessary to achieve approximately 100 percent of estimated costs.
- *Physician payments:* As instructed by the Steering Committee, we used Medicare payments as a proxy for costs. According to estimates provided by the Department of Healthcare and Family Services, physician services represent approximately nine percent of total services and are paid at approximately 56 percent of Medicare physician rates (using 2006 Medicare locality 99 rates). As such, the Consulting Team identified nine percent of estimated public program premium costs for the under 65 population and increased those costs by 1.7857, the percentage necessary to achieve approximately 100 percent Medicare's payment rates.
- *Payment for all other services:* As discussed with the Steering Committee, estimating costs for additional provider types requires additional analyses that go beyond the Task Force's timeframe and budget. Should the General Assembly choose to increase provider payments to an estimated 100 percent of costs for these other categories of providers, additional analyses are needed.

These estimates do not include funding from Illinois' recently passed provider tax program. As this program might not be renewed at the time of implementation of the expansion or afterwards, we have not included provider tax funding in this model to provide the most conservative estimate possible. Should the provider tax program be available, however, less funding might be needed to pay providers an estimated 100 percent of costs (within upper payment limitations).

Provider payment increases applied to the State's SCHIP program could potentially cause the State to exceed its SCHIP allotment; additional analyses would be needed to determine the extent to which this might occur.

## Behavioral Assumptions

As in all healthcare modeling estimates, arriving at an estimate of how many of those eligible would take newly offered coverage is an imprecise process. Our approach was as follows:

- *Individual Behavioral Assumptions.* Consistent with earlier modeling of proposals for the Task Force, we used a standard set of assumptions. These assumptions varied the take-up rate by the following factors:
  - Family income (as a percent of FPL);
  - Whether the coverage offered resembles public coverage, employer coverage or individual (direct) coverage
  - Whether the purchasing environment is voluntary or mandatory

In addition, we assumed that model components that subsidize coverage already being purchased (to avoid equity concerns) would have a take-up rate of 90 percent, regardless of family income. The specific assumptions used for each component are listed in Exhibit X-4 at the end of this Section.

- *Employer Behavioral Assumptions.* As described in Section V, employers will be subject to a partial or full employer assessment. In this new environment, the employer's participation decision will drive the impact of the proposal on the workers. The intent of the employer assessment is to encourage employers who have historically offered to continue to do so (entitling the employer to a full or partial credit against the assessment).<sup>12</sup> While a modestly lower-cost option is available to small employers (and premium assistance to their workers), based on the experience of programs in other states, we do not expect many non-offering employers to begin offering the new coverage.

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<sup>12</sup> As described in Appendix C, we used data from the Medical Expenditure Panel Survey-Insurance Component employer survey to estimate the number of workers associated with various types of employers (e.g., workers in firms that were small and non-offering).

**Exhibit X-1 - Summary of Updated Health Care Expansion Model (includes an individual mandate)  
2007 Coverage and Costs for the Under 65 Population**

<i>Note: Cost and coverage estimates presented here represent high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as needed for a s for a State appropriations estimate.</i>		<b>Option A: All Carriers Offer Standard Plan</b>	<b>Option B: State Self-Insured Plan</b>
<b>I. Changes in Coverage (in thousands)</b>			
A. Total newly covered under proposal	Total individuals	1,520	1,520
	Percent of uninsured	89%	89%
B. Currently insured residents participating in new coverage programs	Total individuals	2,040	2,034
	Percent of currently insured	21%	21%
C. Total newly covered under Medicaid or SCHIP (a)	Total individuals	230 (a)	230 (a)
D. Remaining uninsured	Total individuals	185	185
	% of baseline uninsured	11%	11%
<b>II. Costs Associated With Enrollment in New Coverage Options(b) (\$ in millions)</b>			
A. Federal Medicaid/SCHIP funds		428 (c)	428 (c)
B. State	1. Health insurer assessment	Not Applicable	Not Applicable
	2. Employer fees or taxes	1,486	1,486
	3. Employee payroll tax (d)	Not Applicable	Not Applicable
	4. Medicaid/SCHIP funds (e)	428 (c)	428 (c)
	5. Source to be determined	2,781	2,280
C. Annual per capita state coverage costs for all individuals participating in new coverage options ((IIB.4+IIB.5)/(IA+IB)) <i>Note: Includes funding from employer assessment; calculation varies due to rounding from detail spreadsheet</i>		901	762
D. Annual per capita state coverage costs for all newly insured individuals (excludes funding from employer assessment, see footnote f)		2,304 (f)	2,041 (f)
<b>III. Cost Increases Associated with Medicaid and SCHIP Provider Payment Rate Increases (\$ in millions) (g)</b>			
A. Existing public programs (baseline): Federal Share		549	549
B. Existing public programs (baseline): State Share		410	410
C. New public programs and new enrollment in existing programs: Federal Share		77	77
D. New public programs and new enrollment in existing public programs: State Share		359	761
E. Total provider payment rate increase (IIIA+IIIB+IIIC+IIID)		1,395	1,798
<b>IV. Proposal Components Not Modeled That May Result in Changes to Estimates Coverage and Costs</b>			
Selected Medicaid expansions for individuals with disabilities. Inclusion of the disabled populations are not expected to have a substantial impact on the number of newly insured, as these individuals are generally high-cost; however, they may have an impact on total costs. Information from the Campaign for Better Health Care indicates that, for the unmodeled expansion of income eligibility for the Aged, Blind or Disabled (AABD) program from 100 percent to 300 percent of the FPL, 20,000 to 49,000 individuals might be covered.			
<b>V. Total Cost to State (\$ in millions)</b>			
A. Including funding from employer assessment (IIB4+IIB5+IIIB)		3,618	3,118
B. Including funding from employer assessment and excluding provider payment rate increase (IIB4+IIB5-IIID)		2,850	1,946

- (a) Includes all residents newly enrolled in public coverage that are eligible for Federal Match whether due to an expansion or due to new enrollment under existing eligibility rules.
- (b) Represents costs of coverage (including administrative costs); excludes implementation costs.
- (c) Includes expansion populations and residents previously eligible but not enrolled (who have enrolled due to the mandate).
- (d) Employer assessment amount reflects a policy whereby firms of 25 or more employees are subject to the assessment. If firms of 10 or more workers were subject to the assessment, total revenue from the assessment would increase by \$267 million for a total assessment of \$1,753 million.
- (e) Increases in Medicaid/SCHIP spending represent new Medicaid spending and assume no additional SCHIP funds are available.
- (f) Does not reflect the funds available through new employer payroll tax assessments because these cannot be allocated to subpopulations.
- (g) Reflects a general estimate of additional hospital and physician payments for Medicaid and SCHIP-funded programs, and the state-only funded expansion of coverage to childless adults (under 65 population only). Rate increase does not include funding from Illinois' recently passed provider tax program as this program might not be renewed at the time of implementation of the expansion, or afterwards. Should the provider tax program be available, however, less funding might be needed to pay providers at an estimated 100 percent of costs (within upper payment limitations).

