The
Advisory Boards
to the Illinois Department of Public Health

525 - 535 W. Jefferson St. • Springfield, Illinois 62761-0001

Dear Governor Blagojevich and members of the General Assembly:

For the past eighteen months, the members of the Adequate Health Care Task Force (AHCTF) have worked diligently to build a plan to fulfill the provisions of the Health Care Justice Act which, if implemented, would provide access to affordable health care to all residents of Illinois. We are honored to have been selected to participate in this process and proud to have worked with an incredibly thoughtful, talented and committed team representing the insurance industry, labor, physicians, health care professionals, hospitals, non-profit health organizations, health care associations, health care consumer groups, the legislature and state governmental agencies.

We are pleased to present the Adequate Health Care Task Force Health Care Coverage Expansion Plan ("Expansion Plan"), as well as two minority reports, to the Governor's Office and members of the General Assembly. The goals of the Expansion Plan are as follows: comply with the Health Care Justice Act; preserve the current employer-based coverage system with its employer contributions and benefits of personal income tax and Federal Insurance Contributions Act (FICA) exemptions; require personal financial responsibility for health care; encourage cost-effective, high quality care; minimize administrative spending on health care; spread the cost of coverage broadly across workers, employers and taxpayers; and minimize new State costs by adopting policies to promote cost-effectiveness, requiring an employer contribution for coverage and optimizing the use of Federal matching funds.

The Expansion Plan includes provisions the AHCTF believes, if funded and implemented, will meet the goals stated above. Under the Expansion Plan, individuals will be required to obtain health care coverage and those under 400 percent of the federal poverty level (FPL) will have subsidized coverage options available to them. All employers will be expected to contribute to the health care costs of their workers and may meet this obligation either by providing a voluntary health insurance plan or by paying an amount to the state that is scaled to wages. Changes to insurance regulations are designed to spread risk, stabilize premiums and reduce administrative costs for all Illinoisans.

The members of the AHCTF are eager to work with the Governor and the General Assembly to bring this plan to reality through the development and passage of viable legislation that will ensure all residents of Illinois have access to quality, affordable health care. We stand ready to answer any questions or address any concerns you or the General Assembly might have in order to accelerate the momentum underlying our efforts.

Sincerely,

Wayne M. Lerner, D.P.H., F.A.C.H.E.
Chairman, Adequate Health Care Task Force
President and CEO
Holy Cross Hospital
Chicago, Ill.

State of Illinois
Adequate Health Care Task Force

Created by P.A. 93-0973

Final Report

January 26, 2007

Supported by
Illinois Department of Public Health
and Prepared by

NAVIGANT
CONSULTING

ADEQUATE HEALTH CARE TASK FORCE

Steering Committee

Member	Appointing Authority
Wayne Lerner, D.P.H., Chairman	Minority Leader of the Senate
Sen. David Koehler, Vice Chair	Speaker of the House
Joe Roberts	Minority Leader of the House
Ruth Rothstein	Governor
Quentin Young, M.D.	President of the Senate

Task Force Members

Member	Appointing Authority
Craig Backs, M.D.	Minority Leader of the House
Anthony L. Barbato, M.D.	Speaker of the House
Kenneth Boyd	Speaker of the House
Catherine Bresler	Minority Leader of the Senate
Timothy M. Carrigan	Governor
Rep. Elizabeth Coulson	Minority Leader of the House
Jan Daker	Governor
Margaret A. Davis, R.N.	President of the Senate
J. Terry Dooling	President of the Senate
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Wayne Lerner, D.P.H.	Minority Leader of the Senate
Niva Lubin-Johnson, M.D.	Governor
Sen. Iris Y. Martinez	President of the Senate
Pamela D. Mitroff	Minority Leader of the Senate
James M. Moore	Minority Leader of the Senate
Mike Murphy	Minority Leader of the House
Joseph Orthoefer *(Resigned)*	Speaker of the House
Rep. Brandon W. Phelps	Speaker of the House
Tracey Printen	Minority Leader of the House
Kenneth Robbins	Minority Leader of the House
Joe Roberts	Minority Leader of the House
Ruth Rothstein	Governor
Gregory S. Smith	Minority Leader of the Senate
Kenneth L. Smithmier	Minority Leader of the Senate
Sen. Donne E. Trotter	President of the Senate
Tom Villanova *(Replaced J. Orthoefer)*	Speaker of the House
Quentin Young, M.D.	President of the Senate

State Agency Representatives

Name	Agency
David Carvalho	Illinois Department of Public Health
Michael Gelder	Illinois Department on Aging
Michael McRaith	Illinois Department of Financial and Professional Regulation - Division of Insurance
Anne Marie Murphy	Illinois Department of Healthcare and Family Services
Ralph Schubert *(Replaced by Myrtis Sullivan, M.D.)*	Illinois Department of Human Services

Navigant Consulting, Inc. and Consulting Team

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EXECUTIVE SUMMARY

In response to growing concerns that a significant percentage of Illinoisans are without health care coverage, Governor Rod Blagojevich signed the 2004 Health Care Justice Act[1] ("the Act") and charged the Adequate Health Care Task Force (the "Task Force") with developing a health care access plan to ensure that all Illinois residents have access to affordable quality health care, including access to a full range of preventive, acute and long-term health care services.

Starting in August 2005, the Task Force met as a group to discuss issues related to the Act and to hear from stakeholders representing state agency representatives, interest groups and advocacy groups to become more informed about health care access issues in Illinois. Beginning in October 2005, the Task Force conducted a series of public hearings across the State, during which Illinois residents and stakeholders could present their views and concerns about access to health care services in Illinois.

To assist in the development of the health care access plan, the Illinois Department of Public Health contracted with Navigant Consulting, Inc., in May 2006, whose project team also included consultants from Mathematica Policy Research and Milliman Inc. (the "Consulting Team"). The Consulting Team worked with the Task Force over a period of eight months to evaluate six health care access proposals and develop a recommendation for a Health Care Coverage Expansion Model. The report that follows discusses the processes used by the Task Force to develop the final model that it is recommending to the Illinois Legislature and the features of the recommended model, including estimated costs and areas for further study.

The Task Force solicited input and heard recommendations from stakeholders regarding proposed models for achieving access to health care. The Task Force reviewed five proposals from stakeholders representing:

- The Campaign for Better Health Care and Health and Disability Advocates
- The Illinois Hospital Association
- Citizen Action/Illinois; Illinois for Health Care; Service Employees International Union State Council; American Federation of State, County and Municipal Employees Council 31; Sargent Shriver National Center on Poverty Law; Center for Tax and Budget Accountability and United Power for Action and Justice
- Members of the Adequate Health Care Task Force Associated with the Insurance Industry

[1] Illinois Department of Public Health, "Health Care Justice Act." Available online: http://www.idph.state.il.us/hcja/index.htm.

- Physicians for National Health Program and Health, Medicine Policy Research Group and Access Living

Reflecting the information gathered throughout their meetings, the Task Force developed a list of interests related to access to care and requested that the Consulting Team provide a summary of how each of the five proposals submitted for consideration met those interests. The Task Force then recommended the five proposals for evaluation by the Consulting Team, and charged the Consulting Team with developing a sixth proposal for a "hybrid" model that would combine features of the five proposals under consideration and incorporate industry-wide best practices and experiences from other states.

Using the predetermined set of evaluation criteria approved by the Task Force, the Consulting Team evaluated each of the stakeholder proposals as well as the Consulting Team's Hybrid Model. Over a period of several months, the Consulting Team revised the Hybrid Model at the Task Force's direction, focusing on the following goals:

Goals of the Health Care Coverage Expansion Model

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

In considering options for the development of a health care coverage expansion model, the Task Force also identified items of "high" and "medium" consensus that influenced the selection of model features.

As a result of these revisions and ongoing review and comments from the Task Force, the Consulting Team developed a final Health Care Coverage Expansion Model ("Expansion Model") and members met in December to review that model and vote on the proposal that it would submit to the Legislature. This Expansion Model contained two options for implementation described in more detail below: Option A relies on private insurance carriers for persons seeking coverage in the small group and individual markets while Option B includes a State self-insured plan for such persons.

By majority vote, the Task Force decided to submit the Expansion Model described below to the Legislature. Task Force members also voted to indicate a strong preference for the private insurance carrier-focused implementation option (Option A).

Health Care Coverage Expansion Model

The Expansion Model is projected to extend coverage to 89 percent of the currently uninsured population (1.5 million out of 1.7 million uninsured) in Illinois, for an overall coverage rate of 98 percent of the non-elderly population. In addition to the new coverage options available to the currently uninsured population, many low-income individuals who are currently insured will also be eligible for premium assistance under the proposal. Key features of the Expansion Model are illustrated below.

All Illinois residents will be required to obtain health care coverage and those under 400 percent of the federal poverty level (FPL) will have subsidized coverage options available to them. It is expected that all employers will contribute to the health care costs of their workers. Employers may meet this obligation either by providing a voluntary health insurance plan or by paying an amount to the state that is scaled to wages. The Expansion Model contains changes to insurance regulations designed to spread risk, stabilize premiums and reduce administrative costs for all Illinoisans.

Key Features of the Health Care Coverage Expansion Model

- The current State Children's Health Insurance Program (SCHIP) and Medicaid benefit packages will be maintained.

- A comprehensive, standard benefit package ("Comprehensive Standard Plan") will be available on a guaranteed-issue basis to all individuals and small groups. The Expansion Model includes two coverage and implementation options ("Option A" and "Option B"), and the Task Force has recommended that the General Assembly consider the implications of adopting either Option A or Option B, but notes that Task Force members voted to indicate a strong preference for Option A.

Option A	Option B
• Insurance carriers will be required to offer the Comprehensive Standard Plan in the small group and non-group market if they offer products in those markets	• State self-insured plan will provide the Comprehensive Standard Plan in the small group and non-group markets and carriers may voluntarily offer the Plan on a guaranteed-issue basis.

- All Illinois residents, including undocumented immigrants and non-residents enrolled in Illinois colleges and universities, must obtain qualified health insurance coverage or pay a penalty. The mandate is enforced through the state income tax system, but the penalties are not applied to people with no income tax filing obligation and hardship exemptions are available.

Key Features of the Health Care Coverage Expansion Model

- Public coverage will be expanded to cover additional low-income parents, childless adults with very low incomes and specific disabled populations.

- Employers will be expected to contribute to health insurance coverage for their workers by paying a per worker assessment that will be used to partially cover the cost of the premium subsidies. Employers will receive a credit against this assessment if they provide coverage directly. The Expansion Model does not include a specific recommendation as to the extent of the employer assessment and the specific conditions under which an employer will receive a credit against the assessment.

- Small employers with a majority of low-wage workers are encouraged to offer coverage by allowing them to contribute as little as 50 percent of the cost of single coverage when offering the Comprehensive Standard Plan. Workers with incomes under 400 percent of the FPL will be eligible for premium subsidies to help cover the remaining premium. These employers must enroll at least 75 percent of full-time workers who otherwise do not have evidence of coverage and establish a Section 125 plan, which allows employees to contribute to premiums on a pre-tax basis.

- State-funded premium subsidies will be available for residents below 400 percent of the FPL for employer-based coverage or – if no employer offer is available – for the Comprehensive Standard Plan purchased in the non-group market.

- A number of changes to the insurance market will be implemented to further the goals of the Act and the Task Force, including a reinsurance program for Comprehensive Standard Plan products, minimum medical loss ratios of 85 percent, tighter limits on the variation in a carrier's base rates for all products, and limits on annual rate increases for the Comprehensive Standard Plan. These changes must be viewed in the context of an individual mandate environment, and as such should not be considered stand-alone recommendations.

- The State will establish and administer the *Illinois Health Education and Referral Center (IHERC)* that will operate as an enrollment broker and information clearinghouse on coverage options, premium costs, provider quality, individual health care literacy and other information to educate consumers, and make recommendations regarding program monitoring to avoid fraud and abuse.

- Provider payments for current and future public programs will be increased to 100 percent of costs (with consideration of upper payment limit rules and regulations that apply to various provider groups), and payments will be provided in a timely manner.

- IHERC will provide web-based information on existing provider quality efforts.

- The State will implement Long-Term Care Partnerships in Illinois to encourage the purchase of long-term care coverage.

- Additional strategies are proposed to increase access to care, including State grants for capital investments, health care workers and public health interventions to underserved areas and building on existing scholarship and assistance programs to increase the number of providers of color and providers serving underserved areas.

Implicit in the Expansion Model proposed by the Adequate Health Care Task Force for the General Assembly's consideration is the recognition that substantial funding is required to accomplish the Act's goals. Preliminary estimates of state funding requirements are shown below.

Estimated State Funding Required for the Health Care Coverage Expansion Model (First Full Year of Program Operation)

- Estimated state funding requirements of $3.6 billion (Option A) or $3.1 billion (Option B)
- Assumes an employer assessment totaling approximately $1.5 billion[2]
- Includes an estimated $769 million (Option A) or $1.171 million (Option B)of total State costs to pay increases to Medicaid providers up to 100 percent of costs (includes payments for existing public program participants) [3]
- Does not include implementation costs

(Note: estimates assume the availability of additional federal Medicaid/SCHIP matching funds)

This report describes the processes used by the Task Force to develop the Health Care Coverage Expansion Model that the Task Force is recommending to the Illinois Legislature. The report discusses the features of the recommended model, including estimated costs and areas for further study.

The proposed Expansion Model is comprehensive, involving all sectors of the health care industry. The Task Force understands that there are many details in the implementation of this model that must be worked out to avoid unintended consequences, support robust provider and insurance markets, contain costs and provide individuals with access to quality health care. While there are clearly many details to resolve after the General Assembly makes its final decision regarding a health care coverage expansion, this proposal presented by the Task Force is intended to be the next step in the process of helping to meet the Act's goals of expanding access to coverage to all residents of Illinois.

[2] The Expansion Model does not include a specific recommendation as to the extent of the employer assessment and the specific conditions under which an employer will receive a credit against the assessment. Appendix E provides a description of the employer assessment approach used for purposes of the cost and coverage estimates.

[3] As described in Chapter III, these estimates do not include funding from Illinois' recently passed provider tax program because this program may no longer be available upon or after expansion implementation. Estimate reflects increases in payments to hospitals and physicians; the estimates of hospital and physician payment increases may be understated because the estimates of pre-existing public program coverage may have understated the higher health care costs of populations with disabilities covered by Medicaid. Additional analyses would be needed to determine payment increase to achieve 100 percent of estimated costs for other providers, as recommended by the Task Force.

CHAPTER I: THE ADEQUATE HEALTH CARE TASK FORCE

This Chapter describes the responsibilities of the Adequate Health Care Task Force ("Task Force" and the process the Task Force used to develop the Health Care Coverage Expansion Model ("Expansion Model").

Overview of the Responsibilities of the Adequate Health Care Task Force

Illinois Public Act 93-0973, the Health Care Justice Act ("the Act"), encourages Illinois to implement a health care plan that provides access to a full range of preventive, acute and long-term health care services, and maintains and improves the quality of health care services. The Act established the Task Force, containing 29 voting members — five appointed by the Governor, and six appointments by each of the four leaders of the General Assembly (the Speaker of the House, the House Minority Leader, the President of the Senate and the Senate Minority Leader). The directors of the departments of Public Health, Healthcare and Family Services and Aging, along with the secretary of the Department of Human Services, are ex officio members.

The Task Force was led by a Steering Committee, consisting of the Chairperson and Vice Chairperson of the Task Force and three additional members. Each appointing authority was represented on the Steering Committee The role of the Steering Committee was to develop recommendations regarding different key issues to present to the Task Force, such as project timelines and goals for each Task Force meeting.

According to the Act, the health care access plan should include:

- An integrated system or systems of health care delivery
- Incentives to be used to contain costs
- Core benefits
- Reimbursement mechanisms for health care providers
- Administrative efficiencies
- Mechanisms for generating spending priorities based on multidisciplinary standards of care established by verifiable replicated research studies demonstrative quality and cost effectiveness of interventions, providers and facilities
- Methods for reducing cost of prescription drugs both as part of, and as separate from, the health care access plan

- Appropriate reallocation of existing health care resources
- Equitable financing of the proposal
- Recommendations concerning the delivery of long-term care services

The Act further required that the Task Force seek public input on the development of the health care access plan by holding public hearings and establishing a web site for the Task Force for input to be provided and to keep the public informed. To provide input and help inform its decision-making process, the Task Force held a series of public hearings over several months to offer Illinois residents, state agency representatives, special interest and advocacy groups and other stakeholder groups the opportunity to review and address various options under Task Force consideration. The web site provides agendas and minutes of these public hearings, as well as other information provided to the Task Force, and can be referenced at: http://www.idph.state.il.us/hcja.

The Act further required that the Department of Public Health contract with an independent research entity to assist in assessing financial costs and the different health care models being discussed by the task Force. Pursuant to a Request for Proposal process, the Department of Public Health engaged Navigant Consulting, Inc. (Navigant Consulting) to assist the Task Force. Navigant Consulting's team includes Mathematica Policy Research, Inc. and Milliman, Inc., referred to in the remainder of this report as the "Consulting Team."

Process Used by the Adequate Health Care Task Force to Develop a Health Care Coverage Expansion Model

In addition to the public hearings, which were attended by representatives of the Task Force, and which were conducted over an eight-month period, the Task Force met and received presentations from various stakeholders, including academics. These presentations were designed to be educational in nature, informing Task Force members about the issues facing various stakeholders in accessing health care. In addition, the Task Force received various proposals to expand access to care from a number of stakeholders. The sponsors of five of these proposals requested that the Task Force consider their proposals as the recommended model to fulfill the requirements of the Act.

In May 2006, the Task Force voted to select the five proposals, submitted by stakeholders, for the Consulting Team to further evaluate and requested that the Consulting Team develop a sixth proposal for the Task Force's consideration – referred to as the hybrid model. The Task Force instructed the Consulting Team to base the hybrid model on features from the five proposals that best addressed the goals of the Act, the Task Force's interests and objectives and best practices and innovations from other states' approaches.

To better evaluate the information and proposals the Task Force received, the Steering Committee determined that the Task Force should identify, based on the information members heard as well as the members' own understanding of health care access issues, a series of "interests" that would guide the development of the recommended health plan. In May 2006, the Task Force developed a list of 92 interests and requested that the Consulting Team provide a summary of how each of the five proposals being considered for evaluation by the Task Force addressed these interests (Appendix A). Proposers had the opportunity to comment on the Consulting Team's summaries and the Task Force reviewed this summary in June and July of 2007.

In addition, the Steering Committee requested that the Consulting Team recommend a set of criteria to assess the various proposals and recommendations presented to the Task Force. The Consulting Team reviewed the Task Force members' interests, developed draft criteria with a scoring and weighting approach and presented it to the Task Force in June 2006. These criteria include, for example, access, financing, quality and availability of resources to implement and maintain the program. Within each of the major criteria, the Consulting Team identified evaluation questions and assigned points and weights, so that each of the health plan proposals could be "scored" and compared to each other. While the evaluation process was still somewhat subjective, the weighting and scoring allowed a more consistent evaluation of each of the proposals. In July 2006, the Task Force met to review the criteria and voted on the final criteria, points and weighting for the Consulting Team to use for purposes of the evaluation. The specific criteria and a more detailed description can be found in Chapter II of this document, and in Appendix B.

The Consulting Team met with each of the proposers of the five stakeholder proposals to clarify features of their proposals, review the evaluation results and make modifications to the evaluations as needed. At the same time, the Consulting Team developed its hybrid model and scored and evaluated it using the same process used to evaluate the other five proposals.

The Consulting Team presented the evaluation of the five proposals and the sixth hybrid model at the July 25, 2006 Task Force meeting, and Task Force Members considered these evaluations over a several-week period. At the next Task Force meeting held on August 15, 2006, Task Force members discussed the various proposals and determined that it would be difficult for the group as a whole to come to some consensus on desirable model features because of the complexity of the issues and the varying interests and goals of various Task Force members.

To continue to achieve progress in the development and evaluation of model options, the Task Force determined that developing a list of "consensus items" would be beneficial. These were model features that the Task Force (based on a majority vote) concluded should be built into the revised hybrid model. Task Force members developed broad groups of proposal features and voted on each of the items to determine if that particular feature should be included in the hybrid model. As a result of the vote, the Task Force identified "high", "medium" and "low" consensus model features. The goal of the Task Force, with the help of the Consulting Team,

was then to create a health plan proposal that could address all of the "high" consensus items and most of the "medium" consensus items. Table I.1 below identifies the high, medium and low consensus items.

Table I.1: Adequate Health Care Task Force's High, Moderate and Low Consensus Items

High Consensus	Moderate Consensus	Low Consensus
• State refundable tax credits/premium assistance • Medicaid and SCHIP expansions • Long-term care partnerships recently allowed by the Deficit Reduction Act • Strategies for spreading risk • Reinsurance • Adequate and timely payment to providers • Adequate supply and distribution of providers (i.e., incentives for providers to practice in underserved areas such as loan repayment) • Comprehensive benefit package • Maximizing federal Medicaid funds • Additional employer commitment through new take-up of employer-based insurance by employees • Minimizing all costs not related to the direct provision of health care, including administrative costs and costs resulting from fraud and abuse	• Employer and individual mandates • Publishing provider and insurer costs • Publishing provider and insurer quality measures • Continued use of commercial plans • Additional state tax revenue • Public body to evaluate plan performance and make recommendations for improvement	• Replacement of current health care system with single payer • State-run insurance plan • Increased use of additional task forces to address capital and technology issues • Safety net benefit package • Use of Health Savings Accounts or Medicaid personal savings accounts to provide flexible benefits • Selective reductions in Medicaid benefits, as allowed by the Deficit Reduction Act • Health insurer "windfall profit" assessment

In addition, the Task Force requested that the Consulting Team modify the hybrid model to address "high" and "moderate" consensus items. The Consulting Team presented the resulting hybrid model to the Task Force on September 26, 2006. Reflecting the different approaches that could be used to achieve the Health Care Justice Act's goals and the Task Force's consensus items, the revised model included two different approaches to coverage and implementation. The Steering Committee provided instructions to the Consulting Team for further modifications

to the hybrid model that reflected the discussions at the September 26th meeting and a series of meetings of eight subgroups convened in October and early November to discuss specific model features. The Consulting Team made the modifications requested by the Steering Committee and presented the revised hybrid model for the Task Force's consideration during its December 7, 2006 meeting.

During the December 7, 2006 Task Force meeting, the Task Force voted to submit the revised hybrid model including the two different approaches to coverage and implementation, to the General Assembly as the Task Force's Health Care Coverage Expansion Model for legislative consideration. While doing so, the Task Force noted members' strong preference for the coverage and implementation approaches that involved private insurance carriers ("Option A") over a state self-insured plan ("Option B"), described further in Chapter III. The Task Force also invited the inclusion of any minority reports in the Final Report, which can be found in Appendix C.

Summary

In developing a health care coverage expansion plan, the Task Force spent considerable time considering comments from the general public and other stakeholders. The Task Force considered carefully these comments as well as proposals submitted by stakeholders to determine consensus on the features of an expansion model. Chapter II provides more information about the health care access plans that the Task Force considered and the results of the evaluation of those plans using predetermined criteria. Chapter III provides a detailed description of the Expansion Model.

CHAPTER II: EVALUATION OF SIX PROPOSALS REVIEWED BY THE ADEQUATE HEALTH CARE TASK FORCE

Introduction

As described in Chapter I, in May 2006, the Task Force selected five proposals for the Consulting Team to evaluate, as shown in Table II.1 below. The Task Force also requested that the Consulting Team develop and evaluate a sixth "Hybrid" proposal.

Table II.1: Proposals Evaluated by the Consulting Team

Name of Proposal	Sponsoring Stakeholders
Consumer HealthCare Access Strategy	Campaign for Better Health Care and Health and Disability Advocates
Expanding Coverage for the Illinois Uninsured	Illinois Hospital Association
Healthy Illinois Plan	Citizen Action/Illinois; Illinois for Health Care; Service Employees International Union State Council; American Federation of State, County and Municipal Employees Council 31; Sargent Shriver National Center on Poverty Law; Center for Tax and Budget Accountability and United Power for Action and Justice
Recommendations Concerning the Uninsured, Health Care Access and Affordability, and Affordability of Health Insurance in Illinois	Members of the Adequate Health Care Task Force Associated with the Insurance Industry
Single-Payer Health Insurance Program	Physicians for National Health Program, Health and Medicine Policy Research Group and Access Living
Hybrid Plan	Developed by the Consulting Team

The Consulting Team evaluated these proposals using a set of predetermined criteria, and a system of points and weights, recommended by the Consulting Team and modified and accepted by the Task Force. Using these criteria, points and weights, the Team created an overall ranking for each proposal. The Task Force approved criteria shown in Table II.2 to evaluate each of the proposals; Appendix B provides a detailed description of these criteria.

Table II.2: Criteria Used to Evaluate Proposals

Criteria (weight)	Description
Access (15)	Provides access, regardless of employment or health status, to all Illinois residents; provides portability, no matter employment status
Financing (15)	Financed progressively so the proposal is broad-based, fair and affordable to individuals and businesses
Benefit Package (15)	Provides a full range of preventive, acute, and long-term heath care services that maximize health and functional status for all Illinois residents
Provider Payment (10)	Promotes fair payment to providers to promote access to care
Implementation (7)	Plan is economically and politically feasible
Quality (7)	Maintains and improves the quality of health care services offered to Illinois residents
Cost-efficiency (7)	Provides incentives for cost containment measures, keeping costs under control to promote sustainability of programs
Availability of Resources, Capital and Technology (5)	Addresses issues related to infrastructure and adequacy of providers and safety-net system; considers for funding of new technologies, capital expansions
Prevention and Wellness (10)	Contains provisions that would reward individuals who follow best personal practices for personal health
Consumer and Stakeholder Participation (2.5)	Encourages regional and local consumers, providers, employers and other stakeholders to participate in decisions regarding coverage, resources and financing
Consumer Autonomy (4)	Retains consumer freedom of choice among providers, provider networks and health plans
Provider Autonomy (2.5)	Protects provider-patient relationships

Evaluation Results

Appendix D provides the results of the evaluations of the six proposals, which includes a brief summary of the proposal, the ranking of the proposal by criteria and the rationale for scoring each proposal. Additional background information for each proposal and the Consulting Team's preliminary cost and coverage estimates for each proposal can also be found on the Task Force's website (http://www.idph.state.il.us/hcja/resources.htm).

The Consulting Team evaluated each proposal in comparison to the other five proposals, and drew conclusions about its relative strengths and weaknesses, as summarized below.

Consumer Health Care Access Strategy – Campaign for Better Health Care and Health and Disability Advocates

To ensure access to affordable health coverage, this proposal includes provisions that provide new health care coverage options to all of the uninsured, including significant Medicaid and state-funded public program expansions, and increases in funding to safety-net providers to provide access to care for any remaining uninsured populations. The proposal also recommends the creation of a small group purchasing pool and the implementation of an employer "play or pay" provision, which is intended to encourage employer offers of coverage and serve as a financing mechanism. The extensive nature of these expansions results in an estimated two-thirds of the uninsured obtaining coverage, according to the Consulting Team's preliminary estimates. The proposers have indicated that implementing an individual mandate might be considered, assuming that affordable options are available to individuals and that the initial approach suggested does not have the desired effect.

This proposal has a broad-based financing mechanism that includes an increased employer financing commitment, with the remaining financing coming largely from beneficiary contributions, federal and State Medicaid funds and general State revenues. It also suggests insurance market reforms that may reduce premium costs.

The proposal also recommends a comprehensive benefit package, including mental health and substance abuse services, and a range of long-term care services for individuals covered under the Medicaid expansions. For the purchasing pool, it recommends a comprehensive benefit package similar to the Illinois State Employee benefit package. It also encourages consumer and stakeholder participation in program design by establishing five regional task forces that will monitor implementation of health access strategies in their respective regions.

Although this proposal's approach of expanding Medicaid and SCHIP is an effective way of providing comprehensive coverage to a large number of uninsured Illinoisans, discussions between the Consulting Team and the Department of Healthcare and Family Services could not confirm that approaches relying on an 1115 waiver could be reliably implemented. While a portion of the proposed expansions could be implemented using a State Plan amendment, an 1115 federal waiver would be necessary to obtain federal Medicaid funding for a majority of the proposed newly Medicaid and SCHIP-eligible populations. However, the State has already committed the funding streams most frequently used by States to make 1115 programs budget-neutral, so the State's ability to obtain waiver approval would likely rely on its ability to move SCHIP eligibles into the Medicaid program to free up the State's SCHIP allotment. Also, the implementation of an employer "play or pay" approach would face significant legal challenges from employers related to ERISA preemptions.

Similar to the insurance industry proposal discussed below, this proposal 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 an individual's income. The proposal also establishes a Prevention and Health Education Advisory task force that will develop a disease prevention and health education program, but it is unclear the extent in which this task force will have the authority to implement its recommendations. Appendix D-1 provides the detailed evaluation of this proposal.

The proposal's relative strengths and weaknesses include the following:

Strengths	Weaknesses
• Ability to provide access to health coverage to uninsured Illinoisans – if provisions of proposal were fully implemented, preliminary estimates indicate that approximately two-thirds of Illinoisans currently uninsured are estimated to obtain coverage • Broad based financing plan • Focus on a comprehensive benefit package • Focus on consumer and stakeholder participation in the program design	• Implementation difficulties • Limited focus on prevention and wellness

Expanding Coverage for the Illinois Uninsured – The Illinois Hospital Association

This proposal recommends two employer-sponsored initiatives that use a safety net benefit package, Medicaid/SCHIP expansions, state-subsidized premium subsidies and expansion of State high-risk pool. Since this proposal relies heavily on existing public health coverage options and new employer sponsored coverage, implementation of its components could occur within one to three years. The proposal recommends that the State offer a limited benefit package to sole proprietors and small businesses and create a purchasing cooperative that brings small businesses together to purchase this new product. With political support, the creation of this new State-sponsored package and purchasing cooperative could be implemented quickly. However, expansions and changes to the State's Medicaid program would require an 1115 federal waiver that achieves budget neutrality, which, as discussed previously, could be difficult.

The financing for this proposal is broad-based and includes State and federal Medicaid funds, employer and beneficiary contributions and general State revenues. The proposal also suggests insurance market changes to reduce premium costs. The proposal also supports an increase in public program provider payment rates to promote access to health care services. Due to the voluntary nature of this expansion, including the reliance on non-offering employers to

voluntarily beginning to offer health care insurance, a small portion of uninsured Illinois residents would obtain coverage according to preliminary estimates (10 percent).

The proposal lacks some provisions included in the other proposals submitted to the Task Force, including recommendations on how to improve the quality of care provided throughout the State, and provisions for new capital, technology, medical education or research other than those initiatives that already exist in the system. Appendix D-2 provides the detailed evaluation of this proposal.

The proposal's relative strengths and weaknesses include the following:

Strengths	Weaknesses
• Likelihood that the proposal could be implemented within one to three years • Broad based financing plan • Focus on improving public program provider payment to improve access to services • Emphasis on supporting employer offers of coverage and providing low-cost coverage options	• Ability to expand health care coverage to all of Illinois' uninsured; approximately 10 percent of Illinois' uninsured are estimated to obtain health care coverage as a result of the proposal's policies • Uses a limited benefit package for some elements of expansion • Lack of quality improvement and capital and technology initiatives • Lack of consumer and stakeholder participation in program implementation

Healthy Illinois Plan – Group of Unions and Advocacy Organizations

This proposal implements a State self-funded insurance plan that would be funded by a "windfall profit assessment" of insurers. The proposal also contains provisions for cost-effectiveness in that it attempts to control growth in overall per capita expenditures by obtaining provider discounts by negotiating rates through a new State self-funded health plan, requiring hospitals to submit an annual report that lists cost increases and controlling capital and technology expenditures through a more stringent Certificate of Need process. This proposal makes improving health care quality a central goal by creating the Healthy Illinois Quality Forum, which would promote best practices and develop incentives (e.g., pay-for-performance) to encourage providers to develop these practices and promote common quality measures for Illinois providers and insurers.

The proposal also creates a Health Resource Plan that coordinates the development of health care facilities and resources based on statewide cost, quality and access goals and strategies. It also promotes prevention and wellness by incentivizing individuals to adopt healthy lifestyles by subsidizing health club memberships and covering preventive services without copayments or deductibles.

Although this proposal creates a State self-funded insurance plan that would be available to small employers and municipalities and individuals not eligible for current public program or employer-sponsored insurance, due to the voluntary nature of this program, coverage is not expected for all Illinois residents. Preliminary estimates indicate that approximately one fifth of Illinois' uninsured would receive coverage.

Financing of this proposal is not broad based; the majority of funding will come from an insurer "windfall profit assessment", which will be borne primarily by individuals currently participating in private coverage. The proposal also does not contain provisions to maximize federal financial participation and the Consulting Team's preliminary estimates show that after the insurer assessment, additional funding would still be necessary. The proposal also does not address issues related to timeliness or adequacy of provider payments made by the State. Appendix D-3 provides the detailed evaluation of this proposal.

The proposal's relative strengths and weaknesses include the following:

Strengths	Weaknesses
• Focus on improving health care quality • Cost-effectiveness provisions • Plan to improve the availability of resources • Provisions to improve prevention and wellness	• Limited ability to provide access to health coverage for all of the State's uninsured – preliminary estimates indicate that approximately only one-fifth of Illinois uninsured would receive coverage • Narrow financing mechanism • Does not address provider payment issues

Proposal – Members of the Adequate Health Care Task Force Associated with the Insurance Industry

This proposal increases private market coverage options through Health Savings Accounts and Consumer-Directed Health Plans, and promotes Medicaid reform, including Medicaid expansions to childless adults and a Medicaid/SCHIP-funded premium assistance program. The proposal suggests several changes to the Medicaid program, including requiring Medicaid eligibles to enroll in managed care unless they enroll in a Medicaid personal health account option. The proposal also contains provisions to encourage take-up of long-term care insurance, and to educate consumers on health care coverage options.

Since this proposal relies heavily on existing market and public health coverage options, implementation of its components could occur within one to three years. The proposal recommends using the tax system to encourage the purchase of health coverage and expanding Medicaid by achieving cost savings in the current program. Implementing tax reforms would require federal legislation, while expansions and changes to the State's Medicaid program

would require an 1115 federal waiver that achieves budget neutrality. Both of these changes would be difficult in that they require extensive political support and the State's ability to achieve cost savings in the Medicaid program. Due to the voluntary nature of this proposal, slightly less than one -third of Illinois' uninsured residents are projected to obtain coverage; preliminary estimates indicate that approximately 28 percent of the uninsured would obtain coverage.

To assure quicker implementation of the tax reforms and budget neutrality in the Medicaid program, this proposal also recommends implementing the provisions at a state level first, implementing mandatory managed care and personal health accounts in the Medicaid program and modifying current Medicaid benefits.

This proposal also encourages accelerating the adoption of health information technology and related infrastructure and recommends using savings from implementing Medicaid managed care and reducing Medicaid benefits to reimburse providers more fairly, which could increase funding to the safety-net system. It also maintains and encourages consumer autonomy by providing individuals and businesses enrolled in the private market with health plan and provider network options and does not restrict providers' clinical autonomy.

The proposal also has a limited focus on improving prevention and wellness. It 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 an individual's income. The proposal also does not include provisions to provide consumers with opportunities to provide input on program design. Appendix D-4 provides the detailed evaluation of this proposal.

The proposal's relative strengths and weaknesses include the following:

Strengths	Weaknesses
• The likelihood of implementation within one to three years, with the exception of components of the expansion that rely on federal law • Focus on improving the availability of resources and implementing technology • Focus on consumer and provider autonomy	• Limited ability to provide access to health coverage for all of the State's uninsured, if fully implemented, preliminary estimates indicate that approximately one third of Illinois' currently uninsured would receive coverage • Limited focus on comprehensive coverage • Limited focus on consumer and stakeholder participation in the program design

Single-Payer Health Insurance Program – Physicians for a National Health Program, Health and Medicine Policy Research Group, and Access Living

This proposal recommends consolidation of administration and financing of Illinois' health care system into one public program that covers all Illinois residents with a comprehensive benefit package, resulting in almost all of Illinois' residents obtaining health care coverage according to preliminary estimates.

