FEASIBILITY REPORT FOR COVERAGE AFFORDABILITY INITIATIVES IN ILLINOIS

APRIL 2021

Executive Summary

Since enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, the State of Illinois has expanded its Medicaid program, partnered with the federal government to operate a Health Insurance Marketplace where residents can purchase subsidized private health insurance, and operated a robust consumer outreach and enrollment assistance program. These efforts led to an historic decline in the numbers of uninsured Illinoisans. However, over the last four years, uninsured rates have begun to increase, and many face challenges affording insurance coverage, while those with insurance often face high cost-sharing barriers to accessing care.

To improve access to health coverage, it is critical that the state improve health insurance affordability and reduce inequities in our health care system. Despite progress under the ACA, health insurance is still not sufficiently affordable for the people of Illinois, and there are racial, ethnic, and geographic disparities that impose barriers to coverage and care.

On July 7, 2020, the Governor signed SB 1864 (Illinois Public Act 101-0649). The legislation instructs the Department of Healthcare and Family Services (HFS), in consultation with the Department of Insurance (DOI) (the Interagency Working Group) to oversee a feasibility study that explores policy options to make health insurance more affordable for low- and middle-income Illinois residents. This study is designed to provide policymakers with a menu of policy options to improve health care affordability, reduce the number of uninsured residents, and improve health equity.

Policy Options Considered in this Study

Policies were chosen for this study based on their likelihood of helping the state achieve its overarching goals of:

- Reducing the numbers of uninsured,
- Increasing affordability, and
- Improving health equity.

Policies were also selected if they have been implemented or studied in other states and have demonstrated the potential to improve affordability and/or expand coverage. For each of these goals, the state must consider multiple priorities, including:

- Improving affordability in terms of both premiums and cost-sharing;
- Aligning with existing systems and programs;
- Leveraging federal funding; and
- Minimizing market disruption.

The extent to which combinations of policies to address various groups' needs was also considered.

The process also benefited from verbal and written input from organizations representing providers, insurers, people with chronic conditions and disabilities, low-income workers, as well as individual health care consumers. These stakeholders and individuals shared views on target populations, provider reimbursement, the affordability of coverage, and structural inequities in health care.

Ultimately, the Interagency Working Group identified six policy options for inclusion in the study, each of which are considered separately but could be pursued in various combinations:

- **Basic Health Program**. The ACA gives states the option of administering a Basic Health Program (BHP) in lieu of Marketplace coverage for individuals with incomes up to 200 percent of the federal poverty line (FPL) who would otherwise be eligible for federal Advance Premium Tax Credits (APTCs). BHP coverage must be at least as affordable and as comprehensive as the Marketplace coverage for which enrollees would have qualified. The federal government provides the state with 95 percent of what it would have spent on APTCs if BHP enrollees had received those APTCs through the Marketplace. Currently two states – Minnesota and New York – have implemented a BHP.
- **State Premium and Cost-sharing Subsidies**. States may build on the federal government's APTCs and Cost-sharing Reductions (CSRs) provided by the ACA by funding subsidies to lower premiums and/or cost-sharing for Marketplace enrollees. Currently five states — California, Colorado, Massachusetts, New Jersey, and Vermont — have committed state dollars to provide premium subsidies or premium and cost-sharing subsidies for individual market health insurance.
- **Public Option Plan**. A public option plan is a government-backed health plan that would compete on the Marketplace with private health plans. The public option may reduce costs through lower administrative costs and/or by paying lower provider prices. Washington has implemented a public option plan and several other states are considering legislation to create a public option.
- **Medicaid Buy-in**. Under a Medicaid Buy-in, the state would make Medicaid, or Medicaid-like, coverage available to consumers who are not otherwise eligible. A Medicaid buy-in has the potential to reduce costs by leveraging a state's existing Medicaid infrastructure and lower provider reimbursement rates. The target population for the Medicaid buy-in could be either narrow (i.e., only for those up to 400 percent FPL who are ineligible for federal premium tax credits) or broad (i.e., anyone not already

eligible for Medicare, Medicaid or CHIP). No state has implemented a Medicaid buy-in program, but the option is being studied in several states.

- **Transitioning to a State-based Marketplace.** Illinois could take over responsibility for operating the Health Insurance Marketplace from the federal government. This would mean the state would run the eligibility and enrollment, consumer outreach and assistance, and plan management functions. Several of the above proposed policies would benefit from if not require the state to transition to a State-based Marketplace.
- **State-supported Marketing and Outreach.** The state could increase its investment in outreach, education, and enrollment assistance to consumers eligible for Marketplace coverage and/or Medicaid.

Defining and Assessing Policy Options: Considerations for Illinois

The Interagency Working Group directed the actuarial and consulting firm Milliman, Inc. to assess the impact of four of the above policy options: (1) a Basic Health Program, (2) state-funded premium and cost-sharing subsidies, (3) a public option plan, and (4) a Medicaid buy-in on Illinois uninsured rates, affordability, and health equity. Milliman was also directed to estimate the state's cost of funding each program. Additionally, for each policy, the Interagency Working Group considered the experience in other states, if applicable, and summarized the potential benefits and risks of implementing the policy.

Highlights of the results of the modeling scenarios specified by the Interagency Working Group for the four policy options are summarized in the table below. The results reflect a 7.1 percent unemployment rate in calendar year (CY) 2022 and that each policy option has reached a steady-state of enrollment. Each policy option scenario was modeled independently; further analysis may be needed if multiple policy options are implemented. The modeling results do not take into account the more generous Marketplace financial assistance included in the American Rescue Plan Act of 2021 (ARP). The enhanced APTCs provided under that law will sunset at the end of calendar year 2022.

Calendar Year 2022 Projected Steady-state Results[a] By Policy Option – 7.1% Unemployment Scenario

POLICY OPTION	ESTIMATED ELIGIBLES	ESTIMATED STEADY-STATE ENROLLEES	ESTIMATED ENROLLEES PREVIOUSLY UNINSURED [% UNINSURED REDUCTION][b] <=200% FPL	> 200% FPL	ALL FPLs	ESTIMATED ENROLLEES WITH LOWER PREMIUM vs SLCS[g]	COST SHARING[e]	REQUIRED STATE FUNDING (NOT INCLUDING ADMIN COSTS) ($MILLIONS)[c]
Basic health program								
Minnesota Model	216,000	135,000	23,000 [4.1%]	- [0.0%]	23,000 [2.5%]	132,000	74,000	$ --[d]
New York Model	216,000	139,000	27,000 [5.0%]	- [0.0%]	27,000 [3.0%]	136,000	139,000	$ --[d]
Zero Premium Model	216,000	188,000	72,000 [13.2%]	- [0.0%]	72,000 [7.9%]	187,000	188,000	$ --[d]
State-Funded premium tax credit (PTC)/cost sharing reduction (CSR)								
Massachusetts Model	712,000	368,000	32,000 [5.8%]	24,000 [6.6%]	55,000 [6.1%]	327,000	238,000	$ 364
No FPL Limit for PTCs	712,000	324,000	- [0.0%]	9,000 [2.5%]	9,000 [1.0%]	107,000	-	$ 182
California Model	712,000	329,000	6,000 [1.2%]	9,000 [2.4%]	15,000 [1.7%]	230,000	-	$ 113
HEC Proposals[h]	712,000	424,000	53,000 [9.7%]	54,000 [14.9%]	106,000 [11.7%]	423,000	248,000	$ 796
Marketplace public option								
10% Premium Reduction	712,000	319,000	- [0.0%]	6,000 [1.7%]	6,000 [0.7%]	106,000	-	$ --[k]
20% Premium Reduction	712,000	328,000	- [0.0%]	13,000 [3.5%]	13,000 [1.4%]	116,000	-	$ --[k]
30% Premium Reduction	712,000	339,000	- [0.0%]	20,000 [5.7%]	20,000 [2.2%]	137,000	-	$ --[k]
Medicaid buy-in								
Targeted	535,000	128,000	43,000 [7.9%]	16,000 [4.6%]	60,000 [6.6%]	N/A	f	$ 289
Broad – Basic	6,235,000	430,000	40,000 [7.3%]	33,000 [9.0%]	72,000 [8.0%]	183,000	f	$ 274[j]
Broad – Enhanced	6,235,000	802,000	89,000 [16.3%]	57,000 [15.7%]	146,000 [16.1%]	762,000	802,000[i]	$ 1,052[j]

Notes:

a. Values have been rounded.
b. Of the approximately 906,000 non-elderly (age less than 65) uninsured, approximately 546,000 have household income up to 200% FPL and 360,000 have household income greater than 200% FPL.
c. Additional fiscal analysis is needed to determine the administrative costs for the state to implement and operate the program.
d. Milliman estimates that there will be surplus funds under the BHP of approximately $99 million for the Minnesota model, $59 million for the New York model, and $34 million for the Zero Premium model. Surplus funds are required to be used to reduce premiums and cost sharing for BHP enrollees and may be carried over from year to year. They may not be used to cover administrative costs.

e. Estimated enrollees with lower cost sharing is in comparison to Silver level actuarial values(as defined by the federal actuarial value calculator), including CSRs for those eligible, via the Marketplace.
f. Estimated enrollees with lower cost sharing is not available for the employer-sponsored insurance (ESI) market. For the Individual market and uninsured, cost sharing is the same actuarial value as Silver coverage via the Marketplace, including CSRs for those eligible.
g. Estimated enrollees with lower premiums in comparison to the estimated CY 2022 second lowest cost silver plan (SLCS) premium assuming that no policy options are implemented.
h. HEC proposals reflects PTCs and CSRs similar to levels in proposals by the United Stated House Energy & Commerce committee.
i. Estimated enrollees with lower cost sharing is for the Individual market and uninsured only. Estimated enrollees with lower cost sharing is not available for the ESI market.
j. State funding estimates assume that the state secures federal pass-through funding via a Section 1332 waiver of approximately $4 million for the Broad – Basic variation and approximately $984 million for the Broad – Enhanced variation.
k. The state will not have to fund the cost of public option coverage (except for administrative costs) if it chooses a model that transfers claims risk to insurers. Federal pass-through funding, contingent on the federal government considering the Marketplace public option an approvable 1332 waiver, may be available if the state chooses to apply for a Section 1332 waiver. If approved, the federal pass-through funding could be used to support other state programs, such as PTCs, CSRs, and undocumented individuals. However, such benefits (depending upon design and eligibility requirements) may increase utilization of federal PTCs, reducing available pass-through funding.

The Interagency Working Group further sought to assess the potential benefits and risks of Illinois transitioning from a Federally Facilitated Marketplace (FFM) to a State-based Marketplace (SBM), as well the effects of investing in outreach and consumer assistance to enroll the eligible uninsured into subsidized coverage. This assessment was done without actuarial modeling.

Basic Health Program

As directed by the Working Group, Milliman modeled three variations of a BHP:

- *Minnesota model*: Patterned after the premium and cost-sharing parameters used by Minnesota's BHP.
- *New York model*: Patterned after the premium and cost-sharing parameters used by New York's BHP, the Essential Plan.
- *Zero Premium model*: A BHP with zero premium, with cost-sharing parameters patterned after those used by New York's Essential Plan.

In both the Minnesota and New York models, BHP premiums are, on average, significantly less than what eligible Illinoisans could expect to pay for a Marketplace Silver plan. Under a Minnesota model, about 135,000 individuals would enroll, nearly all of whom would have a lower premium. The number of uninsured individuals in the state is estimated to decrease by approximately 23,000. New York's model, which offers modestly lower premiums and, for most eligible enrollees, lower cost-sharing, is estimated to generate slightly higher enrollment (about 139,000, nearly all of whom would see lower costs relative to the benchmark) and a somewhat larger net reduction in the number of uninsured (27,000). In comparison, the more generous

Zero Premium model may produce substantially larger reductions in uninsurance and somewhat broader affordability gains. Milliman estimates that 188,000 Illinoisans would enroll in such a model, 72,000 of whom would be newly insured (corresponding to a 7.9 percent reduction in the uninsured rate).

Notably, approximately 20 percent of current Marketplace enrollees in the target population are enrolled in Bronze level plans with a low (often $0) after-subsidy premium and high out-of-pocket costs (the average Bronze plan enrollee is responsible for 40 percent of their costs). In a Minnesota or New York model BHP, these individuals could face higher premiums, relative to their existing coverage. While the cost-sharing benefits provided by a BHP plan likely would be substantially more generous than the Marketplace Bronze plan, Milliman estimates that about 2,000 Marketplace enrollees would elect to be uninsured rather than enroll in a BHP at a relatively higher premium. This would not be an issue in the Zero Premium model.

Each model could be expected to produce comparatively large reductions in uninsurance among documented immigrants, particularly recently documented immigrants. All BHP options are projected to reduce premiums for nearly all enrollees, regardless of race, ethnicity, or geographic differences.

State Costs

Milliman estimates that if BHP provider reimbursement rates are held to Medicaid levels, the combination of federal BHP funding and enrollee contributions through premiums and cost-sharing will be sufficient to fund the cost of coverage for the program in CY 2022 at a steady state of enrollment. Under Milliman's estimates, federal (non-state) funding streams would produce a surplus in the state's BHP trust fund in CY 2022 of approximately $34 million (in the Zero Premium model) to $99 million (in the Minnesota model). Federal BHP surpluses must go into a BHP trust fund and can only be spent to lower premiums and/or cost-sharing, or to make covered benefits more generous. BHP trust funds may be carried over year-to-year. State funding would be required for state implementation and oversight costs, as federal BHP dollars cannot be used for state administration.

Benefits and Risks of a BHP

Nearly all BHP enrollees would benefit from significantly lower premiums and all would experience equal or reduced cost-sharing in comparison to what they could expect to pay for a Marketplace benchmark Silver plan. Reductions in enrollee spending are expected to ensure high retention among current Marketplace enrollees who would need to transition to the BHP and generate increased take-up among Illinoisans who are now uninsured. Moreover, a BHP would generate comparatively large improvements in affordability and coverage take-up

among documented immigrants. In terms of financing, to the extent provider reimbursement rates for the BHP can be set consistent with the Medicaid program, non-administrative costs to the state may be minimal.

However, state spending could be needed to the extent provider reimbursements under the program are higher than assumed in this study. Also, a BHP will alter the size and risk composition of the state's individual market in ways that likely will, at least modestly, increase individual market premiums and reduce federal premium subsidies for Marketplace enrollees.

Notably, while a BHP will offer eligible enrollees coverage with a much lower premium than a Marketplace Silver plan and equal or reduced cost-sharing, some existing Bronze plan enrollees would face higher BHP premiums in a Minnesota or New York style program, relative to their current coverage. Research suggests that imposition of even a modest premium increase under such circumstances is likely to discourage enrollment. Accordingly, at least some existing Marketplace enrollees may choose to drop coverage rather than enroll in a BHP with a premium if a non-zero premium model is selected. Finally, while the BHP framework is flexible, federal law limits the scope of the program.

State Premium and Cost-sharing Subsidies

As directed by the Interagency Working Group, Milliman modeled four variations of a state-funded coverage subsidy program:

- *Massachusetts model*: This option would provide premium and cost-sharing subsidies to enrollees with household incomes up to 300 percent FPL.
- *No FPL limit*: This option would provide premium subsidies to otherwise eligible individuals with household incomes above 400 percent FPL.
- *California model*: This option would provide premium subsidies to federal APTC-eligible enrollees with household incomes from 200-400 percent FPL and to otherwise eligible individuals with household incomes ranging from 400-600 percent FPL.
- *House Energy & Commerce Committee proposal*: Patterned after legislation proposed by members of the U.S. House Energy & Commerce Committee (HEC), this option would provide premium and cost-sharing subsidies to federal APTC-eligible enrollees with household incomes up to 400 percent FPL and premium subsidies to otherwise eligible individuals with household incomes above 400 percent FPL.

Milliman estimates that each subsidy program option will increase enrollment in comprehensive individual market coverage relative to existing policy. The HEC proposal, which would reduce enrollee contributions to premiums across income ranges and by the largest magnitude, accordingly is anticipated to produce the largest increase in enrollment among

individuals currently uninsured in Illinois (106,000, an approximately 12 percent decrease in the number of uninsured). The relatively more modest premium subsidy enhancements offered by the other modeled options are projected to generate relatively smaller coverage gains.

Milliman projects that each subsidy program option would also decrease premium and cost-sharing burdens for a significant share of existing enrollees. Again, the HEC model would generate savings for the largest number of enrollees: about 423,000 would experience lower premiums and roughly 248,000 would see reduced cost-sharing.

Percent reductions in uninsurance among the modeled options are projected to be smaller for Blacks and Hispanic/Latino individuals, relative to white individuals and Asian Americans, though the state may be able to modify the subsidy structure to achieve different impacts. The HEC option is projected to lower premiums for virtually all enrollees, regardless of demographic characteristics. The comparatively more targeted Massachusetts model still is expected to reduce premiums for the vast majority of those with coverage, including about 93 percent of Black enrollees and 91 percent of enrollees who are documented immigrants. Both models would also reduce cost-sharing obligations for most enrollees, and particularly among Black and Hispanic/Latino enrollees.

State Costs

State funding obligations associated with these four options vary widely. Milliman estimates that program costs in CY 2022, excluding administrative costs, may range from approximately $113 million (for the California model) to $796 million (the HEC model).

Benefits and Risks of a State Subsidy Program

All four of the subsidy program options modeled by Milliman are projected to increase coverage take-up, by a range of approximately 9,000 (for the No FPL Limit model) to as much as 106,000 (under the HEC model). A state subsidy program would also reduce financial burdens for many existing enrollees. In addition, a subsidy program could be expected to improve the health of the individual market risk pool, leading to a further reduction in premiums. The state would also have significant flexibility to design its program and to target additional subsidies to populations identified as having the greatest need.

However, a subsidy program requires a state funding source. The program expected to produce the largest improvements in coverage are those that provide the most generous subsidies and require the largest funding to support. Furthermore, it would be challenging for the state to operate such a program without first transitioning to a SBM.

Public Option Plan

For modeling purposes, the Interagency Work Group specified that the public option plan would be offered through the individual market, both on- and off-Marketplace. The public option would be required to meet the same standards as existing Marketplace plans, including the minimum benefit and coverage generosity standards, participation in the ACA's risk adjustment program, and requirements to protect people with pre-existing conditions.

As directed by the Interagency Working Group, Milliman modeled three potential scenarios for a public option plan:

(1) A 10 percent reduction in premiums for the Second Lowest-cost Silver Plan (SLCSP);
(2) A 20 percent reduction in SLCSP premiums; and
(3) A 30 percent reduction in SLCSP premiums.

In the 10 percent scenario, Milliman estimates that 6,000 uninsured Illinoisans would gain coverage as a result of the public option plan, rising to 13,000 newly insured under the 20 percent scenario and 20,000 under the 30 percent scenario. Over 85 percent of the additional enrollment will come from people with a household income over 400 percent FPL who do not qualify for Marketplace APTCs. Because premium contributions are capped at a percentage of income for those up to 400 percent FPL eligible for subsidies, their net premiums will remain the same across the three scenarios. Since there is a higher concentration of whites than people of color at higher income levels, whites will benefit from a public option plan more than minorities. A public option plan would therefore not play a significant role in reducing racial and ethnic disparities in uninsured rates.

State Costs

The public option scenarios described above would be budget neutral to the state for the cost of coverage. State funding for state implementation and oversight costs are to be determined pending a full state fiscal analysis. Additionally, if the state chooses to bear financial risk for paying claims under the public option, further actuarial analysis of the cost of coverage would be needed to further evaluate and account for the level of financial risk to the state.

Benefits and Risks of a Public Option Plan

Offering a state-sponsored public option plan has the potential to lower premiums for thousands of Illinois residents and increase enrollment in insurance. It achieves these goals by targeting the primary driver of health care costs – provider reimbursement – without the need for state financing. If coupled with standardized benefit designs that limit enrollee cost-sharing

for high-value services, the plan could also help address a primary affordability challenge for current Marketplace enrollees.

However, implemented on its own, the public option would not directly benefit lower-income Marketplace enrollees who are eligible for subsidies. Indeed, subsidy eligible individuals may need to switch to a lower-cost Marketplace plan or risk paying a higher net premium, if the public option lowers the price of the SLCSP. Additionally, implemented on its own, the public option plan would do little to advance health equity in Illinois, as the primary beneficiaries of the lower premiums associated with the new plan would be Illinoisans with income greater than 400 percent FPL, whom are disproportionately white.

There is also a potential risk that provider reimbursement will need to be increased to meet network adequacy standards if there are not sufficient incentives for provider participation, especially in areas where provider markets are less competitive. The state would need to find the right balance of provider reimbursement levels and premiums to spur competition without prompting insurer exits from the Marketplace.

Medicaid Buy-in

For modeling purposes, the Interagency Working Group specified that enrollees would pay premiums for coverage under the state's Medicaid program infrastructure, and that the buy-in program would not be eligible for federal matching funds. The Working Group further specified that the Medicaid managed care program would administer the benefits and use its provider reimbursement schedule. The Working Group asked Milliman to model a targeted eligibility and two broad eligibility variations of a Medicaid buy-in:

- *Targeted Buy-in:* Only those Illinois residents not already eligible for Medicare or comprehensive Medicaid coverage and up to 400 percent FPL who are either an undocumented immigrant or in the family glitch would be eligible for this buy-in program (populations not currently eligible for federal premium assistance in the Marketplace). Premiums would be established to mirror the income-based APTCs available via Marketplace plans and cost-sharing would be consistent with a Silver-level plan, with CSR variations available based on household income.
- *Broad Buy-in, Basic:* All residents not already eligible for Medicare or comprehensive Medicaid coverage in Illinois would be eligible for this buy-in program, including those currently eligible for Marketplace subsidies and employer-sponsored insurance. Premiums would be 30 percent lower than assumed CY 2022 premiums for the SLCSP, with premium contributions capped consistent with the federal maximums based on household income.

- *Broad Buy-in, Enhanced:* Same eligibility as for the Basic, Broad Buy-in, but premiums and cost-sharing would be set consistent with the Massachusetts model up to 300 percent FPL. For those over 300 percent FPL, premiums would be 30 percent lower than the assumed CY 2022 SLCSP, with premium contributions capped consistent with the federal maximums based on household income, and the plan would cover, on average, 73 percent of claims costs.

Milliman estimates that approximately 535,000 Illinois residents would be eligible for the targeted buy-in option. Approximately 60,000 individuals of the approximately 187,000 uninsured who are eligible would gain coverage, representing 32 percent of uninsured residents being eligible for the targeted buy-in.

For the broad buy-in options, Milliman estimates that approximately 6.2 million Illinois residents would be eligible. Of the estimated 580,000 eligible uninsured, Milliman estimates that approximately 72,000, or 12 percent, would enroll in the Basic version and approximately 146,000, or 25 percent, would enroll in the Enhanced version.

Undocumented immigrants will experience the largest reductions in uninsurance rates across all three Medicaid buy-in variations, ranging from approximately 30-40 percent. Hispanic/Latino residents will also see significant declines, from approximately 10-25 percent. Conversely, Black or African American residents will experience smaller declines in their uninsurance rates – under 2 percent in the targeted and broad-Basic variations and 7.6 percent under the broad-Enhanced program.

State Costs

As federal Medicaid matching funds would not be available for the targeted Medicaid buy-in, the state would need to pick up any costs associated with the buy-in that are not covered by enrollee premiums and cost-sharing. An approved 1332 waiver would make federal pass-through funding available for the broad Medicaid buy-in models. Milliman estimates state costs, including off-sets from federal pass-through funding, to be approximately $289 million for the cost of coverage for the targeted buy-in. For the broad-Basic buy-in option, Milliman estimates a cost to the state of approximately $274 million for the cost of coverage. For the broad-Enhanced option, Milliman estimates a state cost of $1.052 billion for the cost of coverage. These estimates do not include state administrative costs, which are to be determined pending additional state fiscal analysis. Additionally, the estimates for the broad buy-in options assume federal pass-through funding via a federal Section 1332 waiver.

Both the targeted and broad Medicaid buy-in programs would directly benefit populations identified by stakeholders as in need of intervention, including undocumented immigrants and individuals caught in the family glitch with incomes up to 400 percent FPL.

However, both targeted and broad buy-in programs come with a significant cost to the state. And a broad Medicaid buy-in program, if it siphons away significant numbers of individuals currently enrolled in the individual market, could de-stabilize the Marketplace. Additionally, with approximately 80 to 85 percent of enrollees in a broad Medicaid buy-in estimated to transition from individual or employer-sponsored insurance, where provider reimbursement is significantly higher than Medicaid, some providers may be unwilling to voluntarily participate in a broad Medicaid buy-in at Medicaid reimbursement levels.

Transitioning to a State-based Marketplace

The ACA required the establishment of new health insurance Marketplaces in each state, either run by the state or operated by the federal government via HealthCare.gov. In addition to being the path through which individuals can receive financial assistance, the Marketplaces were designed to help organize insurance markets, promote competition, and help consumers more effectively compare their health plan options.

Since November 2013, Illinois' Marketplace has been run by the federal government, although the DOI has overseen Marketplace plan management functions. Initially, the "Get Covered Illinois" program ran a website with a Medicaid/Marketplace eligibility screening tool, a call center, a large statewide in-person assister program, and a large paid and earned media campaign. However, federal grants supporting the outreach and consumer assistance activities expired in 2017. As a result, DOI continues to oversee plan management, but the consumer outreach and assistance program has been significantly smaller, with limited budget and staffing.

In recent years, several states have transitioned, or are considering a transition, from a Federally Facilitated Marketplace (FFM) to a State-based Marketplace (SBM), including Nevada, New Jersey, Pennsylvania, Kentucky, Maine, New Mexico, and Virginia. The primary factors driving states to switch from an FFM to a full SBM are a greater ability to improve the consumer experience and exercise more control over their insurance market. In addition, several of the recently transitioning states have benefited from significantly lower start-up costs than existed in 2013, and have been able to generate savings that can help subsidize other affordability initiatives, such as reinsurance.

Benefits and Risks of a State-Based Marketplace

Several of the policy options modeled in this feasibility study would be best optimized if the state runs its own Marketplace. In particular, having an SBM would help ensure a more seamless consumer experience should the state implement state-funded premium and/or cost-sharing subsidies. Similarly, should the state want to provide a public option plan with priority placement on the Marketplace website or have a more data-driven consumer outreach campaign targeting the uninsured, it would need to operate its own Marketplace.

Conversely, if the state chooses to implement a Broad Medicaid buy-in option, it could provide a disincentive to transition to a full SBM. If significant numbers of Marketplace enrollees shift to the buy-in program, it will likely result in a smaller pool of enrollees in the Marketplace, which in turn means a smaller base from which to finance Marketplace operations.

State-Supported Marketing and Outreach

The ACA requires Marketplaces to provide outreach, education, and enrollment assistance to consumers eligible for Marketplace coverage or Medicaid. SBMs are responsible for administering a "navigator" program, for advertising their enrollment portals, and for informing residents about their coverage options. In FFM states, the federal government is obligated to pay for marketing and outreach and, since 2017, has drastically reduced funding for these activities. While federal support is likely to rebound under the Biden administration, states may themselves prioritize marketing and outreach and finance these tasks to suit their residents' needs.

Benefits and Risks of State-Supported Marketing and Outreach

National surveys have documented the effectiveness of consumer assistance programs in facilitating Marketplace and Medicaid enrollment, and research has found that greater awareness of the ACA was strongly associated with higher application rates for Medicaid and the Marketplace. Public investments in such consumer assistance and marketing efforts have been found to be cost effective and capable of providing a large return on investment by improving both the size and health of the individual market risk pool. In Illinois, more than two-thirds of the uninsured population, including most uninsured individuals at lower incomes and the vast majority of uninsured Black residents, are already eligible for subsidized coverage through Medicaid/CHIP or the Marketplace. This suggests increased state investments in marketing and outreach could produce substantial affordability and coverage benefits in a manner that increases health equity.

