

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

**Modified Hybrid Model -  
Revised to Reflect High and Moderate  
Consensus Items**

**September 20, 2006  
Draft and Preliminary**



## Introduction

At the August 15, 2006 Adequate Health Care Task Force meeting, the Task Force requested that the consulting team modify the hybrid model to:

- Reflect items that the Task Force designated as high consensus
- Use items designated as moderate consensus as necessary to achieve the Health Care Justice Act goals

Table 1 on the following page provides a listing of the high, moderate and low consensus items identified during the August 15, 2006 meeting. Table 2 highlights the differences between the August 15, 2006 hybrid model and the modified hybrid model described here. The components of this model are meant to be implemented as one comprehensive strategy.

To clearly illustrate the impact of the application of features based on high and moderate consensus items, we have developed a two-tiered model. Tier I reflects all of the high consensus items and Tier II layers moderate consensus items – most notably the individual mandate and employer assessment – on top of the Tier I strategies to achieve a higher level of coverage of the uninsured than achieved through Tier I.

In addition, we have provided two alternative coverage approaches within both tiers for the Task Force's consideration. Option A provides additional coverage options in the form of a new standard, comprehensive plan that all carriers must offer. Option B provides additional coverage options through voluntary private market offerings and a State self-insured plan. While the Task Force had indicated that a State-run insurance plan is a low consensus item, we included this item in Option B as it helps the State achieve several high consensus items.<sup>1</sup>

The following exhibits describe the hybrid model:

- Exhibit 1: Graphic Overview of Modified Hybrid Model
- Exhibit 2: Overview of Options A and B within Tier I and II
- Exhibit 3: Summary Graphic of Individual and Family Coverage Options
- Exhibit 4: Summary Graphic of Employer Options
- Exhibit 5: Summary Graphic of Insurance Market Reforms
- Exhibit 6: Summary of Modified Hybrid Model by High and Moderate Consensus Items
- Exhibit 7: Tier I Description
- Exhibit 8: Tier II Description

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<sup>1</sup>Specifically, the coverage approach used in Option B facilitates an adequate supply and distribution of providers, minimizes costs not related to the direct provision of health care and provides a comprehensive benefit package at a comparatively affordable price.

- Exhibit 9: Example of Premium Assistance Determination
- Exhibit 10: Cost and Coverage Estimates
- Exhibit 11: Impact of Modified Hybrid Model on the Uninsured by Selected Characteristics

**Table 1: Summary of the Adequate Health Care Task Force’s High, Moderate and Low Consensus Items**

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

**Table 2: Major Differences Between Original and Modified Hybrid**

	Original Hybrid	Modified Hybrid
<b>Premium Assistance</b>	<ul style="list-style-type: none"> <li>Provide premium assistance for all individuals with an employer offer of coverage, regardless of insurance status</li> </ul>	<ul style="list-style-type: none"> <li>In Tier I, premium assistance for employer-based coverage available only when individual is currently not taking up offer of coverage</li> </ul>
	<ul style="list-style-type: none"> <li>Subsidize premium and deductible for eligible populations</li> </ul>	<ul style="list-style-type: none"> <li>Subsidize premiums only for eligible populations</li> </ul>
<b>Reinsurance</b>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Uses a state-run program that reinsures only guaranteed issue individual products and all comprehensive small group products, and is funded by all insurers (based on a National Association of Insurance Commissioners model reinsurance program)</li> </ul>
<b>Benefit Package</b>	<ul style="list-style-type: none"> <li>Uses a high-deductible standard product that is Health Savings Account-compliant</li> </ul>	<ul style="list-style-type: none"> <li>Standard product cannot be a high-deductible plan and thus is not Health Savings Account-compliant</li> </ul>
<b>Individual Mandate and Employer Assessment</b>	<ul style="list-style-type: none"> <li>Individual mandate and employer assessment immediately applied</li> </ul>	<ul style="list-style-type: none"> <li>Individual mandate and employer assessment applied only in Tier II</li> </ul>
<b>Public Expansions</b>	<ul style="list-style-type: none"> <li>Includes childless adults under Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>Pays for childless adults with state-only funds under the assumption that population cannot be covered under the Medicaid program using the Federal government's budget neutrality provisions</li> </ul>
<b>Administration</b>	<ul style="list-style-type: none"> <li>Illinois Health Education and Referral Center (IHERC) did not have a public governing board</li> </ul>	<ul style="list-style-type: none"> <li>IHERC has a public Board that performs an oversight function</li> <li>Addition of fraud and abuse provision</li> </ul>
<b>Insurance Market Reforms</b>	<ul style="list-style-type: none"> <li>No new cap on rate increases in individual market</li> </ul>	<ul style="list-style-type: none"> <li>Individual guaranteed issue premiums may not increase more than 115 percent of medical trend across all of carrier's products in market</li> </ul>
	<ul style="list-style-type: none"> <li>No required medical loss ratios</li> </ul>	<ul style="list-style-type: none"> <li>Required medical loss ratio</li> </ul>

# Exhibit 1: Modified Hybrid Model Overview – Tiers I and II

## Illinois Adequate Health Care Task Force

### IHERC – Administrative Body and Oversight Board

### Various Insurance Market Changes to Further Spread Risk and Reduce Administrative Costs

#### Individual Mandate Option (Tier II)

#### New Coverage Options

- » Parents 185-200% of the FPL (SCHIP-funded)
- » Childless adults (State-only funds via Medicaid)
- » Various Medicaid expansions for disabled
- » Premium assistance up to 400% of the FPL, with special provision to support small low wage firms
- » Additional support
  - › Option A: All carriers offer Comprehensive Standard Plan
  - › Option B: State self-insured plan

#### Existing Coverage Options

- » Public programs
- » Employer-based coverage
- » Individual market

#### Funding Sources

- » Federal and State Medicaid and SCHIP funds
- » Employer and employee premium payments
- » Additional State tax revenue
- » Employer assessment
- » Payments from individuals not complying with mandate

#### Employer Assessment Option (Tier II) (if health insurance not provided)

# Exhibit 2: Overview of Options A and B within Tier I and II Illinois Adequate Health Care Task Force

Most modified hybrid model features apply to all scenarios, including:

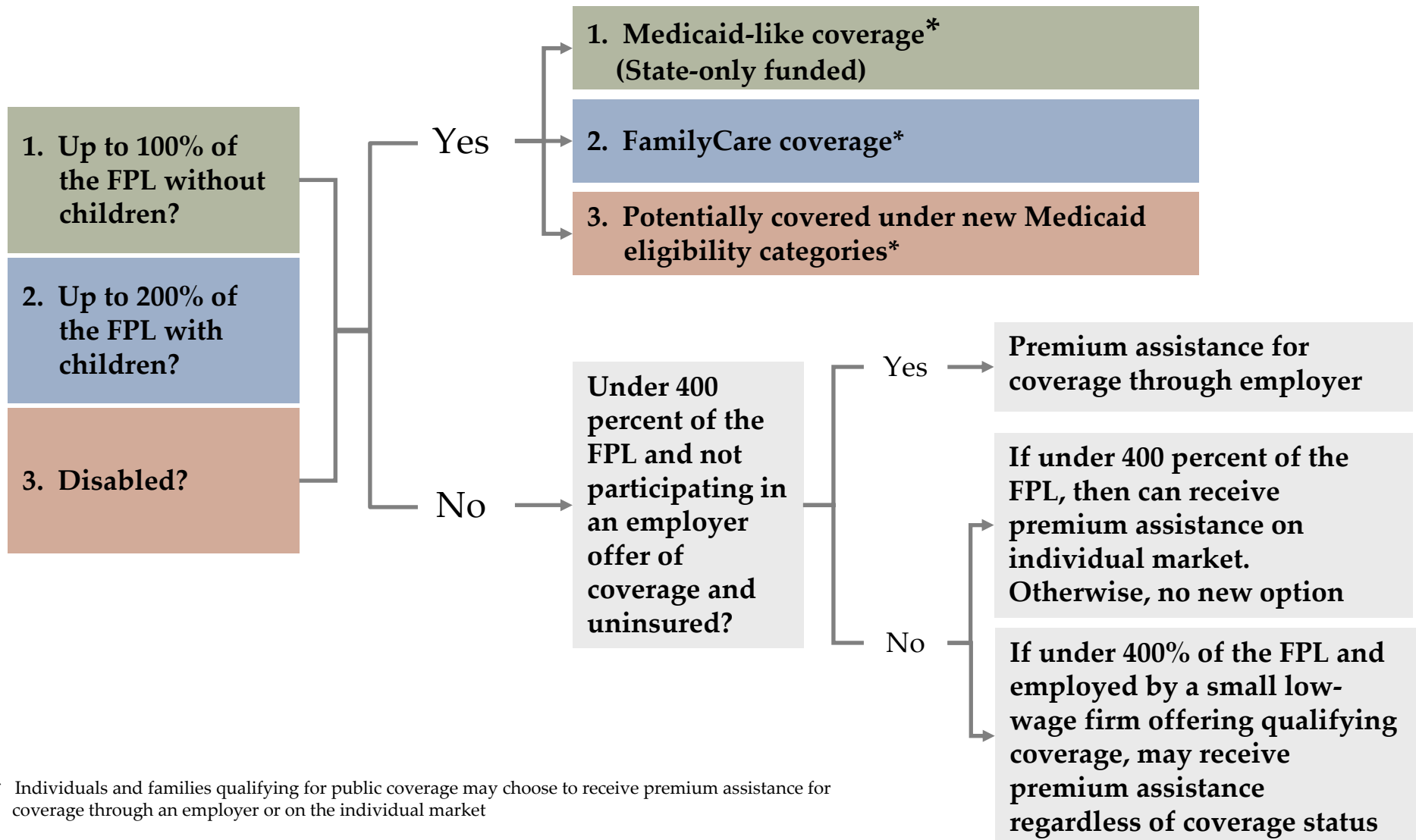
- IHERC administrative body
- State-funded premium assistance
- Public program expansions
- Insurance market changes:
  - Individual guaranteed issue premiums may not increase more than 115% of medical trend across all of carrier's products in market.
  - Comprehensive guaranteed issue products (small group and individual) may be reinsured, with reinsurance premiums capped at 400% of carrier's base rate