By creating a single health insurance plan that is mandatory for all Illinois residents, this proposal provides universal access to and automatic enrollment in health coverage by all Illinoisans regardless of individuals' employment status. The financing of this plan is broad-based since it completely revises current load-sharing by spreading health care costs over the entire State population via the income tax system. The proposal also plans to continue to draw down federal funds, and assumes that federal funding provided to the State in the future would be indexed to the average rate of growth in funds provided to other states' programs.

The benefit package proposed is the most comprehensive package proposed to the Task Force and is more comprehensive than most plans currently offered in the State; it covers all medically necessary services, including dental and vision, mental health, home-and community based services and the medical portion of nursing home care. It also has the strongest controls on growth in overall and per capita expenditures, since it sets and enforces global budgets for hospitals and indexes spending growth to GDP.

As such, this proposal also strongly limits current consumer and provider autonomy. Although consumers would have a choice of providers, they would be required to enroll in the new health plan and would likely not be able to access all desired services. Providers also would have no choice but to accept this new plan and, since global budgets would be used to control costs, it is highly likely that some services would be restricted.

Since this Single-Payer Health Insurance Plan proposes the largest and most comprehensive changes to the current health care system, it is, by far, the most difficult to implement. Implementing this plan would require significant legal and regulatory changes to consolidate public funding, implement new payroll and income taxes and obtain needed federal Medicaid and Medicare waivers. The proposer acknowledges that the financing for this transition should be stretched out over 15 to 20 years due to the large capital outlay required by the State.

Appendix D-5 provides the detailed evaluation of this proposal.

The proposal's relative strengths and weaknesses include the following:

Strengths	Weaknesses
• Ability to provide almost universal access to health coverage to all uninsured Illinoisans; preliminary estimates indicate that 90 percent of uninsured Illinoisans would obtain coverage • Broad based financing plan • Comprehensive benefit package design • Focus on cost-efficiency	• Significant implementation barriers • Limited consumer autonomy • Limited provider autonomy

Hybrid Plan – Consulting Team

Note: The evaluation of the hybrid plan described in this section is the evaluation of the original hybrid plan submitted to the Task Force in July of 2006. It is not an evaluation of the final model described in Chapter III and proposed by the Task Force for the Legislature's consideration.

This proposal combines the strengths of features within the other five proposals and in other states to create a plan that provides a comprehensive benefit package to the State's uninsured. This proposal includes an individual mandate (i.e., all residents must obtain health care coverage), an employer assessment, insurance market changes, expansions of Medicaid/SCHIP and state-subsidized premium subsidies. The extensive expansion in this proposal combined with the individual mandate and employer assessment result in 90 percent of Illinois' uninsured receiving coverage according to preliminary estimates.

This proposal includes significant Medicaid expansions, an individual mandate coupled with the introduction of premium subsidies, a guaranteed-issue product and an employer assessment provision. The proposal provides a comprehensive benefit package to almost all of the uninsured in Illinois through either a public program or through a new standard health benefit package that would cover preventive, acute, mental health, substance abuse and long-term health care services.

Assuming political support, this plan was designed to be implemented over a two- to three-year period. Implementation would require changes to health insurance laws and insurance regulations. However, like the previous proposals discussed, the employer assessment provision would face significant legal challenges from employers related to ERISA preemptions and the ability of the State to expand Medicaid coverage would be dependent on its ability to demonstrate budget neutrality in its 1115 waiver application.

This proposal does include some provisions to limit costs and focus on prevention and wellness, including cost-sharing for individuals and the publication of comparative information on premium costs to encourage consumers to shop for insurance products and allowing individual insurance products to include a premium penalty for tobacco use; however, these provisions may be as effective as the provisions included in some of the other proposals discussed previously. Appendix D-6 provides the detailed evaluation of this proposal.

The proposal's relative strengths and weaknesses include the following:

Strengths	Weaknesses
• Ability to provide access to health coverage to most uninsured Illinoisans; preliminary estimates indicate that approximately 90 percent of currently uninsured Illinoisans would have coverage • Comprehensive benefit package design • Ease of implementation	• Limited focus on cost-efficiency with significant cost to State due to the volume of individuals covered • Somewhat limited focus on prevention and wellness

Summary

The Task Force used the evaluation of the six proposals – developed using agreed-upon criteria – to further evaluate the five proposals set forth by key stakeholders and the sixth Consulting Team proposal. The Task Force also used the information from the evaluation as a basis for further clarifying the focus and goals of a potential coverage expansion. From August to November 2006, the Task Force met as a group and in various subgroups to understand the nuances of the suggested features of the hybrid proposal and to review modifications to the hybrid model.

Based on these recommendations, the Steering Committee recommended to the Consulting Team a set of final changes to be made to the model. Chapter III provides a description of the Health Care Coverage Expansion Model that the Task Force voted to recommend to the Illinois Legislature.

CHAPTER III: ADEQUATE HEALTH CARE TASK FORCE'S PROPOSED HEALTH CARE COVERAGE EXPANSION MODEL TO INCREASE ACCESS TO CARE

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

As established by the Task Force, the goals of the Expansion Model are described below.

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

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

The main features of the Expansion Model are:

- The State will maintain the current State Children's Health Insurance Program (SCHIP) and Medicaid benefit packages.

- A comprehensive, standard benefit package ("Comprehensive Standard Plan") will be available on a guaranteed-issue basis to all individuals and small groups. The Expansion Model includes two coverage and implementation options:

    - » Under Option A, insurance carriers will be required to offer the Comprehensive Standard Plan in the small group and non-group market if they offer products in those markets.

    - » Under Option B, a State self-insured plan will provide the Comprehensive Standard Plan in the small group and non-group markets and carriers may voluntarily offer the package on a guaranteed-issue basis. The State self-insured plan will use Medicaid providers and pay 105 percent of Medicaid rates.

    - » The Task Force recommends that the General Assembly consider the implications of adopting either Option A or Option B, but a majority of Task Force members (determined by vote) expressed a strong preference for Option A.

- All Illinois residents, including undocumented immigrants and non-residents enrolled in Illinois colleges and universities, must obtain qualified health insurance coverage or pay a penalty.

- Public coverage will be expanded to cover additional low-income parents, childless adults with very low incomes and specific disabled populations.

- Employers will be expected to contribute to health insurance coverage for their workers by paying a per worker assessment that will be used to partially cover the cost of the premium subsidies. Employers will receive a credit against this assessment if they provide coverage directly. While the cost estimates (described further below) include an estimate of one potential assessment structure (described in Appendix E), the Task Force does not make a specific recommendation as to the extent of the employer assessment and the specific conditions under which an employer will receive a credit against the assessment.

- Small employers with a majority of low-wage workers are encouraged to offer coverage by allowing them to contribute as little as 50 percent of the cost of single coverage when offering the Comprehensive Standard Plan. Workers with incomes under 400 percent of FPL will be eligible for premium subsidies to help cover the remaining premium. These employers must enroll at least 75 percent of full-time workers who otherwise do not have evidence of coverage and establish a Section 125 plan, which allows employees to contribute to premiums on a pre-tax basis.

- State-funded premium subsidies will be available for residents below 400 percent of the FPL for employer-based coverage or – if no employer offer is available – for the Comprehensive Standard Plan purchased in the non-group market.

- A number of changes to the insurance market will be implemented to further the goals of the Act and the Task Force, including a reinsurance program for Comprehensive Standard Plan products, minimum medical loss ratios of 85 percent, tighter limits on the variation in a carrier's base rates for all products, and limits on annual rate increases for the Comprehensive Standard Plan. These changes must be viewed in the context of an individual mandate environment, and as such should not be considered stand-alone recommendations.

- The State will establish and administer the Illinois Health Education and Referral Center (IHERC) that will operate as an enrollment broker and information clearinghouse on coverage options, premium costs, provider quality, individual health care literacy and other information to educate consumers, as well as make recommendations regarding program monitoring to avoid fraud and abuse.

- Provider payments for current and future public programs will be increased to 100 percent of costs (with consideration of upper payment limit rules and regulations that apply to various provider groups) to enhance access to health care services.

- IHERC will provide web-based information on existing provider quality efforts.

- The State will implement Long-Term Care Partnerships in Illinois to encourage the purchase of long-term care coverage.

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

The following sections of this chapter provide additional detail regarding plan features.

Comprehensive Benefit Package and Quality of Care

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

Comprehensive Benefit Package

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

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

Second, a comprehensive, standard benefit package that includes all Illinois mandated benefits will be available on a guaranteed-issue basis to all individuals and small groups. By making a product guaranteed-issue, carriers that offer the product will be required to accept all applicants if they meet the contractual terms of coverage (for example, meet minimum employee participation thresholds for a group plan). In compliance with federal law, coverage for small groups (2 – 50) is guaranteed-issue in every state, but each state determines whether individual coverage is guaranteed-issue. Illinois does not currently require that individual coverage be guaranteed-issue.[4] The availability of guarantee-issue coverage is essential if an individual mandate is to be imposed.

The Task Force recommends that the proposed Comprehensive Standard Plan include acute care and preventive services, and long-term care benefits consistent with a typical commercial package. As such, Medicaid cost-sharing limits do not apply and long-term care benefits will not be as comprehensive as those that Medicaid provides. While the Task Force is not recommending a specific benefit structure, Appendix F provides a summary of the benefit plan used to estimate the cost of this proposal. This example represents a typical comprehensive commercial benefit package.

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

[4] Individuals unable to obtain coverage in the non-group market are able to seek coverage through the State's high risk pool; high risk pool premiums are capped at 125 to 150 percent of market rates, which are unrestricted.

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

Quality of Care

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

- IHERC (the administrative entity charged with oversight of the coverage expansion) will offer a website providing "one-stop shopping" links to provider quality of care initiatives.

- IHERC will convene a panel of experts to advise IHERC on quality improvement.

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

Individual Mandate

The individual mandate will require that all Illinois residents,[5] including undocumented immigrants and non-residents enrolled in Illinois colleges and universities, have qualified health coverage. Children will be included in this mandate and parents will be responsible for ensuring compliance with the mandate on their behalf. For purposes of the mandate, qualified health coverage is defined as major medical coverage such as:

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

- Employer-sponsored coverage or non-group coverage

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

[5] Except members of Native American tribes.

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

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

Public Program Expansions

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

Medicaid Expansions for Selected Disabled Populations

The State will expand Medicaid coverage to the following disabled populations:

- Aid to the Aged, Blind and Disabled (AABD) program – Expand income eligibility from 100 percent to 300 percent of the FPL for the blind and disabled.

- Health Benefits to Workers with Disabilities (HBWD) – Increase income eligibility from 200 percent of FPL to 350 percent of FPL and remove asset and spousal deeming barriers. It will also expand Medicaid coverage to former enrollees of the HBWD Program.

- Children with disabilities up to 300 percent of the FPL – Implement a Medicaid buy-in.

- Individuals deemed "probably eligible for SSI" – Reinstate the Interim Assistance Program. This program will allow interim SSI recipients to receive necessary medical coverage by helping them provide evidence to prove eligibility for SSI, thus entitling them to Medicaid.

State Children's Health Insurance Program (SCHIP)

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

The expansion to include additional low-income parents will require a modification to the State's current 1115 federal waiver. The State will also either identify savings in the current Medicaid population to maintain budget neutrality (requirement of 1115 federal waiver) or make the low-income parents eligible for Medicaid through a State Plan Amendment, creating a new Medicaid eligibility category. Both approaches will require approval by the Centers for Medicare and Medicaid Services to ensure continued availability of federal matching funds for the expansion population.

New Public Coverage Option for Childless Adults

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

Provider Payment Increases

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

Employer Coverage and Related Small Group Market Changes

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

- Premium assistance for individuals under 400 percent of the FPL that must be used for employer coverage if available; this assistance is more generous in the group market than in the non-group market to preserve the incentive for employers to offer coverage.

- Modest incentives for low-wage, small employers to begin offering coverage.

- Small group insurance market changes that spread risks broadly and stabilize premiums.

- Employer assessments to establish a baseline level of employer commitment to health care coverage for their workers.

These Expansion Model features are described below.

Premium Assistance for Workers and Their Dependents under 400 Percent of the FPL

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

Support for Small, Low-Wage Employers

Small, low-wage employers may provide the Comprehensive Standard Plan (under Option A) or the State self-insured plan (under Option B) using contribution and enrollment levels that will be less than the levels typically required by insurers. Specifically, small low-wage employers may contribute as little as 50 percent of the cost of single coverage when they offer the Standard Comprehensive product, and no contribution will be required for dependents.[6] However, these employers must:

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

- Enroll at least 75 percent of full-time workers who otherwise do not have evidence of qualified coverage[7]

- Establish a Section 125 plan, which allows employees to contribute to premiums on a pre-tax

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

Small Group Insurance Market Changes

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

- Carriers must file small group rates for State review and approval.

- For approval, small group rates must reflect a minimum medical loss ratio of 85 percent. Illinois does not currently have minimum medical loss ratio requirements for the small group market.

- Rates for each product will not vary by more than 130 percent of a carrier's base rate, accounting for all rating factors a carrier may use except geography. Currently, Illinois has comprehensive rate bands of plus or minus 25 percent for small group coverage – that is, the premium cannot exceed 167 percent of the lowest premium for the same product sold to a small group in the same location. As in current law, premium increases cannot exceed medical trend plus 15 percentage points.

- To increase the predictability of future rate increases for guaranteed-issue Comprehensive Standard Plan products only, the annual rate increases for this product only will not exceed 115 percent of the medical cost trend across each carrier's entire book of small group business.

- Carriers must permit the lower contribution requirement for firms meeting the small, low-wage criteria and offering the comprehensive standard plan to their employees.

- As discussed below, reinsurance for this product will be available on a voluntary basis.

[7] 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.

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

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

- *Option A:* Carriers operating in the small group markets must offer the Standard Comprehensive Plan, and (as for other small group products) it must be offered guaranteed-issue.

- *Option B:* Carriers operating in the small group markets may voluntarily offer a guaranteed issue Standard Comprehensive Plan.

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

- Insurers must pay a $5,000 deductible for all individuals, employees or dependents ceded to the reinsurance program either at first issue or at renewal, after which the reinsurance program will pay all claims.

- All carriers writing either individual or group coverage in Illinois, as well as other licensed third-party administrators of health benefits plans in the State, will contribute to pool losses (net of reinsurance premiums paid) in proportion to their medical claims paid, including risk and non-risk business. While ceding risk will voluntary on the part of insurers, their participation in the funding of the reinsurance program will be required to ensure a stable funding source.

In addition, similar (but not identical) to the Connecticut and New Hampshire reinsurance programs, premiums will be capped at 400 percent of each carrier's base rate, respectively, for non-group guaranteed-issue products and the Standard Comprehensive Plan for small groups.[8]

Employer Assessment

To place employers on a more equal footing regarding their role in the funding of health care, the proposed model requires a minimum level of employer effort that will be required of all employers. Sometimes referred to as "pay-or-play," employers will pay an assessment to the State, with potential assessment exemptions and phase-ins for small employers. Employers will

[8]The intent of this provision is to encourage insurers to cede approximately five percent of covered lives to the reinsurance program to help stabilize premiums in the guaranteed-issue product.

receive a credit against this assessment if they provide at least a minimum level of coverage. The State will use the revenue collected through the assessment to partially fund premium assistance for low-income individuals and other state activities associated with the proposed model.[9]

The goals of the employer assessment are:

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

The proposed health care coverage Expansion Model described here does not specify the extent of the employer assessment and the specific conditions under which an employer will receive a credit against the assessment. For purposes of the cost and coverage estimates provided in this report and for demonstration purposes only, a potential employer assessment structure is used that initially applies to employers with 25 or more employees and extends to employers with 10 or more employees in the third year of the program. As described in more detail in Appendix E, this sample assessment requires employers to contribute at least 4.8 percent of payroll for their Illinois workers (subject to a cap of $2,500 per employee).

Given the far-reaching implications of the assessment on employers in Illinois, the final determination of the parameters for the assessment is identified as another area for further study.

Non-Group Market Changes

To facilitate compliance with the individual mandate, individuals will have access to at least one guaranteed-issue insurance product in the non-group market (the Comprehensive Standard Plan). Individuals who do not have an employer offer of coverage and have incomes under 400 percent of FPL will be able to use state-subsidized premium assistance to purchase this coverage in the non-group market (i.e., individual market) if they do not have an offer of coverage from their employer. Insurance market changes will also spread risk and stabilize premium levels in the non-group market. Illinois does not currently offer coverage on a guaranteed-issue basis in the non-group market; individuals unable to obtain coverage in the non-group market are able to seek coverage through the State's high risk pool; high risk pool premiums are capped at 125 to 150 percent of market rates, which are unrestricted.

[9] The structure of the employer assessment is designed to accomplish the state goals, not to collect a specific percentage of the funds needed to finance the Expansion Model.

Premium Assistance for Selected Coverage

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

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

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

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

Non-Group Insurance Market Changes

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

- Carriers must file rates for State review and approval.

- For approval, non-group rates for all non-group products must reflect a medical loss ratio of at least 85 percent. Illinois does not currently have minimum medical loss ratio requirements for the non-group market.

- Rates for any product cannot vary by more than 130 percent of a carrier's base rate for that product, accounting for all rating factors a carrier may use except geography.

To encourage broad pooling of risk and increase the predictability of future rate increases for the guaranteed-issue, comprehensive product, the annual rate increases for the guaranteed-

issue comprehensive product cannot exceed 115 percent of the medical cost trend across each carrier's entire book of non-group business. Currently, Illinois does not restrict individual rates, either related to the overall variation in premiums, variation in premiums for specific rate factors, or premium increases. Carriers may use any rate factors they choose to set premiums for individual coverage.

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

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

  - » Individuals eligible for subsidies

  - » Individuals ineligible for subsidies

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

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

To support the non-group market, the State will develop and operate a reinsurance program to voluntarily reinsure guaranteed-issue comprehensive non-group products. While carriers will cede risk voluntarily, participation by all carriers to finance pool losses will be mandatory.

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

As stated above, the Task Force recommends that the General Assembly fund further analyses of these insurance market changes.

Additional Strategies to Increase Access to Care

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

- Increase access to providers in underserved areas, by:

» Targeting State grants for capital investments, health care workers and public health interventions to underserved areas.

» Increasing access to providers in rural areas in conjunction with the State Rural Health Care Access Plan, and through other efforts demonstrated to improve access in rural areas, such as telemedicine and financial incentives, and medical and nursing school tuition loan forgiveness.

» Building on two pre-existing programs – the Illinois Medical Student Scholarship Program and the Rural Medical Illinois Assistance Program – to increase the number of providers of color and providers serving underserved areas (using state-only funds and, if available, federal funds) and expanding these programs to emphasize:

- Supporting scholarship or loan programs
- Targeting a wide variety of health care professionals (physicians, nurses, mental health professionals, etc.)
- Supporting faculty positions in health care education (raised as a particular concern for downstate Illinois)
- Evaluating current "buy out" provisions[10] from the program to determine if they should be made more onerous; funnel money received from these provisions back into the program

- Increase home-and community-based services and reform the State's long-term care system by:

» Implementing Long-Term Care Partnerships in Illinois to encourage the purchase of long-term care coverage. These Partnerships, authorized by the Deficit Reduction Act of 2005, will allow the State Medicaid agency to disregard any assets or resources in an amount equal to the insurance benefit payments into a qualified long-term care insurance partnership policy, for purposes of determining eligibility for Medicaid-funded long-term care services.

» Building on the State's current activities to implement the Older Adult Services Act (OASA) by supporting the Department of Aging's efforts to develop single points of entry for the full range of available long-term care

[10] For example, an individual receives a scholarship for medical education in return for working in an underserved area and accepts a position with a different employer who buys the individual out from the obligation.

services and restructuring the Medicaid Program's nursing facility payment methodology to create incentives for nursing facilities to provide home- and community-based services.

» Offering incentives or assistance to organizations to create additional adult day care centers, community-based residential facilities and affordable housing with supportive services.

» Increasing collaboration among state agencies that are responsible for institutional and home- and community-based long-term care, including agencies that are responsible for different groups of long-term care users (e.g., elders, nonelderly adults with physical disabilities, adults with behavioral problems and children with physical or cognitive disabilities) and agencies that receive funding from different sources (e.g., Medicaid and the Administration on Aging).

Program Administration

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

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

- Establishing a premium assistance schedule and providing oversight of premium assistance payments to health insurance carriers.

- Working with carriers to understand issues related to premium assistance payments, including the need to promptly notify IHERC about disenrollment of individuals.

- Assisting with eligibility determinations for and enrollment in the State's premium assistance program.

- Providing price comparisons of different insurance carriers' offerings of the Comprehensive Benefit Package in the non-group and small group markets.

- Providing information via the web and telephone regarding consumer coverage options, i.e., providing information to individuals regarding the individual mandate and individuals' specific public and private options for obtaining coverage and the price of that coverage. This information would be specific to an individual or family income level and other characteristics that could determine their coverage options. As part of this effort, IHERC's webpage will include an interactive health insurance and medical assistance decision tree, which will help explain the different coverage options for Illinois residents and their costs.[11]

- Providing price and benefit comparisons of the long-term care policies that carriers offer.

- Providing links to the Department of Public Health's Consumer Guide to Health Care and other websites associated with quality initiatives.

- Monitoring and reporting on uncompensated care through existing reporting mechanisms to determine the impacts of coverage initiatives.

- Publishing and updating insurance carriers' standardized product description and the base rate for each product.

- Reviewing state products, and making recommendations for adoption of proven technologies to identify and address fraud and abuse.

- Reporting on the commercial market's best practices regarding fraud and abuse and making recommendations for public program fraud and abuse policies.

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

- Monitor compliance with medical loss ratio requirements for carriers who offer coverage in the small group or non-group markets

- Monitor rates charged by these carriers to ensure that savings are passed through to purchasers of these policies (in conjunction with IHERC)

- Collect information on insurance carriers' standardized product description and the base rate for each product

[11] IHERC could build on the Division of Insurance's Ombudsman and/or the Medicaid Program's Primary Care Case Management enrollment broker as models.

- Under Option A, monitor insurance carriers' compliance with the requirement to offer the Comprehensive Standard Plan on a guaranteed-issue basis to separate risk pools and provide applicants information about this product

The Department of Revenue will:

- Determine compliance with tax penalties for the individual mandate and employer assessment

- Coordinate with IHERC regarding tax penalties and the employer assessment

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

Coverage and Cost Estimates

This section presents the detailed cost and coverage estimates for the updated health coverage Expansion Model. Exhibits III.1 and III.2 at the end of this chapter provide overall cost and coverage estimates, and cost estimates for each component of the proposed coverage expansion.

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

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

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

For the first full year of program operation, approximately $3.6 billion (Option A) or $3.1 billion (Option B) in State funding will be needed, assuming the availability of additional federal Medicaid/SCHIP matching funds and an employer assessment totaling approximately $1.5 billion. Increases in Medicaid provider payment rates represent an estimated $769 million (Option A) or $1.171 million of total State costs (Option B).[12] Total State costs without the provider payment increase are approximately $2.9 billion (Option A) and $1.9 billion (Option B). Under Option B, providers are paid the increased Medicaid rates plus five percent; these increases represent $403 million in State funding.[13] To the extent that the employer assessment is structured to collect less funding, the State will need to identify additional state funds.

Overview of Estimation Methodology

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

The estimation approach accounts for differences in benefit design, provider contractual allowances, administrative costs and availability of federal funds in the simulation of each of the proposal components. Each proposal component is modeled separately; when individuals are eligible for more than one coverage option, potential duplication of individuals between proposal components is removed in calculating overall coverage results.

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

Base Data

The model is based on 2000 Census data for the state of Illinois. These data provide rich detail on income, age, family type, employment status and immigration status.[14] The Census data were supplemented with information from the 2004 Current Population Survey (CPS) to impute

[12] Increases in provider payment rates do not include funding from Illinois' recently passed provider tax program because this program may no longer be available upon or after expansion implementation. This estimate reflects increases in payments to hospitals and physicians; additional analyses would be needed to determine payment increase to achieve 100 percent of estimated costs for other providers.

[13] This estimate reflects public program payment increases for hospitals and physicians only.

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

the probability of health coverage and firm size to persons in each demographic and income category in the 2000 Census.

All data was adjusted to 2007 population and workforce projections and adjustments were made to estimates of Medicaid and State Children's Health Care Program (SCHIP) recipients (a population that is typically undercounted in household surveys) to match administrative data from the Illinois Department of Healthcare and Family Services (DHFS). The model applies research estimates to calculate the percentage of the immigrant population that is ineligible for federal match in the Medicaid and SCHIP programs.[15]

Actuarial Assumptions

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

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

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

[15] 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 (i.e., who have a temporary work visa or student visa) are generally ineligible for Medicaid and SCHIP. All pregnant women can receive a temporary Medicaid card for prenatal care, labor and delivery. All income-eligible persons, regardless of immigration status, are eligible for Medicaid coverage for emergency room care.

Estimating Increases in Public Program Provider Payment

The model incorporated public program provider payment increases to 100 percent of estimated costs (within federal upper payment limits), using the following approach:[16]

- *Hospital payments:* For modeling purposes, the floor for reimbursement for hospitals is 100 percent of costs as determined by the current Medicaid payment structure. According to estimates provided by DHFS, hospital services represent approximately 32 percent of total services and are paid at approximately 68 percent of estimated costs (does not include disproportionate share hospital payments or the payments resulting from the pending provider tax assessment). As such, the Consulting Team identified 32 percent of estimated public program premium costs for the under 65 population and increased those costs by 1.4707, the amount necessary to achieve payments that would approximate 100 percent of estimated costs.

- *Physician payments:* As instructed by the Steering Committee, the Consulting Team used Medicare payments as a proxy for costs. According to estimates provided by DHFS, physician services represent approximately nine percent of total services and are paid at approximately 56 percent of Medicare physician rates (using 2006 Medicare locality 99 rates). As such, the Consulting Team identified nine percent of estimated public program premium costs for the under 65 population and increased those costs by 1.7857, the percentage necessary to achieve payments that would be approximately 100 percent Medicare's payment rates.

- *Payment for all other services:* As discussed with the Steering Committee, estimating costs for additional provider types requires additional analyses that go beyond the Task Force's timeframe and budget. Should the General Assembly choose to increase provider payments to an estimated 100 percent of costs for these other categories of providers, additional analyses are needed.

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

[16] For modeling purposes, the floor for reimbursement for hospitals is 100 percent of costs as determined by the current Medicaid payment structure. The estimates of hospital and physician payment increases may be understated because the estimates of pre-existing public program coverage may have understated the higher health care costs of populations with disabilities covered by Medicaid.

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

Behavioral Assumptions

As in all health care modeling estimates, arriving at an estimate of how many of those eligible would take newly offered coverage is an imprecise process. The approach used to develop these estimates was, as follows:

- *Individual Behavioral Assumptions:* Consistent with earlier modeling of proposals for the Task Force, a standard set of assumptions was used. These assumptions varied the take-up rate by the following factors:

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

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

- *Employer Behavioral Assumptions:* As described earlier in this Chapter, employers will be subject to a partial or full employer assessment. While the structure of the employer assessment is not specified by the Task Force, this assessment is intended to encourage employers who have historically offered coverage to continue to do so (entitling the employer to a full or partial credit against the assessment).[17] The premium assistance program is also intended to maintain current rates of employer offers of coverage by increasing employee demand for this type of coverage. In addition, a modestly lower-cost option is available to small employers (and premium assistance to their workers). Based on the experience of programs in other states, however, it would be not expected that many non-offering employers would begin offering the new coverage.

[17] As described in Appendix D, data from the Medical Expenditure Panel Survey-Insurance Component employer survey were used to estimate the number of workers associated with various types of employers (e.g., workers in firms that were small and non-offering).

Summary

The Task Force decided in December to submit the Expansion Model to the Illinois Legislature based on a majority vote. The majority of Task Force members also voted to include both Option A and Option B in the Expansion Model for the legislative consideration, and by a majority vote, expressed a strong preference for Option A. Chapter IV provides additional information on issues raised in regards to these two options

The Task Force developed a Health Care Coverage Expansion Model that is complex and comprehensive. Many assumptions were made about cost and coverage under this Expansion Model, and the Task Force recognizes that additional work is necessary to refine this model to determine a precise implementation and operation cost to the State. The Task Force further recognizes that additional discussion and studies regarding interactions between program features may be necessary to refine this model, as discussed further in Chapter IV.

Exhibit III.1 - Summary of Health Care Expansion Model
2007 Estimated Coverage and Costs for the Under 65 Population

Note: Cost and coverage estimates presented here represent high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as needed for a State appropriations estimate.		Option A: All Carriers Offer Comprehensive Standard Plan	Option B: State Self-Insured Plan
I. Changes in Coverage (in thousands)			
A. Total newly covered under proposal	Total individuals	1,520	1,520
	Percent of uninsured	89%	89%
B. Currently insured residents participating in new coverage programs	Total individuals	2,040	2,034
	Percent of currently insured	21%	21%
C. Total newly covered under Medicaid or SCHIP (a)	Total individuals	230 (a)	230 (a)
D. Remaining uninsured	Total individuals	185	185
	% of baseline uninsured	11%	11%
II. Costs Associated with Enrollment in New Coverage Options(b) ($ in millions)			
A. Federal Medicaid/SCHIP funds		428 (c)	428 (c)
B. State	1. Health insurer assessment	Not Applicable	Not Applicable
	2. Employer fees or taxes	1,481	1,481
	3. Employee payroll tax (d)	Not Applicable	Not Applicable
	4. Medicaid/SCHIP funds (e)	428 (c)	428 (c)
	5. Source to be determined	2,785	2,285
C. Annual per capita state coverage costs for all individuals participating in new coverage options ((IIB.4+IIB.5)/(IA+IB)) *Note: Includes funding from employer assessment; calculation varies due to rounding from Exhibit III.2*		902	763
D. Annual per capita state coverage costs for all newly insured individuals *(excludes funding from employer assessment, see footnote f)*		2,304 (f)	2,041 (f)
III. Cost Increases Associated with Medicaid and SCHIP Provider Payment Rate Increases ($ in millions) (g)			
A. Existing public programs: Federal share		549	549
B. Existing public programs: State share		410	410
C. New public programs: Federal share		77	77
D. New public programs: State share		359	761
E. Total provider payment rate increase (IIIA+IIIB+IIIC+IIID)		1,395	1,798
IV. Proposal Components Not Modeled That May Result in Changes to Estimates Coverage and Costs			
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.			
V. Total Cost to State ($ in millions)			
A. Including funding from employer assessment (IIB4+IIB5+IIIB)		3,623	3,123
B. Including funding from employer assessment and excluding provider payment rate increase (IIB4+IIB5-IIID)		2,854	1,951

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

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

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

(d) The proposed Expansion Model does not specify the structure of the employer assessment. For purposes of these cost and coverage estimates, the employer assessment amount reflects a policy whereby firms of 25 or more employees are subject to the assessment. If firms of 10 or more workers were subject to the assessment, total revenue from the assessment would increase by $261 million for a total assessment of $1,742 million. Appendix E provides additional detail.

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

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

(g) Reflects a general estimate of additional hospital and physician payments for Medicaid and SCHIP-funded programs, and the state-only funded expansion of coverage to childless adults (under 65 population only). These estimates do not include funding from Illinois' recently passed provider tax program because this program may no longer be available upon or after expansion implementation. Should the provider tax program be available, however. less funding might be needed to pay providers at an estimated 100 percent of costs (within upper payment limitations). Estimate reflects an overall 22.1 percent increase in payments to hospitals and physicians; Section III provides additional information regarding this calculation. The estimates of hospital and physician payment increases may be understated because the estimates of pre-existing public program coverage may have understated the higher health care costs of populations with disabilities covered by Medicaid. Additional analyses would be needed to determine payment increase to achieve 100 percent of estimated costs for other providers, as recommended by the Task Force.

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

Exhibit III.2 - Health Care Expansion Model by Component -- Estimated Coverage and Costs for 2007 for the Under 65 Population

Note: Cost and coverage estimates presented here represent high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as needed for a State appropriations estimate.	Reference to Exhibit III.1	Option A: All Carriers Offer Comprehensive Standard Plan								
		Overall	Public program expansion Family Care Expansion to 200% FPL	Individual Mandate New Public Program Enrollment under Existing Eligibility Rules	Public program expansion Childless Adults Eligible for State-Funded Medicaid-Like Program to 100% FPL	Premium Subsidies Impact on Workers with a Small, Low-Wage Employer Eligible to Purchase New Comprehensive Standard Plan	Premium Subsidies Direct Subsidies for Workers with Employer Offer of Coverage	Premium Subsidies Impact of Subsidies for Adults Purchasing in Non-Group Market	Insurers to offer "standard plan" Insurance Take-Up by Uninsured Residents Ineligible For Subsidies	Employer Assessment Non-Offering Employers with 26 Or More Workers in Illinois Face An Assessment
I. Total Population Eligible for Program		Footnote 1	54,924	2,384,398	509,037	415,598	3,055,604	1,092,719	320,938	
A. Total Uninsured in Eligible Population		Footnote 1	17,319	313,233	356,395	89,031	193,362	973,654	320,938	
II. Total Estimated Program Enrollment		3,560,229 (2)	51,629	306,597	483,585	80,604	2,025,623	552,109	256,751	
A. Overall Participation Rate		Footnote 1	94%	13%	95%	19%	66%	51%	80%	
B. Annual Overall Coverage Cost per Participant *(includes employer, employee and subsidy amounts)*		$ 4,227	$ 2,943	$ 3,279	$ 3,209	$ 4,440	$ 4,357	$ 4,881	$ 5,137	
C. Annual Overall Subsidy Cost per Participant		$ 1,439	$ 2,766	$ 2,929	$ 3,209	$ 1,773	$ 109	$ 3,961		
D. Annual State Subsidy Cost per Participant *(includes State Medicaid/SCHIP Funds and other unspecified sources of State funds; at the overall level, new assessments are netted out)*	II.C	$ 902	$ 1,383	$ 1,742	$ 3,209	$ 1,773	$ 109	$ 3,961		
III. Total Newly Covered under Proposal	**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)*		$ 4,145	$ 2,879	$ 3,279	$ 2,989	$ 4,691	$ 5,062	$ 4,806	$ 5,137	
C. Annual Program Subsidy Cost per Newly Insured *(does not include employer fees or insurer assessments)*		$ 2,557	$ 2,702	$ 2,929	$ 2,989	$ 1,842	$ 208	$ 3,898	$ -	
D. Annual State Subsidy Cost per Newly Insured *(includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)*	II.D	$ 2,304	$ 1,351	$ 1,742	$ 2,989	$ 1,842	$ 208	$ 3,898	$ -	
E. Enrollment of Newly Insured as a Percent of Total Program Enrollment		43%	32%	100%	70%	20%	6%	87%	100%	
IV. Currently insured residents participating in new coverage programs	**I.B**	2,039,870	35,349	-	145,010	64,234	1,911,817	69,078		
A. Annual Coverage Cost per Previously Insured Resident *(includes employer, employee and subsidy amounts)*		$ 4,289	$ 2,973	$ -	$ 3,721	$ 4,376	$ 4,315	$ 5,407		
B. Annual Program Subsidy Cost per Previously Insured Resident		$ 605	$ 2,796	$ -	$ 3,721	$ 1,756	$ 103	$ 4,403		
C. Annual State Subsidy Cost per Previously Insured Resident *(includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)*		$ 581	$ 1,398	$ -	$ 3,721	$ 1,756	$ 103	$ 4,403		

Exhibit III.2 - Health Care Expansion Model by Component -- Estimated Coverage and Costs for 2007 for the Under 65 Population

Note: Cost and coverage estimates presented here represent high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as needed for a State appropriations estimate.	Reference to Exhibit III.1	Option A: All Carriers Offer Comprehensive Standard Plan								
		Overall	Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Insurers to offer "standard plan"	Employer Assessment
			Family Care Expansion to 200% FPL	New Public Program Enrollment under Existing Eligibility Rules	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 Comprehensive Standard Plan	Direct Subsidies for Workers with 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
V. Costs Associated with Enrollment in New Coverage Options(3)										
A. New Federal Medicaid/SCHIP Funds	II.A	$ 427,644,998 (4)	$ 71,414,405	$ 363,799,760	$ -	$ -	$ -	$ -		
B. New Health Insurer Assessments	II.B.1	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
C. Employers:				0						
Premium Contributions		$ 6,681,561,991	$ -	$ -	$ -	$ 168,578,657	$ 7,213,326,170	$ -		
New Fees or Taxes	II.B.2	$ 1,481,293,371 (5)		$ -			$ -	$ -		$ 1,481,293,371
D. Residents:		$ -		$ -						
Premium Contributions		$ 3,246,219,661	$ 9,116,733	$ 107,377,661	$ -	$ 46,392,984	$ 1,391,649,029	$ 507,874,708	$ 1,318,923,943	
New Payroll Taxes	II.B.3	$ -		$ -	$ -			$ -		
State Income Taxes		$ -		$ -				$ -		
E. New State Medicaid/SCHIP Funds	II.B.4	$ 427,644,998 (6)	$ 71,414,405	$ 348,661,424	$ -	$ -	$ -	$ -		
F. Other State Funds (source to be determined)	II.B.5	$ 2,785,427,548	$ -	185,485,608	$ 1,551,631,134	$ 142,928,599	$ 221,272,093	$ 2,186,886,824		
VI. Total		$ 15,049,792,567	$ 151,945,543	$ 1,005,324,454	$ 1,551,631,134	$ 357,900,240	$ 8,826,247,292	$ 2,694,761,532	$ 1,318,923,943	
VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Current Public Program Coverage										
A. State Costs	III.B	$ 410,316,110 (7)								
B. Federal Costs	III.A	$ 548,662,518 (7)								
VIII. Total Point-of-Service Cost Sharing Under the Program		$ 2,287,622,063	$ 9,103,616	$ -	$ -	$ 69,345,856	$ 1,568,474,435	$ 482,635,918	$ 310,345,638	
IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians		46%	3%	17%	26%	0%	0%	0%	0%	0%

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

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

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

(4) In addition to the Federal and State SCHIP/Medicaid spending associated with the new coverage options, these totals include an amount of $7,569,168 associated with moving some SCHIP parents into Medicaid (lower match rate) to fund the coverage of eligible but not yet 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.