*Note:* Program includes these features which have not been shown to impact cost and coverage: (1) New rate band structure in the individual and small group market; (2) a voluntary, insurer-funded individual and small group reinsurance program to stabilize premiums (this model assumes no commitment of state funds for the program).

Exhibit X-2 - Updated Health Care Expansion Model by Component (includes individual mandate) -- Coverage and Costs for 2007 (Under Age 65)

Note: These estimates reflect a modeling approach designed to support comparisons across proposals. Using a common platform, the model provides high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as for a state appropriations estimate.	Reference to Summary Page	Option A: All Carriers Offer Standard Plan								
		Overall	Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Require Insurers to offer "standard plan"	Employer Assessment
			Family Care Expansion to 200% FPL	New Public Program Enrollment Under Existing Eligibility Rules (no crowd out provisions)	Childless Adults eligible for state-funded Medicaid like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market	Insurance take-up by uninsured Residents ineligible for subsidies	Non-offering employers with 26 or more workers in Illinois face an assessment
<b>I. Total Population Eligible for Program</b>		Footnote 2	54,924	2,384,398	509,037	415,598	3,055,604	1,092,719	320,938	
A. Total Uninsured in Eligible Population		Footnote 2	17,319	313,233	356,395	89,031	193,362	973,654	320,938	
<b>II. Total Estimated Program Enrollment</b>		3,560,229 (1)	51,629	306,597	483,585	80,604	2,025,623	552,109	256,751	
A. Overall Participation Rate		Footnote 2	94%	13%	95%	19%	66%	51%	80%	
B. Annual Overall Coverage Cost per Participant (includes employer, employee and subsidy amounts)		\$ 4,207	\$ 2,943	\$ 3,279	\$ 3,209	\$ 4,440	\$ 4,318	\$ 4,881	\$ 5,137	
C. Annual Overall Subsidy Cost per Participant		\$ 1,439	\$ 2,766	\$ 2,929	\$ 3,209	\$ 1,773	\$ 109	\$ 3,961		
D. Annual State Subsidy Cost per Participant (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds; at the overall level, new assessments are netted out)	IIC	\$ 901	\$ 1,383	\$ 1,742	\$ 3,209	\$ 1,773	\$ 109	\$ 3,961		
<b>III. Total Newly Covered under Proposal</b>	IA	1,520,360	16,280	306,597	338,575	16,370	113,806	483,031	256,751	
A. Participation among Eligible Uninsured		N/A	94%	98%	95%	18%	59%	50%	80%	
B. Annual Overall Coverage Cost per Newly Insured (includes employer, employee and subsidy amounts)		\$ 4,145	\$ 2,879	\$ 3,279	\$ 2,989	\$ 4,691	\$ 5,062	\$ 4,806	\$ 5,137	
C. Annual Program Subsidy Cost per Newly Insured (does not include employer fees or insurer assessments)		\$ 2,557	\$ 2,702	\$ 2,929	\$ 2,989	\$ 1,842	\$ 208	\$ 3,898	\$ -	
D. Annual State Subsidy Cost per Newly Insured (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)	IID	\$ 2,304	\$ 1,351	\$ 1,742	\$ 2,989	\$ 1,842	\$ 208	\$ 3,898	\$ -	
E. Enrollment of Newly Insured as a Percent of Total Program Enrollment		43%	32%	5%	70%	20%	6%	87%	100%	
<b>IV. Currently insured residents participating in new coverage programs</b>	IB	2,039,870	35,349	-	145,010	64,234	1,911,817	69,078		
A. Annual Coverage Cost per Previously Insured Resident (includes employer, employee and subsidy amounts)		\$ 4,251	\$ 2,973	\$ -	\$ 3,721	\$ 4,376	\$ 4,274	\$ 5,332		
B. Annual Program Subsidy Cost per Previously Insured Resident		\$ 605	\$ 2,796	\$ -	\$ 3,721	\$ 1,756	\$ 103	\$ 4,403		
C. Annual State Subsidy Cost per Previously Insured Resident (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)		\$ 578	\$ 1,398	\$ -	\$ 3,721	\$ 1,756	\$ 103	\$ 4,338		

**Exhibit X-2 - Updated Health Care Expansion Model by Component (includes individual mandate) -- Coverage and Costs for 2007 (Under Age 65)**

Note: These estimates reflect a modeling approach designed to support comparisons across proposals. Using a common platform, the model provides high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as for a state appropriations estimate.	Reference to Summary Page	Option A: All Carriers Offer Standard Plan								
			Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Require Insurers to offer "standard plan"	Employer Assessment
		Overall	Family Care Expansion to 200% FPL	New Public Program Enrollment Under Existing Eligibility Rules (no crowd out provisions)	Childless Adults eligible for state-funded Medicaid like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market	Insurance take-up by uninsured Residents ineligible for subsidies	Non-offering employers with 26 or more workers in Illinois face an assessment
<b>V. Costs Associated with Enrollment in New Coverage Options(3)</b>										
A. New Federal Medicaid/SCHIP Funds	IIA	\$ 427,644,998 (4)	\$ 71,414,405	\$ 363,799,760	\$ -	\$ -	\$ -	\$ -		
B. New Health Insurer Assessments	IIB.1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
C. Employers:				0						
Premium Contributions		\$ 6,610,366,406	\$ -	\$ -	\$ -	\$ 168,578,657	\$ 7,134,474,905	\$ -		
New Fees or Taxes	IIB.2	\$ 1,486,205,006 (7)	\$ -				\$ -	\$ -		\$ 1,486,205,006
D. Residents:		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
Premium Contributions		\$ 3,246,219,661	\$ 9,116,733	\$ 107,377,661	\$ -	\$ 46,392,984	\$ 1,391,649,029	\$ 507,874,708	\$ 1,318,923,943	
New Payroll Taxes	IIB.3	\$ -	\$ -	\$ -	\$ -			\$ -		
State Income Taxes		\$ -	\$ -	\$ -				\$ -		
E. New State Medicaid/SCHIP Funds	IIB.4	\$ 427,644,998 (5)	\$ 71,414,405	\$ 348,661,424	\$ -	\$ -	\$ -	\$ -		
F. Other State Funds (source to be determined)	IIB.5	\$ 2,780,515,913	\$ -	185,485,608	\$ 1,551,631,134	\$ 142,928,599	\$ 221,272,093	\$ 2,186,886,824		
<b>VI. Total</b>		\$ 14,978,596,982	\$ 151,945,543	\$ 1,005,324,454	\$ 1,551,631,134	\$ 357,900,240	\$ 8,747,396,027	\$ 2,694,761,532	\$ 1,318,923,943	
<b>VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Current Public Program Coverage</b>										
A. State Costs	IIIB	\$ 410,316,110 (6)								
B. Federal Costs	IIIA	\$ 548,662,518 (6)								
<b>VIII Total Point-of-Service Cost Sharing Under the Program</b>		\$ 2,287,622,063	\$ 9,103,616	\$ -	\$ -	\$ 69,345,856	\$ 1,568,474,435	\$ 482,635,918	\$ 310,345,638	
<b>IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians</b>		46%	3%	17%	26%	0%	0%	0%	0%	0%

(1) In the case of overlapping population, Overall results have been adjusted to remove estimated duplication of enrollees between proposal options.