The following features differ between scenarios:

	Option A	Option B
<b>Tier I</b>	<ul style="list-style-type: none"> <li>• Premium assistance applies to Standard Comprehensive Plan offered guaranteed issue by commercial carriers using commercial providers</li> </ul>	<ul style="list-style-type: none"> <li>• Premium assistance applies to State self-insured plan using Medicaid providers and enhanced Medicaid rates</li> <li>• Premium assistance may be applied to new guaranteed issue products if carriers voluntarily offer them.</li> </ul>
	<ul style="list-style-type: none"> <li>• Rates in the individual market cannot vary by more than 135% within a geographic area.</li> <li>• Rates must reflect a minimum medical loss limit of 80%</li> </ul>	
<b>Tier II</b>	<b>Features in Addition to Tier I</b>	
	<ul style="list-style-type: none"> <li>• Rates in the individual market cannot vary by more than 130% within a geographic area.</li> <li>• Rates must reflect a minimum medical loss limit of 85%</li> <li>• Individual mandate</li> <li>• Employer Assessment</li> </ul>	

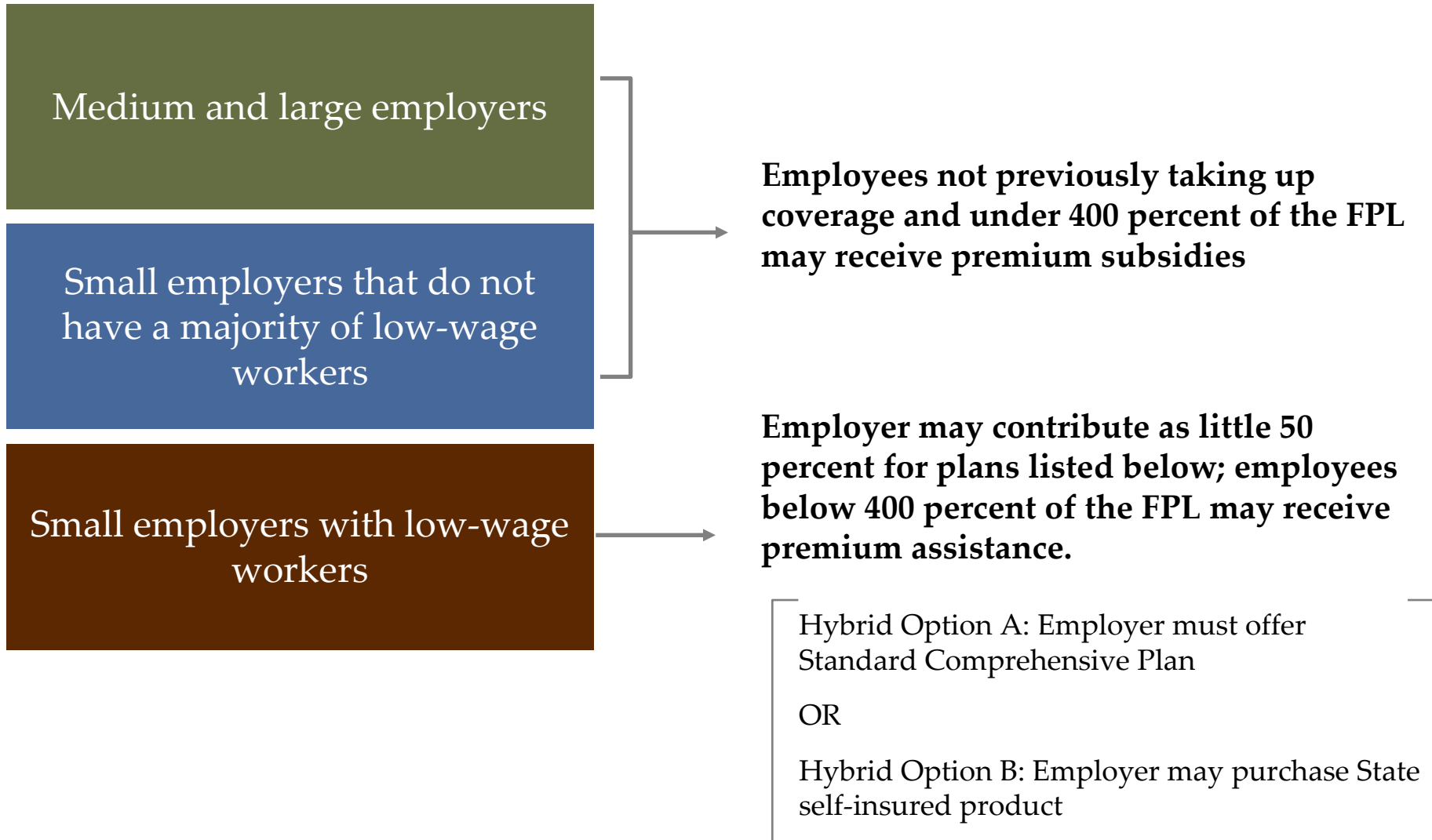
# Exhibit 3: New Individual and Family Coverage Options – Modified Hybrid Model

## Illinois Adequate Health Care Task Force



\* Individuals and families qualifying for public coverage may choose to receive premium assistance for coverage through an employer or on the individual market

## Exhibit 4: New Employer Health Benefit Options – Modified Hybrid Model Illinois Adequate Health Care Task Force



## Exhibit 5: Changes to the Insurance Market Illinois Adequate Health Care Task Force

Individual	Small Group	Large Group
1. Carriers must file rates for State review and approval.		No Change
2. For rate approval, individual and small-group rates must reflect a minimum medical loss ratio of either 80% (Tier I – without individual mandate) or 85% (Tier II – with individual mandate).		
3. Rates cannot vary by more than: <ul style="list-style-type: none"> <li>» Without individual and employer mandate: 135% of carrier’s base rate (accounting for all rating factors a carrier may use except geography)</li> <li>» With individual and employer mandate: 130% of carriers base rate (accounting for all rating factors a carrier may use except geography)</li> </ul>	3. Rates cannot vary by more than 130% of carrier’s base rate (accounting for all rating factors a carrier may use except for geographic location).	
4. Annual rate increases for guaranteed issue comprehensive products cannot exceed 115% of the medical cost trend across carrier’s entire book of individual and small group business, respectively.		
5. Carriers fund a voluntary reinsurance program to reinsure guaranteed issue individual products and all comprehensive small group products		
<b>Option A:</b> All insurance carriers must: <ul style="list-style-type: none"> <li>» Offer a guaranteed issue standard comprehensive small group and individual product, if they write coverage in these markets, respectively</li> <li>» Provide individuals and small employer information about standard products and premium assistance</li> </ul>		
<b>Option B:</b> Carriers may offer guaranteed-issue, reinsured individual and/or small group comprehensive products that qualify for premium assistance, but are not required to do so.		

**Exhibit 6: Summary of Modified Hybrid Model by High and Moderate Consensus Items**

AHCTF Consensus	Tier I	Tier II (includes all Tier I policies)
<b>A. High Consensus</b>		
1. Medicaid and State Children’s Health Insurance Program (SCHIP) expansions 2. Maximizing Federal Medicaid funds	Expand public coverage for parents up to 200 percent of the federal poverty level (FPL). Expand Medicaid to include additional disabled populations. Under Tier II, some additional state funding may be necessary as the number of eligibles participating in Medicaid and SCHIP would increase, likely exceeding the cost of the State’s SCHIP allotment.	
3. State-refundable tax credits/premium assistance 4. Additional employer commitment through new take-up of employer-based insurance by employees	Provide premium assistance to individuals and families up to 400 percent of the FPL. Require that premium assistance be used for employer offer of coverage if available. Encourage low-wage small employers to offer health insurance through new coverage options and require small, low wage employers offering these new options to also offer Section 125 plans	
5. Strategies for spreading risk	New Coverage Options: <ul style="list-style-type: none"> <li>• Option A: All carriers must offer a Standard Comprehensive Plan.</li> <li>• Option B: Uninsured individuals without an offer of employer coverage and small low-wage employers may join a State self-insured plan centered around traditional Medicaid providers, including Federally Qualified Health Centers (FQHCs).</li> </ul> Restrict rate bands and annual rate increases in the small group and individual health insurance market and create new guaranteed issue products for the individual and small group market. <sup>2</sup>	
6. Reinsurance	Not applicable	Encourage participation in guaranteed issue products through employer assessment and individual mandate.
7. Long-term care partnerships recently allowed by the Deficit Reduction Act	Implement long-term care partnerships.	

<sup>2</sup>We recognize that provider rates vary widely and additional analysis and discussion with providers and other stakeholders is necessary to determine how to calculate this increase.

**Exhibit 6: Summary of Modified Hybrid Model by High and Moderate Consensus Items**

<b>AHCTF Consensus</b>	<b>Tier I</b>		<b>Tier II (includes all Tier I policies)</b>
8. Adequate and timely payment to providers	Increase payments to Medicaid providers by three percent in the first year and increase an additional three percent based on quality of care indicators in the second year <sup>3</sup> .		
9. Adequate supply and distribution of providers (i.e., incentives for providers to practice in underserved areas such as loan repayment)	Improve timeliness of Medicaid payments. Under Option B, providers will receive 105 percent of Medicaid rates (including increases) <sup>4</sup> .		
10. Minimizing all costs not related to the direct provision of health care, including minimizing administrative costs, fraud and abuse.	Increase home- and community based services throughout the State and increase collaboration among state agencies responsible for institutional and home- and community based services. Under Option B – Provide new insured demand (reducing uncompensated care) and higher payment rates to Medicaid providers through State self-insured plan.		
	To improve competition, require that all insurers report medical loss ratios on individual and small group major medical products.		
	Require insurers to report base premiums for standard products.		
	Require that individual and small-group rates for offerings assume a medical loss ratio of at least 80 percent.	Require that individual and small-group rates have a medical loss ratio of at least 85 percent.	
	Build on disease management and cost-sharing policies of Medicaid and SCHIP through related expansions. Oversight body (Illinois Health Education and Research Center Board or “IHERC”) will make recommendations for adoption of proven technologies to identify and address fraud and abuse for state products. IHERC will also report on the commercial market’s best practices regarding fraud and abuse and make recommendations for public program fraud and abuse policies. Option B - Takes advantage of lower Medicaid administrative costs.		