Assessing the Menu of Policy Options: Considerations for Illinois

All of the policy options modeled for this study are projected to reduce the number of Illinoisans without insurance and/or make coverage more affordable for enrollees, compared to

existing individual market health insurance options. Most options would do both. As described more fully above, the magnitude of these benefits, and the estimated cost to the state of implementation, will vary significantly by policy.

Several of these policy options, in addition to reducing the number of uninsured, are also projected to reduce premiums and/or cost-sharing for enrollees, depending on their income, as shown in the CY2020 Project Steady-State Results by Policy Option table above. The distribution of gains, by income level, race, ethnicity, immigration status, and geography, are also expected to be different across options.

The policies described in the study are not mutually exclusive and, if combined, may offer complementary benefits. Combining policy options, and considering Section 1332 waiver opportunities, may also enable the state to realize benefits from multiple policies with comparatively lower costs.

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Introduction

Since enactment of the Patient Protection and Affordable Care Act (ACA), the state of Illinois has expanded its Medicaid program, partnered with the federal government to operate a Health Insurance Marketplace where residents can purchase subsidized private health insurance, and operated a robust consumer outreach and enrollment assistance program. Driven by these efforts, 874,000 Illinoisans gained health insurance coverage and the nonelderly uninsured rate was cut nearly in half, falling from 16.2 percent in 2010 to 8.3 percent in 2015.[1]

Having health coverage has been shown to improve access to critical health care services, including primary and preventive care, and to improve health care outcomes.[2] The ACA has been associated with increased use of preventive and outpatient services among low-income populations.[3] The ACA has also been shown to reduce health care-related financial strain, particularly for lower-income families.[4] And the expansion of Medicaid has been associated with significant reductions in mortality.[5]

However, in the last four years the coverage gains under the ACA have eroded. Since 2016, the non-elderly uninsured rate in Illinois has increased from 7.6 percent to 8.7 percent, with 907,000 non-elderly residents uninsured in 2019.[6] The number of uninsured children in the state has grown to 120,000, a 46 percent increase since 2016.[7] For individuals earning between $17,690 and $31,900 (between 138-250 percent of the Federal Poverty Level) per year, the uninsured rate is 13.3 percent.[8] Between 2016 and 2019, the uninsured rate among Black Illinoisans has grown from 8.3 to 10.6 percent. The uninsured rate among Hispanics/Latinos was 16.3 percent in 2019.[9] These coverage losses are likely to be compounded by job- and income-loss related to the COVID-19 pandemic and its economic fallout.[10]

For those with incomes too high for Medicaid, the primary reason they are uninsured is the cost of coverage.[11] Similarly, many who are eligible for Medicaid or highly subsidized Marketplace coverage may not enroll due to perceptions that the coverage is unaffordable or offers insufficient value, as well as burdensome bureaucratic hurdles. Many with low incomes are not eligible for any government-supported coverage options because they are undocumented.

Those who are insured often face difficulties affording their deductibles and other cost-sharing.[12] This is particularly true for those enrolled in ACA Marketplace plans, but enrollee cost-sharing has been rising for individuals with employer-sponsored insurance as well. A key reason the cost of health insurance coverage is increasing is the high and rising prices that commercial insurers pay for health care services, particularly for hospital-based care.[13] In Illinois, insurers in the commercial group market pay hospital providers on average 281 percent

of the Medicare rate for the same service; for outpatient services they pay almost 325 percent of the Medicare rate, on average.[14] (By comparison, commercial group-market insurers in Ohio pay hospitals on average 235 percent of Medicare rates; in Michigan they pay 190 percent of Medicare rates).*

There is also increasing recognition that access to health care coverage and services are heavily influenced by systemic inequities and entrenched racial prejudice.[15] These historical injustices have contributed to insufficient access to jobs that offer health benefits, economic stability, quality education, and safe neighborhoods. These are often referred to as the social determinants of health (SDOH), which drive population health outcomes. While this feasibility study focuses specifically on improving health care affordability, which is a key factor in individuals' ability to obtain services and improve their health, it does not attempt to address all of the health care system's challenges. It is but one piece of a larger effort to advance health care access and improve the SDOH in Illinois.

To improve access to health coverage, it is critical that the state improve health insurance affordability and reduce inequities in our health care system. Despite progress under the ACA, health insurance is still not sufficiently affordable for the people of Illinois, and even where it is affordable, racial, ethnic, and geographic disparities impose barriers to coverage and care. The state has an opportunity to foster an environment where health insurance coverage is more affordable and accessible for all Illinois residents. To help achieve this goal, this feasibility study is designed to provide policymakers with a menu of policy options to improve health insurance affordability, reduce the number of uninsured residents, and improve health equity. The study examines the following options:

- Establishing a Basic Health Program;
- Financing premium and/or cost-sharing subsidies to wrap around federal financial assistance;
- Creating a public option plan;
- Implementing a Medicaid buy-in program;
- Transitioning to a state-run Health Insurance Marketplace; and
- Investing in outreach and consumer assistance to enroll the eligible uninsured into subsidized coverage.

This menu approach represents an acknowledgment that none of these is a silver bullet option for improving affordability. Each policy option may affect different populations in different

* Some insurers may pay lower provider reimbursement rates for their Marketplace products than they do for their commercial group market products.

ways. The menu can help policymakers weigh options through an analysis of each policy's cost, impact, and administrative complexity. Policymakers may choose to implement one policy or multiple policy options.

Legislative Background

On July 7, 2020, the Governor signed SB 1864 (Illinois Public Act 101-0649). The legislation instructs the Department of Healthcare and Family Services (HFS), in consultation with the Department of Insurance (DOI), (hereinafter referred to as the Interagency Working Group) to oversee a feasibility study that explores policy options to make health insurance more affordable for low- and middle-income Illinois residents. In selecting policies to study, the legislation requires the inclusion of those policies designed to increase health care affordability and access, including those implemented in other states or nationally. To the extent such programs have been implemented in other states, the legislation requires an assessment of best practices in those states, as well as an Illinois-specific actuarial and economic analysis of demographic and market dynamics of each of the selected policy options.

The legislation further instructs the Interagency Working Group to develop cost estimates for each policy, along with the impact of the policies on: (1) health insurance affordability and access, and (2) uninsured rates for low- and middle-income residents, with data broken out by geography, race, ethnicity, and income level. With respect to this latter charge, the Interagency Working Group worked to ensure that health equity was incorporated into the assessment of policy options. Because certain policies may achieve more optimal outcomes when implemented in combination with other policies, the legislation requires that the study include an evaluation of how multiple policies together could affect costs and outcomes, as well as how policies could be structured to leverage federal matching or pass-through funding. This study is designed to inform decision making during the state legislature's 2021 spring session.

Assessment of the Current Health Care Coverage Landscape

Existing Programs Designed for Low- and Moderate-income Families

Illinois expanded Medicaid under the ACA, making Medicaid available to single, childless adults up to 138 percent of the federal poverty level (FPL) (annual income of $12,760 per individual, $17,240 per couple) without an asset test below age 65. Additionally, Illinois does not apply citizenship requirements to Medicaid or the Children's Health Insurance Program (CHIP) for the following populations:

- Children age 18 or younger;
- Pregnant women including up to 60 days postpartum; or

- Individuals age 65 and older who otherwise would have qualified under the Aid to the Aged Blind and Disabled (AABD) medical program (under the state-funded Health Benefits for Immigrant Seniors program).

For eligible individuals between 138 and 400 percent FPL, the ACA provides for federally funded premium subsidies. It also provides help with plan cost-sharing for those up to 250 percent FPL.

Medicaid Landscape

In State Fiscal Year (SFY) 2020, there were 3 million full benefit Medicaid and CHIP members and 46,984 partial benefit[†] Medicaid members, for a total of 3.1 million Medicaid and CHIP members in Illinois. About 2.5 million members, or 80 percent, are enrolled in a fully capitated managed care health plan (1.2 million are enrolled in Medicaid MCOs in Cook County; 1.3 million enrolled in Medicaid MCOs outside of Cook County). Medicaid and CHIP members are excluded from managed care if, for example, they are enrolled in another source of comprehensive medical insurance, qualify for Medicaid monthly through spenddown, or pay premiums to participate in CHIP due to their higher income level. As of July 1, 2019, the mandatory long-term services and supports program was implemented for dual eligible (persons receiving Medicare and Medicaid) members receiving long-term care services in facilities or through Home and Community Based Services (HCBS) waivers. An additional 60,217 dual eligible members are enrolled in Medicare-Medicaid Alignment Initiative (MMAI) plans in the Greater Chicago Region (53,457 enrollees) and Central Illinois Region (6,760).[16]

Illinois was a late adopter of managed care. While mandatory Medicaid managed care has been statewide since January 2018 for most non-dual eligible individuals, the Medicaid managed care market is less mature than many other states with large managed care programs. Many providers have had challenges submitting claims to MCOs, largely due to a combination of provider billing confusion and MCO system programming issues. However, over the past few years, the launch of a Provider Resolution Portal (aka Provider Complaint Portal), the publication of an Illinois Association of Medicaid Health Plans Comprehensive Billing Manual by provider type, biweekly HFS/MCO/provider meetings focused on resolving systemic claims issues, and fewer MCOs have resulted in significant progress in preventing and resolving billing issues more efficiently.

[†] Enrollment numbers for partial Medicaid benefits include emergency medical for non-citizens, Veterans Care, Warriors Assistance, Medicaid presumptive eligibility for pregnant women, long term care provisional eligibility, Medicaid eligible Department of Corrections inmates, chronic renal care, mental health screening, and programs for Medicare premiums and cost-sharing support.

In early 2015, the Illinois Medicaid program had over 20 care coordination entities, including fully capitated Medicaid MCOs that provided care coordination and paid healthcare claims and provider-led entities that were paid a per member per month fee to provide care coordination while health care services were reimbursed through traditional fee-for-service (FFS). Depending on the county, member enrollment into an MCO or care coordination entity was mandatory, voluntary, or not an option and only the FFS Primary Care Case Management (PCCM) program that connected members to primary care physicians to promote medical homes was available. The various care coordination entities were able to select what areas of the state they wanted to be offered in as well as what categories of Medicaid eligibility they wanted to serve (e.g., parents and caretaker relatives; children; seniors and persons with disabilities).

The managed care program has gone through many transitions and consolidations since early 2015 and has largely transitioned to a statewide fully capitated MCO model that requires most populations to select an MCO or be assigned to one, with annual "switch" periods. Beginning January 1, 2018, the Medicaid managed care program, HealthChoice Illinois, became a statewide program in which participating HMOs were required to provide statewide coverage, with the exception of county government health plans or minority owned health plans that could select to only be offered in Cook County. The FFS PCCM program ended with the statewide managed care expansion and, as a result, HFS no longer maintains an infrastructure to serve a large number of FFS members.

Currently, there are four statewide Medicaid Managed Care plans: Aetna Better Health (Aetna/CVS), HCSC/BCBS, Meridian (Centene), and Molina. There is an additional health plan option, CountyCare, sponsored by Cook County Health, and offered in Cook County only.

Health Insurance Marketplace Landscape

The ACA created a health insurance exchange, also known as a Health Insurance Marketplace, to provide subsidized premiums through Advance Premium Tax Credits (APTCs) for consumers between 100-400 percent FPL and reduced out-of-pocket costs through Cost-Sharing Reductions (CSR) for consumers up to 250 percent FPL.[17] See Exhibit 1.

Exhibit 1. Income Threshold for Premium Tax Credit and Cost-sharing Reductions by Household Size (2020 Federal Poverty Level Guidelines to be applied for 2021 Coverage)

% FPL	Annual Income for Household Size			
	1	2	3	4
100	$12,760	$17,240	$21,720	$26,200
138	$17,609	$23,791	$29,974	$36,156
150	$19,140	$25,860	$32,580	$39,300
200	$25,520	$34,480	$43,440	$52,400
250	$31,900	$43,100	$54,300	$65,500
300	$38,280	$51,720	$65,160	$78,600
400	$51,040	$68,960	$86,880	$104,800

**Source: Georgetown University Center on Health Insurance Reforms, Navigator Resource Guide, October 2020. Available at http://navigatorguide.georgetown.edu/federal-poverty-level.*

If an individual's income is between 100-400 percent FPL, they may qualify for APTCs if they are not eligible for other comprehensive coverage, such as Medicare, Medicaid, or affordable and adequate employer-sponsored insurance.[18] APTCs are provided on a sliding scale based on income, which lowers their monthly premium for a health insurance plan purchased via the Marketplace. The amount of the APTC that each enrollee receives is pegged to the premium for a benchmark plan (the second-lowest-cost Silver plan, or SLCSP) available in their area. Individuals over 400 percent FPL must pay the full premium. See Exhibit 2.

Exhibit 2. Maximum Benchmark Plan Premium Liability as a Percentage of Household Income for APTC-eligible Individuals, 2021

% FPL	% of Income Required to Pay Premium (at lowestlevel of income band)	% of Income Required to Pay Premium (at highest level of income band)
100-133	2.07	2.07
133-150	3.10	4.14
150-200	4.14	6.52
200-250	6.52	8.33
250-300	8.33	9.83
300-400	9.83	9.83

**Source: Internal Revenue Service, Rev. Proc. 2020-36. Available at https://www.irs.gov/pub/irs-drop/rp-20-36.pdf.*

Note: Linear interpolation is used to determine the applicable percentage for income levels within the FPL range.

The ACA further requires plans sold in the individual and small employer insurance markets, including through the Marketplace, to adhere to minimum standards for coverage generosity, or "actuarial value" (AV). AV refers to the average percentage of total costs for covered benefits that a plan will cover. The ACA establishes coverage levels as follows:

- Bronze plans have a 60 percent AV, meaning that the plan covers, on average, 60 percent of an enrollee's health costs;
- Silver plans have a 70 percent AV, meaning that the plan covers, on average, 70 percent of an enrollee's health costs;
- Gold plans have an 80 percent AV, meaning that the plan covers, on average, 80 percent of an enrollee's health costs;
- Platinum plans have a 90 percent AV, meaning that the plan covers, on average, 90 percent of an enrollee's health care costs.

Due to their lower levels of coverage generosity, Bronze plans tend to come with the lowest monthly premium. Platinum plans tend to have the highest monthly premiums. Because the value of an enrollee's APTC is tied to the benchmark SLCSP, enrollees who choose to buy more generous coverage must pay the difference in premiums between that plan and the benchmark plan. The ACA's subsidy structure thus creates an incentive for consumers to seek out, and for insurers to offer, plans with lower premiums.

APTC-eligible individuals with incomes between 100-250 percent of FPL who purchase a Silver-level plan may qualify for a CSR plan that lowers their deductible and other out-of-pocket costs. The lower the enrollee's household income, the more generous the CSR plan, as measured by its AV. CSR plans are only available at the Silver level, so individuals who qualify for a CSR plan, but enroll in a Bronze plan, do not receive federal cost-sharing assistance. See Exhibit 3.

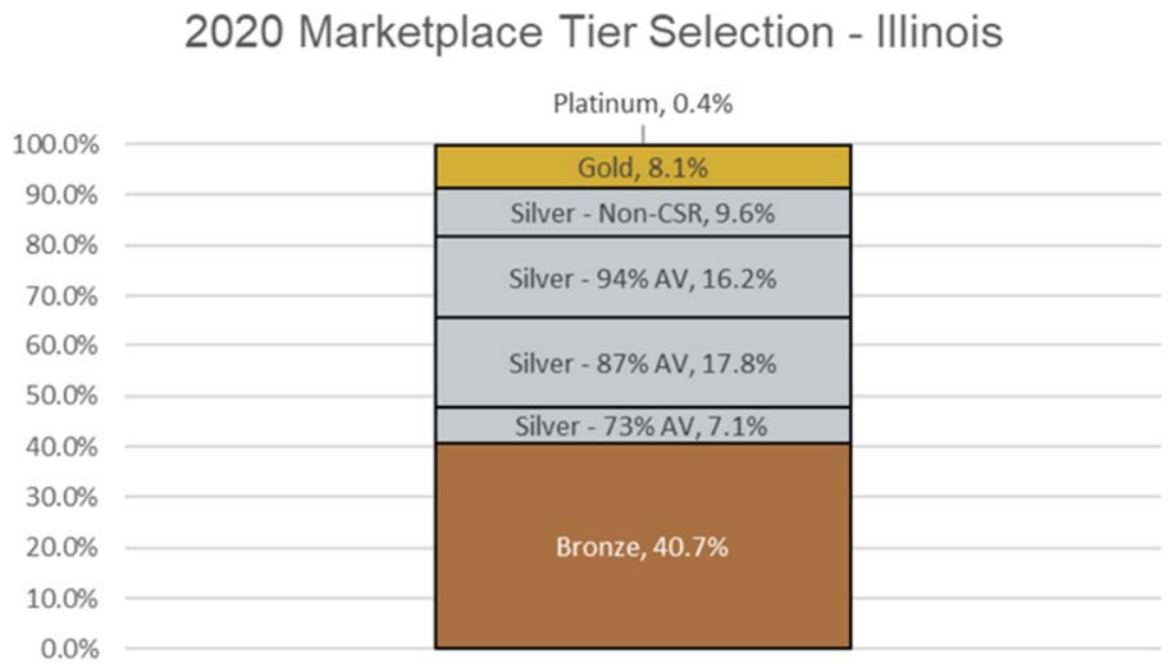
Exhibit 3. The Effect of CSR Plans on Enrollee Cost-sharing (Illustrative Examples)

	CSR Plan for 100-150% FPL	CSR Plan for 151-200% FPL	CSR Plan for 201-250% FPL	Standard Silver plan (no CSRs)
Actuarial value	94%	87%	73%	70%
Deductible	$250	$800	$4,500	$7,150
Maximum out-of-pocket limit	$550	$1,700	$5,700	$7,350
Inpatient hospital coinsurance	10% (after deductible)	10% (after deductible)	30% (after deductible)	30% (after deductible)
Physician visit copay	$5	$10	$30	$70

**Source: Center on Budget & Policy Priorities, "Key Facts: Cost-sharing Reductions," August 2020. Available at https://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/.*

The subsidy structure and incentives established by the ACA tend to result in most enrollees choosing either a Bronze or Silver-level plan. See for example Exhibit 4.

Exhibit 4. 2020 Marketplace Plan Level Selection – Illinois



Source: Centers for Medicare & Medicaid Services, 2020 Marketplace Open Enrollment Period Public Use Files.

Eligibility for federal financial assistance through the Marketplace is based on other factors in addition to household income and household size. Undocumented individuals do not qualify for APTCs (and are not permitted to enroll in the Marketplace at all). If an individual is eligible for Medicaid or Medicare, or has been offered affordable major medical health insurance from his or her employer, they are also not eligible for APTCs or CSRs.

Illinois Marketplace Operational Structure

Illinois is an FFM, using the HealthCare.gov platform. The Illinois Department of Insurance (DOI) reviews and approves insurers' plans and rates before they can be offered on the Marketplace; those that meet state and federal standards are called "Qualified Health Plans" (QHPs). Initially, the "Get Covered Illinois" program ran a website with a Medicaid/Marketplace eligibility screening tool and a Consumer Checkbook tool to assist with health plan selection, a call center, a large statewide in-person assister program, and a large paid and earned media campaign. However, federal grants supporting these activities expired in 2017. As a result, although the DOI continues to oversee QHPs, the consumer assistance and outreach program has been significantly smaller, with limited budget and staffing.

Marketplace enrollment in Illinois peaked in 2016 with 300,000 enrollees. Enrollment declined to 273,000 enrollees in 2020.[‡] The decline has been most dramatic among unsubsidized enrollees, with a 58.9 percent drop between 2016 and 2019.[19] Average premiums for the SLCSP increased significantly in 2017 and 2018 but appear to have stabilized between 2019 and 2021. In 2014, the average benchmark plan monthly premium was $227 and eight insurers offered QHPs on the Marketplace in Illinois (although not all insurers participated statewide). In 2018, the average benchmark premium peaked at $486 per month, and the number of insurers participating dropped to four. These metrics improved somewhat in 2020, with average benchmark monthly premiums of $451, with five insurers participating. In 2021, there will be eight insurers participating on the Marketplace (although not all are statewide) and the premium rate for the SLCSP will decline by 6 percent to $424 per month.[20]

Consumers receiving APTCs have protections from large premium increases because the amount they pay is capped at a percent of their income. In other words, as the premium for the SLCSP rises, so does the amount of APTC eligible enrollees receive. Of consumers receiving APTC, the average amount they receive increased from $364 per month in 2017 to $500 per month in 2020. The percent of Illinois Marketplace consumers receiving APTC increased from 79 percent in 2017 to 82 percent in 2020, largely due to the decline in enrollment among those

[‡] The 2020 enrollment numbers reflect effectuated enrollment; average enrollment over the year may be lower.

ineligible for subsidies. However, during that same time period, the percent of Illinois Marketplace consumers receiving CSRs decreased from 47 percent to 41 percent.[21]

2021 Marketplace Plan Analysis

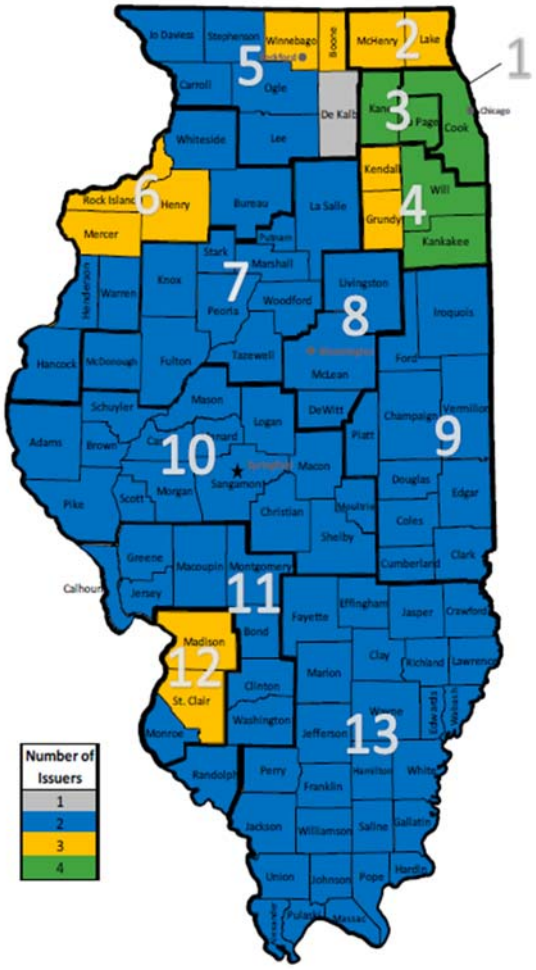
On the Marketplace, there are eight insurers offering 179 QHPs for Plan Year 2021:

- Celtic Insurance Company (parent company is Centene) - (HMO)*
- CIGNA HealthCare of Illinois, Inc. (CIGNA) - (HMO)
- Quartz Health Benefit Plans Corporation (Quartz, QHPC) - (HMO)
- Health Alliance Medical Plans, Inc. (HAMP) - (HMO and POS)
- Health Care Service Corporation (HCSC, aka Blue Cross Blue Shield, BCBS) – (HMO and PPO)*
- Mercy Care HMO, Inc. - (HMO)**
- Bright Health Insurance Company – (HMO)**
- SSM Health Plans – (HMO)**

*Company also offers a Medicaid managed care plan in Illinois.
**Company is new to the Illinois Marketplace in 2021.

Three new companies entered the Illinois Marketplace in 2021, and two existing participants – Celtic and CIGNA – expanded their service areas. Still, most counties have only two insurers and only one insurer (HCSC/BCBS) offers plans in DeKalb County. See Exhibit 5. At various points in time, there was more overlap between the Medicaid Managed Care Organizations (MCOs) and Marketplace health plans, but this changed as fewer insurers offered Marketplace coverage and the Medicaid managed care program transitioned to statewide coverage with fewer plan offerings. At various points, Health Alliance, CIGNA-HealthSpring, and Humana also participated in both Medicaid-only MCOs and the Marketplace. Today, HCSC/BCBS and Centene are the only insurers to offer a Medicaid MCO and QHPs.

Exhibit 5. Number of Marketplace Insurers by Rating Area* and County, 2021.



*Every state has an established number of geographic rating areas, determined by the department of insurance, that all insurers must uniformly use to set premium rates.

As the benchmark plan, the SLCSP's decrease in premiums compared to other plans can result in higher after-subsidy premiums for some enrollees whose SLCSP-based APTC decreased more than their plan's premium; these enrollees would need to switch health plans in order to pay the same amount of net premium.

Prior to 2019, there were consecutive years of significant rate increases and a declining number of insurers. In 2016, HCSC/BCBS increased premiums by 17.5 percent on average; about 80 percent of Illinois Marketplace enrollees were enrolled in BCBS plans. Large premium increases

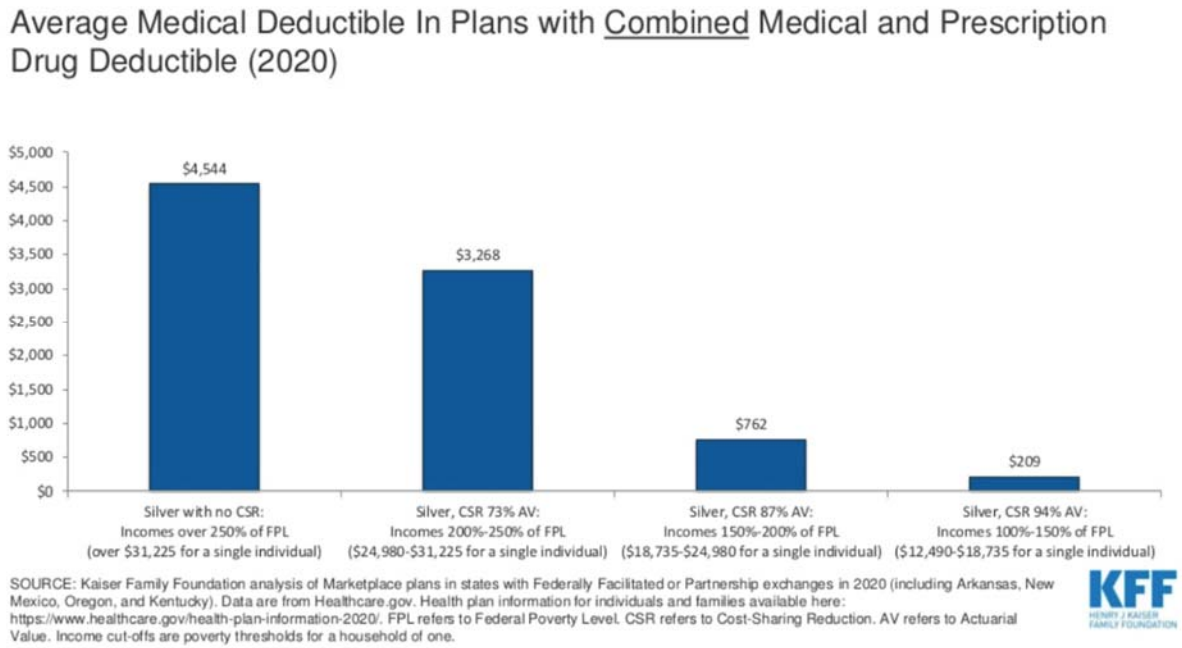
followed in subsequent years, with an average premium increase of 45-55 percent for the lowest-cost plan depending on the metal level in 2017, and an average premium increase of 16-35 percent for the lowest cost plan in 2018, depending on the metal level.[22] This was largely attributable to competitive trends in the individual market as well as "Silver loading" in 2018. Silver loading is a practice initiated for Plan Year 2018, after the Trump administration stopped reimbursing QHP insurers for the cost of providing the CSR benefit. Most states, including Illinois, allowed plans to increase Silver plan premiums to make up the costs.[23] The practice of Silver loading increased the premium for the SLCSP, resulting in increased APTCs for eligible consumers up to 400 percent FPL.

