



Gwyn Davidson
Associate Director

gdavidson@navigantconsulting.com
312.583.5752 direct

August 10, 2006

Adequate Health Care Task Force
James R. Thompson Center
100 W. Randolph, Suite 6-600
Chicago, IL 60601

Dear Adequate Health Care Task Force Members:

During the July 25, 2006 Adequate Health Care Task Force meeting, the Task Force requested that the Navigant Consulting team:

- Respond to Task Force members' and proposers' questions regarding the evaluation and modeling of the proposals
- Provide the Task Force with any resulting changes to the July 25, 2006 Evaluation of Proposals and Presentation of Hybrid Model.

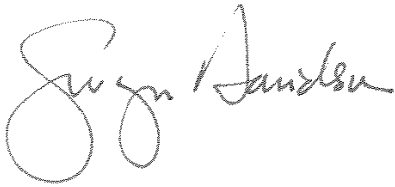
As such, we have enclosed the following documents:

- Answers to questions from Task Force members and responses to selected key issues raised since the July 25, 2006 meeting
- Summary of overall observations regarding effectiveness and efficiencies of different program components
- Replacement pages and sections for the July 25, 2006 report, as follows:
 - Section II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry
 - Section II.C – Proposal Evaluation: Healthy Illinois (pages 4 and 11 only)
 - Section II.E – Proposal Evaluation: Single Payer (page 12 only)

- Section III – Scoring Summary (page 6 only)
- Sections V and VI (Cost and Coverage Quantitative Model Methodology, Assumptions and Results – please note that we are still in the process of completing changes to the results for the Illinois Hospital Association and will provide those as soon as they are ready.

We look forward to meeting with you August 15, 2006 to discuss changes to our evaluation.
Thank you.

Sincerely,

A handwritten signature in cursive script that reads "Gwyn Davidson". The signature is written in black ink and is positioned above the typed name.

Gwyn Davidson
Associate Director

I. Summary of Proposal

This proposal expands access to care by promoting private market coverage options, including the use of consumer-directed health plans (CDHPs). The proposal encourages the use of health savings accounts (HSAs) in a variety of ways and recommends providing tax incentives to small employers and employees to make coverage more affordable. The proposal uses the private market in the following ways:

- Implements federal and State refundable and advanceable tax credits for small employers and low-income individuals (excluding those individuals eligible for the vouchers described below).
- Requires that the two principal ICHIP pools offer CDHP options with HSA-compatible high deductible health plans.
- Recommends voluntary, federally-subsidized individual and/or small group reinsurance pool for high-risk individuals.

In addition, the proposal reforms Medicaid to contain costs and allow Medicaid consumers to choose private sector options or a more traditional Medicaid plan and supports limited public program expansions. This proposal emphasizes blending Medicaid coverage with private sector coverage and in the long-term having a seamless system that provides Medicaid consumers with a set amount of dollars that are sufficient to fund their “insurance “coverage while providing them with additional choice. The specific Medicaid changes contained in this proposal are:

- Medicaid expansion for single, childless adults at or below 100 percent of the federal poverty level (FPL), which will be funded by implementation of long-term care partnerships pursuant to provisions of the federal Deficit Reduction Act of 2005, Medicaid managed care and through efficiencies gained by the consolidation of existing state health and medical assistance programs.
- Medicaid and SCHIP-funded premium assistance program that will provide subsidies to assist uninsured low- and middle-income individuals and families in purchasing health insurance through the employer or in the private market (similar to Oregon’s Family Health Insurance Assistance Program).

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

- Personal health accounts to Medicaid beneficiaries who enroll in a CDHP option.
- Requiring Medicaid eligibles to enroll in managed care unless they enroll in a Medicaid personal health account option; the expected savings from the program will be used to increase reimbursement rates to hospitals and physicians.
- Increasing enrollment in public programs, including Medicaid, for individuals who are public-program eligible but not enrolled, and increasing payments to Medicaid and SCHIP providers.

Individuals in Medicaid or SCHIP will likely receive a somewhat reduced Medicaid benefit package depending on the benefit restrictions enacted to fund additional coverage expansions. The benefit package offered to people receiving their health coverage through the private market will vary according to the private market's offerings. The proposal also contains provisions to encourage take-up of long-term care insurance, and to educate consumers on health care coverage options.

The proposal also recommends accelerating the adoption of health information technology and related infrastructure to improve quality, patient safety and efficiency, reduce administrative burdens on providers, and to reduce treatment variation. It suggests increasing pay-for-performance and implementing an on-going consumer-targeted patient safety initiative, increasing consumer education related to health care coverage and increasing consumer involvement in health care decisions.

See Appendix VII.A for additional information regarding this proposal.

**II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry
Adequate Health Care Task Force**

Evaluation of Proposal

A. Criteria

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
<p>1. Access</p> <p><i>Criteria Weight: 15.0</i></p> <p><i>Possible Points: 10.0</i></p> <p><i>Assigned Points: 7.0</i></p> <p><i>Total Weighted Score: 10.5</i></p>	<p>a) Provides coverage to all Illinois residents</p> <p><i>Assign 1-5 points, 5 represents coverage to all residents</i></p> <p>b) Mandates coverage</p> <p><i>Assign 1 point if coverage is mandatory</i></p> <p>c) Includes provisions to avoid crowd-out of private insurance</p> <p><i>Assign 1-2 points for provisions to avoid crowd-out of private insurance</i></p> <p>d) Includes provisions for portability, i.e., individuals maintain coverage as life circumstances (e.g., employment, transition from Medicaid, etc.) and health status change</p> <p><i>Assign 1-2 points for provisions for portability</i></p>	<p>a) 4.0 points – Increases private market insurance options (for Medicaid and non-Medicaid populations) and includes limited Medicaid expansions. Preliminary model results indicate that these efforts would result in health care coverage for over approximately one-third of Illinois’ currently uninsured population. The proposal does not require take-up by employers and individuals of the new health care coverage options, however, and projected take-up of proposed options – with the exception of the Medicaid expansion to childless adults – ultimately results in a somewhat limited impact on the number of uninsured.</p> <p>b) 0.0 points – Does not include individual or employer mandate.</p> <p>c) 2.0 points – Avoids crowd-out through emphasis on private insurance.</p> <p>d) 1.0 point – Does not include options to make COBRA more affordable or provide other coverage during</p>	<ul style="list-style-type: none"> • Attempts to make insurance more affordable by providing subsidies, vouchers and tax incentives to those who cannot currently afford health insurance, promoting HSAs and recommending insurance market reforms to allow lower-priced products to enter the market. • Provides for additional connections to the private insurance market for Medicaid recipients.

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		insurance transitions such as a job loss.	
<p>2. Financing</p> <p><i>Criteria Weight: 15.0</i></p> <p><i>Possible Points: 9.0</i></p> <p><i>Assigned Points: 7.0</i></p> <p><i>Total Weighted Score: 11.7</i></p>	<p>a) Finances additional costs through an approach that incorporates proper load-sharing between providers, insurers, state government and patient/taxpayers</p> <p><i>Assign 1-5 points for approaches that spread burden of costs across providers, insurers, state and federal government and taxpayers</i></p> <p>b) Maximizes federal funds</p> <p><i>Assign 1-2 points for approaches that maximize federal funds</i></p> <p>c) Enhances affordability for small employers</p> <p><i>Assign 1-2 points for features that enhance affordability for small employers</i></p>	<p>a) 3.0 points – Finances plan through Medicaid funds, State revenue growth above three percent, employer contributions and individual contributions. Linking funding to state revenue growth, while a common practice, means that at times when the revenue growth target is not met, funding for the health care expansion would be at risk. While the proposal includes provisions to incent insurers to offer High Deductible Health Plans and other health plans (i.e., eliminating premium taxes on high-deductible health plans offered with HSAs), it does not contain specific provisions that will increase insurer or provider commitments to assist in financing costs through controlling health care costs or committing additional resources to the funding of care for the uninsured.</p> <p>b) 2.0 points – Uses federal funds to expand coverage to childless adults under 100 percent of the FPL in Medicaid, and to provide premium subsidies for an employer-based program similar to Oregon’s Family Health Insurance Assistance Program.</p>	<ul style="list-style-type: none"> • Establishes a specific source of funding for expansion financing (state revenue growth above three percent). • Uses long-term care partnerships as a method to achieve long-term savings for long-term care services. • Does not provide information on how the State will finance the development of plans that encourage small businesses to work together to access and maintain health insurance in their local communities. • Specifies that funding for the childless adult expansion will come from (1) mandatory Medicaid managed care, and (2) decreased benefits for the current Medicaid/SCHIP population. Preliminary modeling results indicate that due to the high take-up rate of the childless adult expansion, funding requirements will be significant. • The proposal’s emphasis on expanding employer-based sources of coverage will allow employers

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		<p>The proposal attempts to effectively use Medicaid funds by seeking savings from the current Medicaid program to accomplish this goal (i.e., reducing benefits to the current Medicaid-eligible population, implementing mandatory managed care beyond the State’s primary care case management program, consolidating existing state health and medical assistance programs, and using long-term care partnerships). It is not clear if this approach will result in the necessary savings.</p> <p>c) 2.0 points – Promotes state and federal tax incentives for small employers.</p>	<p>that newly offer health care coverage to obtain tax exclusions.</p>
<p>3. Benefit Package</p> <p><i>Criteria Weight: 15.0</i></p> <p><i>Possible Points: 10.0</i></p> <p><i>Assigned Points: 7.0</i></p> <p><i>Total Weighted Score: 10.5</i></p>	<p>a) Provides full range of benefits specified in the Health Care Justice Act:</p> <p>i) Acute care services</p> <p>ii) Preventive services, including age-appropriate preventive care screening</p> <p>iii) Parity for mental health and substance abuse services</p> <p>iv) Long-term care service package, including rehabilitative services to transition patients from more</p>	<p>a) 7.0 points – Allows for limits on benefits provided, including those offered by Medicaid. The proposal promotes HSAs, allows individuals flexibility in purchasing a wide range of benefits, including dental and vision services and over the counter drugs (items which are normally not covered under traditional health plans). However, the extent to which individuals can access this wider range of benefits depends on their ability to contribute to the HSA. Given the limited take-up of HSAs in the state,</p>	<ul style="list-style-type: none"> • Includes provision allowing individuals and small businesses to opt out of mandated benefits may lead to less expensive, but also less comprehensive benefit packages for those who obtain coverage in the private market. As such, it may not be as responsive to the needs of individuals with disabilities or needs that result from a major illness or injury. • Expands Medicaid, which provides a comprehensive benefit package including mental health and

**II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry
Adequate Health Care Task Force**

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	<p>costly inpatient settings to home and community</p> <p>v) Services for the developmentally disabled, such as home- and community-based services and supports</p> <p><i>Assign 0 – 10 points for services offered</i></p>	<p>this flexibility is not expected to result in large increases in the number of uninsured obtaining access to a full range of benefits.</p> <p>Proposal encourages the purchase of long-term care insurance through Long-Term Care Partnerships. Proposal does not address parity for substance abuse services and lacks recommendations on the additional provision of services for the developmentally disabled population.</p> <p>Proposer indicates that current private insurance offerings contain a full range of benefits; actual benefits available to an individual covered by private insurance will depend on the coverage policies of the particular benefit package.</p>	<p>substance abuse services for some groups and services for the developmentally disabled, it also suggests reductions in Medicaid benefits for certain populations (as allowed by the Deficit Reduction Act without a waiver) to obtain the cost-savings to expand benefits to other populations. Depending on how benefit adjustments are implemented, this change could result in reduced access to care for current Medicaid eligibles.</p> <ul style="list-style-type: none"> • Includes preventive services for current and new Medicaid eligibles and preventive services for employers and/or individuals who purchase coverage on the private market and choose to include preventive care in their benefit package. • Recommends that the State develop long-term care partnerships, which will encourage individuals to purchase long-term care insurance. • Recommends that certain state benefit mandates that are not also federally mandated be removed.