<sup>3</sup> We recognize that provider rates vary widely and additional analysis and discussion with providers and other stakeholders is necessary to determine how to calculate this increase.

<sup>4</sup> We recognize that provider rates vary widely and additional analysis and discussion with providers and other stakeholders is necessary to determine how to calculate this increase.

**Exhibit 6: Summary of Modified Hybrid Model by High and Moderate Consensus Items**

<b>AHCTF Consensus</b>	<b>Tier I</b>	<b>Tier II (includes all Tier I policies)</b>
11. Comprehensive benefit package	<p>Maintain Medicaid and SCHIP benefit packages, provider networks and reimbursement schedules for Medicaid and SCHIP expansion populations and the Medicaid-like program for childless adults.</p> <p>Both the Standard Comprehensive Plan (Option A) and the State self-insured plan (Option B) offer comprehensive benefits consistent with commercial plans.</p>	
<b>B. Moderate Consensus</b>		
1. Employer mandate	None	Require an employer assessment; employers may receive a credit for assessment if they provide health care coverage to employees.
2. Individual mandate		Implement an individual mandate.
<p>3. Public body to evaluate plan performance and make recommendations for improvement</p> <p>4. Publishing provider and insurer quality measures</p> <p>5. Publishing provider and insurer costs</p>	<p>Establish IHERC, which will:</p> <ul style="list-style-type: none"> <li>• Determine eligibility for premium assistance and pay premium assistance amounts directly to insurance companies</li> <li>• Publish insurer medical loss ratios and standardized cost and benefit information on insurers' standardized packages (Option A) or on guaranteed issue products (Option B)</li> <li>• Report on provider quality monitoring</li> </ul> <p>Monitor compliance with new insurance regulations through the Division of Insurance</p> <p>Provide mechanism for consumer and government oversight of coverage strategies through IHERC Board.</p>	<ul style="list-style-type: none"> <li>• Require Illinois Department of Revenue to track employer assessments and individual penalties</li> <li>• Push forward e-prescribing by 2011</li> </ul>

**Exhibit 6: Summary of Modified Hybrid Model by High and Moderate Consensus Items**

<b>AHCTF Consensus</b>	<b>Tier I</b>	<b>Tier II (includes all Tier I policies)</b>
6. Continued use of employer plans	New commercial coverage options are available. Require that premium assistance be used for employer offer of coverage if available.	
7. Additional state tax revenue	Additional state revenue required for state-only funded premium assistance, state portion of Medicaid and SCHIP expansions, and childless adult coverage.	

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Exhibit 7: Modified Hybrid Model Tier I Description

Program Component	Tier I - Policy
<b>A. Coverage Approach</b>	
<p>1. Medicaid and SCHIP Expansion</p>	<p><u>SCHIP</u></p> <p>Expand SCHIP coverage for parents from 185 percent of the FPL to 200 percent of the FPL. Illinois would modify its current 1115 waiver to (1) make lower-income parents of SCHIP children Medicaid-eligible, and (2) use the “freed up” SCHIP allotment to cover parents from 185 to 200 percent of the FPL. This expansion would require that the State identify savings in the current Medicaid population to maintain Medicaid budget neutrality. Alternatively, the State could decide to make the lower-income parents of SCHIP children eligible for Medicaid through a State Plan Amendment, creating a new Medicaid eligibility category. Either one of these options would require extensive conversations with the Centers for Medicare and Medicaid Services.</p> <p><u>Medicaid</u></p> <p>Expand Medicaid to include additional disabled populations, specifically:</p> <ul style="list-style-type: none"> <li>• Expand income eligibility for Aid to the Aged, Blind and Disabled (AABD) program from 100 percent to 300 percent of the FPL.</li> <li>• Increase income eligibility for Health Benefits to Workers with Disabilities (HBWD) from 200 percent of FPL to 350 percent of FPL and remove asset and spousal deeming barriers.</li> <li>• Expand Medicaid coverage to former enrollees of HBWD Program.</li> <li>• Implement a Medicaid buy-in for children with disabilities up to 300 percent of the FPL.</li> <li>• Reinstatement of Interim Assistance Program for individuals deemed “probably eligible for SSI”. This allows interim SSI recipients to receive necessary medical coverage and help them provide evidence to prove eligibility for SSI, thus entitling them to Medicaid.</li> </ul>

**Exhibit 7: Modified Hybrid Model Tier I Description**

Program Component	Tier I - Policy
2. State-Only Funded Program	Cover childless adults under 100 percent of the FPL through the Medicaid program using state funds. Using the Medicaid program to cover this population allows the State to use an existing health coverage vehicle with comparatively low administrative costs and provider rates.
3. New Coverage Options	<p>Use one of the following new health insurance options in the small-group and individual market:</p> <p><u>Option A</u></p> <p>All carriers must offer a guaranteed issue “Standard Comprehensive Plan” to small groups and individuals. The plan must include a full range of preventive and acute health care services, and some long-term health care services.</p> <p><u>Option B</u></p> <p>The State offers a self-insured health plan that includes a full range of preventive and acute health care services, and some long-term health care services.<sup>5</sup> This benefit package is offered through the Medicaid provider network, including FQHCs; provider payments equal 105 percent of Medicaid rates (including increases). Premiums for this product will vary by age and location, but not by health status or any other factor.</p>
4. Premium Assistance  (State-only funds)	<p>Individuals under 400 percent of the FPL who are not eligible for a public program may qualify for premium assistance if they:</p> <ul style="list-style-type: none"> <li>• Do not have an offer of coverage through an employer; or</li> <li>• Have an offer of coverage through an employer but have been uninsured for the last six months;<sup>6</sup> or</li> </ul>

<sup>5</sup> This design is very similar to that used by the Arizona Health Care Group, a state-sponsored small-group purchasing cooperative established contracting only Medicaid managed care plans. Similarly, New York requires all health maintenance organizations (HMOs) to offer the Healthy New York product; HMOs that are also Medicaid/SCHIP contractors account for a substantial share of total enrollment in Healthy New York.

<sup>6</sup> This provision is intended to reduce crowd out of employer coverage.

**Exhibit 7: Modified Hybrid Model Tier I Description**

<p><b>Program Component</b></p>	<p><b>Tier I - Policy</b></p>
<p><i>Premium Assistance, continued</i></p>	<ul style="list-style-type: none"> <li>• Are employed in a small low-wage firm (regardless of current insurance status) that offers either:                             <ul style="list-style-type: none"> <li>➤ <u>Option A</u> – Standard Comprehensive Plan</li> <li>➤ <u>Option B</u> – State-insured plan</li> </ul> </li> </ul> <p>Qualifying individuals must use premium assistance to purchase employer-based coverage if available (no benefit equivalency test is applied). If such coverage is not available, premium assistance may be used to purchase any individual product available on a guaranteed-issue basis (under Option B, this includes the State self-insured plan).</p> <p>The premium assistance amount will be based on:</p> <ul style="list-style-type: none"> <li>• <u>Under Option A</u>, the lowest-cost Comprehensive Standard Product in the beneficiary’s geographic area (see description under section B “Benefits” below), or</li> <li>• <u>Under Option B</u>, the cost of the state self-insured plan in the beneficiary’s geographic area (see description under section B “Benefits” below).</li> </ul> <p>After premium assistance, the net premium for all enrolled family members will not exceed six percent of family income in the individual market and four percent of family income in the group market. Exhibit 9 provides an example of premium subsidy determination.</p>
<p>5. Changes to Insurance Market</p>	<p><u>Overall</u></p> <ul style="list-style-type: none"> <li>• Insurers must file all small group and individual rates for State review and approval.</li> <li>• Small group rates cannot vary by more than 130 percent of the carrier’s base rate within a geographic location, accounting for all rating factors that the carrier may use. Across geographic areas, rates may vary more than 130 percent, if justified by the carrier’s credible claims experience in those areas.</li> </ul>

**Exhibit 7: Modified Hybrid Model Tier I Description**

<p><b>Program Component</b></p>	<p><b>Tier I - Policy</b></p>
<p><i>Changes to Insurance Market, continued</i></p>	<ul style="list-style-type: none"> <li>• Individual rates cannot vary by more than 135 percent of the carrier’s base rate within a geographic location, accounting for all rating factors that the carrier may use. Across geographic areas, rates may vary more than 135 percent, if justified by the carrier’s credible claims experience in those areas.</li> <li>• Annual rate increases for health status, claims experience or duration in the small group or individual product cannot exceed 115 percent of the medical cost trend across the carrier’s entire book of individual and small-group business, respectively.</li> <li>• Illinois will establish a voluntary program to reinsure all guaranteed issue, comprehensive individual and small group products (see #A7 Reinsurance below).</li> </ul> <p><u>Under Option A</u></p> <ul style="list-style-type: none"> <li>• All insurance carriers that offer, respectively, individual or small group coverage must:               <ul style="list-style-type: none"> <li>➢ Provide all individuals and small group coverage applicants information about the Comprehensive Standard Product and the availability of premium assistance.</li> <li>➢ Offer a Comprehensive Standard Product guaranteed issue to individuals or small groups (as defined by IHERC)<sup>7</sup>.</li> <li>➢ Set premiums for the Comprehensive Standard Product based on:                   <ul style="list-style-type: none"> <li>– In the individual market, two separate risk pools:                       <ul style="list-style-type: none"> <li>▪ Individuals eligible for subsidies<sup>8</sup> – premiums may be adjusted only for age and geographic location</li> <li>▪ All other individual applicants for the standard product, adjusted only for age and geographic location</li> </ul> </li> </ul> </li> </ul> </li> </ul>

<sup>7</sup> Small groups are defined as groups between 2-50 – in compliance with HIPAA, all small-group commercial products must be guaranteed issue to groups 2-50.