(2) Not a relevant concept at the "Overall" level due to overlapping eligibility between program components.

(3) Represents costs of coverage (including administrative costs); excludes implementation

(4) In addition to the Federal and State SCHIP/Medicaid spending associated with the new coverage options, these totals include an amount of \$7,569,168 associated with moving some SCHIP parents into Medicaid (lower match rate) to fund the coverage of eligible but not yet approach assumes that CMS would allow Illinois to expand Medicaid to SCHIP parents using income disregards. As this approach is untested and requires extensive conversations with CMS, it is possible that the State would be responsible for the entire cost of this care.

(6) Reflects an overall 22.1 percent increase in Medicaid/SCHIP provider payment rates.

(7) Employer assessment applied to firms of 25 or more employees. If firms of 10 or more workers were subject to the assessment, total revenue from the assessment would increase by \$267 million for a total assessment of \$1,753 million.

Exhibit X-2 - Updated Health Care Expansion Model by Component (includes individual mandate) -- Coverage and Costs for 2007 (Under Age 65)

Note: These estimates reflect a modeling approach designed to support comparisons across proposals. Using a common platform, the model provides high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as for a state appropriations estimate.	Reference to Summary Page	Option B: State Self-Insured Plan								
			Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Require Insurers to offer "standard plan"	Employer Assessment
		Overall	Family Care Expansion to 200% FPL	New Public Program Enrollment Under Existing Eligibility Rules (no crowd out provisions)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market	Insurance take-up by uninsured Residents ineligible for subsidies	Non-offering employers with 26 or more workers in Illinois face an assessment
<b>I. Total Population Eligible for Program</b>		Footnote 2	54,924	2,384,398	509,037	415,598	3,055,604	1,092,719	320,938	
A. Total Uninsured in Eligible Population		Footnote 2	17,319	313,233	356,395	89,031	193,362	973,654	320,938	
<b>II. Total Estimated Program Enrollment</b>		3,553,985 (1)	51,629	306,597	483,585	71,269	2,025,623	552,116	256,751	
A. Overall Participation Rate		Footnote 2	94%	13%	95%	17%	66%	51%	80%	
B. Annual Overall Coverage Cost per Participant (includes employer, employee and subsidy amounts)		\$ 4,095	\$ 2,943	\$ 3,279	\$ 3,209	\$ 4,069	\$ 4,318	\$ 4,208	\$ 5,137	
C. Annual Overall Subsidy Cost per Participant		\$ 1,300	\$ 2,766	\$ 2,929	\$ 3,209	\$ 1,403	\$ 109	\$ 3,131	\$ -	
D. Annual State Subsidy Cost per Participant (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds; at the overall level, new assessments are netted out)	IIC	\$ 762	\$ 1,383	\$ 1,742	\$ 3,209	\$ 1,403	\$ 109	\$ 3,131	\$ -	
<b>III. Total Newly Covered under Proposal</b>	IA	1,520,276	16,280	306,597	338,575	16,113	113,806	483,031	256,751	
A. Participation among Eligible Uninsured		N/A	94%	98%	95%	18%	59%	50%	80%	
B. Annual Overall Coverage Cost per Newly Insured (includes employer, employee and subsidy amounts)		\$ 3,929	\$ 2,879	\$ 3,279	\$ 2,989	\$ 4,069	\$ 5,062	\$ 4,147	\$ 5,137	
C. Annual Program Subsidy Cost per Newly Insured (does not include employer fees or insurer assessments)		\$ 2,295	\$ 2,702	\$ 2,929	\$ 2,989	\$ 1,482	\$ 208	\$ 3,083	\$ -	
D. Annual State Subsidy Cost per Newly Insured (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)	IID	\$ 2,041	\$ 1,351	\$ 1,742	\$ 2,989	\$ 1,482	\$ 208	\$ 3,083	\$ -	
E. Enrollment of Newly Insured as a Percent of Total Program Enrollment		43%	32%	5%	70%	23%	6%	87%	100%	
<b>IV. Currently insured residents participating in new coverage programs</b>	IB	2,033,709	35,349	-	145,010	55,156	1,911,817	69,085		
A. Annual Coverage Cost per Previously Insured Resident (includes employer, employee and subsidy amounts)		\$ 4,216	\$ 2,973	\$ -	\$ 3,721	\$ 4,069	\$ 4,274	\$ 4,568		
B. Annual Program Subsidy Cost per Previously Insured Resident		\$ 557	\$ 2,796	\$ -	\$ 3,721	\$ 1,380	\$ 103	\$ 3,464		
C. Annual State Subsidy Cost per Previously Insured Resident (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)		\$ 531	\$ 1,398	\$ -	\$ 3,721	\$ 1,380	\$ 103	\$ 3,411		

**Exhibit X-2 - Updated Health Care Expansion Model by Component (includes individual mandate) -- Coverage and Costs for 2007 (Under Age 65)**

Note: These estimates reflect a modeling approach designed to support comparisons across proposals. Using a common platform, the model provides high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as for a state appropriations estimate.	Reference to Summary Page	Option B: State Self-Insured Plan									
		Overall	Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Require Insurers to offer "standard plan"	Employer Assessment	
			Family Care Expansion to 200% FPL	New Public Program Enrollment Under Existing Eligibility Rules (no crowd out provisions)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market	Insurance take-up by uninsured Residents ineligible for subsidies	Non-offering employers with 26 or more workers in Illinois face an assessment	
<b>V. Costs Associated with Enrollment in New Coverage Options(3)</b>											
A. New Federal Medicaid/SCHIP Funds	IIA	\$ 427,644,998 (4)	\$ 71,414,405	\$ 363,799,760	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
B. New Health Insurer Assessments	IIB.1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
C. Employers:			0	0	0				0	0	
Premium Contributions		\$ 6,597,632,110	\$ -	\$ -	\$ -	\$ 144,983,008	\$ 7,134,474,905	\$ -	\$ -	\$ -	
New Fees or Taxes	IIB.2	\$ 1,486,205,006 (7)	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ 1,486,205,006	
D. Residents:		\$ -	0	0	0				\$ -	\$ -	
Premium Contributions		\$ 3,333,745,958	\$ 9,116,733	\$ 107,377,661	\$ -	\$ 44,958,114	\$ 1,391,649,029	\$ 594,717,262	\$ 1,318,923,943	\$ -	
New Payroll Taxes	IIB.3	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ -	
State Income Taxes		\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ -	
E. New State Medicaid/SCHIP Funds	IIB.4	\$ 427,644,998 (5)	\$ 71,414,405	\$ 348,661,424	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
F. Other State Funds (source to be determined)	IIB.5	\$ 2,279,628,745	\$ -	\$ 185,485,608	\$ 1,551,631,134	\$ 100,024,895	\$ 221,272,093	\$ 1,728,566,501	-	-	
<b>VI. Total</b>		\$ 14,552,501,814	\$ 151,945,543	\$ 1,005,324,454	\$ 1,551,631,134	\$ 289,966,017	\$ 8,747,396,027	\$ 2,323,283,763	\$ 1,318,923,943	\$ -	
<b>VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Current Public Program Coverage</b>											
A. State Costs	IIIB	\$ 410,316,110 (6)									
B. Federal Costs	IIIA	\$ 548,662,518 (6)									
<b>VIII Total Point-of-Service Cost Sharing Under the Program</b>		\$ 2,269,593,249	\$ 9,103,616	\$ -	\$ -	\$ 62,907,909	\$ 1,568,474,435	\$ 468,657,243	\$ 310,345,638	\$ -	
<b>IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians</b>		80%	3%	17%	26%	4%	0%	30%	0%	0%	