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
			<ul style="list-style-type: none"> Does not specifically address populations that may have specific needs (i.e., rural health care, developmentally disabled, etc.)
<p>4. Implementation</p> <p><i>Criteria Weight: 7.0</i></p> <p><i>Possible Points: 15.0</i></p> <p><i>Assigned Points: 10.5</i></p> <p><i>Total Weighted Score: 4.9</i></p>	<p>a) Legal and regulatory changes required to implement the proposal can be accomplished within 1-3 years</p> <p><i>Assign 0-5 points for ability to obtain legal and regulatory approvals that are necessary for implementation</i></p> <p>b) Federal waivers, if required, can be implemented within 1-3 years</p> <p><i>Assign 0-5 points for feasibility in obtaining federal waivers</i></p> <p>c) Includes provisions for a reasonable phase-in period that does not cause significant disruptions for employers or consumers</p> <p><i>Assign 0-3 points for reasonable phase-in approaches and timelines</i></p> <p>d) Includes accountabilities for ongoing performance, cost and quality</p> <p><i>Assign 0-2 points for features that assure accountabilities related to ongoing performance, cost and quality</i></p>	<p>a) 4.0 points – Assuming political support, the State could accomplish proposed changes within 1-3 years although the proposal’s recommendations related to federal tax credits will require federal legislation to implement, which could prove difficult. The proposer has indicated it would consider implementing the tax provisions on a state level while pursuing the tax credits at the federal level.</p> <p>b) 3.0 points – An 1115 federal waiver will be necessary to obtain federal Medicaid and SCHIP funding for the proposed expansion of coverage to childless adults. The ability of the State to obtain this waiver would rely on the ability to achieve budget neutrality. While the State could implement this expansion as part of a block grant approach, budget neutrality is still a component of any arrangement between the federal and state government. The proposer has</p>	<p>Requires elimination of premium taxes on high-deductible health plans offered with HSAs.</p> <p>Proposer has indicated that moving to a “funding-centric” system (i.e., block grant or personal health accounts) would enhance predictability and stability of costs.</p>

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		<p>indicated that sufficient cost savings could be achieved by (1) implementing mandatory Medicaid managed care (beyond the State’s current primary care case management program) and personal health accounts, (2) modifying Medicaid benefits, (3) implementing long-term care partnerships, and (4) consolidating existing state health and medical assistance programs. As the State recently implemented a primary care case management program and is using savings from that initiative to help fund the All Kids expansion, it is unclear if sufficient cost-savings could be achieved for budget neutrality purposes.</p> <p>c) 2.5 points – Lacks information on phase-in period for Medicaid’s transition to personal health accounts and mandatory managed care, and any reductions in Medicaid benefits. Also does not include information on a phase-in period for regulatory changes, tax cuts and introduction of vouchers and subsidies.</p> <p>d) 1.0 point – While the proposal supports accelerating the adoption of health insurance technology and indicates that establishing an health</p>	

**II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry
Adequate Health Care Task Force**

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		<p>information technology infrastructure is necessary to improve quality, patient safety and efficiency, it does not provide specific policies to accomplish this goal. The proposal indicates that quality tracking and reporting is required to reduce treatment variation, suggests basing more reimbursement on pay-for-performance and recommends improving health literacy, but does not establish specific programs or policies to achieve these goals. Maintains current system's accountabilities regarding performance, cost and quality.</p>	

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
<p>5. Quality</p> <p><i>Criteria Weight: 7.0</i></p> <p><i>Possible Points: 2.0</i></p> <p><i>Assigned Points: 1.5</i></p> <p><i>Total Weighted Score: 5.3</i></p>	<p>a) Creates incentives for providers to adopt practices demonstrated to improve quality (e.g., greater adherence to practice guidelines, consideration of some predictive aspects of care like genomes)</p> <p><i>Assign 1 point for incentives to improve quality</i></p> <p>b) Promotes integration and coordination among parts of the delivery system</p> <p><i>Assign 1 point for provisions that promote coordination within delivery system</i></p>	<p>a) 1.0 points – Proposes increasing the use of pay-for-performance, but does not provide a specific approach to do so.</p> <p>b) 0.5 points – Does not include specific provisions to promote integration and coordination among parts of the delivery system beyond what the current system provides. The proposer does recommend several initiatives to increase coordination among health plan options for consumers (i.e., a web-enabled “health insurance and medical assistance decision tree” and a public-awareness campaign regarding coverage options).</p>	<ul style="list-style-type: none"> Proposes implementing an on-going consumer-targeted patient safety initiative and accelerating the adoption of health information technology and related infrastructure to improve quality. Recommends that the Illinois Department of Public Health implement the “Consumer Guide to Health Care”, which will make public hospital comparison information relating to volume of cases, average charges, risk-adjusted mortality rates and nosocomial infection rates.
<p>6. Cost-efficiency</p> <p><i>Criteria Weight: 7.0</i></p> <p><i>Possible Points: 12.0</i></p> <p><i>Assigned Points: 6.5</i></p> <p><i>Total Weighted Score: 3.8</i></p>	<p>a) Controls growth in overall and per capita expenditures for health care:</p> <ul style="list-style-type: none"> i) Health insurance premiums ii) Public program expenditures iii) Capital iv) Technology v) Administrative costs vi) Prescription drugs vii) Others 	<p>a) 6.0 points – Proposes consumer-engaged approaches in the public and private market, but is somewhat limited in its scope of cost-containment policies beyond what the current system provides.</p> <ul style="list-style-type: none"> Public program expansion takes advantage of primary care case management, disease management and Medicaid rebates. While the proposal recommends mandatory Medicaid managed care to reduce overall per capita expenditures for 	<ul style="list-style-type: none"> Proposal recommends a reinsurance program for plans participating in the purchasing pools that may reduce premium costs and help reduce variability in the small group market. As the State is essentially picking up the remaining costs above the reinsurance threshold on the high cost cases, a reinsurance program can help control costs as risk-bearing insurers continue to contain costs for patients whose

**II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry
Adequate Health Care Task Force**

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	<p><i>Assign 0-10 points for features that control growth in expenditures</i></p> <p>b) Provides mechanisms for generating spending priorities based on multidisciplinary standards of care established by verifiable, replicated research studies demonstrating quality and cost-effectiveness of interventions, providers and facilities</p> <p><i>Assign 0-2 points for mechanisms that take into account standards of care in establishing spending priorities</i></p>	<p>Medicaid program, the ability of Medicaid managed care to achieve additional significant savings is questionable. The State is currently implementing Medicaid managed care through the implementation of a primary care case management program. The State is planning to use the savings from this program to fund the All Kids expansion.</p> <ul style="list-style-type: none"> • The proposal’s emphasis on the use of HSAs may allow consumers to be more connected to their costs of care, and thus be more cost-conscious. • Does not provide recommendations for containing insurer or provider administrative costs and may increase administrative costs through the addition of new coverage options. • Recommends reducing excessive, unnecessary regulation and litigation, but does not recommend on how to reduce these costs beyond monitoring judicial decisions that arise following new Medical Malpractice reform law. 	<p>costs do not meet the reinsurance threshold.</p> <ul style="list-style-type: none"> • This proposal, by expanding coverage to additional uninsured, assists providers in reducing their uncompensated costs. It does not however, contain specific provisions to incentivize providers to be more cost-effective. • While proposal recommends reducing excessive, unnecessary regulation and litigation, it does not state how reductions should occur. • This proposal does not provide incentives for the use of electronic health records and health information technology; however, it proposes accelerating the adoption of health information technology and related infrastructure. The proposer expects that federal legislation will affect this as will the implementation of HIPAA and Electronic Data Interchange (EDI) standards.

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		<ul style="list-style-type: none"> • Includes cost-sharing for individuals. <p>b) 0.5 points – Does not include mechanisms for generating spending priorities; maintains current health care system’s approach.</p>	
<p>7. Availability of Resources, Capital and Technology</p> <p><i>Criteria Weight: 5.0</i></p> <p><i>Possible Points: 6.0</i></p> <p><i>Assigned Points: 3.0</i></p> <p><i>Total Weighted Score: 2.5</i></p>	<p>a) Includes provisions for new capital, technology, medical education, research</p> <p><i>Assign 0-4 points for features that address expenditures for new capital, technology, medical education and research</i></p> <p>b) Includes provisions to protect and enhance, where necessary, the safety-net system</p> <p><i>Assign 0-2 points for features that protect and enhance the safety-net system</i></p>	<p>a) 2.0 points – Proposes accelerating the adoption of health information technology and related infrastructure; however does not provide details on how the State or the private market could encourage acceleration.</p> <p>b) 1.0 points – Recommends using savings from implementing Medicaid managed care and reducing Medicaid benefits and/or eligibles to reimburse providers more fairly, which could increase funding to the safety-net system.</p>	<p>The ability of Medicaid managed care to achieve additional significant savings is questionable. The State is currently implementing Medicaid managed care through the implementation of a primary care case management program. The State is planning to use the savings from this program to fund the All Kids expansion.</p>

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
<p>8. Prevention and Wellness</p> <p><i>Criteria Weight: 10</i></p> <p><i>Possible Points: 2.0</i></p> <p><i>Assigned Points: 1.0</i></p> <p><i>Total Weighted Score: 5.0</i></p>	<p>a) Includes incentives that reward individual wellness</p> <p><i>Assign 1 point for wellness incentives</i></p> <p>b) Contains policies to promote continuity of care</p> <p><i>Assign 1 point for policies to promote continuity of care</i></p>	<p>a) 0.5 points – Includes individual cost-sharing, which might promote wellness by encouraging individuals to participate in their own care, however, the full impact of this relationship is unclear and may vary based on the individual’s income.</p> <p>b) 0.5 points – Promotes continuity of care by expanding Medicaid, which now includes primary care case management and disease management programs, and easing the transition between Medicaid and private coverage. Provides comprehensive benefit package through public insurance, but private insurance may not cover all needed services (e.g., a wide range of rehabilitation or long-term care services), which could reduce continuity of care.</p>	

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
<p>9. Consumer and Stakeholder Participation</p> <p><i>Criteria Weight: 2.5</i> <i>Possible Points: 3.0</i> <i>Assigned Points: 1.0</i> <i>Total Weighted Score: 0.8</i></p>	<p>a) Provides consumers (and their advocates) with opportunities to participate in program design at both the local and regional level</p> <p><i>Assign 1-3 points for opportunities for consumer input regarding technologies, capital and program design</i></p>	<p>a) 1.0 points – Does not include provisions to provide consumers with opportunities to provide input regarding technology and capital. Encourages the State to fund and develop a program to help communities work together to access and maintain health insurance for small businesses on a local and regional basis.</p>	
<p>10. Consumer Autonomy</p> <p><i>Criteria Weight: 4.0</i> <i>Possible Points: 1.0</i> <i>Assigned Points: 1.0</i> <i>Total Weighted Score: 4.0</i></p>	<p>a) Provides consumers with choices of health plans and provider networks</p> <p><i>Assign 1 point for provisions that provide consumers with choices related to health plans and provider networks</i></p>	<p>a) 1.0 points – Provides individuals and businesses enrolled in the private market with health plan and provider network options. Restricts Medicaid eligible individuals to a managed care health plan; however, they will still have a choice of provider.</p>	

II.A – Proposal Evaluation: Recommendations from Members of the AHCTF Associated with the Insurance Industry Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
<p>11. Provider Autonomy</p> <p><i>Criteria Weight: 2.5</i></p> <p><i>Possible Points: 1.0</i></p> <p><i>Assigned Points: 1.0</i></p> <p><i>Total Weighted Score: 2.5</i></p>	<p>a) Preserves providers’ clinical autonomy</p> <p><i>Assign 1 point for provisions that promote provider autonomy in caregiving practices</i></p>	<p>a) 1.0 points – Does not restrict providers’ clinical autonomy.</p>	<p>The implementation of mandatory Medicaid managed care through an at-risk Health Maintenance Organization (HMO), if implemented, could restrict Medicaid provider autonomy. However, the implementation of HSAs on the private market and personal health accounts in Medicaid may increase both consumer and provider autonomy.</p>
<p>12. Provider Payment</p> <p><i>Criteria Weight: 10.0</i></p> <p><i>Possible Points: 4.0</i></p> <p><i>Assigned Points: 1.5</i></p> <p><i>Total Weighted Score: 3.8</i></p>	<p>a) Addresses current deficiencies in timeliness of payment and fee schedule issues that might affect access to care (relates to State programs)</p> <p><i>Assign 0-2 for provisions related to improved timeliness of payment and fee schedule issues</i></p> <p>b) Reduces administrative burdens on providers</p> <p><i>Assign 0-2 points for provisions that reduce administrative burdens on providers</i></p>	<p>a) 1.0 points – Ability to increase Medicaid provider fee schedule issues relies on achieving savings through Medicaid mandatory managed care and reductions in Medicaid benefits. The ability of Medicaid managed care to achieve additional significant savings is questionable. The State is currently implementing Medicaid managed care through the implementation of a primary care case management program and is using those savings to fund the State’s All Kids expansion.</p> <p>b) 0.5 points – Proposal does not address current administrative burdens related to providers and maintains the current system’s approach.</p>	<p>Proposer’s emphasis on providing Medicaid eligibles with a private sector option might result in more payments for Medicaid eligibles being made at commercial insurer rates.</p>

**II.C – Proposal Evaluation: Healthy Illinois Developed By The Healthy Illinois Campaign
Adequate Health Care Task Force**