<sup>8</sup> For individuals not eligible for premium assistance, this product will compete with the state high-risk pool

**Exhibit 7: Modified Hybrid Model Tier I Description**

Program Component	Tier I - Policy
	<p style="text-align: center;">– In the small group market, risk pooled across all small groups of 2-50 employees</p> <p><u>Under Option B</u></p> <p>Carriers offering a guaranteed issue individual market product that complies with the provisions under “Overall” (above) may benefit from the reinsurance program (see #A7 Reinsurance, below) and may also benefit from enhanced participation because the product will be eligible for premium assistance. Carriers that offer a guaranteed issue small group product may also benefit from the reinsurance program; these (and all small group) products that comply with the provisions under “Overall” may also benefit from enhanced participation because the product will be eligible for premium assistance.</p>
<p>6. Small, Low-Wage Employer Product</p>	<p>Small, low-wage employers may offer either the Comprehensive Standard Plan (under Option A) or the state self-insured plan (under Option B) if they:</p> <ul style="list-style-type: none"> <li>• Contribute at least 50 percent of the cost of single coverage (no contribution will be required for dependents)</li> <li>• Enroll at least 75 percent of full-time workers who otherwise do not have evidence of qualified coverage<sup>9</sup></li> <li>• Establish a Section 125 plan to help employees contribute to premiums on a pre-tax basis</li> </ul> <p>These contribution and enrollment levels are less than the levels required by most insurers, encouraging employers to offer coverage to most of their workers.</p>
<p>7. Reinsurance</p>	<p>Use a state-run voluntary reinsurance program to reinsure only guaranteed issue individual products and all comprehensive small group products, specifically:</p> <ul style="list-style-type: none"> <li>• Insurers must pay a \$5,000 deductible on all individuals, employees, or dependents ceded to the reinsurance program, after which the reinsurance program will pay all claims.<sup>10</sup></li> </ul>

<sup>9</sup> Qualified coverage will include employer group coverage, Medicaid, Medicare or coverage under any other Federal program that finances comprehensive health care services for the worker.

**Exhibit 7: Modified Hybrid Model Tier I Description**

<p><b>Program Component</b></p>	<p><b>Tier I - Policy</b></p>
<p><i>Reinsurance, continued</i></p>	<ul style="list-style-type: none"> <li>• All carriers writing either individual or group coverage in Illinois, as well as other licensed third-party administrators of health benefits plans in the State, will contribute to pool losses (net of reinsurance premiums paid) in proportion to their medical claims paid, including risk and non-risk business.</li> <li>• Reinsurance premiums will be capped at 400 percent of each carrier’s base rate for individual market guaranteed issue products and their comprehensive small-group products, respectively.<sup>11</sup></li> </ul> <p>Individuals offered only the guaranteed issue product(s) of any carrier, or offered a guaranteed issue product at a higher premium than available in the state’s high-risk pool (ICHIP), are eligible for ICHIP.</p>
<p>8. Long-Term Care Coverage</p>	<ul style="list-style-type: none"> <li>• Implement Long-Term Care Partnerships in Illinois. The Deficit Reduction Act of 2005 allows states to update their State Plan to allow for a Long-Term Partnership program. This program would allow the State Medicaid agency to disregard any assets or resources in an amount equal to the insurance benefit payments into a qualified long-term care insurance partnership policy, for purposes of determining eligibility for Medicaid funded long-term care services.</li> <li>• Encourage businesses to provide long-term care insurance.</li> <li>• Increase public awareness of long-term care insurance to by providing descriptions of the benefits and costs of long-term care plans on IHERC’s webpage.</li> </ul>

<sup>10</sup> Based on a National Association of Insurance Commissioners (NAIC) model reinsurance program

<sup>11</sup> The intent of this provision is to encourage insurers to cede approximately 5 percent of covered lives to the reinsurance program, to help stabilize premiums in the guaranteed issue product.

**Exhibit 7: Modified Hybrid Model Tier I Description**

Program Component	Tier I - Policy
<b>B. Benefit Package</b>	
1. Medicaid and SCHIP	Maintain current Medicaid and SCHIP benefit packages, provider networks and reimbursement schedules for expansion populations and the Medicaid-like program for adults without children under 100 percent of the FPL. The current Medicaid benefit package is comprehensive and includes extensive long-term care service and services for people with developmental disabilities.
2a. Standard Package (Option A)  2b. State Self-insured Plan (Option B)	Include a full range of preventive and acute health care services, and some long-term health care services, consistent with a typically comprehensive commercial insurance plan with moderate cost sharing. High-deductible health plans will not be considered comprehensive.

**Exhibit 7: Modified Hybrid Model Tier I Description**

Program Component	Tier I - Policy
<b>C. Non-Coverage Access Strategies</b>	
1. Provider Payment	<p><u>Medicaid Provider Payment</u></p> <p>Increase payments to Medicaid providers by three percent in the first year and increase payment by an additional three percent in future years based on compliance with selected quality indicators.<sup>12</sup> Improve timeliness of payment to Medicaid providers.</p> <p><u>Under Option B</u></p> <p>Provider payment rates for State self-insured plan are set at 105 percent of Medicaid rates (adjusted per above description).<sup>13</sup></p>
2. Increased Supply and Distribution of Providers	<ul style="list-style-type: none"> <li>• Increase access to providers in underserved areas.               <ul style="list-style-type: none"> <li>➢ Target State grants for capital investments, health care workers and public health interventions to underserved areas.</li> <li>➢ Increase access to providers in rural areas in conjunction with the State Rural Health Care Access Plan, and through other efforts demonstrated to improve access in rural areas, such as telemedicine and financial incentives, and medical and nursing school tuition loan forgiveness.</li> </ul> </li> <li>• Increase home-and community-based services and reform long-term care system in the State.               <ul style="list-style-type: none"> <li>➢ Build on the State’s current activities to implement the Older Adult Services Act (OASA) by supporting the</li> </ul> </li> </ul>

<sup>12</sup> We recognize that provider rates vary widely and additional analysis and discussion with providers and other stakeholders is necessary to determine how to calculate this increase.

<sup>13</sup> We recognize that provider rates vary widely and additional analysis and discussion with providers and other stakeholders is necessary to determine how to calculate this increase.

**Exhibit 7: Modified Hybrid Model Tier I Description**

<p><b>Program Component</b></p>	<p><b>Tier I - Policy</b></p>
<p><i>Increased Supply and Distribution of Providers, continued</i></p>	<p>Department of Aging’s efforts to develop single points of entry for the full range of available long-term care services and restructuring the Medicaid Program’s nursing facility payment methodology to create incentives for nursing facilities to provide home- and community-based services.</p> <ul style="list-style-type: none"> <li>➤ Offer incentives or assistance to organizations to create additional adult day care centers, community-based residential facilities and affordable housing with supportive services.</li> <li>➤ Increase collaboration among state agencies that are responsible for institutional and home- and community-based long-term care, including agencies that are responsible for different groups of long-term care users (e.g., elders, nonelderly adults with physical disabilities, adults with behavioral problems with children with physical or cognitive disabilities) and agencies that receive funding from different sources (e.g., Medicaid and the Administration on Aging).</li> </ul> <p><u>Under Option B:</u></p> <p>Enhanced Medicaid rates encourage providers to participate in the state-sponsored plan. Option B includes and supports existing and new Medicaid provider networks.</p>
<p><b>D. Funding Source</b></p>	
<p>1. Federal Funds</p>	<p>Use federal funds as part of Medicaid and SCHIP expansions.</p>
<p>2. Additional State Tax Revenue</p>	<p>Increase State tax revenue through targeted tax increases to pay for:</p> <ul style="list-style-type: none"> <li>• Additional State Medicaid share for public program expansions</li> <li>• Medicaid-like coverage for childless adults under 100 percent of the FPL</li> <li>• New state-funded premium assistance</li> <li>• Program administration and increases in ICHIP</li> </ul>

**Exhibit 7: Modified Hybrid Model Tier I Description**

Program Component	Tier I - Policy
3. Employer Contributions	Use employer contributions to fund a portion of the premium to cover the cost of insuring their employees.
4. Individual Contributions	Use individual contributions to pay for a portion of the premiums, co-payments and deductibles to help pay for the cost of their health insurance.
<b>E. Administration</b>	
1. Administrative Body	<p><u>IHERC</u></p> <p>Establish IHERC, which will:</p> <ul style="list-style-type: none"> <li>• Oversee the implementation of new coverage options.</li> <li>• Establish a premium assistance schedule and oversee premium assistance payments to health insurance carriers.</li> <li>• Assist with eligibility determination for and enrollment in the State’s premium assistance program and in determining subsidy amounts.</li> <li>• In cooperation with the Department of Insurance, establish a standard health plan reporting system for the purpose of assisting individuals and small groups to compare available guaranteed issue products and premiums.</li> <li>• Publish and update insurance carriers’ standardized product description and the base rate for each product.</li> <li>• Review state products, and make recommendations for adoption of proven technologies to identify and address fraud and abuse.</li> <li>• Report on the commercial market’s best practices regarding fraud and abuse and make recommendations for public program fraud and abuse policies.</li> </ul>