- (1) In the case of overlapping population, Overall results have been adjusted to remove estimated duplication of enrollees between proposal options.
- (2) Not a relevant concept at the "Overall" level due to overlapping eligibility between program components.
- (3) Represents costs of coverage (including administrative costs); excludes implementation
- (4) In addition to the Federal and State SCHIP/Medicaid spending associated with the new coverage options, these totals include an amount of \$7,569,168 associated with moving some SCHIP parents into Medicaid (lower match rate) to fund the coverage of eligible but not yet approach assumes that CMS would allow Illinois to expand Medicaid to SCHIP parents using income disregards. As this approach is untested and requires extensive conversations with CMS, it is possible that the State would be responsible for the entire cost of this care.
- (6) Reflects an overall 22.1 percent increase in Medicaid/SCHIP provider payment rates.
- (7) Employer assessment applied to firms of 25 or more employees. If firms of 10 or more workers were subject to the assessment, total revenue from the assessment would increase by \$267 million for a total assessment of \$1,753 million.

**Exhibit X-3: Impact of Updated Health Care Expansion Model Including Individual Mandate on the Uninsured by Selected Characteristics  
2007 Estimates for the Under 65 Population**

	Illinois Baseline Uninsured (000)	Option A: All Carriers Offer Standard Plan		Option B: State Self-Insured Plan	
		Remaining Uninsured (000)	Percentage Reduction in Uninsured	Remaining Uninsured (000)	Percentage Reduction in Uninsured
<b>By Age:</b>					
0-18	175	12	93%	13	93%
19-23	346	34	90%	34	90%
24-44	749	79	89%	79	89%
45-64	434	59	87%	58	87%
<b>By Income as a percent of FPL:</b>					
<100% FPL	446	22	95%	22	95%
100%-199% FPL	359	16	96%	16	95%
200%-299% FPL	326	30	91%	30	91%
300%-399% FPL	203	42	80%	42	80%
400% + FPL	371	74	80%	74	80%
<b>Adults By Family Type:</b>					
Childless	1,038	115	89%	115	89%
Parents	492	57	88%	57	88%
<b>Adults By Employment Status:</b>					
Full-time College Student	60	9	84%	9	84%
Full-time Worker	759	56	93%	55	93%
Part-time Worker	312	56	82%	56	82%
Self-employed	135	23	83%	23	83%
Unemployed	13	3	78%	3	78%
Other Non-worker	251	25	90%	25	90%
<b>Total Uninsured</b>	<b>1,705</b>	<b>185</b>	<b>89%</b>	<b>185</b>	<b>89%</b>

*Note:* Section V of the August 15th Evaluation Report provides a description of the data used for this analysis.

**Exhibit X-4: Modeling Assumptions for Updated Health Care Expansion Model (including individual mandate)**

	Option A:						Option B:					
	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Employer Assessment	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Employer Assessment
	Family Care Expansion to 200% FPL (at Medicaid Rates)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Small, low-wage employers eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Subsidies for Adults purchasing in non-group market	Applies to employers with 25 or more workers in Illinois	Family Care Expansion to 200% FPL (at Medicaid Rates)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Small, low-wage employers eligible to purchase state self-insured plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Subsidies for Adults purchasing state self-insured plan in non-group market	Applies to employers with 25 or more workers in Illinois
<b>1. General Approach</b>												
Mandatory or Voluntary?	Individual Mandate	Individual Mandate	Individual Mandate	Individual Mandate	Individual Mandate	Mandatory for Employers	Individual Mandate	Individual Mandate	Individual Mandate	Individual Mandate	Individual Mandate	Mandatory for Employers
How are premiums rated ? (if applicable)	n/a	n/a	Uses New Rating Rules featuring greater Rate Compression & G.I.	n/a	Uses New Rating Rules featuring greater Rate Compression & G.I.	n/a	n/a	n/a	Uses New Rating Rules featuring greater Rate Compression & G.I.	n/a	Uses New Rating Rules featuring greater Rate Compression & G.I.	n/a
<b>2. Eligible (affected) Population(s)</b>												
Age	Adults (19-64)	Adults (19-64)	All ages 0-64	All ages 0-64	Adults (19-64)	n/a	Adults (19-64)	Adults (19-64)	All ages 0-64	All ages 0-64	Adults (19-64)	n/a
Income	185%-200% FPL	0-100% FPL	0-400% FPL	0-400% FPL	0-400% FPL	n/a	185%-200% FPL	0-100% FPL	0-400% FPL	0-400% FPL	0-400% FPL	n/a
Family Status	Parents	Childless Adults & Parents ineligible for SCHIP	n/a	n/a	n/a	n/a	Parents	Childless Adults & Parents ineligible for SCHIP	n/a	n/a	n/a	n/a
Work/Student Status	n/a	n/a	FT Workers	FT Workers and their dependents	n/a	n/a	n/a	n/a	FT Workers	FT Workers and their dependents	n/a	n/a
Firm Type	n/a	n/a	2-25; low wage; any offering status	Employer Offers	Non-offering Employer	n/a	n/a	n/a	2-25; low wage; any offering status	Employer Offers	Non-offering Employer	n/a
Current Coverage Status	Eligible for Medicaid/SCHIP	n/a	n/a	n/a	Must be Uninsured or Individually Insured	n/a	Eligible for Medicaid/SCHIP	n/a	n/a	n/a	Must be Uninsured or Individually Insured	n/a