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
<p>3. Benefit Package</p> <p><i>Criteria Weight: 15.0</i></p> <p><i>Possible Points: 10.0</i></p> <p><i>Assigned Points: 7.0</i></p> <p><i>Total Weighted Score: 10.5</i></p>	<p>a) Provides full range of benefits specified in the Health Care Justice Act:</p> <ul style="list-style-type: none"> i) Acute care services ii) Preventive services, including age-appropriate preventive care screening iii) Parity for mental health and substance abuse services iv) Long-term care service package, including rehabilitative services to transition patients from more costly inpatient settings to home and community v) Services for the developmentally disabled, such as home- and community-based services and supports <p><i>Assign 0 – 10 points for services offered</i></p>	<p>a) 7.0 points – The State self-funded insurance plan’s benefit package will include comprehensive services for hospitalization and prescription drugs, in addition to maintaining coverage for those services and diseases mandated by the Illinois Insurance Code. The proposer has indicated that it is their intent that alcohol and substance abuse services will be mandated benefits.</p> <ul style="list-style-type: none"> • Proposal does not address long-term care services or services for the developmentally disabled. • Proposer indicated that benefit package will cover up to 30 outpatient visits per calendar year for substance abuse. • The proposal does not change the benefit package for existing public programs. 	<ul style="list-style-type: none"> • This proposal does not contain provisions for special populations (such as the developmentally disabled), rural health care or other communities. • In the absence of an employer mandate, proposal does not address the comprehensiveness of coverage currently provided by employers and the potential for underinsurance. • This proposal places a high value on prevention and removes cost-sharing for preventive services.
<p>4. Implementation</p> <p><i>Criteria Weight: 7.0</i></p> <p><i>Possible Points: 15.0</i></p> <p><i>Assigned Points: 10.0</i></p>	<p>a) Legal and regulatory changes required to implement the proposal can be accomplished within 1-3 years</p> <p><i>Assign 0-5 points for ability to obtain legal and regulatory approvals that are necessary for implementation</i></p> <p>b) Federal waivers, if required, can be</p>	<p>a) 5.0 points – Assuming political support, proposed changes could be accomplished within 1-3 years and will involve changes to health insurance law and insurance company regulations.</p> <p>b) Not applicable – Excluded from</p>	<ul style="list-style-type: none"> • For employers who are currently providing benefits, there will be minimal disruption for the first year of program operation. If, however, enrollment is extended to larger employers after one year of program operation, some crowd-out could occur and result in reduced options

**II.C – Proposal Evaluation: Healthy Illinois Developed By The Healthy Illinois Campaign
Adequate Health Care Task Force**

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
<p>12. Provider Payment</p> <p><i>Criteria Weight: 10.0</i></p> <p><i>Possible Points: 4.0</i></p> <p><i>Assigned Points: 0.0</i></p> <p><i>Total Weighted Score: 0.0</i></p>	<p>a) Addresses current deficiencies in timeliness of payment and fee schedule issues that might affect access to care (relates to State programs)</p> <p><i>Assign 0-2 for provisions related to improved timeliness of payment and fee schedule issues</i></p> <p>b) Reduces administrative burdens on providers</p> <p><i>Assign 0-2 points for provisions that reduce administrative burdens on providers</i></p>	<p>a) 0.0 points – Does not specifically address issues related to timeliness of payment or fee schedules for public programs.</p> <p>b) 0.5 points – Proposal does not address administrative burden related to providers and maintains the current system’s approach.</p>	<p>The Healthy Illinois proposal is focused on a State self-funded insurance plan and does not discuss access under current public programs.</p>

**II.E – Proposal Evaluation: Single Payer Health Insurance Program for Illinois – Physicians for a National Health Program,
Health and Medicine Policy Research Group, Access Living, UE Western Region and Metro Seniors
in Action**

Adequate Health Care Task Force

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
<p>10. Consumer Autonomy</p> <p><i>Criteria Weight: 4.0</i> <i>Possible Points: 1.0</i> <i>Assigned Points: 0.5</i> <i>Total Weighted Score: 2.0</i></p>	<p>a) Provides consumers with choices of health plans and provider networks</p> <p><i>Assign 1 point for provisions that provide consumers with choices related to health plans and provider networks</i></p>	<p>a) 0.5 points –Allows consumer unrestricted choice of providers. Restricts consumers’ choices in health plans, since only the single payer plan would be available, but the benefits meet or exceed every plan currently sold in Illinois. In addition, consumers could choose between a fee-for-service plan or receiving services through a staff-model HMO, as well as providers. In addition, they can purchase a “gap” plan for any uncovered services. Patients will lose “choice” to go bankrupt when they get sick.</p>	<p>Proposer notes that multiple choice of health plans (and corresponding provider networks) is no longer an issue under the single payer system, and that consumers will have their choice of doctors. Consumers may not be able to access all desired services, however, if shortfalls in global budgeting result in service restrictions by those providers.</p>
<p>11. Provider Autonomy</p> <p><i>Criteria Weight: 2.5</i> <i>Possible Points: 1.0</i> <i>Assigned Points: 0.5</i> <i>Total Weighted Score: 1.3</i></p>	<p>a) Preserves providers’ clinical autonomy</p> <p><i>Assign 1 point for provisions that promote provider autonomy in caregiving practices</i></p>	<p>a) 0.5 points – Suggests that providers can provide all medically necessary services. However, since global budgets will be used to control costs, it is highly likely that some services will be restricted and that waiting lists will form.</p>	<ul style="list-style-type: none"> Proposer indicates that doctors will have more autonomy in practice under single payer as they will no longer need to deal insurance companies and their varying rules, regulations, and payment details.

III – Summary of Preliminary Evaluation Scoring
Adequate Health Care Task Force

Criteria	Weight	Possible Points	Possible Weighted Score	Illinois Hospital Association		Campaign for Better Health Care and Health and Disability Advocates		Single Payer		Healthy Illinois		Selected Insurance Industry TF Members		Hybrid		
				Points Scored	Weighted Scoring	Points Scored	Weighted Scoring	Points Scored	Weighted Scoring	Points Scored	Weighted Scoring	Points Scored	Weighted Scoring	Points Scored	Weighted Scoring	
				D	E=(D/B)*A	F	G=(F/B)*A	H	I=(H/B)*A	J	K=(J/B)*A	L	M=(L/B)*A	N	O=(N/B)*A	
12 Provider Payment																
a. Addresses current deficiencies in timeliness of payment and fee schedule issues that might affect access to care (relates to State programs). Assign 0-2 for provisions related to improved timeliness of payment and fee schedule issues.		2.0		2.0	2.0	2.0	2.0	2.0	0.0		1.0		1.0			
b. Reduces administrative burdens on providers. Assign 0-2 points for provisions that reduce administrative burdens on providers.		2.0		0.5	0.5	1.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5		
<i>Subtotal</i>	<i>10.0</i>	<i>4.0</i>	<i>10.0</i>	<i>2.5</i>	<i>6.3</i>	<i>2.5</i>	<i>6.3</i>	<i>3.0</i>	<i>7.5</i>	<i>0.5</i>	<i>1.3</i>	<i>1.5</i>	<i>3.8</i>	<i>1.5</i>	<i>3.8</i>	
Total	100.0	75.0	100.0	49.0	70.0	55.0	75.4	58.0	85.4	50.0	70.7	48.0	65.3	55.5	76.3	

* Points for federal waiver implementation are not included in weighted scoring as the proposer did not include federal waivers in the proposal.

V. Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

This section describes the methodology used to develop the cost and coverage quantitative model and the assumptions used to model the various access strategies presented in Section VI. We first describe the model itself and the overall approach to estimates the costs and participation involved in the different strategies. We then provide the specific assumptions used to model each proposal at a high level.

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 legislative estimate.

The Estimation Approach

We use a population-based simulation model to estimate the cost and coverage impacts of each proposal. We assume in all estimates that the proposal is fully implemented in 2007. These estimates do not include implementation costs. All estimates are for residents age 0-64 in order to remove the impact of almost universal Medicare coverage among the population age 65 or older.

The estimation approach accounts for differences in benefit design, contractual allowances from providers, and administrative costs. It offers estimates of potential payroll tax revenues, availability of federal matching funds, and insurer assessments and employer fees. It does not estimate employment impacts or other potential secondary impacts.

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.¹ We supplemented these data 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.

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

¹ By way of comparison, the Illinois sample in the Census 5 percent Public Use Micro Sample (PUMS) contains 619,232 observations for the state of Illinois and the 2004 Current Population Survey contains just 7,198 observations. Note: the census data do not distinguish between full and part-time college students. For proposals that required this distinction, we defined full-time students as those that were students and worked more 30 or more hours. If a proposal included ¾ time students, these were assumed to represent an additional 20 percent of eligible students (compared to full-time alone).

V. Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

match in the Medicaid and SCHIP programs.² Illinois uses state-only funds to cover legal immigrant children who are otherwise eligible for Medicaid and SCHIP but who immigrated too recently to qualify under federal rules.³

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 interchangeable elements including:

- 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 rates⁴

These factors were developed using Milliman Inc.'s actuarial expertise and a proprietary model calibrated to Illinois-specific charge and utilization factors. For certain public program expansions, a further adjustment to per capita program costs was made to the cost of new enrollees to account for the fact that they already had maternity coverage under Medicaid/SCHIP if their income was below 200 percent of the FPL.

In addition, Milliman supplied estimates of the premium savings associated with two reinsurance subsidy designs:

- One reimbursed insurers for 90 percent of claims between \$5,000 and \$75,000 (modeled after the Healthy New York program)
- The second reinsurance design targeted claims over \$200,000.

² 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 to say, 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. Everyone, regardless of immigration status, is eligible for Medicaid coverage for emergency room care.

³ These Medicaid recipients represent less than one percent of current Medicaid/SCHIP enrollment in the state according the Illinois Department of Healthcare and Family Services.

⁴ In addition to the administrative cost estimates provided by Milliman, we also used a 6.3 percent administrative rate for the State's ICHIP program, as provided by Illinois' Division of Insurance.

V. Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Estimates Related to Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage

One proposal subsidized the premium payments for COBRA, a program in which employees may be allowed to continue their health insurance benefits for up to 18 months after either voluntary or involuntary termination if the employer has 20 or more employees. The Illinois Continuation Law further provides that employees of any employer group policy must be offered COBRA for nine months.⁵ Employees who choose to purchase this coverage must pay 102 percent of the full premium.⁶

COBRA eligibles are not directly available in the baseline data. Employer survey data for Illinois indicates that 61 percent of wage and salary workers in Illinois (ages 19 to 64) currently have employer-based coverage and would be eligible for COBRA. However, job loss disproportionately affects those without coverage. Some older studies estimate that between 45 and 35 percent of recently unemployed people had health coverage in their former job (Neuschler and Taylor 2002). For purposes of this model, we assume that, on average, 40 percent of the recently unemployed are COBRA-eligible.⁷ We varied this percentage by income level, as shown in the table below.

Table 1: Percent of Currently Unemployed with Access to COBRA by Income as a Percent of the Federal Poverty Level (FPL)

Income	Percent of Currently Unemployed Workers with Access to COBRA
<200 percent FPL	32
200-299 percent FPL	55
300 percent+ FPL	67
Weighted Average	40

Source: Author's estimates.

⁵ http://www.healthinsurancefinders.com/Resources/cr_illinois_continuation_rights_law.pdf

⁶ Active employees typically pay 15 to 27 percent of the total premium.

⁷ Because of the steep premiums, on average only 19 percent of those eligible for the coverage take COBRA (Spencers, 2005). Contributing to this low take up is the fact that approximately 75 percent of those who are unemployed have coverage.

V. Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Estimates Related to the State's High Risk Pool (ICHIP)

Illinois currently operates two high-risk pools.⁸ There is no public information on the total population *eligible* for traditional ICHIP (i.e., those who are denied coverage in the individual market) or on the income distribution associated with ICHIP eligibles. For purposes of the model, we assumed that total number of traditional ICHIP eligibles equals 6,000 (the total currently enrolled) plus the maximum number of individuals ever wait-listed (3,000). HIPAA-CHIP eligibles (who may not be wait-listed) currently total to 10,000. We assume all eligibles are under 300 percent of FPL, an assumption that probably generates conservative (that is, relatively high) estimates of additional funding that might be required to support income-related subsidies, when that is proposed.

Table 2: Population Assumed Eligible for ICHIP Under 300 Percent FPL in 2007 by Enrollment Status

Population	Traditional ICHIP	HIPAA CHIP
Enrolled	6,000	10,000
Eligible but not enrolled	3,000	0

The model assumes that ICHIP enrollees cost 2.5 times as much as a similarly situated non-ICHIP enrollee reflecting their greater medical need.

Payroll Assessments

New payroll assessments are modeled using a total state payroll of \$223 billion reflecting data from Illinois County Business Patterns projected to 2007.⁹

Behavioral Assumptions

Estimating how many of those eligible would take newly offered coverage is an imprecise exercise in this model, as in all health care modeling efforts.

⁸ Illinois residents who are denied coverage in the individual market can purchase coverage from the state's HIPAA-CHIP, if they came to the individual market with creditable coverage (as defined by the Health Insurance Portability and Accountability Act also known as HIPAA). Premiums in this pool are required by statute to not be less than 125 percent or more than 150 percent of the average rate charged on the individual market for similar coverage. By federal law, this pool cannot impose preexisting condition limitations nor can it have a waiting list. The pool is funded by premiums and by an assessment on private group and individual insurance premiums. Those who are denied coverage but lack the "creditable coverage" needed to qualify for the HIPAA pool may purchase coverage in the Illinois Comprehensive Health Insurance Plan (ICHIP), which is subject to a six-month pre-existing condition exclusion. Currently, premiums in this pool are set at 143 percent of the standard risk rate. The pool is funded through premiums and a state appropriation.