**Exhibit 7: Modified Hybrid Model Tier I Description**

<b>Program Component</b>	<b>Tier I - Policy</b>
<i>Administrative Body (Continued)</i>	<p><u>Division of Insurance</u></p> <ul style="list-style-type: none"> <li>• Monitor compliance with medical loss ratio requirements for carriers who offer coverage in the small group or individual market.</li> <li>• Monitor rates charged by these carriers to ensure that savings are passed through to purchasers of these policies.</li> <li>• Collect information on insurance carriers’ standardized product description and the base rate for each product.</li> <li>• Under Option A, monitor insurance carriers’ compliance with requirement to offer the standard plan guaranteed issue to separate risk pools and provide applicants information about this product.</li> </ul>
<p><b>F. Implementation</b></p>	
<p>1. Medicaid and SCHIP Expansions</p>	<ul style="list-style-type: none"> <li>• Use State Plan Amendment to expand coverage to the disabled.</li> <li>• Use a federal waiver to expand coverage to parents of SCHIP children – create savings by identifying savings in the existing Medicaid population. Alternatively, the State could choose to create a new Medicaid eligibility category for lower-income SCHIP parents through a State Plan Amendment.</li> </ul>
<p>2. Changes in State Law</p>	<p>Change State insurance laws to implement various changes recommended for the insurance market.</p>

Exhibit 7: Modified Hybrid Model Tier I Description

Program Component	Tier I - Policy
G. Quality Assurance Strategies	
<p>1. Publishing Provider and Insurer Quality Measures and Other Strategies</p>	<p><u>IHERC</u></p> <ul style="list-style-type: none"> <li>• Provide comparisons of providers on quality measures.</li> <li>• Provide links to the Department of Public Health’s Consumer Guide to Health Care and other websites associated with quality initiatives.</li> <li>• Convene panel of experts to develop quality initiatives and advise IHERC on quality improvement.</li> <li>• Provide “one-stop shopping” for consumers to compare providers’ performance on quality measures, including providing quality performance information from:               <ul style="list-style-type: none"> <li>➢ The Center for Medicare and Medicaid Services (CMS) Medicare provider quality indicators</li> <li>➢ Illinois’ “Consumer Guide to Health Care”</li> <li>➢ The Illinois Department of Public Health’s nursing home database</li> <li>➢ The Illinois Department of Financial and Professional Regulation’s on-line physician database</li> </ul> </li> </ul> <p><u>Quality Initiatives</u></p> <ul style="list-style-type: none"> <li>• Pursue performance rewards programs through partnerships with organizations like the Leapfrog Group and Bridges to Excellence and provide website resources and links to:               <ul style="list-style-type: none"> <li>➢ Leapfrog Group quality and safety questionnaire database</li> <li>➢ Bridges to Excellence Physician Quality Ratings tool</li> </ul> </li> </ul>

**Exhibit 7: Modified Hybrid Model Tier I Description**

Program Component	Tier I - Policy
<p><i>Publishing Provider and Insurer Quality Measures and Other Strategies, continued</i></p>	<ul style="list-style-type: none"> <li>• Allow State-specified plans to prohibit payment for costs related to “never events”.</li> <li>• Request that the Division of Safety within the Department of Public Health work with the American Health Information Community to make health information digital and interoperable. This collaboration will push forward the State’s goal of e-prescribing by 2011.</li> </ul> <p><u>IHERC Oversight Board</u></p> <ul style="list-style-type: none"> <li>• Consists of consumers and state policy makers.</li> <li>• Reviews and makes recommendations regarding state-funded health care coverage program design.</li> <li>• Monitors uninsurance rates.</li> <li>• Monitors provider and health insurance carrier performance.</li> </ul>
<p><b>H. Cost-Efficiency Strategies</b></p>	
<p>1. Insurer Administrative Costs</p>	<p>Require the Division of Insurance to approve individual or small group rates only if they reflect a minimum medical loss ratio of 80 percent.</p>
<p>2. Use of Medicaid provider network structure</p>	<p>Option B allows the State to use the existing Medicaid provider network and administrative costs (albeit at enhanced Medicaid rates).</p>

Exhibit 8: Modified Hybrid Model Tier II Description

Program Component	Tier II - Policy
<b>A. Coverage Approach</b>	
1. Individual Mandate	<p>Require all Illinois residents<sup>14</sup>, including undocumented immigrants and non-residents enrolled in Illinois colleges and universities, to have qualified health coverage. Qualified health coverage will be defined as:</p> <ul style="list-style-type: none"> <li>• Public coverage (Medicare, Medicaid, SCHIP, ICHIP, Tricare or other military health coverage, state-only funded programs)</li> <li>• Employer-sponsored coverage or non-group coverage</li> </ul> <p>Children are included in this mandate and parents are responsible for ensuring compliance with the mandate on their behalf. Residents who fail to comply with the mandate will pay a penalty that the State will assess through the State income tax system. Residents and non-resident students cannot enroll in Illinois colleges and universities unless they have qualified coverage. The State could allow exemptions from the mandate based on hardship. The penalty will equal:</p> <ul style="list-style-type: none"> <li>• <u>Under Option A:</u> 115 percent of the lowest cost plan (rated by age and gender) offered by the three largest carriers in the individual's geographic area for the Comprehensive Standard Plan.</li> <li>• <u>Under Option B:</u> 115 percent of the average premium for the state self-insured plan (for specific age, gender and geography).</li> </ul> <p>The penalty will be progressive based on gross income; residents with no income tax filing obligations will not be subject to the penalty.</p>

<sup>14</sup> Except members of Native American tribes

**Exhibit 8: Modified Hybrid Model Tier II Description**

Program Component	Tier II - Policy
2. Employer Assessment	<p>Implement an employer assessment that requires every employer who employs at least 25 Illinois residents who work at least 20 hours a week for four consecutive weeks to pay a fee to the State equal to eight percent of the total payroll for Illinois-based employees (up to \$2,500 per employee). Employers will receive a credit against this fee if they prove one of the following:</p> <ul style="list-style-type: none"> <li>➤ Eight percent of the total payroll-for Illinois based employees (up to \$2,500 per employee) is used to purchase health care insurance for those employees</li> <li>➤ Eighty percent of the firm’s employees who are Illinois residents and who work 20 hours or more in a week for four consecutive weeks are covered by qualified health coverage, as defined for the individual mandate</li> </ul>
3. Changes to the Insurance Market	<p>Reduce rate variation in the individual market from 135 percent to 130 percent of the carrier’s base rate, accounting for all rating factors that the carrier may use, excluding geographic location.</p>

**Exhibit 8: Modified Hybrid Model Tier II Description**

<b>Program Component</b>	<b>Tier II - Policy</b>
<b>B. Funding Source</b>	
1. Federal Funds	<p>Increased Medicaid expenditures produced by additional public program enrollment through implementation of the individual mandate. As the State is currently using all of its SCHIP allotment and is anticipated to continue to do so, the State would need to cover all of the costs of individuals eligible for SCHIP program once this allotment is exceeded. The State may be able to move its SCHIP parents into Medicaid using income disregards. This approach is untested, however, and would require extensive conversations with the Federal government and potentially changes to the State’s current 1115 waiver.</p> <p>Under Tier II, the State may be able to redirect all or a portion of its Medicaid disproportionate share hospital funds to fund the additional expansions as the decrease in uninsured and corresponding uncompensated care would result in a reduced need for these funds based on the State’s current disproportionate share hospital payment structure.</p>
2. Additional State Tax Revenue	Increased State tax revenue needed to fund additional enrollment in public programs (jointly funded with the Federal government and funded solely with State funds) and to administer the program.
3. Employer Assessments and Contributions	Collect employer assessments (see #A2 Employer Assessment above).
4. Individual Penalties and Contributions	Collect individual penalties (see #A1 Individual Mandate above).

Exhibit 8: Modified Hybrid Model Tier II Description

Program Component	Tier II - Policy
<b>C. Administration</b>	
<p>1. Administrative Body</p>	<p><u>IHERC</u></p> <ul style="list-style-type: none"> <li>• Provide information via the web and telephone regarding consumer coverage options (e.g., provide information to individuals regarding the individual mandate and their specific public and private options for obtaining coverage.)</li> <li>• Provide price comparisons of different insurance carriers’ offerings of the State-specified benefit packages.</li> <li>• Provide price comparisons of different insurance carrier’s offerings of long-term care policies and included benefits.</li> <li>• Monitor and report on uncompensated care through existing reporting mechanisms to determine the impacts of insurance initiatives.</li> <li>• <u>Under Option A</u> – IHERC will provide price comparisons of different insurance carriers’ offerings of the Standard Comprehensive Plan.</li> <li>• Under Option B – IHERC will provide price comparisons of different insurance carriers’ guaranteed issue products.</li> </ul> <p><u>Department of Revenue</u></p> <ul style="list-style-type: none"> <li>• Determine compliance with tax penalties for individual mandate and employer assessment.</li> <li>• Coordinate with IHERC regarding tax penalties and employer assessment.</li> </ul>

**Exhibit 8: Modified Hybrid Model Tier II Description**

Program Component	Tier II - Policy
<b>D. Implementation</b>	
1. Changes in State Law	<ul style="list-style-type: none"> <li>• Change State law to allow for employer assessments.</li> <li>• Change State law to allow for an individual mandate.</li> <li>• Change State tax law to support penalties for non-compliance by individuals to the mandate.</li> </ul>
<b>E. Cost-Efficiency Strategies</b>	
1. Insurer Administrative Costs	Require the Division of Insurance to approve individual or small group rates only if they reflect a minimum loss ratio of 85 percent.

**Exhibit 9: Summary of Premium Assistance Determination -- Modified Hybrid Model  
Illinois Adequate Health Care Task Force**

**A. Objectives**

1. Each adult in the same FPL range is faced with the same post-subsidy premium cost.
2. If all family members enroll, the post-subsidy premium cost does not exceed the a benchmark affordability standard (four percent of gross income in the group market and six percent in the individual market).
3. The post-subsidy premium cost is lower for group coverage than for non-group to avoid employers dropping coverage (because their employees would not be worse off in the non-group market).