(5) The proposed Expansion Model does not specify the structure of the employer assessment. For purposes of these cost and coverage estimates, the employer assessment amount reflects a policy whereby firms of 25 or more employees are subject to the assessment. If firms of 10 or more workers were subject to the assessment, total revenue from the assessment would increase by $261 million for a total assessment of $1,742 million. Appendix E provides additional detail.

Exhibit III.2 - Health Care Expansion Model by Component -- Estimated Coverage and Costs for 2007 for the Under 65 Population

Note: Cost and coverage estimates presented here represent high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as needed for a State appropriations estimate.		Option A: All Carriers Offer Comprehensive Standard Plan								
			Public program expansion	Individual Mandate	Public program expansion	Premium Subsidies	Premium Subsidies	Premium Subsidies	Insurers to offer "standard plan"	Employer Assessment
	Reference to Exhibit III.1	Overall	Family Care Expansion to 200% FPL	New Public Program Enrollment under Existing Eligibility Rules	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 Comprehensive Standard Plan	Direct Subsidies for Workers with 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

(6) In addition to the Federal and State SCHIP/Medicaid spending associated with the new coverage options, these totals include expenditures 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.

(7) Reflects an overall 22.1 percent increase in Medicaid/SCHIP provider payment rates; Section III provides additional information regarding this calculation. Estimate reflects increases in payments to hospitals and physicians; the estimates of hospital and physician payment increases may be understated because the estimates of pre-existing public program coverage may have understated the higher health care costs of populations with disabilities covered by Medicaid. Additional analyses would be needed to determine payment increase to achieve 100 percent of estimated costs for other providers, as recommended by the Task Force.

Exhibit III.2 - Health Care Expansion Model by Component -- Estimated Coverage and Costs for 2007 for the Under 65 Population

Note: Cost and coverage estimates presented here represent high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as needed for a State appropriations estimate.	Reference to Exhibit III.1	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	Childless Adults Eligible for State-Funded Medicaid-Like Program to 100% FPL	Impact on Workers with a Small, Low-Wage Employer Eligible to Purchase State Self-Insured Plan	Direct Subsidies for Workers with 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
I. Total Population Eligible for Program		Footnote 1	54,924	2,384,398	509,037	415,598	3,055,604	1,092,719	320,938	
A. Total Uninsured in Eligible Population		Footnote 1	17,319	313,233	356,395	89,031	193,362	973,654	320,938	
II. Total Estimated Program Enrollment		3,553,985 (2)	51,629	306,597	483,585	71,269	2,025,623	552,116	256,751	
A. Overall Participation Rate		Footnote 1	94%	13%	95%	17%	66%	51%	80%	
B. Annual Overall Coverage Cost per Participant *(includes employer, employee and subsidy amounts)*		$ 4,115	$ 2,943	$ 3,279	$ 3,209	$ 4,069	$ 4,357	$ 4,208	$ 5,137	
C. Annual Overall Subsidy Cost per Participant		$ 1,300	$ 2,766	$ 2,929	$ 3,209	$ 1,403	$ 109	$ 3,131	$ -	
D. Annual State Subsidy Cost per Participant *(includes State Medicaid/SCHIP Funds and other unspecified sources of State funds; at the overall level, new assessments are netted out)*	II.C	$ 763	$ 1,383	$ 1,742	$ 3,209	$ 1,403	$ 109	$ 3,131	$ -	
III. Total Newly Covered under Proposal	**I.A**	1,520,276	16,280	306,597	338,575	16,113	113,806	483,031	256,751	
A. Participation among Eligible Uninsured		N/A	94%	98%	95%	18%	59%	50%	80%	
B. Annual Overall Coverage Cost per Newly Insured *(includes employer, employee and subsidy amounts)*		$ 3,929	$ 2,879	$ 3,279	$ 2,989	$ 4,069	$ 5,062	$ 4,147	$ 5,137	
C. Annual Program Subsidy Cost per Newly Insured *(does not include employer fees or insurer assessments)*		$ 2,295	$ 2,702	$ 2,929	$ 2,989	$ 1,482	$ 208	$ 3,083	$ -	
D. Annual State Subsidy Cost per Newly Insured *(includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)*	II.D	$ 2,041	$ 1,351	$ 1,742	$ 2,989	$ 1,482	$ 208	$ 3,083	$ -	
E. Enrollment of Newly Insured as a Percent of Total Program Enrollment		43%	32%	100%	70%	23%	6%	87%	100%	
IV. Currently insured residents participating in new coverage programs	**I.B**	2,033,709	35,349	-	145,010	55,156	1,911,817	69,085		
A. Annual Coverage Cost per Previously Insured Resident *(includes employer, employee and subsidy amounts)*		$ 4,254	$ 2,973	$ -	$ 3,721	$ 4,069	$ 4,315	$ 4,633		
B. Annual Program Subsidy Cost per Previously Insured Resident		$ 557	$ 2,796	$ -	$ 3,721	$ 1,380	$ 103	$ 3,464		
C. Annual State Subsidy Cost per Previously Insured Resident *(includes State Medicaid/SCHIP Funds and other unspecified sources of State funds, does not include employer fees or insurer assessments)*		$ 533	$ 1,398	$ -	$ 3,721	$ 1,380	$ 103	$ 3,464		

Exhibit III.2 - Health Care Expansion Model by Component -- Estimated Coverage and Costs for 2007 for the Under 65 Population

Note: Cost and coverage estimates presented here represent high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as needed for a State appropriations estimate.	Reference to Exhibit III.1	Option B: State Self-Insured Plan								
		Overall	Public program expansion Family Care Expansion to 200% FPL	Individual Mandate New Public Program Enrollment under Existing Eligibility Rules	Public program expansion Childless Adults Eligible for State-Funded Medicaid-Like Program to 100% FPL	Premium Subsidies Impact on Workers with a Small, Low-Wage Employer Eligible to Purchase State Self-Insured Plan	Premium Subsidies Direct Subsidies for Workers with Employer Offer of Coverage	Premium Subsidies Impact of subsidies for Adults Purchasing in Non-Group Market	Require Insurers to offer "standard plan" Insurance Take-Up by Uninsured Residents Ineligible For Subsidies	Employer Assessment Non-Offering Employers with 26 Or More Workers in Illinois Face An Assessment
V. Costs Associated with Enrollment in New Coverage Options(3)										
A. New Federal Medicaid/SCHIP Funds	II.A	$ 427,644,998 (4)	$ 71,414,405	$ 363,799,760	$ -	$ -	$ -	$ -	$ -	$ -
B. New Health Insurer Assessments	II.B.1	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
C. Employers:			0	0	0				0	0
Premium Contributions		$ 6,668,947,736	$ -	$ -	$ -	$ 144,983,008	$ 7,213,326,170	$ -	$ -	$ -
New Fees or Taxes	II.B.2	$ 1,481,293,371 (5)	$ -	$ -	$ -		$ -	$ -	$ -	$ 1,481,293,371
D. Residents:		$ -	0	0	0				$ -	$ -
Premium Contributions		$ 3,333,745,958	$ 9,116,733	$ 107,377,661	$ -	$ 44,958,114	$ 1,391,649,029	$ 594,717,262	$ 1,318,923,943	$ -
New Payroll Taxes	II.B.3	$ -	$ -	$ -	$ -			$ -	$ -	$ -
State Income Taxes		$ -	$ -	$ -	$ -			$ -	$ -	$ -
E. New State Medicaid/SCHIP Funds	II.B.4	$ 427,644,998 (6)	$ 71,414,405	$ 348,661,424	$ -	$ -	$ -	$ -	$ -	$ -
F. Other State Funds (source to be determined)	II.B.5	$ 2,284,540,380	$ -	$ 185,485,608	$ 1,551,631,134	$ 100,024,895	$ 221,272,093	$ 1,728,566,501	-	-
VI. Total		$ 14,623,817,440	$ 151,945,543	$ 1,005,324,454	$ 1,551,631,134	$ 289,966,017	$ 8,826,247,292	$ 2,323,283,763	$ 1,318,923,943	$ -
VII. Costs Associated with Medicaid/SCHIP Provider Payment increases for Current Public Program Coverage										
A. State Costs	III.B	$ 410,316,110 (7)								
B. Federal Costs	III.A	$ 548,662,518 (7)								
VIII. Total Point-of-Service Cost Sharing Under the Program		$ 2,269,593,249	$ 9,103,616	$ -	$ -	$ 62,907,909	$ 1,568,474,435	$ 468,657,243	$ 310,345,638	$ -
IX. Percentage Increase in Non-Elderly Patient Load for Medicaid Physicians		80%	3%	17%	26%	4%	0%	30%	0%	0%

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

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

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

(4) In addition to the Federal and State SCHIP/Medicaid spending associated with the new coverage options, these totals include an amount of $7,569,168 associated with moving some SCHIP parents into Medicaid (lower match rate) to fund the coverage of eligible but not yet 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.

(5) The proposed Expansion Model does not specify the structure of the employer assessment. For purposes of these cost and coverage estimates, the employer assessment amount reflects a policy whereby firms of 25 or more employees are subject to the assessment. If firms of 10 or more workers were subject to the assessment, total revenue from the assessment would increase by $261 million for a total assessment of $1,742 million. Appendix E provides additional detail.

Exhibit III.2 - Health Care Expansion Model by Component -- Estimated Coverage and Costs for 2007 for the Under 65 Population

Note: Cost and coverage estimates presented here represent high-level cost, participation and financing estimates. The estimates consider major factors that affect cost and coverage, but may not (for reasons of time and available data) consider some factors that should be considered in developing more precise estimates, such as needed for a State appropriations estimate.		Option B: State Self-Insured Plan								
			Public program expansion	**Individual Mandate**	**Public program expansion**	**Premium Subsidies**	**Premium Subsidies**	**Premium Subsidies**	**Require Insurers to offer "standard plan"**	**Employer Assessment**
	Reference to Exhibit III.1	**Overall**	Family Care Expansion to 200% FPL	New Public Program Enrollment under Existing Eligibility Rules	Childless Adults Eligible for State-Funded Medicaid-Like Program to 100% FPL	Impact on Workers with a Small, Low-Wage Employer Eligible to Purchase State Self-Insured Plan	Direct Subsidies for Workers with 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

(6) In addition to the Federal and State SCHIP/Medicaid spending associated with the new coverage options, these totals include expenditures 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.

(7) Reflects an overall 22.1 percent increase in Medicaid/SCHIP provider payment rates; Section III provides additional information regarding this calculation. Estimate reflects increases in payments to hospitals and physicians; the estimates of hospital and physician payment increases may be understated because the estimates of pre-existing public program coverage may have understated the higher health care costs of populations with disabilities covered by Medicaid. Additional analyses would be needed to determine payment increase to achieve 100 percent of estimated costs for other providers, as recommended by the Task Force.

Exhibit III.3: Impact of Health Care Expansion Model Including Mandate on the Uninsured by Selected Characteristics 2007 Estimates for the Under 65 Population

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

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

CHAPTER IV: AREAS FOR ADDITIONAL STUDY AND CONSIDERATION

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

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

- *Subsidization of Cost-Sharing*: The proposal includes subsidies of premium costs in the individual or small group market for individuals under 400 percent of the FPL. These subsidies do not cover point-of-service cost-sharing such as copayments, which can vary widely across employers and in the non-group market. Because cost-sharing can be a barrier to access to care, especially for low-income individuals, it is important to further consider cost-sharing levels under the expansion approach. While populations with very low incomes will likely be eligible for public coverage featuring very limited cost-sharing (i.e., low-income parents up to 200 percent of the FPL and childless adults up to 100 percent of the FPL), there may be individuals under 400 percent of the FPL who face prohibitive cost-sharing levels. Additional analyses are needed to determine the impact on access to care if cost-sharing subsidies are not available for low-income populations.

- *Ability of Low-Income Individuals with Employer Offers of Coverage to Use Premium Assistance in the Non-Group Market*: To sustain and promote employer-sponsored coverage, the proposed model specifies that individuals under 400 percent of the FPL must apply their premium assistance to an employer offer of coverage, if available. If an employer offer of coverage is not available, the individual may use the premium subsidy to purchase the Comprehensive Standard Plan in the non-group market. The Task Force notes that it is likely that there will be some employers whose benefit packages are less comprehensive than the Comprehensive Standard Plan and, thus, less appealing to individuals (especially if an individual requires extensive health care services).

  Further, very limited employer benefit packages may not provide the level of access intended by the Health Care Justice Act. One approach to resolve this issue is to allow individuals under 400 percent of the FPL with employer offers of coverage to use their premium assistance in the non-group market if their employer's benefit package does not meet a minimum standard. However, such a "safety valve," if not

set at appropriate levels, could encourage employers to reduce the level of coverage so that employees purchase coverage elsewhere.

- *Future Study for Employer Assessment Policy*: As mentioned in Chapter III, the Task Force recommends additional study of the parameters surrounding the employer assessment. Issues for additional study include:

  - » Employer incentives to drop or not offer coverage, based on the amount of the assessment.

  - » Whether or not the assessment should reward employers who provide coverage for dependents – the Task Force notes that the employer assessment policy used for cost and coverage estimates does not recognize dependent coverage as counting towards the credit against the employer assessment. As a result, it is possible that employers could be disincented to provide dependent coverage.

  - » Amount of an assessment as compared to the cost of providing coverage to an employee.

  - » Administrative burden of complying with the assessment.

  - » Impact of the assessment on all employers' finances and, in particular, small employers.

  - » Impact of the assessment on the State's ability to retain employers.

  To inform decisions regarding the employer assessment, the Task Force also recommends that the General Assembly fund an analysis to quantify the number of uninsured individuals who are estimated to be covered by this proposal, by income level, employer size (fewer or more than 25 employees) and their sources of coverage and financing (i.e., premium assistance, new public program or other).

- *Further Study of Proposed Group and Non-Group Insurance Market Changes***:** Group and non-group insurance market changes designed to spread risk and stabilize premiums are key elements of the proposal. The Task Force recommends that the General Assembly fund studies of the potential impact of these insurance market changes to inform the deliberations surrounding this proposed approach. For example, the Task Force recommends that the General Assembly fund the following studies:

  - » Comparative analysis of Illinois market and markets in other states that have regulations similar to the ones proposed for Illinois. This analysis would

include NAIC data and would specifically examine carrier entry and exit from the market, as well as detail on insurer size and market trends. The Task Force notes, however, that there are no other states which have introduced these market changes contemporaneously with the imposition of an individual mandate.

  - » Detailed analysis of the impact of the proposed regulations using Illinois carriers' enrollment and premium information. This would entail a "data call" from the State to obtain the information from a sample of large and small carriers in Illinois.

  - » Analysis of multiple years of National Association of Insurance Commissioners (NAIC) information for the State of Illinois to understand the stability of the medical loss ratios observed in 2001-2005 in both the individual and small group markets. This analysis would include a review of companies' financial information reported to NAIC to consider their administrative cost, surplus, and profitability during those years.

- *Further Analyses of Option A/Option B Issues:* The Task Force notes that under Option B, it is possible that employers will begin offering coverage through Option B's State self-insured plan, thereby moving away from seeking coverage through private insurance carriers. This may have unintended consequences for the insurance industry and may also result in providers receiving an increasing proportion of their payments from the State self-insured plan. The Task Force recommends that the State further explore the effect of changing payment levels created on providers created by this Option.

Summary

The Task Force's proposed Expansion Model makes significant changes to Illinois' current health care environment. As such, additional study and attention is warranted to fully anticipate the impact of the Expansion Model, and to make adjustments so that unintended consequences do not occur. The Task Force understands that there are many details to be worked out in the implementation of this model and encourages additional discussion that is supported as needed by additional funding of detailed analyses.

Appendix A: Adequate Health Care Task Force's Listing of Key Interests

APPENDIX A: ADEQUATE HEALTH CARE TASK FORCE'S LISTING OF KEY INTERESTS

Matrix Overview: For each interest identified by the Adequate Health Care Task Force on May 9 and 23, 2006, Navigant Consulting, Inc. reviewed information submitted by proposers and indicated if the proposal meets that interest ("Yes" or "No"); if the answer is not a clear "yes" or "no," we provided a brief summary of what the proposal included related to this interest. We have indicated when an interest was not specifically addressed in the proposer's materials to avoid inappropriate assumptions regarding the proposer's intent. Please note that additional evaluation is needed to determine whether a proposal's approach to an interest is feasible or effective.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
ADHERENCE TO HEALTH CARE JUSTICE ACT STATUTORY CRITERIA						
1.	**Provides access to a full range of preventive, acute, and long-term health care service**	Proposes coverage for each Illinois uninsured segment of the population. With respect to working uninsured, proposes a Safety Net Benefit Package offered through new employer-based programs (Employer-Sponsored Insurance Initiative [ESI] and Small Employer Purchasing Cooperative [SEPC]) include preventive care and core components of basic major medical protection. Dental, skilled nursing facility and vision services could be obtained at an extra cost. CHIP coverage and Medicaid expansion for parents includes a comprehensive benefit package.	Yes – Expands Medicaid and State Children's Health Insurance Program (SCHIP) coverage to include dental and vision benefits for adults. Existing Medicaid package is comprehensive and includes preventive, acute and long-term care benefits. Purchasing pool benefits equal to Illinois State Employee benefit options, which include a comprehensive set of preventive and acute services, plus access to hospice and long-term care.	Yes – Covers all medically necessary services, including acute, rehabilitative, long-term and home care, mental health and substance abuse, dental services, occupational health care, prescription drugs and medical supplies, durable medical equipment, vision and preventive and public health measures.	Yes – Includes a comprehensive package of benefits that includes, at a minimum, hospitalizations, mental health, prescription drugs and preventive care, and meets the requirements for mandated coverage under the Illinois Insurance Code.	Non-public benefit package content not specifically addressed; however, proposer indicates that public benefit package would follow existing statutory and regulatory requirements, except that individuals and small groups would be allowed to opt out of benefit mandates they consider unnecessary; Medicaid and SCHIP expansion to single childless adults includes a comprehensive benefit package. Proposes premium assistance as well as refundable and advanceable health insurance State tax credits to make coverage more affordable and accessible.
2.	**Provides core benefits for all Illinois residents**					
3.	**Core benefits that would be provided under each type of plan**					

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
4.	**Maintains and improves the quality of health care services offered to Illinois residents**	Not specifically addressed in proposer's materials.	Requires that the Illinois Department of Public Health (IDPH) and other state agencies that monitor and oversee quality provide a written report every six months to the Guaranteed Health Security Task Force that that would oversee the implementation of a health access plan. Task Force will have the authority to initiate any additional advisory task force that is needed.	Contains 10 key quality principles but provides limited information on how those quality principles would be implemented for an Illinois-specific payer model. Promotes electronic health records, electronic lab reporting and electronic prescribing to improve quality and patient safety. Promotes single standard of care through benefit design, and directs resources to underserved areas. Promotes evidence-driven process to improve quality and expects to facilitate Continuous Quality Improvement through use of complete and integrated database generated by single billing and reimbursement system.	Creates a Healthy Illinois Quality Forum that will (1) gather and disseminate information on healthcare quality and patient safety, (2) conduct research on best practices, (3) identify and promote the adoption of nationally endorsed performance measures and (4) establish incentives for consumers to adopt healthier lifestyles (e.g., full coverage of preventive care, health club discounts, smoking cessation programs).	Proposes accelerating adoption of health information technology and related infrastructure needed to improve quality, patient safety and efficiency and reduce treatment variation. Proposes increasing the use of pay-for-performance, and implementing an on-going consumer-targeted patient safety initiative.
5.	**Provides portability of coverage, regardless of employment status**	Provides subsidies for various populations, expansion of CHIP high risk pool for those with pre-existing conditions, expansion of Medicaid. Provides expansion of continuation coverage for the unemployed.	Expands COBRA and coverage would be available for individuals in public programs and the new purchasing pool regardless of employment status.	Yes, for all residents of Illinois	Not specifically addressed in proposer's materials; however, proposer indicates that the rights of portability for Healthy Illinois Plan participants would be the same as for individuals with private insurance.	Proposes vouchers to allow Medicaid-eligibles to enroll in their employers' plans; proposes health savings accounts for individuals moving from public to private programs.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
6.	**Encourages regional and local consumer participation**	Not specifically addressed in proposer's materials.	Yes – Contains a regional and local consumer participation mechanism by establishing five regional task forces, which include consumers, to monitor the implementation of the health access strategies in their region and to work with the newly established advisory committees.	Yes – Proposer indicates that consumers sit on Board of single payer plan, participate in determination of benefit package in conjunction with providers and experts, participate in allocation of budget and health planning (including capital funds for infrastructure expansion, purchase of major equipment, etc.), and participate in local long-term care agencies. Consumers have free choice of providers which the proposer indicates will allow patients to choose to receive care from the most responsive, highest quality providers.	The Health Resource Plan will provide a roadmap for allocating resources to under served areas, will be developed with regional and local input and will become a part of the State's Certificate of Need process, which also requires regional and local input.	Recommends State to encourage and fund the development of programs to help communities, employers and employees work together to access and/or maintain health insurance for small businesses on a local and regional basis (e.g. Three Share Plan).
7.	**Contains cost-containment measures**	Yes – Includes cost-sharing for participating individuals, employer contributions and a scaled-back benefit package. In addition, recommends implementing reinsurance and restricting underwriting in the small group market and improving the Health Care Purchasing Group Act to gain economies of scale and/or contain costs.	Yes – Includes cost-sharing for participating individuals. Establishes Technology Development Advisory Task Force. Uses reinsurance for purchasing pool. Proposes a study of the use of reinsurance in the overall insurance market. Promotes cost containment by expanding Medicaid, and using disease management and primary care case management within Medicaid to control costs. Limits administrative overhead for	Yes – Sets and enforces global budgets for hospitals and nursing homes, with separate budgets for capital expansion and operations. Expects to reduce overhead in doctor's offices, hospitals and nursing homes due to simplified billing and payment. Expects to streamline insurance overhead, eliminating many functions the proposer classifies as unnecessary, such as marketing. Negotiates fees with providers and prices with drug and	Yes – Requires health insurance companies to justify increases greater than 6 percent in their index rate, determine if health facilities' major expansions are consistent with state health goals, require hospitals to submit annual reports to Healthy Illinois Authority listing cost increases, require public reporting of providers' and insurance companies' cost increases and profits.	Proposes personal health accounts for Medicaid consumers to encourage them to manage their health care spending and engage them in managing their utilization of services and health care; promotes consumer-engaged approaches in the public and private market, including Health Savings Accounts. Uses Medicaid managed
8.	**Incentives to be used to contain costs**					

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
			purchasing pool.	equipment manufacturers. Pays specialists at primary care rate if patient does not have a referral. Fraud detection and reduction. Shift workforce towards primary care. Does not cover services that are not considered medically necessary. Requires the use of a prescription drug formulary based upon prices negotiated with drug manufacturers. Allows for the introduction of deductibles and co-payments after two years, if necessary. Allows for non-profit staff-model HMO Coverage option.		care.
9.	**Provides a mechanism for reviewing and implementing multiple approaches to preventive medicine based on new technologies**	Not specifically addressed in proposer's materials.	Establishes a Prevention and Health Education Advisory Task force and Technology Task Force that will examine this issue.	Proposer indicates that the single payer approach permits evidence-based technology assessment and intervention at individual and community level, and facilitates linkage with public health system and "long-term" view of prevention.	Not specifically addressed in proposer's materials; however, propser indicates that this task will be undertaken by the Healthy Illinois Quality Forum.	Not specifically addressed in proposer's materials.
10.	**Promotes affordable coverage options for the small business market**	Yes.	Yes.	The single payer approach spreads the cost of health care across the entire population, potentially reducing the cost to small business compared with current system.	Yes.	Yes.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
11.	**An integrated system or systems of health care delivery**	Not specifically addressed in proposer's materials.	Establish a Capital and Network Infrastructure Advisory Task Force that will be responsible for making recommendations regarding a more effective, integrated system.	Outlines a health planning function, which could promote an integrated system of health care.	Creates a Health Resource Plan that will establish a comprehensive and coordinated approach to the development of healthcare facilities and resources.	Not specifically addressed in proposer's materials.
12.	**Reimbursement mechanisms for health care providers**	Proposes Medicaid payment for Medicaid and SCHIP expansion and new Employer Sponsored Insurance (ESI) initiative. Recommends Medicaid rate increases. Proposes commercial rates for Small Employer Purchasing Cooperative (SEPC) and CHIP expansion.	Uses targeted reimbursement rate increases for public program expansions; does not change ICHIP provider payments; uses State employee health insurance provider reimbursement for purchasing pool.	Uses global budgets for institutional providers and non-profit, staff-model HMOs. Uses negotiated fee schedule for physicians, some salaried physicians. Uses state formulary for drugs.	Recommends that the State negotiate reimbursement rates on behalf of the self-funded insurance plan.	Uses savings from implementing a "true" managed care Medicaid system to increase Medicaid provider reimbursement; additional information not provided.
13.	**Administrative efficiencies**	Through use of current Medicaid program; further administrative efficiencies gained from pooling under the Division of Insurance.	Consolidates individual and small group market in new purchasing pool and establishes a 7 percent administrative overhead limit in the purchasing pool	Consolidates private and public health insurance's administrative functions. Potentially reduces insurance overhead and overhead associated with billing and reimbursement in hospitals, doctor's offices, and nursing homes (e.g., itemized, per-patient charges would not be needed for billing purposes).	Consolidates functions that are now being undertaken by a myriad of agencies into one agency, the Healthy Illinois Authority.	Not specifically addressed in proposer's materials.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
14.	**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**	Not specifically addressed in proposer's materials.	Establishes a Guaranteed Health Security Task Force that will be responsible for overseeing these issues.	Proposer indicates that single payer approach fosters evidence-based medicine/standards of care. Approach does not cover services that it designates as not medically necessary or ineffective.	Creates a Healthy Illinois Quality Forum that will (1) gather and disseminate information on healthcare quality and patient safety, (2) conduct research on best practices, (3) identify and promote the adoption of nationally endorsed performance measures and (4) establish incentives for consumers to adopt healthier lifestyles (e.g., full coverage of preventive care, health club discounts, smoking cessation programs).	Not specifically addressed in proposer's materials.
15.	**Methods for reducing the cost of prescription drugs both as part of, and as separate from, the health care access plan**	Not specifically addressed in proposer's materials.	Builds on Medicaid and the State Employee Health Benefits Plan, which could allow the state to consolidate drug purchases for its programs, which in turn may reduce costs due to increased negotiating power. Uses Medicaid disease management and restrictive formularies to reduce costs.	Uses a state formulary; negotiates drug and equipment prices with manufacturers; buys in bulk. Uses uniform database and electronic prescribing to guide drug prescribing.	Proposer indicates that the Healthy Illinois Authority will have the authority to negotiate prices with pharmaceutical companies.	Not specifically addressed in proposer's materials.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
16.	**Appropriate reallocation of existing health care resources**	Not specifically addressed in proposer's materials.	Uses regional and advisory task forces to address issues related to capital and network infrastructure and health professional expansion.	Use regional health planning boards to determine appropriation of funds for construction or renovation of health facilities and purchases of major medical equipment; Please refer to items 7 and 11.	Please refer to item 6.	Not specifically addressed in proposer's materials.
17.	**Equitable financing of each proposal**	To be determined. Please refer to items 73 – 75.	To be determined. Please refer to items 73 – 75.	To be determined. Please refer to items 73-75. Proposer indicates that the single payer approach spreads health care costs over the whole population and "replaces regressive sources of funding (that is, sources that make low-income and sick persons pay a higher share of their income for health care than the more affluent and healthy) with progressive funding sources (e.g., out-of-pocket funds are regressive since they disproportionately affect the sick; taxes on wages are progressive since low-income people pay less)".	To be determined. Please refer to items 73 – 75. Proposer indicates that the insurer tax ("windfall profit assessment") will capture some (but not all) of the additional profit that insurance companies would receive as a result of reduced uncompensated care under this proposal.	To be determined. Please refer to items 73 – 75.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
18.	**Recommendations concerning the delivery of long-term care services[1]**	Not specifically addressed in proposer's materials.	Proposer's plan builds on the Medicaid program and the proposer indicates that Medicaid's current long-term care reform efforts will succeed in rebalancing the long-term care system.	Proposal recommends expanding social and community-based services and integrating them with institutional care, and establishing a local public agency in each community to determine eligibility and coordination of home and nursing home long-term care. The local public agency would receive a global budget and contract with long-term care providers for the full range of LTC services. Single payer advocates have a proposal that discusses long term care (JAMA, Harrington et al. 12/4/91).	Not specifically addressed in proposer's materials.	Yes – Recommends implementation of long-term care partnership program, as allowed by the recent national budget reconciliation act.

[1] Includes: (A) those currently covered under Title XIX of the Social Security Act, (B) recommendations on potential cost sharing arrangements for long-term care services and the phasing in of such arrangements over time, (C) consideration of the potential for utilizing informal care-giving by friends and family members, (D) recommendations on cost-containment strategies for long-term care services, (E) the possibility of using dependent financing for the provision of long-term care services, and (F) the projected cost to the State of Illinois over the next 20 years if no changes were made in the present system of delivering and paying for long-term care services.