⁹ Available at <http://censtats.census.gov/cgi-bin/cbnpnaic/cbpsel.pl>

V. Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Individual Behavioral Assumptions. To minimize the variation in results related solely to differences in participation or take-up assumptions, we used a standard set of assumptions that varied by:

- Family income (as a percent of FPL);
- Whether the coverage offered resembles public coverage, employer coverage or individual (direct) coverage; and
- Whether the purchasing environment is voluntary or mandatory

Proposals that subsidized existing current coverage were assumed to have a take-up rate of 90 percent, regardless of family income. We assumed that a single payer system would enroll all residents automatically (an implied take-up rate of 100 percent).

Employer Behavioral Assumptions. Several proposals would target employers, so that the impact on the worker would be contingent upon the employer's participation decision.¹⁰ Employers who already offer coverage are assumed to continue to do so. Non-offering employers are assumed to be unlikely to begin offering as the result of an employer subsidy reflecting the findings of several research studies (Reschovsky and Hadley 2001; McLaughlin and Zellers, 1992; Thorpe, Hendricks, Garnick, et al. 1992; Marquis and Long 2001; Kronick 2006; Rosenberg 2002; Fronstin 2005; Brown and Stevens 2006). The most prevalent reason why an employer would not begin to offer coverage is low demand among their work force. Many workers in these firms have coverage elsewhere or have a low preference for coverage. One study found that over 50 percent of businesses that do not offer coverage have either zero or one uninsured worker. There are very few small businesses that do not offer coverage and that have substantial numbers of uninsured workers (Kronick 2006).

Assumptions Specific to the Proposals

The six access proposals selected by the Task Force typically have multiple components. We estimated cost and coverage for each component separately and then summed the estimates across components, adjusting to remove duplicate counts of individuals who may be eligible for more than one component. The assumptions that support estimates for each component are summarized in Exhibits 1 through 6 on the following pages. Section VI provides the cost and coverage results associated with each proposal.

¹⁰ Note that we are working with a population based file and do not have firm level information. We used the Medical Expenditure Panel Survey-Insurance Component for Illinois and other data to estimate the number of workers associated with various types of employers (e.g., workers in firms that were small and non-offering) to the model the impacts of the proposals. This is an admittedly an imprecise approach that is unable to completely capture the effect of employer decisions based on a diverse work force.

V. Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

References

- Brown, Lawrence D. and Beth Stevens Charge. Of The Right Brigade? Communities, Coverage, And Care For The Uninsured. *Health Affairs*, May/June 2006; 25(3): w150-w161.
- Chernew, M.,K Frick, and C G McLaughlin The demand for health insurance coverage by low-income workers: can reduced premiums achieve full coverage? *Health Serv Res*. 1997 October; 32(4): 453–470.
- Fix, M. and W. Zimmerman All Under One Roof: Mixed-Status Families in an Era of Reform. Washington, DC: The Urban Institute, 1999.
- Fronstin, Paul and Jason Lee. A Community Expands Access to Health Care: The Case of Access Health in Michigan. *Health Affairs*, May/June 2005.
- Kronick R and Olsen LC. A needle in a haystack? Uninsured workers in small businesses that do not offer coverage, *Health Services Research*, 2006 Feb;41(1):40-57.
- Marquis, M S, and S H Long. To offer or not to offer: the role of price in employers' health insurance decisions. , *Health Serv Res*. 2001 October; 36(5): 935–958.
- Neuschler, Ed and Lynn Taylor. Covering Displaced Workers and Their Children: Issues and Alternatives. Institute for Health Policy Solutions, January 2002.
- Reschovsky, James D. and Jack Hadley Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly, Center for Studying Health System Change, Issue Brief No. 46, December 2001.
- Rosenberg, Stephen N. Lessons from a Small Business Health Insurance Demonstration, the Commonwealth Fund, February 2002
- Spencers 2004 COBRA Benefit Reports.
- Thorpe, K. E., A. Hendricks; D. Garnick; K. Donelan; J. P. Newhouse Reducing the number of uninsured by subsidizing employment-based health insurance. Results from a pilot study, *JAMA*. 1992;267:945-948.
- Kaiser Commission on Medicaid and the Uninsured, [Uninsured Workers in America](#), July 2004.

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 1: Modeling Assumptions: Selected Members of the AHCTF Associated with the Insurance Industry

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 legislative estimate.

Coverage/Access Approach						
General Approach	Public program expansion	Individual Mandate w/ public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	
	Childless Adults eligible for Medicaid up to 100% FPL	Direct Subsidies For Employer Coverage (a.k.a FHIAP)	Direct Subsidies For Individual Coverage (a.k.a FHIAP)	Advanceable, Refundable Tax credits for those ineligible for Direct Subsidies	Small Employer Tax Credits	
Mandatory or Voluntary?	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	
1. Eligible (affected) Population(s)*						
Age	Adults (19-64)	All ages 0-64	All ages 0-64	All ages 0-64	All ages 0-64	
Income	0-100% FPL	0-185% FPL	0-185% FPL	0-185% FPL	All Incomes	
Family Status	Childless Adults	n/a	n/a	n/a	n/a	
Work/Student Status	n/a	FT Workers and their dependents	n/a	n/a	FT Workers and their dependents	
Firm Type	Non-offering Employer	Employer Offers	Non-offering Employer	n/a	1-25; low wage; any offering status	
Current Coverage Status	Must be Uninsured	Must be Uninsured	Must be Uninsured	n/a	n/a	
		<i>In FHIAP, workers cannot get subsidy unless they cover eligible dependents</i>		<i>Those eligible for other programs will be netted out.</i>		
2.a. Individual Premium Subsidy Detail:						
What Type of Subsidy?	Indirect	Direct	Direct	Direct	Direct	
Reinsurance Subsidy ?	No Reinsurance	No Reinsurance	No Reinsurance	No Reinsurance	No Reinsurance	
Relief from Benefit Mandates**	n/a	n/a	n/a	n/a	n/a	
<i>See below for specific subsidies</i>						
2.b. Employer Premium Subsidy Detail:						
Subsidy Percent	0%	0%	0%	0%	50%	

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 1: Modeling Assumptions: Selected Members of the AHCTF Associated with the Insurance Industry

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 legislative estimate.

Coverage/Access Approach						
General Approach	Public program expansion	Individual Mandate w/ public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	
		Childless Adults eligible for Medicaid up to 100% FPL	Direct Subsidies For Employer Coverage (a.k.a FHIAP)	Direct Subsidies For Individual Coverage (a.k.a FHIAP)	Advanceable, Refundable Tax credits for those ineligible for Direct Subsidies	Small Employer Tax Credits
3. Employer Requirements for Participation (if applicable):						
Firm Type	Non-offering Employer	Employer Offers	Non-offering Employer	n/a	1-25; low wage; any offering status	
Minimum ER Contribution (as a percent of premium)	n/a	n/a	n/a	n/a	0%	
4. Health Benefit Detail:						
Scope of Covered Services	Medicaid w/o Maternity	Typical Commercial	Qualified HDHP	Current Coverage	Typical Commercial	
Provider Discounts	Medicaid - 50% Facility/75% Medicare Fees	Commercial - 30% Facility/125% Medicare Fees	Commercial - 30% Facility/125% Medicare Fees	Commercial - 30% Facility/125% Medicare Fees	Commercial - 30% Facility/125% Medicare Fees	
Plus a Medicaid Provider reimbursement increase of	6%	n/a	n/a	n/a	n/a	
Administrative Expense	Public Program - 4% of Premium	Average Employer - 20% of Premium	Individual Market - 30% of Premium	Average Employer - 20% of Premium	Small Employer - 25% of Premium	

V – Cost and Coverage Quantitative Model Methodology and Assumptions
Adequate Health Care Task Force

Exhibit 1: Modeling Assumptions: Selected Members of the AHCTF Associated with the Insurance Industry

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 legislative estimate.

Coverage/Access Approach						
General Approach	Public program expansion	Individual Mandate w/ public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	
	Childless Adults eligible for Medicaid up to 100% FPL	Direct Subsidies For Employer Coverage (a.k.a FHIAP)	Direct Subsidies For Individual Coverage (a.k.a FHIAP)	Advanceable, Refundable Tax credits for those ineligible for Direct Subsidies	Small Employer Tax Credits	
5. Financing of Subsidies & Program Administration:						
General	None specified; use consultants best approach	Federal/State Tax Expenditures	Federal/State Tax Expenditures	None specified; use consultants best approach	None specified; use consultants best approach	
Is state effort eligible for Federal Match?	Yes, at Medicaid Rates	Yes, at SCHIP Rates	Yes, at SCHIP Rates	No	No	
Amount of Insurers assessment (if applicable)	n/a	n/a	n/a	n/a	n/a	
Amount of ER Payroll assessment (if applicable)	n/a	n/a	n/a	n/a	n/a	
Amount of EE Payroll assessment (if applicable)	n/a	n/a	n/a	n/a	n/a	

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 1: Modeling Assumptions: Selected Members of the AHCTF Associated with the Insurance Industry

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 legislative estimate.

Coverage/Access Approach						
General Approach	Public program expansion	Individual Mandate w/ public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	
	Childless Adults eligible for Medicaid up to 100% FPL	Direct Subsidies For Employer Coverage (a.k.a FHIAP)	Direct Subsidies For Individual Coverage (a.k.a FHIAP)	Advanceable, Refundable Tax credits for those ineligible for Direct Subsidies	Small Employer Tax Credits	
Assumed Premium Subsidy Rates (By % of FPL)						
<100%	100%	95%	95%	95%	95%	0%
100-149%	0%	80%	80%	80%	80%	0%
150-199%	0%	50%	50%	50%	50%	0%
200-249%	0%	0%	0%	0%	0%	0%
250-299%	0%	0%	0%	0%	0%	0%
300%+	0%	0%	0%	0%	0%	0%
Assumed Participation Rates (By % of FPL)						
<100%	90%	54.4%	29%	90%	90%	54.4%
100-149%	39%	65%	40%	90%	90%	65%
150-199%	39%	65%	40%	90%	90%	65%
200-249%	39%	75%	50%	90%	90%	65%
250-299%	39%	75%	50%	90%	90%	65%
300%+	39%	82%	57%	90%	90%	65%

* Note: This is program eligibility which may be different from subsidy eligibility. ** Proposal includes relief from benefit mandates but insufficient specifics to model.

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 2: Modeling Assumptions: Campaign for Better Health Care and Health and Disability Advocates

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 legislative estimate.

Coverage/Access Approach								
General Approach		Public program expansion	Public program expansion	New State Coverage program	Premium Subsidies	Premium Subsidies	New Purchasing Pool featuring Carrier Reinsurance subsidy	New Purchasing Pool featuring Carrier Reinsurance subsidy
		Family Care Expansion to 300% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	Reinstate Aid to Medically Indigent for Childless Adults and non-citizens to 300% FPL	Premium Assistance for COBRA Coverage	Premium Assistance for ICHIP Coverage	Impact on Workers w/ a participating employer	Impact on Individuals (pool also features premium subsidies)
Mandatory or Voluntary?	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary
1. Eligible (affected) Population(s)*								
Age	Adults (19-64)	Adults (19-23)	Adults (19-64)	All age 0-64	Adults (19-64)	All age 0-64	All age 0-64	All age 0-64
Income	185%-300% FPL	All Incomes	0-300% FPL	0-400% FPL	0-250% FPL	All Incomes	All Incomes	All Incomes
Family Status	Parents	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Work/Student Status	n/a	full-time student	n/a	Unemployed	n/a	FT Workers and their dependents	n/a	n/a
Firm Type	n/a	n/a	n/a	n/a	n/a	1-25; any offering status	n/a	n/a
Current Coverage Status	Must be Uninsured	Must be Uninsured	Ineligible for Medicaid/SCHIP & Uninsured	Eligible for COBRA	Eligible for ICHIP	n/a	n/a	n/a

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 2: Modeling Assumptions: Campaign for Better Health Care and Health and Disability Advocates

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 legislative estimate.

Coverage/Access Approach								
General Approach	Public program expansion	Public program expansion	New State Coverage program	Premium Subsidies	Premium Subsidies	New Purchasing Pool featuring Carrier Reinsurance subsidy	New Purchasing Pool featuring Carrier Reinsurance subsidy	
	Family Care Expansion to 300% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	Reinstate Aid to Medically Indigent for Childless Adults and non-citizens to 300% FPL	Premium Assistance for COBRA Coverage	Premium Assistance for ICHIP Coverage	Impact on Workers w/ a participating employer	Impact on Individuals (pool also features premium subsidies)	
2.a.	Individual Premium Subsidy Detail:							
What Type of Subsidy?	Indirect	Indirect	Indirect	Direct	Direct	Indirect	Direct	
Reinsurance Subsidy ?	No Reinsurance	No Reinsurance	No Reinsurance	No Reinsurance	No Reinsurance	90 percent of claims between \$10,000 and \$75,000.	90 percent of claims between \$10,000 and \$75,000.	
Relief from Benefit Mandates	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
<i>See below for specific subsidies</i>								
2.b.	Employer Premium Subsidy Detail:							
Subsidy Percent	0	0	0	0	0	0	0	

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 2: Modeling Assumptions: Campaign for Better Health Care and Health and Disability Advocates

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 legislative estimate.