Beyond premiums, Marketplace enrollees have faced affordability challenges due to high deductibles and other cost-sharing, similar to trends in the employer-sponsored insurance market. A 2019 survey found that over half of individuals with high deductible plans, defined as at least a $3,000 deductible for individual coverage or a $5,000 deductible for family coverage, reported that the amount of personal savings they could access in the short-term was less than their deductible.[24] This is problematic for individuals and families because:

- In 2021, the median deductible for a self-only Silver plan (not including CSR-eligible plans) on the Illinois Marketplace is $4,115.
- In 2020, the ACA's annual limits on in-network cost-sharing was $8,150 for individual coverage and $16,300 for a family policy. In 2021, these limits increase to $8,550 and $17,100, respectively.

The availability of CSRs significantly reduces out-of-pocket costs for enrollees, especially up to 200 percent FPL. See Exhibit 6.

Exhibit 6.



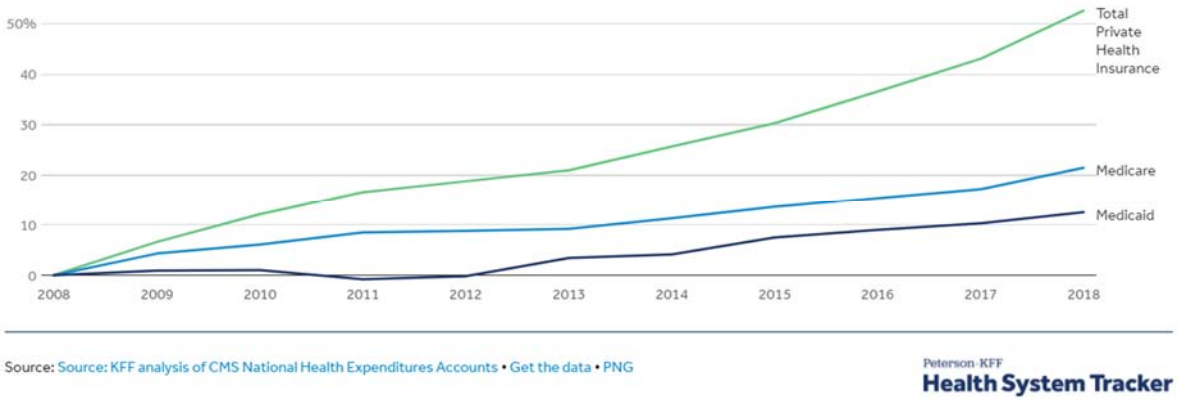
Coverage through Employer-sponsored Insurance

The majority of Illinois residents under age 65 receive their health insurance through their employer.[25] However, employer-sponsored insurance (ESI) has been gradually eroding as a source of coverage, with a 5 percent decline in the number of Illinois residents with ESI between 2008 and 2018.[26] The declines in ESI are most acute in the small employer market, with the percent of small employers offering ESI in Illinois dropping from 41.4 percent in 2008 to 35.0 percent in 2019.[27] These data do not yet reflect the impact of the COVID-19 pandemic and related economic contraction, which could exacerbate the trend.

The value of ESI has also been eroding. The average annual deductible for a single Illinois worker in 2019 was $1,876. Nationally, deductibles increased 25 percent over the previous five years and 79 percent over the previous ten years.[28]

A primary reason ESI offer rates are declining and employee cost-sharing is rising is the high cost of coverage. The average annual premium for a family now exceeds $21,000.[29] These premiums are driven primarily by the prices charged for health care services, particularly hospital services and prescription drugs.[30] See Exhibit 7.

Exhibit 7. Cumulative national growth in per enrollee spending by private insurance, Medicare, and Medicaid, 2008 - 2018



Racial, Ethnic, and Geographic Disparities in Access to Coverage, Care, and Health Status

A comprehensive understanding of the health care landscape in Illinois requires a clear-eyed assessment of longstanding disparities that exist in access to coverage, use of health care services, and health outcomes. Black and Hispanic or Latino Illinoisans are more likely to be uninsured than white residents, with 10.6 percent of Black residents uninsured, and almost 16.3 percent of Hispanic or Latino residents uninsured in 2019. The relatively high rate of uninsurance among the Hispanic/Latino community has been attributed to lack of eligibility for subsidized coverage due to immigration status and work in jobs concentrated in industries that are less likely to offer employer coverage, such as agriculture, service sector, and construction.[31] See Exhibit 8.

Exhibit 8. Illinois Uninsured Rates in 2019, by Race and Ethnicity

	Percent of Illinois Residents Under Age 65 Lacking Health Insurance									
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Illinois Total	16.0	14.7	15.0	14.6	11.5	8.3	7.6	8.0	8.3	8.7
White	13.1	12.2	12.5	12.2	9.6	6.8	6.3	6.6	7.2	7.5
Black or African American	22.0	20.6	20.6	20.7	15.1	9.7	8.3	8.9	10.1	10.6
American Indian and Alaska Native	20.6	21.5	17.7	16.8	15.3	12.6	15.6	13.9	7.0	11.6
Asian	16.9	14.2	14.9	14.3	10.8	8.1	6.8	6.0	7.2	6.8
Hispanic/Latino	29.0	26.7	26.7	26.7	21.8	18.3	16.2	16.7	16.2	16.3

Source: U.S. Census Bureau, American Community Survey, 2010-2019

The COVID-19 pandemic has placed a spotlight on racial and ethnic inequities not only in our health care system, but also with respect to underlying factors that can significantly affect

health outcomes, such as access to jobs that offer health benefits, quality housing, and nutrition. Nationally, Black individuals are 4.7 times more likely than white individuals to be hospitalized with COVID-19, and more than 2 times more likely to die from the virus than white individuals; Hispanic and Latino individuals are 2.8 times more likely to be diagnosed with COVID-19 than white individuals, and 4.6 times more likely to be hospitalized.[32] In a recent study of COVID-19 trends by race and ethnicity in Cook County, researchers found that Black residents of Chicago have a death rate 3.3 times as great as white residents.[33] The same populations upon whom COVID-19 is having an outsized impact are those more likely to be uninsured or underinsured, and less likely to be in a financial position to pay out-of-pocket for high quality health care.

In Illinois, there are also wide disparities in access to critical health care services based on geography, with limited access to primary care, dental, and mental health services in many parts of the state. For example, although Illinois has in the state one primary care physician to serve every 543 residents, there is only one primary care provider for every 12,900 people in Johnson County.[34] And while the state has one dentist for every 1,603 residents, on average, there is only one dentist for every 15,770 people in Lawrence County.[35] Close to five million Illinoisans live in a community designated as a "Mental Health Professional Shortage Area."[36] Further, less densely populated counties have also had fewer choices among health insurers. For example, in 2020, residents in all of the counties outside of the Chicago area only had one or two insurers offering health plans through the Marketplace and only one insurer offered coverage statewide.

Outside of this feasibility study, the state's health care and hospital transformation plan is designed to improve health outcomes in the most distressed Illinois communities, as determined by the CDC's Social Vulnerability Index and areas disproportionately impacted by COVID-19, and areas served by critical access and safety net hospitals, including rural areas of Illinois. Members of these communities have shared stories about historic, cultural, economic, and logistical barriers to health care, reflecting a disconnect between the care they need and the care they receive. Innovative healthcare transformation partnerships in these communities will be funded to fill health care delivery gaps, tackle the social and structural determinants of health, and empower individuals within the communities to determine what services they need.[37]

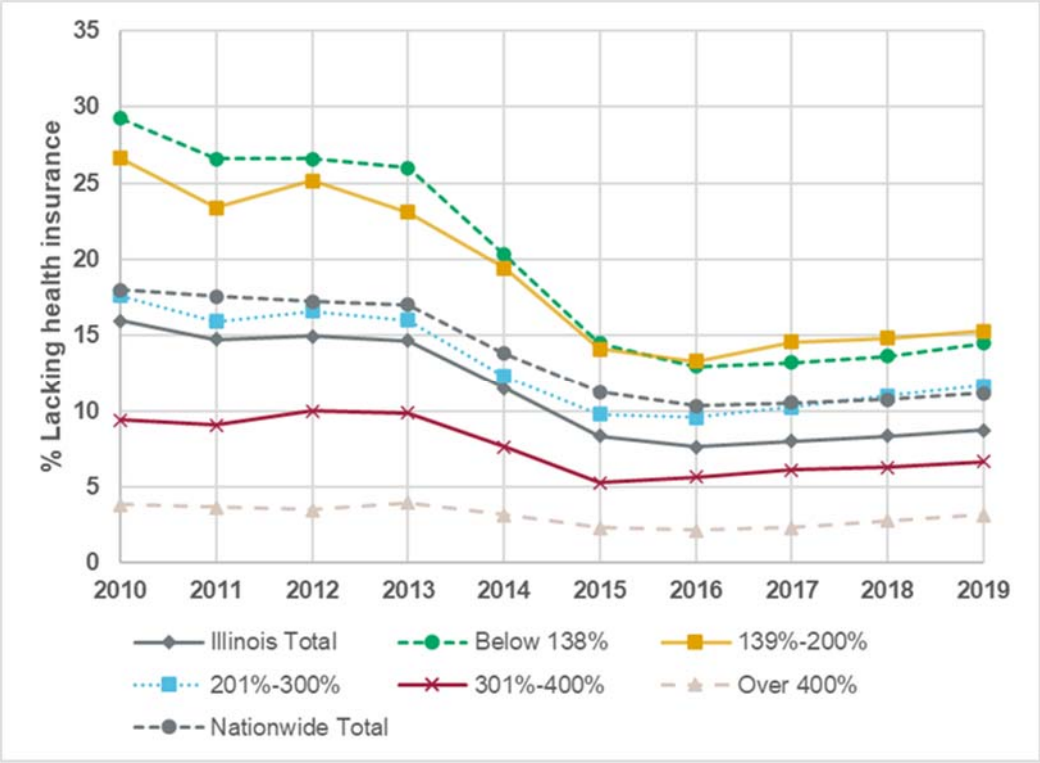
Health Coverage Gaps

Uninsured by Income Level

Though Medicaid expansion and the state's efforts to enroll the subsidy-eligible population in Marketplace coverage has produced coverage gains among lower income residents, the

uninsured rate remains higher at lower income levels. Individuals with lower incomes are less likely to work in jobs where ESI is offered or affordable. At lower income levels, individuals also have less disposable income to spend on premiums or to be able to afford their health care if it has high out-of-pocket costs. See Exhibit 9.

Exhibit 9. Illinois Non-Elderly Uninsured Rate by FPL, 2010-2019



Source: *Source: U.S. Census Bureau, American Community Survey, 2010-2019*

The uninsured cite concerns about coverage affordability as the primary reason they do not enroll.[38] In 2018, 62 percent (536,000) of the uninsured population in Illinois were eligible for but not enrolled in Medicaid or subsidized Marketplace coverage.[39]

Affordability "Cliffs"

Under the ACA's Medicaid expansion and APTCs, eligibility and the generosity of subsidies decrease as household income rises, with significant reductions at certain income levels. Lower income individuals (if not eligible for Medicaid) receive the most generous APTCs, while those closer to 400 percent FPL receive a much smaller subsidy. After 400 percent FPL, individuals are not eligible for APTCs. This can result in affordability "cliffs" for those individuals whose income falls just over the thresholds for more generous financial help. Examples of points where affordability cliffs occur include:

- Just above 138 percent FPL. These individuals are not eligible for Medicaid, which generally requires no premiums or cost-sharing, but they may be eligible for Marketplace subsidies. These individuals must devote a minimum of 2.07 percent of income to premiums; they also face out-of-pocket cost sharing as the most generous CSR plan covers 94 percent of an average enrollee's costs (meaning the average enrollee is responsible for 6 percent of their health care costs).
- Just above 200 percent FPL. These individuals may still qualify for a CSR plan, but these plans are required to cover only 73 percent of an average enrollee's out-of-pocket costs (meaning the average enrollee is responsible for 27 percent of their health care costs).
- Just above 250 percent FPL. These individuals are not eligible for any CSR plans.
- Just above 400 percent FPL. These individuals are not eligible for any APTCs or for CSR plans. This cut off in subsidies hits older adults particularly hard, because, under the ACA, insurers may charge them premiums up to three times the amount charged to a young person.

The "Family Glitch"

Individuals may only qualify for APTCs if they do not have access to an alternative, affordable comprehensive coverage option, such as Medicaid, Medicare, or ESI. Under the ACA, the definition of "affordable" coverage is a plan where the employee's share of the premium does not exceed 9.83 percent of household income. Because employers typically do not subsidize family premiums as generously as they do self-only premiums, for many individuals, their premiums for a family plan would be considered unaffordable. However, under regulations promulgated by the IRS, the assessment of affordability is solely based on what an employee has to pay for self-only coverage, not how much the employee has to pay to add their family to the plan. This is often called the "Family Glitch," and it means that an estimated 6 million Americans (and 211,000 Illinoisans) with unaffordable offers of ESI are deemed ineligible for federal subsidies through the Marketplace.[40] While many of these families may purchase the ESI coverage in spite of the high premium, and others have children eligible for CHIP (aka All Kids), many also likely forego coverage due to cost.

Health Coverage Options Limited by Immigration Status

The Medicaid and Marketplace programs both limit coverage based on immigration status. See Exhibit 10.

Exhibit 10. Eligibility for Illinois Coverage Programs.

Program	Legal Permanent Residents for > 5 years, other qualified Non-Citizens	Legal Immigrants not Included in Colum 1	Undocumented individual
QHP through the Marketplace with APTC eligibility	√	√	
Medicaid	√		
All Kids if a child is under 19	√	√	√
Pregnant women	√	√	√
Aid to the Aged Blind or Disabled	√		
Health Benefits for Immigrant Seniors		√	√

*"Qualified non-citizens" include asylees, refugees, Cuban/Haitian entrants, and others. For a more detailed description, see https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.

These limits result in an estimated 223,000 undocumented Illinoisans being uninsured, 214,000 of which would qualify for either Medicaid or Marketplace premium tax credits based on their income.[41]

Process for Identifying Particular Policies

Policies were chosen for this study based on their likelihood of helping the state achieve its overarching goals of reducing uninsurance, increasing affordability, and improving health equity.[§] However, there are multiple priorities underlying these goals, such as:

- Improving affordability in terms of both premiums and cost-sharing;
- Aligning with existing systems and programs;
- Leveraging federal funding; and
- Minimizing market disruption.

In some cases, achieving one priority may impede the achievement of another priority. The Interagency Working Group also considered the impact of different policies on different groups

[§] For purposes of this study, "health equity" is defined as when "everyone has the opportunity to attain optimal health regardless of race, ethnicity, gender, income level, or other social factors that create barriers to health." Although inequities based on disability and gender identity were flagged as important areas for the state to address, the Interagency Working Group was unable to include breakouts for these populations in the modeling of the policy options prior to the report deadline.

of people. For example, individuals in these groups have different needs that may need to be met through different policies:

- Tax credit-eligible individuals from 250-400 percent FPL concerned about premiums or deductibles;
- Individuals up to 138 percent FPL who are eligible for Medicaid but who remain uninsured;
- Individuals between 138-200 percent FPL who are eligible for APTCs and CSRs but remain uninsured;
- Individuals ineligible for affordable coverage due to immigration status;
- Individuals whose access to care and health outcomes are adversely affected by structural racism and discrimination;
- "Family glitch" spouses;
- Individuals with incomes 400-600 percent of the federal poverty line; and
- Residents in higher-cost regions.

For example, an initiative to improve the affordability of premiums for individuals above 400 percent FPL that results in a lower premium for the SLCSP could mean higher after-APTC premiums for some individuals up to 400 percent FPL. State policymakers will have to determine which priorities are most important if and when they conflict with each other.

It was also important that the state could leverage federal resources and existing state infrastructure to support implementation of these policies and reduce state costs. The Interagency Working Group also sought to minimize any adverse impacts on other populations. The extent to which policies could be combined with other policies to address various groups' needs was also considered. Policies were also selected if they have been implemented or studied in other states, and have demonstrated the potential to improve affordability and/or expand coverage.

Engagement with Health Care Stakeholders

The process also benefited from eight 90-minute interviews with organizations representing:

- Hospital, behavioral health, physician, and federally qualified health center providers;
- Commercial and Medicaid insurers;
- Consumer advocates, including advocates for health care justice, people with chronic conditions and disabilities, people who experience health care access and affordability issues, people who are not documented; and

- A union that represents low-income workers who do not always have access to employer-sponsored insurance. See Appendix D.

These interviews were conducted between September 15-25, 2020.

For the 90-minute stakeholder interviews, the state sought a diverse representation of viewpoints and for provider meetings requested a mix of urban and rural as well as large and small providers. For hospitals and other organizations with a consumer, member, or patient advisory board, the state requested the inclusion of individuals from these boards in the stakeholder interview meeting to hear feedback directly from individuals who may be impacted by the affordability options being studied; unfortunately, there was not representation from these boards at most meetings. This is an opportunity for improvement in the next round of stakeholder engagement. Attendees at the 90-minute meetings included representatives from 11 consumer advocacy organizations, nine associations, seventeen providers, seven insurers, one union representing low-wage workers, and one community board member for a consumer advocacy organization.

The majority of the 90-minute stakeholder meetings were reserved for attendee feedback on the state's proposed areas of study, current health coverage affordability and accessibility challenges, advancing health and racial equity within the feasibility study, and provider rate variances across insurance products. The interviews led to helpful feedback on the proposed areas of study. For example, as a result of the feedback from stakeholder meetings, the state added to the study a standalone health and racial equity chapter and a chapter on increasing investment in consumer assistance.

The state also sought feedback on the feasibility study during the November 6, 2020 meeting of the Medicaid Advisory Committee (MAC) as well as during the October 1, 2020 and December 3, 2020 MAC Public Education Subcommittee meetings. During these meetings, the state followed the same format as the 90-minute stakeholder interviews, and they were intended as an opportunity to update the public on the status of the feasibility study and receive feedback from any individual or stakeholder who had not attended a 90-minute stakeholder meeting.

Advocates also organized two community listening sessions, held on October 28 and 29, 2020. The 14 diverse individuals who participated in the listening sessions were uninsured, enrolled in Medicaid, enrolled in a Marketplace plan, or enrolled in an employer health plan at the time of the listening session, and some had experience being enrolled in different types of health coverage at different points in their lives. Some attendees did not have access to affordable insurance options because of their immigration status, including being undocumented. An interpreter was provided for individuals whose first language was not English and an American

Sign Language interpreter was also provided. During the listening sessions, state staff listened to the attendees' experience accessing health insurance and health care services, including what worked and did not work for them, the biggest barriers they or people they know faced, how cost has impacted them, and what affordable means to them.

Throughout the stakeholder engagement process, consumers and health care stakeholders offered their thoughts verbally and in writing on target populations, provider reimbursement, the affordability of coverage, and structural inequities in health care. Some common themes from these interviews, public meetings, listening sessions, and letters included:

- Addressing affordability of both premiums and cost-sharing, including deductibles, coinsurance, and co-payments.
- Increasing the investment in community outreach.
- Providing a more streamlined enrollment experience and supporting consumers with personalized assistance.
- Reducing inequities in the health care system that have resulted in poorer access and outcomes for people of color, people with disabilities, and rural residents, or based on gender identity, sexual orientation or and socioeconomic status.
- Affordability challenges for individuals eligible to receive federal APTCs, including:
    - Determining the premium is still not affordable and remaining uninsured, or
    - Buying lower or no premium bronze plans and treating the coverage as catastrophic health insurance due to high deductibles and co-insurance costs.
- Providing affordable coverage options to undocumented populations.
- Improving Medicaid reimbursement rates.
- Consideration of transitioning to a State-Based Marketplace.
- Maintaining stability of the Marketplace.
- Improving the affordability of unsubsidized premiums by lowering provider commercial reimbursement rates, while maintaining network adequacy.
- Maintaining the stability of and not adversely impacting the market for employer-sponsored insurance.
- Targeting policy solutions to the undocumented, individuals up to 400 percent FPL, and those caught in the family glitch.
- Maintaining protections for individuals with pre-existing conditions.
- Requiring better communication with consumers about covered services and the network status of providers.

- Improving access to and affordability of behavioral health services, including continuity of care and access issues when individuals transition from Medicaid to Marketplace coverage.
- Expanding access to and comprehensiveness of dental coverage.

Additionally, in September 2020, researchers at the University of Illinois at Chicago (UIC) who were conducting focus groups with the five most distressed areas in Illinois for the Healthcare Transformation proposal, shared that the influence of economic factors on individuals' health care journeys had become a common theme.[42] The diverse group of focus group attendees had a mix of insurance statuses, including being uninsured or insured through Medicaid, Medicare, an individual plan, or an employer plan, were from South Chicago, West Chicago, South Cook, West Cook, and the East St. Louis metro area, and varied in age, race, and ethnicity.[43] Economic factors impacting the focus group attendees' ability to access health care included:

- Difficulty staying healthy due to an inability to afford healthy food.
- Challenges recognizing a health need and/or deciding to get care because of being uninsured or underinsured, unable to afford the cost of care, immigration status, or a lack of time to seek primary care.
- Difficulty arranging and getting to and from care without a car or being unable to afford transit and not receiving information about resources available to help through their preferred channel of communication.
- Not receiving care due to a lack of no-cost services.
- Not managing daily health conditions due to the cost of medication.

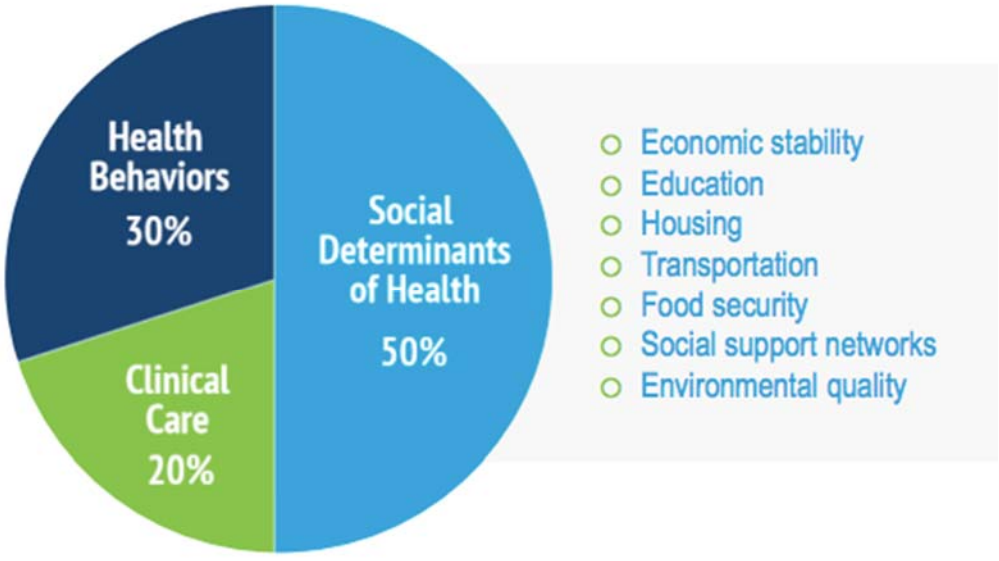
Stakeholder feedback was taken into account by the Interagency Working Group as proposals within this feasibility study were discussed and scenarios for modeling were developed. The state will conduct another stakeholder feedback and engagement process after release of the feasibility study report to have continued and new discussions with stakeholders and individuals who could be impacted directly by the proposals within the feasibility study. The research, data, and modeling results of the feasibility study will help inform these conversations. In the next round of the feedback, the state also will seek to engage stakeholders who have not yet provided feedback on the feasibility study. The state welcomes assistance in identifying these individuals and groups (beyond those listed in Appendix D).

Advancing Health and Racial Equity

Being uninsured or underinsured can lead to debt, bankruptcy, and housing instability. Even with health insurance coverage, many individuals have challenges accessing health care that meets their needs, including people of color, individuals with disabilities, LGBTQ individuals, individuals whose primary language is not English, and individuals who live in urban and rural areas with provider shortages. Physical barriers, language barriers, and a lack of diversity among providers also contribute to inequities in health care access and outcomes.[44] While expanding eligibility for subsidized insurance programs and reducing cost-sharing at the point of service will not solve all of these challenges, expanding access to affordable health care can be one piece of a larger, systemic effort to advance health and racial equity in Illinois.

Health equity is when "everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, or socioeconomic status."[45] Research has shown that social, economic, and environmental factors, including access to health care services, high quality jobs, economic stability, a quality education, and quality neighborhoods, also known as the social determinants of health (SDOH)[46] can determine a full 50 percent of population health outcomes[47] and contribute to racial inequalities in health.[48] See Exhibit 11.

Exhibit 11. Influence of Social Determinants of Health on Health Outcomes



**Source: Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine 50(2):129-135. https://doi.org/10.1016/j.amepre.2015.08.024.*

Health Care Affordability and Access Challenges

Being uninsured or underinsured impacts an individual's economic stability and their ability to access health care services. Obtaining and maintaining health insurance and accessing health care services can be a particular challenge for many low-income individuals and individuals in jobs that do not offer good health insurance benefits. An individual who does not have access to affordable health insurance can be uninsured or underinsured because they cannot afford to use their health insurance due to high deductibles and out-of-pocket costs.

A consistent theme among consumer advocates, providers, and individuals who participated in listening sessions and focus groups, was the barriers to care posed by high premiums and out-of-pocket costs, acknowledging that lower premium plans often come with high deductibles and other cost-sharing. Many consumers find little value in the insurance they do have, due to these high out-of-pocket barriers to accessing services. The Commonwealth Fund defines an individual with insurance as being "underinsured" when:

- Out-of-pocket costs are more than 10 percent of household income for individuals above 200 percent FPL;
- More than 5 percent of household income for individuals up to 200 percent FPL; or
- When the deductible alone is more than 5 percent of household income.

This definition does not count monthly premiums as part of the out-of-pocket costs.[49]

The Interagency Working Group received recurring feedback from focus group participants, advocates, and providers about the consequences of underinsurance. Many shared personal stories, or the stories of individuals they were helping, who enrolled in high deductible plans, including Bronze level Marketplace plans, and were scared to use their health insurance. They knew they could not afford the high deductibles and co-insurance. Some individuals dropped their coverage because they could not afford to use it, and they needed the premium money to pay for rent or food. Similarly, providers talked about underinsured patients on high deductible plans with bills that end up in collections and patients who stop accessing services they need because of the out-of-pocket costs. Some providers also noted that in some cases, underinsured patients may have been better off if they were uninsured because then they could have accessed charity care programs on sliding income scales that would have been more affordable to them.