APPENDIX A: ADEQUATE HEALTH CARE TASK FORCE'S LISTING OF KEY INTERESTS

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
ACCESS						
19.	**Broadest possible coverage for largest number of people with a sustainable financing mechanism**	Proposes a population-based plan that is voluntary with the exception of college students. Financing from State tax revenue, employer tax, Federal Medicaid and SCHIP funding, individual and employer contributions and college tuition requirement.	Provides coverage options for all the uninsured. Proposes expanding public programs and encouraging enrollment. Provides voluntary coverage options for uninsured individuals not eligible for public programs. If proposed efforts do not cover all uninsured, proposes implementation of individual mandate. Financing from employer "pay or play," federal Medicaid funds and federal grants, state funds and individual cost-sharing.	Covers all the uninsured using new taxes (i.e., earmarked public funds) and existing public health care spending. Proposer indicates that single payer approach uses savings on administrative overhead to cover all the uninsured without an increase in total health spending in Illinois. Proposer also indicates that single payer system "implements proven effective mechanisms for cost containment to slow future inflation, thus making health spending sustainable over the long-term".	Proposes voluntary coverage for uninsured individuals not eligible for public programs. Funding, in part, through tax on health insurance carriers and employer and employee contributions.	Provides incentives to increase participation in private insurance and expands Medicaid and SCHIP. Financing through state general revenue in excess of three percent, savings from Medicaid managed care, and state and federal subsidies.
20.	**To remove the term "uninsured" from our vocabulary**	No, program is voluntary.	Yes – Proposes a program that in its first phase will offer health insurance access to anyone; in later phases, individual mandate to be considered only if proposed options have been implemented and a significant portion of population remains uninsured.	Yes.	No, program is voluntary.	No - Proposed market and Medicaid reforms relate to voluntary coverage.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
21.	**Universal access to maximize health and functional status**	Proposal provides access to various voluntary coverage options.	Yes – Proposes a program that in its first phase will offer health insurance access to anyone; in later phases, individual mandate to be considered only if proposed options have been implemented and a significant portion of population remains uninsured.	Yes.	No – Proposes a program that is voluntary.	No – Proposes a program that is voluntary.
22.	**To develop infrastructure to sustain the health care access that insurance should provide**	Builds on existing infrastructure: Medicaid, SCHIP, CHIP and private coverage.	Builds on existing infrastructure: Medicaid, SCHIP and private coverage. Establishes Health Professional Expansion Advisory Task Force and Capital and Network Infrastructure Advisory Task Force to address this issue.	Yes – Recommends one state-controlled insurer that would build on current Medicare infrastructure.	Builds on existing infrastructure: Medicaid, SCHIP and private coverage.	Builds on existing infrastructure: Medicaid, SCHIP and private coverage.
23.	**Enable patients' freedom of choice**	Yes.	Yes.	Yes.	Yes.	Yes.
24.	**Reduce health disparities, recognize ethnic and cultural differences, provide access to care — regardless of ability to pay or pre-existing condition**	Expands insurance options to the uninsured.	Expands insurance options for those who are not able to pay for insurance; recommends performance standards for purchasing pool to assure that the State insurance pool meets the needs of Illinois residents with chronic health conditions or a medical history of past conditions.	Expands coverage to all uninsured.	Expands insurance options to the uninsured and establishes an Illinois Quality Forum to promote nationally established best practices to reduce regional, economic and racial disparities in the health care system. Proposer indicates that the Health Resources Plan will provide a roadmap for the allocation of resources in a manner that will	Expands insurance options to the uninsured.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
					reduce disparities.	
25.	**Increase number of providers of color in areas and locations of need in the state**	Not specifically addressed in proposer's materials.	Establishes Health Professional Expansion Advisory Task Force that will develop incentives to a wide range of medical personnel to fulfill their educational degrees and training in exchange for locating in medically underserved areas.	Proposer indicates that single payer approach provides financial incentives to providers to work in underserved areas, and to residency programs to increase diversity in training programs.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.
26.	**Be flexible enough to serve different communities with different needs** *(We assume that "communities" refers to regional or local geographic areas)*	Not specifically addressed in proposer's materials.	Uses regional and advisory task forces to address issues related to capital and network infrastructure for different regional areas, and supports an educational program that includes cultural competence training and strategies to overcome language barriers. Please refer to item 25.	Proposes that each community long-term care public agency address the needs in its specific district using a single budgetary allotment. Proposer indicates that the use of separate capital budgets allows for health planning that meets community needs.	Not specifically addressed in proposer's materials.	Recommends that State encourage and fund the development of programs to help communities, employers and employees work together to access and/or maintain health insurance for small businesses on a local and regional basis (e.g. Three Share Plans in communities that wish to explore those options).
27.	**Equal treatment with no discrimination**	Continues current system of private and public coverage.	Yes – Expands current system of private and public coverage to include specific coverage for people regardless of disability and immigration status.	Yes – Creates unified system that "will not discriminate on the basis of race, religion, creed, gender, age, nationality, disability, sexual orientation, or immigration status."	Continues current system of private and public coverage. Individuals may join the Healthy Illinois Plan regardless of health status.	Continues current system of private and public coverage.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
28.	**Respect individual choices** *(We assume this refers to choices related to choice of coverage)*	Yes – Individuals receiving premium subsidies, employers participating in small employer purchasing cooperatives and college students purchasing health insurance will be able to choose among the coverage options provided by their employers or their respective universities.	Yes – the State Employee Health Benefits offers options for plans, as do most employer plans. In addition, the proposal offers new avenues for coverage through the purchasing pool and public program expansions.	Uninsured individuals would receive the coverage option designed by the Illinois Health Care Agency. Individuals could purchase "gap" coverage on the private market.	Uninsured individuals would receive the coverage option designed by the Healthy Illinois Authority.	Advocates for statutory and regulatory changes that would allow for more flexible plan design.
29.	**Provide for relief in underserved areas — both personnel and plan**	Includes increased Medicaid reimbursement and expansion of coverage to the uninsured, which could potentially increase funding to underserved areas.	Establishes Health Professional Expansion Advisory Task Force to expand the supply of medical personnel and a Capital and Network Infrastructure Advisory Task Force to assess infrastructure needs and work directly with provider and business community to develop options for improvements. Recommends targeted reimbursement rate increases for public program expansions, which could potentially increase funding to underserved areas.	Provides financial incentives to attract primary care providers to underserved areas. Distributes funding for construction or renovation of health facilities and for purchases of major equipment through state and local health planning boards. Provides training for additional primary care providers and long-term care workers. Permits the Commissioner of the Illinois Health Care Agency to adjust payments for certain types of providers or services to reflect desired changes in the allocation of health resources, which could potentially increase funding to underserved areas.	Please refer to item 26.	Please refer to item 26. Recommends using savings from implementing a true managed care Medicaid system to reimburse providers more fairly, which could potentially increase funding to underserved areas.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
30.	**Expand utilization of all health care professionals**	Not specifically addressed in proposer's materials.	Please refer to items 22, 25, 26 and 29.	Includes a health planning component that involves monitoring provider utilization and adjusting policies as needed.	Please refer to item 26. The Health Resource Plan will consider all resources, including healthcare professionals.	Not specifically addressed in proposer's materials.
31.	**Supports provider infrastructure in areas where there is a lack of providers**	Please refer to item 29.	Please refer to items 22, 25, 26 and 29.	Please refer to item 29.	Please refer to item 26.	Not specifically addressed in proposer's materials.
32.	**A plan that smoothes out transition from one plan to another**	Provides bridge loans to continue individual health coverage under COBRA and expands the State's Continuation Law. Expands Illinois Continuation Law to provide coverage for 18 months after employment ends (instead of current nine month period).	Yes – purchasing pool provides portability and expanded COBRA provides easier transition between employer-based coverage.	Not applicable, there would be only one health plan.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.
33.	**Promotes systems that allow individuals to make their own medical and financial decisions rather than government budgeting process**	Yes.	Yes.	Proposer indicates that while the single payer approach uses a government budget process it allows individuals to make their own medical decisions and receive medical care without the risk of personal bankruptcy. Patient care and the delivery of care remains mostly private; only the financing is public.	Yes.	Yes.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
34.	**A system that promotes continuity of care**	Provides various coverage options to promote continuity of care.	The Capital and Network Infrastructure Advisory Task Force will address this issue. Provides various coverage options to promote continuation of care.	Provides one coverage option for all uninsured to promote continuity of care. Lists the following quality improvement principle: "Continuity of primary care is needed to overcome provider fragmentation and overspecialization."	Provides various coverage options to promote continuity of care.	Provides various coverage options to promote continuity of care.
35.	**Protect and enhance physician-patient relationship**	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Yes -- patients can choose and change their doctors and other caregivers. Proposer indicates that the single payer approach supports the continuity of caregivers, thus enhancing the physician-patient relationship.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.
36.	**Re-energizing health facilities planning functions**	Not specifically addressed in proposer's materials.	Please refer to item 29.	Please refer to item 29.	Please refer to item 26.	Not specifically addressed in proposer's materials.
37.	**Increase education on all available coverage options**	Yes – Proposes to educate uninsured and the State about benefits and availability of coverage and proposes to increase current enrollment efforts.	Increases enrollment outreach for public programs.	There is only one major coverage option; private insurers may market "gap" coverage for uncovered services.	Not specifically addressed in proposer's materials.	Yes – Expands Division of Insurance Ombudsman program by offering a "health insurance and medical assistance decision tree" matrix.
38.	**Increased access without shifting the burden of cost**	Proposes to increase access to insurance by making insurance more available and affordable.	Proposes to increase access to insurance by making insurance more available and affordable.	Uses savings from consolidating administrative overhead in the health system to cover the uninsured.	Proposes to increase access to care by providing voluntary comprehensive coverage.	Proposes to increase access to insurance by making insurance more available and affordable.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
39.	**A plan should create incentives to encourage providers to practice in underserved areas and with special populations**	Please refer to item 29.	Please refer to items 25 and 26.	Uses financial incentives to attract primary care providers to work in underserved areas. Proposer indicates that the single payer approach shifts graduate medical education funds to adjust mix of training programs to train more primary care providers.	Please refer to item 26.	Not specifically addressed in proposer's materials.
40.	**Creating health care delivery system that aligns the incentives of the patients, physicians/ providers and payers**	Not specifically addressed in proposer's materials.	Proposer indicates that the Guaranteed Health Security Task Force will address this issue.	Proposer indicates that the single payer approach "keeps ("aligns") physicians on the side of patients as their advocates within the delivery system". Use of global budgets for provider payment could create tensions between providers and patients and statewide authorities.	Will include incentives to reward provider performance.	Not specifically addressed in proposer's materials.
41.	**Government must play a role for any system, with no one able to opt out — everyone in**	Proposes a voluntary program, except for college students; includes expansion of public programs.	Yes – Proposes a public/private partnership. If proposed efforts do not cover everyone, then individual mandate (with consumer protections) will be implemented.	Yes – involves public financing of a mostly private health delivery system.	Proposes a voluntary program with government involvement.	Proposes a voluntary program with government involvement.
42.	**Create a tipping point in the U.S. by ensuring health care for all residents**	No.	Yes – If proposed efforts do not cover everyone, then individual mandate will be implemented and all residents will have access to health care.	Yes - Proposer indicates that the single payer approach could "inspire courage to tackle other domestic problems and unite people across social spectrum".	No – Plan is voluntary.	No.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
BENEFITS						
43.	**Plan must include rehabilitation services and services for the developmentally disabled** *(New interest from May 26, 2006 meeting)*	Rehabilitation services and services to the developmentally disabled might be included depending on pricing of safety net benefit packages. Includes an expansion of Medicaid, which covers rehabilitation services and services for the developmentally disabled.	Includes an expansion of Medicaid, which covers rehabilitation services and services for the developmentally disabled.	Yes.	Not specifically addressed in proposer's materials.	Includes an expansion of Medicaid, which covers rehabilitation services and services for the developmentally disabled.
44.	**Include dental benefits**	Included in Medicaid and SCHIP expansion. Not included in safety net benefit package proposed for employer-based initiatives Employer Sponsored Insurance (ESI) Initiative and Small Employer Purchasing Cooperative (SEPC), but could be purchased for an additional fee.	Yes – Recommends expanded dental and vision benefits for adults in public program options and includes dental benefits for those in purchasing pool since they will receive State Employee Benefit Plan.	States that system would cover all medically necessary services including dental benefits.	Not specifically addressed in proposer's materials.	Not addressed through private insurance expansions and not clear if the Medicaid expansion to single childless adults would include dental benefits.
45.	**Mandated education on end of life care and incentives for individuals to have living will**	Not specifically addressed in proposer's materials.	Prevention and Health Education Advisory Task Force would address this issue.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.
46.	**Funding parity for mental health services**	Mental health and substance abuse services might be included depending on the pricing of the	Expands number of people with both Medicaid and State Employee Health Benefit Plan coverage. Both	Yes -- Covers all medically necessary services including mental health and substance abuse	Benefit package covers mental health services; additional details not specifically	Not specifically addressed in proposer's materials.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
47.	**Mental health services should include substance abuse services** (*New interest from May 26, 2006 meeting)*	safety benefit package.	plans include mental health services.	services, and medications.	addressed in proposer's materials.	
48.	**Mental health parity**					
QUALITY OF CARE						
49.	**Single standard of care for all citizens in Illinois**	No.	Proposer establishes an annual report on quality control measures by the Illinois Department of Public Health to the newly established Guaranteed Health Security Task Force.	Creates a unified system that does not treat patients differently based on employment, financial status or source of payment.	No - but creates a Healthy Illinois Quality Forum that will promote nationally established best practices to reduce regional, economic and racial health care disparities.	Supports evidence-based care for providers and health information technology and infrastructure needed to reduce treatment variation.
50.	**Preserve the ability of physicians and other providers to provide best care possible to patients and populations**	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Yes (within budgetary constraints) – Proposal states health care must be guided by the precepts of Continuous Quality Improvement.	Develops incentives to encourage the adoption of performance measures, but does not mandate the adoption of such measures.	Not specifically addressed in proposer's materials.
51.	**A plan that provides culturally competent- quality care**	Not specifically addressed in proposer's materials.	Creates a Prevention and Health Education Task Force that has an educational program that includes cultural competence training and strategies.	Please refer to item 39.	Please refer to item 24.	Not specifically addressed in proposer's materials.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
52.	**Foster best practices by research, education and incentives**	Not specifically addressed in proposer's materials.	Establishes Technology Development Advisory Task Force that will address this issue.	Please refer to items 4, 9 and 39 on Continuous Quality Improvement, etc. Proposer indicates that the single payer approach "counters drug industry dominance of physician prescribing with data, formulary, and electronic prescribing".	Please refer to item 4.	Not specifically addressed in proposer's materials.
53.	**Continued medical innovation**	Not specifically addressed in proposer's materials.	Establishes Technology Development Advisory Task Force that will propose improvements for, among other things, medical advances.	Proposal continues National Institute of Health and Agency for Healthcare Research and Quality Agency for Healthcare Research and Quality initiatives. Proposer indicates that single approach supports more sophisticated outcomes research on new processes of care, drugs, procedures, and those areas of greatest need and potential for true break-through guide investment in innovation. Proposer indicates that the single payer approach will detect unsafe drugs faster.	Please refer to item 4.	Not specifically addressed in proposer's materials.
54.	**Use some predictive aspects of care, for example, genomes**	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
55.	**Health literacy**	Not specifically addressed in proposer's materials.	Establishes a Prevention and Health Education Advisory Task Force that will develop a multi-faceted disease prevention and health education program.	Not specifically addressed in proposer's materials.	The Healthy Illinois Quality Forum will develop programs to promote healthier lifestyles.	Promotes consumer involvement in health care decisions.
56.	**Alleviate need for defensive medical practices**	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Proposer indicates that the single payer approach allows for timely care and continuity of caregivers which fosters improved quality and reduces malpractice. Proposer indicates that the approach eliminates lawsuits for future medical expenses.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.
57.	**Supports medical education and medical research**	Not specifically addressed in proposer's materials.	Establishes Technology Development Advisory Task Force and the Health Professional Expansion Advisory Task Force that will address this issue.	Proposer indicates that proposal provides financial support for medical education, especially in the area of primary care.	Please refer to item 4.	Not specifically addressed in proposer's materials.
58.	**Encourage best personal practices for personal health**	Not specifically addressed in proposer's materials.	Establishes Prevention and Health Education Advisory Task Force that will oversee this issue.	Supports the development of preventive health programs through the global budgeting approach, which eliminates the need to attribute and bill these costs to individual patients.	Establishes incentives for consumers to adopt healthier lifestyles – e.g., health club discounts and full coverage of preventive care.	Encourages patients to become more engaged through use of consumer-engaged plans (including Health Savings Accounts); collects and disseminates cost and quality information to consumers; improves health care literacy.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
59.	**Eliminate preventable error**	Not specifically addressed in proposer's materials.	Establishes Technology Development Advisory Task Force that will consider improvements in data collection, quality of care and patient safety that will promote efficiencies.	Proposal contains several quality principles that, if successfully implemented, could potentially reduce preventable errors. Proposal includes electronic medical record, lab results and prescribing to reduce preventable errors. Approach includes feedback to providers on how their practices compare to the practices of others (from uniform database) in an effort to reduce provider errors.	Not specifically addressed in proposer's materials, although proposal includes a Healthy Illinois Quality Forum that will promote nationally established best practices and recommended measures that all Illinois providers should adopt.	Supports the adoption of health information technology and related infrastructure to improve quality and patient safety.
60.	**Maximize the value by encouraging all participants to efficiently use the system**	Includes individual cost-sharing provisions.	Includes individual cost-sharing provisions; additional information not available in proposer's materials.	Proposer indicates that the approach improves and expands primary care, targeting "the most efficient providers". Proposer indicates that specialists have incentive to see patients referred by primary care doctors, but does not provide specific information on those incentives. Proposal includes a database to identify physician outliers.	Not specifically addressed in proposer's materials, although proposal promotes establishing incentives for consumers to adopt healthier lifestyles.	Please refer to item 56.
61.	**Increased personal responsibility**	Not specifically addressed in proposer's materials.	Yes – If proposed efforts do not cover everyone, then individual mandate (with consumer protections) will be implemented. Individual cost-sharing may increase personal responsibility.	Proposal's prevention and public health initiatives could potentially increase individual self-care and wellness.	Not specifically addressed in proposer's materials.	Please refer to item 56.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
62.	**Use purchasing power to negotiate better health costs (especially pharmacy, etc)**	Obtains savings through increased group purchasing and reforming the insurance market, which could allow State and private market to further consolidate drug purchases.	Builds on Medicaid and the State Employee Health Benefits Plan, which could allow the State to consolidate drug purchases and other purchases for it programs.	Obtains savings through bulk purchasing, negotiated fees, global budgets, streamlined administration, health planning, etc.	The state will negotiate directly with providers and may negotiate with pharmaceutical companies.	Not specifically addressed in proposer's materials.
PREVENTIVE MEDICINE						
63.	**Recognize the value of clinical and community preventive services**	Yes – please refer to items 1-3.	Please refer to items 1-3, 53.	Yes (within budgetary constraints) – Emphasis on prevention and timely primary care, see items 1-3.	Includes preventive care in benefit package and does not apply co-payments or deductibles for these services; establishes incentives for consumers to adopt healthier lifestyles – e.g., health club discounts and full coverage of preventive care – Please refer to items 1-3.	Please refer to items 1-3, 53.
64.	**A plan that focuses on prevention and health as well as health care**					
65.	**Eliminate preventable disease and disability**	Safety net benefit package will offer the uninsured preventive care and reflect core components of basic major medical protection.	Please refer to item 53 and 57.	Uses population-based data to guide prevention, public health and planning.	Please refer to items 63 -64.	Not specifically addressed in proposer's materials.
66.	**Reward wellness**	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Proposer indicates that full coverage of primary care and prevention encourages and rewards wellness with good health outcomes for patient and family.	Establishes incentives for consumers to adopt healthier lifestyles – e.g., health club discounts and full coverage of preventive care.	Uses Health Savings Accounts for some populations.

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CAPITAL AND TECHNOLOGY						
67.	**To incentivize use of electronic medical records and health information technology — to improve efficiency and quality of care**	Not specifically addressed in proposer's materials.	Establishes a Technology Development Advisory Task Force that will undertake a systematic assessment of technological weaknesses and inefficiencies and proposes improvement for quality of care, patient safety and other medical and education advances.	Yes – provides all practitioners with electronic medical record software (i.e., VISTA) for no cost with electronic lab results and prescribing. Proposer indicates that unified database will permit advanced health services research to improve efficiency and quality. Proposer indicates that the United Kingdom, Canada, Australia and other single payer systems exceed the United States in information technology investment.	The Healthy Illinois Quality Forum will collect and disseminate examples of effective uses of electronic technology for such things as medical records and physical order entry.	Proposes acceleration of the adoption of health information technology and establishes a health information technology (HIT) infrastructure to improve quality, patient safety and efficiency, to reduce treatment variation, base more reimbursement on pay-for-performance and improve health literacy.
PROVIDER REIMBURSEMENT						
68.	**Fair payment to providers to assure increased access to care**	Please refer to item 12.	Please refer to item 12.	Includes negotiated fees, simplified billing and rapid payment. Please refer to item 12.	Please refer to item 12.	Please refer to item 12.
69.	**Address deficiencies in timeliness of payment and fee schedules to ensure access to care**	Requires that adequate reimbursement rates must be offered to health care providers by state programs, including Medicaid, to address access issues.	Recommends study of targeted provider reimbursement rate increases, medical school repayment options and increased funding for public health districts, community health centers, free clinics and other safety net providers.	Approach uses fees that are comparable to those of Medicare and Blue Cross PPOs and provides rapid payment. Proposer indicates that this approach will substantially reduce overhead for physicians and that net incomes for physicians in primary care will rise. Proposer indicates that physicians with Medicaid patients	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
				will see incomes rise.		
ROLE OF PRIVATE MARKET						
70.	**Less government — more flexibility**	Continues public/private insurance programs.	Continues public/private insurance programs.	Provides individual with choice of any doctor or hospital. Provides less flexibility for private insurers, who are prohibited from participation outside of "gap" coverage. Delivery system remains mostly private. Proposal includes tax-based financing and government administration.	Like the state employee health insurance program, the Healthy Illinois Plan will be a self-funded insurance plan that contracts with one or more private third-party administrators.	Continues public/private insurance programs.
71.	**Preserve and expand private sector options**	Yes – Builds upon private insurance offerings.	Yes – Builds upon private insurance offerings.	No – Neither preserves nor expands insurance administration. Requires that investor-owned, for-profit hospitals and nursing homes to non-profit status (owners are paid a reasonable fixed rate of return on existing equity). Proposer indicates that private, non-profit delivery of care may expand, replacing some current public delivery (e.g., county hospital).	Impact is varied – may reduce the potential for new insurance offerings for small businesses, but supports employer-based health insurance.	Yes – Builds upon private insurance offerings.
72.	**Universal access to health care that maximizes private sector options**	Not universal, but identifies and fills gaps in the current system with a combination of public and private sector options.	Yes – Uses a variety of new and expanded private and public sector options.	Please refer to item 71.	The Healthy Illinois Plan would be a self-funded plan administered by one or more private insurance companies.	Not universal, but attempts to identify and fill the gaps in the current system with a combination of public and private sector options.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
73.	**Finance progressively so it is fair and affordable to individuals and businesses**	Uses general state tax revenues and increased employer and employee contributions that do not vary based on income unless the employee is below 200 percent of the federal poverty level. These employees may receive vouchers for a portion of their premiums.	Involves employer contributions, individual contributions, federal grants, state funding and Medicaid funding. Includes a cap on total out-of-pocket costs for people below 300 percent of the federal poverty level, and also provides subsidies for individuals, sole proprietors and small businesses.	Retains 60 percent of health funding that is financed by taxes. Replaces "regressive" sources of funds (premiums by individuals and business; out-of-pocket payments) with "progressive" sources, such as payroll taxes. Please refer to item 17.	Uses employer contributions, individual contribution and windfall profit assessment.	Uses federal and state tax subsidies, tax credits to individuals and small employers, more flexible benefit mandates; eliminates state premium taxes on high-deductible health plans.
74.	**Financed in a real way — no smoke and mirrors**					
75.	**Private/public financing**					
76.	**Finance expenditures and income through a government single payer system**	No.	No.	Yes.	No.	No.
77.	**Plan should incorporate proper load sharing between providers, insurers, state government and patient/taxpayers**	Please refer to items 71-75.	Please refer to items 71-75.	Please refer to items 71-75.	Please refer to items 71-75.	Please refer to items 71-75.
78.	**To reconnect consumer of health care to its true cost, and their personal responsibility for positive outcome**	Yes – Includes individual cost-sharing, which connects consumers to the cost of their own health care with limits for those who cannot afford to pay.	Yes – Includes individual cost-sharing, which connects consumers to the cost of their own health care with limits for those who cannot afford to pay.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Limited – Uses Health Savings Accounts for some populations.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
ADMINISTRATION AND IMPLEMENTATION						
79.	**Create one reimbursement form**	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Yes.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.
80.	**Reduced overhead costs**	See item 13.	Recommends an administrative overhead limit for the purchasing pool of no more than 7percent.	Yes.	Not specifically addressed in proposer's materials.	Proposes reduction in excessive, unnecessary regulation and litigation, but does not provide details.
81.	**Be cognizant of budgetary pressure**	Yes – Recognizes the need for significant financing and the need to adjust coverage approaches in light of budgetary constraints.	Yes – Recognizes the need to analyze various cost-sharing, reinsurance and other components in light of budgetary constraints.	Yes – Uses global budgets.	Yes – Establishes a new and dedicated funding stream.	Yes — Promotes increased use of managed care and coverage approaches that make consumers more aware of health care costs (i.e., Health Care Accounts).
82.	**Simplify administration**	No.	Provides opportunity for State to consolidate administrative function due to ICHIP expansion, Medicaid expansion, and Purchasing Pool.	Yes.	Consolidates into one agency, the Healthy Illinois Authority, functions that are now currently fulfilled by various agencies.	No.
83.	**Simplify coverage options**	No.	No.	Yes.	Proposer states that for small businesses, Healthy Illinois will be the most affordable plan on the market that provides comprehensive benefits.	No.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
84.	**A plan that is implementable**	Builds on current infrastructure.	Builds upon current public and private insurance, establishes Regional and Advisory task forces.	Establishes a State office to administer the plan, builds on infrastructure developed by Medicare and quality improvements and electronic medical record developed by the Veteran's Administration.	Builds on current infrastructure. Through the state employee health insurance program, the state has already shown that it can establish and maintain a self-funded insurance plan.	Suggests building upon current insurance mechanisms.
OTHER						
85.	**Minimize conflicts of interest – i.e., third-party self-referral**	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.
86.	**Having a consensus plan**	To be determined, states that the proposal has been "crafted based on today's economic, political and insurance environment".	To be determined; however attempts to balance approaches from across the political spectrum, balance public and private mechanisms and balance financial responsibility among individuals, employers, states and federal government.	To be determined.	To be determined.	To be determined.
87.	**Plan should be politically and economically pragmatic**					
88.	**Plan has chance of being implemented politically** *Note – new interest from May 23, 2006 meeting*	To be determined.	To be determined.	To be determined.	To be determined.	To be determined.

	Interest	Illinois Hospital Association	Campaign for Better Health Care and Health and Disability Advocates	Single Payer	Healthy Illinois	Selected Insurance Industry TF Members
89.	**Solution that's bold enough to question the status quo — if that status quo is not in the best interests of society as a whole**	Builds upon "status quo" and develops new approaches for expansion of access to health care.	Builds upon "status quo" and develops new approaches for expansion of access to health care and cost containment measures.	Yes.	Proposer states that Healthy Illinois is an integrated framework that focuses, *simultaneously*, on costs, access and quality.	Builds upon "status quo."
90.	**Globally responsible**	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.	Proposer indicates that proposal is in agreement with International Declaration of Human Rights.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.
91.	**Health care system is part of a larger culture and economy**	Not specifically addressed.	Uses advisory task forces; focuses on connections between health care system and larger culture and economy.	Yes.	Not specifically addressed in proposer's materials.	Not specifically addressed in proposer's materials.
92.	**Plan must include population health as well as individual health** *(New interest from May 23, 2006 meeting)*	Not specifically addressed in proposer's materials.	Establishes a Prevention and Health Education Advisory Task Force that will address this issue.	Yes.	Proposed Health Resource Plan and Healthy Illinois Quality Forum provide macro-level approaches to health improvement.	Not specifically addressed in proposer's materials.

Appendix B: Adequate Health Care Task Force's Evaluation Criteria

APPENDIX B: ADEQUATE HEALTH CARE TASK FORCE'S EVALUATION CRITERIA

Criteria	Weight	Evaluation Topics	Scoring	Other Considerations
1. Access – Provides access, regardless of employment or health status, to all Illinois residents; provides portability, no matter employment status	**15.0**	a) Provides access to all Illinois residents b) Mandates access c) Includes provisions to avoid crowd-out of private insurance d) Includes provisions for portability, i.e., individuals maintain access as life circumstances (e.g., employment, transition from Medicaid, etc.) and health status change	**Maximum Points: 10** a) Score 1-5, 5 represents access to all residents b) Score 1 if access is mandatory c) Score 1-2 for provisions to avoid crowd-out of private insurance d) Score 1-2 for provisions for portability	• If individuals/groups are excluded, what is the reason for their exclusion? • Does the proposal suggest the use of copays/deductibles that could limit access to services? • Does the proposal address issues related to language or cultural barriers or geographic distances?
2. Financing –Financed progressively so the proposal is broad-based, fair and affordable to individuals and businesses	**15.0**	a) Finances additional costs through an approach that incorporates proper load-sharing between providers, insurers, state government and patient/taxpayers b) Maximizes federal funds c) Enhances affordability for small employers	**Maximum Points: 9** a) Score 1-5 for approaches that spread burden of costs across providers, insurers, state and federal government and taxpayers. b) Score 1-2 for approaches that maximize federal funds c) Score 1-2 for features that enhance affordability for small employers	• What is the cost of the program to each of those parties bearing some of the burden (i.e., who are the winners and losers)? What stakeholders bear the largest burdens, in relationship to the status quo? How are these costs financed? • To what extent is the option funded by public vs. private funds? • Whose health care services are subsidized by government and whose are not? How are subsidies determined (i.e., do the more needy get larger subsidies)?

APPENDIX B: ADEQUATE HEALTH CARE TASK FORCE'S EVALUATION CRITERIA

Criteria	Weight	Evaluation Topics	Scoring	Other Considerations
3. Benefit Package – Provides a full range of preventive, acute, and long-term heath care services that maximize health and functional status for all Illinois residents	**15.0**	a) Provides full range of benefits specified in the Health Care Justice Act: 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	**Maximum Points: 10** a) Score 1 – 10 for services offered	• Is the proposal flexible to serve different communities with different needs? • Are there proposals to revise mandated benefits? • Does the proposal contain policies that would reduce preventable disease and disability?

Criteria	Weight	Evaluation Topics	Scoring	Other Considerations
4. Implementation – Plan is economically and politically feasible	**7.0**	a) Legal and regulatory changes required to implement the proposal can be accomplished within 1-3 years b) Federal waivers, if required, can be implemented within 1-3 years c) Includes provisions for a reasonable phase-in period that does not cause significant disruptions for employers or consumers d) Includes accountabilities for ongoing performance, cost and quality	**Maximum Points: 15** a) Score 0-5 for ability to obtain legal and regulatory approvals that are necessary for implementation b) Score 0-5 for feasibility in obtaining federal waivers c) Score 0-3 for reasonable phase-in approaches and timelines d) Score 0-2 for features that assure accountabilities related to ongoing performance, cost and quality	• Are there provisions for phasing in the approach? Is the rate of implementation feasible? What are the implementation challenges? • What level of disruption is created for employers who are currently providing benefits? • Does the proposal require federal waivers? How likely is it that the State can obtain these waivers? • What effect will implementation have on labor markets, employment levels and composition in affected business entities and government?
5. Quality – Maintains and improves the quality of health care services offered to Illinois residents	**7.0**	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) b) Promotes integration and coordination among parts of the delivery system	**Maximum Points: 2** a) Score 1 for incentives to improve quality b) Score 1 for provisions that promote coordination within delivery system	• What is the potential effect on quality of care? • Does the proposal provide culturally competent quality care?

APPENDIX B: ADEQUATE HEALTH CARE TASK FORCE'S EVALUATION CRITERIA

Criteria	Weight	Evaluation Topics	Scoring	Other Considerations
6. Cost-efficiency – Provides incentives for cost containment measures, keeping costs under control to promote sustainability of programs	**7.0**	a) Controls growth in overall and per capita expenditures for health care: ➢ Health insurance premiums ➢ Public program expenditures ➢ Capital ➢ Technology ➢ Administrative costs ➢ Prescription drugs ➢ Others 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	**Maximum Points: 12** a) Score 0-10 for features that control growth in expenditures b) Score 0-2 for mechanisms that take into account standards of care in establishing spending priorities	• Does the proposal promote efficient use of resources? • Does the proposal encourage efficient use of the system by all participants (e.g., alleviates need for defensive medical practices)? • Does the proposal build in managed care features (care coordination, case management, disease management, etc.) that are demonstrated to control costs and improve quality? • Does the proposal include provisions that would allow insurers, State government, health plans, etc. to negotiate prices for health care services? • Does the proposal incentivize the use of electronic medical records and health information technology to improve efficiency? • Are health plans mandated to participate in some purchasing arrangement? • Does the proposal contain provisions that would produce market distortions or inefficiencies? • Does the proposal include recommendations that are efficient and economically feasible?

APPENDIX B: ADEQUATE HEALTH CARE TASK FORCE'S EVALUATION CRITERIA

Criteria	Weight	Evaluation Topics	Scoring	Other Considerations
7. **Availability of Resources, Capital and Technology –** Addresses issues related to infrastructure and adequacy of providers and safety-net system; considers for funding of new technologies, capital expansions	**5**	a) Includes provisions for new capital, technology, medical education, research b) Includes provisions to protect and enhance, where necessary, the safety-net system	**Maximum Points: 6** a) Score 0-4 for features that address expenditures for new capital, technology, medical education and research b) Score 0-2 for features that protect and enhance the safety net system	• Does the proposal provide options for relief in underserved areas? • Does the proposal create incentives to use all types of health care professionals? • Does the proposal increase the number of providers of color in areas and locations of need in the State? • How will determinations be made regarding expenditures for capital expansions, new technologies, etc.? • Does the approach rely on a health facilities planning function? • Does the proposal appropriately reallocate existing health care resources? • Does the proposal contain supports for medical education and research?
8. **Prevention and Wellness –** Contains provisions that would reward individuals who follow best personal practices for personal health	**10.0**	a) Includes incentives that reward individual wellness b) Contains policies to promote continuity of care	**Maximum Points: 2** a) Score 1 for wellness incentives b) Score 1 for policies to promote continuity of care	• Does the proposal provide provisions to educate consumers about health care decisions (e.g., obtain results of quality studies)?

Criteria	Weight	Evaluation Topics	Scoring	Other Considerations
9. Consumer and Stakeholder Participation – Encourages regional and local consumers, providers, employers and other stakeholders will participate in decisions regarding coverage, resources and financing	**2.5**	a) Provides consumers (and their advocates) with opportunities to participate in program design at both the local and regional level	**Maximum Points: 3** a) Score 1-3 for opportunities for consumer input regarding technologies, capital and program design :	• Does the proposal allow health care to be purchased locally, or are decisions made by the State through a public model? • Does the proposal contain provisions for consumers to participate in policy making regarding technologies and capital?
10. Consumer Autonomy –Retains consumer freedom of choice among providers, provider networks and health plans	**4.0**	a) Provides consumers with choices of health plans and provider networks	**Maximum Points: 1** a) Score 1 for provisions that provide consumers with choices related to health plans and provider networks	• Does the proposal provide for acceptable level of control over consumers, employers, providers and health plans? • Do consumers have the opportunity to consider various options regarding service delivery, e.g., fee-for-service vs. health maintenance organization (HMO) options? • Does the proposal contain provisions for providing education to consumers, providers, employers and other stakeholders on all available coverage options?
11. Provider Autonomy – Protects provider-patient relationships	**2.5**	a) Preserves providers' clinical autonomy	**Maximum Points: 1** a) Score 1 for provisions that promote provider autonomy in caregiving practices	

Criteria	Weight	Evaluation Topics	Scoring	Other Considerations
12. Provider Payment – Promotes fair payment to providers to promote access to care	**10.0**	a) Addresses current deficiencies in timeliness of payment and fee schedule issues that might affect access to care (relates to State programs) b) Reduces administrative burdens on providers	**Maximum Points: 4** a) Score 0-2 for provisions related to improved timeliness of payment and fee schedule issues b) Score 0-2 for provisions that reduce administrative burdens on providers	

Appendix C-1: Competition and Flexibility Key to Quality, Accessible Health Care in Illinois – A Minority Report in Dissent from the Majority Recommendation of the Illinois Adequate Health Care Task Force

Competition and Flexibility Key to Quality, Accessible Health Care in Illinois – A Minority Report in Dissent from the Majority Recommendation of the Illinois Adequate Health Care Task Force

The members of the Adequate Health Care Task whose signatures appear at the conclusion of this document do hereby dissent from the majority which has approved the final Hybrid Model Plan for consideration by the Governor and the Illinois General Assembly. We submit this Minority Report to express our deep concern regarding the provisions and recommendations contained in the majority- approved plan and the quality of the underlying data upon which those recommendations are based.

This minority report asserts that the plan advanced by the Adequate Health Care Task Force will, if implemented, increase health care costs, reduce consumer choice of health care coverage, have a negative effect on the quality of health care provided to the citizens of Illinois and restrain job growth.

I. Overview –

In August, 2004, the Illinois General Assembly passed the Health Care Justice Act, creating the Adequate Health Care Task Force under the banner of one worthy and ambitious goal: "It is a policy goal of the state of Illinois to ensure that all residents have access to quality health care at costs that are affordable." As members of the insurance and employee benefits industries, we were pleased to be invited to participate in the process, and we were impressed with the commitment of the General Assembly and the Department of Public Health to develop a fair and workable process. Today, after two years, one million dollars in taxpayer funds and hundreds of volunteer hours, the Task Force delivers its report back to the General Assembly. **Unfortunately, it is the opinion of the undersigned that the report jeopardizes the very goal articulated in the Act.**

It is important to note that the terms "health care" and "health insurance" have become virtually – and incorrectly - interchangeable in the public mind. Unfortunately, this false belief has served to cloud many of the issues related to reform of America's health system and covering the uninsured. In fact, this distinction is not clear in the recommendations of the Task Force nor was it clear during our deliberations. One of the guiding principles of our minority report and our recommendations to the Task Force is that health insurance is expensive because health care is expensive. **Sadly, the Task Force recommendations do absolutely nothing to address these costs. And, the recommended Hybrid Plan will add to administrative complexity – and costs – for employers, insurers and the State of Illinois.**

When considering the uninsured, this background cannot be ignored. Many people are uninsured because health care services are expensive. Illinois has one of the most competitive health insurance markets in the country. This helps keep administrative costs in check while providing consumers with dynamic and innovative health insurance products.

It must be said that we believe the Task Force did much valuable work. The public hearing process, where Illinois citizens were given the chance to express their strong views about our health care system, was eye-opening – often movingly so.

Throughout this minority report, we will outline our strong concerns regarding the process; the data and facts used – or ignored – during deliberations; specific concerns with the Task Force recommendations; and our suggestions for a more workable solution. We urge members of the Illinois General Assembly to reject the Task Force proposal, and we offer our assistance in developing real policy solutions that will fulfill the Health Care Justice Act's goal of increased access to quality care at costs that are affordable.

II. Process Concerns

Legislative

- The Illinois Health Care Justice Act was passed in 2004. The Act was initially drafted to move Illinois to a single-payer, government run health care system. As the bill was amended, the creation of the task force was added. However, the goals articulated in the Act directed the outcome to one that would rely heavily on an expansion of government to fully meet the goals enumerated in the Act.
- The task force was not appointed for more than one year after the Act was passed into law. During this year, consumer-directed health care, a movement to engage consumers more actively in health care decision-making, was gaining ground across the nation. It is likely that a Health Care Justice Act considered in 2005 would have taken a different approach to the problem of the uninsured.

Organizational

- The task force was appointed by each of the Legislative Leaders and the Governor. This structure was transplanted to the organizational structure of the task force. This was especially constraining given the development of a Steering Committee to direct the task force's efforts. Only one member appointed by each of the appointing authorities was allowed on the Steering Committee.
- Most of the meetings of the task force were conducted as a committee-of-the-whole limiting dialogue and input.
- Meeting topics and presenters were biased in favor of government expansion proposals. Private sector alternatives and considerations were only considered after they were demanded by the signers of this minority report.

Operational

- Discussion of critical issues was severely limited by the structure of the meetings. Meetings were almost exclusively seminars on different aspects of the health care system and discussion was limited.
- Critical issues that became embedded in the consultants' analysis were not discussed by the task force or were not determined by task force members. There was little discussion or attempts to reach agreements on the critical issues of employers mandates, individual mandates, measures to control health care costs, the role of government in providing and paying for health care and problems or opportunities with Medicaid.
- Most votes taken by the task force were articulated as straw polls. These straw polls were then used to determine the direction of the proposals. Few votes were recorded votes.
- The Steering Committee made decisions regarding analysis and development of proposals that did not reflect votes of the task force. The consultants were instructed to pursue development solely of the hybrid plan alternative despite desires by task force members to continue consideration of all proposals.