**Exhibit X-4: Modeling Assumptions for Updated Health Care Expansion Model (including individual mandate)**

	Option A:						Option B:					
	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Employer Assessment	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Employer Assessment
	Family Care Expansion to 200% FPL (at Medicaid Rates)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Small, low-wage employers eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Subsidies for Adults purchasing in non-group market	Applies to employers with 25 or more workers in Illinois	Family Care Expansion to 200% FPL (at Medicaid Rates)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Small, low-wage employers eligible to purchase state self-insured plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Subsidies for Adults purchasing state self-insured plan in non-group market	Applies to employers with 25 or more workers in Illinois
<b>3. Subsidy Detail:</b>												
What Type of Subsidy	Indirect	Indirect	Direct	Direct	Direct	n/a	Indirect	Indirect	Direct	Direct	Direct	n/a
Reinsurance Subsidy ?	No Reinsurance	No Reinsurance	No Reinsurance	No Reinsurance	No Reinsurance	n/a	No Reinsurance	No Reinsurance	No Reinsurance	No Reinsurance	No Reinsurance	n/a
Limit Medical Loss to:	n/a	n/a	85%	n/a	85%	n/a	n/a	n/a	85%	n/a	85%	n/a
<b>4. Employer Requirements for Participation (if applicable):</b>												
<i>Firm Type</i>	n/a	n/a	2-25; low wage; any offering status	n/a	n/a	n/a	n/a	n/a	2-25; low wage; any offering status	n/a	n/a	n/a
Minimum ER Contribution (as a percent of premium)	n/a	n/a	50%	n/a	n/a	n/a	n/a	n/a	50%	n/a	n/a	n/a
Minimum Participation Rules	n/a	n/a	75%	n/a	n/a	n/a	n/a	n/a	75%	n/a	n/a	n/a

**Exhibit X-4: Modeling Assumptions for Updated Health Care Expansion Model (including individual mandate)**

	Option A:						Option B:					
	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Employer Assessment	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Employer Assessment
	Family Care Expansion to 200% FPL (at Medicaid Rates)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Small, low-wage employers eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Subsidies for Adults purchasing in non-group market	Applies to employers with 25 or more workers in Illinois	Family Care Expansion to 200% FPL (at Medicaid Rates)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Small, low-wage employers eligible to purchase state self-insured plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Subsidies for Adults purchasing state self-insured plan in non-group market	Applies to employers with 25 or more workers in Illinois
<b>5. Health Benefit Detail:</b>												
Scope of Covered Services	SCHIP for Families>150% FPL (no maternity)	Medicaid w/o Maternity	Typical Commercial w/ mandated benefits	Typical Commercial w/ mandated benefits	Typical Commercial w/ mandated benefits	n/a	SCHIP for Families>150% FPL (no maternity)	Medicaid w/o Maternity	Typical Commercial w/ mandated benefits	Typical Commercial w/ mandated benefits	Typical Commercial w/ mandated benefits	n/a
<i>Average Plan Value (given scope)</i>	95%	100%	80%	80%	80%	n/a	95%	100%	80%	80%	80%	n/a
Provider Discounts	Medicaid - 50% Facility/75% Medicare Fees	Medicaid - 50% Facility/75% Medicare Fees	Commercial - 30% Facility/125% Medicare Fees	Commercial - 30% Facility/125% Medicare Fees	Commercial - 30% Facility/125% Medicare Fees	n/a	Medicaid - 50% Facility/75% Medicare Fees	Medicaid - 50% Facility/75% Medicare Fees	Medicaid - 50% Facility/75% Medicare Fees	Commercial - 30% Facility/125% Medicare Fees	Medicaid - 50% Facility/75% Medicare Fees	Medicaid - 50% Facility/75% Medicare Fees
<i>Plus a Medicaid Provider reimbursement increase of</i>	22%	22%	n/a	n/a	n/a	n/a	22%	22%	Medicaid Rates * 1.05	n/a	Medicaid Rates * 1.05	n/a
Administrative Expense	Public Program - 4% of Premium	Public Program - 4% of Premium	Sm ER- Med Loss Limit of 85%	Average Employer - 20% of Premium	Individual-Med Loss Limit of 85%	n/a	Public Program - 4% of Premium	Public Program - 4% of Premium	Public Program - 4% of Premium	Average Employer - 20% of Premium	Public Program - 4% of Premium	n/a

**Exhibit X-4: Modeling Assumptions for Updated Health Care Expansion Model (including individual mandate)**

	Option A:						Option B:					
	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Employer Assessment	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Employer Assessment
	Family Care Expansion to 200% FPL (at Medicaid Rates)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Small, low-wage employers eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Subsidies for Adults purchasing in non-group market	Applies to employers with 25 or more workers in Illinois	Family Care Expansion to 200% FPL (at Medicaid Rates)	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Small, low-wage employers eligible to purchase state self-insured plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Subsidies for Adults purchasing state self-insured plan in non-group market	Applies to employers with 25 or more workers in Illinois
<b>6. Financing of Subsidies &amp; Program Administration:</b>												
General	State Revenues (w/ Federal Match)	State Revenues (no Federal Match)	State Revenues (no Federal Match)	State Revenues (no Federal Match)	State Revenues (no Federal Match)	n/a	State Revenues (w/ Federal Match)	State Revenues (no Federal Match)	State Revenues (no Federal Match)	State Revenues (no Federal Match)	State Revenues (no Federal Match)	n/a
Is state effort eligible for Federal Match?	Yes, at Medicaid Rates	No	No	No	No	n/a	Yes, at Medicaid Rates	No	No	No	No	n/a
Amount of ER Payroll assessment (if applicable)						4.8%						4.8%
<b>7. Assumed Employee Subsidy Rates</b>												
<100%	100%	100%	88%	69%	91%	n/a	100%	100%	88%	87%	69%	n/a
100-149%	100%	0%	86%	61%	92%	n/a	100%	0%	87%	83%	61%	n/a
150-199%	94%	0%	80%	46%	87%	n/a	94%	0%	82%	76%	46%	n/a
200-249%	0%	0%	75%	31%	83%	n/a	0%	0%	77%	69%	31%	n/a
250-299%	0%	0%	70%	15%	79%	n/a	0%	0%	72%	62%	15%	n/a
300%+	0%	0%	61%	1%	74%	n/a	0%	0%	66%	54%	1%	n/a
<b>8. Assumed Participation Rates</b>												
<100%	0%	95%	0%	0%	0%	n/a	0%	95%	0%	0%	0%	n/a
100-149%	0%	0%	95%	95%	95%	n/a	0%	0%	95%	95%	95%	n/a
150-199%	94%	0%	94%	94%	94%	n/a	94%	0%	94%	94%	94%	n/a
200-249%	0%	0%	92%	92%	92%	n/a	0%	0%	92%	92%	92%	n/a
250-299%	0%	0%	88%	88%	88%	n/a	0%	0%	88%	88%	88%	n/a
300%+	0%	0%	80%	80%	80%	n/a	0%	0%	80%	80%	80%	n/a

## Appendix A: High, Moderate and Low Consensus Items

The table below lists the Adequate Health Care Task Force’s High, Moderate and Low consensus items, as determined at the August 15, 2006 Task Force meeting.