Coverage/Access Approach								
General Approach	Public program expansion	Public program expansion	New State Coverage program	Premium Subsidies	Premium Subsidies	New Purchasing Pool featuring Carrier Reinsurance subsidy	New Purchasing Pool featuring Carrier Reinsurance subsidy	
		Family Care Expansion to 300% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	Reinstate Aid to Medically Indigent for Childless Adults and non-citizens to 300% FPL	Premium Assistance for COBRA Coverage	Premium Assistance for ICHIP Coverage	Impact on Workers w/ a participating employer	Impact on Individuals (pool also features premium subsidies)
3. Employer Requirements for Participation (if applicable):								
	<i>Firm Type</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>1-25; any offering status</i>	<i>n/a</i>
	Minimum ER Contribution (as a percent of premium)	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
4. Health Benefit Detail:								
	Scope of Covered Services	SCHIP for Families>150% FPL	SCHIP for Families>150% FPL (no maternity)	SCHIP for Families>150% FPL (no maternity)	Typical Commercial	Current Coverage	Typical Commercial	Typical Commercial
	Provider Discounts	Medicaid - 50% Facility/75% Medicare Fees	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	Commercial - 30% Facility/125% Medicare Fees
	<i>Plus a Medicaid Provider reimbursement increase of</i>	<i>6%</i>	<i>6%</i>	<i>6%</i>	<i>0%</i>	<i>0%</i>	<i>0%</i>	<i>0%</i>

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 2: Modeling Assumptions: Campaign for Better Health Care and Health and Disability Advocates

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 legislative estimate.

Coverage/Access Approach								
General Approach	Public program expansion	Public program expansion	New State Coverage program	Premium Subsidies	Premium Subsidies	New Purchasing Pool featuring Carrier Reinsurance subsidy	New Purchasing Pool featuring Carrier Reinsurance subsidy	
	Family Care Expansion to 300% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	Reinstate Aid to Medically Indigent for Childless Adults and non-citizens to 300% FPL	Premium Assistance for COBRA Coverage	Premium Assistance for ICHIP Coverage	Impact on Workers w/ a participating employer	Impact on Individuals (pool also features premium subsidies)	
Administrative Expense	Public Program - 4% of Premium	Public Program - 4% of Premium	Public Program - 4% of Premium	Average Employer - 20% of Premium	ICHIP Rates - 6.3% of Premium	ICHIP Rates - 6.3% of Premium	ICHIP Rates - 6.3% of Premium	
5. Financing of Subsidies & Program Administration:								
General	State Revenues (w/ Federal Match)	State Revenues (w/ Federal Match)	State Revenues	None specified; use consultants best approach	Federal Grants	Employer Assessments	Employer Assessments	
Is state effort eligible for Federal Match?	Yes, at SCHIP Rates	Yes, at SCHIP Rates	No	No	No	No	No	
Amount of Insurers assessment (if applicable)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Amount of ER Payroll assessment (if applicable)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Amount of EE Payroll assessment (if applicable)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 2: Modeling Assumptions: Campaign for Better Health Care and Health and Disability Advocates

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 legislative estimate.

Coverage/Access Approach								
General Approach	Public program expansion	Public program expansion	New State Coverage program	Premium Subsidies	Premium Subsidies	New Purchasing Pool featuring Carrier Reinsurance subsidy	New Purchasing Pool featuring Carrier Reinsurance subsidy	
	Family Care Expansion to 300% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	Reinstate Aid to Medically Indigent for Childless Adults and non-citizens to 300% FPL	Premium Assistance for COBRA Coverage	Premium Assistance for ICHIP Coverage	Impact on Workers w/ a participating employer	Impact on Individuals (pool also features premium subsidies)	
Assumed Premium Subsidy Rates (By % of FPL)								
<100%	100%	100%	100%	80%	80%	50%	50%	
100-149%	100%	100%	100%	80%	80%	35%	35%	
150-199%	95%	95%	95%	70%	50%	35%	35%	
200-249%	76%	76%	76%	60%	50%	0%	0%	
250-299%	76%	76%	76%	50%	0%	0%	0%	
300%+	0%	53%	0%	25%	0%	0%	0%	
Assumed Participation Rates (By % of FPL)								
<100%	90%	90%	90%	0%	90%	97%	29%	
100-149%	90%	90%	90%	8%	90%	70%	40%	
150-199%	39%	39%	39%	8%	90%	70%	40%	
200-249%	39%	39%	40%	25%	90%	43%	10%	
250-299%	39%	39%	40%	40%	90%	43%	10%	
300%+	39%	39%	40%	60%	90%	43%	10%	

* Note: this is program eligibility which may be different from subsidy eligibility

V – Cost and Coverage Quantitative Model Methodology and Assumptions
Adequate Health Care Task Force

Exhibit 3: Modeling Assumptions: Healthy Illinois

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 legislative estimate.

Coverage/Access Approach		
General Approach	New State Coverage program	
	Impact on Small Firm Workers	Impact on Individual purchasers
Mandatory or Voluntary?	Voluntary	Voluntary
1. Eligible (affected) Population(s)*		
Age	All ages 0-64	All ages 0-64
Income	All Incomes	All Incomes
Family Status	n/a	n/a
Work/Student Status	FT Workers and their dependents	n/a
Firm Type	2-25; any offering status	n/a
Current Coverage Status	n/a	Ineligible for Medicaid/SCHIP & Uninsured
2.a. Individual Premium Subsidy Detail:		
What Type of Subsidy?	Direct	Direct
Reinsurance Subsidy ?	No Reinsurance	No Reinsurance
Relief from Benefit Mandates	n/a	n/a
<i>See below for specific subsidies</i>		
2.b. Employer Premium Subsidy Detail:		
Subsidy Percent	50%	0
3. Employer Requirements for Participation (if applicable):		
Firm Type	1-25; non-offering	n/a
Minimum ER Contribution (as a percent of premium)	60%	n/a
	<i>(of the post subsidy amount)</i>	

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 3: Modeling Assumptions: Healthy Illinois

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 legislative estimate.

Coverage/Access Approach			
General Approach		New State Coverage program	
		Impact on Small Firm Workers	Impact on Individual purchasers
4.	Health Benefit Detail:		
	Scope of Covered Services	Typical Commercial	Typical Commercial
	Provider Discounts	Commercial - 30% Facility/125% Medicare Fees	Commercial - 30% Facility/125% Medicare Fees
	<i>Plus a Medicaid Provider reimbursement increase of</i>	0%	0%
	Administrative Expense	ICHIP Admin Expense -- 6.3%	ICHIP Admin Expense -- 6.3%
5.	Financing of Subsidies & Program Administration:		
	General	Insurer Assessments	Insurer Assessments
	Is state effort eligible for Federal Match?	No	No
	Amount of Insurers assessment (if applicable)	4%	4%
	Amount of ER Payroll assessment (if applicable)	n/a	n/a
	Amount of EE Payroll assessment (if applicable)	n/a	n/a
	Assumed Premium Subsidy Rates (By % of FPL)		
	<100%	95%	95%
	100-149%	95%	95%
	150-199%	25%	25%
	200-249%	25%	25%
	250-299%	25%	25%
	300%+	0%	0%
	Assumed Participation Rates (By % of FPL)		
	<100%	54.4%	29%
	100-149%	65%	40%
	150-199%	65%	40%
	200-249%	75%	50%
	250-299%	75%	50%
	300%+	82%	0%

* Note: this is program eligibility which may be different from subsidy eligibility

V – Cost and Coverage Quantitative Model Methodology and Assumptions
Adequate Health Care Task Force

Exhibit 4: Modeling Assumptions: Single Payer Health Insurance Program

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 legislative estimate.

Coverage/Access Approach			
General Approach		New State Coverage program	Individual Mandate w/ public program expansion
		Single Payer System featuring automatic enrollment	Partial funding through a 7% (ER) and 2% (EE) payroll tax
	Mandatory or Voluntary?	Mandatory for Individuals	
1.	Eligible (affected) Population(s)*		
	Age	All Illinois Residents	
	Income	All Incomes	
	Family Status	n/a	
	Work/Student Status	n/a	
	Firm Type	n/a	
	Current Coverage Status	n/a	
2.a.	Individual Premium Subsidy Detail:		
	What Type of Subsidy?	Indirect	
	Reinsurance Subsidy ?	No Reinsurance	
	Relief from Benefit Mandates	n/a	
	<i>See below for specific subsidies</i>		
2.b.	Employer Premium Subsidy Detail:		
	Subsidy Percent	0%	

V – Cost and Coverage Quantitative Model Methodology and Assumptions
Adequate Health Care Task Force

Exhibit 4: Modeling Assumptions: Single Payer Health Insurance Program

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 legislative estimate.

Coverage/Access Approach		
General Approach	New State Coverage program	Individual Mandate w/ public program expansion
	Single Payer System featuring automatic enrollment	Partial funding through a 7% (ER) and 2% (EE) payroll tax
3.	Employer Requirements for Participation (if applicable):	
	<i>Firm Type</i>	n/a
	Minimum ER Contribution (as a percent of premium)	n/a
4.	Health Benefit Detail:	
	Scope of Covered Services	SCHIP for Families above 150% FPL
	Provider Discounts	Medicare - 40% Facility/100% Medicare Fees
	<i>Plus a Medicaid Provider reimbursement increase of</i>	
	Administrative Expense	Public Program - 4% of Premium
5.	Financing of Subsidies & Program Administration:	
	General	Various
	Is state effort eligible for Federal Match?	Yes, for some residents
	Amount of Insurers assessment (if applicable)	
	Amount of ER Payroll assessment (if applicable)	7%
	Amount of EE Payroll assessment (if applicable)	2%

V – Cost and Coverage Quantitative Model Methodology and Assumptions
Adequate Health Care Task Force

Exhibit 4: Modeling Assumptions: Single Payer Health Insurance Program

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 legislative estimate.

Coverage/Access Approach			
General Approach		New State Coverage program	Individual Mandate w/ public program expansion
		Single Payer System featuring automatic enrollment	Partial funding through a 7% (ER) and 2% (EE) payroll tax
Assumed Premium Subsidy Rates (By % of FPL)			
	<100%	100%	
	100-149%	100%	
	150-199%	100%	
	200-249%	100%	
	250-299%	100%	
	300%+	100%	
Assumed Participation Rates (By % of FPL)			
	<100%	100%	
	100-149%	100%	
	150-199%	100%	
	200-249%	100%	
	250-299%	100%	
	300%+	100%	

** Note: this is program eligibility which may be different from subsidy eligibility*

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 5: Modeling Assumptions: Illinois Hospital Association

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 legislative estimate.

PLACEHOLDER FOR PENDING REVISED RESULTS

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 5: Modeling Assumptions: Illinois Hospital Association

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 legislative estimate.

PLACEHOLDER FOR PENDING REVISED RESULTS

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 5: Modeling Assumptions: Illinois Hospital Association

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 legislative estimate.

PLACEHOLDER FOR PENDING REVISED RESULTS

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 5: Modeling Assumptions: Illinois Hospital Association

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 legislative estimate.

PLACEHOLDER FOR PENDING REVISED RESULTS

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 5: Modeling Assumptions: Illinois Hospital Association

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 legislative estimate.

PLACEHOLDER FOR PENDING REVISED RESULTS

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 6: Modeling Assumptions: Hybrid Model

Note: The objective of this model is to measure each of the strategies using a common set of assumptions related to the proposals. The model provides a useful tool for comparing proposals to each other, but does not provide detailed cost, participation or financing data. For example, it is possible to compare the models to each other to determine which yields the greatest coverage in terms of number of newly insured, but more in-depth analysis would be required to determine the precise number of newly covered individuals.

Coverage/Access Approach						
General Approach		Public program expansion	Public program expansion	Public program expansion	Individual Mandate; premium subsidies for standard plan	Employer Pay or Play
		Family Care Expansion to 200% FPL	Childless Adults eligible for Medicaid up to 100% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	All but uninsured residents assumed to keep their current coverage; uninsured used subsidies to purchase coverage in the individual market if ineligible for public programs	Employers with 26 or more Illinois workers must pay an assessment of 8 percent of payroll; employers that offer coverage can receive a credit against the fee
Mandatory or Voluntary?	Mandatory for Individuals	Mandatory for Individuals	Mandatory for Individuals	Mandatory for Individuals	Mandatory for Employers	
How are premiums rated (if applicable)	n/a	n/a	n/a	Uses revised market rating rules	n/a	
1. Eligible (affected) Population(s)*						
Age	Adults (19-64)	Adults (19-64)	Adults (19-23)	All ages 0-64	All ages 0-64	
Income	185%-200% FPL	0-100% FPL	All Incomes	100% FPL +	All Incomes	
Family Status	Parents	Childless Adults	n/a	n/a	n/a	
Work/Student Status	n/a	n/a	full-time student	n/a	Workers and their dependents	
Firm Type	n/a	n/a	n/a	n/a	Non-offering Employer	
Current Coverage Status	n/a	n/a	n/a	n/a	n/a	
				<i>Under an individual mandate, crowd-out provisions would not apply.</i>		<i>Must be Ineligible for Medicaid/SCHIP to receive subsidies</i>

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 6: Modeling Assumptions: Hybrid Model

Note: The objective of this model is to measure each of the strategies using a common set of assumptions related to the proposals. The model provides a useful tool for comparing proposals to each other, but does not provide detailed cost, participation or financing data. For example, it is possible to compare the models to each other to determine which yields the greatest coverage in terms of number of newly insured, but more in-depth analysis would be required to determine the precise number of newly covered individuals.