**B. Example for Families at 100 to 150 Percent of FPL (2007):**

Using the FPL range mid-point, the post-subsidy premium cost per adult in a 2 person family is determined to be:

	Non-Group Market		Group Market	
	6% of Gross Income		4% of Gross Income	
	Annual	Monthly	Annual	Monthly
1. Family income in 2007 for 2 person family:	\$16,993	\$1,416	\$16,993	\$1,416
2. Post-subsidy premium amount if both adults enroll:	\$1,020	\$85	\$680	\$57
<i>Post-subsidy premium cost as a percent of income:</i>	6%	6%	4%	4%
3. Post-subsidy premium amount for 1 adult:	\$510	\$42	\$340	\$28
<i>Post-subsidy premium cost as a percent of income:</i>	3%	3%	2%	2%

Using the FPL range mid-point, the post-subsidy premium cost per child is determined to be:

	Non-Group Market		Group Market	
	6% of Gross Income		4% of Gross Income	
	Annual	Monthly	Annual	Monthly
1. Family income increment associated with the addition of a family member	\$4,361	\$363	\$4,361	\$363
2. Post-subsidy premium amount for 1 child:	\$262	\$22	\$174	\$15
<i>Post-subsidy premium cost as a percent of income:</i>	2%	2%	1%	1%

The above calculations keep the cost per family under the benchmark affordability standard for various combinations of family size and enrolled members within this FPL range.

**Exhibit 10 - Summary of Modified Hybrid Model -- Coverage and Costs for 2007 (Under Age 65)**

**Illinois Adequate Health Care Task Force**

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.		TIER I		TIER II	
		Option A: All Carriers Offer Standard Plan	Option B: State Self- Insured Plan	Option A: All Carriers Offer Standard Plan	Option B: State Self-Insured Plan
<b>I. Changes in Coverage (in thousands)</b>					
A. Total newly covered under proposal	Total individuals	547	548	1,520	1,521
	Percent of uninsured	32%	32%	89%	89%
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	84	97	2,027	2,014
	Percent of currently insured	1%	1%	21%	21%
C. Total newly covered under Medicaid or SCHIP (a)	Total individuals	9	9	230 (a)	230 (a)
D. Remaining uninsured	Total individuals	1,158	1,157	185	184
	Percent of baseline uninsured	68%	68%	11%	11%
<b>II. Costs Associated With Enrollment in New Coverage Options(b) (\$ in millions)</b>					
A. Federal Medicaid/SCHIP funds		12	12	408 (c)	408 (c)
B. State	1. Health insurer assessment	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	2. Employer fees or taxes	Not Applicable	Not Applicable	1,419	1,419
	3. Employee payroll tax	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	4. Medicaid/SCHIP funds (d)	12	12	408 (c)	408 (c)
	5. Source to be determined	2,027	1,604	2,949	2,166
C. Annual per capita state coverage costs for all individuals participating in new coverage options ((II.B.4+II.B.5)/(I.A+I.B)) (calculation varies due to rounding from detail spreadsheet)		3,231	2,506	946	728
D. Annual per capita state coverage costs for all newly insured individuals		3,202	2,620	2,355 (e)	1,931 (e)
<b>III. State Costs Associated with Medicaid and SCHIP Provider Payment Rate Increases For Baseline Existing Coverage (\$ in millions)</b>		61 (f)	61 (f)	122 (g)	122 (g)
<b>IV. Additional Proposal Components Not Modeled That May Result in Changes to the Number of Uninsured or Program Costs</b>					
		Selected Medicaid expansions for individuals with disabilities. Inclusion of the disabled populations are not expected to have a substantial impact on the number of newly insured, as these individuals are generally high-cost; however, they may have an impact on total costs. Information from the Campaign for Better Health Care indicates that, for the unmodeled expansion of income eligibility for the Aged, Blind or Disabled (AABD) program from 100 percent to 300 percent of the FPL, 20,000 to 49,000 individuals might be covered.			

(a) Includes all residents newly enrolled in public coverage that are eligible for Federal Match whether due to an expansion or due to new enrollment under existing eligibility rules.

(b) Represents costs of coverage (including administrative costs); excludes implementation costs.

(c) Includes expansion populations as well as residents previously eligible but not enrolled (who have enrolled due to the mandate).

(d) Increases in Medicaid/SCHIP spending represent new Medicaid spending and assume no additional SCHIP funds are available.

(e) Does not reflect the funds available through new employer payroll tax assessments because these cannot be allocated to subpopulations.

(f) Reflects an overall 3 percent increase in Medicaid/SCHIP provider payment rates.

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

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

**Exhibit 10 - Modified Hybrid Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)**  
**Illinois Adequate Health Care Task Force**

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	Tier I-Option A: All Carriers Offer Standard Plan					Tier I-Option B: State Self-Insured Plan						
		Overall	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Overall	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies
			Family Care Expansion to 200% FPL	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Uninsured Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market		Family Care Expansion to 200% FPL	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Uninsured Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market
<b>I. Total Population Eligible for Program(s)</b>		Footnote 2	17,319	356,395	415,598	193,362	1,092,719	Footnote 2	17,319	356,395	415,598	193,362	1,092,719
A. Total Uninsured in Eligible Population		Footnote 2	17,319	356,395	89,031	193,362	973,654	Footnote 2	17,319	356,395	89,031	193,362	973,654
<b>II. Total Estimated Program Enrollment</b>		631,182	9,437	320,755	58,119	65,274	185,905	644,610	9,437	320,755	72,859	65,274	185,905
A. Overall Participation Rate		Footnote 2	54%	90%	14%	34%	17%	Footnote 2	54%	90%	18%	34%	17%
B. Annual Overall Coverage Cost per Participant (includes employer, employee and subsidy amounts)		\$ 4,219	\$ 2,682	\$ 2,805	\$ 4,916	\$ 4,908	\$ 6,307	\$ 3,498	\$ 2,682	\$ 2,805	\$ 3,679	\$ 4,908	\$ 4,243
C. Annual Overall Subsidy Cost per Participant		\$ 3,249	\$ 2,521	\$ 2,805	\$ 2,095	\$ 150	\$ 5,364	\$ 2,525	\$ 2,521	\$ 2,805	\$ 1,136	\$ 150	\$ 3,296
D. Annual State Subsidy Cost per Participant (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds; at the overall level, new assessments are netted out)	I.L.C.	\$ 3,231	\$ 1,261	\$ 2,805	\$ 2,095	\$ 150	\$ 5,364	\$ 2,506	\$ 1,261	\$ 2,805	\$ 1,136	\$ 150	\$ 3,296
<b>III. Total Newly Covered under Proposal</b>	I.A.	547,398	9,437	320,755	12,308	65,274	147,931	548,029	9,437	320,755	14,251	65,274	147,931
A. Participation among Eligible Uninsured		N/A	54%	90%	14%	34%	15%	N/A	54%	90%	16%	34%	15%
B. Annual Overall Coverage Cost per Newly Insured (includes employer, employee and subsidy amounts)		\$ 4,034	\$ 2,682	\$ 2,805	\$ 5,355	\$ 4,908	\$ 6,340	\$ 3,433	\$ 2,682	\$ 2,805	\$ 3,679	\$ 4,908	\$ 4,265
C. Annual Program Subsidy Cost per Newly Insured (does not include employer fees or insurer assessments)		\$ 3,224	\$ 2,521	\$ 2,805	\$ 2,137	\$ 150	\$ 5,450	\$ 2,642	\$ 2,521	\$ 2,805	\$ 1,238	\$ 150	\$ 3,370
D. Annual State Subsidy Cost per Newly Insured (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)	I.L.D.	\$ 3,202	\$ 1,261	\$ 2,805	\$ 2,137	\$ 150	\$ 5,450	\$ 2,620	\$ 1,261	\$ 2,805	\$ 1,238	\$ 150	\$ 3,370
E. Enrollment of Newly Insured as a Percent of Total		87%	100%	100%	21%	100%	80%	85%	100%	100%	20%	100%	80%
<b>IV. Currently insured residents participating in new coverage programs</b>	I.B.	83,784	-	-	45,811	-	37,974	96,581	-	-	58,607	-	37,974
A. Annual Coverage Cost per Previously Insured Resident (includes employer, employee and subsidy amounts)		\$ 5,395	\$ -	\$ -	\$ 4,798	\$ -	\$ 6,114	\$ 3,850	\$ -	\$ -	\$ 3,679	\$ -	\$ 4,112
B. Annual Program Subsidy Cost per Previously Insured Resident		\$ 3,418	\$ -	\$ -	\$ 2,083	\$ -	\$ 5,028	\$ 1,857	\$ -	\$ -	\$ 1,111	\$ -	\$ 3,008
C. Annual State Subsidy Cost per Previously Insured Resident (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)		\$ 3,392	\$ -	\$ -	\$ 2,083	\$ -	\$ 4,970	\$ 1,843	\$ -	\$ -	\$ 1,111	\$ -	\$ 2,973

Exhibit 10 - Modified Hybrid Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)