High Consensus	Moderate Consensus	Low Consensus
<ul style="list-style-type: none"> <li>• State refundable tax credits/premium assistance</li> <li>• Medicaid and SCHIP expansions</li> <li>• Long-term care partnerships recently allowed by the Deficit Reduction Act</li> <li>• Strategies for spreading risk</li> <li>• Reinsurance</li> <li>• Adequate and timely payment to providers</li> <li>• Adequate supply and distribution of providers (i.e., incentives for providers to practice in underserved areas such as loan repayment)</li> <li>• Comprehensive benefit package</li> <li>• Maximizing Federal Medicaid funds</li> <li>• Additional employer commitment through new take-up of employer-based insurance by employees</li> <li>• Minimizing all costs not related to the direct provision of health care, including administrative costs and costs resulting from fraud and abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Employer and individual mandates</li> <li>• Publishing provider and insurer costs</li> <li>• Publishing provider and insurer quality measures</li> <li>• Continued use of commercial plans</li> <li>• Additional state tax revenue</li> <li>• Public body to evaluate plan performance and make recommendations for improvement</li> </ul>	<ul style="list-style-type: none"> <li>• Replacement of current health care system with single payer</li> <li>• State-run insurance plan</li> <li>• Increased use of additional task forces to address capital and technology issues</li> <li>• Safety net benefit package</li> <li>• Use of Health Savings Accounts or Medicaid personal savings accounts to provide flexible benefits</li> <li>• Selective reductions in Medicaid benefits, as allowed by the Deficit Reduction Act</li> <li>• Health insurer “windfall profit” assessment</li> </ul>

## **Appendix B: Comprehensive Standard Plan Summary**



**Navigant Consulting, Inc.**  
**Adequate Health Care Task Force**  
**Summary Plan Description**  
**“Typical Commercial”**

<b>Service Category</b>	<b>Cost Sharing Provisions</b>
Inpatient Facility	\$250 Co-payment per Admission
Outpatient Surgery	\$100 Co-payment per Service
Emergency Room <sup>1</sup>	\$200 Co-payment per Visit
Primary Care Visits	\$20 Co-payment per Visit
Specialty Care Visits	\$30 Co-payment per Visit
Durable Medical Equipment	20% Coinsurance
Prescription Drugs-Retail <sup>2</sup>	
Generic	\$10 Co-payment per Prescription
Preferred Brand	\$20 Co-payment per Prescription
Non-Preferred Brand	\$40 Co-payment per Prescription
Dental Services	
Class I (Preventive and Diagnostic)	0% Coinsurance
Class II (Basic)	20% Coinsurance
Class III (Major)	50% Coinsurance

1. Emergency Room co-payment waived if admitted.
2. Mail-order pharmacy co-payments are 2X the retail co-payments.
3. Cost sharing provisions based on the State of Illinois HMO employee benefit plan with adjustments to the primary care physician and specialty care physician co-payments.
4. Long term care is excluded with exception of skilled nursing facility and rehabilitation services.

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## Appendix C: Sample Employer Assessment Analysis

As discussed in Section V, an employer assessment is included in the health care coverage expansion model to accomplish several of Task Force objectives. This section provides background on the two main employer assessments considered by the Task Force that have been used to estimate costs under the proposed expansion.

### Background

As detailed in Exhibit C-1, the Task Force has considered two main versions of the employer assessment. The most significant differences between the two versions are:

- *Qualifying for credit against assessment:* In the first version, an employer will receive a credit against the assessment if eighty percent of the firm's employees (who are Illinois residents and who work 20 hours or more in a week for four consecutive weeks) were covered by qualified health coverage (through employer or otherwise)<sup>1</sup> In the second version, the employer's credit will be based on coverage of their own workers. Workers who are covered elsewhere (i.e., through a spouse's coverage) will not count towards the credit.
- *Percent of payroll used for assessment:* In the first version, the assessment will be set at eight percent of total payroll (subject to a cap). In the second version, the assessment will be set at 4.8 percent of total payroll (subject to a cap).

During the October 17, 2006 Steering Committee Meeting, the Consulting Team noted that, theoretically, in an individual mandate environment, no employers will have to pay the assessment under the first version because their employees will have obtained coverage – through an employer, a public program, the individual market or family member – to comply with the individual mandate. As such, the Consulting Team recommended that the employer assessment policy be adjusted so that employers will pay an assessment if they are not meeting a benchmark financial commitment to employee healthcare.

### High Level Comparison of Estimates Previously Provided

Over the past several months, the Consulting Team has provided several estimates of Version 1 and Version 2 of the employer assessment, and intermediate versions to facilitate Subgroup discussions. Exhibit C-2 provides a summary of these estimates and illustrates the changes over time, namely:

- Changes to the assessment structure (see discussion above and Exhibit C-1)

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<sup>1</sup> In the September 26, 2006 modified hybrid model, any type of coverage (offered by employer or by a different public or private source) qualifies as coverage eligible for a credit.

## Appendix C: Sample Employer Assessment Analysis

- An expansion in our scope of work permitted the development of more detailed distribution of employers using proprietary data from the Agency for Healthcare Quality and Research (AHRQ). As it became available, this data permitted more precise estimates on the distribution of employers by percent of workforce covered, percent of payroll spent on health coverage, the number of workers who work fewer than 20 hours a week, and payroll differences between offering and non-offering firms. See “Methodological Note” below.
- Version 2 estimates break out the public (state and local government) and private sector.

### Detailed Estimates of Proposed Employer Assessment

Exhibits C-3 and C-4 illustrates the impact of Version 2’s proposed assessment structure on Illinois employers in 2007 by private sector (Tables B-D) and public sector (Table E). Exhibit C-3 applies the assessment to firms with 25 or more employees (as proposed for the first year of program operation), which results in a total estimated employer assessment of \$1.486 billion. Exhibit C-4 applies the assessment to firms with 10 or more employees (as proposed for later years of program operation), which results in a total estimated employer assessment of \$1.753 billion. All estimates are calibrated to 2007 to facilitate analysis of the impact. Exhibits C-3 and C-4 provide the following information for each version of the assessment:

- Table A: Summary of estimated employer assessment
- Table B: Estimated assessment for private sector firms by offering and non-offering employers
- Table C: Estimated assessment for private sector firms by firm size
- Table D: Summary of private sector firms receiving a full credit against the employer assessment
- Table E: Estimated assessment for public sector firms

As these Exhibits demonstrate, the bulk of the assessment comes from employers who offer coverage but at levels that are below the specified benchmark. In part, this is reflective of the fact that there are few non-offering firms in these size ranges. Of all firms who offer and have 25 or more workers, we estimate that 50 percent of them (representing 41 percent of all workers in such firms) will be subject to a partial assessment. On average, the per worker assessment is small for these offering employers, averaging about 2 percent of payroll among offering firms subject to a partial assessment.