Analytical

- The consultants made decisions regarding relative importance of issues that had not been determined by the task force. Proposals were weighed against these consultant-derived standards. Example: Proposals were assessed for "proper load-sharing" a term that was neither defined by the task force nor by the consultants.
- Consultants ignored facts and statistics that conflicted with their world view. These facts were supported by multiple and reliable sources. They were unwilling to incorporate these facts into their analysis as an addition to their own data. The most egregious evidence of this was the use of administrative costs in both the public and private health care sectors that were sharply divergent from multiple alternative sources.
- Consultants consistently used data external to the state of Illinois even when data specific to Illinois was available and more valid. Illinois' health care and insurance markets are distinctly different from Maine, Massachusetts or New York, for example.
- Consultants did not provide any econometric analysis to support their recommendations or analysis. Recommendations to greatly increase the state's spending for health care or those to require businesses to shoulder a dramatic increase in costs should only be considered in tandem with possible outcomes.

III. Specific Concerns Regarding the "Hybrid" Plan Adopted by the Task Force

- The proposed hybrid model expands government through the employer system. The hybrid model also proposes significant cost increases from the employer community to pay for the changes. Employer fees or taxes are estimated to

increase by $1.5 billion with nearly $3.6 billion in additional spending from funding sources that have not yet been identified.

- The Hybrid Model fails to include options to engage consumers in the use of the health care system utilizing the recently enacted federal laws regarding Health Savings Accounts (HSAs). While these plans call for high deductible health plans in order to qualify for the tax-favored HSAs, they have been well-received by people who had been uninsured. More importantly, these plans are undergoing almost constant change with new provisions enacted in December, 2006 that are expected to make these plans even more attractive and cost-effective alternatives.

- The Hybrid Model seems opposed to the creation of plans that focus on wellness and consumer choice. The Hybrid Model provides very little insight as to how cost containment is addressed. The Hybrid Model's recommendations of "guaranteed" issue for insurance coverage and dramatic reductions in the small group rating bands arguably remove any incentive for individuals to engage in wellness behavior. These proposals in particular fail to encourage employees to practice more healthy lifestyles, which is an essential part of reducing the need for remedial heath care treatment and services and thus the cost of health care. The Hybrid Model uses the private sector as a smokescreen to accomplish dramatic increases in government intervention into the system of employer-provided health care benefits. By requiring a specific amount to be spent by an employer on health care benefits and defining a "standard health care benefit package", innovation and cost-effectiveness will be diminished. Employer needs for flexibility and innovation have driven plan design, and have proven to be more cost effective methods of providing health care benefits.

- While the Hybrid Model purports to spread the "pain" to all parties, the employer community is responsible to shoulder the bulk of the costs, to the tune of $1.5 billion in new fees or taxes for employers. Employers will likely also be called upon to pay for the lion's share of the $3.6 billion for which the Hybrid Model fails to provide funding. The plan does nothing to address health care costs or affordability. Rate restrictions are imposed on private insurers, but there are no cost-containment measures on the provider side. Cost containment needs to be spread across all participants in the healthcare industry, not just one constituent. Premium subsidies will help reduce employees' share of the cost of coverage, but do nothing to reduce the overall cost of coverage. Unless the subsidies are large enough to make coverage truly affordable, they will do nothing to increase employee participation.

- "Risk spreading strategies" such as the creation of a state-sponsored self-insured plan fail to spread risk and discourage innovation in the private sector. What incentive does a private plan have to provide guaranteed issue products if a state self-insured plan exists? What appeal is there for consumers to buy into a plan that relies on Medicaid providers and rates? Higher reimbursement rates are probably not enough to get more providers on board, creating access problems that would not exist under a private plan. The social stigma imposed by Medicaid may further limit consumer interest.

- The voluntary nature of the reinsurance program is counterproductive. A voluntary program provides no guarantees that an adequately- funded reinsurance program will exist, so carriers cannot base rate determinations on the assumption that reinsurance will act as stop-loss coverage. Without a reinsurance program, higher risk consumers will remain in the general insurance pool, preventing carriers from lowering rates. A plan- funded reinsurance program would have to create significant savings for carriers in order to make it worth participating in the program.

- The authors of this minority report do not support the individual mandate included in the Task Force's recommended plan. If health insurers are allowed to develop innovative, affordable products and to educate consumers on the value of health insurance, the authors believe that market forces will reduce the number of uninsured Illinois residents as an example, in 2004-2005, private insurance carriers provided new individual health insurance policies to 753,000 people across the country who previously had been uninsured.

- Given the number of state mandated benefits currently required in Illinois, the authors of this minority report are concerned that "affordable" products may not be available to every individual in Illinois. Further, because the proposed penalty on individuals who do not obtain coverage is minimal, it may not be an effective means of ensuring that every individual obtains health insurance coverage.

- The authors oppose the play-or-pay mandate on employers contained in the plan being recommended by the Task Force. Such mandates create a perverse incentive for small employers to escape compliance with the mandate through various means such as reducing wages, hiring independent contractors instead of full-time employees, or reducing the size of their workforce below the threshold for the mandate. As an alternative, the authors of this minority report support federal tax credits to encourage small employers to offer coverage to their workers.

- The play-or-pay mandate on employers also likely violates The Employee Retirement Income Securities Act (ERISA), the federal law that regulates voluntarily established employee benefit plans in the private market, including health care. The mandate requires employers to maintain a minimum plan of benefits, or face penalties. The sample assessment used in the 7th version of the Updated Coverage Expansion Model put forth by the Adequate Health Care Task Force would require employers to contribute at least 4.8 percent of payroll for their Illinois employees. These are the same type of legal requirements imposed on employee welfare benefit plans that were struck down by the Maryland federal district court in the recent legal challenge to the Maryland Fair Share Health Care Fund Act (also known as the Maryland "Wal-Mart" law, for its principal effect upon Wal-Mart.).[1]

  The Maryland law imposed several requirements on non-governmental employers of 10,000 or more people in that state. It required a for-profit employer failing to spend up to 8% of the total wages paid to employees in the state on health insurance costs to pay to the state an amount equal to the difference between what the employer spent for health insurance costs, and the 8% of total wages paid to Maryland employees. The Maryland law also required an employer to report annually its total number of employees in the state, the amount spent by the employer on health insurance costs, and the percentage of payroll the employer spent on health insurance costs.

  In general, ERISA preempts state laws relating to employee welfare benefit plans. The main objective of ERISA's preemption clause is to avoid different state legal obligations to permit nationally uniform administration of employee welfare benefit plans. In its decision, the Maryland federal court emphasized that because the purpose and impact of the Maryland law would be to require Wal-Mart to expand its ERISA health plan, thus interfering with the national uniform administration of the Wal-Mart plan, ERISA preempted the state law. Similarly, the current Task Force proposal requires employers to maintain a minimum plan of benefits (or face penalties) and to spend a certain percentage of payroll on employee benefits, and would similarly violate ERISA.

  - The authors of this minority report are concerned that the Adequate Health Care Task Force's health care reform plan could pose regulatory and operational issues for health plans through the Illinois Health Education and Referral Center (IHERC).
    - The IHERC approval process will likely commoditize products available to consumers, thus limiting choice in the marketplace.
    - It is very unclear what the funding source of IHERC will be. If IHERC is funded, in whole or in part, by insurer assessments, insurers' administrative costs will rise. Any such increase in cost will likely be passed down to consumers in the form of higher premium prices.

[1] Retail Industry Leaders Ass'n v. Fielder, Civil No. JFM-06-316 (July 19, 2006), found at http://www.mdd.uscourts.gov/Opinions152/Opinions/Walmartopinion.pdf

- The regulatory roles of the Division of Insurance and the IHERC are not yet clear, which may lead to confusion in the health insurance industry, postpone the introduction of new, affordable products to consumers, and provide for unnecessary dual regulation.

- The Hybrid proposal includes new insurance regulations including a provision called "guaranteed issue." Existing HIPAA Portability laws have accommodated for sick individuals who are not otherwise eligible for health insurance to obtain coverage through the State Health Insurance Pools. To implement another/different layer of "Guaranteed issue" in Illinois right now would be to add an inconsistent layer of regulation on our system and would impose a requirement that has proven ineffective in other states. For many reasons, "guarantee issue" of individual coverage has driven carriers out of the individual marketplace in many states. It allows people to wait until they are sick to buy insurance, thus driving up the cost of coverage. It is often compared to allowing people to buy homeowners insurance when their house is already on fire.

  While the concept of "guaranteed issue" appears to be attractive it has been found to, quite understandably, drive up insurance prices. Insurance then tends to become less attractive to everyone except those who have a serious health condition. The cycle continues as fewer healthy people purchase insurance, business dwindles and insurers leave the market. Ultimately, less competition and fewer insurers in the market push prices even higher. This has happened in every state that has experimented with "guaranteed issue."

IV. Positive Suggestions for Viable Change

The authors of this minority report presented a plan to the Adequate Health Care Task Force that met all of the requirements of the Health Care Justice Act and did so utilizing the savings realized through a mandatory managed care program for Medicaid to fund the costs of the program expansions contained therein. No new taxes or enhanced revenue streams are necessary to implement this plan. This minority report reasserts the position that the State of Illinois should consider its adoption. That plan is based on the following guiding principles:

- Preserve health plan and provider choice
- Build on the respective strengths of the private market and government
- Maximize the employment-based system of providing health insurance
- Engage consumers in taking a more active role in their health and utilization of health care
- Recognize the diversity of the uninsured

The plan itself presents the following framework for reducing the number of uninsured in Illinois:

1. **Medicaid reform and reaching the public program eligible:**

   - **HIFA waivers and block grants**: Through the use of HIFA waivers or block grants expand eligibility to the population of single childless adults with incomes at 100% or below of the federal poverty level and who have been uninsured for more than one year and have no access to some form of private insurance coverage.
   - **Increase portability of coverage** through vouchers that allow Medicaid eligible beneficiaries to enroll in their employers' plans.
   - **Personal Health Accounts (PHAs)** should be provided to Medicaid beneficiaries who enroll in a consumer-engaged (i.e. "consumer-driven") option, with the use of such accounts being restricted to the payment of health care expenses and health insurance premiums. This would empower these beneficiaries to manage some of their own health care dollars and get them more engaged in managing their health and utilization of health care.
   - **Managed care Medicaid**: Medicaid enrollees who choose not to enroll in a consumer-engaged option should "default" to enrollment in a state-run managed care Medicaid program.
   - **Long term care partnerships**: Implement long term care partnerships in Illinois in view of the recently passed (February, 2006) federal budget reconciliation law.
   - **Public program outreach**: Enroll eligible low-income individuals into currently available public programs to significantly reduce uninsurance among people who are eligible for coverage but are not currently enrolled. The State of Illinois should also research and evaluate the feasibility of implementation of an aggressive public education/outreach program as a means of maximizing public program participation.

2. **Reaching the non-afforders**: Public policy should be advanced that allows carriers to more readily develop coverage opportunities for small business and individuals who wish to purchase private coverage but for whom the cost is out of reach.
   - **Encourage the further development of Health Savings Accounts and Consumer Directed Health Care.**
   - **Provide tax incentives to individuals, employers and carriers to help make coverage more affordable**

3. **Reaching the voluntarily uninsured**:
   a. Encourage product innovation in the private sector to expand choices of lower-cost options.
   b. Develop a multi-faceted public awareness campaign to educate individuals on the availability of coverage, and to educate small employers on the tax treatment of insurance, rate protections, and the availability of coverage in our state on a guarantee issue basis (be it because of SEHIRA, or through CHIP and HIPAA-CHIP).

4. **Reaching the chronically uninsurable:**
   a. Maintain appropriate funding and management of Illinois' high-risk pools (HRPs).
   b. Limit coverage provided through HRPs and implement a mechanism to mainstream high-risk individuals into the private health insurance market.
   c. Require the two principal CHIP pools (Sections 7 and 15) to offer a CDHP (consumer-drive health plan) option that incorporates an HSA-compatible high deductible health plan (HDHP).

Improve Quality and Make Coverage More Affordable

5. **Improve quality of care and patient safety** - Accelerating adoption of health information technology (HIT) and establishing an HIT infrastructure are needed to improve quality, patient safety and efficiency.

    - Reduce treatment variation
    - Base more reimbursement on Pay-For-Performance
    - Improve health literacy

6. **Increase consumer involvement in health care decisions**

7. **Reduce excessive, unnecessary regulation and litigation**

8. **Consider the use of reinsurance pools as a means of achieving greater affordability of health insurance**: Evaluate the cost-effectiveness and feasibility of a voluntary, federally-subsidized individual and/or small group reinsurance pool set up strictly to handle the financial side of insuring high-risk individuals. Reinsurance pools, if administered correctly, have the potential to become important market-stabilizers.

Other

9. **Health savings accounts should be used as a "bridge" option for citizens moving from public to private programs**.

10. **Inventory current public insurance and medical assistance programs** to determine such things as 1) enrollment, 2) costs (overhead and costs of care), and 3) overlap with other programs, and determine which current state government-sponsored programs could be modified or even eliminated as part of an overall streamlining and consolidation initiative.

11. **"Health insurance and medical assistance" decision tree:** The Division of Insurance's Ombudsman program has a database application that phone counselors use in steering citizens to insurance, public health, and medical assistance programs that are available at state, county, and township levels in Illinois. It should web-enable this same application and provide a "health insurance and medical assistance" decision tree. Citizens should be able to enter information about themselves (e.g., name, address, date of birth, marital status, information about dependent children, gross household income, etc.), and receive a "report" showing ALL the programs they are eligible for that includes hyperlinks to websites, addresses, and phone numbers where one may turn for further assistance and counseling.

V. Conclusion

The Adequate Health Care Task Force was a noble effort to allow citizens across Illinois to express their concerns about the health care system and have their voices heard. Many people testified at the hearings in every Congressional district. None of them advocated the status quo, especially for Medicaid. The shortcomings of the Medicaid system were more than poor payments to medical providers. The shortcomings included a dearth of

providers willing to provide care, concern that the system is not responsive to patient needs and concerns that navigating the state's bureaucracy is difficult, and at times impossible.

The Hybrid Model adopted by the Task Force does not reflect the needs expressed by the people that testified. Instead, it preserves and enhances the Medicaid safety net as a safety net for providers. Illinois needs and deserves a Medicaid safety net for patients.

The task force report also overlooks the real – and potentially grave – effects on jobs and job growth in Illinois that can result from the assessment on employers. Apart from the questions of whether such a scheme can legally be accomplished, such a scheme should not have been considered without serious and sober discussion regarding the impact on Illinois jobs, the ability of employees to earn a decent living and whether businesses will be able to flourish with this new financial and administrative burden.

It goes without saying that the effects on the insurance industry – one that has been very vibrant in Illinois and that contributes more than $16 billion in Gross State Product (all insurers) to Illinois' economy – will be negatively impacted if the hybrid is enacted into law. The evidence is clear and convincing – in states that have enacted similar insurance regulations – the insurance market has suffered and premiums have escalated and insurance options narrowed.

Perhaps the gravest flaw of the final report is that it did not deliver on many of the very real deliverables contemplated by the Health Care Justice Act. It does not consider increasing cost-efficiency in the system and it does nothing to increase the availability of preventive services or wellness. It also does nothing to expressly add to the availability of health care resources, capital and technology. And, sadly, it does not provide consumers with choices of medical plans, medical providers or benefit packages.

It is for all of these flaws and failures that we, the undersigned, do hereby dissent from the majority recommendation of the Illinois Adequate Health Care Task Force.

Pamela Mitroff
DuPage County

Joe Roberts
Dekalb County

Michael R. Murphy
Sangamon County

Gregory S. Smith
Peoria County

Catherine Bresler
Cook County

Appendix C-2: Single Payer Minority Report

Proposal:

A Single-Payer Health Insurance Program for Illinois

Minority Report

Adequate Health Care Task Force

PREPARED ON BEHALF OF TASK FORCE MEMBERS SUPPORTING A SINGLE-PAYER PROGRAM FOR ILLINOIS:

Anthony Barbato | Kenneth Boyd | Jan Daker | Margaret Davis
J. Terry Dooling | Jim Duffett | Arthur G. Jones | Wayne Lerner
Niva Lubin-Johnson | Ruth Rothstein | Quentin D. Young

Preface

The Illinois State Legislature passed the Health Care Justice Act in 2004. This law created the Adequate Health Care Task Force, a group charged with making health care reform proposals for the state. The 29 members of the Task Force held hearings in each of the state's congressional districts and extensive deliberations reviewing some seven proposals. The group majority supported a "hybrid" plan by a vote of 16 to 6.

The single-payer proposal, herein transmitted, received a vote of 9 for and 13 against (Two additional Task Force Members who were unable to attend also support the single-payer proposal, bringing the total endorsement to at least 11 of the 29).

This Minority Report is a recommendation to the legislature in accord with the Health Care Justice Act's instruction that the Adequate Health Care Task Force "...make recommendations for a health care access plan or plans that would provide access to a full range of preventive, acute, and long-term health care services to residents of the State of Illinois."

Task Force Members Voting in Favor of the Single-Payer Proposal

Kenneth Boyd

Margaret Davis

J. Terry Dooling

Jim Duffett

Arthur G. Jones

Wayne Lerner

Niva Lubin-Johnson

Ruth Rothstein

Quentin D. Young

Task Force Members who Indicated Support for the Single-Payer Proposal, But were Not Present at Voting

Anthony L. Barbato

Jan Daker

Introduction

Despite high levels of health spending, our state's health system fails tens of millions of Illinoisans. More than 1.8 million Illinois residents were uninsured in 2005, 14.3 percent of our total population.

Even for those lucky enough to have coverage, rising costs have encouraged the development of skimpy insurance products that offer little protection from financial disaster when illness strikes. Nearly one-in-five *insured* Americans now goes without needed care due to costs. Of the more than 40,000 Illinoisans bankrupted by medical bills in 2004, more than three-quarters had coverage when they got sick.

Equally troubling is the disastrous effect of rising health costs on Illinois' economy. Skyrocketing costs impede job growth, wages, benefits and international competitiveness. Even giant employers such as GM and Ford have proven unable to use their market power to control spending growth. As employers find no option but to cut coverage, an ever-worsening fiscal crisis looms for the state.

It doesn't have to be this way. Illinois already spends enough to provide comprehensive health coverage to all residents, but that money is squandered in a fragmented, irrational payment system. In their drive to cover only healthy, profitable Illinoisans, private insurance companies erect massive, costly bureaucracies to fight claims and screen out the sick. They consume dollars spent for care, but produce only paperwork headaches. Physician offices and hospitals must employ huge staffs to deal with the bureaucracy, and business is saddled with the burden of administering health benefits. Nearly one-third (31 percent) of our health spending is consumed by this administrative waste

The following proposal would replace private insurers with a single public or quasi-public payer for health services. **The resulting savings would be more than $13 billion, enough to provide comprehensive coverage for all.** Benefits include:

- **Comprehensive, universal coverage** for all physician, hospital, long-term, mental health, dental, and vision care; and prescription drugs and medical supplies.

- **Free choice of doctor and hospital** for patients, and **freedom from HMO dictates over patient care** for physicians.

- **Long-term cost control** through a negotiated formulary with physicians, global budgets for hospitals, and bulk purchasing of drugs and medical supplies so benefits are sustainable.

- **No additional spending** is required, as current public financing sources are rolled into a single fund. Current spending on premiums and out-of-pocket spending would be changed into a modest personal income contribution.

Proposal: Single-Payer Health Insurance Program for Illinois
Submitted By: Physicians for a National Health Program and Health and Medicine Policy Research Group

Proposal Summary

Overview: This proposal uses the savings from simplified administration of the health financing system to cover all the uninsured in Illinois. Since a single-payer, Medicare, is already the payer for people 65 and over and the disabled, and public funds already pay for a majority of health spending, single payer is also known as "Improved and Expanded Medicare for All" (e.g. HR 676, with 69 co-sponsors). Single-payer would replace the 40 percent of health spending currently raised through "premiums" and "out-of-pocket payments" with income-defined contributions. Existing public and private health care providers would continue to deliver care. Private health insurers would be allowed to sell supplemental or "gap" coverage.

1. Access	• *New populations covered* – All Illinois residents (national implementation would provide coverage to all U.S. residents). • *Number of uninsured covered* –1.8 million in Illinois (46 million if implemented nationwide). • *Number of underinsured with additional benefit coverage* – All.
2. Methods of Coverage	Establish state health insurance plan to cover all residents, folding in Medicare, Medicaid, and other publicly-funded programs (if implemented nationally, expand Medicare to cover all residents). All licensed providers may participate in the program.
3. Means Testing	None.
4. Crowd-out policies	Not applicable – proposal limits sale of private health insurance to supplemental benefits ("gap" coverage).
5. Financing	• Set Illinois budget at level of spending in the year preceding the establishment of the program, adjusted for inflation (if implemented nationally, set budget for total expenditures at the same proportion of the gross national product as health costs represented in the year preceding the establishment of the national health program). • Replace current sources of financing (private insurance premiums and out-of-pocket payments, considered "regressive" tax sources by the proposer) with alternative sources including income-defined contributions by employers and employees (e.g. seven percent employer and two percent employee) – considered "progressive" tax sources by the proposer.
6. Cost Containment Incentives	• Obtain savings through bulk purchasing, negotiated fees, global budgets, streamlined administration, health planning, uniform and inter-operable medical records, and emphasis on prevention and timely primary care. • Implement policies on "supply" and physician side – e.g. increasing the number of primary care providers and limiting the number of new specialists in fields with over-supply; monitoring for extreme practice patterns; setting limits on regional spending for physicians' services; using financial incentives to attract primary care providers to underserved areas.

Physicians for a National Health Program and Health and Medicine Policy Research Group, continued

7. Estimated Cost	• Total Illinois health spending remains the same in first year, with an estimated savings of 8 to 10 percent annually in future years through a decreased rate of growth in health care costs.
8. Benefits	• Covers all medically necessary services including acute, rehabilitative, long-term and home care, mental health services, dental services, occupational health care, prescription drugs and medical supplies, and preventive and public health measures. Unnecessary or ineffective treatments would be excluded from coverage (e.g. cosmetic surgery). If implemented nationwide, expand Medicare benefit package as necessary. • *Long term care* – Expand social and community-based services to use with and as an alternative to nursing homes. • *Preventive care* – Coverage for full schedule of preventive services. • *Acute care* – Comprehensive coverage to free choice of doctor/hospital; need referral by a primary care provider for first visit to free choice of specialist (no referral needed for subsequent visits).
9. Preventive Medicine Component	• Global budgets allow institutional providers to work with public health entities to deliver population-based prevention. • Universal access to prevention and primary care with no cost-sharing.
10. Program Administration	• Establish a state office to administer the plan, which may use Medicare's subcontractor to process claims, Blue Cross Blue Shield of Illinois, if desired. If implemented nationwide, use Medicare's existing system of national and regional offices. • Establish a local public agency in each community to determine eligibility and coordinate home and nursing home long-term care. This agency would contract with long-term care providers for the full range of needed long-term care services.
11. Quality Improvement	The single payer would adhere to the following quality principles: • Creation of a unified, universal system that does not treat patients differently based on employment, financial status, or source of payment (i.e. a "single standard of care") is a prerequisite to (and the best guarantor of) high-quality care. • Continuity of primary care is needed to overcome provider fragmentation and over-specialization. • A uniform, confidential electronic medical record and resulting database are critical to supporting clinical practice and creating the information infrastructure needed to improve care. Use the Veteran's Administration's IT system as a model. • Financial neutrality of medical decision making is essential to reconcile distorting influences of physician payment mechanisms with ubiquitous uncertainties in clinical medicine. • Quality requires both research and prevention. Funding for medical research is maintained. Prevention means looking beyond medical treatment of sick individuals to community-based public health efforts to prevent disease, improve functioning and well-being, and reduce health disparities.

Physicians for a National Health Program and Health and Medicine Policy Research Group, continued

	• Emphasis should shift from micro-management of providers' practices to macro-allocation decisions. • Effective cost control is needed to ensure availability of quality health care both to individuals and the nation.
12. Capital and Technology	• Appropriate funds for the construction or renovation of health facilities and for purchases of major equipment from the national health program budget. Distribute appropriated funds through state and regional health-planning boards. • Pay owners of investor-owned, for-profit hospitals and nursing homes a reasonable fixed rate of return on existing equity until these providers have been converted to not-for-profit status. Finance conversion with bonds over 15-year term.
13. Provider Reimbursement	• Pay physicians a negotiated fee schedule (negotiated through physician representatives, possibly state medical societies); physicians could also work on salary for hospitals or clinics, or for a staff-model health maintenance organization (HMO). • Pay hospitals, nursing homes, community heath centers, non-profit, staff model HMOs and home health care agencies a global budget to cover operating expenses, negotiated annually with the state single payer plan based on past expenditures, previous financial and clinical performance. Fund hospital expansions and other substantive capital investments separately. • Pay each community long-term care public agency a single budgetary allotment to cover the full array of long-term care services in its district. • Pay for all medically necessary prescription drugs and medical supplies using a national formulary. Negotiate drug and equipment prices with manufacturers and purchase in bulk. Where therapeutically equivalent drugs are available, the formulary would specify use of the lowest cost medication, with exceptions available in case of medical necessity.
14. Implementation	• Obtain Medicare and Medicaid waivers for implementation in Illinois. • Enroll all Illinois residents with proof of residence for January 1, 2007 start-date and collect income-defined contributions through (already existing) IRS or, at the state level, the Illinois Dept of Revenue. • Retrain displaced insurance industry and other clerical workers (e.g. as home health and nursing home aides, radiology technicians and in other workforce shortage areas).

Sources:

May 9, 2006 Presentation to the Adequate Health Care Task Force by Steffie Woolhandler, MD

"A Better-Quality Alternative: Single-Payer National Health System Reform." Division of General Medicine/Primary Care, Cook County Hospital, Chicago, Ill (Dr Schiff); the Division of General Internal Medicine and the Institute for Health Policy Studies, San Francisco General Hospital, University of California-San Francisco (Dr Bindman); and the Department of Health Policy and Management, Harvard School of Public Health, Boston, Mass (Dr Brennan) *JAMA*. September 14, 1994; 272.

Physicians for a National Health Program and Health and Medicine Policy Research Group, continued

"Proposal of the Physicians Working Group for Single-Payer National Health Insurance."Physicians Working Group for Single-Payer National Health Insurance. *JAMA*. August 13, 2003, 290.

"Paying for National Health Insurance and Not Getting It", Steffie Woolhandler MD, MPH and David Himmelstein, MD, Harvard Medical School and Cambridge Hospital, Health Affairs, July/Aug 2002, 88

"An Equitable Way to Pay for Universal Coverage" Edith Rasell, MD, PhD, International Journal of Health Services, 1999, 179-188

SPECIFICATIONS OF THE SINGLE-PAYER PROPOSAL FOR ILLINOIS

The single-payer proposal creates a single source of comprehensive health insurance for all Illinois residents. The program includes a comprehensive benefits package covering hospital care, physician services, and prescription drugs. It would also cover durable medical equipment, eyeglasses and rehabilitative services. People would have their choice of physicians, hospitals, and other caregivers.

The benefits package would, at a minimum, equal that received by Illinois legislators, state employees, and uniformed servicemen.

The program would place hospitals and other health facilities on annual budgets for operations and capital expenditures, thus eliminating the need for billing for hospital care. The majority of providers would be reimbursed on a fee-for-service basis unless they are salaried employees of a hospital. Health professionals would continue to operate their own practices and health facilities would remain independently owned.

We summarize the major components of the program created under the proposal in the following sections:

- Governance
- Eligibility
- Covered services
- Benefits Design
- Disposition of Medicaid
- Exclusion of Workers Compensation Medical Benefits
- Non-profit staff-model HMO coverage option
- Provider payments in first year
- Program Financing
- Health spending in future years
- (New) Special provisions for Quality Improvement
- (New) Special provisions for Long Term Care
- (New) Special provisions for Health Planning/Workforce Issues
- (New) Special provisions for Mental Health
- (New) Special provisions for Dental and Vision

A similar proposal is pending in the state of California (SB 840 is the current bill number, it was SB 921 last year). A fiscal analysis of SB 921 is in included in the appendix to this submission, along with a slightly different single payer plan for California (prepared as part of the California "Health Care Options Project") and fiscal analyses for single payer plans in several other states (Maine, Georgia, Massachusetts, and Vermont).

A. Governance

We assume that an independent agency is established to administer the single-payer system for Illinois called the Illinois Health Care Agency (IHCA). The program would be directed by a Commissioner in conjunction with a public state board and Chief Medical Officer. The Commissioner would be responsible for administration of the program including:

- Implementing eligibility standards and program enrollment
- Adopting a benefits package
- Establish formulae for setting health expenditure budgets
- Administer the program including providing for the prompt payment of providers
- Negotiate prices for prescription drugs and durable medical equipment
- Recommending an evidence-based benefits package
- Other administrative functions
- Other quality and planning functions, including:
- Establish criteria for capital expansions and infrastructure development
- Measure and evaluate indicators of health care quality.
- Establish regions for long-term care integration

Within the Office of the Attorney General:

An Inspector General for Health would have broad subpoena powers to investigate fraud in the program and to respond to consumer complaints.

(New) Consumer Participation:

At least one-third of the members of the public state board, including all committees dedicated to benefits design, health planning, quality, and long-term care, should be consumers. Hospitals and other facilities that receive global budgets must have at least one-third consumers on their governing boards. Long-term care public agencies receiving global budgets must have consumers on their Boards.

Thus, consumers shall participate in determination of benefit package in conjunction with providers and experts. Consumers also participate in allocation of budget and health planning, including capital funds for infrastructure expansion, purchase of major equipment, etc. Consumers help shape local long-term care arrangements.

Finally, free choice of provider allows patients to shape the system by choosing to receive their care from the most responsive, highest quality providers.

B. Eligibility

All state residents would be covered for a standard benefits package after a 3-month waiting period. The waiting period is designed to avoid covering out-of-state residents with pre-existing conditions who might relocate to Illinois solely to take advantage of the

program. The three month residency requirement is assumed to be waived for the following:

- People relocating to Illinois to take a job
- People experiencing a change in family status due to divorce or death of a spouse
- For emergency services
- (New) For pregnant women

C. Covered Services

The plan would cover the following services:

- Inpatient/outpatient health facility or clinic services
- Inpatient and outpatient professional provider services by licensed professionals
- Diagnostic imaging, laboratory services, and other diagnostic and evaluative services
- Rehabilitative care
- Emergency transportation and necessary transportation for health care services for disabled people
- Home and Community based care (for people with limitations in ADL) and the medical portion of nursing home and other institutional care
- Prescription drugs that are listed on the system formulary. Off-formulary prescription drugs may be included where special standards and criteria are met
- Mental Health Care
- Dental care
- Durable medical equipment including hearing aid

Services not covered by the program include:

- Non-prescription medications and non-durable medical supplies
- Health services determined to have no medical indication
- Surgery, dermatology, orthodontia, prescription drugs, and other procedures primarily for cosmetic purposes, unless required to correct congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery
- Private rooms in inpatient facilities unless determined to be medically necessary by a qualified licensed health care provider in the system
- Room and board in long-term care (except for low-income).
- Services provided by unlicensed or unaccredited providers

D. Benefits Design

For the first two years of the program, there would be no deductibles or co-payments under the program. However, the benefits package would be designed to increase emphasis on primary and preventive care as follows:

- Participants would be encouraged to select a primary care physician from one of the primary care specialties including internists, family physicians, pediatricians, family nurse practitioners and physician assistants practicing under supervision of a physician as required under the Illinois code. Women would have the option of selecting a gynecologist for primary care. Permanently disabled persons would have the option of choosing a specialist who knows their condition(s) well.

- (Modified) Patient visits to physician specialists without a referral by a primary care provider would be paid at the primary care rate, giving specialists an incentive to work collaboratively with primary care doctors (Referral is not required for each follow-up visit to a specialist.)

After two years, the commissioner is authorized to adjust deductibles and/or co-payments if necessary subject to the following restrictions:

- Co-payment amounts would be limited not to exceed $250 per individual and $500 per family per year
- Deductibles would be limited not to exceed $250 per individual and $500 per family per year
- No co-payments or deductibles will be established for preventive care

(New) For the purposes of economic modeling, the modest co-pays and deductibles that may be applied starting in the third year (as stated above) should be included in the modeling so that the AHCTF has a full assessment of the costs of the program.

The proposal would require the use of a prescription drug formulary based upon prices negotiated with pharmaceutical manufacturers. Under this system, specific drugs are selected for inclusion in the formulary for each type of medical therapy. Providers would not be permitted to prescribe off-formulary medications (usually higher cost) unless the formulary drug is ineffective or inappropriate (e.g., side-effects from formulary medication).

The proposal would also negotiate for discounts with manufacturers of durable medical equipment. Under this system, the state would contract with suppliers who offer the lowest price for their equipment. This means that the medical equipment offered by manufacturers and/or suppliers who do not bid the lowest price in the competitive bidding process generally would not be covered under the program. This design would enable the state to negotiate deep discounts for durable medical equipment.

E. Disposition of Medicaid

Funding for Medicaid would be redirected into the state fund that would provide benefits to all Illinoisans. No current beneficiary of Medicaid shall lose coverage of any service.

These services include:

- Nursing home care including room and board for low income people who have or would qualify for Medicaid.
- Certain non-prescription medications
- Non-durable medical equipment
- Non-emergency transportation
- EPSDT services for children now covered under Medicaid, including:
    - Hearing
    - Medically necessary orthodontia
    - Non-rehabilitative therapies including
        - Speech therapy
        - Occupational therapy
        - Physical therapy

F. Exclusion of Workers Compensation Medical Benefits

We assume that the medical component of the workers compensation program would be unaffected and remain separate from the Act. Thus we assume no change in workers compensation medical coverage and benefits. The medical component of workers compensation could be folded into the program in the future.

G. Non-profit staff-model HMO Coverage Option

- A "Kaiser-like" option for Illinois is maintained. HMOs that employ physicians on salary, own clinics, and deliver care on a private, non-profit basis receive a global budget. People who choose this option are generally assumed to be required to remain in the plan for a year. However, there is a three month trial period in which patients may disenroll for any reason. They may also disenroll at any time if the health plan can not provide needed care.

- Global budgets with adjustment for the health of the enrollees to avoid overpayment or underpayment based on selective enrollment.

H. Provider Payments in First Year

Health spending for covered services under the program would be determined through a budgeting process designed to control the growth in health spending for Illinois. Spending in the first year of the program would be determined as follows:

- Hospitals and clinics would be given annual budgets that in the first year are equal to what total spending for hospital and clinic services would have been in that year under the current system. Separate budgets would be set for operations and capital expansion.

- Fee-for-service (FFS) payment rates for other providers would be set so that on average, payment rates under the program in the first year are equal to overall average payment rates across all payers in today's system (i.e., private payers, Medicare and Medicaid) for each individual unit of service. These include payments from private payers, Medicare, and self-pay (includes prices for services purchased by the uninsured and prices paid by insured people for services that are not covered under their health plan).

The program would permit the Commissioner to adjust payments for certain types of providers or services to reflect desired changes in the allocation of health resources. For example, payments for primary care services could be increased to reflect a desired increase in emphasis on primary and preventive care. However changes in reimbursement levels for other services would be adjusted so that total spending does not exceed the aggregate levels of spending determined above.

Hospital budgets and aggregate FFS provider payments would be adjusted to reflect the following:

- Increased utilization for newly insured
- Increased utilization due to elimination of co-payments
- Changes in spending due to the primary care model
- Reductions in bad debt and charity care costs for providers
- Provider administrative savings

I. Financing

The program would be financed with funds that would have been used for public programs under current law and certain dedicated taxes created under the program. Federal Medicaid, Medicare, and other necessary waivers would be obtained.

- Funding for current federal and state health insurance programs would be recovered including:
    - Medicaid (state and federal shares)
    - State Children's Health Insurance Program (SCHIP)
    - Medicare (including contributions by the federal government to Part D)
    - IHS
    - VA and CHAMPUS
    - FEHBP
    - Categorical programs (e.g. Ryan White Care Act)
    - State health care safety net funds
    - County safety net funds to the extent not needed for safety net services

We assume that the amounts of state and county funding would be indexed by the allowable rate of growth in spending (i.e., GDP growth) as determined by the Commissioner though the budgeting process. Because health spending has been growing considerably faster than the rate of growth in state GDP, this would result in lower levels of health spending for state and county governments in future years than what they would face under current cost trends.

However, we assume that the amount of federal funding provided to the state in future years would be indexed to the average rate of growth in costs in these programs nationally. This is designed to assure that federal funding for the state is not reduced over-time. Thus, from the federal government's perspective, the program is designed to be budget-neutral.