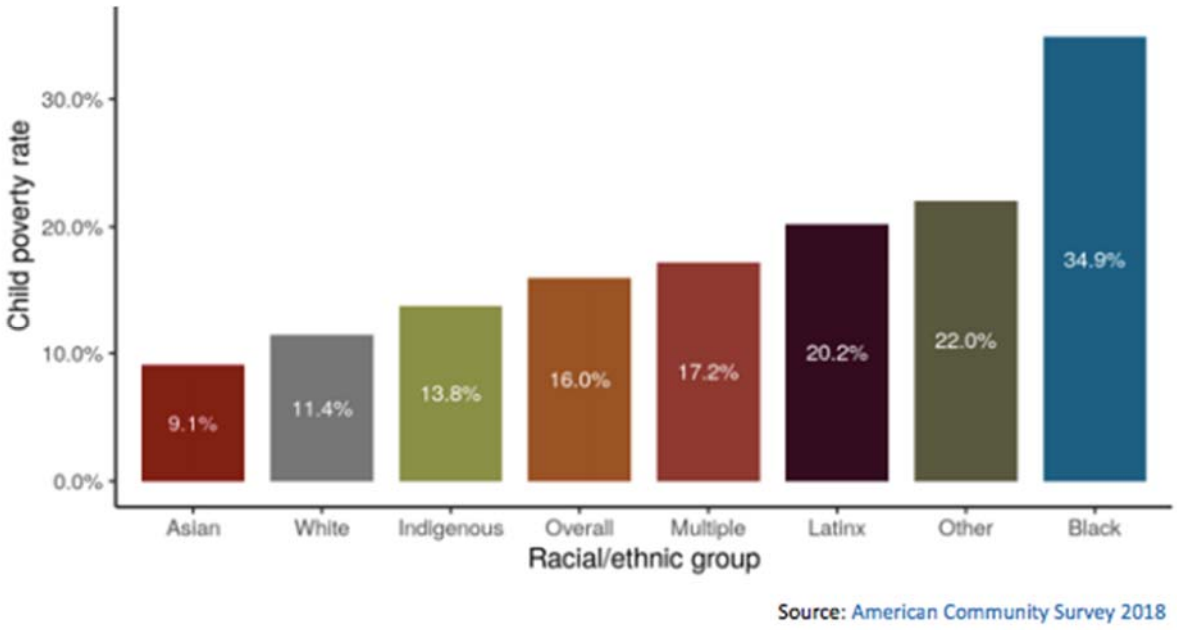
Systemic Challenges, Including Disproportionate Challenges for People of Color

All individuals living in high poverty areas have a greater likelihood of being uninsured than those living in higher income areas. However, people of color have high rates of being uninsured regardless of where they live.[50] This may be in part because the primary source of

insurance for individuals under age 65 is employer-sponsored insurance, which is often not available to workers in industries with a high proportion of people of color.[51]

In Illinois, several counties have high concentrations of people of color who live in poverty. In 11 counties, 80 percent of Black individuals live in poverty and in 20 counties, 20 percent of Hispanic individuals live in poverty.[52] Additionally, in Illinois, more than one in three Black children experience poverty.[53] Child poverty rates highlight the story of intergenerational poverty; 42 percent of children born to parents in the bottom fifth of the economic distribution remain there as adults.[54] See Exhibit 12.

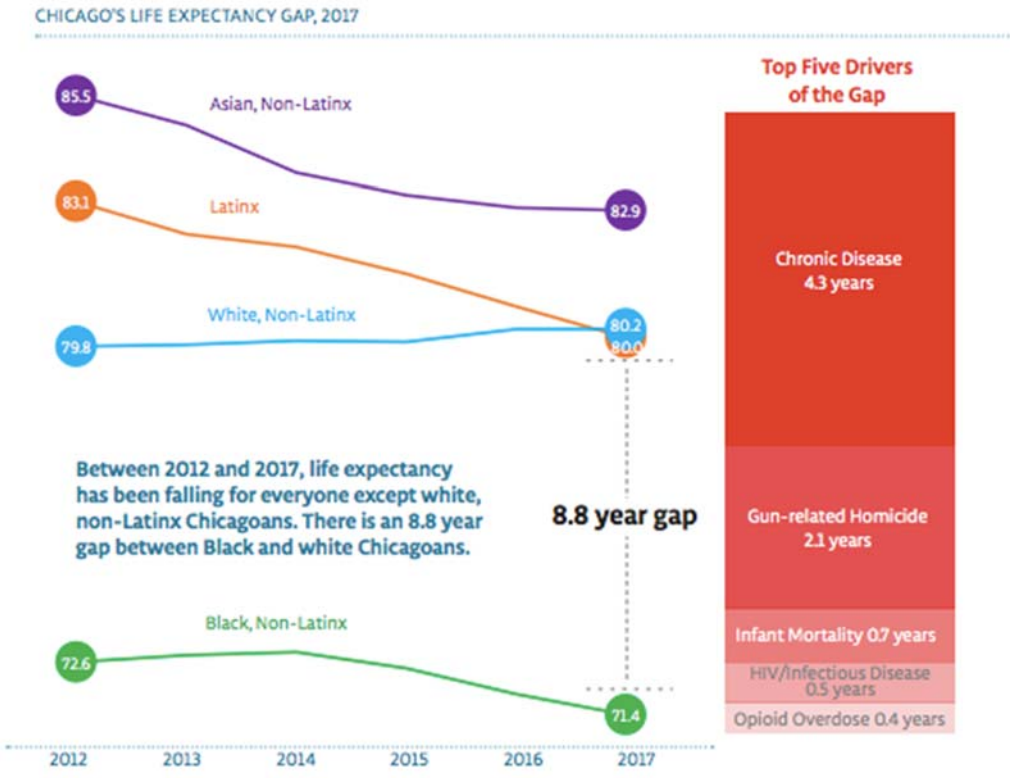
Exhibit 12: Illinois Child Poverty Rates by Race and Ethnicity



**Source: Illinois Interagency Workgroup on Poverty and Economic Insecurity, "2020 Interim Report." On file with HFS.*

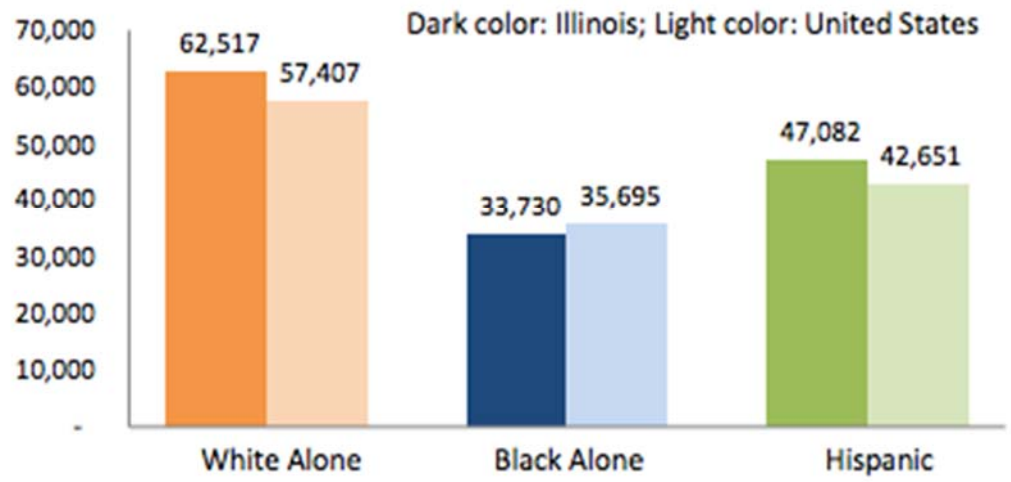
Poverty creates barriers to accessing quality health services, healthy food, recreation opportunities and other necessities needed for good health, as noted in the Chicago Department of Public Health's Healthy Chicago report. The influence of SDOH on health outcomes is often summarized as, "a person's health is more a matter of one's zip code than their genetic code."[55] The Healthy Chicago report notes that the distribution of poverty in Chicago, primarily concentrated on the South and West sides, is "directly linked to long-standing historical discrimination and segregation across the city."[56] This is further reflected in the gap of life expectancy in Chicago by race and ethnicity, with chronic disease being the primary driver. See Exhibit 13.

Exhibit 13. Chicago's Life Expectancy Gap and Drivers of the Gap, 2017



SDOH are influenced by the distribution of money, power, and resources. Black individuals have lower median household income in Illinois and the U.S. compared to white individuals and Hispanic individuals, with the median household income for Black individuals being half of what it is for white individuals. Additionally, while the median household income was higher in Illinois than the national average for white and Hispanic individuals, it was lower for Black individuals.[57] See Exhibit 14.

Exhibit 14. Median Household Income in Dollars by Race and Ethnicity for Illinois and the United States, 2011-2015

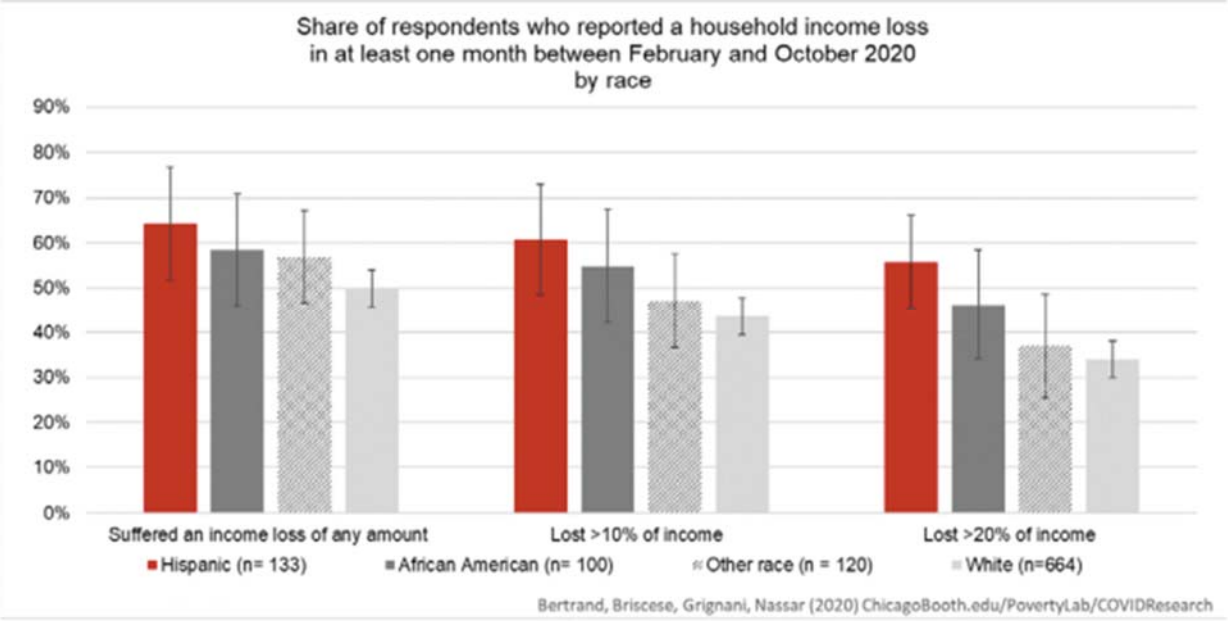


**Source:* Illinois Department of Public Health, "Health Disparities Report for Illinois and Illinois Counties, 2011-2015 Data." Available at https://dph.illinois.gov/sites/default/files/publications/v5health-disparities-report.pdf.

These systemic issues have been exacerbated by the coronavirus pandemic both in regards to exposure to COVID-19 and lost income. Many of the country's low-income essential workers, who are disproportionately people of color, are more likely to be exposed to COVID-19 because they work in a service industry that requires reporting to work in person and are over-represented in crowded communities with poor housing, both make physical distancing less feasible.[58]

Additionally, over 50 percent of Hispanic households and 46 percent of Black households have lost more than 20 percent of their income in at least one month between February and October 2020, compared to 33 percent of white households.[59] See Exhibit 15.

Exhibit 15. COVID-19 Pandemic Income Loss by Race



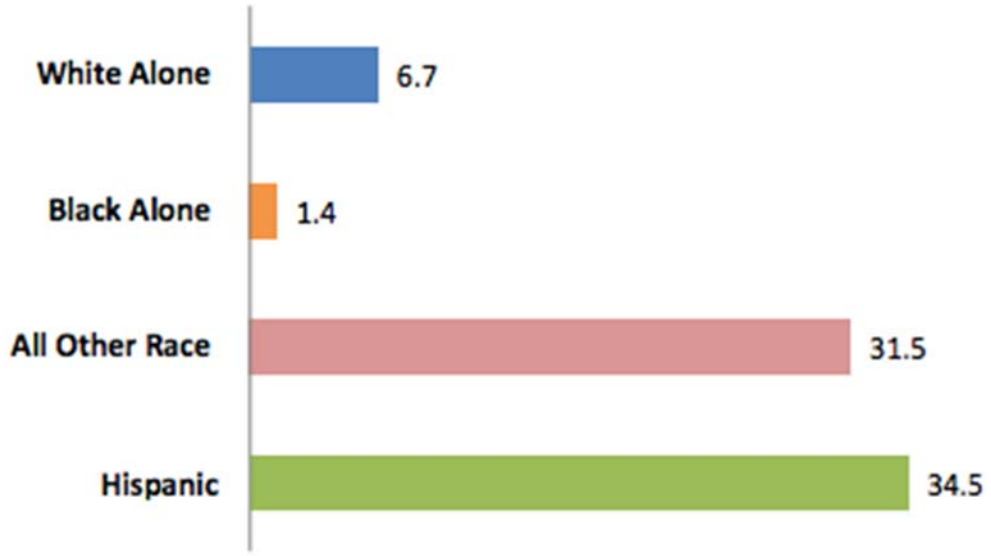
**Source:* Bertrand M, Briscese G, Grignani M, Nassar S, "The Impact of COVID-19 on American Households." Available at https://urbanlabs.uchicago.edu/attachments/35aad783b678629dfc01687859ad9483e52b0da5/store/8d642ada30ce83192d0d21da0eeb76957ea229494d5fa5ec48dcd31e2f97/HH-Survey-report_final.pdf.

People of color also are less likely to be insured, which diminishes access to health care.[60] In Illinois, racial and ethnic disparities in health insurance coverage and access in Illinois are reflected in people of color being more likely to be uninsured, more likely to go without care due to cost, and more likely to not have a usual source of care.

Additionally, the uninsured rate of Latinos is disproportionately impacted by government policies that exclude access to more affordable health insurance coverage based on immigration status. The Illinois Department of Public Health (DPH) also attributes the disparity to "mistrust of the system, concerns about immigration status, uncertainty about navigating the health care system, language barrier, and lack of culturally competent service providers," and notes that, "ensuring equity in accessing and utilizing health care services makes for a healthier workforce and a thriving economy."[61]

DPH also notes that Limited English Proficiency (LEP) can be a barrier to an individual's ability to access or engage in health care decisions for themselves or loved ones and that Illinois has a high percentage of Hispanics (34.5 percent) and other individuals (31.5 percent) who speak English less than very well.[62] See Exhibit 16.

Exhibit 16. Percent of Population Age 5 Years and Over Who Speak English Less Than Very Well in Illinois by Race/Ethnicity, 2011-2015



Source: U.S. Census Bureau, 2011-2015 American Community Survey, 5-year estimates

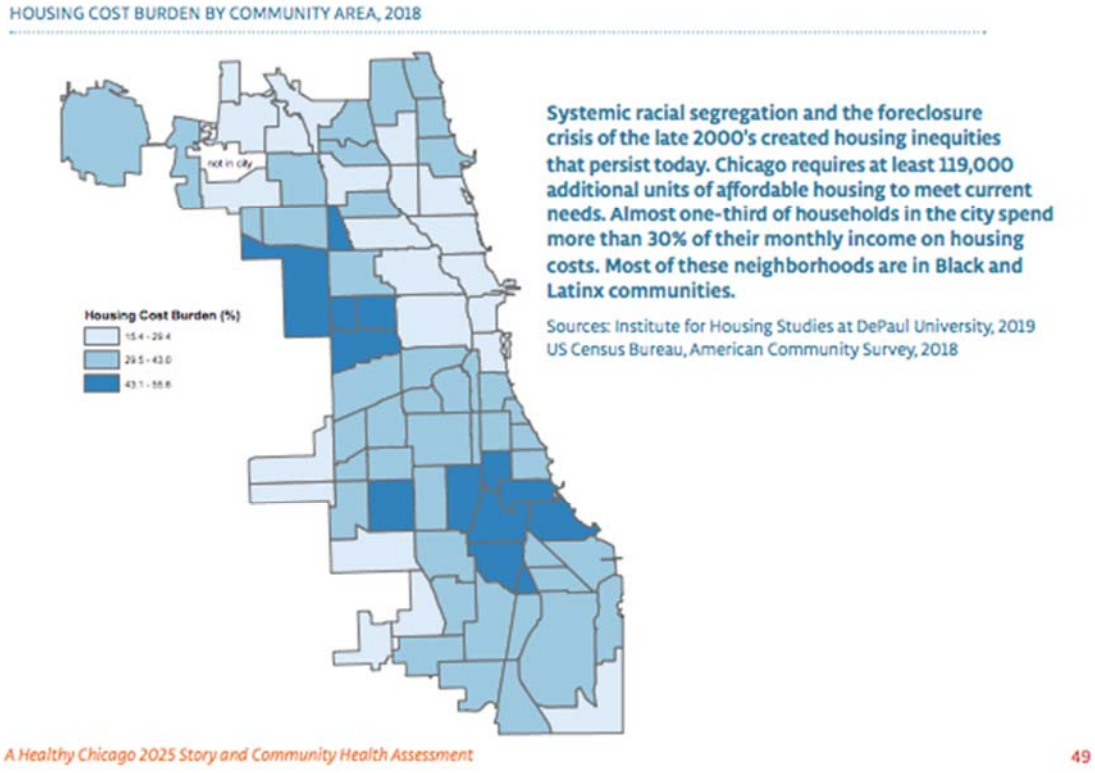
**Source:* Illinois Department of Public Health, "Health Disparities Report for Illinois and Illinois Counties, 2011-2015 Data." Available at https://dph.illinois.gov/sites/default/files/publications/v5health-disparities-report.pdf.

As part of the stakeholder engagement process, consumer advocates discussed the barriers to enrollment for immigrant communities, including language access and what they viewed as the chilling effect of recent federal immigration policies. In addition to urging the state to provide affordable coverage options to immigrants who are ineligible for government health insurance programs today, stakeholders advocated for investments in community education and enrollment assistance, with modes and messages that are targeted and resonate with each community. This need is also highlighted in the DPH Disparities Report, which states that, "The continued diversification of the state presents a need for better data collection and more specialized health care and outreach efforts in minority communities."[63]

The cost of housing also impacts an individual's ability to afford health insurance.. While health insurance premiums tend to be lower in the Chicago area where there is more provider competition and higher in areas without provider competition, the cost of living is a factor in what an individual can afford within their budget. For example, in high-cost areas of the state, like Chicago, almost one-third of households spend more than 30 percent of their monthly

income on housing costs. In Chicago, this housing cost burden disproportionately impacts Black and Latino communities. The money in a household's budget after paying for food, heat, and other necessities may keep even relatively low health insurance premiums out of reach. See Exhibit 17.

Exhibit 17. Housing Cost Burden by Chicago Community Area (2018)



**Source: Chicago Department of Public Health, "Healthy Chicago 2025." Available at https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/HC2025_917_FINAL.pdf.*

The Wealth Gap

Wealth can be defined as assets minus debts. The gap between high and low-income households has increased over past decades and is continuing to grow. The wealth gap remains even when controlling for differences in education, income, or savings rates. Further, while white families hold substantially more debt that Black or Latino families, because white families have more assets relative to debt, such as owning homes that help build equity and save money over time, they have more wealth overall.[64] While higher incomes can help increase wealth, if debts are higher than assets, high-income earners can still have low or no wealth.

An Urban Institute report notes that while local wealth data are limited, homeownership, asset poverty, debt and credit data in Chicago indicate a racial wealth gap. This is demonstrated by disparities in:

- Homeownership rates for Black families (35 percent), Latino families (43 percent), and white families (54 percent);
- Median home value for Black homeowners ($145,000), Latino homeowners ($180,000), and white homeowners ($275,000);
- The estimated percent of Black households (67 percent), Latino households (71 percent), and white households (49 percent) who do not have enough saved to live above the poverty level for three months; and
- Predominantly white neighborhoods having a higher average credit score (732) than neighborhoods that are predominantly people of color (583).[65]

The Urban Institute recommends multiple policies and programs to help Black and Latino families build savings and assets, including making savings go further by supporting policies and programs that increase families' liquid and long-term savings. Making health insurance premiums and cost-sharing more affordable can be one component of this strategy.

Even prior to the COVID-19 pandemic, the number of families at risk financially was growing. The percentage of U.S. households with zero or negative wealth increased from 15.5 percent in 1983 to 21.2 percent in 2016. In a 2015 Federal Reserve Board survey, 46 percent of respondents reported that, "they would have trouble coming up with $400 in an emergency and living paycheck to paycheck is now a commonplace middle-class experience." This wealth inequity is even more burdensome for Black and Latino families who also face additional obstacles created by racial injustice, including residential segregation in impoverished neighborhoods, discrimination in bank lending, discriminatory policing and sentencing, and job-based discrimination.[66]

Even before the pandemic, Black families had 13 cents of net worth and Latino families had 19 cents for every dollar of wealth held by white families. Additionally, Black college graduates have less wealth than white high school dropouts, Black full-time workers have less wealth than unemployed white people, and two-parent Black families have less wealth than single-parent white families.[67]

The wealth gap results in people of color having a greater risk of being uninsured or underinsured, leaving them more economically vulnerable when they have health care needs. During times of illness or unemployment, greater wealth and a higher income make it easier to pay medical bills and allow for less stress about financial hardships.[68]

Reducing "bad" and delinquent debt can help reduce wealth inequity.[69] Large medical bills can decimate an individual or family's finances. Increasing access to more affordable health insurance can help shield individuals from high out-of-pocket medical costs and improve their overall financial status, in addition to making access to necessary health care services more affordable. Individuals with difficulty paying medical expenses may need to borrow money, may struggle with other necessities like food, heat, and rent, are more likely to be contacted by collection agencies, are more likely to find it challenging to save money and make other investments, and are more likely to declare bankruptcy.[70]

These findings are consistent with research studying Medicaid expansions, which find that they substantially reduce the financial burden of medical care on low-income individuals and increase their financial wellbeing and food security.[71] In Illinois, Medicaid is offered without premiums or co-pays, making it especially affordable to eligible low-income families. However, a substantial number of uninsured individuals who are eligible for Medicaid in Illinois are not enrolled. Promoting health insurance enrollment into Medicaid coverage in under-resourced communities could help increase the number of individuals in those communities who not only have access to health care and help improve their financial wellbeing.[72]

Measuring Equity

Advancing health equity is not about worsening the health of those who are better off; it is about measuring how access to and use of health care services and health outcomes change over time, and then taking intentional efforts to improve the health of excluded or under-resourced groups.[73] To advance health and racial equity, it is important to break out the impact of a policy or program on less advantaged groups within the population to enable policymakers to better assess policy options and take actions to achieve greater equity.[74] This feasibility report highlights breakouts of the impact of each policy option by income, race, ethnicity, and geography in accordance with statutory language.

Additionally, when evaluating policy options, Racial Equity Impact Assessments (REIAs) can be a powerful tool for systematically examining how a proposed policy may impact under-resourced groups. REIAs require decision makers to challenge assumptions, biases, and beliefs by providing systemic ways to engage and seek feedback from those who will be affected by the decision. REIAs highlight unintended consequences before policy decisions are made, and can lead to a wider range of policy options being considered by decision-makers. For example, an REIA includes asking if a policy, regulation, program, or budget under consideration:

- Results in any racial or ethnic groups being more advantaged or disadvantaged;
- Addresses root causes of racial inequalities;

- Reduces or eliminates racial inequality; and
- At a minimum, asks how a policy could move forward without causing further harm.

During the development process of this feasibility study, a consultant dedicated to racial equity used an adaption of the Race Forward/Government Alliance on Racial Equity (GARE) REIA tool.[75] GARE's Racial Equity Action Plan, emphasizes that "racial equity is realized when race can no longer be used to predict life outcomes, and outcomes for all groups are improved."[76] As this feasibility study is presenting a menu of policy options for decision-makers, continuing to use an REIA tool as the options are discussed could help policymakers and stakeholders systemically consider the ability of different policies to advance health and racial equity. Additionally, HFS staff used the Race Forward/GARE REIA tool to assess its ability to incorporate racial equity into the report development process. Using the REIA tool helped identify the need to further deepen the level of engagement with consumers who face affordability challenges when trying to enroll in or use their health insurance. In the next round of stakeholder engagement, the state welcomes assistance in identifying individuals and groups who have not yet provided feedback and engaging them in the discussion.

Evaluating Feasibility Study Proposals by Race and Ethnicity

Advancing health and racial equity requires eliminating barriers and inequalities so that everyone can access health care services regardless of race, ethnicity, disability, gender identity, sexual orientation, geography, or other socioeconomic factors. While health care affordability is only one component of advancing health and racial equity, it can have a transformative impact. The State of Illinois can help advance health and racial equity through the creation of a more robust outreach and enrollment assistance program that includes an intentional focus on marginalized communities, new programs to give undocumented individuals an affordable coverage option, and initiatives that increase health plan affordability for premiums and out-of-pocket costs. Tables that demonstrate impact of the policies within the feasibility study by race and ethnicity are provided throughout the report to assist stakeholders, policymakers, and legislators in evaluating each policy's ability to help advance health and racial equity in Illinois.

Defining and Assessing Policy Options: Considerations for Illinois

The Interagency Working Group directed Milliman to assess the impact of the following policy options for expanding insurance coverage, improving affordability, and achieving health equity:

(1) Establishing a Basic Health Program;
(2) Financing premium and/or cost-sharing subsidies to wrap around federal financial assistance;
(3) Creating a public option plan; and
(4) Implementing a Medicaid buy-in program.

The Interagency Working Group also assessed the impact of two additional policy options for expanding insurance coverage, improving affordability, and achieving health equity. It was determined that these two policy options did not lend themselves to actuarial modeling given the data available:

(5) Transitioning to a State-based Marketplace; and
(6) Expanding state-supported consumer assistance and outreach.

Each of these policy options is described in six separate chapters below. In addition to a review of key design decisions for each option, each chapter includes:

- A review of the experience in other states, if applicable;
- The results of actuarial modeling, when applicable, of the policy's impact on (a) health insurance affordability and access, (b) uninsured rates for non-elderly Illinoisans, broken out by geography, race, ethnicity, and income level, and (c) state costs; and
- A discussion of the benefits and risks of implementing the policy.

For each option, Milliman reflects a baseline non-elderly uninsured population of approximately 906,000 Illinoisans in CY 2022, over one-third of whom (326,000) they estimate to be eligible for Medicaid. The target population for the policy options modeled by Milliman are the 580,000 uninsured individuals who are not eligible for Medicare or Medicaid due to their income level or immigration status and the 355,000 individuals who buy coverage through the individual market.

Highlights for the results of the modeling for each policy option are summarized in Exhibit 18 below. The actuarial analysis considered the cost of coverage, not the administrative cost to the state. The modeling results do not take into account the more generous Marketplace financial assistance included in the American Rescue Plan Act of 2021 (ARP). The enhanced APTCs provided under that law will sunset at the end of calendar year 2022.