## Appendix C: Sample Employer Assessment Analysis

### Methodological Note

The employer assessment estimates described here use a database constructed from 2004 Illinois and U.S. Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) data. Illinois data alone does not provide enough detail for this analysis so we have used the “richer” U.S. data to impute additional distributional detail for Illinois employers regarding the percent of their workforce covered and average health care spending as a percent of payroll. We projected these estimates to 2007 using workforce and payroll projections. Two, closely related, sourced payroll data were used to facilitate our analysis. The Agency for Healthcare Quality and Research provided a distribution containing employer health care spending as a percent of payroll that used payroll data that were derived from IRS business records. We also used Illinois payroll data from County Business Patterns to show average payroll for each of our employer groups (also ultimately derived from IRS records). We also used data from the Medical Expenditure Panel Survey-Household Component (MEPS-HC) data to estimate the number of workers who worked fewer than 20 hours a week and to refine our estimates of how average payroll differed between offering and non-offering employers. Despite the additional distributional detail, these estimates should still be considered general estimates.

**Appendix C: Example of an Employer Assessment Policy**

**Exhibit C-1: Comparison of Employer Assessment Version 1 and Version 2**

Feature	Version 1: Original Employer Assessment (September 20, 2006)	Version 2: Employer Assessment Presented at Steering Committee Meeting (November 6, 2006)
<b>Employers subject to the assessment</b>	Every employer who employs at least 25 Illinois residents who work at least 20 hours a week	<p><i>Years 1 and 2</i> – Every employer who employs at least 25 Illinois residents who work at least 20 hours a week</p> <p><i>Year 3 and beyond</i> – Every employer who employs at least 10 Illinois residents who work at least 20 hours a week (allowing time to identify and resolve issues related to the assessment before applying to very small employers)</p>
<b>Amount of assessment</b>	Eight percent of total payroll up to a maximum of \$2,500 per employee	4.8 percent of total payroll up to a maximum of \$2,500 per employee
<b>Conditions for obtaining a credit against the assessment</b>	<p><u>Full Credit</u></p> <p>Employers will receive a credit against the assessment if they prove one of the following:</p> <ol style="list-style-type: none"> <li>1. Eight percent of the total payroll for Illinois based employees (up to \$2,500 per employee) is used to purchase health care insurance for those employees.</li> <li>2. Eighty percent of the firm’s employees who are Illinois residents and who work 20 hours or more in a week for four consecutive weeks are covered by qualified health coverage, as defined for the individual mandate (coverage in the individual market, through</li> </ol>	<p><u>Full Credit</u><sup>2</sup></p> <ol style="list-style-type: none"> <li>1. Employers must demonstrate that 60 percent of their Illinois –based full-time equivalent (FTE) workforce is enrolled in coverage sponsored by the employer; <u>and</u></li> <li>2. Employers must demonstrate that they spend either:               <ol style="list-style-type: none"> <li>a. \$2,500 per FTE worker; or</li> <li>b. 4.8 percent of total payroll (equivalent to the target of eight percent of average payroll applied to the threshold of 60 percent of the workforce)</li> </ol> </li> </ol> <p><u>Partial Credit</u></p> <p>Employers may receive a partial credit against the assessment if</p>

<sup>2</sup>The structure of the assessment will have to be coordinated with the below-market contribution provision that is being offered to small, low-wage employers in the proposed coverage approach. Small, low-wage employers who cover their workers under that model provision should not be subject to an assessment. If necessary, an exemption should be included for them.

**Appendix C: Example of an Employer Assessment Policy**

**Exhibit C-1: Comparison of Employer Assessment Version 1 and Version 2**

Feature	Version 1: Original Employer Assessment (September 20, 2006)	Version 2: Employer Assessment Presented at Steering Committee Meeting (November 6, 2006)
	<p>an employer, family member, public program, etc.)</p> <p><u>Partial Credit</u> – Not specified although the ability to obtain a partial credit was assumed under this model.</p>	<p>they offer coverage but cannot meet the first criterion, i.e., 60 percent of their FTE workforce is not enrolled in employer-sponsored coverage. In those cases, their assessment will be equal to:</p> <ol style="list-style-type: none"> <li>1. The difference between the number of full time equivalent employees representing 60 percent of their workforce and the number of FTE workers covered, multiplied by:</li> <li>2. The lesser of eight percent of average payroll per FTE worker or \$4,167.<sup>3</sup></li> </ol> <p>If employers meet the first criterion (i.e., 60 percent of their Illinois-based FTE workforce are enrolled in coverage sponsored by the employer) but neither of the second set of criteria (i.e., employer spends \$2,500 per worker or eight percent of payroll on health care), they can still obtain a partial credit, with the remaining assessment equal to 4.8 percent of total payroll less total employer spending on coverage (this percentage is consistent with the approach to calculating the full assessment).</p>
<p><b>Safeguards for Certain Categories of Firms</b></p>	<p>Not specified</p>	<ol style="list-style-type: none"> <li>1. Firms that have more than 60 percent of their workforce taking up an employer offer of coverage that is consistent with the guaranteed-issue comprehensive benefit plan in the individual market may apply for a special credit against the assessment. This policy is intended to safeguard firms that, because their workforce may be young and healthy, may have high take-up levels of coverage but whose health care</li> </ol>

<sup>3</sup> Because the partial assessment will be applied to only 60 percent of their full time equivalent workforce, we divided \$2,500 by .6 to determine the \$4,167 amount. For firms subject to the cap, the net result will be an assessment equal to \$2,500 per full time equivalent worker overall.

**Appendix C: Example of an Employer Assessment Policy**

**Exhibit C-1: Comparison of Employer Assessment Version 1 and Version 2**

<b>Feature</b>	<b>Version 1: Original Employer Assessment (September 20, 2006)</b>	<b>Version 2: Employer Assessment Presented at Steering Committee Meeting (November 6, 2006)</b>
		spending as a percentage of payroll may be low.  2. Firms that are undergoing financial difficulty and are unable to pay the assessment for reasons beyond their control (i.e., natural disaster or other unavoidable situation) may have access to a special appeals process to achieve a credit against the assessment.

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Exhibit C-2: Overview of Employer Assessment Analyses Provided to the Adequate Healthcare Task Force

	Version 1		Intermediate Estimates (for Subgroup discussions)		Version 2	
<b>Simulation Date:</b>	9/26/2006	10/30/2006	11/1/2006	11/1/2006	12/7/2006	12/7/2006
<b>I. Assessment Parameters</b>						
Firms included in Estimate	All Sizes	Firms of 25 or more Employees	Firms of 25 or more Employees	Firms of 10 or more Employees	Firms of 25 or more Employees	Firms of 10 or more Employees
Type of workers included (if they met firm size requirements)	Workers in all sectors		Only private-sector workers		Workers in all sectors with the exception of workers who worked less than 20 hours	
Total Payroll Assessment Rate	8%		4.8%		4.8%	
<b>2. Simulation Assumptions</b>						
Simulation Year	2007		2004		2007	
<i>Non-offering Firms:</i>						
Number of Firms Facing Assessment	Not Estimated		3,403	17,063	Not Estimated	
Workers in Firms Facing an Assessment	783,527	123,038	95,877	242,297	82,889	205,244
Average Payroll Assumption	\$ 22,638	\$ 22,638	\$ 26,951	\$ 26,807	\$ 17,425	\$ 21,680
<i>Offering Firms:</i>						
Number of Firms Facing Assessment	Insufficient Data to Estimate		35,644	45,477	Not Estimated	
Workers in Firms Facing an Assessment	Insufficient Data to Estimate		1,678,181	1,830,615	1,901,524	2,071,087
Average Payroll Assumption	Insufficient Data to Estimate		\$ 33,195	\$ 33,396	\$ 38,591	\$ 39,113
<b>Total Simulated Annual Assessment</b> (\$ in millions)	\$ 1,419	\$ 223	\$ 1,235	\$ 1,519	\$ 1,486	\$ 1,753