Illinois Adequate Health Care Task Force

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	Tier I-Option A: All Carriers Offer Standard Plan						Tier I-Option B: State Self-Insured Plan					
		Overall	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Overall	Public program expansion	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies
			Family Care Expansion to 200% FPL	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Uninsured Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market		Family Care Expansion to 200% FPL	Childless Adults eligible for state-funded Medicaid-like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Uninsured Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market
<b>V. Costs Associated with Enrollment in New Coverage Options(3)</b>													
A. New Federal Medicaid/SCHIP Funds	II.A	\$ 11,896,038	\$ 11,896,038	\$ -	\$ -	\$ -	\$ -	\$ 11,896,038	\$ 11,896,038	\$ -	\$ -	\$ -	\$ -
B. New Health Insurer Assessments	II.B.1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
C. Employers:									0	0			
1. Premium Contributions		\$ 364,840,280	\$ -	\$ -	\$ 130,932,875	\$ 268,021,849	\$ -	\$ 362,559,809	\$ -	\$ -	\$ 134,037,120	\$ 268,021,849	\$ -
2. New Fees or Taxes	II.B.2	\$ -				\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -
D. Residents:		\$ -						\$ -	0	0			
1. Premium Contributions		\$ 247,120,954	\$ 1,518,643	\$ -	\$ 33,053,414	\$ 42,556,302	\$ 175,409,260	\$ 265,164,211	\$ 1,518,643	\$ -	\$ 51,251,010	\$ 42,556,302	\$ 176,109,901
2. New Payroll Taxes	II.B.3	\$ -	\$ -				\$ -	\$ -	\$ -	\$ -			\$ -
3. State Income Taxes		\$ -					\$ -	\$ -	\$ -	\$ -			\$ -
E. New State Medicaid/SCHIP Funds	II.B.4	\$ 11,896,038	\$ 11,896,038	\$ -	\$ -	\$ -	\$ -	\$ 11,896,038	\$ 11,896,038	\$ -	\$ -	\$ -	\$ -
F. Other State Funds (source to be determined)	II.B.5	\$ 2,027,147,930	\$ -	\$ 899,721,832	\$ 121,734,181	\$ 9,765,917	\$ 997,169,029	\$ 1,603,530,161	\$ -	\$ 899,721,832	\$ 82,786,110	\$ 9,765,917	\$ 612,695,534
<b>VI. Total</b>		\$ 2,662,901,241	\$ 25,310,720	\$ 899,721,832	\$ 285,720,469	\$ 320,344,068	\$ 1,172,578,289	\$ 2,255,046,258	\$ 25,310,720	\$ 899,721,832	\$ 268,074,240	\$ 320,344,068	\$ 788,805,435
<b>VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Baseline Coverage</b>		(6)						(6)					
A. State Costs	III	\$ 61,012,490						\$ 61,012,490					
B. Federal Costs		\$ 81,605,879						\$ 81,605,879					
<b>VIII. Total Point-of-Service Cost Sharing Under the Program</b>		\$ 371,203,965	\$ 1,511,080	\$ -	\$ 61,443,933	\$ 74,262,028	\$ 243,439,167	\$ 333,374,264	\$ 1,511,080	\$ -	\$ 68,987,034	\$ 74,262,028	\$ 199,558,333
<b>IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians</b>		18%	1%	18%	0%	0%	0%	32%	1%	18%	4%	0%	10%

(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

(5) Tier II: In addition to the Federal and State SCHIP/Medicaid spending associated with the new coverage options, these totals include an amount of \$7,076,974 associated with moving some SCHIP parents into Medicaid (lower match rate) to fund the coverage of eligible but not yet enrolled SCHIP children that enroll due to the mandate. This approach assumes that CMS would allow Illinois to expand Medicaid to SCHIP parents using income disregards. As this approach is untested and requires extensive conversations with CMS, it is possible that the State would be responsible for the entire cost of this care.

(6) Reflects an overall 3 percent increase in Medicaid/SCHIP provider payment rates.

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

**Exhibit 10 - Modified Hybrid Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)**  
**Illinois Adequate Health Care Task Force**

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	Tier II-Option A: All Carriers Offer Standard Plan								
		Overall	Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Require Insurers to offer "standard plan"	Employer Assessment
			Family Care Expansion to 200% FPL	New Public Program Enrollment Under Existing Eligibility Rules (no crowd out provisions)	Childless Adults eligible for state-funded Medicaid like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market	Insurance take-up by uninsured Residents ineligible for subsidies	Non-offering employers with 26 or more workers in Illinois face an assessment
<b>I. Total Population Eligible for Program(s)</b>		Footnote 2	54,924	2,384,398	634,635	415,598	3,055,604	1,092,719	320,938	
A. Total Uninsured in Eligible Population		Footnote 2	17,319	313,233	356,395	89,031	193,362	973,654	320,938	
<b>II. Total Estimated Program Enrollment</b>		3,547,027	51,629	306,597	475,176	75,803	2,025,623	552,116	256,751	
A. Overall Participation Rate		Footnote 2	94%	13%	75%	18%	66%	51%	80%	
B. Annual Overall Coverage Cost per Participant (includes employer, employee and subsidy amounts)		\$ 4,446	\$ 2,828	\$ 3,108	\$ 3,121	\$ 4,608	\$ 4,624	\$ 5,248	\$ 5,777	
C. Annual Overall Subsidy Cost per Participant		\$ 1,461	\$ 2,658	\$ 2,780	\$ 3,121	\$ 1,958	\$ 117	\$ 4,254		
D. Annual State Subsidy Cost per Participant (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds; at the overall level, new assessments are netted out)	I.L.C.	\$ 946	\$ 1,329	\$ 1,650	\$ 3,121	\$ 1,958	\$ 117	\$ 4,254		
<b>III. Total Newly Covered under Proposal</b>	I.A.	1,520,360	16,280	306,597	338,575	16,370	113,806	483,031	256,751	
A. Participation among Eligible Uninsured		N/A	94%	98%	95%	18%	59%	50%	80%	
B. Annual Overall Coverage Cost per Newly Insured (includes employer, employee and subsidy amounts)		\$ 4,338	\$ 2,764	\$ 3,108	\$ 2,887	\$ 5,036	\$ 5,438	\$ 5,166	\$ 5,777	
C. Annual Program Subsidy Cost per Newly Insured (does not include employer fees or insurer assessments)		\$ 2,597	\$ 2,595	\$ 2,780	\$ 2,887	\$ 2,004	\$ 223	\$ 4,184	\$ -	
D. Annual State Subsidy Cost per Newly Insured (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)	I.I.D.	\$ 2,355	\$ 1,297	\$ 1,650	\$ 2,887	\$ 2,004	\$ 223	\$ 4,184	\$ -	
E. Enrollment of Newly Insured as a Percent of Total		43%	32%	5%	71%	22%	6%	87%	100%	
<b>IV. Currently insured residents participating in new coverage programs</b>	I.B.	2,026,667	35,349	-	136,600	59,434	1,911,817	69,085		
A. Annual Coverage Cost per Previously Insured Resident (includes employer, employee and subsidy amounts)		\$ 4,524	\$ 2,857	\$ -	\$ 3,702	\$ 4,490	\$ 4,576	\$ 5,744		
B. Annual Program Subsidy Cost per Previously Insured Resident		\$ 609	\$ 2,688	\$ -	\$ 3,702	\$ 1,945	\$ 111	\$ 4,742		
C. Annual State Subsidy Cost per Previously Insured Resident (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)		\$ 583	\$ 1,344	\$ -	\$ 3,702	\$ 1,945	\$ 111	\$ 4,672		

**Exhibit 10 - Modified Hybrid Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)**  
**Illinois Adequate Health Care Task Force**

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	Tier II-Option A: All Carriers Offer Standard Plan								
		Overall	Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Require Insurers to offer "standard plan"	Employer Assessment
			Family Care Expansion to 200% FPL	New Public Program Enrollment Under Existing Eligibility Rules (no crowd out provisions)	Childless Adults eligible for state-funded Medicaid like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market	Insurance take-up by uninsured Residents ineligible for subsidies	Non-offering employers with 26 or more workers in Illinois face an assessment
<b>V. Costs Associated with Enrollment in New Coverage Options(3)</b>										
A. New Federal Medicaid/SCHIP Funds	II.A	\$ 408,099,084 (5)	\$ 68,621,258	\$ 346,554,801	\$ -	\$ -	\$ -	\$ -		
B. New Health Insurer Assessments	II.B.1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
C. Employers:				0						
1. Premium Contributions		\$ 7,060,522,491	\$ -	\$ -	\$ -	\$ 159,365,866	\$ 7,643,239,837	\$ -		
2. New Fees or Taxes	II.B.2	\$ 1,418,799,966		\$ -			\$ -	\$ -		\$ 1,418,799,966
D. Residents:		\$ -		\$ -						
1. Premium Contributions		\$ 3,525,870,473	\$ 8,760,161	\$ 100,553,008	\$ -	\$ 41,511,027	\$ 1,487,323,285	\$ 548,948,732	\$ 1,483,178,684	
2. New Payroll Taxes	II.B.3	\$ -		\$ -	\$ -			\$ -		
3. State Income Taxes		\$ -		\$ -				\$ -		
E. New State Medicaid/SCHIP Funds	II.B.4	\$ 408,099,084 (5)	\$ 68,621,258	\$ 332,400,852	\$ -	\$ -	\$ -	\$ -		
F. Other State Funds (source to be determined)	II.B.5	\$ 2,948,687,624	\$ -	173,424,200	1,483,021,918	\$ 148,391,533	\$ 236,900,061	\$ 2,348,750,537		
<b>VI. Total</b>		\$ 15,770,078,723	\$ 146,002,676	\$ 952,932,862	\$ 1,483,021,918	\$ 349,268,426	\$ 9,367,463,184	\$ 2,897,699,269	\$ 1,483,178,684	
<b>VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Baseline Coverage</b>										
A. State Costs	III	\$ 122,024,980 (7)								
B. Federal Costs		\$ 163,211,758 (7)								
<b>VIII. Total Point-of-Service Cost Sharing Under the Program</b>		\$ 2,874,105,609	\$ 8,718,902	\$ -	\$ -	\$ 79,445,234	\$ 1,999,769,296	\$ 631,889,556	\$ 348,440,497	
<b>IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians</b>		46%	3%	17%	26%	0%	0%	0%	0%	0%

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

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

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

(4) See notes in summary detail for additional information

(5) Tier II: In addition to the Federal and State SCHIP/Medicaid spending associated with the new coverage options, these totals include an amount of \$7,076,974 associated with moving some SCHIP parents into Medicaid (lower match rate) to fund the coverage of eligible but not yet enrolled SCHIP children that enroll due to the mandate. This approach assumes that CMS would allow Illinois to expand Medicaid to SCHIP parents using income disregards. As this approach is untested and requires extensive conversations with CMS, it is possible that the State would be responsible for the entire cost of this care.

(6) Reflects an overall 3 percent increase in Medicaid/SCHIP provider payment rates.