EXHIBIT 18. CY 2022 Projected Steady-state Results[a] By Policy Option – 7.1% Unemployment Scenario

POLICY OPTION	ESTIMATED ELIGIBLES	ESTIMATED STEADY-STATE ENROLLEES	ESTIMATED ENROLLEES PREVIOUSLY UNINSURED [% UNINSURED REDUCTION][b]			ESTIMATED ENROLLEES WITH LOWER		REQUIRED STATE FUNDING (NOT INCLUDING ADMIN COSTS) ($MILLIONS)[c]
			<=200% FPL	> 200% FPL	ALL FPLs	PREMIUM vs SLCS[g]	COST SHARING[e]	
Basic health program								
Minnesota Model	216,000	135,000	23,000 [4.1%]	- [0.0%]	23,000 [2.5%]	132,000	74,000	$ --[d]
New York Model	216,000	139,000	27,000 [5.0%]	- [0.0%]	27,000 [3.0%]	136,000	139,000	$ --[d]
Zero Premium Model	216,000	188,000	72,000 [13.2%]	- [0.0%]	72,000 [7.9%]	187,000	188,000	$ --[d]
State-Funded premium tax credit (PTC)/cost sharing reduction (CSR)								
Massachusetts Model	712,000	368,000	32,000 [5.8%]	24,000 [6.6%]	55,000 [6.1%]	327,000	238,000	$ 364
No FPL Limit for PTCs	712,000	324,000	- [0.0%]	9,000 [2.5%]	9,000 [1.0%]	107,000	-	$ 182
California Model	712,000	329,000	6,000 [1.2%]	9,000 [2.4%]	15,000 [1.7%]	230,000	-	$ 113
HEC Proposals[h]	712,000	424,000	53,000 [9.7%]	54,000 [14.9%]	106,000 [11.7%]	423,000	248,000	$ 796
Marketplace public option								
10% Premium Reduction	712,000	319,000	- [0.0%]	6,000 [1.7%]	6,000 [0.7%]	106,000	-	$ --[k]
20% Premium Reduction	712,000	328,000	- [0.0%]	13,000 [3.5%]	13,000 [1.4%]	116,000	-	$ --[k]
30% Premium Reduction	712,000	339,000	- [0.0%]	20,000 [5.7%]	20,000 [2.2%]	137,000	-	$ --[k]
Medicaid buy-in								
Targeted	535,000	128,000	43,000 [7.9%]	16,000 [4.6%]	60,000 [6.6%]	N/A	f	$ 289
Broad – Basic	6,235,000	430,000	40,000 [7.3%]	33,000 [9.0%]	72,000 [8.0%]	183,000	f	$ 274[j]
Broad – Enhanced	6,235,000	802,000	89,000 [16.3%]	57,000 [15.7%]	146,000 [16.1%]	762,000	802,000[i]	$ 1,052[j]

Notes:

a. Values have been rounded.
b. Of the approximately 906,000 non-elderly (age less than 65) uninsured, approximately 546,000 have household income up to 200% FPL and 360,000 have household income greater than 200% FPL.
c. Additional state fiscal analysis is needed to determine the administrative costs for the state to operate the program.
d. Milliman estimates that there will be surplus funds under the BHP of approximately $99 million for the Minnesota model, $59 million for the New York model, and $34 million for the Zero Premium model. Surplus funds are required

to be used to reduce premiums and cost sharing for BHP enrollees and may be carried over from year to year. They cannot be used to cover administrative costs.

e. Estimated enrollees with lower cost sharing is in comparison to Silver level actuarial values(as defined by the federal actuarial value calculator), including CSRs for those eligible, via the Marketplace.
f. Estimated enrollees with lower cost sharing is not available for the employer-sponsored insurance (ESI) market. For the Individual market and uninsured, cost sharing is the same actuarial value as Silver coverage via the Marketplace, including CSRs for those eligible.
g. Estimated enrollees with lower premiums in comparison to the estimated CY 2022 second lowest cost silver plan (SLCS) premium assuming that no policy options are implemented.
h. HEC proposals reflects PTCs and CSRs similar to levels in proposals by the United Stated House Energy & Commerce committee.
i. Estimated enrollees with lower cost sharing is for the Individual market and uninsured only. Estimated enrollees with lower cost sharing is not available for the ESI market.
j. State funding estimates assume that the state secures federal pass-through funding via a Section 1332 waiver of approximately $4 million for the Broad – Basic variation and approximately $984 million for the Broad – Enhanced variation.
k. The state does not need to finance the cost of public option coverage (except administrative costs) if it chooses a model that transfers claims risk to insurers. Federal pass-through funding, contingent on the federal government considering the Marketplace public option an approvable 1332 waiver, may be available if the state chose to apply for a Section 1332 waiver. If approved, the federal pass-through funding could be used to support other state programs, such as PTCs, CSRs, and undocumented individuals. However, such benefits (depending upon design and eligibility requirements) may increase utilization of federal PTCs, reducing available pass-through funding.

The Working Group further sought to assess the benefits and risks of Illinois transitioning from a FFM to a State-based Marketplace (SBM), as well the effects of investing in outreach and consumer assistance to enroll the eligible uninsured into subsidized coverage. These are discussed in greater detail below.

Chapter 1. Basic Health Program: Overview and Impact Analysis

The ACA gives states the option to create a coverage program, called the Basic Health Program (BHP), for certain low-income residents who would otherwise be eligible to purchase subsidized individual market health insurance through the Marketplace. With a BHP, states have the opportunity to develop a more affordable alternative to Marketplace coverage that potentially also offers enrollees improved continuity with Medicaid and CHIP.

Eligibility for the BHP is limited by federal law to APTC-eligible residents with incomes from 138-200 percent FPL and documented immigrants under 138 percent FPL who are not yet eligible for Medicaid due to its five-year waiting period for some non-citizens. For those who qualify, the BHP replaces the Marketplace as the source of subsidized coverage (eligible individuals may not choose between the programs).

Health plans sold through the BHP must be standardized. They must offer benefits that are as comprehensive as Marketplace QHPs and must be structured so as to be at least as affordable as the subsidized Marketplace coverage for which enrollees otherwise would have qualified. In practice, as described below, in the two states that operate BHPs, plan premiums have been significantly less than Marketplace coverage. BHP plans may be offered, at the implementing state's discretion, by a range of insurance providers, including entities that offer QHPs and/or Medicaid MCOs. A state's BHP enrollees become a distinct risk pool that is separate from the individual market and the Medicaid program.

Under the ACA, the federal government will partially fund a state's BHP. Federal funding is equal to approximately 95 percent of the value of the APTCs the federal government would have paid for the state's BHP enrollees, had those individuals enrolled in a QHP through the Marketplace. The state must finance any costs of BHP coverage not covered by the federal funding, or by enrollee premiums and cost-sharing, as well as all costs of administering the program.

To date, two states, Minnesota and New York, have established BHPs. Each built upon existing state coverage programs and Medicaid infrastructure and leveraged relatively low provider rates to provide their BHP enrollees comprehensive coverage at a more affordable cost than would have been available to them through the Marketplace.

Basic Health Program: Design Considerations

Policymakers choosing to implement a BHP have multiple critical decisions to make, which may involve tradeoffs that produce disparate effects for different coverage populations. Examples of critical design decisions include:

- **Enrollee costs**. At what levels will the state set premiums and cost-sharing for BHP enrollees?
- **Equity**. What are the demographic characteristics of Illinoisans likely to be affected by a BHP? How can program parameters be designed to advance health equity?
- **Financing**. How will the state fund the administrative costs of a BHP? To the extent coverage costs exceed available federal funding and enrollee contributions, how will these costs be covered?
- **Program administration**. Will the state administer a BHP in conjunction with its Medicaid MCO program? Will the state need to transition to a SBM to operationalize a BHP?
- **Provider reimbursement and network adequacy**. Will the BHP reimburse providers at Medicaid rates, or at higher levels? What incentives, if any, will providers need to participate in a BHP in sufficient numbers to ensure that enrollees have timely access to needed services?
- **Interaction with federal policy**. The Trump administration's decision, in 2017, to stop reimbursing QHP issuers for the cost of providing CSR plans led to changes in the federal BHP funding formula and litigation (now resolved) with the two states with BHPs. Future changes to CSR financing are likely to affect the level of federal BHP funding.[77]

Overview of State Experiences with the Basic Health Program: Minnesota and New York

While a number of states have considered whether to pursue a BHP, thus far only two states, Minnesota and New York, have established the program.[78]

Minnesota's BHP, MinnesotaCare, is the successor entity to a state coverage program of the same name that was created in 1992 and financed by a combination of state dollars and federal funds available through a Medicaid Section 1115 waiver. The state converted the old program to a BHP effective January 1, 2015. Though this transition changed the federal funding stream, most enrollees in the original program were eligible for and shifted into the BHP with the same premiums, cost-sharing, and benefits as had been available to them previously.[79] MinnesotaCare is administered by the Minnesota Department of Human Services, which also runs the state's Medicaid program.

Like Medicaid, MinnesotaCare has year-round enrollment. By March 2020, enrollment in the program was approximately 73,000.[80] Notably, a small subset of this total (about 5,000 enrollees) is comprised of individuals who are Deferred Action for Childhood Arrivals (DACA) grantees or who are age 65 or over and ineligible for Medicare. These individuals are ineligible for federal BHP funding; their coverage costs are financed by state dollars and enrollee premiums and cost-sharing.

MinnesotaCare's benefit package is similar to Medicaid's and is more robust than what is offered by Marketplace health plans. Premiums are based on income and determined on a sliding scale. Individuals with household income under 35 percent FPL pay $0; those at the top end of the eligibility range (at 200 percent FPL) pay $80 monthly. MinnesotaCare plans have no deductible and use standard cost-sharing parameters that are the same across income levels. Under state law, these parameters must be updated by the state as needed to maintain an actuarial value of 94 percent.[81]

Enrollees in every county of the state have a choice of at least two MinnesotaCare plans (federal BHP rules require at least this minimum level of choice).[82] In every county, there is at least one insurer that participates both in the BHP and Medicaid, and in the vast majority of counties, there is overlap between insurer participation in the BHP and the Marketplace.[83] BHP plans receive capitated payments at rates similar to those paid by Medicaid. Notwithstanding the lower payment rates relative to the commercial market, during the initial years of the BHP, MinnesotaCare provider networks were relatively broader than those available to Marketplace consumers.[84] There is no recent publicly available comparison of network breadth across the programs, however, so it is unclear whether this difference has been maintained.

In New York, as in Minnesota, the BHP grew from an existing health coverage program that long predated the ACA. Using state dollars, New York had provided Medicaid coverage to lawfully present immigrants who did not qualify for federal Medicaid funding since the early 2000s. During a phased implementation period running from April 2015 to January 2016, the state transitioned these existing enrollees to the BHP, called the "Essential Plan," and opened enrollment to other BHP-eligible populations. By converting the wholly state-funded coverage program to a BHP, New York saved an estimated $1 billion in the 2016 state fiscal year. The Essential Plan is administered by the New York Department of Health, which also houses the state's Medicaid program and its ACA Marketplace, which is integrated with its Medicaid eligibility system.

Eligible individuals may enroll in New York's Essential Plan year-round. BHP enrollment has grown substantially since the program's launch and at a rate far greater than that experienced by the state's Marketplace. In 2016, the Essential Plan included roughly 220,000 individuals with incomes from 138-200 percent FPL (out of a total enrollment of about 380,000). In the absence of the BHP, these individuals would have qualified for Marketplace coverage that, while subsidized, would have been more expensive than a BHP plan (see below).[85] By 2019 (the last year for which detailed enrollment data are available), enrollment in this income group had more than doubled, rising to about 480,000.[86] By contrast, during the same time, subsidized enrollment (among those at 200-400 percent FPL) through New York's Marketplace rose by

approximately 7 percent.[87] By the end of July 2020, Essential Plan enrollment had exceeded 830,000 and was more than two and a half times the size of the state's individual market.[88]

Essential Plan enrollees qualify for one of four different plans, depending on household income. Individuals who otherwise would have qualified for state-funded Medicaid in the absence of the BHP enroll in plans (Essential Plans 3 and 4) that offer benefits consistent with the state's Medicaid program. Individuals above the Medicaid income threshold, who otherwise would have qualified for Marketplace coverage without the BHP, enroll in plans (Essential Plans 1 and 2) that offer benefits consistent with QHPs. The plan available to individuals at the top end of the income eligibility range (150-200 percent FPL) has a $20 monthly premium, while the plans serving enrollees at lower incomes have no premiums. Cost-sharing parameters are standard within each plan but vary across them, becoming more generous as enrollee income decreases. No plan utilizes a deductible and all have actuarial values that exceed equivalent Marketplace coverage.[89]

In 2019, 16 insurers participated in the Essential Plan. Fourteen of these insurers also participated in Medicaid, while 11 plans overlapped with the Marketplace.[90] Every county had at least two participating insurers; most were served by four or more.[91] New York's BHP plans are paid at rates similar to Medicaid and typically have offered provider networks similar to Medicaid, as well.[92]

Considerations for Illinois: Impact Analysis

The actuarial and consulting firm Milliman, Inc. was retained to model enrollment and funding estimates for several policy options, including a BHP. In its report (see Appendix A), Milliman assesses the impact of the BHP on Illinois' health insurance landscape for CY 2022, the earliest year in which implementation of the program is feasible. For the purpose of these assessments, Milliman projects that, for CY 2022, baseline enrollment in the state's individual health insurance market will be approximately 355,000 (about 116,000 of whom would be eligible for the BHP). Milliman further estimates that approximately 100,000 uninsured individuals will be eligible for a BHP.[93]

For modeling purposes, the Interagency Working Group specified that Illinois would administer a BHP in conjunction with its Medicaid MCO program. The BHP would offer benefits generally consistent with the Medicaid program (excluding long term care and waiver services) and would reimburse providers at Medicaid rates.

Milliman modeled three variations of a BHP:

- *Minnesota model*: Patterned after the premium and cost-sharing parameters used by the MinnesotaCare BHP, described above.
- *New York model*: Patterned after the premium and cost-sharing parameters used by New York's BHP, the Essential Plan, as described above.
- *Zero Premium model*: A BHP with zero premium and cost-sharing parameters patterned after those used by New York's Essential Plan. See Exhibit 19.

Exhibit 19. Basic Health Program Monthly Out-of-pocket Adult Premiums and Cost-sharing Actuarial Values

MONTHLY OUT-OF-POCKET ENROLLEE PREMIUM					COST-SHARING ACTUARIAL VALUE			
FPL RANGE	MN MODEL	NY MODEL	ZERO PREMIUM	Marketplace	MN MODEL	NY MODEL	ZERO PREMIUM	Marketplace
Below 138%	$0	$0	$0	$23-$31	94%	100%	100%	94%
138% up to 150%	$25	$26	$0	$47-$68	94%	100%	100%	94%
150%-200%	$37-$80	$46	$0	$68-$143	94%	91%	91%	87%

Notes:

a. Values have been rounded.
b. Adults with household income below 138% FPL are limited to documented immigrants still in the five-year waiting period for Medicaid
c. eligibility.
d. Minnesota premiums from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4139A-ENG and were modified to $0 below 138% FPL for Illinois modeling.
e. Minnesota cost sharing benefit design: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4858A-ENG
f. New York premiums from https://www.nyhealthinsurer.com/new-york-essential-plan/ and include dental and vision coverage to be consistent with modeled benefits.
g. New York cost sharing benefit design: https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20H%20-%20EP%20Benefits%20and%20Cost-Sharing_.pdf
h. Out-of-pocket Marketplace premiums based on projected CY 2022 federal poverty level and premium tax credit percentages.
i. New York cost sharing actuarial values were estimated using the CY 2021 CMS actuarial value calculator. Minnesota cost sharing actuarial value is based on the state's actuary's assessment of actual cost sharing percentages.

Estimated Impacts on Coverage Take-up and Cost for Enrollees

In both the Minnesota and New York models, BHP premiums are, on average, significantly less than what eligible Illinoisans could expect to pay for a Marketplace Silver plan. The relative

affordability of the program would, on balance, drive enrollment gains under each scenario. Milliman estimates that approximately 216,000 Illinoisans would be eligible for a BHP in CY 2022. Under a Minnesota model, about 135,000 individuals would enroll, nearly all of whom would be able to access a reduced premium, relative to the Marketplace's benchmark Silver plan. The number of uninsured individuals in the state would decrease by approximately 23,000. New York's model, which offers modestly lower premiums and, for most eligible enrollees, lower cost-sharing, would generate slightly higher enrollment (about 139,000, nearly all of whom would see lower costs relative to the benchmark) and a somewhat larger net reduction in the number of uninsured (27,000).

In comparison, the more generous Zero Premium model would produce substantially larger reductions in uninsurance and somewhat broader affordability gains. Milliman estimates that 188,000 Illinoisans would enroll in such a model, 72,000 of whom would be newly insured (corresponding to a 7.9 percent reduction in the uninsured rate). Virtually all enrollees would experience lower premiums, relative to a Marketplace Silver plan, and cost-sharing.

Notably, approximately 20 percent of current Marketplace enrollees in the target population are enrolled in Bronze level plans with a low (often $0) after-subsidy premium and high out-of-pocket costs (the average Bronze plan enrollee is responsible for 40 percent of their costs). In a Minnesota or New York model BHP, these individuals could face higher premiums, relative to their existing coverage. While the cost-sharing benefits provided by a BHP plan likely would be substantially more generous than the Marketplace Bronze plan, Milliman estimates that about 2,000 Marketplace enrollees would elect to be uninsured rather than enroll in a BHP at a relatively higher premium. This would not be an issue in the Zero Premium model.

Since eligibility for a BHP is limited to individuals at 200 percent FPL or below, the coverage and affordability benefits noted above necessarily would be concentrated among Illinoisans at low income levels. Milliman also summarized the impact of the BHP models by race, ethnicity, and immigration status. See Exhibit 20. Each model could be expected to produce comparatively large reductions in uninsurance among documented immigrants, particularly recently documented immigrants. As none of the modeled options extends subsidy eligibility to individuals with undocumented immigration status, the uninsured rate among this population would be unchanged. Percentage reductions in the number of uninsured across geographic regions are relatively similar across all models.

Exhibit 20. Percent Reduction in Uninsured by Race, Ethnicity and Immigration Status*

	State BHP Options		
	Minnesota	**New York**	**Zero Premium**
Non-Hispanic/Latino			
Asian	3.9%	4.7%	10.7%
Black or African-American	2.4%	2.8%	8.2%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	17.0%
White	2.8%	3.3%	8.7%
Hispanic/Latino	2.1%	2.5%	6.7%
Documented immigrant			
Less than 5 Years	21.5%	23.3%	26.7%
5 or More Years	2.8%	3.5%	11.5%

* Milliman's analysis found a 0.0% reduction in uninsured rates among American Indian/Alaska Natives in the three scenarios. For a more detailed analysis of the impact of the BHP scenarios by race, ethnicity, and immigration status, see Appendix A. Modeling assumptions did not vary by race and ethnicity.

All BHP options are projected to reduce premiums for nearly all enrollees, regardless of demographic characteristics. See Exhibit 21. The New York and Zero Premium models, which feature plans with more generous cost-sharing parameters than the does the Minnesota model, are also expected to reduce cost-sharing for almost all enrollees. The share of enrollees with reduced cost-sharing under the Minnesota model is comparatively more modest and is smallest among Asian Americans and recently documented immigrants.

Exhibit 21. Share of Program Enrollees with Reduced Premiums or Cost-Sharing by Race, Ethnicity and Immigration Status*

	State BHP Options					
	Minnesota		New York		Zero Premium	
	Lower Premium	Lower Cost-Sharing	Lower Premium	Lower Cost-Sharing	Lower Premium	Lower Cost-Sharing
Non-Hispanic/Latino						
Asian	96.7%	38.1%	96.8%	100.0%	100.0%	100.0%
Black or African American	97.1%	63.5%	94.3%	100.0%	100.0%	100.0%
White	99.2%	60.6%	98.1%	100.0%	100.0%	100.0%
Hispanic/Latino	96.7%	60.3%	96.5%	100.0%	100.0%	100.0%
Documented immigrant						
Less than 5 Years	99.1%	10.7%	99.2%	100.0%	100.0%	100.0%
5 or More Years	96.2%	73.0%	92.3%	100.0%	100.0%	100.0%

*For a more detailed summary of the impact of the BHP scenarios by race, ethnicity, and immigration status, see Appendix A. Modeling assumptions did not vary by race and ethnicity.

Implementation of a BHP would remove many current Marketplace enrollees from the individual market risk pool. Milliman projects that enrollment in the individual market would decrease by approximately 35 percent. Moreover, because the enrollees who would transition from the Marketplace to the BHP are generally younger and healthier than those who remain, the smaller individual market risk pool would also be relatively sicker. Milliman estimates these changes would cause unsubsidized premiums in the individual market to increase by about 4-6 percent for a given age.

Estimated State Costs

Milliman estimates that if BHP provider reimbursement rates are held to Medicaid levels, the combination of federal BHP funding and enrollee contributions through premiums and cost-sharing will be sufficient to fund the cost of coverage for the program in CY 2022 at a steady state of enrollment. Under Milliman's estimates, federal (non-state) funding streams would

produce a surplus in the state's BHP trust fund in CY 2022 of approximately $34 million (in the Zero Premium model) to $99 million (in the Minnesota model). Federal BHP surplus funds are required to be used to reduce premiums and cost-sharing or enhance benefits for BHP enrollees and could be carried over from year to year. State funding would be required for state implementation and oversight costs, as federal BHP dollars cannot be used for state administrative purposes.

Role of the Health Insurance Marketplace

A BHP requires an eligibility and enrollment platform. In Minnesota and New York, the state-run ACA Marketplaces serve this function. Though each state's BHP is administered by the Medicaid program, it is the state's Marketplace that is the primary enrollment pathway for residents to access the BHP. HealthCare.gov, by contrast, has never been used in connection with a BHP and generally cannot be customized to operationalize state-specific rules or reforms.

Accordingly, without an SBM, the state would need to determine to what extent it may be possible to modify its Medicaid eligibility systems to support a BHP.[**] Additionally, as noted above, a BHP is likely to reduce the number of covered lives in the Marketplace to a significant degree. A smaller pool of enrollees in the Marketplace can mean a smaller base from which to finance Marketplace operations. However, in the event the state's BHP were to take advantage of existing marketplace systems or administrative structures, the state could assess BHP insurers for such benefits and use the revenue to offset any BHP-induced reductions in Marketplace funding.

Discussion

Benefits of a Basic Health Program

Nearly all BHP enrollees would benefit from significantly lower premiums. Depending on the model, most or all would experience reduced cost-sharing in comparison to what they could expect to pay for a Marketplace benchmark Silver plan. These projected improvements align with stakeholder feedback emphasizing the importance of addressing cost-sharing affordability, given the difficulty that many enrollees now face in accessing care because of plans' high cost-sharing requirements. Reductions in enrollee spending are expected to ensure high retention among current Marketplace enrollees who would need to transition to the BHP and generate increased take-up among Illinoisans who are now uninsured. Milliman estimates BHPs structured along the lines of Minnesota's and New York's could reduce the number of

[**] A fuller discussion of the role of a SBM in facilitating this policy option is provided in Chapter 5, "Transitioning to a State-based Marketplace."

uninsured Illinoisans by approximately 23,000 to 27,000. Implementation of the Zero Premium variant of the New York model would newly insure about 72,000 people.

These gains would address inequities in coverage take-up by income and immigration status. Illinoisans below 200 percent FPL are more likely to be uninsured than those at higher incomes. BHP eligibility is specific to this income range and, as described above, the program could be expected to produce significantly more affordable coverage and modest reductions in uninsurance among the target population.

Moreover, a BHP would generate comparatively large improvements in affordability and coverage take-up among documented immigrants. The uninsured rate for residents in this immigration category is disproportionately high (14.9 percent compared to 6.3 percent for citizens). A Minnesota or New York model BHP could be expected to reduce the percentage of uninsured among this population by 6-7 percent, with gains concentrated among recently documented immigrants. Milliman estimates a reduction of approximately 14 percent in uninsured documented immigrants under the Zero Premium model.

A BHP may also improve enrollee care and reduce the administrative burdens of coverage. A BHP well-integrated with the state's Medicaid and Marketplace may facilitate smooth transitions across coverage programs and reduce episodes of uninsurance attributable to churn. With this objective in mind, Illinois is likely to leverage its Medicaid managed care program in the establishment of any BHP, which could enable enrollees to stay with the same plan during a transition between the BHP and Medicaid. To the extent insurers and providers choose to participate across all three programs — as has been the case in Minnesota and New York — enrollees may experience still greater continuity of care. In addition, BHP enrollees are not required to reconcile their income and coverage subsidy at tax time, as Marketplace enrollees must do with respect to the federal premium tax credit. This alleviates complexity and enhances financial predictability for enrollees compared to Marketplace coverage.

In terms of financing, to the extent provider reimbursement rates for the BHP can be set consistent with the Medicaid program, as assumed in this analysis, non-administrative costs to the state may be minimal. Milliman projects federal BHP funding and enrollee contributions will produce a federal BHP trust fund surplus in CY 2022 that can be used to provide additional financial assistance to BHP enrollees or insulate the state from future BHP outlays in the event of reduced federal funding. BHP trust fund dollars cannot be used to cover or off-set administrative costs.

This study does not attempt to quantify administrative costs for any of the modeled policy options. However, it is reasonable to assume that the Zero Premium model will require less

administrative funding relative to the other BHP options because the state would not collect and administer enrollee premiums.

Finally, the state has substantial latitude over BHP plan design and program administration. While Minnesota and New York provide models for how BHP has been used to date, their approaches need not be adopted wholesale and, as illustrated by the Zero Premium model, may be modified to address state-specific objectives and fiscal obligations.

Risks Associated with a Basic Health Program

BHP funding for a given year is largely a function of the difference between provider reimbursement rates in the BHP compared to such rates in the Marketplace. While, as modeled, a BHP paying Medicaid rates would enable a surplus and not require the state to incur costs (beyond administrative costs) in CY 2022, state spending could be needed to the extent provider reimbursements under the program are higher than assumed. This could occur if, for example, Medicaid reimbursement levels and other program parameters were insufficient to encourage adequate provider participation.

A BHP will alter the size and risk composition of the state's Marketplace and broader individual market in ways that likely will affect, at least modestly, individual market premiums and federal premium subsidies for Marketplace enrollees. While the BHPs in Minnesota and New York do not appear to have reduced the stability of those states' individual markets, nor materially undermined the value proposition of Marketplace coverage, the effects of program implementation are likely to be variable across states. Milliman projects that in Illinois, implementation of a BHP would reduce individual ACA market enrollment by approximately 35 percent and, further, that the people transitioning from the Marketplace to the BHP generally will be younger and healthier than the individual market enrollees who remain. These changes to the risk pool are expected to cause unsubsidized individual ACA market premiums to rise by approximately 4-6 percent.[94] At the same time, implementation would also exert downward pressure on the premiums of Marketplace Silver plans. This is because a BHP would reduce the need for Marketplace insurers to engage in significant "Silver loading" (since a BHP would remove the bulk of individuals who receive a CSR benefit, including all of those who, at incomes up to 200 percent FPL, receive robust CSRs, from the Marketplace risk pool). If the net result of these opposing forces (decreasing Silver premiums due to less Silver loading, increasing premiums due to a less healthy risk pool) is a lower Silver plan premium, federal premium subsidies for Marketplace enrollees will be smaller, too.

While a BHP will offer eligible enrollees coverage with a much lower premium than a Marketplace Silver plan and, depending on the model, reduce cost-sharing for some or all

enrollees, some enrollees will face higher premiums relative to their actual coverage if a non-zero premium model is selected. Milliman estimates that approximately 20 percent of current enrollees in the target population are enrolled in Bronze plans with an after-subsidy premium that is lower than what their BHP premium would be under a Minnesota or New York model (and that is often $0). Research suggests that imposition of even a modest premium increase under such circumstances is likely to discourage enrollment. Accordingly, at least some existing Marketplace enrollees may choose to drop coverage rather than enroll in a BHP with a premium.

Finally, while the BHP framework is flexible, federal law limits the scope of the program. Notably, the BHP is designed to improve affordability for populations already eligible for federal financial assistance under the ACA. It does not permit states to use federal funds to broaden eligibility to groups, including the undocumented and individuals subject to the family glitch, who are barred from accessing such assistance.