Exhibit C-3: Simulation of Version 2 of the Employer Assessment (firms of 25 or more workers)

Table A: Summary of Estimated Employer Assessment (2007)

	Total Assessment Amount (in Millions)
Private Sector Firms	\$ 1,309
Public Sector Firms	\$ 177
<b>Total</b>	<b>\$ 1,486</b>

Table B: Private Sector Firms Facing an Assessment (2007)

Employer Type	Percent of All Establishments with 25 or More Employees	Number of Workers	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
<b>Non-offering Employers:</b>	4%	82,889	\$ 17,425	\$ -	0%	\$ 69	\$ 836	4.8%
<b>Offering Employers:</b>								
Firms covering less than 60% of workers	47%	1,577,040	\$ 38,307	\$ 1,668	4.4%	\$ 1,235	\$ 783	2.0%
Firms covering 60% or more of their workers yet spending less than 4.8% of payroll	1%	26,477	\$ 66,315	\$ 2,998	4.5%	\$ 5	\$ 186	0.3%
<b>Total (Offering and Non-Offering)</b>	<b>53%</b>	<b>1,686,405</b>	<b>\$ 37,721</b>	<b>\$ 1,607</b>	<b>4.3%</b>	<b>\$ 1,309</b>	<b>\$ 776</b>	<b>2.1%</b>

Exhibit C-3: Simulation of Version 2 of the Employer Assessment (firms of 25 or more workers)

Table C: Private Sector Firms Facing an Assessment by Firm Size (2007)

Firm Size	Percent of All Establishments with 25 or More Employees	Number of Workers	Average Payroll per Worker**	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
Less than 10 employees		-	\$ -	\$ -	0.0%	\$ -	\$ -	
10-24 employees	0%	-	\$ -	\$ -	0.0%	\$ -	\$ -	0.0%
25-99 employees	20%	486,106	\$ 37,058	\$ 1,532	4.1%	\$ 380	\$ 782	2.1%
100-999 employees	7%	345,646	\$ 40,426	\$ 1,158	2.9%	\$ 307	\$ 888	2.2%
1000 or more	26%	854,654	\$ 37,003	\$ 1,638	4.4%	\$ 622	\$ 728	2.0%
<b>Total (All Firms Sizes)</b>	<b>53%</b>	<b>1,686,405</b>	<b>\$ 37,721</b>	<b>n/a</b>	<b>n/a</b>	<b>\$ 1,309</b>	<b>\$ 776</b>	<b>2.1%</b>

Table D: Private Sector Firms Receiving a Full Credit Against the Assessment (2007)

	Percent of All Establishments with 25 or More Employees	Number of Workers	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll
<b>Offering Employers:</b>	47%	2,353,734	\$ 52,971	\$ 5,055	9.5%

Table E: Public Sector Employers Facing an Assessment (2007)

	Number of Workers	Percent of Entire Public Sector Workforce (20 or more hours/week)	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
<b>Offering Employers:</b>	298,007	38%	\$ 37,629	\$ 3,032	8.1%	\$ 177	\$ 595	1.6%

Sources: Estimates by Mathematica Policy Research, Inc. based on 2004 Medical Expenditure Panel Survey-Insurance Component for the U.S. and Illinois.

Exhibit C-4: Simulation of Version 2 of the Employer Assessment (firms of 10 or more workers)

Table A: Summary of Estimated Employer Assessment (2007)

	Total Assessment Amount (in Millions)
Private Sector Firms	\$ 1,576
Public Sector Firms	\$ 177
<b>Total</b>	<b>\$ 1,753</b>

Table B: Private Sector Firms Facing an Assessment by Offering and Non-Offering Employers (2007)

Employer Type	Percent of All Establishments with 10 or More Employees	Number of Workers	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
<b>Non-offering Employers:</b>	15%	205,244	\$ 21,680	\$ -	0%	\$ 209	\$ 1,018	4.7%
<b>Offering Employers:</b>								
Firms covering less than 60% of workers	42%	1,738,837	\$ 38,856	\$ 1,689	4.3%	\$ 1,356	\$ 780	2.0%
Firms covering 60% or more of their workers yet spending less than 4.8% of payroll	1%	34,243	\$ 65,063	\$ 2,809	4.3%	\$ 11	\$ 314	0.5%
<b>Total (Offering and Non-Offering)</b>	<b>58%</b>	<b>1,978,323</b>	<b>\$ 37,528</b>	<b>\$ 1,533</b>	<b>4.1%</b>	<b>\$ 1,576</b>	<b>\$ 796</b>	<b>2.1%</b>

Exhibit C-4: Simulation of Version 2 of the Employer Assessment (firms of 10 or more workers)

Table C: Private Sector Firms Facing an Assessment by Firm Size (2007)

Firm Size	Percent of All Establishments with 10 or More Employees	Number of Workers	Average Payroll per Worker**	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
Less than 10 employees		-	\$ -	\$ -	0.0%	\$ -	\$ -	
10-24 employees	21%	284,152	\$ 35,747	\$ 1,008	2.8%	\$ 261	\$ 917	2.6%
25-99 employees	14%	493,872	\$ 37,431	\$ 1,542	4.1%	\$ 386	\$ 781	2.1%
100-999 employees	5%	345,646	\$ 40,426	\$ 1,158	2.9%	\$ 307	\$ 888	2.2%
1000 or more	18%	854,654	\$ 37,003	\$ 1,638	4.4%	\$ 622	\$ 728	2.0%
<b>Total (All Firms Sizes)</b>	<b>58%</b>	<b>1,978,323</b>	<b>\$ 37,528</b>	<b>n/a</b>	<b>n/a</b>	<b>\$ 1,576</b>	<b>\$ 796</b>	<b>2.1%</b>

Table D: Private Sector Firms Receiving a Full Credit Against the Assessment (2007)

	Percent of All Establishments with 10 or More Employees	Number of Workers	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll
<b>Offering Employers:</b>	42%	2,505,703	\$ 52,868	\$ 5,022	9.5%

Table E: Public Sector Employers Facing an Assessment (2007)

	Number of Workers	Percent of Entire Public Sector Workforce (20 or more hours/week)	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
<b>Offering Employers:</b>	298,007	38%	\$ 37,629	\$ 3,032	8.1%	\$ 177	\$ 595	1.6%

Sources: Estimates by Mathematica Policy Research, Inc. based on 2004 Medical Expenditure Panel Survey-Insurance Component for the U.S. and Illinois.