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

**Exhibit 10 - Modified Hybrid Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)**  
**Illinois Adequate Health Care Task Force**

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	Tier II-Option B: State Self-Insured Plan								
		Overall	Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Require Insurers to offer "standard plan"	Employer Assessment
			Family Care Expansion to 200% FPL	New Public Program Enrollment Under Existing Eligibility Rules (no crowd out provisions)	Childless Adults eligible for state-funded Medicaid like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non group market	Insurance take-up by uninsured Residents ineligible for subsidies	Non-offering employers with 26 or more workers in Illinois face an assessment
<b>I. Total Population Eligible for Program(s)</b>		Footnote 2	54,924	2,384,398	634,635	415,598	3,055,604	1,092,719	320,938	
A. Total Uninsured in Eligible Population		Footnote 2	17,319	313,233	356,395	89,031	193,362	973,654	320,938	
<b>II. Total Estimated Program Enrollment</b>		3,534,968	51,629	306,597	475,176	88,758	2,025,623	552,116	256,751	
A. Overall Participation Rate		Footnote 2	94%	13%	75%	21%	66%	51%	80%	
B. Annual Overall Coverage Cost per Participant (includes employer, employee and subsidy amounts)		\$ 4,217	\$ 2,828	\$ 3,108	\$ 3,121	\$ 3,782	\$ 4,624	\$ 3,917	\$ 5,777	
C. Annual Overall Subsidy Cost per Participant		\$ 1,245	\$ 2,658	\$ 2,780	\$ 3,121	\$ 1,214	\$ 117	\$ 2,915	\$ -	
D. Annual State Subsidy Cost per Participant (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds; at the overall level, new assessments are netted out)	I.L.C.	\$ 728	\$ 1,329	\$ 1,650	\$ 3,121	\$ 1,214	\$ 117	\$ 2,915	\$ -	
<b>III. Total Newly Covered under Proposal</b>	I.A.	1,521,037	16,280	306,597	338,575	18,452	113,806	483,031	256,751	
A. Participation among Eligible Uninsured		N/A	94%	98%	95%	21%	59%	50%	80%	
B. Annual Overall Coverage Cost per Newly Insured (includes employer, employee and subsidy amounts)		\$ 3,908	\$ 2,764	\$ 3,108	\$ 2,887	\$ 3,782	\$ 5,438	\$ 3,859	\$ 5,777	
C. Annual Program Subsidy Cost per Newly Insured (does not include employer fees or insurer assessments)		\$ 2,173	\$ 2,595	\$ 2,780	\$ 2,887	\$ 1,315	\$ 223	\$ 2,869	\$ -	
D. Annual State Subsidy Cost per Newly Insured (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)	I.L.D.	\$ 1,931	\$ 1,297	\$ 1,650	\$ 2,887	\$ 1,315	\$ 223	\$ 2,869	\$ -	
E. Enrollment of Newly Insured as a Percent of Total		43%	32%	5%	71%	21%	6%	87%	100%	
<b>IV. Currently insured residents participating in new coverage programs</b>	I.B.	2,013,931	35,349	-	136,600	70,306	1,911,817	69,085		
A. Annual Coverage Cost per Previously Insured Resident (includes employer, employee and subsidy amounts)		\$ 4,448	\$ 2,857	\$ -	\$ 3,702	\$ 3,782	\$ 4,576	\$ 4,261		
B. Annual Program Subsidy Cost per Previously Insured Resident		\$ 544	\$ 2,688	\$ -	\$ 3,702	\$ 1,188	\$ 111	\$ 3,233		
C. Annual State Subsidy Cost per Previously Insured Resident (includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)		\$ 519	\$ 1,344	\$ -	\$ 3,702	\$ 1,188	\$ 111	\$ 3,185		

**Exhibit 10 - Modified Hybrid Results by Proposal Component -- Coverage and Costs for 2007 (Under Age 65)**  
**Illinois Adequate Health Care Task Force**

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	Tier II-Option B: State Self-Insured Plan									
		Overall	Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Require Insurers to offer "standard plan"	Employer Assessment	
			Family Care Expansion to 200% FPL	New Public Program Enrollment Under Existing Eligibility Rules (no crowd out provisions)	Childless Adults eligible for state-funded Medicaid like program to 100% FPL	Impact on Workers with a small, low-wage employer eligible to purchase New Standard Plan	Direct Subsidies For Workers w/ Employer Offer of Coverage	Impact of subsidies for Adults purchasing in non-group market	Insurance take-up by uninsured Residents ineligible for subsidies	Non-offering employers with 26 or more workers in Illinois face an assessment	
<b>V. Costs Associated with Enrollment in New Coverage Options(3)</b>											
A. New Federal Medicaid/SCHIP Funds	II.A	\$ 408,099,084 (5)	\$ 68,621,258	\$ 346,554,801	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
B. New Health Insurer Assessments	II.B.1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
C. Employers:			0	0	0				0	0	
1. Premium Contributions		\$ 6,974,595,547	\$ -	\$ -	\$ -	\$ 167,822,696	\$ 7,643,239,837	\$ -	\$ -	\$ -	\$ -
2. New Fees or Taxes	II.B.2	\$ 1,418,799,966	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ 1,418,799,966	
D. Residents:		\$ -	0	0	0				\$ -	\$ -	\$ -
1. Premium Contributions		\$ 3,530,591,977	\$ 8,760,161	\$ 100,553,008	\$ -	\$ 60,054,507	\$ 1,487,323,285	\$ 553,493,205	\$ 1,483,178,684	\$ -	\$ -
2. New Payroll Taxes	II.B.3	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ -	\$ -
3. State Income Taxes		\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ -	\$ -
E. New State Medicaid/SCHIP Funds	II.B.4	\$ 408,099,084 (5)	\$ 68,621,258	\$ 332,400,852	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
F. Other State Funds (source to be determined)	II.B.5	\$ 2,165,623,937	\$ -	\$ 173,424,200	\$ 1,483,021,918	\$ 107,768,189	\$ 236,900,061	\$ 1,609,235,593			\$ -
<b>VI. Total</b>		\$ 14,905,809,595	\$ 146,002,676	\$ 952,932,862	\$ 1,483,021,918	\$ 335,645,392	\$ 9,367,463,184	\$ 2,162,728,798	\$ 1,483,178,684	\$ -	\$ -
<b>VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Baseline Coverage</b>											
A. State Costs	III	\$ 122,024,980 (7)									
B. Federal Costs		\$ 163,211,758 (7)									
<b>VIII. Total Point-of-Service Cost Sharing Under the Program</b>		\$ 2,756,334,579	\$ 8,718,902	\$ -	\$ -	\$ 85,992,893	\$ 1,999,769,296	\$ 532,265,340	\$ 348,440,497	\$ -	\$ -
<b>IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians</b>		81%	3%	17%	26%	5%	0%	30%	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

(5) Tier II: In addition to the Federal and State SCHIP/Medicaid spending associated with the new coverage options, these totals include an amount of \$7,076,974 associated with moving some SCHIP parents into Medicaid (lower match rate) to fund the coverage of eligible but not yet enrolled SCHIP children that enroll due to the mandate. This approach assumes that CMS would allow Illinois to expand Medicaid to SCHIP parents using income disregards. As this approach is untested and requires extensive conversations with CMS, it is possible that the State would be responsible for the entire cost of this care.

(6) Reflects an overall 3 percent increase in Medicaid/SCHIP provider payment rates.

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

**Exhibit 11: Impact of Modified Hybrid Model on the Uninsured by Selected Characteristics (2007 and Under Age 65 Population)**  
**Illinois Adequate Health Care Task Force**

	Illinois Baseline Uninsured (000)	TIER I				TIER II			
		Option A: All Carriers Offer Standard Plan		Option B: State Self-Insured Plan		Option A: All Carriers Offer Standard Plan		Option B: State Self-Insured Plan	
		Remaining Uninsured (000)	Percentage Reduction in Uninsured	Remaining Uninsured (000)	Percentage Reduction in Uninsured	Remaining Uninsured (000)	Percentage Reduction in Uninsured	Remaining Uninsured (000)	Percentage Reduction in Uninsured
<b>By Age:</b>									
0-18	175	175	0%	175	0%	12	93%	13	93%
19-23	346	213	39%	212	39%	34	90%	34	90%
24-44	749	506	32%	505	33%	79	89%	78	90%
45-64	434	264	39%	264	39%	59	87%	59	86%
<b>By Income as a percent of FPL:</b>									
<100% FPL	446	125	72%	125	72%	22	95%	22	95%
100%-199% FPL	359	263	27%	264	27%	16	96%	17	95%
200%-299% FPL	326	236	28%	236	28%	30	91%	30	91%
300%-399% FPL	203	163	20%	162	20%	42	80%	40	80%
400% + FPL	371	371	0%	371	0%	74	80%	74	80%
<b>Adults By Family Type:</b>									
Childless	1,038	588	43%	588	43%	115	89%	114	89%
Parents	492	395	20%	394	20%	57	88%	57	88%
<b>Adults By Employment Status:</b>									
Full-time College Student	60	37	39%	37	39%	9	85%	9	85%
Full-time Worker	759	523	31%	522	31%	59	92%	58	92%
Part-time Worker	312	183	41%	183	41%	53	83%	53	83%
Self-employed	135	97	28%	97	28%	23	83%	23	83%
Unemployed	13	7	44%	7	44%	2	82%	2	82%
Other Non-worker	251	136	46%	136	46%	26	90%	26	90%
<b>Total Uninsured</b>	<b>1,705</b>	<b>1,158</b>	<b>32%</b>	<b>1,157</b>	<b>32%</b>	<b>185</b>	<b>89%</b>	<b>184</b>	<b>89%</b>

*Note:* Section V of the August 15th Evaluation Report provides a description of the data used for this analysis. Under Tier I, we estimate the impact on the uninsured of only the new coverage options described in the modified hybrid model. As additional enrollment in AllKids is predicted to occur in future years, this approach may underestimate an increase in the number of insured children. In Tier II, we include additional enrollment in AllKids as a result of the individual mandate.