Costs in excess of the amounts of spending collected from existing programs would be raised through new progressive dedicated taxes created to replace regressive insurance premiums and out-of-pocket payments eliminated under the program. These would be determined during the modeling process by the fiscal analyst, but might include:

- Payroll tax on employers and employees (e.g. ~ 7% and ~ 2%, respectively)
- Business tax on self-employed net-income (both parts of payroll tax)
- Non-wage/business tax: small ~ 2 percent (non-wage and investment income)
- Surcharge on Income: 2 percent of income above $250,000 (all taxable income)

The business and payroll tax rates would be adjusted each year to the level required to pay for the program. The adjustment might include raising the floor and ceiling that the tax applies to (e.g. payroll tax floor $7,000 and ceiling $200,000).

J. Health Spending in Future Years

The program would determine the increase in health spending permitted in each year. We assume that the program is required in legislation to constrain the rate of growth in health spending so it does not exceed the long-term rate of growth in gross domestic product (GDP) for Illinois. Budget levels would be set on the basis of the long-run projected rate of growth in GDP rather than actual GDP growth. This is necessary so that funding levels for the health care system do not fluctuate over time with short-term variations in state GDP growth.

Spending caps would be implemented through:

- Annual hospital and clinic budgets for operations
- Annual hospital and clinical capital expansion budgets
- Caps on the rate of growth in negotiated FFS provider payment rates

Spending levels for services would be adjusted to reflect the cost of prescription drugs and durable medical equipment (with bulk purchasing savings) so that aggregate spending under the program is within budgeted levels. For purposes of this analysis, we assumed that FFS payment rates also would be adjusted to reflect any increases in utilization of FFS services that occur during the year so that aggregate spending for these services does not exceed budgeted levels (without an adjustment for increased utilization, spending would increase above budgeted levels).

The system would include reports to providers on quality of care indicators and referral patterns for comparison purposes. Peer review also would be established to monitor referral patterns and quality of care indicators.

K. (New) Special provisions for Quality Improvement

The single payer proposal for Illinois would be guided by 10 key quality principles, particularly the principles of evidence-driven standards of care and continuous quality improvement (below).

- We propose providing all practitioners with standardized confidential electronic medical record software (such as VISTA) for no cost with electronic lab results, and prescribing. The resulting unified database will support clinical practice and create the information infrastructure needed to improve care overall.

    i. Electronic medical records, electronic prescribing (based on a state formulary, adapted from the VA formulary) and lab reporting are critical to error reduction and patient safety.

    ii. The VA has already developed the needed software for physician practices and provides a model for improving quality system-wide. Taking advantage of advances already developed in the public sector (including Medicare) will allow Illinois to become a leader in health care IT.

    iii. The integrated database will facilitate more sophisticated outcomes research (on new processes of care, drugs, and procedures) as well as fraud detection. Some possible uses are: to identify physician outliers who order excess diagnostic tests or referrals; to identify unsafe drugs and safer alternatives, to identify underserved areas for mammograms or other preventive measures; and to determine outcomes and best practices for specialized services (e.g. dialysis).

    iv. Permits evidence-based outcomes assessment and intervention at individual, physician, and community level. Improving individual providers' care can best be accomplished via supporting their ability to practice quality care coupled with pooled outcomes data and patient feedback.

- We propose that health planning should assess and direct resources – both monetary and the health (and public health) care workforce - as needed to improve quality. For example, capital investments (in clinics, emergency departments, etc), caregivers, and targeted public health interventions are needed in underserved areas. Increases are needed in the primary care workforce at all levels (nurses, physician assistants, primary care physicians, etc). There are more details Section L (below) but some are included here because health planning is so critical to improving quality.

    i. Use regional health planning boards to determine distribution of funds for construction or renovation of health facilities and purchases of major medical equipment. Work in conjunction with public health department to also deploy targeted public health interventions (the unified database and epidemiological studies will be especially useful in this regard).

    ii. Enlarge the primary care workforce by using Illinois' hospitals' share of Graduate Medical Education funds, as well as modest bonuses, enhanced fees, and non-monetary professional rewards (such as public recognition, leadership opportunities, etc) to attract more professionals into primary care training programs, primary care practices, and underserved areas.

    iii. Special strategies to increase the diversity of the primary care workforce will need to be tested and implemented until there is minority representation in the workforce equal to the state's population. "Raiding" the workforce of developing countries is not an acceptable strategy.

- We propose to regionalize specialized surgeries and tests. Currently, redundant surgical suites jeopardize quality when complicated surgeries like heart bypasses are performed too infrequently to maintain proficiency.

- In addition to facilitating improved quality, single payer reduces the cost of the current malpractice system. Timely care and continuity of caregivers fosters improved quality, so there is less malpractice. EHRs and electronic prescribing reduce errors. In addition, the proposal eliminates lawsuits for future medical expenses (the majority of cases), since future medical expenses are covered. Thus, defensive medicine and malpractice premiums will fall substantially (by 50 percent or more). Also, under single payer the focus in malpractice cases can broaden from "who will pay for mistakes" to "how can we learn from mistakes and prevent them," which is critical to improving quality.

Reprinted from "A Better Quality Alternative: Single Payer National Health System Reform" Schiff et al, JAMA 9/14/94.

1. There is a profound and inseparable relationship between access and quality: universal insurance coverage is a prerequisite for quality care.

2. The best guarantor of universal high-quality care is a unified system that does not treat patients differently based on employment, financial status, or source of payment.

3. Continuity of primary care is needed to overcome fragmentation and overspecialization among health care practitioners and institutions.

4. A standardized confidential electronic medical record and resulting database are key to supporting clinical practice and creating the information infrastructure needed to improve care overall.

5. Health care delivery must be guided by the precepts of CQI (continuous quality improvement.

6. New forums for enhanced public accountability are needed to improve clinical quality, to address and prevent malpractice, and to engage practitioners in partnerships with their peers and patients to guide and evaluate care.

7. Financial neutrality of medical decision making is essential to reconcile distorting influences of physician payment mechanisms with ubiquitous uncertainties in medicine.

8. Emphasis should shift from micromanagement of providers' practices to macroallocation decisions. Public control over expenditures can improve quality by promoting regionalization, coordination, and prevention.

9. Quality means prevention. Prevention means looking beyond medical treatment of sick individuals to community-based public health efforts to prevent disease, improve functioning and well-being, and reduce health disparities.

10. Affordability is a quality issue. Effective cost control is needed to ensure availability of quality health care both to individuals and the nation.

L. (New) Special provisions for Long Term Care

PNHP's proposal for Illinois long-term care reform is based on work by Dr. Christine Cassell, former Professor of Geriatrics at the U of C and current President of the American Board of Internal Medicine, and Charlene Harrington, RN, Ph.D., the nation's leading investigator into quality problems in nursing homes. Their proposal, "A National Long-term Care Program for the United States: A Caring Vision" appeared in the JAMA, December 4, 1991. Their recommendations are adapted for the state of Illinois.

We propose the incorporation of LTC into the publicly funded state health program. We borrow from the experience in the Canadian provinces of Manitoba and British Columbia, where LTC is part of the basic health care entitlement regardless of age or income. Case managers and specialists in needs assessment (largely non-physicians) evaluate the need for LTC and authorize payment for services.

Specific features and budgeting process

- Establish a state LTC Planning and Payment Board, and a local public agency in each community to determine eligibility and coordination of home and nursing home long term care.
- The local public agency will receive a global budget and contract with long term care providers for the full range of LTC services. Nursing homes, home care agencies, and other institutional providers will be paid a global budget to cover all operating costs and would not bill on a per-patient basis. Individual practitioners may continue to be paid on a fee-for-service basis or could receive salaries from institutional providers. Support for innovation, training of LTC personnel, and monitoring the quality of care will be greatly augmented, as a portion of the funds saved on administrative overhead are shifted into long-term care service provision (see below)
- Separate capital budgets allow for health planning that meets community needs.
- Expand social and community based services, and integrate them with institutional care. Logic dictates that the system emphasize social services, not just medical ones, with social service and nursing personnel rather than physicians often coordinating care
- The public program, with a single, uniform benefit package, would consolidate all current federal and state programs for LTC. At present, 80 federal programs finance LTC services, including Medicare, Medicaid, the Department of Veterans Affairs, and Older Americans Act.
- Coverage would extend to anyone, regardless of age or income, needing assistance with one or more activity of daily living (ADL) or instrumental activity of daily living (IADL). In the first 5 years, priority is given to patients needing assistance with three or more ADL or IADLs, and to those who can avoid institutional care with home and community-based care.
- Clerical and other administrative workers who lose their jobs as a result of the single payer will be given incentives to re-train and take employment in the expanded home and community-based health care sector which is currently understaffed. Training and in-service education of LTC professionals, paraprofessionals, and informal care givers should be expanded. Salaries, working conditions, and skill levels of workers in this area need to be upgraded.
- Removing financial barriers to LTC will increase demand for formal services. In the first year, allow for a 25 percent increase in home and community-based care (in addition to any savings from institutional care). The program is to be financed entirely by tax revenues, without premiums, deductibles, co-payments or coinsurance, with the exception of "room and board" payments by patients who are not low-income needing institutional care.

M. (New) Special provisions for Health Planning/Workforce Issues

The Illinois single payer will allow the state to do real health planning, directing resources to areas of unmet need in terms of both geography and specialty (e.g. public health, prevention, primary care, long-term care, and mental health and substance abuse, etc.). The goal of health planning is to assure that the most appropriate providers are delivering timely, high quality care, to all patients, and that public health interventions and new capital appropriations will maximally improve the health of state residents.

Some specific features:

- Improve and expand primary care, the most efficient setting for care delivery. Give modest financial incentives to providers to work in underserved areas, along with other professional rewards (recognition, leadership opportunities, etc). Similar incentives may be given to increase the diversity of the workforce.
- Shift graduate medical education funds to adjust mix of training programs to increase the diversity of health professionals and to train more primary care providers.
- Pay specialists at primary care rate if patient does not have a referral, giving specialists incentives to work collaboratively with primary care physicians.
- Distribute funding for construction or renovation of health facilities and for purchases of major equipment to underserved areas, reducing health disparities.
- Buy out investor owned, for profit delivery facilities (mostly nursing homes). Pay for the cost of the physical plant only, not the "brand name." Finance the buy-back with 15-20 year bonds.
- Set and meet targets for decreasing health disparities, and increasing prevention, every year. Use the unified database to identify areas of need and assess progress.
- Create a long-term plan for educating and hiring the appropriate mix of health care professionals and allied health professionals that are needed in the state.

N. (New) Special provisions for Mental Health Coverage Parity

Millions of Illinois residents are uninsured and under-insured for mental illness/substance abuse. Many patients in need of hospital or residential care are unable to obtain inpatient services even if they have insurance. Breakthroughs in medications in recent years have made mental illness more treatable than ever but are unaffordable for many.

Very ill patients are often expected to juggle complicated medication routines with little support; in many cases severely mentally ill homeless patients are discharged to the streets. Jails have become the largest inpatient facilities for the treatment of the severely mentally ill. Suicidal patients are sometimes given a 1-800 number to call in lieu of prompt access to urgent care.

Health care is a right, and all residents of Illinois should have access to high-quality services for mental illness and substance abuse, with coverage on par with the coverage of medical or surgical care.

An overview of our proposal on mental health:

Mental health care and substance abuse treatment must be available to all, and the substandard care that is now the norm must be upgraded. Coverage should include the full range of effective treatments, including: outpatient psychotherapy and medication management; acute inpatient care; rehabilitation and occupational therapy; a range of substance abuse treatment options (including inpatient) and medications.

To the extent possible, patients should have their choice of physicians, other caregivers, and treatment settings, and new mental health facilities should be preferentially located in neighborhoods with the greatest needs. The delivery system should be entirely not-for-profit to prevent the continued diversion of resources to profits.

There should not be arbitrary caps on inpatient or outpatient care for the seriously mentally-ill. The mental health professions must give increased attention to the seriously mentally ill, and to substance abuse treatment. In addition, there is a particular need for more focus on illnesses in children.

Specific features:

- Payment for mental health care should be on the same terms as payments for other medical services; patients with serious mental illness (e.g. depression, bi-polar disorder, schizophrenia) should not be subject to higher co-pays or deductibles. Research shows that out-of-pocket charges have the impact of discouraging both necessary and unnecessary care and most negatively impact the poor.

- There are large unmet needs in mental health and substance abuse treatment in Illinois. Substantial new resources will be needed to upgrade mental health services. Statewide mental health surveys can be used to supplement the unified database to understand where the unmet needs are greatest.

- Some of the new resources needed in mental health care can be garnered by eliminating the for-profit managed mental health intermediaries (e.g. Magellan) that have come to dominate care in the past decade, and whose overhead and profits may consume 50% or more of the total money designated for mental health services.

- Additionally, resources should be diverted from the criminal justice system; excessive incarceration is, at present, the major response to serious mental illness and substance abuse.

- Grossly inflated medication prices should be cut through exerting the purchasing power of a single payer.

- As in all sectors of health care, spending and patterns of care should be audited to ensure that the most urgent needs are met first, and that ineffective, harmful, and cost-ineffective practices are eliminated.

- We advocate a mental health system based on compassion and science rather than on the dictates of the market.

O. (New) Special provisions for Dental and Vision

Dental benefits are included in the state single payer program, with the exception of purely cosmetic dentistry.

Vision screenings are covered, along with one pair of eyeglasses per year.

Appendix D-1: Campaign for Better Health Care and Health and Disability Advocates

APPENDIX D-1: CAMPAIGN FOR BETTER HEALTH CARE AND HEALTH AND DISABILITY ADVOCATES

Summary of Proposal

The Consumer Health Care Access Strategy proposal requires that employers contribute to health care coverage, and expands Medicaid and the State Children's Health Insurance Program (SCHIP) and state-only funded programs. While the proposal focuses on offering affordable options that will provide incentives to uninsured residents to take up health insurance, the proposal indicates that the State should consider an individual mandate if a significant portion of the uninsured population does not have coverage after program implementation (assuming affordable insurance options are available to individuals).

The proposal includes two employer-based strategies to expand coverage to the working uninsured:

- Small group purchasing pool that will coordinate coverage on behalf of individuals, sole proprietors and small employers (2 – 50 employees) who cannot afford insurance on the private market. The proposal suggests that the State should subsidize a reinsurance program to keep the premium affordable for this population, and also consider reinsurance for all carriers in the individual and small group markets.

- Employer "pay or play" that will require every employer to spend a minimum amount on health insurance, calculated either on the percentage of the employer's payroll or on a flat fee per employee calculated using the average premium cost for an Illinois PPO plan. For those employers who already provide coverage, this contribution will be reduced by the amount the employer already spends on health care premiums. Employer payments will help fund the state coverage initiatives, including the state share of the proposal's public coverage expansions, as described below.

The proposal includes a number of public coverage expansion strategies, including:

- Medicaid and SCHIP expansions

  - Expand Aid to the Aged, Blind and Disabled (AABD) program to 300 percent of the federal poverty level (FPL).
  - Expand All Kids to young adults ages 19 to 23 who remain in an educational setting.
  - Expand FamilyCare for parents from 185 to 300 percent of the federal poverty level (FPL), with a Medicaid buy-in option for parents at higher income levels.
  - Expand Health Benefits to Workers with Disabilities (HBWD) eligibility from 200 to 350 percent of the FPL with removal of asset and spousal deeming barriers. Also, cover former enrollees of HBWD program that became income ineligible due to earnings or age.

  - Use Medicaid buy-in program for children with disabilities up to 300 percent of the FPL.

- State-only funded expansions

  - Reinstate the Aid to Medically Indigent program for those uninsured low-income childless adults and non-citizens who are not otherwise Medicaid-eligible up to 300 percent of the FPL.
  - Use sliding scale subsidies for Illinois' high risk pool (ICHIP) premiums for individuals with high expected medical costs.[1]
  - Employ sliding scale subsidies for COBRA premiums for low-income individuals.

For these public expansions, the proposal recommends that the State exclude preventive services from cost-sharing and consider limited cost-sharing for individuals between 200 and 300 percent of the FPL, capped at two percent of family income. Individuals in the new Medicaid expansion population will have access to the Medicaid benefit package, with expanded dental and vision benefits for adults. The benefit package offered to individuals in the purchasing pool will mirror the benefits currently offered to Illinois State Employees. The proposal does not specifically address long-term care; however, individuals who obtain coverage through Medicaid expansion will be eligible for Medicaid long-term care benefits.

The proposal also discusses exploring innovative ways to increase enrollment in public health care programs and expanding access to providers via targeted provider rate increases, medical school repayment options and increased funding to safety-net providers. It also proposes a "Guaranteed Health Security" (GHS) Task Force, housed under the Illinois Department of Health, which will be responsible for implementation of an on-going assessment of the plan. The GHS task force will be assisted by four additional advisory task forces: the Technology Development Advisory Task Force, the Capital and Network Infrastructure Advisory Task Force, the Health Professional Expansion Advisory Task Force and the Prevention and Health Education Advisory Task Force. These advisory task forces will make recommendations to the GHS Task Force on their respective topics.

Additional background information for this proposal can also be found on the Task Force's website (http://www.idph.state.il.us/hcja/resources.htm).

[1] This could potentially be funded using federal funds; the State High Risk Pool Funding Extension Act of 2006 established the availability of grants for states that have a qualified high risk pool that incurred losses. States can use these "Bonus Grants for Supplemental Consumer Benefits" for low income premium subsidies, reductions in cost-sharing requirements and expansion of the pool, among other consumer benefits.

Evaluation of Proposal

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
1. Access *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 8.5 *Total Weighted Score:* 12.8	a) Provides coverage to all Illinois residents *Assign 1-5 points, 5 represents coverage to all residents* b) Mandates coverage *Assign 1 point if coverage is mandatory* c) Includes provisions to avoid crowd-out of private insurance *Assign 1-2 points for provisions to avoid crowd-out of private insurance* d) Includes provisions for portability, i.e., individuals maintain coverage as life circumstances (e.g., employment, transition from Medicaid, etc.) and health status change *Assign 1-2 points for provisions for portability*	a) **4.0 points** – Includes provisions that provide new health care coverage options to all of the uninsured and promotes increases in funding to safety-net providers to provide access to care for the remaining uninsured populations. The proposal does not guarantee take-up by employers and individuals of the new health care coverage options. The employer "pay or play" policy will encourage non-offering employers to begin offering coverage. Preliminary model results indicate that these efforts would result in health care coverage for over approximately two thirds of Illinois' currently uninsured population. b) **1.0 points** – While proposal does not include an individual mandate, such a mandate could be considered if (1) voluntary coverage options fail to cover all uninsured and (2) affordable and comprehensive insurance options are available to low- and middle-income populations. c) **2.0 points** – Suggests establishing a waiting period for new coverage, limiting eligibility to uninsured or underinsured populations, subsidizing employer-based	• While the uninsured have many new options for coverage, the lack of an individual mandate and the use of cost-sharing will result in less than 100 percent take-up. • Beyond the recommended reinsurance program for the small group market, the proposal does not address how to provide incentives to employers to provide a comprehensive and affordable coverage to part-time workers. The proposer has indicated the employer mandate could be structured to include coverage to part-time workers. • Recommends consideration of community rating and guaranteed issue for the new purchasing pool; as well as a standard benefit package for all the health plans so that plans have a strong incentive to compete on price.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		coverage through premium assistance and providing third party liability or imposing sliding scale premium contributions. d) **1.5 points** – Makes COBRA and ICHIP coverage more affordable and establishes a purchasing pool that is available to everyone, regardless of employment status. It may be very challenging, however, to make COBRA subsidies high enough to induce substantial take-up. The purchasing pool will still be available, however, to individuals who cannot afford COBRA even with the subsidy.	
2. Financing *Criteria Weight:* 15.0 *Possible Points:* 9.0 *Assigned Points:* 8.0 *Total Weighted Score:* 13.3	a) Finances additional costs through an approach that incorporates proper load-sharing between providers, insurers, state government and patient/taxpayers *Assign 1-5 points for approaches that spread burden of costs across providers, insurers, state and federal government and taxpayers* b) Maximizes federal funds *Assign 1-2 points for approaches that maximize federal funds* c) Enhances affordability for small employers *Assign 1-2 points for features that*	a) **4.0 points** – Includes moderate changes to load-sharing – the proposal increases employer financing commitment, with remaining financing coming largely from beneficiary contributions, federal Medicaid funds, State Medicaid funds and general State revenues. Suggests insurance market reforms that may reduce premium costs. b) **2.0 points** – Proposes significant Medicaid expansions, which allow the State to access federal matching funds. c) **2.0 points** – Establishes a purchasing	• Suggests insurance market reforms that may reduce premium costs – i.e., use of community rating and a limit on insurer administrative expenses for the purchasing pool. Community rating would have the effect of reducing premium costs for high-cost individuals, with a corresponding increase in premium costs for healthier individuals. • The proposal's heavy emphasis on expanding employer-based sources of coverage will have the effect of drawing more federal dollars into the State through the tax exclusions.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	enhance affordability for small employers	pool for individuals, sole proprietors and small businesses and provides incentives, including premium assistance and subsidies, for individuals and businesses to join the pool. Also recommends a reinsurance program for coverage purchased through the purchasing pool, which may increase affordability for small employers.	
3. Benefit Package *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 8.0 *Total Weighted Score:* 12.0	a) Provides full range of benefits specified in the Health Care Justice Act: 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 *Assign 0 – 10 points for services offered*	a) **8.0 points** – Recommends Medicaid expansions that will provide a comprehensive benefit package including mental health and substance abuse services for some groups, services for the developmentally disabled and a range of long-term care services. The majority of people covered by this proposal continue to receive private commercial-style coverage that may contain somewhat limited benefits. The purchasing pool will offer a benefit package similar to Illinois State Employee benefit package, which offers a range of options – including a comprehensive set of preventive and acute services, plus access to home care and skilled nursing facility care. ICHIP also offers a very comprehensive benefits package. Proposal does not include recommendations related to long-term care; however, the recommended Medicaid expansions	Expansions are aimed at increasing coverage to a comprehensive benefit package. To the extent that individuals take up this coverage, the proposal may be able to serve different communities with different needs. The proposal does directly target people with disabilities to meet their needs, but does not contain specific policies that would reduce preventable disease and disability.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		include comprehensive long-term provisions.	
4. Implementation *Criteria Weight:* 7.0 *Possible Points:* 15.0 *Assigned Points:* 10.0 *Total Weighted Score:* 4.7	a) Legal and regulatory changes required to implement the proposal can be accomplished within 1-3 years *Assign 0-5 points for ability to obtain legal and regulatory approvals that are necessary for implementation* b) Federal waivers, if required, can be implemented within 1-3 years *Assign 0-5 points for feasibility in obtaining federal waivers* c) Includes provisions for a reasonable phase-in period that does not cause significant disruptions for employers or consumers *Assign 0-3 points for reasonable phase-in approaches and timelines* d) Includes accountabilities for ongoing performance, cost and quality *Assign 0-2 points for features that assure accountabilities related to ongoing performance, cost and quality*	a) **4.0 points** – Assuming political support, the State could likely accomplish proposed changes within 1 to 3 years. Most observers believe that if the State were to pass an employer "pay or play" approach, they would face significant legal challenges from employers related to ERISA preemptions. Implementation would involve changes to health insurance law and insurance company regulations. The State could implement Medicaid changes within this time period and would require a change in Illinois' State Plan. b) **3.0 points** – While a portion of the proposed expansions could be implemented using a State Plan amendment, an 1115 federal waiver will be necessary to obtain federal Medicaid funding for the majority of the proposed newly Medicaid and SCHIP-eligible populations (i.e., FamilyCare and 21-23 year old college student expansion). The State has currently committed all of its disproportionate share hospital and SCHIP funding, which are the two major sources of funding that states generally use to make 1115 waiver programs budget neutral. As such, the State's ability to obtain waiver	• While requirement that employers either provide health coverage or pay a fee to the State levels the playing field among employers in terms of health care costs, this provision might increase the cost of doing business in Illinois, potentially causing some employers to leave the State. Conversely, it could be argued that employers would benefit from healthier workers and the potential stabilization health care costs through the other provisions of this proposal. • Establishes task forces that will make recommendations on different aspects of the health care system in the State; however, it is unclear what authority these task forces will have to implement change in the system.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		approval would likely rely on its ability to move SCHIP eligibles into the Medicaid program so that SCHIP allotment could be freed up to fund the expansion. It is not clear at this point if the federal government will allow a shift in SCHIP populations to the Medicaid program. If not, alternative approaches to achieving budget neutrality for waiver approval purposes could be considered but discussions with the Centers for Medicare and Medicaid Services will be critical to confirm feasibility. c) **2.0 points** – Suggests that some components be phased in during the first and second years with ongoing recommendations by the newly established technical and regional advisory committees; does not specify which components would be best suited to a phase-in. d) **1.0 points** – While proposal suggests the use of new task forces that will be responsible for overseeing the implementation of the current plan and monitoring different components of the health care system, the description of the authority and funding of these task forces is not clear enough to determine if they will have a real impact on performance, cost and quality.	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
5. Quality *Criteria Weight:* 7.0 *Possible Points:* 2.0 *Assigned Points:* 1.5 *Total Weighted Score:* 5.3	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) *Assign 1 point for incentives to improve quality* b) Promotes integration and coordination among parts of the delivery system *Assign 1 point for provisions that promote coordination within delivery system*	a) **1.0 points** – Does not include specific incentives for providers to adopt practices demonstrated to improve quality beyond what the current system requires. Proposal requires report on health care quality in Illinois every six months. b) **0.5 points** – Establishes a Capital and Network Infrastructure Task Force that the proposer indicates will be responsible for making recommendations to integrate the system; however it is unclear the leverage this Task Force will have to implement their recommendations.	• Recommends that the Illinois Department of Public Health and all other State agencies monitoring health care quality provide a written assessment of quality of care in the State to the Guaranteed Health Care Task Force every six months and provide a yearly briefing. • Establishes the Prevention and Health Education Advisory Task Force that will develop a health education program that will include cultural competence training and strategies to overcome language barriers.
6. Cost-efficiency *Criteria Weight:* 7.0 *Possible Points:* 12.0 *Assigned Points:* 7.0 *Total Weighted Score:* 4.1	a) Controls growth in overall and per capita expenditures for health care: i) Health insurance premiums ii) Public program expenditures iii) Capital iv) Technology v) Administrative costs vi) Prescription drugs vii) Others *Assign 0-10 points for features that control growth in expenditures* b) Provides mechanisms for generating spending priorities based on multidisciplinary standards of care established by verifiable, replicated	a) **6.0 points** – Controls costs through the following methods: • Limits administrative overhead for insurance carriers participating in the purchasing pool, however, may increase administrative costs through the addition of new coverage options. • Consolidates drug purchasing for its state programs. • Takes advantage of primary care case management and disease management in its Medicaid and SCHIP expansions, along with reduced administrative costs historically found in the Medicaid Program.	• While the proposal recommends a reinsurance program for plans participating in the purchasing pools that may reduce premium costs, it may not reduce overall and per capita expenditures for health care because the State is essentially picking up the remaining costs above the reinsurance threshold on the high-cost cases. However, the private risk-bearing insurer will still have an incentive to contain costs for patients whose costs do not meet the reinsurance threshold to increase their profits. • By expanding coverage to additional uninsured, this proposal assists providers in reducing their uncompensated costs for the

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	research studies demonstrating quality and cost-effectiveness of interventions, providers and facilities *Assign 0-2 points for mechanisms that take into account standards of care in establishing spending priorities*	• Includes cost-sharing for individuals. b) **1.0 points** – Establishes the GHS Task Force, which the proposer indicates will oversee mechanisms to generate spending priorities; however, it is unclear if these priorities will be based on multidisciplinary standards of care. While the Task Force will have the authority to implement policies and procedures, funding will be necessary to make implementation possible.	uninsured. It does not however, contain specific provisions to make providers more cost-effective. • Expands Medicaid, which includes disease management and care coordination activities that are projected to reduce health care costs. • Does not specifically incentivize the use of electronic health records and health information technology; however establishes a Technology Development Advisory Task Force that will assess technological weakness and inefficiencies and propose improvements.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
7. Availability of Resources, Capital and Technology *Criteria Weight:* 5.0 *Possible Points:* 6.0 *Assigned Points:* 3.5 *Total Weighted Score:* 2.9	a) Includes provisions for new capital, technology, medical education, research *Assign 0-4 points for features that address expenditures for new capital, technology, medical education and research* b) Includes provisions to protect and enhance, where necessary, the safety-net system *Assign 0-2 points for features that protect and enhance the safety-net system*	a) **2.0 points** – Establishes various Task Forces to address capital, technology, medical education and research issues but does not specify the extent to which these Task Forces will have the authority to implement their recommendations. b) **1.5 points** – Establishes the Health Professional Expansion Advisory Task Force that will develop incentives to a wide range of medical personnel to fulfill their education and training in exchange for locating to underserved areas. Recommends targeted reimbursement rate increases for public program expansions and increases in funding to underserved areas and safety-net providers. Proposal does not specify the extent to which the Task Force will have the authority to implement its recommendations, or the targeted amount of increased funding to safety-net providers.	• The proposed Capital and Network Infrastructure Advisory Task Force will assess current needs and develop options for improvement • The Technology Development Advisory Task Force will assess the current technological infrastructure. • The Health Professional Expansion Advisory Task Force will study the expansion of the State Medical Scholarship Program.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
8. Prevention and Wellness *Criteria Weight:* 10.0 *Possible Points:* 2.0 *Assigned Points:* 1.0 *Total Weighted Score:* 5.0	a) Includes incentives that reward individual wellness *Assign 1 point for wellness incentives* b) Contains policies to promote continuity of care *Assign 1 point for policies to promote continuity of care*	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. While the proposal establishes a Prevention and Health Education Advisory task force that will develop a multi-faceted disease prevention and health education program that community health centers and public health districts will lead, the proposal does not specify the extent to which the Task Force will have the authority to implement its recommendations. b) **0.5 points** – Promotes continuity of care by expanding Medicaid, which now includes primary care case management and disease management programs and provides a comprehensive benefit package through public insurance; however private insurance, including the Illinois State Employee benefit package, may not cover needed services, like rehabilitation or long-term care.	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
9. Consumer and Stakeholder Participation *Criteria Weight:* 2.5 *Possible Points:* 3.0 *Assigned Points:* 3.0 *Total Weighted Score:* 2.5	a) Provides consumers (and their advocates) with opportunities to participate in program design at both the local and regional level *Assign 1-3 points for opportunities for consumer input regarding technologies, capital and program design*	a) **3.0 points** – Allows for regional and local consumer participation by establishing five regional Task Forces that will monitor implementation of health access strategies in their respective regions.	
10. Consumer Autonomy *Criteria Weight:* 4.0 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 4.0	a) Provides consumers with choices of health plans and provider networks *Assign 1 point for provisions that provide consumers with choices related to health plans and provider networks*	a) **1.0 points** – Provides individuals and businesses enrolled in the purchasing pool with health plan and provider network options similar to those provided to State employees.	Allows for the choice between service delivery options for both Medicaid eligible individuals and individuals enrolled in the purchasing pool.
11. Provider Autonomy *Criteria Weight:* 2.5 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 2.5	a) Preserves providers' clinical autonomy *Assign 1 point for provisions that promote provider autonomy in caregiving practices*	a) **1.0 points** – Does not restrict providers' clinical autonomy.	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
12. Provider Payment *Criteria Weight:* 10.0 *Possible Points:* 4.0 *Assigned Points:* 2.5 *Total Weighted Score:* 6.3	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* b) Reduces administrative burdens on providers *Assign 0-2 points for provisions that reduce administrative burdens on providers*	a) **2.0 points** – Includes targeted reimbursement rate increases for public program expansions and recommends increases in funding for public health districts and community health centers. Lacks information on improving timeliness of payment to providers. b) **0.5 points**– Proposal does not address administrative burden related to providers and maintains the current system's approach.	

Appendix D-2: Illinois Hospital Association

APPENDIX D-2 ILLINOIS HOSPITAL ASSOCIATION

Summary of Proposal

The Illinois Hospital Association's proposal increases access to health care coverage by making coverage more affordable and using strategies that are targeted at specific groups of the uninsured and their needs. The proposal expands Medicaid and the State Children's Health Insurance Program (SCHIP), as well as the State Comprehensive Health Insurance Plan (CHIP) and builds on current private market coverage.

The proposal includes two major employer-based strategies to expand coverage to the working uninsured:

- Employer Sponsored Insurance Initiative (ESI) that will allow self-employed individuals and small businesses to purchase a limited benefit package ("Safety Net Benefit Package") from the State.

- Small Employer Purchasing Cooperative (SEPC) that will assist self-employed individuals and small businesses statewide to come together to purchase the "Safety Net Benefit Package" on the private market.

To qualify for either ESI or SEPC, self-employed individuals and small businesses cannot have offered health insurance during the previous 12 months. Employer contributions will partially finance the SEPC, which will cover 60 percent of premium costs, with the remainder financed by beneficiaries (low-income beneficiaries could receive subsidies as described below). ESI will be financed via an employer tax per employee and federal matching funds for those employees that are newly Medicaid-eligible under this initiative (i.e. employees 19-64 working for an eligible employer whose family income is equal to or less than 200 percent of the FPL and are otherwise not eligible for Medicaid).

The proposal's public coverage expansion strategies include:

- Medicaid/SCHIP expansion for parents from 185 to 200 percent of the federal poverty level (FPL), and for individuals 19-64 years of age who work for employers eligible for ESI, but who are not otherwise eligible for Medicaid and whose family income is equal to or less than 200 percent of the FPL.

- Expansion of All Kids to 18-22 year olds enrolled full time in college with incomes up to 200 percent of the FPL.

- State-subsidized premium subsidies in the form of health insurance vouchers that will assist residents with incomes at or below 200 percent of the FPL. Low-income individuals up to 250 percent of the FPL in the State's high risk pool (CHIP) will also be eligible to receive vouchers.

- Expansion of the State's high risk pool (Section 7 CHIP pool) by providing vouchers for persons rejected from coverage due to preexisting medical conditions.

The proposal also includes strategies to expand coverage for students and individuals between jobs:

- Requires that full-time and part-time college students obtain health care coverage through their learning institution, or through another source (paid for out-of-pocket). Accordingly, require colleges and universities to include a minimum health benefit package as part of tuition and fees.

- Provides bridge loans to unemployed individuals and expands the Illinois Continuation Law to allow for COBRA-like timeframes for coverage until 18 months after employment ends instead of the current nine months of coverage.

The proposal also suggests implementing a reinsurance program to either subsidize insurance for small groups and low-income workers, to operate as a risk transfer plan for all carriers providing health insurance in the State or for those insurers participating in small employer initiatives.

The proposer designed the "Safety Net Benefit Package" that will be offered to enrollees of ESI and SEPC to provide coverage for preventive care and reflect the core components of basic major medical protection. This package does not include skilled nursing facility, dental or vision services, albeit those services can be made available for purchase for an additional fee. Individuals who obtain coverage through the Medicaid expansion may gain access to long-term care benefits currently available in Medicaid, assuming that any new Medicaid expansion would not limit the benefits available to newly covered individuals.[1]

Additional background information for this proposal can also be found on the Task Force's website (http://www.idph.state.il.us/hcja/resources.htm).

[1] The Deficit Reduction Act of 2005 allows states some flexibility in the benefit package offered to newly Medicaid eligible individuals.