Chapter 2. State Premium and Cost-Sharing Subsidies: Overview and Impact Analysis

To increase coverage affordability, reduce uninsurance, and improve access to medical care, states can, and some do, subsidize the purchase and use of comprehensive individual market health insurance.

The ACA provides eligible individuals with household incomes ranging from 100-400 percent FPL with a federal premium tax credit to defray the cost of a health plan purchased through the Marketplace, and cost-sharing reduction plans for eligible individuals with household incomes from 100-250 percent FPL. These provisions of the ACA have made comprehensive coverage far more affordable for millions of Americans.

But while the vast majority of Marketplace enrollees rely on and benefit from these federal subsidies, the amount of an eligible individual's APTC and CSR benefit is based on household income and becomes substantially less generous as income rises. At all eligible income levels, cost continues to be the chief barrier to enrolling in and using coverage, as the federal subsidy program requires a contribution to premiums that may exceed what many individuals consider affordable. Individuals with household incomes above 400 percent FPL must bear the full cost of coverage.

Moreover, there are hundreds of thousands of individuals in Illinois alone whose modest incomes would render them eligible for federal subsidies but who are prohibited from receiving them due to other federal restrictions. Those unable to access federal coverage assistance include the undocumented and individuals subject to the "family glitch."

Individuals who are unable to afford comprehensive individual market coverage may go uninsured. Alternatively, they may consider purchasing products, such as short-term, limited duration insurance, that offer limited benefits and are not required to adhere to ACA protections, including those related to preexisting conditions. These products are unlikely to serve as a sustainable source of coverage for most individuals, may be ill-suited for individuals in less-than-perfect health, and tend to segment the insurance market by health status. This can lead to higher costs and fewer choices for people who rely on comprehensive coverage.

To address these risks and expand affordable coverage options, five states — California, Colorado, Massachusetts, New Jersey, and Vermont — have committed state dollars to provide premium subsidies or premium and cost-sharing subsidies for comprehensive individual market health insurance, using approaches that complement the federal subsidy structure. By adding state subsidies on top of the federal subsidies, these states have chosen to increase the amount of financial assistance available to low- and middle-income individuals, for whom the current

federal subsidies may be insufficient, to subsidize coverage for residents who are ineligible for federal assistance, or both.

State Subsidies: Design Considerations

Policymakers designing a state subsidy program have multiple critical decisions to make, many of which will depend on the availability of state and federal resources or the willingness to generate new revenue. Examples of critical design decisions include:

- **Eligibility**. Will the subsidy program be available to residents who are already eligible to receive federal subsidies? Alternatively, or in addition, will the program target individuals who are currently ineligible for federal assistance, for example, due to income, immigration status, or the family glitch?
- **Which costs to target?** Will the state subsidize premiums, reduce eligible enrollees' cost-sharing exposure, or both?
- **Equity**. What are the demographic characteristics of Illinoisans likely to be affected by the subsidy program? How can program parameters be designed to advance health equity?
- **Financing**. Will the state develop new funding sources, such as an insurance provider assessment — adopted by two other states with subsidy programs, Colorado and New Jersey — to finance the program? Are there sources of federal funding that may be accessed — for example, via a Section 1115 or Section 1332 waiver —to defray state costs?
- **Program administration**. What entity or entities will determine eligibility for the state subsidy and administer payments? Will the state need to enact legislation to transition to a State-Based Marketplace to implement a subsidy program?
- **Interaction with federal policy**. Were the state to pursue a Section 1115 or Section 1332 waiver to secure partial federal funding for the subsidy program, how would the terms and obligations imposed by such waivers affect the design of the subsidy program and the populations to which it is targeted?

Overview of State Subsidy Programs and Federal Proposals to Enhance Subsidies

Four states — California, Massachusetts, New Jersey, and Vermont — currently subsidize premiums and/or cost-sharing for comprehensive individual market coverage, while a fifth, Colorado, will do so beginning in 2022. See Exhibit 22. Additional states, including Maryland and Washington, are studying how such programs might be implemented.[95]

Exhibit 22. State Subsidy Programs for Individual Market Health Coverage

State	Income Eligibility	Other Eligibility Differences (vs. federal)	Subsidy Structure	Funding Source(s)
California	Up to 138% FPL; 200-600% FPL	---	Premium tax credit, sliding scale based on income	State general fund
Colorado	Up to 400% FPL (beginning 2022)	---	Premium subsidy	Assessment on health insurers and hospitals
	Up to 300% FPL (beginning 2023)	Available to individuals not eligible for federal APTCs or public coverage	To be determined	
Massachusetts	Up to 300% FPL	---	Standard plans with reduced premiums and cost sharing. Premium reductions follow a sliding scale based on income. Cost-sharing parameters vary by income tier.	-Federal Section 1115 waiver -Assessment on health insurers -Other state funds
New Jersey	Up to 400% FPL	---	Premium subsidy, variable by income tier	Assessment on health insurers
Vermont	Premium subsidy: Up to 300% FPL	---	Premium subsidy, fixed at 1.5% of income	-Federal Section 1115 waiver -Other state funds
	Cost-sharing subsidy: 200-300% FPL		Cost-sharing reductions, variable by income tier	

Massachusetts has subsidized individual health insurance since before the ACA, pursuant to health reforms enacted by the state in 2006. Currently, the state's ConnectorCare program provides premium and cost-sharing assistance to approximately 225,000 individuals with incomes up to 300 percent FPL.[96] Participating insurers must offer health plans that adhere to standard benefit and cost-sharing designs, as set by ConnectorCare. There are three standard plan types (designated "Type 1" through "Type 3"), which vary only in their cost-sharing parameters. Plan Type 1 was designed to align with the state's Medicaid MCO cost-sharing parameters and requires only nominal enrollee cost-sharing, while each successive plan type is relatively less generous. Applicants qualify for a single plan type, which is determined based on income (e.g., applicants at the low end of the income scale qualify for the most generous plan, Type 1). Premium subsidies decrease along a sliding scale as income rises.

Notably, Massachusetts' subsidy program operates in concert with numerous other reforms designed to improve coverage affordability. In addition to utilizing standard plan designs, as noted above, the state also:

- Has merged its individual and small group markets;
- Requires individuals to maintain coverage, if they can afford to do so, or else pay a penalty (an individual mandate);
- Requires insurers with over 5,000 covered lives to participate on the Marketplace;
- Uses an "active purchasing" competitive bidding model to encourage insurers to offer lower premiums and links state subsidy amounts to the lowest-cost Silver plan (rather than the federal benchmark, second lowest cost silver plan, or SLCSP); and
- Sets a more stringent medical loss ratio standard than the federal government to reduce administrative costs.

Since implementation of these reforms in the late 2000s, the state has achieved the lowest uninsured rate and some of the lowest average premiums in the country.[97]

Vermont is the only other state that currently provides both premium and cost-sharing assistance for residents to purchase comprehensive individual market coverage. Since the rollout of the ACA Marketplaces in 2014, the state has subsidized individual market premiums by reducing, by 1.5 percent, the amount of income that enrollees at 300 percent FPL and below are expected to contribute. For example, an individual at 250 percent FPL must contribute 8.29 percent of income before receiving federal APTCs; Vermont lowers the individual's contribution to 6.79 percent by paying the difference. The state's cost-sharing reductions are similarly layered onto the federal framework. Eligible Vermonters with incomes between 200-250 percent FPL may enroll in a Silver plan with 77 percent AV (rather than the 73 percent AV provided by the federal CSR benefit), while those at incomes from 250-300 percent FPL (above the federal cutoff for CSRs) may enroll in a modestly enriched 73 percent AV Silver plan.

For 2020, California implemented what is currently structured as a three-year, temporary premium subsidy program targeted at both individuals currently receiving federal APTCs as well as those whose income renders them ineligible for such assistance. For Californians already eligible for federal APTCs who have incomes (1) up to 138 percent FPL or (2) from 200-400 percent FPL, the state program lowers the required contribution to premiums. Low-income individuals in the first category see their contributions reduced to zero, while those in the second category benefit from more modest reductions calculated on a sliding scale. At the same time, the program extends financial protection to enrollees with incomes between 400-600 percent FPL by establishing premium contribution caps where none exist in the federal

framework. See Exhibit 23. Following the 2020 open enrollment period, about 625,000 Californians were receiving the new state subsidy, most in conjunction with federal assistance. About 32,000 individuals between 400-600 percent FPL were newly subsidized with state assistance averaging about $500 per month.[98] The Marketplace experienced large (41.2 percent) increases in new enrollments for 2020 but, due to a decline in renewals, saw only a small (1.6 percent) enrollment increase overall.[99] Early indications suggest that these new enrollees are relatively healthier than those from the prior year, and the resulting improvement in the risk pool has helped to moderate premiums for 2021.[100] Because the state implemented an individual mandate to maintain coverage at the same time as the subsidy program, the isolated effect of the new subsidies on enrollment is unclear.

Exhibit 23. California's Subsidy Program: Required Contributions to Premiums, by Household Income (2021)

Household income as percent of FPL	California		Federal	
	Low End	High End	Low End	High End
Up to 138%	0.00%	0.00%	2.07%	2.07%
138% - 150%	Same as federal	Same as federal	3.10%	4.14%
150% - 200%	Same as federal	Same as federal	4.14%	6.52%
200% - 250%	6.24%	7.80%	6.52%	8.33%
250% - 300%	7.80%	8.90%	8.33%	9.83%
300% - 400%	8.90%	9.68%	9.83%	9.83%
400% - 450%	9.68%	14.00%	---	---
450% - 500%	14.00%	16.00%	---	---
500% - 600%	16.00%	18.00%	---	---

Note: The "Low End" is the percentage of household income that must be contributed by individuals at the low end of the corresponding FPL range; the "High End" is the corresponding percentage that applies to individuals at the high end of the corresponding FPL range. Linear interpolation is used to determine the applicable percentage for income levels within the FPL range.

Two additional states, Colorado and New Jersey, enacted legislation in 2020 to establish individual market coverage subsidy programs. New Jersey implemented its program on an expedited basis for the 2021 open enrollment period and to coincide with the state's transition from HealthCare.gov to its own Marketplace enrollment platform. Though the structure of the New Jersey subsidy may be modified in future years, the initial version of the program provides premium relief by income tiers for individuals already eligible for federal APTCs. Colorado's program, like New Jersey's, will be funded in part by an assessment on insurers that replaces the expiring federal insurance provider tax.[101] The Colorado program will be administered by a new enterprise housed within the insurance division and is composed of two parts targeting distinct populations. Starting in 2022, the state will provide premium subsidies to Coloradans

already eligible for federal APTCs. In 2023, Colorado will launch "state-subsidized individual health coverage plans" for individuals up to 300 percent FPL who are ineligible for federal subsidies or public coverage. This program is intended to improve access to coverage and reduce uncompensated care by reducing affordability barriers still experienced by lower-income residents, including undocumented individuals and those caught in the family glitch. The subsidized plans will be offered outside the Marketplace by a public benefit corporation that is legally distinct from but wholly owned by the Marketplace.[102]

In addition to these state efforts already underway, there are numerous federal proposals to enhance the generosity of the ACA's premium and cost-sharing subsidies that, in the absence of federal action, could be adapted for state implementation.[103] For example, members of the U.S. House Energy and Commerce Committee have proposed legislation that, among its other provisions, would smooth the current "subsidy cliff' by eliminating the 400 percent FPL income eligibility threshold.[104] In the absence of this cap, eligible individuals would receive assistance if plan premiums exceeded a certain percentage of their income (as is the case for individuals up to 400 percent FPL today); the benefit itself would naturally phase out at higher income levels, as premium costs comprise a progressively smaller share of income. A state might consider a similar approach and provide financial protection for all otherwise eligible individuals above the federal income cutoff, by subsidizing premiums up to a set percentage of household income.

Considerations for Illinois: Impact Analysis

The actuarial and consulting firm Milliman, Inc. was retained to model enrollment and funding estimates for several policy options, including a state-funded premium and/or cost-sharing subsidy program for individual market health insurance. In its report (see Appendix A), Milliman assesses the impact of a subsidy program on Illinois' health insurance landscape for CY 2022, the earliest year in which implementation of such a program is feasible. For the purpose of these assessments, Milliman projects that, for CY 2022, baseline enrollment in the state's individual health insurance market will be approximately 355,000 (about 341,000 of whom would be eligible for the subsidy program). Milliman further estimates that approximately 371,000 uninsured individuals will be eligible for a state-funded subsidy program with eligibility parameters matching those modeled here.

Milliman's modeling does not take into account the more generous premium tax credits in the American Rescue Plan Act of 2021 (ARP), signed into law on March 11. 2021. The more generous financial assistance available under the ARP is only available during calendar years 2021 and 2022. Milliman's modeling evaluates costs at a steady state enrollment, which may take three years to reach, and the likelihood of the more generous financial assistance being

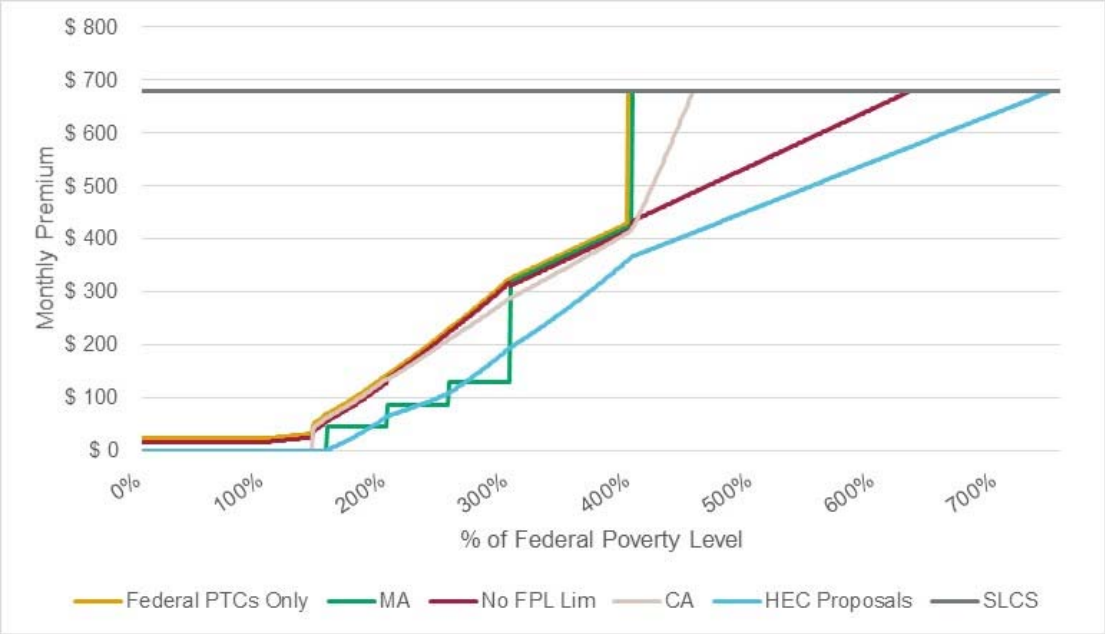
extended beyond 2022 is unknown, so Milliman's modeling uses the standard ACA premium tax credit table as the assumed financial assistance available.

As directed by the Interagency Working Group, Milliman modeled four variations of a state-funded coverage subsidy program:

- *Massachusetts model*: Patterned after the subsidy structure offered by Massachusetts' ConnectorCare program, described above, this option would provide premium and cost-sharing subsidies to enrollees with household incomes up to 300 percent FPL.
- *No FPL limit*: This option would provide premium subsidies to otherwise eligible individuals with household incomes above 400 percent FPL. Individuals would be expected to contribute no more than a set percentage of household income to premiums; the state subsidy would cover remaining premium costs.
- *California model*: Patterned after California's subsidy program, described above, this option would provide premium subsidies to federal APTC-eligible enrollees with household incomes from 200-400 percent FPL and to otherwise eligible individuals with household incomes ranging from 400-600 percent FPL.
- *House Energy & Commerce Committee proposal*: Patterned after legislation proposed by members of the U.S. House Energy & Commerce Committee (HEC), this option would provide premium and cost-sharing subsidies to federal APTC-eligible enrollees with household incomes up to 400 percent FPL and premium subsidies to otherwise eligible individuals with household incomes above 400 percent FPL.

Exhibits 24 and 25 provide visual comparisons of the existing federal premium subsidy program and the state premium subsidy options modeled by Milliman. Exhibit 24 illustrates the average annual enrollee premium for benchmark SLCSP for a 40-year old nonsmoker in southeast Illinois, before subsidies (denoted by the horizontal line) and with subsidies, as applicable, under existing federal law and the modeled state premium subsidy program options.

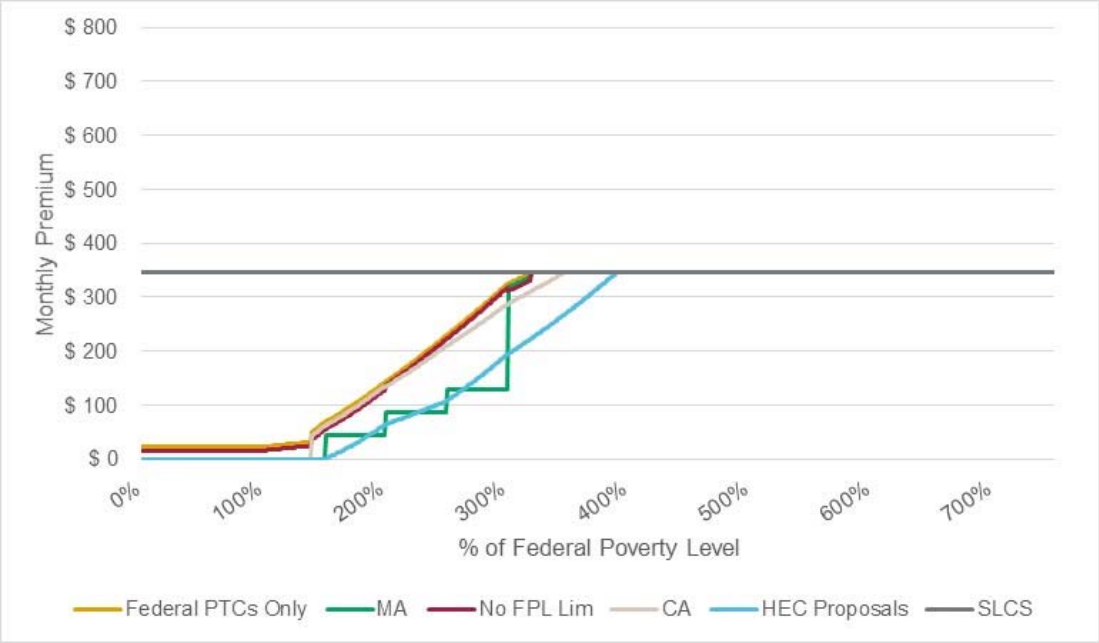
Exhibit 24. Estimated CY 2022 Monthly Enrollee Premium by Federal Poverty Level Under Each Subsidy Program, Southeast Illinois



Notes: Illustrated premium is for the second lowest cost Silver (SLCS) plan in southeast Illinois, for a 40-year old individual who does not use tobacco. Lines are offset slightly for illustrative purposes where premiums are identical. All programs ultimately reach the level of the SLCS monthly premium ($678). For a more detailed summary, see Appendix A.

Exhibit 25 provides the same illustration, but for an enrollee in Chicago.

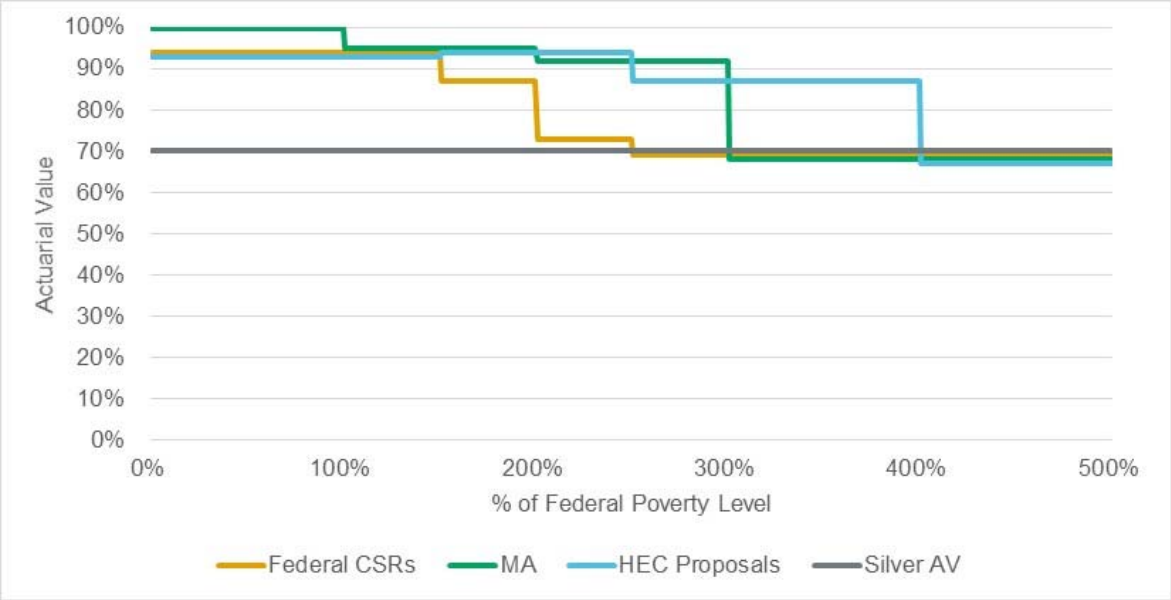
Exhibit 25. Estimated CY 2022 Monthly Enrollee Premium by Federal Poverty Level Under Each Subsidy Program, Chicago



Notes: Illustrated premium is for the second lowest cost Silver (SLCS) plan in Chicago, for a 40-year old individual who does not use tobacco. Lines are offset slightly for illustrative purposes where premiums are identical. All programs ultimately reach the level of the SLCS monthly premium ($345). For a more detailed summary, see Appendix A.

Exhibit 26 provides a visual comparison of the existing federal cost-sharing benefit and the state-funded cost-sharing subsidy options modeled by Milliman. It illustrates the AV for a Silver plan without a cost-sharing benefit (denoted by horizontal line at 70 percent AV) and with such benefits, as applicable, under existing federal law and the two modeled state subsidy program options that offer cost-sharing assistance (the Massachusetts and HEC models).

Exhibit 26. Estimated Cost-Sharing Reduction Actuarial Values by Federal Poverty Level Under Each Subsidy Program



Notes: Lines are offset slightly for illustrative purposes where actuarial values (AVs) overlap. The No FPL Limit and California models do not provide state-funded cost-sharing subsidies and instead use default federal cost-sharing reduction (CSR) definitions. Illustrated AVs are for Silver plan coverage, including CSR benefits for those eligible. For a more detailed summary, see Appendix A.

Estimated Impacts on Coverage Take-up and Enrollee Costs

Milliman estimates that each subsidy program option will increase enrollment in comprehensive individual market coverage relative to existing ACA policy. Enrollment gains vary significantly across the four options based primarily on the degree to which each program reduces enrollees' out-of-pocket spending on Marketplace premiums and, to a lesser extent, its effect on enrollee cost-sharing. The HEC proposal, which would reduce enrollee contributions to premiums across income ranges and by the largest magnitude, accordingly is anticipated to produce the largest increase in enrollment among individuals currently uninsured in Illinois (106,000, corresponding to an approximately 12 percent decrease in the number of uninsured). The relatively more modest premium subsidy enhancements offered by the other modeled options are projected to generate relatively smaller coverage gains. See Exhibit 27. In general, enrollment increases are expected to be highest among individuals who, due to the state premium subsidy, are newly positioned to purchase a Silver plan with a $0 premium.

Exhibit 27: CY 2022 Projected Results By State-funded PTC/CSR Program

PROGRAM	ESTIMATED ENROLLEES	ESTIMATED ENROLLEES PREVIOUSLY UNINSURED UP TO 200% FPL	ESTIMATED ENROLLEES PREVIOUSLY UNINSURED OVER 200% FPL	ESTIMATED ENROLLEES WITH LOWER PREMIUM	ESTIMATED ENROLLEES WITH LOWER COST SHARING	STATE FUNDING PTCs (MILLIONS)	STATE FUNDING CSRs (MILLIONS)
Massachusetts	368,000	32,000	24,000	327,000	238,000	$ 151.0	$ 213.0
No FPL Limit for PTCs	324,000	-	9,000	107,000	-	$ 182.0	$ 0.0
California	329,000	6,000	9,000	230,000	-	$ 113.0	$ 0.0
HEC	424,000	53,000	54,000	423,000	248,000	$ 511.0	$ 285.0

*Milliman estimates approximately 712,000 Illinoisans are eligible for Marketplace coverage.

Milliman projects that each subsidy program option would also decrease premium and cost-sharing burdens for a significant share of existing enrollees. Again, the HEC model would generate savings for the largest number of enrollees: about 423,000 would experience lower premiums and roughly 248,000 would see reduced cost-sharing. The California model, providing a more modest premium subsidy enhancement (compared to the HEC model) to individuals both above and below the federal APTC threshold, could be expected to lower premiums for about 230,000 residents, while a Massachusetts-style program could be expected to reduce premiums for approximately 327,000 Illinoisans and lower cost-sharing for 238,000 individuals.

Milliman also summarized the impact of the four subsidy program models by race, ethnicity, and immigration status. Percent reductions in uninsurance are projected to be largest among whites and Asian Americans across models and generally would be relatively smaller for Blacks and Hispanic/Latino individuals. See Exhibit 28. Each model could be expected to produce comparatively large reductions in uninsurance among documented immigrants. As none of the modeled options extends subsidy eligibility to individuals with undocumented immigration status, the uninsured rate among this population would be unchanged. Percentage reductions in the number of uninsured across geographic regions are relatively similar across all models.

Exhibit 28. Percent Reduction in Uninsured by Race, Ethnicity and Immigration Status*

	State Subsidy Program Option			
	Massachusetts	**No FPL Limit**	**California**	**HEC Proposal**
Non-Hispanic/Latino				
American Indian and Alaska Native	0.3%	0.1%	0.6%	2.6%
Asian	7.5%	1.0%	3.3%	12.9%
Black or African-American	6.4%	0.5%	1.4%	12.0%
Native Hawaiian and Other Pacific Islander	1.0%	0.0%	0.0%	17.1%
White	7.2%	2.0%	2.0%	14.8%
Hispanic/Latino	4.7%	0.2%	1.2%	8.6%
Documented immigrant				
Less than 5 Years	26.7%	0.5%	21.6%	31.5%
5 or More Years	7.1%	1.2%	1.2%	17.4%

*For a more detailed summary of the impact of the subsidy program scenarios by race, ethnicity, and immigration status, see Appendix A. Modeling assumptions did not vary by race and ethnicity.

The HEC option, which reduces enrollee contributions to premiums across incomes, accordingly is projected to lower premiums for virtually all enrollees, regardless of demographic characteristics. See Exhibit 29. The comparatively more targeted Massachusetts model still is expected to reduce premiums for the vast majority of those with coverage, including about 92 percent of Black enrollees and 95 percent of enrollees who are documented immigrants in the country less than 5 years. Both models would also reduce cost-sharing obligations for most enrollees, and particularly among Black and Hispanic/Latino enrollees.

The share of enrollees with cheaper premiums is estimated to be more modest under the California model and, especially, the No FPL Limit option. Gains among people of color, relative to whites, are also projected to be smaller under these models, compared to the Massachusetts and HEC models options.