Coverage/Access Approach						
General Approach	Public program expansion	Public program expansion	Public program expansion	Individual Mandate; premium subsidies for standard plan	Employer Pay or Play	
		Family Care Expansion to 200% FPL	Childless Adults eligible for Medicaid up to 100% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	All but uninsured residents assumed to keep their current coverage; uninsured used subsidies to purchase coverage in the individual market if ineligible for public programs	Employers with 26 or more Illinois workers must pay an assessment of 8 percent of payroll; employers that offer coverage can receive a credit against the fee
2.a	Individual Premium Subsidy Detail:					
	What Type of Subsidy?	Indirect	Indirect	Indirect	Direct	n/a
	Reinsurance Subsidy	No Reinsurance	No Reinsurance	No Reinsurance	No Reinsurance	n/a
	Relief from Benefit Mandates	n/a	n/a	n/a	n/a	n/a
	<i>See below for specific subsidies</i>					
2.b	Employer Premium Subsidy Detail:					
	Subsidy Percent		0%	0%	0%	n/a
3.	Employer Requirements for Participation (if applicable):					
	<i>Firm Type</i>	n/a	n/a	n/a	n/a	<i>Non-offering Employer</i>
	Minimum ER Contribution (as a percent of premium)	n/a	n/a	n/a	n/a	n/a

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 6: Modeling Assumptions: Hybrid Model

Note: The objective of this model is to measure each of the strategies using a common set of assumptions related to the proposals. The model provides a useful tool for comparing proposals to each other, but does not provide detailed cost, participation or financing data. For example, it is possible to compare the models to each other to determine which yields the greatest coverage in terms of number of newly insured, but more in-depth analysis would be required to determine the precise number of newly covered individuals.

Coverage/Access Approach						
General Approach	Public program expansion	Public program expansion	Public program expansion	Individual Mandate; premium subsidies for standard plan	Employer Pay or Play	
		Family Care Expansion to 200% FPL	Childless Adults eligible for Medicaid up to 100% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	All but uninsured residents assumed to keep their current coverage; uninsured used subsidies to purchase coverage in the individual market if ineligible for public programs	Employers with 26 or more Illinois workers must pay an assessment of 8 percent of payroll; employers that offer coverage can receive a credit against the fee
4. Health Benefit Detail:						
Scope of Covered Services	SCHIP for Families >150% FPL (no maternity)	Medicaid w/o Maternity	SCHIP for Families >150% FPL (no maternity)	Current Coverage	n/a	
Provider Discounts	Medicaid - 50% Facility/75% Medicare Fees	Medicaid - 50% Facility/75% Medicare Fees	Medicaid - 50% Facility/75% Medicare Fees	n/a	n/a	
<i>Plus a Medicaid Provider reimbursement increase of</i>	6%	6%	6%	n/a	n/a	
Administrative Expense	Public Program - 4% of Premium	Public Program - 4% of Premium	Public Program - 4% of Premium	n/a	n/a	

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 6: Modeling Assumptions: Hybrid Model

Note: The objective of this model is to measure each of the strategies using a common set of assumptions related to the proposals. The model provides a useful tool for comparing proposals to each other, but does not provide detailed cost, participation or financing data. For example, it is possible to compare the models to each other to determine which yields the greatest coverage in terms of number of newly insured, but more in-depth analysis would be required to determine the precise number of newly covered individuals.

Coverage/Access Approach						
General Approach	Public program expansion	Public program expansion	Public program expansion	Individual Mandate; premium subsidies for standard plan	Employer Pay or Play	
	Family Care Expansion to 200% FPL	Childless Adults eligible for Medicaid up to 100% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	All but uninsured residents assumed to keep their current coverage; uninsured used subsidies to purchase coverage in the individual market if ineligible for public programs	Employers with 26 or more Illinois workers must pay an assessment of 8 percent of payroll; employers that offer coverage can receive a credit against the fee	
5. Financing of Subsidies & Program Administration:						
General	State Revenues (w/ Federal Match)	State Revenues (w/ Federal Match)	State Revenues (w/ Federal Match)	State Revenues		n/a
Is state effort eligible for Federal Match?	Yes, at SCHIP Rates	Yes, at Medicaid Rates	Yes, at SCHIP Rates	No		No
Amount of Insurers assessment (if applicable)	0%	0%	0%	0%		0%
Amount of ER Payroll assessment (if applicable)	0%	0%	0%	0%		8%
Amount of EE Payroll assessment (if applicable)	0%	0%	0%	0%		0%

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 6: Modeling Assumptions: Hybrid Model

Note: The objective of this model is to measure each of the strategies using a common set of assumptions related to the proposals. The model provides a useful tool for comparing proposals to each other, but does not provide detailed cost, participation or financing data. For example, it is possible to compare the models to each other to determine which yields the greatest coverage in terms of number of newly insured, but more in-depth analysis would be required to determine the precise number of newly covered individuals.

Coverage/Access Approach						
General Approach	Public program expansion	Public program expansion	Public program expansion	Individual Mandate; premium subsidies for standard plan	Employer Pay or Play	
	Family Care Expansion to 200% FPL	Childless Adults eligible for Medicaid up to 100% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	All but uninsured residents assumed to keep their current coverage; uninsured used subsidies to purchase coverage in the individual market if ineligible for public programs	Employers with 26 or more Illinois workers must pay an assessment of 8 percent of payroll; employers that offer coverage can receive a credit against the fee	
Assumed Premium Subsidy Rates (By % of FPL)						
<100%	100%	100%	100%	100%	100%	100%
100-149%	100%	0%	100%	100%	100%	100%
150-199%	94%	0%	95%	98%	98%	98%
200-249%	76%	0%	76%	90%	90%	90%
250-299%	76%	0%	76%	75%	75%	75%
300%+	0%	0%	53%	6%	6%	6%
Assumed Participation Rates (By % of FPL)				<i>6% is a blended rate reflecting subsidized and unsubsidized persons</i>		
<100%	95%	95%	95%	95%	95%	95%
100-149%	95%	95%	95%	95%	95%	95%
150-199%	94%	94%	94%	94%	94%	94%
200-249%	92%	92%	92%	92%	92%	92%
250-299%	88%	88%	88%	88%	88%	88%
300%+	80%	80%	80%	80%	80%	80%

V – Cost and Coverage Quantitative Model Methodology and Assumptions

Adequate Health Care Task Force

Exhibit 6: Modeling Assumptions: Hybrid Model

Note: The objective of this model is to measure each of the strategies using a common set of assumptions related to the proposals. The model provides a useful tool for comparing proposals to each other, but does not provide detailed cost, participation or financing data. For example, it is possible to compare the models to each other to determine which yields the greatest coverage in terms of number of newly insured, but more in-depth analysis would be required to determine the precise number of newly covered individuals.

Coverage/Access Approach					
	Public program expansion	Public program expansion	Public program expansion	Individual Mandate; premium subsidies for standard plan	Employer Pay or Play
General Approach	Family Care Expansion to 200% FPL	Childless Adults eligible for Medicaid up to 100% FPL	Expand All Kids Eligibility to adults 19-23 in school full-time	All but uninsured residents assumed to keep their current coverage; uninsured used subsidies to purchase coverage in the individual market if ineligible for public programs	Employers with 26 or more Illinois workers must pay an assessment of 8 percent of payroll; employers that offer coverage can receive a credit against the fee
6.	Other aspects of this strategy not governed by model parameters:				
				No cost sharing for primary and preventive services	

* Note: this is program eligibility which may be different from subsidy eligibility

VI - Summary of Proposals -- Coverage and Costs for 2007 (Under Age 65 Population)

Adequate Health Care Task Force

Note: Revised results for the Illinois Hospital Association's proposal are pending and will be provided as soon as they are ready.

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 legislative estimate.		Campaign for Better Health Care and Health and Disabilities Advocates	Single Payer	Selected Members of the Insurance Industry	Healthy Illinois/Citizens Action ⁽¹⁾	Hybrid
I. Changes in Coverage (in thousands)						
A. Total newly covered under proposal	Total individuals	1,086	1,705	473	344	1,552
	Percent of uninsured	64%	100%	28%	20%	91%
B. Currently insured residents participating in new coverage programs (i.e., through changing to new coverage option, including receipt of subsidies towards premiums)	Total individuals	755	9,205 (a)	441	838	8,857 (a)
	Percent of currently insured	8%	96%	5%	9%	93%
C. Total covered under new Medicaid or SCHIP expansions	Total individuals	70	Not Applicable	392	Not Applicable	723
	Total individuals	619	(0)	1,232	1,361	153
D. Remaining Uninsured	Total individuals	619	(0)	1,232	1,361	153
	Percent of baseline uninsured(i)	36%	0%	72%	80%	9%
II. Costs Associated With Enrollment in New Coverage Options(i) (\$ in millions)						
A. Federal Medicaid/SCHIP funds		127	See note below	631	Not Applicable	2,600
B. State	1. Health insurer assessment	Not Applicable	Not Applicable	Not Applicable	572 (a)	Not Applicable
	2. Employer fees or taxes	Footnote A	15,677	Not Applicable	Not Applicable	1,419
	3. Employee payroll tax	Not Applicable	4,479	Not Applicable	Not Applicable	Not Applicable
	4. Medicaid/SCHIP funds (ii)	68	See note below	483	-	2,061
	5. Source to be determined	3,352	See note below	952	1,544	3,936
C. Annual per capita state coverage costs for all individuals participating in new coverage options ((IIB4+IIB5)/(IA+AB))		1,857	Not Applicable	1,570	1,791	682
D. Annual per capita state coverage costs for all newly insured individuals		2,536	Not Applicable	1,393	2,400	1,855
III. State Costs Associated with Medicaid and SCHIP Provider Payment Increases For Baseline Existing Coverage (\$ in millions)		122 (b)	Not Applicable	122 (a)	Not Applicable	122 (b)
IV. Additional proposal components not modeled that may result in changes to the number of uninsured or program costs						
<p>1. Selected Medicaid expansions for individuals with disabilities (c)</p> <p>2. Community rating and guaranteed issue for the individual and small group markets</p> <p>3. Employer play-or-pay (footnote a)</p> <p>4. Consideration of individual mandate with consumer protections if sufficient coverage levels are not achieved</p>		<p>1. According to several analyses, it may be possible to pay for such a program using the "funds already in the system." Since a single payer program has never been implemented at the state level, the feasibility of such a financing mechanism remains theoretical.</p> <p>2. Potential savings from bulk purchasing of pharmaceuticals and medical supplies</p>	<p>1. Transitioning Medicaid population to personal health accounts and mandatory managed care</p> <p>2. Refundable and advanceable federal income tax credits for small employers to offer coverage to their workers</p> <p>3. State income tax subsidies for HSAs for citizens attempting to transition from public program to private health insurance coverage.</p> <p>4. Eliminate existing state premium taxes on high deductible health plans (HDHPs); existing state premium taxes totaled to less than one percent of total premiums. While exact numbers are not available, less than three percent of privately insured people in Illinois have this type of plan(b). As such, we assume that the impact on coverage will be minimal.</p> <p>5. While the proposal included a voluntary, federally-subsidized individual and/or small group reinsurance pool, this model assumes no commitment of state funds for the pool and too little impact on premiums to induce new coverage.</p>	<p>1. Potential discounts that the proposer indicates could be obtained by leveraging purchasing power of the bargaining pool. With the exception of the Federal Employees Health Benefits Program, few purchasing pools have been able to command below market rates on a sustained basis.</p>	<p>1. New rate band structure of the individual and small group market</p> <p>2. State subsidy costs could include an additional \$1.2 billion reflecting the costs of subsidizing the deductible of the standard plan; these subsidies would vary depending on percent of the population purchased the plan.</p>	

VI - Summary of Proposals -- Coverage and Costs for 2007 (Under Age 65 Population)

Adequate Health Care Task Force

Note: Revised results for the Illinois Hospital Association's proposal are pending and will be provided as soon as they are ready.

- (i) Represents costs of coverage (including administrative costs); excludes implementation costs.
- (ii) To facilitate discussion, State Medicaid/SCHIP spending is shown as a cost. For waiver approval, the impact on program spending would have to be budget neutral, and/or SCHIP allotment neutral. However, the mechanism by which this would be accomplished is not specified in every proposal.