Evaluation of Proposal

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
1. Access *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 8.0 *Total Weighted Score:* 12.0	a) Provides coverage to all Illinois residents *Assign 1-5 points, 5 represents coverage to all residents* b) Mandates coverage *Assign 1 point if coverage is mandatory* c) Includes provisions to avoid crowd-out of private insurance *Assign 1-2 points for provisions to avoid crowd-out of private insurance* d) Includes provisions for portability, i.e., individuals maintain coverage as life circumstances (e.g., employment, transition from Medicaid, etc.) and health status change *Assign 1-2 points for provisions for portability*	a) **3.5 points** – Provides the vast majority of uninsured with additional health care insurance coverage options. The proposal does not guarantee take-up by employers and individuals of the new health care coverage options, however, and projected take-up of proposed options indicates somewhat limited participation. Preliminary model results indicate that these efforts would result in health care coverage for approximately one-fifth of Illinois' uninsured. However, the proposal does not provide coverage to: • Non-disabled individuals who are not eligible for public programs, are not employed or seeking employment or attending college and do not have access to health insurance through a family member. • Part-time workers in firms 25+ who do not have access to coverage through their employer, a family member, and are not eligible for public programs. While the proposal allows bridge loans for the use of COBRA, the take-up of coverage under this option	• The proposal does not: ➢ Contain strong incentives for employers to take up new coverage ➢ Require employers to extend any new coverage to part-time employees. • The recently unemployed may not seek bridge loans because of concern that they may not be able to repay them. While the proposal indicates that these are no-interest loans that will not have to be repaid until a specified number of months after beginning a new job, individuals may be reluctant to incur the future cost, especially if they are relatively healthy and do not perceive an immediate need for health care. • The proposal bases copayments and deductibles for the ESI and SEPC expansions using a sliding scale based on FPL. • The proposal does not specifically address issues related to language or cultural barriers or geographic distances. This evaluation assumes that this approach would rely on expanded health care coverage and corresponding provider payment for previously ineligible populations to

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		would be limited based on consumer perceptions of affordability. b) **0.5 points** – Does not include mandatory coverage, except for college students. However, the proposer has indicated that while the coverage options in their proposal are voluntary, ultimately universal coverage may require employer and individual insurance coverage mandates. c) **2.0 points** – Uses specific crowd-out provisions for the ESI and SEPC programs. d) **2.0 points** – Expands current portability of insurance by (1) expanding the use of COBRA and continuation for individuals transitioning between jobs and (2) requiring the college students obtain health care coverage.	promote the development of linguistically and culturally appropriate providers in previously underserved areas (geographically or otherwise).
2. Financing *Criteria Weight:* 15.0 *Possible Points:* 8.0 *Assigned Points:* 8.0 *Total Weighted Score:* 13.3	a) Finances additional costs through an approach that incorporates proper load-sharing between providers, insurers, state government and patient/taxpayers *Assign 1-5 points for approaches that spread burden of costs across providers, insurers, state and federal government and taxpayers* b) Maximizes federal funds *Assign 1-2 points for approaches that*	a) **4.0 points** – Places the majority of the financing load on employer and beneficiary contributions, Federal Medicaid funds, State Medicaid funds and general State revenues. The proposal also suggests insurance market reforms to reduce premium costs. The proposer has indicated that it would be the Adequate Health Care Task Force's decision as to how the state would collect any additional revenues required for this expansion.	• This proposal focuses on establishing an affordable benefit package that – while less comprehensive than the benefit package specified in the Health Care Justice Act – focuses on affordability for individuals and employers as the proposers point out that approximately half of Illinois' uninsured population is below 200 percent of the FPL. Low-income populations up to 200 percent of the FPL either pay nothing out-of-pocket, or have their health care costs

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	maximize federal funds c) Enhances affordability for small employers *Assign 1-2 points for features that enhance affordability for small employers*	b) **2.0 points** – Uses Medicaid funds to expand coverage to low-income uninsured parents, and those individuals that will be newly Medicaid-eligible under the ESI program. c) **2.0 points** – Provides small employers with the opportunity to participate in a statewide purchasing group that includes a limited benefit package – "Safety Net Benefit Package". Also considers the use of reinsurance for small employers, placing further restrictions on underwriting or rates under Illinois' Small Employer Health Insurance Rating Act, and examining possible reforms to the Health Care Purchasing Group Act.	subsidized, depending on the specific FPL level. • The proposal's emphasis on expanding employer-based sources of coverage will allow employers that newly offer health care coverage to obtain tax exclusions.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
3. Benefit Package *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 7.0 *Total Weighted Score:* 10.5	a) Provides full range of benefits specified in the Health Care Justice Act: 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 *Assign 0 – 10 points for services offered*	a) **7.0 points** –While the proposer's Medicaid expansion to parents will include the full Medicaid package, the Safety Net Benefit Package proposed for the ESI and SEPC populations is limited to preventive care and the core components of basic major medical protection unless extra benefits such as vision and dental are purchased independently of the standard package. While the benefit package would include mental health, substance abuse and rehabilitation services, and services for the developmentally disabled, significant service and/or unit limitations would be necessary to stay within the cost constraints proposed ($150/month premium). The proposer has indicated a support for mental health and substance abuse parity, and also indicated that these would be limited as all other benefits in the Safety Benefit Package– by service/unit restrictions. The proposal also does not does not include long-term care.	This proposal's Safety Net Benefit Package emphasizes preventive care services, and services related to major medical protection. As such, it may not be as responsive to the needs of individuals with disabilities or needs that result from a major illness of injury. Also the proposal does not include long-term care services, which are important to people with physical, developmental disabilities, the elderly, and people with ongoing mental health needs.
4. Implementation *Criteria Weight:* 7.0 *Possible Points:* 15.0 *Assigned Points:* 10.5	a) Legal and regulatory changes required to implement the proposal can be accomplished within 1-3 years *Assign 0-5 points for ability to obtain legal and regulatory approvals that are necessary for implementation* b) Federal waivers, if required, can be	a) **5.0 points** – Assuming political support, the State could accomplish proposed changes within 1-3 years. b) **3.0 points** – An 1115 federal waiver would be necessary to obtain federal Medicaid and SCHIP funding for the newly eligible portion SCHIP and	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
Total Weighted Score: 4.9	implemented within 1-3 years *Assign 0-5 points for feasibility in obtaining federal waivers* c) Includes provisions for a reasonable phase-in period that does not cause significant disruptions for employers or consumers *Assign 0-3 points for reasonable phase-in approaches and timelines* d) Includes accountabilities for ongoing performance, cost and quality *Assign 0-2 points for features that assure accountabilities related to ongoing performance, cost and quality*	Medicaid beneficiaries. The State has currently committed all of its disproportionate share hospital and SCHIP funding, which are two of the major sources of funding that states generally use to make 1115 waiver programs budget neutral. As such, the State's ability to obtain waiver approval will largely rely on its ability to move SCHIP eligibles into the Medicaid program so that SCHIP allotment could be freed up for waiver funding purposes. It is not clear at this point whether or not the federal government will allow a shift in SCHIP populations to the Medicaid program. If not, alternative approaches to achieving budget neutrality for waiver approval purposes could be considered but discussions with the Centers for Medicare and Medicaid Services will be critical to confirm feasibility. c) **2.0 points** – Does not include provisions for a phase-in period, or indicate whether or not a phase-in period might be necessary. The proposal builds on the State's current health care system, which will ease implementation. Employers may find it difficult to understand and choose between the ESI and SEPC approaches. d) **0.5 points** – Maintains current	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		system's accountabilities regarding performance, cost and quality.	
5. Quality *Criteria Weight:* 7.0 *Possible Points:* 2.0 *Assigned Points:* 1.0 *Total Weighted Score:* 3.5	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) *Assign 1 point for incentives to improve quality* b) Promotes integration and coordination among parts of the delivery system *Assign 1 point for provisions that promote coordination within delivery system*	a) **0.5 points** – Does not include incentives to improve quality beyond those currently included in the health care system. 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 proposal builds on the current health care system structure and does not include specific incentives related to quality or integration and coordination among parts of the delivery system. The proposal's impact on quality of care is likely neutral – neither decreasing nor increasing the current quality of care.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
6. Cost-efficiency *Criteria Weight:* 7.0 *Possible Points:* 12.0 *Assigned Points:* 6.5 *Total Weighted Score:* 3.8	a) Controls growth in overall and per capita expenditures for health care: i) Health insurance premiums ii) Public program expenditures iii) Capital iv) Technology v) Administrative costs vi) Prescription drugs vii) Others *Assign 0-10 points for features that control growth in expenditures* 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 *Assign 0-2 points for mechanisms that take into account standards of care in establishing spending priorities*	a) **6.0 points** – Provides significant incentives to control health insurance premiums costs through health care market reform and the use of reinsurance. 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. Does not provide other incentives to reduce costs. May increase administrative costs through the addition of new coverage options. b) **0.5 points** – Does not include mechanisms for generating spending priorities; maintains current health care system's approach.	• In addition to beneficiary cost-sharing, proposal contains changes that would help slow the rise in health insurance premiums – specifically, the use of a reinsurance program to subsidize health insurance for small groups and low-income workers. • Expands Medicaid, which includes disease management and care coordination activities that may reduce health care costs. • By expanding coverage to additional uninsured, this proposal assists providers in reducing their uncompensated costs for the uninsured. It does not however, contain specific provisions to incent providers to be more cost-effective.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
7. Availability of Resources, Capital and Technology *Criteria Weight:* 5.0 *Possible Points:* 6.0 *Assigned Points:* 1.5 *Total Weighted Score:* 1.3	a) Includes provisions for new capital, technology, medical education, research *Assign 0-4 points for features that address expenditures for new capital, technology, medical education and research* b) Includes provisions to protect and enhance, where necessary, the safety-net system *Assign 0-2 points for features that protect and enhance the safety-net system*	a) **0.5 points** – Does not include provisions for new capital, technology, medical education or research beyond those currently allowed by the current health care system. b) **1.0 points** – While the proposal does not target specific funding at the safety-net system, it does increase coverage for the uninsured which can help relieve the uncompensated care costs borne by safety-net providers. However, because individuals remain uninsured, and some benefit packages are limited, protection of the safety-net system may be limited.	The proposal maintains the current process for allocating resources, capital and technology, although it does decrease the costs of the safety-net system by reducing the number of uninsured.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
8. Prevention and Wellness *Criteria Weight:* 10.0 *Possible Points:* 2.0 *Assigned Points:* 1.5 *Total Weighted Score:* 7.5	a) Includes incentives that reward individual wellness *Assign 1 point for wellness incentives* b) Contains policies to promote continuity of care *Assign 1 point for policies to promote continuity of care*	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. b) **1.0 points –** Promotes continuity of care by expanding Medicaid, which now includes primary care case management and disease management programs, increasing health care coverage options, and allowing for additional coverage during periods of unemployment so that individuals can maintain access to a provider network.	• The proposal does not specifically address individual behaviors regarding prevention and wellness, relying on the current health care system's efforts to do so. • The proposal includes preventive care within the different proposed benefit packages, which may reduce preventable disease and disability.
9. Consumer and Stakeholder Participation *Criteria Weight:* 2.5 *Possible Points:* 3.0 *Assigned Points:* 0.5 *Total Weighted Score:* 0.4	a) Provides consumers (and their advocates) with opportunities to participate in program design at both the local and regional level *Assign 1-3 points for opportunities for consumer input regarding technologies, capital and program design*	a) **0.5 points** – Does not include provisions to provide consumers with opportunities to participate in program design at both the local and regional level beyond those currently allowed by the current health care system.	The proposal maintains the health care system's current approach to allowing for consumer and other stakeholder participation in decisions regarding program design.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
10. Consumer Autonomy *Criteria Weight:* 4.0 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 4.0	a) Provides consumers with choices of health plans and provider networks *Assign 1 point for provisions that provide consumers with choices related to health plans and provider networks*	a) **1.0 points –** Consumers have increased access to health plans through the new coverage options, and receive education related to the availability of coverage.	
11. Provider Autonomy *Criteria Weight:* 2.5 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 2.5	a) Preserves providers' clinical autonomy *Assign 1 point for provisions that promote provider autonomy in caregiving practices*	a) **1.0 points –** Does not restrict providers' clinical autonomy.	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
12. Provider Payment *Criteria Weight:* 10.0 *Possible Points:* 4.0 *Assigned Points:* 2.5 *Total Weighted Score:* 6.3	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* b) Reduces administrative burdens on providers *Assign 0-2 points for provisions that reduce administrative burdens on providers*	a) **2.0 points –** Proposal supports increases in provider payment rates for State programs, including Medicaid. Proposed 40-50 percent increase in hospital payment rates will require additional commitment of funding from the State legislature in addition to any funding required for proposed expansions. b) **0.5 points –** Proposal does not address administrative burden related to providers and maintains the current system's approach.	

Appendix D-3: Healthy Illinois

APPENDIX D-3: HEALTHY ILLINOIS

Summary of Proposal

The Healthy Illinois Campaign[1] proposes the use of a State self-funded insurance plan to provide access to comprehensive health insurance for all Illinois residents not already covered through other public health programs. This voluntary plan provides health insurance for small businesses, small municipalities, self-employed and other uninsured individuals. A third-party administrator will administer the plan and negotiate reimbursement rates with hospitals and practitioners to create a statewide provider network. Additionally

- The State will fund 50 percent of the small employers' total insurance premiums. The remaining 50 percent of the premiums will be covered by a combination of employer contributions (which must be at least 60 percent of the remaining costs) and employee contributions.

- For self-employed and other uninsured individuals under 300 percent of the federal poverty limit (FPL), the State will subsidize up to 80 percent of the insurance costs. The State will calculate the remaining individual contribution based on a sliding scale.

Funding for the State self-funded insurance plan will come from a windfall profit assessment, set at four percent of annual health insurance premiums collected on Illinois insurance polices. The proposal also requires public reporting of providers' and insurance companies' cost increases and profits, establishes a Health Resource Plan to determine if health care facilities' expansions are consistent with state goals, and establishes an Healthy Illinois Quality Forum to promote nationally established best practices and establish incentives for consumers to adopt healthier lifestyles. The proposal does not include a Medicaid or State Children's Health Insurance Program (SCHIP) expansion.

Additional background information for this proposal can also be found on the Task Force's website (http://www.idph.state.il.us/hcja/resources.htm).

[1] The Healthy Illinois Campaign includes Citizen Action/Illinois, Illinois for Health Care, Service Employees International Union State Council, American Federation of State, County and Municipal Employees Council 31, Sargent Shriver National Center of Poverty Law, Center for Tax and Budget Accountability and the United Power for Action and Justice.

Evaluation of Proposal

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
1. Access *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 6.5 *Total Weighted Score:* 9.8	a) Provides coverage to all Illinois residents *Assign 1-5 points, 5 represents coverage to all residents* b) Mandates coverage *Assign 1 point if coverage is mandatory* c) Includes provisions to avoid crowd-out of private insurance *Assign 1-2 points for provisions to avoid crowd-out of private insurance* d) Includes provisions for portability, i.e., individuals maintain coverage as life circumstances (e.g., employment, transition from Medicaid, etc.) and health status change *Assign 1-2 points for provisions for portability*	a) **3.5 points** –Qualifies small employers and municipalities and all individuals not already eligible for public assistance programs and not covered through an employer to enroll in a State self-funded insurance plan. The proposal does not guarantee take-up by employers and individuals of the new health care coverage option, however, and projected take-up of proposed options indicates somewhat limited participation. Preliminary model results indicate that these efforts would result in health care coverage for approximately one-fifth of Illinois' uninsured. b) **0.0 points** – Is voluntary, so coverage for all Illinois residents is not expected. c) **2.0 points** – Contains some crowd-out provisions for the State self-funded insurance plan. d) **1.0 point** – Provides for some portability of coverage because everyone is eligible for the plan and no individual can be excluded as a result of a pre-existing condition. However, individuals must be uninsured before they can apply for the State self-funded insurance plan,	• Covers individuals, using sliding-scale subsidies, who lose health insurance coverage due to unemployment and who cannot afford to purchase other insurance. • Requires that individuals participating in the State self-funded insurance plan certify that — if they are an employee of an eligible employer — their current employer did not provide access to a benefits plan in the 12-month period immediately preceding the eligible individual's application. • Does not specify the method for assessing copayments (i.e., sliding scale, flat fee, etc.). Proposal suggests that preventive services will be fully covered with no cost sharing. • Does not specifically address issues related to language or cultural barriers or geographic distances. It does, however, establish an Illinois Quality Forum to promote nationally established best practices to reduce regional, economic and racial disparities in the health care system. For more information about this Forum, see the Quality section.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		creating the potential for a period of lack of coverage.	
2. Financing *Criteria Weight:* 15.0 *Possible Points:* 9.0 *Assigned Points:* 5.0 *Total Weighted Score:* 8.3	a) Finances additional costs through an approach that incorporates proper load-sharing between providers, insurers, state government and patient/taxpayers *Assign 1-5 points for approaches that spread burden of costs across providers, insurers, state and federal government and taxpayers* b) Maximizes federal funds *Assign 1-2 points for approaches that maximize federal funds* c) Enhances affordability for small employers *Assign 1-2 points for features that enhance affordability for small employers*	a) **3.0 points** – The majority of the funding for the proposal will come from the new windfall profit assessment, which will be borne primarily by individuals currently participating in fully funded private coverage. Employers and individuals will commit additional resources for health care coverage to the extent they participate in the voluntary State self-funded insurance plan. b) **0.0 points** – Proposal does not contain provisions to maximize federal financial participation. c) **2.0 points** – The State self-funded health plan will target small employers and small municipalities; the State will subsidize 50 percent of the small employers' total premium.	• The proposal's financing will come largely from the windfall profit assessment, however preliminary modeling estimates show that additional funding would be necessary. • The proposal's emphasis on expanding employer-based sources of coverage will allow employers that newly offer health care coverage to obtain tax exclusions.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
3. Benefit Package *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 7.0 *Total Weighted Score:* 10.5	a) Provides full range of benefits specified in the Health Care Justice Act: 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 *Assign 0 – 10 points for services offered*	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. • 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.	• 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.
4. Implementation *Criteria Weight:* 7.0 *Possible Points:* 15.0 *Assigned Points:* 10.0 *Total Weighted Score:* 7.0	a) Legal and regulatory changes required to implement the proposal can be accomplished within 1-3 years *Assign 0-5 points for ability to obtain legal and regulatory approvals that are necessary for implementation* b) Federal waivers, if required, can be implemented within 1-3 years *Assign 0-5 points for feasibility in*	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. b) **Not applicable — Excluded from total points that are subject to the criteria weight.** c) **3.0 points** – Proposal suggests the	• 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 for those employers who continue to use the private insurance market.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	obtaining federal waivers c) Includes provisions for a reasonable phase-in period that does not cause significant disruptions for employers or consumers *Assign 0-3 points for reasonable phase-in approaches and timelines* d) Includes accountabilities for ongoing performance, cost and quality *Assign 0-2 points for features that assure accountabilities related to ongoing performance, cost and quality*	following: • Considering capped individual enrollments during a pre-defined phase-in period to control premiums and sustain enrollment. • Considering mandatory waiting periods for those individuals who have withdrawn from the State self-funded health plan after previous enrollment. • Also, proposal suggests an option to phase-in additional enrollment through large employers in the State self-funded plan after the first year of the program. d) **2.0 points** – Includes provisions to monitor ongoing cost through insurance company, hospital and practitioner reporting. Establishes a new agency, Healthy Illinois Authority, to develop system performance and quality improvement measures. Establishes the Healthy Illinois Quality Forum.	• The insurance industry will likely consider the insurance carrier tax as an undue burden on their business, and it may have the impact of reducing the number of carriers in Illinois.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
5. Quality *Criteria Weight:* 7.0 *Possible Points:* 2.0 *Assigned Points:* 2.0 *Total Weighted Score:* 7.0	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) *Assign 1 point for incentives to improve quality* b) Promotes integration and coordination among parts of the delivery system *Assign 1 point for provisions that promote coordination within delivery system*	a) **1.0 points** – Creates a Healthy Illinois Quality Forum, which will promote best practices that reduce regional, economic and racial health care disparities. After the third year of program implementation, the Forum will develop incentives (e.g., pay-for-performance) that encourage the adoption of these measures by insurers, providers and other stakeholders. b) **1.0 points** – Includes a Health Resource Plan that will establish a comprehensive and coordinated approach to the development of healthcare facilities and resources. Also promotes common quality measures for Illinois providers and insurers.	The proposal does not include specific provisions for culturally-competent care, however, the Healthy Illinois Quality Forum could seek to address these issues as part of its focus on regional or racial health care disparities.
6. Cost-efficiency *Criteria Weight:* 7.0 *Possible Points:* 12.0 *Assigned Points:* 9.0 *Total Weighted Score:* 5.3	a) Controls growth in overall and per capita expenditures for health care: i) Health insurance premiums ii) Public program expenditures iii) Capital iv) Technology v) Administrative costs vi) Prescription drugs vii) Others	a) **8.0 points** – Controls growth through the following methods: • Provides incentives to control provider and insurer costs; does not address public program costs separately. • Includes cost-sharing for individuals. • Contains administrative costs by outsourcing plan through a competitive bid process;	• Proposal does not propose any managed care components like care coordination, case management or disease management for the State Plan. • Proposal relies on ability to achieve discounts on provider payments through negotiating rates through the State self-funded health plan. Also will require that hospitals submit an annual report that lists cost increases and hospital operating

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	Assign 0-10 points for features that control growth in expenditures 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 *Assign 0-2 points for mechanisms that take into account standards of care in establishing spending priorities*	however, may increase administrative costs through the addition of new coverage options. Also, creates one State agency, the Healthy Illinois Authority, to coordinate benefits. b) **1.0 point** – While the proposal establishes a Healthy Illinois Quality Forum that will conduct research on best practices, identify and promote the adoption of nationally endorsed performances measures, and gather and disseminate information on healthcare quality and patient safety, this Forum will not specifically generate spending priorities based on these activities.	margin for the fiscal year, and will contain requirements for health care practitioners to report gains in net revenue. • Contains provisions to control capital and technology expenditures through more stringent Certificate of Need process for facility expansions. • Incorporates some cost-sharing for beneficiaries to connect consumers to the cost of their own health care, but not for preventive services. • By expanding coverage to additional uninsured, this proposal will assist providers in reducing their uncompensated cost for the uninsured. Because the State self-funded health plan is able to negotiate lower provider rates, it is possible that the proposal will encourage providers to reduce their prices to be more competitive.
7. Availability of Resources, Capital and Technology *Criteria Weight:* 5.0 *Possible Points:* 6.0 *Assigned Points:* 4.0	a) Includes provisions for new capital, technology, medical education, research *Assign 0-4 points for features that address expenditures for new capital, technology, medical education and research* b) Includes provisions to protect and enhance, where necessary, the safety-	a) **3.0 points** – Creates a biennial Health Resource Plan that will contain a comprehensive, coordinated approach to the development of health care facilities and resources based on statewide cost, quality and access goals and strategies. Providers must coordinate with this plan as part of the Certificate of Need process. The Healthy Illinois Quality	• The Health Resource Plan, which will coordinate health resources and facilities throughout the State, could help the State better focus health planning, target underserved areas and allocate resources. • This proposal relies on a health facilities planning function. • Proposal does not specifically

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
Total Weighted Score: 3.3	net system *Assign 0-2 points for features that protect and enhance the safety-net system*	Forum will conduct research on best practices. Proposal does not specifically address medical education. b) **1.0 points** – While the proposal does not include specific funding that is targeted at the safety-net system, it does increase coverage for the uninsured which will relieve the uncompensated care costs borne by safety-net providers.	address the creation of incentives to use for all types of health care professionals or increase the number of providers of color.
8. Prevention and Wellness *Criteria Weight:* 10.0 *Possible Points:* 2.0 *Assigned Points:* 2.0 *Total Weighted Score:* 10.0	a) Includes incentives that reward individual wellness *Assign 1 point for wellness incentives* b) Contains policies to promote continuity of care *Assign 1 point for policies to promote continuity of care*	a) **1.0 points** – Gives incentives to patients to adopt healthy lifestyles by subsidizing health club memberships and covering preventive services with no copayments or deductibles. 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. b) **1.0 points –** Provides continuity of care by increasing portability of health insurance coverage, regardless of employment status or income.	The State self-funded insurance plan might not include the same provider networks as private insurance products, so not all individuals will be able to achieve continuity of care with regard to providers.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
9. Consumer and Stakeholder Participation *Criteria Weight:* 2.5 *Possible Points:* 3.0 *Assigned Points:* 2.0 *Total Weighted Score:* 1.7	a) Provides consumers (and their advocates) with opportunities to participate in program design at both the local and regional level *Assign 1-3 points for opportunities for consumer input regarding technologies, capital and program design*	a) **2.0 points** – Proposal's Health Resource plan will be developed with both regional and local input. Proposal does not specifically describe any other consumer participation opportunities in program design.	The proposal suggests purchasing health care on the State level.
10. Consumer Autonomy *Criteria Weight:* 4.0 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 4.0	a) Provides consumers with choices of health plans and provider networks *Assign 1 point for provisions that provide consumers with choices related to health plans and provider networks*	a) **1.0 points** – Consumers will have increased access to health plans through the new coverage options.	While individuals will have a new coverage option, they will not have choices with regard to health insurance product (e.g., HMO, PPO) or provider network.
11. Provider Autonomy *Criteria Weight:* 2.5 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 2.5	a) Preserves providers' clinical autonomy *Assign 1 point for provisions that promote provider autonomy in caregiving practices*	a) **1.0 points** – Does not restrict providers' clinical autonomy.	

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

Appendix D-4: Members of the Adequate Health Care Task Force Associated with the Insurance Industry

APPENDIX D-4: MEMBERS OF THE ADEQUATE HEATH CARE TASK FORCE ASSOCIATED WITH THE INSURANCE INDUSTRY

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).

- 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.

Additional background information for this proposal can also be found on the Task Force's website (http://www.idph.state.il.us/hcja/resources.htm).

APPENDIX D-4: MEMBERS OF THE ADEQUATE HEATH CARE TASK FORCE ASSOCIATED WITH THE INSURANCE INDUSTRY

Evaluation of Proposal

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
1. Access *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 7.0 *Total Weighted Score:* 10.5	a) Provides coverage to all Illinois residents *Assign 1-5 points, 5 represents coverage to all residents* b) Mandates coverage *Assign 1 point if coverage is mandatory* c) Includes provisions to avoid crowd-out of private insurance *Assign 1-2 points for provisions to avoid crowd-out of private insurance* d) Includes provisions for portability, i.e., individuals maintain coverage as life circumstances (e.g., employment, transition from Medicaid, etc.) and health status change *Assign 1-2 points for provisions for portability*	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. b) **0.0 points** – Does not include individual or employer mandate. c) **2.0 points** – Avoids crowd-out through emphasis on private insurance. d) **1.0 point** – Does not include options to make COBRA more affordable or provide other coverage during insurance transitions such as a job loss.	• 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.
2. Financing	a) Finances additional costs through an approach that incorporates proper load-sharing between providers,	a) **3.0 points** – Finances plan through Medicaid funds, State revenue growth above three percent, employer	• Establishes a specific source of funding for expansion financing (state revenue growth above three

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
Criteria Weight: 15.0 *Possible Points:* 9.0 *Assigned Points:* 7.0 *Total Weighted Score:* 11.7	insurers, state government and patient/taxpayers *Assign 1-5 points for approaches that spread burden of costs across providers, insurers, state and federal government and taxpayers* b) Maximizes federal funds *Assign 1-2 points for approaches that maximize federal funds* c) Enhances affordability for small employers *Assign 1-2 points for features that enhance affordability for small employers*	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. 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. 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	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 that newly offer health care coverage to obtain tax exclusions.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		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. c) **2.0 points** – Promotes state and federal tax incentives for small employers.	
3. Benefit Package *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 7.0 *Total Weighted Score:* 10.5	a) Provides full range of benefits specified in the Health Care Justice Act: 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 *Assign 0 – 10 points for services offered*	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, this flexibility is not expected to result in large increases in the number of uninsured obtaining access to a full range of benefits. Proposal encourages the purchase of long-term care insurance through Long-Term Care Parternships. Proposal does not address parity for substance abuse services and lacks recommendations on the additional	• 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 of injury. • Expands Medicaid, which provides a comprehensive benefit package including mental health and 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

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		provision of services for the developmentally disabled population. 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.	implemented, this change could result in reduced access to care for current Medicaid eligibles. • 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. • Does not specifically address populations that may have specific needs (i.e., rural health care, developmentally disabled, etc.)
4. Implementation *Criteria Weight:* 7.0 *Possible Points:* 15.0 *Assigned Points:* 10.5	a) Legal and regulatory changes required to implement the proposal can be accomplished within 1-3 years *Assign 0-5 points for ability to obtain legal and regulatory approvals that are necessary for implementation*	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	Requires elimination of premium taxes on high-deductible health plans offered with HSAs. Proposer has indicated that moving to a "funding-centric" system (i.e., block grant or personal health accounts)

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
Total Weighted Score: 4.9	b) Federal waivers, if required, can be implemented within 1-3 years *Assign 0-5 points for feasibility in obtaining federal waivers* c) Includes provisions for a reasonable phase-in period that does not cause significant disruptions for employers or consumers *Assign 0-3 points for reasonable phase-in approaches and timelines* d) Includes accountabilities for ongoing performance, cost and quality *Assign 0-2 points for features that assure accountabilities related to ongoing performance, cost and quality*	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. 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 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	would enhance predictability and stability of costs.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		be achieved for budget neutrality purposes. 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. d) **1.0 point** – While the proposal supports accelerating the adoption of health insurance technology and indicates that establishing an health 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.	

APPENDIX D-4: MEMBERS OF THE ADEQUATE HEATH CARE TASK FORCE ASSOCIATED WITH THE INSURANCE INDUSTRY

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
5. Quality *Criteria Weight:* 7.0 *Possible Points:* 2.0 *Assigned Points:* 1.5 *Total Weighted Score:* 5.3	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) *Assign 1 point for incentives to improve quality* b) Promotes integration and coordination among parts of the delivery system *Assign 1 point for provisions that promote coordination within delivery system*	a) **1.0 points** – Proposes increasing the use of pay-for-performance, but does not provide a specific approach to do so. 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).	• 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.
6. Cost-efficiency *Criteria Weight:* 7.0 *Possible Points:* 12.0 *Assigned Points:* 6.5 *Total Weighted Score:* 3.8	a) Controls growth in overall and per capita expenditures for health care: i) Health insurance premiums ii) Public program expenditures iii) Capital iv) Technology v) Administrative costs vi) Prescription drugs vii) Others *Assign 0-10 points for features that control growth in expenditures*	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. • 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 Medicaid program, the ability of Medicaid managed care to achieve	• 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 costs do not meet the reinsurance threshold.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	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 *Assign 0-2 points for mechanisms that take into account standards of care in establishing spending priorities*	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. • 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. • Includes cost-sharing for individuals.	• 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.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		b) **0.5 points** – Does not include mechanisms for generating spending priorities; maintains current health care system's approach.	
7. Availability of Resources, Capital and Technology *Criteria Weight:* 5.0 *Possible Points:* 6.0 *Assigned Points:* 3.0 *Total Weighted Score:* 2.5	a) Includes provisions for new capital, technology, medical education, research *Assign 0-4 points for features that address expenditures for new capital, technology, medical education and research* b) Includes provisions to protect and enhance, where necessary, the safety-net system *Assign 0-2 points for features that protect and enhance the safety-net system*	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. 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.	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.

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Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
8. Prevention and Wellness *Criteria Weight:* 10 *Possible Points:* 2.0 *Assigned Points:* 1.0 *Total Weighted Score:* 5.0	a) Includes incentives that reward individual wellness *Assign 1 point for wellness incentives* b) Contains policies to promote continuity of care *Assign 1 point for policies to promote continuity of care*	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. 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.	
9. Consumer and Stakeholder Participation *Criteria Weight:* 2.5 *Possible Points:* 3.0 *Assigned Points:* 1.0 *Total Weighted Score:* 0.8	a) Provides consumers (and their advocates) with opportunities to participate in program design at both the local and regional level *Assign 1-3 points for opportunities for consumer input regarding technologies, capital and program design*	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.	

APPENDIX D-4: MEMBERS OF THE ADEQUATE HEATH CARE TASK FORCE ASSOCIATED WITH THE INSURANCE INDUSTRY

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
10. Consumer Autonomy *Criteria Weight:* 4.0 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 4.0	a) Provides consumers with choices of health plans and provider networks *Assign 1 point for provisions that provide consumers with choices related to health plans and provider networks*	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.	
11. Provider Autonomy *Criteria Weight:* 2.5 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 2.5	a) Preserves providers' clinical autonomy *Assign 1 point for provisions that promote provider autonomy in caregiving practices*	a) **1.0 points** – Does not restrict providers' clinical autonomy.	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.

APPENDIX D-4: MEMBERS OF THE ADEQUATE HEATH CARE TASK FORCE ASSOCIATED WITH THE INSURANCE INDUSTRY

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
12. Provider Payment *Criteria Weight:* 10.0 *Possible Points:* 4.0 *Assigned Points:* 1.5 *Total Weighted Score:* 3.8	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* b) Reduces administrative burdens on providers *Assign 0-2 points for provisions that reduce administrative burdens on providers*	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. b) **0.5 points** – Proposal does not address current administrative burdens related to providers and maintains the current system's approach.	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.

Appendix D-5: Single Payer

APPENDIX D-5: SINGLE PAYER

Summary of Proposal

This proposal consolidates the administration and financing of the health financing system into one public program that covers all Illinois residents with a comprehensive benefit package. Financing for the program would come from dedicated payroll, income, and other dedicated taxes (which would replace all current spending by employers and individuals) and consolidated funding from state and federal programs (e.g., Medicaid, State Children's Health Insurance Program, state health care safety net funds, etc.). Financing preserves federal funding levels for programs such as Medicare. Private insurers would be allowed to sell supplemental or "gap coverage," including for the room and board portion of nursing home care. The proposal anticipates using the expected savings from simplifying the administration of the health financing system to cover all the uninsured in Illinois and to upgrade benefits for everyone else. Under the first two years of the program, there would be no cost-sharing for individuals, other than through payroll and income taxes. After two years, deductibles and co-payments would be implemented if necessary; except for primary care and prevention.

The benefit package in the single payer proposal is comprehensive; it includes all medically necessary services including dental and vision benefits. Participants would be encouraged to choose a primary care physician to manage their care. The proposal also includes long-term care services, including home- and community-based services and the medical portion of nursing home and other institutional care. The room and board costs in long-term care facilities would be the individual's responsibility, except for individuals with low-income

Providers would remain as private entities under this proposal; however the proposal requires that investor-owned, for-profit hospitals and nursing homes transition to non-profit status by paying investors a fixed rate of return on existing equity. Hospitals and nursing homes would then receive an annual budget based on total spending for hospital and clinic services in the current system; separate budgets would be set for operations and capital expansion. Fee-for-service payment rates for other providers would be set so they are equal to overall average payment rates across all payers in today's system (i.e., private payers, Medicare and Medicaid).

Additional background information for this proposal can also be found on the Task Force's website (http://www.idph.state.il.us/hcja/resources.htm).