Exhibit 29. Share of Program Enrollees with Reduced Premiums or Cost-Sharing by Race, Ethnicity and Immigration Status*

	State Subsidy Program Option							
	Massachusetts		No FPL Limit		California		HEC Legislation	
	Lower Premium	Lower Cost-Sharing	Lower Premium	Lower Cost-Sharing	Lower Premium	Lower Cost-Sharing	Lower Premium	Lower Cost-Sharing
Non-Hispanic/Latino								
Asian	92.8%	75.9%	21.2%	0.0%	71.6%	0.0%	100.0%	46.6%
Black or African American	91.8%	77.8%	23.8%	0.0%	63.7%	0.0%	100.0%	71.4%
White	87.9%	57.5%	37.9%	0.0%	71.7%	0.0%	100.0%	56.6%
Hispanic/Latino	87.9%	79.8%	23.8%	0.0%	66.8%	0.0%	100.0%	71.2%
Documented immigrant								
Less than 5 Years	95.3%	93.5%	7.4%	0.0%	86.2%	0.0%	100.0%	25.3%
5 or More Years	89.0%	73.4%	25.6%	0.0%	60.1%	0.0%	100.0%	69.2%

*For a more detailed summary of the impact of the subsidy program scenarios by race, ethnicity, and immigration status, see Appendix A. Modeling assumptions did not vary by race and ethnicity.

Estimated State Costs

State funding obligations associated with these options vary widely, generally depending on the relative generosity of the subsidies offered. Milliman estimates that program costs in CY 2022, excluding administrative costs, may range from approximately $113 million (for the California model) to $796 million (the HEC model). Additional state fiscal analysis is needed to determine implementation and oversight administrative costs.

Because the program options vary in subsidy design (in addition to generosity), the anticipated effect of state spending on coverage take-up is nonlinear. For example, while the Massachusetts model is projected to require the second largest state funding commitment of the options modeled, it is expected to be the most cost effective subsidy program for covering previously uninsured Illinoisans. By contrast, the No FPL Limit option is likely to be the second least costly policy, in absolute terms, to implement, but is estimated to be only about a third as effective as the modeled alternatives in reducing uninsurance. See Exhibit 30. Importantly,

however, and as described more fully elsewhere in this section, state subsidy programs are intended to reduce not just *un*insurance, but also *under*insurance, by lowering premium and/or cost-sharing obligations for existing enrollees. The cost effectiveness analysis presented here does not capture the anticipated improvements in affordability for the currently insured.

Exhibit 30. State Program Costs Per Newly Insured Enrollee

State Subsidy Program Option	Estimated Enrollees Previously Uninsured	Estimated Required State Funding (Not Including Admin Costs) ($ Millions)	Approximate State Cost Per Newly Insured Enrollee (Not Including Admin Costs)
Massachusetts	55,000	$364	$6,600
No FPL Limit	9,000	$182	$20,500
California	15,000	$113	$7,400
HEC	106,000	$796	$7,500

Notes: State funding requirements and costs per newly insured enrollees are approximate and do not include administrative costs. As described more fully in the text, each program option, in addition to reducing uninsurance, is also projected to improve the affordability of individual market health insurance for existing enrollees.

Role of the Health Insurance Marketplace

All states that currently offer additional coverage subsidies also operate their own ACA Marketplace and enrollment portal. While it is possible that the state could administer a subsidy program while remaining on HealthCare.gov, the federal platform cannot be customized to reflect operation of the state program. This means, among other considerations, that state subsidy eligibility would be bifurcated from the federal eligibility and enrollment process and that any subsidy offered by the state towards the purchase of a Marketplace plan would not be displayed on HealthCare.gov for consumers to see while shopping for and purchasing a plan. It is thus likely that adoption of a state-run Marketplace and enrollment platform would greatly facilitate the implementation and effectiveness of a state subsidy program.[††]

Notably, federal law prohibits individuals with undocumented immigration status from purchasing QHPs through the ACA Marketplace. While such eligibility rules are among the list of waivable provisions under the ACA's Section 1332 waiver program, the federal government has never assessed such a waiver.[105] Thus, to the extent a state program is designed to improve affordability for undocumented residents, it is possible that the program would need to provide for subsidized coverage via an enrollment pathway outside of the ACA Marketplace structure.

[††] A fuller discussion of the role of a SBM in facilitating this policy option is provided in Chapter 5, "Transitioning to a State-based Marketplace."

This is the approach Colorado is taking with respect to its program to provide subsidized coverage to undocumented residents beginning in 2023.

Discussion

Benefits of a State Subsidy Program

Offering additional premium subsidies makes comprehensive individual market coverage more affordable at the time of purchase. This encourages otherwise eligible individuals who are not currently enrolled to do so, including healthier individuals who might otherwise choose to forego coverage. The provision of additional cost-sharing subsidies likewise makes it more likely that an uninsured individual will take up coverage (though the effect of reduced cost-sharing on enrollment is assumed to be relatively smaller than the effect of reduced premiums). All four of the subsidy program options modeled by Milliman are projected to increase coverage take-up, by a range of approximately 9,000 (for the No FPL Limit model) to as much as 106,000 (under the HEC proposal).

A state subsidy program would also reduce financial burdens for many existing enrollees. In three of the four scenarios, a majority of individuals now with coverage would see their premiums fall. Both of the models that include additional cost-sharing subsidies would also have the effect of lowering most enrollees' out-of-pocket costs, making it more affordable for them to use their coverage to receive health care services. These improvements align with stakeholder feedback emphasizing the importance of addressing cost-sharing affordability, given the difficulty that many enrollees now face in accessing care because of plans' high cost-sharing requirements. In addition, while the two most generous models — the HEC and Massachusetts options — are projected to reduce costs for the vast majority of enrollees, irrespective of race, ethnicity, or immigration status, these two models are likely to produce their largest gains (in terms of the share of enrollees with lower costs) among enrollees of color.

In addition, and as reflected in Milliman's estimates, a subsidy program could be expected to improve the health of the individual market risk pool, leading to a further reduction in premiums. Because uninsured individuals are generally healthier than current individual market enrollees, additional enrollment among this population, due to subsidies, is likely to reduce the morbidity of the risk pool and allow insurers to offer coverage at relatively lower premiums. Early indications from California suggest that new enrollments since the state's implementation of its subsidy program have been relatively healthier and have helped to moderate premiums.[106]

Finally, the state has relatively wide latitude to develop and implement a subsidy program, with significant flexibility to target the benefit as determined appropriate and do so consistent with state fiscal obligations. For example, for the first year of its subsidy program, New Jersey calculated the amount of funding available and then determined how to distribute the premium assistance within that budget.

Risks Associated with a State Subsidy Program

A subsidy program requires a state funding source. Among the four programs modeled, the options expected to produce the largest improvements in coverage affordability and gains in enrollment among the uninsured are those that provide the most generous subsidies and require the largest funding to support. Importantly, however, the relationship between state funding levels and coverage take-up is nonlinear. Some options are expected to be more cost effective than others in reducing uninsurance.

As noted above, it is likely to be difficult to implement an effective state subsidy program using the HealthCare.gov platform, which is not designed to calculate or display the effect of additional state premium or cost-sharing subsidies. Design flexibility, administration, and take-up of such a program are likely to be substantially benefited by establishment of a State-Based Marketplace with a state-specific enrollment website.

Chapter 3. A Public Option Plan: Overview and Impact Analysis

A public option plan is a government-supported health plan that would compete on the Health Insurance Marketplace with private health plans. The level of government support can vary. For example, a state could design the benefits, set premiums and provider reimbursement rates, build the provider network, conduct the marketing, and bear the financial risk of paying claims. Alternatively, a state could delegate some or all of these responsibilities to a Third Party Administrator (TPA) or private insurer, but establish the standards and process by which a TPA or private insurer would be able to offer a "public option" plan.

Stakeholders that provided input on this study identified both high individual market premiums and high enrollee cost-sharing as an ongoing challenge for Illinois residents. A public option plan has the potential to reduce premiums through lower administrative costs and/or paying lower provider reimbursement rates. It can also establish a standardized benefit design that covers high value services, such as primary care, pre-deductible, to lower cost barriers to care. Goals of the public option include providing individual market consumers with the choice of a more affordable plan and spurring private insurers to offer more competitively priced plans. It could also provide employers, particularly small employers, with a lower-cost alternative to commercial insurance.

In 2019, the state of Washington enacted legislation creating a public option plan, with enrollment beginning January 1, 2021.[107] Colorado's legislature considered a public option plan proposal in 2020, but further action was cut short by the COVID-19 pandemic.[108] Additional states, including Maryland, Nevada, and Oregon are also studying the feasibility of a public option plan.[109] Creating a federally run public option plan is also a component of President Biden's health care reform platform. Under the Biden proposal, individuals would be able to enroll in a "Medicare-like" public option plan even if they are already enrolled in a QHP or an employer-sponsored health plan. It envisions reducing costs by using Medicare's buying power to negotiate lower reimbursement rates with hospitals and physicians.[110]

A Public Option Plan: Design Considerations

Policymakers designing a public option plan have multiple critical decisions to make. Many of these decisions involve trade-offs, where one design decision could benefit one population but harm another. Others would involve more or less state involvement and financial risk. Examples of critical design decisions include:

- **Type of Plan**. Will the plan be sponsored by the state, and as such not defined as individual health insurance under the state insurance code? Or will it be offered by a licensed issuer under state insurance law, in which case it will be required to comply

with federal and state standards for the individual market, such guaranteed issue and the single risk pool?

- **Eligibility**. Will the plan be open to anyone in the individual market, including those ineligible for Marketplace plans, such as undocumented individuals? Will it be open to enrollment by employers, and if so, to all employers or just those in the small-group market? Or should enrollment be more limited, such as to areas in the state that currently have the highest premiums, or that lack health plan competition?
- **Allocation of risk**. Who will bear the risk of paying enrollees' health care claims? Will that fall to the state, to a private insurer, or some combination of the two? Will the plan participate in the ACA's single risk pool, risk adjustment program, and be subject to the same marketing and consumer protection standards as Marketplace plans? If the state bears any financial risk, how will that be budgeted and paid for?
- **Competition and choice**. How will the public option affect other insurers in the Marketplace? If competition from a lower-cost, publicly backed plan discourages private insurers from participating in the Marketplace, should the state establish participation incentives for insurers so that consumers can continue to have a choice of plans, public and private?
- **Equity**. What are the demographic characteristics of Illinoisans likely to be affected by the public option? How can program parameters be designed to advance health equity?
- **Network adequacy**. Most public option proposals generate savings by reducing or capping provider reimbursement rates. What incentives, if any, will providers need to participate in a public option in sufficient numbers to ensure that enrollees have timely access to needed services?
- **Benefits**. Will the plan come with a standardized set of benefits that reduces cost-sharing for selected services? If the plan must comply with the ACA's market reforms, will cost-sharing for other services need to be increased in order to meet the required AV targets? What populations would benefit from such a standardized plan design? Are there populations that would be worse off?
- **Intersection with federal policy**. If the state's public option plan results in lower premiums in the individual market, and thus lower costs for the federal government in APTC spending, the state could seek "pass through" funding through an ACA 1332 waiver application. Should the state seek such a waiver and if so, how should any pass through funding be allocated? Also, does the state need to transition to a SBM in order to achieve its goals for a public option plan?

Washington and Colorado Public Option Plan Proposals: Overview and Lessons Learned

Washington and Colorado's public option plans depend largely on capping provider reimbursement rates to achieve the states' goal of reducing unsubsidized premiums in the individual market. They also standardize benefit design to reduce enrollee cost-sharing for selected services. Under Washington's "Cascade Care" program, the state agency that administers Medicaid is required to contract with private insurers to offer a public option plan through the state's health insurance Marketplace. In early 2020, that agency established a bidding process, in which private insurers could bid to offer a public option health plan, beginning January 1, 2021. Winning bidders are responsible for operating and marketing their public option plans and ultimately bear the financial risk of enrollees' health care costs. Public option plans must meet QHP certification standards to participate on the Marketplace, are required to cap provider reimbursement rates at 160 percent of the Medicare rate, (pharmacy benefits and rural hospitals excluded), and primary care providers must be paid at least 135 percent of the Medicare rate. The state attempts to encourage providers to participate in the public option plan network by exempting payments for treating public option plan enrollees from the state's Business & Occupation (B&O) tax.[111]

State law also requires all participating individual market insurers to offer plans with state-established, standardized benefits that eliminate deductibles for high-value services such as primary and urgent care, mental health services, and certain generic drugs.[112] Health insurers are permitted to continue to market plans in which they pay commercially negotiated rates to providers, which would have to compete for individual market enrollees alongside the public option plan.

Colorado's public option proposal is similar in key ways to Washington's program. It relies on private insurers to deliver the benefits and cover claims, but caps the amount they can reimburse hospital providers. As in Washington, Colorado's public option plan would be open to individual market enrollees and offered on the Marketplace, although the legislation envisions opening enrollment to small employers in future years. The proposal would reduce enrollee premiums by setting hospital payment rates at a base rate of 155 percent of Medicare (but with upward adjustments based on hospital-specific characteristics), requiring prescription drug rebates to be passed onto policyholders, and increasing insurers' minimum medical loss ratio to 85 percent.[113] Hospitals that refuse to participate in the public option plan could face a warning, fines, or suspension or revocation of their license from Colorado's Department of Public Health & Environment. In response to concerns that hospitals will increase their prices for employer-based insurance to recoup any losses under the public option, the legislation gives Colorado's Division of Insurance the authority to deny any rate filings for a plan in any market that reflects "a cost-shift" between the public option and that plan. Although Washington chose

not to pursue a 1332 waiver to draw down federal pass-through funding, Colorado's bill would authorize the pursuit of a waiver. Pass-through funding would be used to improve health plan affordability for individuals up to 400 percent FPL. As in Washington, Colorado's bill requires the public option to offer a standardized benefit design that includes pre-deductible coverage of primary and behavioral health care services.[114] See Exhibit 31.

Exhibit 31. The Washington and Colorado State Public Option Plans

Key Features	Washington's Program	Colorado's Proposal
How will the plan be offered?	The plan is marketed through the state's SBM and sold by private insurers that contract with the state.	Private insurers in the individual market will be required to offer the public option plan on and off-Marketplace to ensure at least two insurers per county.
Who's eligible?	Those seeking individual market insurance, whether or not eligible for premium tax credits.	Those seeking individual market insurance, whether or not eligible for premium tax credits. In 2023, plans may be available to small employers.
How will benefits be determined?	Standardized benefit design with cost-sharing parameters set by the state.[b]	Standardized benefit design with cost-sharing parameters set by the state.[d]
How will premiums be reduced?	• Providers will be reimbursed at an average maximum of 160% of Medicare rates.[a] • State officials must study how to support state premium subsidies for people with incomes below 500 percent of FPL.	• Hospital reimbursement will be capped based on a fee schedule.[c] • Plans must spend at least 85 percent of premiums on patient care. • Rebates from drug manufacturers or pharmacy benefit managers must be passed onto policyholders.
How will providers be incentivized to participate?	Payments to providers for delivering services to public plan enrollees are exempt from the state's B&O tax.	If a hospital refuses to participate, the state may issue a warning, impose fines, or suspend, revoke, or impose conditions on the hospital's license.
Is a 1332 waiver authorized?	No	Yes
When will the plans be available?	January, 2021	January, 2022 (in proposed legislation)

Source: 66th Legislature of Washington State, 2019 Regular Session, Ch. 364, Laws of 2019; Colorado HB20-1349, 2020 Regular Session.

[a] Excludes pharmacy benefits and rural hospitals. Reference pricing based on Medicare rates for "the same or similar services in the statewide aggregate." Primary care services (defined by the Washington Health Care Authority) must be reimbursed at at least 135 percent of Medicare. Beginning in 2023, the Washington Health Care Authority may waive this contracting requirement if rates for the public option plan are determined to be no greater than the prior year's rates (adjusted for inflation), or if the Director of the Health Care Authority determines that the requirement prevents the insurer offering the public option plan from meeting network

adequacy standards, and the carrier can attain actuarially sound premiums at least 10 percent lower than the prior plan year through different means.

[b] Public option plans will offer state-prescribed benefits and cost-sharing amounts. In addition, all insurers offering Marketplace plans are required to offer at least one standard Silver plan and at least one standard Gold plan through the Marketplace beginning in January, 2021. Insurers offering any Bronze Marketplace plans are also required to offer at least one standard Bronze plan.

[c] Colorado's public option plans would be required to reimburse hospitals based on a state-established, hospital-specific formula that sets a base reimbursement rate of 155 percent of Medicare, with upwards adjustments for hospital-specific characteristics. Some critical access hospitals would be reimbursed at up to 237 percent of the Medicare rate.

[d] Colorado's public option plans would be required to cover more primary and behavioral health care services that enrollees can access without having to meet their deductible.

Lessons from the Field: Policy and Implementation Challenges

Both Washington and Colorado's public option plan proposals aim to improve the affordability of health insurance through two primary tactics:

- Reducing premiums by capping provider reimbursement rates, and
- Requiring standardized benefit designs that eliminate deductibles for specified high-value services, such as primary care.

Colorado also proposes to lower the amount insurers spend on administrative costs, by increasing the individual market medical loss ratio from 80 to 85 percent. These tactics generated opposition from health industry stakeholders.[115] In Washington, early versions of the public option legislation would have paid providers at 100 percent of the Medicare rate, but after intense opposition from providers, who feared a cut in revenue, legislators increased that limit to 160 percent of Medicare in the final bill.[116] This significantly reduced premium savings for unsubsidized consumers in Washington.

In Washington, the average premium for the 2021 public plan offerings is 4 percent *higher* than 2020 average premiums, and higher than many non-public option plans on the Marketplace in plan year 2021. At the same time, there will be public option plans in only 19 out of 39 counties in Washington. Marketplace officials have identified provider participation and the ability to maintain network adequacy as key long-term challenges with the public option plans, noting that many providers have little incentive to contract with insurers at lower rates. Officials also noted that the state's plethora of participating insurers (13 carriers are in the Marketplace) may reduce their leverage with providers; this would be particularly true in areas where hospital systems are more consolidated. The state's ability to incentivize provider participation is limited to a tax break on revenue from treating public option enrollees. State officials are considering

legislative options to link provider participation in the public option plans to their ability to participate in state employee plan networks.[117]

The insurance industry has also raised concerns about Colorado and Washington's public option proposals, although they appear to be less monolithic in their views than provider representatives.[118] Somewhat unexpectedly, some insurers in Washington were among those calling for raising the cap on provider reimbursement rates. They argued that if individual market premiums became lower than premiums in the small-group market, small employers would have incentives to drop their group plans. One common argument insurers put forward in both Washington and Colorado is that the public option's lower provider reimbursement rates will prompt providers to demand higher reimbursement rates for employer plans, in order to recoup lost revenue. However, there is little empirical evidence to support that significant cost-shifting actually occurs.[119] For example, a Colorado study found that even after the state raised Medicaid reimbursement rates, they did not see a corresponding decrease in the prices hospitals charged to commercial payers.[120]

In Colorado, some consumer advocates raised concerns that a public option, in lowering average premium rates, could perversely make net premiums less affordable for subsidized Marketplace enrollees. If a public option plan reduces the premium for the second lowest cost Silver plan in an area, it will reduce the level of APTCs. Subsidized enrollees who do not switch to a lower cost plan during the open enrollment period could find their net premium increasing. This is in part why Colorado's bill authorizes a 1332 waiver application, and charges state officials with using any pass-through money to improve affordability for those up to 400 percent FPL. Colorado has separately enacted legislation to provide state-financed subsidies to help this population beginning in plan year 2022.

Considerations for Illinois: Impact Analysis

The actuarial and consulting firm Milliman, Inc. was retained to model enrollment and funding estimates for several policy options, including a public option plan. In its report (see Appendix A), Milliman assesses the impact of a public option on Illinois' health insurance landscape for CY 2022, the earliest year a public option could feasibly be implemented.

For modeling purposes, the Interagency Working Group specified that the public option plan would be offered through the individual market, both on- and off-Marketplace.[‡‡] The public option would be required to meet the same standards as existing QHPs, including the minimum benefit and AV standards, participation in the ACA's risk adjustment program, and

[‡‡] Under ACA rules, all insurers must make all their individual market plans available to anyone who applies, even if they are not eligible to purchase through the marketplace.

requirements to protect people with pre-existing conditions. The Working Group specified that cost savings would be generated primarily by limiting the amount the plan reimburses participating providers to a percentile of the Medicare reimbursement rate.

Milliman modeled three potential scenarios for a public option plan:

(4) A 10 percent reduction in SLCSP premiums;
(5) A 20 percent reduction in SLCSP premiums; and
(6) A 30 percent reduction in SLCSP premiums.

In the 10 percent premium reduction scenario, Milliman estimates that 6,000 uninsured Illinoisans would gain coverage as a result of the public option plan, 13,000 under the 20 percent reduction scenario, and rising to 20,000 uninsured Illinois residents under the 30 percent premium reduction scenario. See Exhibit 32.

Exhibit 32. Impact on Marketplace Enrollment by Public Option Scenario and Estimated Provider Reimbursement Rate as a % of Medicare

METRIC	WITHOUT PUBLC OPTION	10% REDUCTION	20% REDUCTION	30% REDUCTION
Previously uninsured	N/A	6,000	13,000	20,000
Estimated provider reimbursement as a % of Medicare	145-185%	120-160%	100-140%	75-115%

a. Provider reimbursement as a % of Medicare applies to inpatient hospital, outpatient hospital, and professional services in composite. Reimbursement for pharmacy and other miscellaneous services were assumed to be the same under the scenarios.

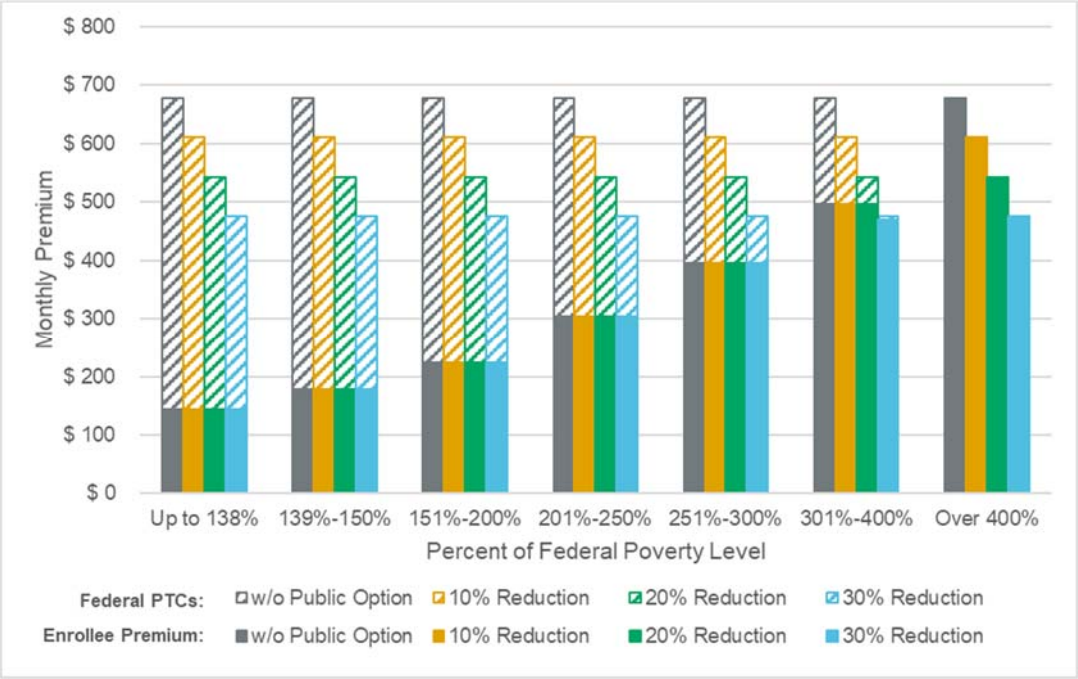
b. Provider reimbursement as a % of Medicare was estimated for the Individual ACA market in composite. Provider reimbursement for plans within a metallic tier that have less than average premiums may be lower.

c. Provider reimbursement as a % of Medicare varies by rating area as well as between inpatient hospital, outpatient hospital, and professional services. In comparison to the composites shown in this figure, reimbursement for inpatient hospital and professional services are typically a lower % of Medicare and reimbursement for outpatient hospital services are typically a higher % of Medicare.

Exhibit 33 provides a visual comparison of these three scenarios and their impact on the amount of premium reduction and federal APTCs by household income level. For illustrative purposes, because premiums rates vary by rating area and age, it presents the perspective of an enrollee age 40 in southeast Illinois[§§], with and without a public option plan.

[§§] To demonstrate geographic differences in premium impacts, a table reflecting the experience for a single, 40-year-old, non-smoking Chicago resident is provided in Appendix A.

Exhibit 33. Public Option SLCSP Premiums, Federal APTCs, and Enrollee Out-of-pocket Premiums by FPL –Single 40-year-old, Southeast Illinois, Non-tobacco User



Note: Values reflect the average within each FPL range.

As illustrated above, individuals above 400 percent FPL, who are ineligible for subsidies, will be the primary beneficiaries of the premium reductions offered by a public option plan. Because premium contributions are capped at a percentage of income for those who qualify for subsidies, their net premiums will remain the same across the three scenarios. The premium reductions provided by the public option plan will increase enrollment and reduce the uninsured. Over 85 percent of the additional enrollment will come from people with a household income over 400 percent FPL. This results in relatively modest enrollment gains compared to some of the other policy options being modeled, and are projected to have no material impact on the overall Marketplace risk pool.

Impact by Race, Ethnicity, Documented Status, and Geography

Milliman also summarized the impact of the three public option scenarios by race, ethnicity, and documented status. See Exhibit 34.

Exhibit 34. Percent Relative Reduction in Uninsured by Race and Ethnicity*

	Public Option Scenario		
	10% Premium Reduction	**20% Premium Reduction**	**30% Premium Reduction**
Non-Hispanic/Latino			
American Indian and Alaska Native	0.9%	1.8%	2.8%
Asian	0.9%	1.8%	3.0%
Black or African American	0.5%	1.0%	1.6%
White	1.2%	2.3%	3.7%
Hispanic/Latino	0.3%	0.6%	1.0%

*Milliman's analysis found a 0.0 percent reduction in uninsured among Native Hawaiian/Pacific Islanders across all three scenarios and a 0.0% impact in uninsured rates among undocumented individuals. For a more detailed analysis of the impact of the three public option scenarios by race, ethnicity, and documented status, see Appendix A. Modeling assumptions did not vary by race and ethnicity.

As noted above, the scenario with the most significant premium reduction (30 percent) would result in an estimated 3.7 percent reduction in the uninsured rate among white Illinoisans, but would only result in a 1.6 percent reduction in the uninsured rate for Black residents and a 1.0 percent reduction for Hispanic/Latino residents. This suggests the public option plan would not play a significant role in reducing the racial and ethnic disparities in uninsured rates.

Milliman's analysis finds only modest differences in the public option's impact on uninsured rates based on geographic area. Milliman also broke down the estimates of numbers of plan enrollees with lower premiums by race, ethnicity, and immigration status. As the public option plan would mirror the AV levels of current QHPs, it would not change enrollees' out-of-pocket cost-sharing. See Exhibit 35.