Campaign for Better Health Care and Health and Disability Advocates

- (a.) Lack of proposal detail meant that additional analyses are necessary to determine the impact of the proposed employer pay-or-play. As such, we do not include any such fees here. For example, if a fee was paid for all workers of employers that do not offer health care coverage and have more than 25 workers, and the fee was set at eight percent of payroll, \$1.4 billion would be collected through this assessment.
- (b.) Reflects an overall six percent increase in Medicaid and SCHIP payments.
- (c.) 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. Proposer has indicated 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.

Single Payer

- (a) Includes any resident that had coverage prior to the implementation of the single payer system

Selected Members of the Insurance Industry

- (a) Reflects an overall six percent increase in Medicaid/SCHIP payments
- (b) U.S. General Accounting Office. Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage, GAO-06-514, April 2006. (Estimates specific to Illinois not available.)

Healthy Illinois

- (a) Equal to four percent of estimated total Illinois insurer premiums of \$14 billion

Hybrid Model

- (a) Includes any resident who complies with the individual mandate and who was previously covered by insurance whether or not they received a subsidy
- (b) Reflects an overall six percent increase in Medicaid payments

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)

Adequate Health Care Task Force

		Campaign for Better Health Care and Health and Disabilities Advocates(4)								
		By Proposal Component:								
			Public program expansion	Public program expansion	New State Coverage program	Premium Subsidies	Premium Subsidies	New Purchasing Pool featuring Carrier Reinsurance subsidy	New Purchasing Pool Carrier Reinsurance subsidy	
<p>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 legislative estimate.</p>		Reference to Summary Page	Overall(1)	Family Care Expansion to 300% FPL	Expand All Kids Eligibility to Adults 19-23 in School Full-Time	Reinstate Aid to Medically Indigent for Childless Adults and non-citizens to 300% FPL	Premium Assistance for COBRA Coverage (up to 400% FPL)	Premium Assistance for ICHIP Coverage (modeling those with current coverage)	Impact on Workers w/ a participating employer	Impact on Individuals (pool also features premium subsidies)
I. Total Population Eligible for Program(s)		Footnote 2	135,783	31,100	991,151	11,523	15,997	1,623,436	10,910,169	
A. Total Uninsured in Eligible Population		Footnote 2	135,783	31,100	991,151	5,696	2,526	100,938	1,704,962	
II. Total Estimated Program Enrollment		1,841,732	53,625	17,347	669,650	1,864	13,093	766,580	373,198	
A. Overall Participation Rate		Footnote 2	39%	56%	68%	16%	82%	47%	3%	
B. Annual Overall Coverage Cost per Participant (includes employer, employee and subsidy amounts)		\$ 3,385	\$ 3,834	\$ 1,865	\$ 2,907	\$ 4,890	\$ 9,691	\$ 2,947	\$ 5,003	
C. Annual Overall Subsidy Cost per Participant		\$ 1,926	\$ 3,110	\$ 1,805	\$ 2,773	\$ 2,198	\$ 6,454	\$ 663	\$ 2,636	
D. Annual State Subsidy Cost per Participant (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds)	II.C	\$ 1,857	\$ 1,089	\$ 733	\$ 2,773	\$ 2,198	\$ 6,454	\$ 663	\$ 2,636	
III. Total Newly Covered under Proposal	I.A.	1,086,437	53,625	17,347	669,650	463	969	60,443	308,198	
A. Participation among Eligible Uninsured		N/A	39%	56%	68%	8%	38%	60%	18%	
B. Annual Overall Coverage Cost per Newly Insured (includes employer, employee and subsidy amounts)		\$ 3,502	\$ 3,834	\$ 1,865	\$ 2,907	\$ 5,473	\$ 9,690	\$ 3,259	\$ 4,957	
C. Annual Program Subsidy Cost per Newly Insured		\$ 2,653	\$ 3,110	\$ 1,805	\$ 2,773	\$ 2,642	\$ 6,242	\$ 869	\$ 2,690	
D. Annual State Subsidy Cost per Newly Insured (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds)		\$ 2,536	\$ 1,089	\$ 733	\$ 2,773	\$ 2,642	\$ 6,242	\$ 869	\$ 2,690	
E. Enrollment of Newly Insured as a Percent of Total Program Enrollment		59%	100%	100%	100%	25%	7%	8%	83%	
IV. Currently Insured residents participating in new coverage programs	I.B.	755,295	-	-	-	1,401	12,124	706,137	65,001	
A. Annual Coverage Cost per Previously Insured Resident (includes employer, employee and subsidy amounts)		\$ 3,344	\$ -	\$ -	\$ -	\$ 4,697	\$ 9,691	\$ 2,920	\$ 5,218	
B. Annual Program Subsidy Cost per Previously Insured Resident		\$ 370	\$ -	\$ -	\$ -	\$ 2,052	\$ 6,471	\$ 61	\$ 2,381	
C. Annual State Subsidy Cost per Previously Insured Resident (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds)		\$ 916	\$ -	\$ -	\$ -	\$ 2,052	\$ 6,471	\$ 646	\$ 2,381	

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)

Adequate Health Care Task Force

		Campaign for Better Health Care and Health and Disabilities Advocates(4)								
		By Proposal Component:								
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 legislative estimate.	Reference to Summary Page	Overall(1)	Public program expansion	Public program expansion	New State Coverage program	Premium Subsidies	Premium Subsidies	New Purchasing Pool featuring Carrier Reinsurance subsidy	New Purchasing Pool featuring Carrier Reinsurance subsidy	
			Family Care Expansion to 300% FPL	Expand All Kids Eligibility to Adults 19-23 in School Full-Time	Reinstate Aid to Medically Indigent for Childless Adults and non-citizens to 300% FPL	Premium Assistance for COBRA Coverage (up to 400% FPL)	Premium Assistance for ICHIP Coverage (modeling those with current coverage)	Impact on Workers w/ a participating employer	Impact on Individuals (pool also features premium subsidies)	
V. Costs Associated with Enrollment in New Coverage Options(3)										
A. New Federal Medicaid/SCHIP Funds	II.A.	\$ 127,006,980	\$ 108,412,023	\$ 18,594,956	\$ -	\$ -	\$ -	\$ -	\$ -	
B. New Health Insurer Assessments	II.B.1.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
C. Employers:										
1. Premium Contributions		\$ 1,249,675,182	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,294,969,364	\$ -	
2. New Fees or Taxes		\$ -								
D. Residents:										
1. Premium Contributions		\$ 1,436,494,940	\$ 38,816,620	\$ 1,036,782	\$ 89,750,940	\$ 5,016,583	\$ 42,379,747	\$ 455,699,843	\$ 883,186,563	
2. New Payroll Taxes	II.B.3	\$ -								
State Income Taxes		\$ -								
E. New State Medicaid/SCHIP Funds	II.B.4	\$ 68,388,374	\$ 58,375,705	\$ 10,012,669	\$ -	\$ -	\$ -	\$ -	\$ -	
F. Other State Funds (source to be determined)	II.B.5	\$ 3,351,937,617		2,702,476		4,097,758	84,502,890			
VI. Total		\$ 6,233,503,093	\$ 205,604,348	\$ 32,346,883	\$ 1,946,482,851	\$ 9,114,341	\$ 126,882,637	\$ 2,259,207,243	\$ 1,867,022,596	
VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Baseline Coverage										
A. State Costs	III.	\$ 122,024,980								
B. Federal Costs		\$ 163,211,758								
VIII. Total Point-of-Service Cost Sharing Under the Program		\$ 1,354,099,180	\$ 8,812,144	\$ 1,896,857	\$ 112,241,187	\$ 4,846,315	\$ 84,269,618	\$ 790,169,037	\$ 408,877,884	
IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians			41%	3%	1%	37%	0%	0%	0%	

Lack of proposal detail meant that additional analyses are necessary to determine the impact of the proposed employer pay-or-play. As such, we do not include any such fees here. For example, if a fee was paid for all workers of employers that do not offer health care coverage and have more than 25 workers, and the fee was set at eight percent of payroll, \$1.4 billion would be collected through this assessment.

- (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 proposal components
- (3) Represents costs of coverage (including administrative costs); excludes implementation
- (4) See notes in summary detail for additional information

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)

Adequate Health Care Task Force

		Healthy Illinois Plan(4)			
		By Proposal Component:			
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 legislative estimate.	Reference to Summary Page	Overall(1)	New State Coverage program	New State Coverage program	Insurer Assessment
			Impact on Small Firm Workers	Impact on Individual purchasers	
I. Total Population Eligible for Program(s)		Footnote 2	1,527,407	1,220,715	
A. Total Uninsured in Eligible Population		Footnote 2	242,491	1,220,715	
II. Total Estimated Program Enrollment		1,182,079	911,603	270,476	
A. Overall Participation Rate		Footnote 2	60%	22%	
B. Annual Overall Coverage Cost per Participant (includes employer, employee and subsidy amounts)		\$ 3,253	\$ 2,947	\$ 4,285	
C. Annual Overall Subsidy Cost per Participant		\$ 1,791	\$ 1,562	\$ 2,560	
D. Annual State Subsidy Cost per Participant (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds)	II.C	\$ 1,791	\$ 1,562	\$ 2,560	
III. Total Newly Covered under Proposal	I.A.	343,663	73,187	270,476	
A. Participation among Eligible Uninsured		N/A	30%	22%	
B. Annual Overall Coverage Cost per Newly Insured (includes employer, employee and subsidy amounts)		\$ 4,040	\$ 3,135	\$ 4,285	
C. Annual Program Subsidy Cost per Newly Insured		\$ 2,400	\$ 1,809	\$ 2,560	
D. Annual State Subsidy Cost per Newly Insured (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds)		\$ 2,400	\$ 1,809	\$ 2,560	
E. Enrollment of Newly Insured as a Percent of Total Program Enrollment		29%	8%	100%	
IV. Currently Insured residents participating in new coverage programs	I.B.	838,416	838,416	-	
A. Annual Coverage Cost per Previously Insured Resident (includes employer, employee and subsidy amounts)		\$ 2,930	\$ 2,930	\$ -	
B. Annual Program Subsidy Cost per Previously Insured Resident		\$ 1,541	\$ 1,541	\$ -	
C. Annual State Subsidy Cost per Previously Insured Resident (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds)		\$ 1,541	\$ 1,541	\$ -	

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)

Adequate Health Care Task Force

	Reference to Summary Page	Healthy Illinois Plan(4)			
		By Proposal Component:			
		Overall(1)	New State Coverage program Impact on Small Firm Workers	New State Coverage program Impact on Individual purchasers	Insurer Assessment
<i>Note:</i> 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 legislative estimate.					
V. Costs Associated with Enrollment in New Coverage Options(3)					
A. New Federal Medicaid/SCHIP Funds	II.A.	\$ -	\$ -	\$ -	
B. New Health Insurer Assessments	II.B.1.	\$ 572,190,310	\$ -	\$ -	\$ 572,190,310
C. Employers:					
1. Premium Contributions		\$ 805,845,355	\$ 805,845,355	\$ -	
2. New Fees or Taxes		\$ -			
D. Residents:		\$ -			
1. Premium Contributions		\$ 922,589,029	\$ 456,255,808	\$ 466,333,221	
2. New Payroll Taxes	II.B.3	\$ -			
State Income Taxes		\$ -			
E. New State Medicaid/SCHIP Funds	II.B.4	\$ -	0	\$ -	
F. Other State Funds (source to be determined)	II.B.5	\$ 1,544,407,998	1424050020	692548287.7	
VI. Total		\$ 3,845,032,691	\$ 2,686,151,183	\$ 1,158,881,509	
VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Baseline Coverage					
A. State Costs	III.	\$ -			
B. Federal Costs		\$ -			
VIII. Total Point-of-Service Cost Sharing Under the Program		\$ 1,237,794,868	\$ 931,234,515	\$ 306,560,352	
IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians		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 proposal components

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

(4) See notes in summary detail for additional information

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)
Adequate Health Care Task Force

**PLACEHOLDER: PENDING REVISED RESULTS FOR ILLINOIS HOSPITAL
ASSOCIATION PROPOSAL**

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)
Adequate Health Care Task Force

**PLACEHOLDER: PENDING REVISED RESULTS FOR ILLINOIS HOSPITAL
ASSOCIATION PROPOSAL**

**VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)
Adequate Health Care Task Force**

		Single Payer Health Insurance Program for IL(4)	
<p><i>Note:</i> 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 legislative estimate.</p>	Reference to Summary Page	Overall(1)	
	I. Total Population Eligible for Program(s)		
A. Total Uninsured in Eligible Population			1,704,962
II. Total Estimated Program Enrollment			10,910,169
A. Overall Participation Rate			100%
B. Annual Overall Coverage Cost per Participant (<i>includes employer, employee and subsidy amounts</i>)		\$	4,146
C. Annual Overall Subsidy Cost per Participant		\$	4,146
D. Annual State Subsidy Cost per Participant (<i>includes State Medicaid/SCHIP Funds and other unspecified sources of State funds</i>)	II.C	\$	3,953
III. Total Newly Covered under Proposal	I.A.		1,704,962
A. Participation among Eligible Uninsured			100%
B. Annual Overall Coverage Cost per Newly Insured (<i>includes employer, employee and subsidy amounts</i>)			4,563
C. Annual Program Subsidy Cost per Newly Insured			4,563
D. Annual State Subsidy Cost per Newly Insured (<i>includes State Medicaid/SCHIP Funds and other unspecified sources of State funds</i>)			4,563
E. Enrollment of Newly Insured as a Percent of Total Program Enrollment			100%
IV. Currently Insured residents participating in new coverage programs	I.B.		9,205,207
A. Annual Coverage Cost per Previously Insured Resident (<i>includes employer, employee and subsidy amounts</i>)		\$	4,074
B. Annual Program Subsidy Cost per Previously Insured Resident		\$	4,074
C. Annual State Subsidy Cost per Previously Insured Resident (<i>includes State Medicaid/SCHIP Funds and other unspecified sources of State funds</i>)		\$	3,845

**VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)
Adequate Health Care Task Force**

		Single Payer Health Insurance Program for IL(4)	
		Reference to Summary Page	Overall(1)
<p><i>Note:</i> 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 legislative estimate.</p>			
V. Costs Associated with Enrollment in New Coverage Options(3)			
A. New Federal Medicaid/SCHIP Funds	II.A.	\$	2,106,114,865
B. New Health Insurer Assessments	II.B.1.	\$	-
C. Employers:			
1. Premium Contributions		\$	-
2. New Fees or Taxes		\$	15,677,294,936
D. Residents:			
1. Premium Contributions		\$	-
2. New Payroll Taxes	II.B.3	\$	4,479,227,125
State Income Taxes		\$	-
E. New State Medicaid/SCHIP Funds	II.B.4	\$	1,658,568,185
F. Other State Funds (source to be determined)	II.B.5	\$	21,310,971,347
VI. Total		\$	45,232,176,458
VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Baseline Coverage			
A. State Costs	III.		Included in above
B. Federal Costs			Included in above
VIII. Total Point-of-Service Cost Sharing Under the Program		\$	-
IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians			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 proposal components

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

(4) See notes in summary detail for additional information

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)

Adequate Health Care Task Force

	Reference to Summary Page	Insurance Industry Plan(4)					
		By Proposal Component:					
		Overall	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Premium Subsidies
<i>Note:</i> 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 legislative estimate.			Childless Adults eligible for Medicaid up to 100% FPL	Direct Subsidies For Employer Coverage (a.k.a FHIAP)	Advanceable, Refundable Tax credits for those ineligible for Direct Subsidies	Direct Subsidies For Individual Coverage (a.k.a FHIAP)	Small Employer Tax Credits
I. Total Population Eligible for Program(s)		Footnote 2	238,121	90,123	135,897	547,122	735,247
A. Total Uninsured in Eligible Population		Footnote 2	238,121	90,123	-	547,122	127,470
II. Total Estimated Program Enrollment		914,127	214,309	53,954	96,793	181,031	425,488
A. Overall Participation Rate		Footnote 2	90%	60%	71%	33%	58%
B. Annual Overall Coverage Cost per Participant (includes employer, employee and subsidy amounts)		\$ 3,584	\$ 2,900	\$ 4,449	\$ 1,738	\$ 4,587	\$ 3,947
C. Annual Overall Subsidy Cost per Participant		\$ 2,260	\$ 2,900	\$ 537	\$ 1,161	\$ 3,747	\$ 1,973
D. Annual State Subsidy Cost per Participant (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds)	II.C	\$ 1,570	\$ 1,450	\$ 188	\$ 1,161	\$ 1,311	\$ 1,973
III. Total Newly Covered under Proposal	I.A.	472,654	214,309	53,954	-	181,031	80,809
A. Participation among Eligible Uninsured		N/A	90%	60%	0%	33%	63%
B. Annual Overall Coverage Cost per Newly Insured (includes employer, employee and subsidy amounts)		\$ 3,764	\$ 2,900	\$ 4,449	\$ -	\$ 4,587	\$ 4,337
C. Annual Program Subsidy Cost per Newly Insured		\$ 2,727	\$ 2,900	\$ 537	\$ -	\$ 3,747	\$ 2,169
D. Annual State Subsidy Cost per Newly Insured (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds)		\$ 1,393	\$ 1,450	\$ 188	\$ -	\$ 1,311	\$ 2,169
E. Enrollment of Newly Insured as a Percent of Total Program Enrollment		52%	100%	100%	0%	100%	19%
IV. Currently Insured residents participating in new coverage programs	I.B.	441,472	-	-	96,793	-	344,679
A. Annual Coverage Cost per Previously Insured Resident (includes employer, employee and subsidy amounts)		\$ 3,391	\$ -	\$ -	\$ 1,738	\$ -	\$ 3,855
B. Annual Program Subsidy Cost per Previously Insured Resident		\$ 1,760	\$ -	\$ -	\$ 1,161	\$ -	\$ 1,928
C. Annual State Subsidy Cost per Previously Insured Resident (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds)		\$ 1,760	\$ -	\$ -	\$ 1,161	\$ -	\$ 1,928

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)

Adequate Health Care Task Force

	Reference to Summary Page	Insurance Industry Plan(4)					
		By Proposal Component:					
		Overall	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Premium Subsidies
<i>Note:</i> 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 legislative estimate.			Childless Adults eligible for Medicaid up to 100% FPL	Direct Subsidies For Employer Coverage (a.k.a FHIAP)	Advanceable, Refundable Tax credits for those ineligible for Direct Subsidies	Direct Subsidies For Individual Coverage (a.k.a FHIAP)	Small Employer Tax Credits
V. Costs Associated with Enrollment in New Coverage Options(3)							
A. New Federal Medicaid/SCHIP Funds	II.A.	\$ 630,577,271	\$ 310,760,501	\$ 18,830,569	\$ -	\$ 440,903,576	\$ -
B. New Health Insurer Assessments	II.B.1.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
C. Employers:							
1. Premium Contributions		\$ 804,889,093	\$ -	\$ 203,108,427	\$ -	\$ -	\$ 601,780,665
2. New Fees or Taxes		\$ -					
D. Residents:		\$ -					
1. Premium Contributions		\$ 405,507,995	\$ -	\$ 7,946,116	\$ 55,879,614	\$ 152,007,346	\$ 237,913,286
2. New Payroll Taxes	II.B.3	\$ -					
State Income Taxes		\$ -					
E. New State Medicaid/SCHIP Funds	II.B.4	\$ 482,969,531	\$ 310,760,501	\$ 10,139,537	\$ -	\$ 237,409,618	\$ -
F. Other State Funds (source to be determined)	II.B.5	\$ 952,071,041			112377089		
VI. Total		\$ 3,276,014,931	\$ 621,521,003	\$ 240,024,650	\$ 168,256,703	\$ 830,320,539	\$ 1,679,387,904
VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Baseline Coverage							
A. State Costs	III.	\$ 122,024,980					
B. Federal Costs		\$ 163,211,758					
VIII. Total Point-of-Service Cost Sharing Under the Program		\$ 802,657,811	\$ -	\$ 53,257,367	\$ 126,460,226	\$ 247,800,727	\$ 453,777,155
IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians		12%	12%	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 proposal components

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

(4) See notes in summary detail for additional information

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)

Adequate Health Care Task Force

	Reference to Summary Page	Hybrid Proposal							
		By Proposal Component:							
		Overall	Public program expansion	Public program expansion	Public program expansion	Individual Mandate	Require Insurers to offer "standard plan"	Individual Mandate	Employer Pay or Play
<i>Note:</i> 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 legislative estimate.			Family Care Expansion to 200% FPL	Childless Adults eligible for Medicaid up to 100% FPL	All Kids eligibility expanded to adults 19-23 in school full-time (note non-residents in Illinois schools subject to individual mandate)	New Public Program Enrollment Under Existing Eligibility Rules	residents assumed to keep their current coverage; uninsured purchase subsidized coverage in the individual market if ineligible for public	Existing Medicaid/SCHIP Coverage	For employers with 26 or more workers in Illinois
I. Total Population Eligible for Program(s)		N/A	256,874	469,640	25,715	807,854	7,809,746	1,245,948	
A. Total Uninsured in Eligible Population		N/A	97,223	325,850	25,715	202,692	1,079,197	-	
II. Total Estimated Program Enrollment		10,409,444	243,370	446,158	23,234	821,358	7,652,611	1,245,948	
A. Overall Participation Rate		N/A	95%	95%	90%	102%	98%	100%	
B. Annual Overall Coverage Cost per Participant (<i>includes employer, employee and subsidy amounts</i>)		\$ 4,840	\$ 2,798	\$ 3,146	\$ 2,067	\$ 2,798	\$ 5,599	\$ 2,594	
C. Annual Overall Subsidy Cost per Participant		\$ 1,107	\$ 2,755	\$ 3,146	\$ 1,701	\$ 2,755	\$ 513	\$ 2,594	
D. Annual State Subsidy Cost per Participant (<i>includes State Medicaid/SCHIP Funds and other unspecified sources of State funds</i>)	II.C	\$ 682	\$ 964	\$ 1,573	\$ 947	\$ 964	\$ 513	\$ 1,143	
III. Total Newly Covered under Proposal	I.A.	1,551,968	92,123	309,557	23,234	207,792	922,062		
A. Participation among Eligible Uninsured		91%	95%	95%	90%	103%	85%		
B. Annual Overall Coverage Cost per Newly Insured (<i>includes employer, employee and subsidy amounts</i>)		\$ 3,024	\$ 2,744	\$ 2,900	\$ 2,067	\$ 2,744	\$ 3,181		
C. Annual Program Subsidy Cost per Newly Insured		\$ 2,496	\$ 2,703	\$ 2,900	\$ 1,701	\$ 2,703	\$ 2,312		
D. Annual State Subsidy Cost per Newly Insured (<i>includes State Medicaid/SCHIP Funds and other unspecified sources of State funds</i>)		\$ 1,855	\$ 946	\$ 1,450	\$ 947	\$ 946	\$ 2,312		
E. Enrollment of Newly Insured as a Percent of Total Program Enrollment		15%	38%	69%	100%	25%	12%		
IV. Currently Insured residents participating in new coverage programs	I.B.	8,857,476	151,247	136,600	-	613,566	6,730,549	1,245,948	
A. Annual Coverage Cost per Previously Insured Resident (<i>includes employer, employee and subsidy amounts</i>)		\$ 5,159	\$ 2,831	\$ 3,702		2,831	\$ 5,931	\$ 2,594	
B. Annual Program Subsidy Cost per Previously Insured Resident		\$ 865	\$ 2,787	\$ 3,702	\$ -	\$ 2,787	\$ 267	\$ 2,594	
C. Annual State Subsidy Cost per Previously Insured Resident (<i>includes State Medicaid/SCHIP Funds and other unspecified sources of State funds</i>)		\$ 475	\$ 975	\$ 1,851	\$ -	\$ 975	\$ 267	\$ 1,143	

VI - Proposal Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)

Adequate Health Care Task Force

	Reference to Summary Page	Hybrid Proposal							
		By Proposal Component:							
		Overall	Public program expansion	Public program expansion	Public program expansion	Individual Mandate	Require Insurers to offer "standard plan"	Individual Mandate	Employer Pay or Play
<i>Note:</i> 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 legislative estimate.									
V. Costs Associated with Enrollment in New Coverage Options(3)									
A. New Federal Medicaid/SCHIP Funds	II.A.	\$ 2,600,054,579	\$ 435,825,884	\$ 701,703,374	\$ 17,530,251	\$ 365,028,717	\$ -	\$ 1,079,966,352	
B. New Health Insurer Assessments	II.B.1.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
C. Employers:									
1. Premium Contributions		\$ 30,205,297,263	\$ -	\$ -	\$ -	\$ -	\$ 30,297,281,220		
2. New Fees or Taxes		\$ 1,418,799,966				\$ -			\$ 1,418,799,966
D. Residents:									
1. Premium Contributions		\$ 8,627,533,581	\$ 10,436,374	\$ -	\$ 8,508,069	\$ 8,518,317	\$ 8,626,260,550	\$ -	
2. New Payroll Taxes	II.B.3	\$ -				\$ -	\$ -		
State Income Taxes		\$ -				\$ -			
E. New State Medicaid/SCHIP Funds	II.B.4	\$ 2,061,349,431	\$ 234,675,476	\$ 701,703,374		\$ 196,553,925	\$ -	\$ 928,416,656	
F. Other State Funds (source to be determined)	II.B.5	\$ 3,936,003,110	0	0	21,994,501		3,925,927,909		
VI. Total		\$ 48,849,037,930	\$ 680,937,734	\$ 1,403,406,748	\$ 48,032,821	\$ 570,100,959	\$ 42,849,469,680	\$ 2,008,383,009	
VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Baseline Coverage									
A. State Costs	III.	\$ 122,024,980							
B. Federal Costs		\$ 163,211,758							
VIII. Total Point-of-Service Cost Sharing Under the Program		\$ 8,085,288,255	\$ 40,808,014	\$ -	\$ 2,540,537	\$ 92,046,244	\$ 7,943,576,679	\$ 30,433,850	
IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians			39%	13%	24%	1%	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 proposal components

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

(4) See notes in summary detail for additional information