Evaluation of Proposal

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
1. Access *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 10.0 *Total Weighted Score:* 15.0	a) Provides coverage to all Illinois residents *Assign 1-5 points, 5 represents coverage to all residents* b) Mandates coverage *Assign 1 point if coverage is mandatory* c) Includes provisions to avoid crowd-out of private insurance *Assign 1-2 points for provisions to avoid crowd-out of private insurance* d) Includes provisions for portability, i.e., individuals maintain coverage as life circumstances (e.g., employment, transition from Medicaid, etc.) and health status change *Assign 1-2 points for provisions for portability*	a) **5.0 points** – Covers all Illinois residents. Modeling estimates indicate all Illinois residents – with the exception of those that have not yet lived in the state for a full three months – would be covered. b) **1.0 points** – Coverage is mandatory c) **2.0 points** – Eliminates private insurance with the exception of supplemental or gap coverage; thus, crowd-out is not an issue. d) **2.0 points** – Provides coverage during all phases of life and employment.	• Restricts eligibility to individuals living in Illinois for three months. Waives restriction for people relocating to Illinois to take a job, people experiencing a change in family status due to divorce or death of a spouse, for emergency services and for pregnant women. Individuals who have not met the three month residency requirement or who are from out-of-state will be charged (or their insurance, if they have coverage) the same rate as the fee schedule. • Allows individuals to purchase, on the private market, coverage for benefits not covered by the system, such as the room and board portion of nursing home care.
2. Financing *Criteria Weight:* 15.0 *Possible Points:* 9.0	a) Finances additional costs through an approach that incorporates proper load-sharing between providers, insurers, state government and patient/taxpayers *Assign 1-5 points for approaches that*	a) **5.0 points** –Completely revises current load-sharing by spreading health care costs over the entire population. b) **2.0 points** – Continues to draw down federal funds, and assumes	• Dissolves the for-profit private insurance market in the State, except for non-profit staff-model HMOs (which do not currently exist in Illinois) and insurers providing supplemental coverage and requires

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
Assigned Points: 9.0 *Total Weighted Score:* 15.0	*spread burden of costs across providers, insurers, state and federal government and taxpayers* b) Maximizes federal funds *Assign 1-2 points for approaches that maximize federal funds* c) Enhances affordability for small employers *Assign 1-2 points for features that enhance affordability for small employers*	that federal funding provided to the State in future years would be indexed to the average rate of growth in costs of other states' programs to assure that federal funding for Illinois is not reduced over time. c) **2.0 points** – Requires small businesses to contribute, via taxes, to the single payer system. However, these contributions may be less expensive than the cost of providing health coverage to employees in the current system, since all employers and individuals would share the cost of coverage.	all for-profit hospitals to transfer to non-profit status. Finances plan through accumulation of all public funds already used for health care in the State, including Medicaid, SCHIP, Medicare (contributions to Part D), Indian Health Service, Veterans Affairs and CHAMPUS and Federal Employee Health Benefit Program funds. Collects "progressive" taxes from individuals and employers to finance costs in excess of the amount of spending collected from existing program. • Relies heavily on the ability to consolidate all current federal and State health care monies used in Illinois. • Places large burden on certain segments of the Illinois economy since it dissolves much of the for-profit private health insurance market in the State, thereby eliminating jobs and creating the need for a job retraining function, as recognized in the proposal. Also, places large burden on for-profit hospitals, since it requires them to transition to non-profit status.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
3. Benefit Package *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 9.0 *Total Weighted Score:* 13.5	a) Provides full range of benefits specified in the Health Care Justice Act: 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 *Assign 0 – 10 points for services offered*	a) **9.0 points** – Covers all medically necessary services, including dental and vision, mental health, home-and community-based services and the medical portion of nursing home care. Does not cover additional nursing home services. Only covers nursing home room and board for low-income people. Allows people to buy "gap" coverage for nursing home "room and board" and any other care not covered under the program.	Excludes the following services: • Non-prescription medications and non-durable medical supplies • Health services determined to have no medical indication • Surgery, dermatology, orthodontia, prescription drugs, and other procedures primarily for cosmetic purposes, unless required to correct congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease or surgery • Private rooms in inpatient facilities unless determined to be medically necessary by a qualified licensed health care provider in the system • Room and board in long-term care (except for low-income) • Services provided by unlicensed or unaccredited providers
4. Implementation *Criteria Weight:* 7.0 *Possible Points:* 15.0 *Assigned Points:* 4.0 *Total Weighted Score:* 1.9	a) Legal and regulatory changes required to implement the proposal can be accomplished within 1-3 years *Assign 0-5 points for ability to obtain legal and regulatory approvals that are necessary for implementation* b) Federal waivers, if required, can be	a) **1.0 point** – Assuming political support, requires significant legal and regulatory changes to consolidate current public funding; implement new payroll and income taxes; and establish a new State agency. Requiring private for-profit hospitals and nursing homes to transition to non-profit status would	• Federal law supersedes state law, and about half of the employees who get health insurance through the workplace are in self-funded ERISA plans, which are governed by federal regulations. The authors of the proposal have been advised by legal experts that an ERISA waiver is not necessary since the program

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	implemented within 1-3 years *Assign 0-5 points for feasibility in obtaining federal waivers* c) Includes provisions for a reasonable phase-in period that does not cause significant disruptions for employers or consumers *Assign 0-3 points for reasonable phase-in approaches and timelines* d) Includes accountabilities for ongoing performance, cost and quality *Assign 0-2 points for features that assure accountabilities related to ongoing performance, cost and quality*	take longer than three years; the proposer recommends that the financing for this transition should be stretched out over 15-20 years since this is a large capital outlay for the state. b) **0.0 points** – Proposal assumes the state will be able to obtain needed Medicaid, Medicare (and, according to some experts, ERISA) waivers. Medicaid funding would require that the State negotiate a block grant with the federal government to main use of all of its Medicaid, SCHIP and disproportionate share hospital funds. No state has ever asked for Medicare or (if it turns out it is needed) ERISA waivers, so it is difficult to evaluate whether they will be forthcoming. All of these changes would not be possible without significant political support, which appears problematic. c) **1.0 points** – Contains provisions to enroll residents and begin collecting payroll and income taxes beginning January 1, 2007. The proposal allows the state to subcontract claims to a private, not-for-profit subs-contractor. Given that Illinois Blue Cross and Blue Shield (and other insurers) currently process Medicare claims in Illinois, the	does not "mandate" that employers provide benefits, but only that they collect a payroll tax (like Medicare). • Seniors in the federal Medicare program are outside of state law. • Contains provisions to retrain and provide financial support for displaced private insurance employees. • Private insurers will lose significant amounts of business. Illinois-based insurers will need to offer allowable insurance products (i.e., supplementary coverage or non-profit staff model HMOs) or choose to sell other forms of insurance (e.g. home, life, etc). For-profit hospital shareholders will be forced to liquidate investments as facilities are turned to non-profit hospitals, and the reasonable fixed rate of return offered by the State might not match the rate available under market conditions. • Global budgeting for institutional providers requires new administrative skills on the part of providers. • Implementation requires a large state-sponsored infrastructure. • The proposal suggests relying on the

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		transition in terms of paying providers is somewhat straightforward. Individuals will not have to change doctors or hospitals. Program implementation will cause significant disruptions for insurers, who are the major "losers" of this proposal. Clerical employees in insurance firms, hospitals, and physicians' offices will face the need to re-train for a new job in the health or other sector, of the economy. d) **2.0 points** – Establishes an independent agency to administer the single-payer system for Illinois. The agency would establish formulae and set health expenditure budgets, negotiate prices for prescription drugs and durable medical equipment, measure and evaluate indicators of quality and be responsible for other quality and planning functions.	experience of Medicare, the Veterans Administration, and other single payer programs to determine the best approach to program administration.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
5. Quality *Criteria Weight:* 7.0 *Possible Points:* 2.0 *Assigned Points:* 2.0 *Total Weighted Score:* 7.0	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) *Assign 1 point for incentives to improve quality* b) Promotes integration and coordination among parts of the delivery system *Assign 1 point for provisions that promote coordination within delivery system*	a) **1.0 points** – Includes provisions to provide feedback to providers on how their practices compare to the practices of other similar providers. Promotes evidence-based outcomes assessment and interventions. b) **1.0 points** – Includes a state health planning function, which will direct resources to areas of unmet need in terms of geography and specialty. Establishes a state long-term care planning board and a local public agency in each community to coordinate home and nursing home long term care. Also, creates integrated database.	• Contains 10 quality principles focused on evidence-driven standards of care and continuous quality improvement. • Creates integrated database will facilitate outcomes research and fraud detection. • Continues National Institute of Health and Agency for Healthcare Research and Quality quality initiatives.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
6. Cost-efficiency *Criteria Weight:* 7.0 *Possible Points:* 12.0 *Assigned Points:* 11.0 *Total Weighted Score:* 6.4	a) Controls growth in overall and per capita expenditures for health care: i) Health insurance premiums ii) Public program expenditures iii) Capital iv) Technology v) Administrative costs vi) Prescription drugs vii) Others *Assign 0-10 points for features that control growth in expenditures* 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 *Assign 0-2 points for mechanisms that take into account standards of care in establishing spending priorities*	a) **9.0 points** – Sets and enforces global budgets for hospitals and nursing homes, and sets spending priorities. Indexes spending growth to growth in GDP in Illinois. Budget levels would be set on the basis of long-run projected rate of growth in GDP over time to prevent fluctuations in health care spending from year to year as the result of the yearly variation in Illinois' GDP. Negotiates fees with providers and prices for prescription drugs and durable medical equipment. Allows for co-payments and deductibles beginning in year two of program. However, cost-containment strategies resemble those used in Canada's system, which has not always been successful in controlling the overall growth in per capita expenditures. b) **2.0 points** – Permits the Commissioner of new State agency to direct resources to areas of unmet need in terms of geography and specialty. Promotes evidence-based outcomes assessment and interventions.	• Consolidates private and public health insurance's administrative functions. Potentially reduces insurance overhead and overhead associated with billing and reimbursement in hospitals' doctor's offices and nursing homes over time. Eliminates insurance marketing costs. • Requires a large initial investment during and after program implementation to transition from the private market to a single-payer system. • Proposal allows for timely care and continuity of caregivers which fosters improved quality and reduces malpractice. • Assumes that malpractice awards would decrease since awards would not include future medical expenses; these expenses would be covered by the single-payer system.
7. Availability of Resources, Capital and Technology	a) Includes provisions for new capital, technology, medical education, research	a) **3.0 points** – Creates separate budgets for capital expansions and operations. Promotes electronic	Does not discuss if providers will be compensated for past investments in electronic health reporting software that

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
Criteria Weight: 5.0 *Possible Points:* 6.0 *Assigned Points:* 4.0 *Total Weighted Score:* 3.3	*Assign 0-4 points for features that address expenditures for new capital, technology, medical education and research* b) Includes provisions to protect and enhance, where necessary, the safety-net system *Assign 0-2 points for features that protect and enhance the safety net system*	health records, electronic lab reporting and electronic prescribing and proposes providing all providers with standard electronic medical software at no cost to the provider. Unified electronic records database may increase opportunities for research. b) **1.0 points** – Sets annual budgets for hospitals and clinics and bases fee-for-service payment rates so that, on average, payment rates under the program in the first year would be equal to overall average payment rates across all payers in today's system and decreases uninsurance rates. Both these initiatives will relieve uncompensated care costs borne by safety-net providers. Consumers will have the option to go to any doctor or hospital, thus relieving traditional "safety net" providers of their burden as the primary caregivers for the uninsured. Overall, however, program will still operate within fixed budgets, which limits opportunities for increases over and above GDP growth.	do not meet new standard and for the transition of health records into this new system.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
8. Prevention and Wellness *Criteria Weight:* 10.0 *Possible Points:* 2.0 *Assigned Points:* 2.0 *Total Weighted Score:* 10	a) Includes incentives that reward individual wellness *Assign 1 point for wellness incentives* b) Contains policies to promote continuity of care *Assign 1 point for policies to promote continuity of care*	a) **1.0 points –** Allows every Illinois resident to have a continuous "medical home" (that is, a primary care doctor or center where they receive preventive and acute care and individuals participate in their own care). Consolidated funding may allow for increased public health efforts by providers. b) **1.0 points –** Provides comprehensive benefit package through public insurance.	• Enlarges primary care workforce by using Illinois hospitals' share of Graduate Medicaid Education funds, bonuses, enhanced fees and non-monetary professional rewards to attract more professionals to primary care training programs.. • Prohibits co-payments or deductibles for preventive care
9. Consumer and Stakeholder Participation *Criteria Weight:* 2.5 *Possible Points:* 3.0 *Assigned Points:* 3.0 *Total Weighted Score:* 2.5	a) Provides consumers (and their advocates) with opportunities to participate in program design at both the local and regional level *Assign 1-3 points for opportunities for consumer input regarding technologies, capital and program design*	a) **3.0 points –** Allows consumers to sit on Board of single payer plan, along with providers and experts, participate in allocation of budget and health planning and participate in local long-term care agencies.	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
10. Consumer Autonomy *Criteria Weight:* 4.0 *Possible Points:* 1.0 *Assigned Points:* 0.5 *Total Weighted Score:* 2.0	a) Provides consumers with choices of health plans and provider networks *Assign 1 point for provisions that provide consumers with choices related to health plans and provider networks*	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.	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.
11. Provider Autonomy *Criteria Weight:* 2.5 *Possible Points:* 1.0 *Assigned Points:* 0.5 *Total Weighted Score:* 1.3	a) Preserves providers' clinical autonomy *Assign 1 point for provisions that promote provider autonomy in caregiving practices*	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.	• 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.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
12. Provider Payment *Criteria Weight:* 10.0 *Possible Points:* 4.0 *Assigned Points:* 3.0 *Total Weighted Score:* 7.5	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* b) Reduces administrative burdens on providers *Assign 0-2 points for provisions that reduce administrative burdens on providers*	a) **2.0 points** – Develops initial fee schedule that is the average of the current public and private fee schedules. The average fees received by some providers would increase under this new system and the average fees of some providers would decrease, depending on the proportion of patients currently seen with public health insurance coverage. Recommends rapid payment to providers. Also, if volume increases, the use of a global budget may pressure a reduction in fees over time. b) **1.0 point** – Reduces administrative burden on providers through simplified billing and administration. However, there is likely to be a large one-time administrative burden during the transition to a single payer system. Global budgeting process for hospitals will require administration time and costs for fee negotiations.	• The fee schedule is negotiated between physicians and the single payer, except in the first year, when a weighted average is used for ease of implementation.

Appendix D-6: Hybrid Model

APPENDIX D-6: HYBRID MODEL

Summary of Proposal

The Health Care Justice Act requires that the Adequate Health Care Task Force provide recommendations for a "health care access plan or plans that would provide access to a full range of preventive, acute and long-term health care services to residents of the State of Illinois". The Navigant Consulting, Mathematica Policy Research and Milliman Consulting team developed a proposal to accomplish the goal of the Health Care Justice Act that all Illinois residents have access to a comprehensive range of health care services. We have referred to this proposal as the "hybrid" model as it draws on features within various proposals introduced by Illinois interest groups, as well as models used in other states.

The "hybrid" proposal recognizes that the substantial additional funding required to accomplish the Act's goal must necessarily come from all parties – consumers, employers, providers, insurance carriers, the State and the federal government – redirecting resources now devoted to other types of spending. In addition, to achieve the goal of providing access to coverage for all Illinois residents, the proposal will require adoption of policies to promote cost-effectiveness of, and access to care. Specifically:

- Individuals would be mandated to obtain health insurance coverage.
- Employers would be mandated to spend a predetermined percentage of their payroll on health care coverage or pay that same amount to the State to help fund premium and deductible subsidies to make the mandated coverage affordable. (Play or Pay).
- Insurers would be limited on the spread in rates between the most expensive and least expensive rate classes for small group and individual products.
- Insurers would be required to make a new standard benefit package available that will qualify for subsidies.
- Current public coverage would be expanded.
- State funded subsidies would be available for residents below 400 percent of the Federal Poverty Level (FPL) who purchase the new standard package (as individuals or through their employer).

- The State would establish and administer the *Illinois Health Education and Referral Center (IHERC)* that would operate as an enrollment broker and information clearinghouse on coverage options, premium costs, provider quality, individual health care literacy and other information to educate consumers.

The goals of the hybrid proposal are three-fold:

- To preserve (and maximize) the population receiving coverage eligible for Federal matching funds
- To preserve the current employer-based coverage system with its employer contribution and federal tax deduction benefits
- To encourage personal responsibility for health care through the mandate and the inclusion of sliding scale deductibles for individuals with incomes over 150 percent of the FPL

Additional background information for this proposal can also be found on the Task Force's website (http://www.idph.state.il.us/hcja/resources.htm).

APPENDIX D-6: HYBRID MODEL

Evaluation of Proposal

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
1. Access *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 9.5 *Total Weighted Score:* 14.3	a) Provides coverage to all Illinois residents *Assign 1-5 points, 5 represents coverage to all residents* b) Mandates coverage *Assign 1 point if coverage is mandatory* c) Includes provisions to avoid crowd-out of private insurance *Assign 1-2 points for provisions to avoid crowd-out of private insurance* d) Includes provisions for portability, i.e., individuals maintain coverage as life circumstances (e.g., employment, transition from Medicaid, etc.) and health status change *Assign 1-2 points for provisions for portability*	a) **5.0 points** – Individual mandate, guaranteed issue and premium subsidy promote coverage for individuals; employer "play or pay" policy and limits on variation between rates between rate classes for individuals and small groups will encourage non-offering employers to begin offering coverage. Preliminary model results indicate that these efforts would result in health care coverage to over 95 percent of Illinois' currently uninsured population. b) **1.0 points** – Includes both an individual mandate and an employer "play or pay" provision. c) **2.0 points** – Avoids crowd-out; individuals eligible for public programs will not be eligible for premium subsides. Proposal encourages employers and individuals to maintain or obtain private market coverage. d) **1.5 point** – Does not include options to make COBRA more affordable; however, includes subsidies for all individuals below 400 percent of the FPL who purchase a new standard package.	• Recommends limits in the variation of rates for different rate classes in the small group and individual market, guaranteed issue for a standard benefit package that will be offered by all health plans so that plans have a strong incentive to compete on price.
2. Financing	a) Finances additional costs through an	a) **4.0 points** – Increases employer	• Suggests insurance market reforms

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
Criteria Weight: 15.0 *Possible Points:* 9.0 *Assigned Points:* 8.0 *Total Weighted Score:* 13.3	approach that incorporates proper load-sharing between providers, insurers, state government and patient/taxpayers *Assign 1-5 points for approaches that spread burden of costs across providers, insurers, state and federal government and taxpayers* b) Maximizes federal funds *Assign 1-2 points for approaches that maximize federal funds* c) Enhances affordability for small employers *Assign 1-2 points for features that enhance affordability for small employers*	financing commitment, individual contributions, federal Medicaid funds, State Medicaid funds and general State revenues. Suggests insurance market reforms to promote risk-sharing across populations. b) **2.0 points** – Proposes significant Medicaid expansions, which allow the State to access federal matching funds. c) **2.0 points** – Recommends limits on the variation of rates between different rate classes in the small group and individual markets, which will likely lower health insurance premiums for small employers and individuals; provides State-funded subsidies to residents below 400 percent of the FPL who purchase the new standard package as individuals or through their employers.	that may reduce premium costs – i.e., limits on the variation of rates in the small group and individual markets and carrier reporting requirements. • The proposal's heavy emphasis on expanding employer-based sources of coverage will have the effect of drawing more federal dollars into the state through the tax exclusions.
3. Benefit Package *Criteria Weight:* 15.0 *Possible Points:* 10.0 *Assigned Points:* 8.0 *Total Weighted Score:* 12.0	a) Provides full range of benefits specified in the Health Care Justice Act: 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	a) **8.0 points** – Recommends Medicaid expansions that will provide a comprehensive benefit package including mental health and substance abuse services for the developmentally disabled and a range of long-term care services. The majority of people covered by this expansion continue to receive private commercial-style coverage. All individuals in the private market would have access to a standard health benefit package that will cover	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	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 *Assign 0 – 10 points for services offered*	preventive, acute, mental health and substance abuse and long-term health care services. The standard package lacks provisions for dental and vision benefits and services for the developmentally disabled, however, as well as extensive long-term care benefits. Proposal recommends coordination with activities related to the Older Adult Services Act, and recommends expansion of home-and community-based resources; also encourages the purchase of long-term care insurance through Long-Term Care Partnerships.	
4. Implementation *Criteria Weight:* 7.0 *Possible Points:* 15.0 *Assigned Points:* 12.0 *Total Weighted Score:* 5.6	a) Legal and regulatory changes required to implement the proposal can be accomplished within 1-3 years *Assign 0-5 points for ability to obtain legal and regulatory approvals that are necessary for implementation* b) Federal waivers, if required, can be implemented within 1-3 years *Assign 0-5 points for feasibility in obtaining federal waivers* c) Includes provisions for a reasonable phase-in period that does not cause significant disruptions for employers or consumers *Assign 0-3 points for reasonable phase-in approaches and timelines*	a) **4.0 points** – Assuming political support, the State could likely accomplish proposed changes within 1 to 3 years. If the State were to pass an employer "play or pay" approach, it could face legal challenges from employers related to ERISA preemptions. Implementation would involve changes to health insurance law and insurance company regulations. The State could implement Medicaid changes within this time period and would require a change in Illinois' State Plan. b) **3.0 points** – While a portion of the proposed expansions could be implemented using a State Plan amendment, an 1115 federal waiver will be necessary to obtain federal	• While requirement that employers either provide health coverage or pay a fee to the State levels the playing field among employers in terms of health care costs, this provision will likely increase the cost of doing business in Illinois, potentially causing some employers to leave the State.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
	d) Includes accountabilities for ongoing performance, cost and quality *Assign 0-2 points for features that assure accountabilities related to ongoing performance, cost and quality*	Medicaid funding for the majority of the proposed newly Medicaid and SCHIP-eligible populations. The State has currently committed all of its disproportionate share hospital and SCHIP funding, which are the two major sources of funding that states generally use to make 1115 waiver programs budget neutral. As such, the State's ability to obtain waiver approval would likely rely on its ability to move SCHIP eligibles into the Medicaid program so that SCHIP allotment could be freed up to fund the expansion. It is not clear at this point if the federal government will allow a shift in SCHIP populations to the Medicaid program. If not, alterative approaches to achieving budget neutrality for waiver approval purposes could be considered but discussions with the Centers for Medicare and Medicaid Services will be critical to confirm feasibility. c) **3.0 points** – Indicates that the plan will be phased in over a two to three year period. d) **2.0 points** – Establishes a State agency that will provide price comparison of carriers' offerings, reports on uncompensated care, comparisons of providers on different quality measures, and other information relevant to the	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
		performance of the new coverage initiatives.	
5. Quality *Criteria Weight:* 7.0 *Possible Points:* 2.0 *Assigned Points:* 1.5 *Total Weighted Score:* 5.3	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) *Assign 1 point for incentives to improve quality* b) Promotes integration and coordination among parts of the delivery system *Assign 1 point for provisions that promote coordination within delivery system*	a) **1.0 points** – Recommends actions to increase public awareness of provider quality and that will allow consumers to compare providers on the basis of quality; recommends payment increases to Medicaid providers that would consider quality, and would be appropriate to the Medicaid population. 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.	

APPENDIX D-6: HYBRID MODEL

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
6. Cost-efficiency *Criteria Weight:* 7.0 *Possible Points:* 12.0 *Assigned Points:* 6.5 *Total Weighted Score:* 3.8	a) Controls growth in overall and per capita expenditures for health care: i) Health insurance premiums ii) Public program expenditures iii) Capital iv) Technology v) Administrative costs vi) Prescription drugs vii) Others *Assign 0-10 points for features that control growth in expenditures* 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 *Assign 0-2 points for mechanisms that take into account standards of care in establishing spending priorities*	a) **6.0 points** – Controls costs through the following methods • Public program expansions take advantage of primary care case management, disease management and Medicaid rebates. • Includes cost-sharing for individuals. • Recommends that IHERC publish comparative information on premium costs, to assist consumers in choosing insurance products b) **0.5 points** – Does not include mechanisms for generating spending priorities; maintains current health care system's approach.	• By expanding coverage to additional uninsured, this proposal assists providers in reducing their uncompensated costs for the uninsured. It does not however, contain specific provisions to make providers more cost-effective. • Expands Medicaid, which includes disease management and care coordination activities that are projected to reduce health care costs. • Does not specifically incentivize the use of electronic health records and health information technology.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
7. Availability of Resources, Capital and Technology *Criteria Weight:* 5.0 *Possible Points:* 6.0 *Assigned Points:* 3.0 *Total Weighted Score:* 2.5	a) Includes provisions for new capital, technology, medical education, research *Assign 0-4 points for features that address expenditures for new capital, technology, medical education and research* b) Includes provisions to protect and enhance, where necessary, the safety-net system *Assign 0-2 points for features that protect and enhance the safety net system*	a) **2.0 points** – Recommends developing more financial incentives to develop access in rural areas. Also recommends that the State partner with American Health Information Community to help meet the State's goal of e-prescribing by 2011. b) **1.0 points** – Increases coverage for the uninsured which can help relieve the uncompensated care costs borne by safety-net providers.	
8. Prevention and Wellness *Criteria Weight:* 10.0 *Possible Points:* 2.0 *Assigned Points:* 1.5 *Total Weighted Score:* 7.5	a) Includes incentives that reward individual wellness *Assign 1 point for wellness incentives* b) Contains policies to promote continuity of care *Assign 1 point for policies to promote continuity of care*	a) **1.0 points** – Allows individual insurance products to include a premium penalty for tobacco use and 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. b) **0.5 points** – Promotes continuity of care by expanding Medicaid, which now includes primary care case management and disease management programs and provides guaranteed issue to a comprehensive standard benefit package.	Prohibits co-payments or deductibles for preventive care for individuals who purchase the standard package.

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
9. Consumer and Stakeholder Participation *Criteria Weight:* 2.5 *Possible Points:* 3.0 *Assigned Points:* 2.0 *Total Weighted Score:* 1.7	a) Provides consumers (and their advocates) with opportunities to participate in program design at both the local and regional level *Assign 1-3 points for opportunities for consumer input regarding technologies, capital and program design*	a) **2.0 points** – Includes consumers and stakeholders in IHERC governing board.	
10. Consumer Autonomy *Criteria Weight:* 4.0 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 4.0	a) Provides consumers with choices of health plans and provider networks *Assign 1 point for provisions that provide consumers with choices related to health plans and provider networks*	a) **1.0 points** – Provides individuals and businesses health plan and provider network options; however, subsidies would only be provided to individuals enrolled in the standard package.	Allows for the choice between service delivery options for both Medicaid eligible individuals and individuals enrolled in the private market.
11. Provider Autonomy *Criteria Weight:* 2.5 *Possible Points:* 1.0 *Assigned Points:* 1.0 *Total Weighted Score:* 2.5	a) Preserves providers' clinical autonomy *Assign 1 point for provisions that promote provider autonomy in caregiving practices*	a) **1.0 points** – Does not restrict providers' clinical autonomy.	

Criteria	Evaluation Topic and Point Methodology	Points and Rationale for Points	Other Considerations
12. Provider Payment *Criteria Weight:* 10.0 *Possible Points:* 4.0 *Assigned Points:* 1.5 *Total Weighted Score:* 3.8	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* b) Reduces administrative burdens on providers *Assign 0-2 points for provisions that reduce administrative burdens on providers*	a) **1.0 points –** Includes targeted reimbursement rate increases for providers who have better performance on quality measures and a prompt payment initiative. b) **0.5 points**– Proposal does not address administrative burden related to providers and maintains the current system's approach.	

Appendix E: Employer Assessment Assumptions Used in Coverage and Cost Estimates

APPENDIX E: EMPLOYER ASSESSMENT ASSUMPTIONS USED IN COVERAGE AND COST ESTIMATES

An employer assessment is included in the Health Care Coverage Expansion Model to accomplish several of Task Force objectives. While the Adequate Health Care Task Force has not made a recommendation as to the parameters of the employer assessment, Exhibit E.1 below provides a summary of the employer assessment used for purposes of the cost and coverage estimates for the proposed Health Care Coverage Expansion Model. This approach was presented at the November 6, 2006 Task Force Steering Committee meeting and was included in the cost and coverage estimates presented at the December 7, 2006 Task Force meeting.

Exhibit E.1: Summary of Employer Assessment Modeling Parameters

Feature	Assessment Parameter
Employers subject to the assessment	*Years 1 and 2* – Every employer who employs at least 25 Illinois residents who work at least 20 hours a week *Year 3 and beyond*— Every employer who employs at least 10 Illinois residents who work at least 20 hours a week (allowing time to identify and resolve issues related to the assessment before applying to very small employers)
Amount of assessment	4.8 percent of total payroll up to a maximum of $2,500 per employee
Conditions for obtaining a credit against the assessment	Full Credit[1] 1. Employers must demonstrate that 60 percent of their Illinois –based full-time equivalent (FTE) workforce is enrolled in coverage sponsored by the employer; and 2. Employers must demonstrate that they spend either: a. $2,500 per FTE worker; or b. 4.8 percent of total payroll Partial Credit Employers may receive a partial credit against the assessment if they offer coverage but cannot meet the first criterion, i.e., 60 percent of their FTE workforce is not enrolled in coverage sponsored by the employer. In those cases, their assessment will be equal to: 1. The difference between the number of FTE employees representing 60 percent of their workforce and the number of FTE workers covered, multiplied by: 2. The lesser of eight percent[2] of average payroll per FTE worker or $4,167.[3]

[1] The structure of the future assessment will have to be coordinated with the new coverage option that is being offered to small, low-wage employers in the proposed coverage approach. This option contains a below-market employer contribution provision. Small, low-wage employers who cover their workers under that model provision should not be subject to an assessment. If necessary, an exemption should be included for them.

APPENDIX E: EMPLOYER ASSESSMENT ASSUMPTIONS USED IN COVERAGE AND COST ESTIMATES

Feature	Assessment Parameter
	If employers meet the first criterion (i.e., 60 percent of their Illinois-based FTE workforce are enrolled in coverage sponsored by the employer) but spends less than $2,500 per worker or 4.8 percent of payroll on health care, they can still obtain a partial credit, with the remaining assessment equal to 4.8 percent of total payroll less total employer spending on coverage (this percentage is consistent with the approach to calculating the full assessment).
Safeguards for Certain Categories of Firms Requested by Task Force Members	1. Firms that that do not meet the minimum financial contributions to healthcare coverage needed to obtain a credit against the assessment, but do have more than 60 percent of their workforce taking up an employer offer of coverage (consistent with the guaranteed-issue comprehensive benefit plan in the individual market) may apply for a special credit against the assessment. This policy is intended to safeguard firms that, because their workforce may be young and healthy, may have high take-up levels of coverage but whose health care spending as a percentage of payroll may be low. 2. Firms that are undergoing financial difficulty and are unable to pay the assessment for reasons beyond their control (i.e., natural disaster or other unavoidable situation) may have access to a special appeals process to achieve a credit against the assessment.

Estimates of Proposed Employer Assessment

Exhibit E.2 provides a summary of the results of the proposed employer assessment; Exhibits E.3 and E.4 provides more detail by private sector (Tables B-D) and public sector (Table E). Exhibit E.3 applies the assessment to firms with 25 or more employees (as proposed for the first year of program operation), which results in a total estimated employer assessment of $1.481 billion. Exhibit E-4 applies the assessment to firms with 10 or more employees (as proposed for later years of program operation), which results in a total estimated employer assessment of $1.742 billion. All estimates are calibrated to 2007 to facilitate analysis of the impact. Exhibits E.3 and E.4 provide the following information for each version of the assessment:

- Table A: Summary of estimated employer assessment
- Table B: Estimated assessment for private sector firms by offering and non-offering employers
- Table C: Estimated assessment for private sector firms by firm size

[2] Eight percent of average payroll applied to the threshold of 60 percent of the workforce is equivalent to 4.8 percent of total payroll. For firms subject to this provision, the net result will be a contribution equal to 4.8 percent of payroll overall.

[3] Because the partial assessment will be applied to only 60 percent of their full time equivalent workforce, $2,500 was divided by .6 to determine the $4,167 amount. For firms subject to the cap, the net result will be an combination of an assessment and coverage contribution equal to $2,500 per full time equivalent worker overall.

- Table D: Summary of private sector firms receiving a full credit against the employer assessment

- Table E: Estimated assessment for public sector firms

As these Exhibits demonstrate, the bulk of the assessment comes from employers who offer coverage but at levels that are below the specified benchmark. In part, this is reflective of the fact that there are few non-offering firms with more than 25 employees. Of all firms who offer and have 25 or more workers, it is estimated that about 50 percent of them (representing 40 percent of all workers in such firms) will be subject to a partial assessment. On average, the per worker assessment is small for these offering employers, averaging about 2 percent of payroll among offering firms subject to a partial assessment.

Methodological Note

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

APPENDIX E: EMPLOYER ASSESSMENT ASSUMPTIONS USED IN COVERAGE AND COST ESTIMATES

Exhibit E.2: Overview of Employer Assessment Used in Cost and Coverage Estimates

I. Assessment Parameters		
Firms included in Estimate	Firms of 25 or more Employees	Firms of 10 or more Employees
Type of workers included (if they met firm size requirements)	Workers in all sectors with the exception of workers who worked less than 20 hours	
Total Payroll Assessment Rate	4.8%	
2. Simulation Assumptions		
Simulation Year	2007	
Non-offering Firms:		
Number of Firms Facing Assessment	Not Estimated	
Workers in Firms Facing an Assessment	82,889	205,244
Average Payroll Assumption	$ 17,425	$ 21,680
Offering Firms:		
Number of Firms Facing Assessment	Not Estimated	
Workers in Firms Facing an Assessment	1,875,047	2,036,844
Average Payroll Assumption	$ 38,200	$ 38,677
Total Simulated Annual Assessment ($ in millions)	**$ 1,481**	**$ 1,742**

Exhibit E.3: Simulation of Employer Assessment (firms of 25 or more workers)

Table A: Summary of Estimated Employer Assessment (2007)

	Total Assessment Amount (in Millions)
Private Sector Firms	$ 1,304
Public Sector Firms	$ 177
Total	$ 1,481

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

Employer Type	Percent of All Establish-ments over size 24	Number of Workers	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
Non-offering Employers:	4%	82,889	$ 17,425	$ -	0%	$ 69	$ 836	4.8%
Offering Employers:								
Firms covering less than 60% of workers	47%	1,577,040	$ 38,307	$ 1,668	4.4%	$ 1,235	$ 783	2.0%
Firms covering 60% or more of their workers yet spending less than 4.8% of payroll (subject to cap)	0%	-	0	0	0.0%	$ -	$ -	0.0%
Total (Offering and Non-Offering)	**52%**	**1,659,928**	**$ 37,265**	**$ 1,585**	**4.3%**	**$ 1,304**	**$ 786**	**2.1%**

Exhibit E.3: Simulation of Employer Assessment (firms of 25 or more workers)

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

Firm Size	Percent of All Establish-ments over size 24	Number of Workers	Average Payroll per Worker**	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
Less than 10 employees	0%	-	$ -	$ -	0.0%	$ -	$ -	0.0%
10-24 employees	0%	-	$ -	$ -	0.0%	$ -	$ -	0.0%
25-99 employees	12%	459,629	$ 35,373	$ 1,447	4.1%	$ 375	$ 816	2.3%
100-999 employees	5%	345,646	$ 40,426	$ 1,158	2.9%	$ 307	$ 888	2.2%
1000 or more	17%	854,654	$ 37,003	$ 1,638	4.4%	$ 622	$ 728	2.0%
Total (All Firms Sizes)	**33%**	**1,659,928**	**$ 37,265**	**$ 1,585**	**4.3%**	**$ 1,304**	**$ 786**	**2.1%**

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

	Percent of All Establish-ments over size 25	Number of Workers	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll
Offering Employers:	48%	2,380,211	$ 52,381	$ 4,998	9.5%

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

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

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

Exhibit E.4: Simulation of Employer Assessment (firms of 10 or more workers)

Table A: Summary of Estimated Employer Assessment (2007)

	Total Assessment Amount (in Millions)
Private Sector Firms	$ 1,565
Public Sector Firms	$ 177
Total	$ 1,742

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

Employer Type	Percent of All Establish-ments over size 9	Number of Workers	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
Non-offering Employers:	15%	205,244	$ 21,680	$ -	0%	$ 209	$ 1,018	4.7%
Offering Employers:								
Firms covering less than 60% of workers	42%	1,738,837	$ 38,856	$ 1,689	4.3%	$ 1,356	$ 780	2.0%
Firms covering 60% or more of their workers yet spending less than 4.8% of payroll (subject to cap)	0%	-	0	0	0.0%	$ -	$ -	0.0%
Total (Offering and Non-Offering)	**57%**	**1,944,080**	**$ 37,043**	**$ 1,511**	**4.1%**	**$ 1,565**	**$ 805**	**2.2%**

Exhibit E.4: Simulation of Employer Assessment (firms of 10 or more workers)

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

Firm Size	Percent of All Establish-ments over size 9	Number of Workers	Average Payroll per Worker**	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll	Total Assessment Amount (in Millions)	Total Assessment Amount per Worker	Assessment Amount as a Percent of Payroll
Less than 10 employees	0%	-	$ -	$ -	0.0%	$ -	$ -	0.0%
10-24 employees	21%	284,152	$ 35,747	$ 1,008	2.8%	$ 261	$ 917	2.6%
25-99 employees	13%	459,629	$ 35,373	$ 1,447	4.1%	$ 375	$ 816	2.3%
100-999 employees	5%	345,646	$ 40,426	$ 1,158	2.9%	$ 307	$ 888	2.2%
1000 or more	18%	854,654	$ 37,003	$ 1,638	4.4%	$ 622	$ 728	2.0%
Total (All Firms Sizes)	**57%**	**1,944,080**	**$ 37,043**	**$ 1,511**	**4.1%**	**$ 1,565**	**$ 805**	**2.2%**

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

	Percent of All Establish-ments over size 9	Number of Workers	Average Payroll per Worker	Employer Health Care Spending Per Worker	Employer Health Care Spending as a Percent of Payroll
Offering Employers:	43%	2,539,946	$ 52,156	$ 4,954	9.5%

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

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

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

Appendix F: Comprehensive Standard Plan Benefits Description

Navigant Consulting, Inc.
Adequate Health Care Task Force
Summary Plan Description
"Typical Commercial"

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

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