Exhibit 35. Percentage of Plan Enrollees with Reduced Premiums by Race and Ethnicity

	Public Option Plan Scenarios					
	10% Reduction		20% Reduction		30% Reduction	
	Lower Premium	Lower Cost-Sharing	Lower Premium	Lower Cost-Sharing	Lower Premium	Lower Cost-Sharing
Non-Hispanic/Latino						
American Indian and Alaska Native	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
Asian	21.7%	0.0%	23.1%	0.0%	25.9%	0.0%
Black or African American	25.9%	0.0%	30.2%	0.0%	34.6%	0.0%
Native Hawaiian/Pacific Islander	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
White	37.7%	0.0%	39.7%	0.0%	44.8%	0.0%
Hispanic/Latino	24.8%	0.0%	29.0%	0.0%	35.1%	0.0%

Note: Milliman did not estimate the impact on premiums for undocumented individuals as their analysis was limited to on-Marketplace coverage. For a more detailed summary of the impact of the public option scenarios by race, ethnicity, and immigration status, see Appendix A. Modeling assumptions did not vary by race and ethnicity.

White Illinoisans would benefit the most from the lower premiums associated with a public option plan. Under the 30 percent premium reduction scenario, almost 45 percent of white Illinoisans would experience lower premiums, compared to approximately 35 percent of Hispanic/Latino residents, 26 percent of Asian residents, and 35 percent Black residents.

State costs

The public option scenarios described above would be budget neutral to the state for the cost of coverage. State funding for state implementation and oversight costs are to be determined pending a full state fiscal analysis. Additionally, if the state chooses to bear some or all financial risk for paying claims under the public option, further actuarial analysis of the cost of coverage would be needed to further evaluate and account for the level of financial risk to the state.

Role of the Health Insurance Marketplace

This feasibility analysis assumes that a public option plan would be offered through the Health Insurance Marketplace. Colorado and Washington currently operate their own SBM, but having an SBM is not a necessary prerequisite to implementing a public option plan. However, should the state want to provide a public option plan, or standardized benefit plans, priority placement

on the Marketplace website, or devise customized consumer decision-support tools to encourage enrollment in such plans, it would need to operate its own Marketplace. In addition, states operating their own Marketplace may have access to more granular enrollment information than is currently available to those states using HealthCare.gov, data that could help inform future adjustments to any public option offering.[***]

Role of an ACA 1332 Waiver

Under the three scenarios modeled, the public option plan is projected to lower premiums for the SLCSP, resulting in a decrease of approximately $285 to $573 million in federal APTCs. Therefore, the state could apply for a waiver under 1332 of the ACA and, if approved, generate federal pass-through funds (of approximately $285 to $573 million) to support other state programs, such as state-funded premium and cost-sharing subsidies, undocumented individuals, or people caught in the family glitch. Additionally, under the ACA, only licensed insurers can offer QHPs through the Marketplace. If the state, and not a licensed insurer, implements a public option plan and bears financial risk, it may need to seek a 1332 waiver of this requirement in order to participate in the Marketplace.

The Role of Standardized Benefit Plans

A universal theme among the stakeholders who provided input on this report was concern over the struggle that many Marketplace enrollees have with high deductibles and other forms of cost-sharing. Many encouraged the state to adopt policies that would promote more pre-deductible coverage of high value services, such as primary care, mental health, and chronic disease management, including for chronic diseases that are disproportionately experienced by people of color. Standardized benefit designs, either as part of the public option plan or in addition to it, could help achieve this aim. However, to the extent the public option plan must comply with the ACA's market rules, the plan must meet the ACA's AV level targets, meaning that lowering cost-sharing for some services must be accompanied by increases in cost-sharing for other services.

Impact on the Market for Employer-sponsored Insurance

The public option plan would have no direct premium effect on the employer group market. However, there could be downstream effects that policymakers may wish to consider. To the extent that premiums for comprehensive insurance products are lower in the individual market than they are in the group market, particularly in the market for employers with under 50 employees, there is a possibility that it could cause some of these employers to shift employees to the individual market. This shift has already been encouraged through federal rules

[***] A fuller discussion of the role of a SBM in facilitating this policy option is provided in Chapter 5, "Transitioning to a State-based Marketplace."

promulgated in 2019, which made it easier for employers to create tax-exempt health reimbursement accounts for employees to purchase individual market insurance. Alternatively, the state could consider offering a public option plan to small employers as a group market product (as Colorado has contemplated).

Some health care stakeholders have raised concerns that providers facing lower reimbursement in the public option plan could demand higher prices from commercial insurers in the group market. As noted above, there is little empirical evidence this happens in practice.[121]

Discussion

Benefits of a Public Option Plan

Offering a state-sponsored public option plan has the potential to lower premiums for thousands of Illinois residents and increase enrollment in insurance by up to 20,000 people. It achieves these goals by targeting the primary driver of high health care costs – provider reimbursement – without the need for state financing for the cost of coverage (outside of administrative costs). If coupled with standardized benefit designs that limit enrollee cost-sharing for high-value services, the plan could also help address a primary affordability challenge for current Marketplace enrollees. Additionally, if coupled with a federal 1332 waiver, the state could leverage federal pass-through payments to finance other coverage programs. It is also possible that competition from a public option plan could spur private insurers to offer lower premium options, as evidence shows that Marketplace consumers are extremely price sensitive.[122]

Risks Associated with a Public Option Plan

On its own, the public option would not directly benefit lower-income Marketplace enrollees who are eligible for subsidies. Undocumented individuals could purchase a public option plan off-marketplace, but they would not be eligible for APTCs or CSRs to defray the costs. This is a population that several stakeholders identified as a priority group for any coverage policy implemented by the state. Additionally, implemented on its own, the public option plan would do little to advance health equity in Illinois, as the primary beneficiaries of the lower premiums associated with the new plan would be white Illinoisans.

Further, if the public option plan has a lower premium relative to other QHPs offered on the Marketplace, enrollees receiving APTCs could face an increase in net premiums if they do not switch to a lower-cost plan. Milliman's analysis further finds that if the public option plan becomes the SLCSP, it could reduce the availability of zero-dollar premium Bronze plans. And, without a 1332 waiver, any savings due to lower premiums would be captured by the federal government, not the state. If the public option plan is a higher-premium option on the

marketplace, for example because it offers more generous coverage, its standardized benefit design would potentially help reduce some consumers' cost-sharing obligations, but not the amount they pay in premium.

Furthermore, if the state chooses to take on the risk of paying claims under the public option plan, it could increase state costs if claims are higher than expected and not covered by enrollee premiums and cost-sharing. There is potential that a public option plan could discourage private insurers from offering plans on the Marketplace if they are unable to compete on premiums. There is also a potential risk that provider reimbursement will need to be increased to meet network adequacy standards if there are not adequate incentives for provider participation, especially in areas where provider markets are less competitive. The state would need to find the right balance of provider reimbursement levels and premiums to spur competition without prompting insurer exits from the Marketplace.

Chapter 4. A Medicaid Buy-in: Overview and Impact Analysis

Under this policy, the state would make Medicaid-like coverage available to consumers who are not otherwise eligible for the program. Such a program could help Illinois meet its goal of reducing the number of uninsured by providing an option to those not eligible for subsidized insurance due to their immigration status or the ACA's "family glitch," as well as other residents who find current coverage options to be unaffordable. Medicaid also has lower provider reimbursement than commercial insurance, thus offering the state a relatively cost-effective route to expand coverage while also reducing enrollees' cost-sharing obligations.

The target population for the Medicaid buy-in could be either narrow (i.e., only for those below 400 percent FPL who are ineligible for APTCs due to legal status or the family glitch) or broad (i.e., anyone not already eligible for Medicare, Medicaid or CHIP). While no state has implemented a Medicaid buy-in program, its feasibility has been or is being studied in states such as Delaware, Maryland, New Mexico, Nevada, and Oregon.[123]

A Medicaid Buy-in: Design Considerations

Policymakers designing a Medicaid buy-in plan have multiple decisions to make. Many of these decisions involve trade-offs, where one design decision could benefit one population but harm another. Others would involve more or less state involvement and financial risk. Examples of critical design decisions include:

- **Eligibility**. Will the plan be open to anyone not already eligible for Medicaid, including those currently eligible for Marketplace subsidies or an employer-sponsored plan? Or should eligibility be more narrowly targeted to those who do not qualify for Marketplace subsidies, such as undocumented residents and those who are in the family glitch?
- **Plan operations and risk allocation**. Should the plan be operated by the state, or by a Medicaid MCO? Who will bear the risk of paying enrollees' health care claims: the state, an MCO, or some combination of the two? Will the risks associated with the buy-in population be shared with the Medicaid population, or will they form a separate risk pool? If the state bears any financial risk, how will that be budgeted and paid for?
- **Financing**. Will the buy-in option be entirely financed by enrollee premiums, subsidized by the state, federal premium tax credits, or some combination of the three?
- **Equity**. What are the demographic characteristics of Illinoisans likely to be affected by the Medicaid buy-in? How can program parameters be designed to advance health equity?
- **Benefits**. Will the benefits and cost-sharing covered by the buy-in plan resemble Medicaid benefits, QHP benefits, or will it offer some other benefit design?

- **Provider reimbursement and network adequacy**. Will the buy-in plan reimburse providers at Medicaid rates, or at higher levels? What incentives, if any, will providers need to participate in a Medicaid buy-in in sufficient numbers to ensure that enrollees have timely access to needed services?
- **Plan competition and market stability**. Will the Medicaid buy-in option compete with commercial insurers for Marketplace enrollees, or the employer group market? If the buy-in attracts considerable enrollment away from the Marketplaces, or from employer-sponsored insurance, will it discourage private insurers and employers from participating in these markets? Are there concerns about adverse selection, and what incentives or mitigation measures could the state establish to maintain market stability?
- **Intersection with federal policy**. Should the state pursue a 1332 waiver in order to use premium tax credits to subsidize Medicaid buy-in enrollees?

Under Study: Medicaid Buy-in Proposals in Delaware, Maryland, New Mexico, Nevada, and Oregon

Maryland's Health Insurance Coverage Protection Commission is studying the feasibility of a Medicaid buy-in (initial findings were presented in the Commission's December 2019 annual report),[124] while in Oregon, the Health Authority was charged with developing a plan for a Medicaid buy-in program by June 2021. Oregon's planners were charged with, to the extent feasible, ensuring that the buy-in has no net cost to the state, provides benefits at least as generous as QHP coverage, and imposes "no more than minimal" cost-sharing.[125] Oregon's initial assessment of the Medicaid buy-in found that it would best serve lower-income individuals who "churn" between Medicaid and QHP coverage due to changes in income status. The report further identified securing adequate provider participation as the program's primary challenge.[126]

In 2018, New Mexico commissioned a study of a "targeted" Medicaid buy-in program that would provide more affordable coverage to individuals in the family glitch and undocumented individuals. The study found that premiums would be 15-28 percent lower than Marketplace premiums and would enroll between 7,000-16,000 New Mexicans.[127] A subsequent legislative fiscal analysis projected costs between $27-$81 million per year, not including administrative costs.[128] The bill to enact the Medicaid buy-in option did not pass, but the legislature in 2019 appropriated funds for additional study and "administrative development" of a buy-in plan.[129] In 2018, Delaware's legislature created a Study Group to assess the feasibility of a Medicaid buy-in. Its report, published in January 2019, concluded that there is "yet to be a single solution presented within the Study Group that would solve all of our challenges and achieve all of the goals voiced to date that is clearly viable and affordable for the State moving forward."[130] Nevada enacted legislation in 2017 to create a Medicaid buy-in program, but it was vetoed by

the then-Governor Sandoval. The state's Legislative Committee on Health Care completed a study of a Medicaid buy-in plan in 2018 and another quantitative analysis is forthcoming.[131]

Considerations for Illinois: Impact Analysis

The actuarial and consulting firm Milliman, Inc. was retained to model enrollment and funding estimates for a Medicaid buy-in program. In its report (see Appendix A), Milliman assesses the impact of a Medicaid buy-in on Illinois' health insurance landscape for CY 2022, the earliest year feasible a Medicaid buy-in plan could be implemented.

For modeling purposes, the Interagency Working Group specified that enrollees would pay premiums for coverage under the state's Medicaid program infrastructure, and that the buy-in program would not be eligible for federal matching funds. The Working Group further specified that the Medicaid managed care program would administer the benefits and use its provider reimbursement schedule. Milliman modeled a targeted eligibility and two broad eligibility variations of a Medicaid buy-in.

- *Targeted buy-in:* Only those Illinois residents not already eligible for Medicare or comprehensive Medicaid coverage and up to 400 percent FPL who are either an undocumented individual or in the family glitch would be eligible for the buy-in program. Premiums would be established to mirror the income-based APTCs available via Marketplace QHPs and cost-sharing would be consistent with a Silver-level AV, with CSR variations available based on FPL (household income and household size).
- *Broad buy-in (Basic):* All residents not already eligible for Medicare or comprehensive Medicaid coverage in Illinois would be eligible for the buy-in program, including those currently eligible for Marketplace subsidies and employer-sponsored insurance. Premiums would be 30 percent lower than assumed CY 2022 premiums for the SLCSP, with premium contributions capped consistent with the federal maximums based on household income. Enrollee premiums would mirror the income-based APTCs available via Marketplace QHPs when federally subsidized premiums are already more than 30 percent lower than the SLCSP premium.
- *Broad buy-in (Enhanced):* Same eligibility as for the Basic broad buy-in, but premiums and cost-sharing would be set consistent with the Massachusetts model[†††] up to 300 percent FPL, resulting in lower premiums than the Marketplace for all enrollees. For those over 300 percent FPL, premiums would be 30 percent lower than the projected CY

[†††] Massachusetts provides state-subsidized premium and cost-sharing subsidies for those up to 300 percent FPL. The program is described in more detail in Chapter 2, "State Premium and Cost-sharing Subsidies."

2022 SLCSP, with premium contributions capped consistent with the federal maximums based on household income, and AV would be 73 percent.

The Targeted Medicaid Buy-in: Assumptions and Coverage, Cost Impacts

The Interagency Working Group specified that the targeted buy-in benefit package would be generally the same as under the Medicaid program, except that long-term care and waiver services would not be covered. However, enrollees' cost-sharing levels would be equal to a Silver-level plan sold via the Marketplace, and enrollees with incomes up to 250 percent FPL could qualify for the same levels of reduced cost-sharing as available via the Marketplace. For modeling purposes, the Interagency Working Group further specified that enrollee premium contributions would be set at the same level as they are through the Marketplace, including if those individuals were eligible for APTCs.

Milliman estimates that 535,000 Illinois residents would be eligible for the targeted buy-in option. Approximately 60,000 individuals of the approximately 187,000 uninsured who are eligible would gain coverage, representing 32 percent of uninsured residents being eligible for the targeted buy-in. Of the approximately 343,000 enrolled in employer-sponsored insurance and eligible for the targeted buy-in, Milliman estimates that approximately 64,000, or 19 percent, would enroll. However, if employees with an affordable offer of employee-only coverage are not eligible to enroll and the state limits eligibility for the family glitch population to just spouses and dependents, enrollment would be lower by approximately 51,000. Of that 51,000, approximately 22,000 would be previously uninsured, or 2.4 percent of the eligible uninsured population. If the state reduces the maximum income eligibility to 200 percent FPL, enrollment would be lower by approximately 39,000 people. Of that number, approximately 16,000 would be previously uninsured, or 1.8 percent of the eligible uninsured population. If the state limits the family glitch population to spouses and dependents and limits enrollment to those up to 200 percent FPL, enrollment would be lower by approximately 74,000. See Exhibit 36.

Exhibit 36. Targeted Medicaid Buy-in Eligibility Variants

	Targeted Medicaid Buy-in Variant			
Metric	As Modeled	Limited to Spouse and Dependent Family Glitch	<=200% FPL Only	Limited to Spouse and Dependent Family Glitch & <=200% FPL Only
Estimated Eligibles	535,000	317,000	254,000	149,000
Estimated Enrollees	128,000	76,000	88,000	54,000
Required State Funding (millions)	$289.0	$170.0	$256.0	$153.5
Estimated Enrollees Previously Uninsured	60,000	37,000	43,000	28,000
Percent Reduction in Uninsured	6.6%	4.1%	4.8%	3.1%

The Broad Medicaid Buy-in – Basic and Enhanced: Assumptions and Coverage, Cost Impacts

Under the broad buy-in Basic version, the Interagency Working Group specified that any Illinois resident not eligible for Medicare or comprehensive Medicaid benefits would be eligible for the buy-in, and that the benefit package would be generally the same as under the Medicaid program, except that long-term care and waiver services would not be covered. However, enrollees' cost-sharing levels would be equal to a Silver-level plan sold via the Marketplace, and enrollees with incomes up to 250 percent FPL would qualify for the same levels of reduced cost-sharing as available via the Marketplace. For modeling purposes, the Working Group further specified that enrollee premiums would be set at 30 percent less than the unsubsidized premium for the SLCSP on the Marketplace, subject to the maximum contribution amount under the federal APTC income schedule. If an enrollee's premiums with APTCs were already more than 30 percent lower than the SLCSP premium, the enrollee's premium would mirror the subsidized premium available via the Marketplace for the SLCSP.

Under the broad buy-in Enhanced version, the Interagency Working Group specified the same eligibility parameters and covered benefits as with the Basic option. However, the Working Group specified that enrollees' premiums and cost-sharing levels should be set to be consistent with the Massachusetts model described above, resulting in reduced premiums for all enrollees compared to the Marketplace. For those over 300 percent FPL, premiums would be set at 30 percent less than the unsubsidized premium for the SLCSP on the Marketplace, subject to the maximum contribution amount under the federal APTC income schedule.

Milliman estimates that approximately 6.2 million Illinois residents would be eligible for the broad buy-in in CY 2022. Of the estimated 580,000 eligible uninsured, Milliman estimates that approximately 72,000, or 12 percent, would enroll in the Basic version and approximately 146,000, or 25 percent, would enroll in the Enhanced version.

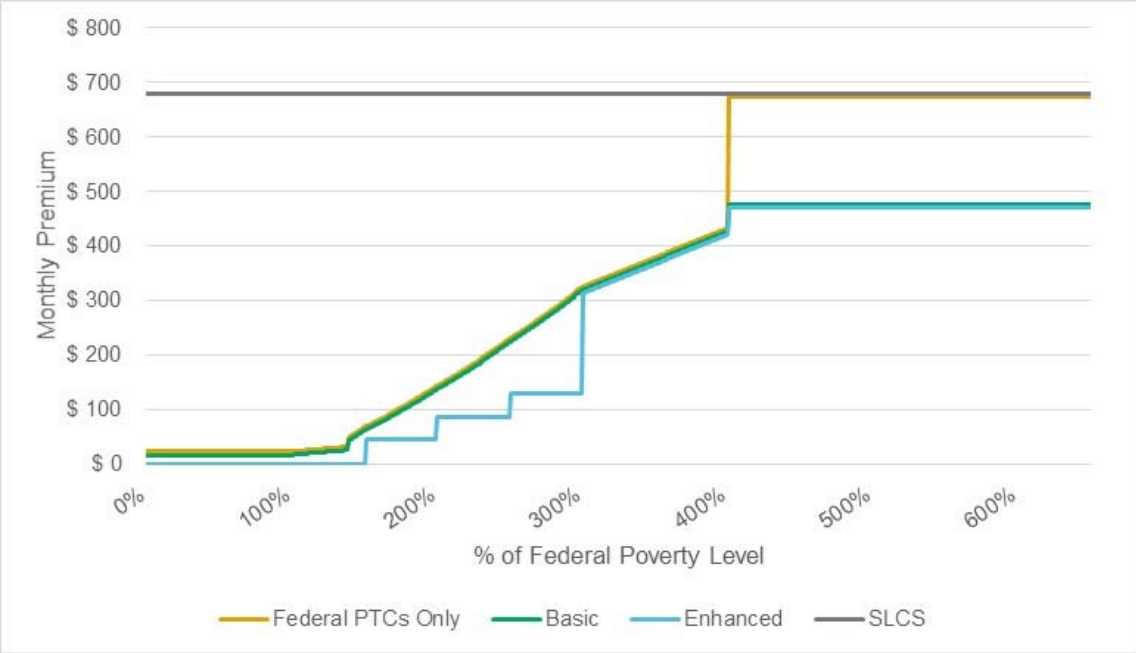
Of the approximately 5.3 million people enrolled in employer-sponsored plans, Milliman estimates that 267,000, or 5 percent, would enroll in the Basic version of the broad buy-in and 398,000, or 8 percent, would enroll in the Enhanced version. While the take up rates among those enrolled in ESI are small, the size of the employer market is large, resulting in enrollees from ESI coverage comprising 50-65 percent of enrollees in these broad buy-in variations.

Of the approximately 350,000 eligible individuals enrolled in individual market plans, an estimated 91,000, or 26 percent, would shift to the Basic version of the broad buy-in program and approximately 259,000, or 74 percent, would shift to the Enhanced version. This would result in a significant reduction in the number of individuals enrolled through the Health Insurance Marketplace. Unlike the Marketplace, the Medicaid buy-in would not offer enrollees choice of metal levels (plans with lower or higher actuarial values).

If the state sets enrollee premiums at 20 percent less than the SLCSP premium instead of 30 percent less, in order to increase provider reimbursement rates, enrollment in the broad buy-in would decline by approximately 38,000 enrollees for Basic version and by about 39,000 for the Enhanced version. Milliman estimates that the cost to the state would decrease by approximately $40 million and $57 million, respectively.

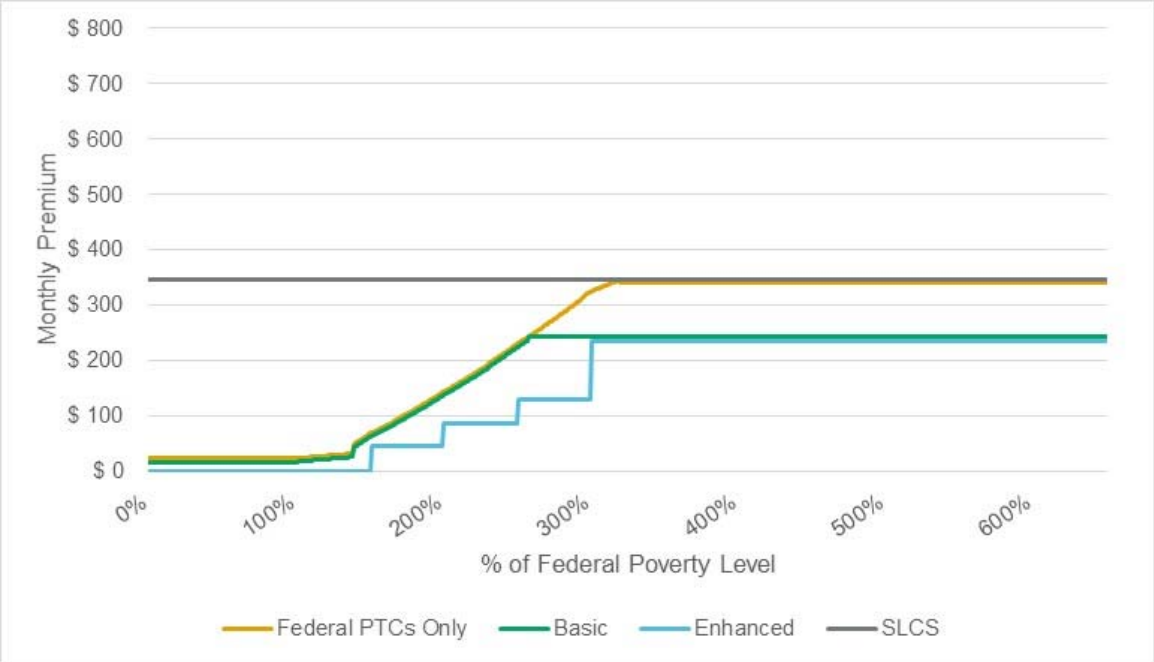
Exhibits 37 and 38 provide a visual comparison of enrollee premiums by household income level in the broad Medicaid buy-in variations, along with comparison to the enrollee premiums on the Marketplace if they are eligible for federal PTCs. Exhibit 37 reflects an enrollee of age 40 in southeast Illinois while Exhibit 38 reflects an enrollee of age 40 in Chicago.

Exhibit 37. Estimated CY 2022 Monthly Enrollee Premiums by FPL for Broad Medicaid Buy-in Programs – Single 40-year-old, Southeast Illinois, Non-tobacco User



*Note: Lines are offset slightly for illustrative purposes where premiums are identical.

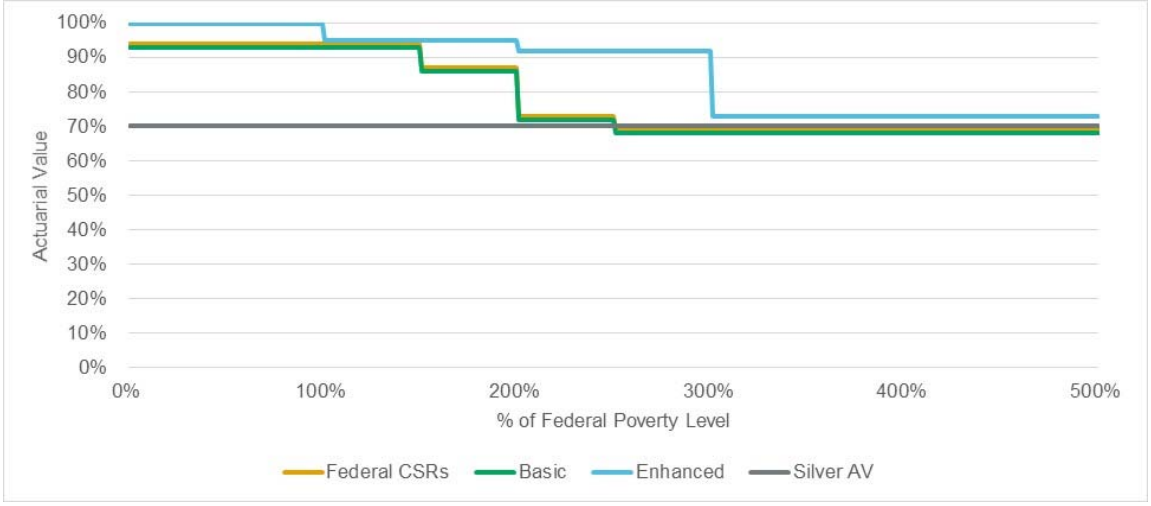
Exhibit 38. Estimated CY 2022 Monthly Enrollee Premium by FPL for Broad Medicaid Buy-in Programs – Single 40-year-old, Chicago, Non-tobacco User



*Note: Lines are offset slightly for illustrative purposes where premiums are identical.

Exhibit 39, below, provides a visual comparison of the cost sharing AVs by FPL level for the broad Medicaid buy-in variations, along with comparison to cost sharing AVs on the Marketplace for enrollees eligible for Marketplace coverage.

Exhibit 39. Estimated Cost-sharing Actuarial Values by FPL Under Each Broad Buy-in Program



*Notes: Lines are offset slightly for illustrative purposes where actuarial values overlap. Federal AVs based on https://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/

Milliman also summarized the impact of the targeted and broad Medicaid buy-in programs by race, ethnicity, and documented status. See Exhibit 40.

Exhibit 40. Percent Reduction in Uninsured by Race, Ethnicity, and Documented Status*

	Medicaid Buy-in Program		
	Targeted	Broad-Basic	Broad-Enhanced
Non-Hispanic/Latino			
American Indian/Alaska Native	2.4%	4.2%	5.3%
Asian	7.5%	9.4%	18.7%
Black or African American	1.6%	1.8%	7.6%
Native Hawaiian/Pacific Islander	1.5%	0.0%	0.7%
White	2.4%	4.9%	12.2%
Hispanic/Latino	12.8%	13.5%	23.4%
Undocumented	29.3%	31.8%	39.2%

*For a more detailed summary, see Appendix A. Modeling assumptions did not vary by race and ethnicity.

Undocumented individuals will experience the largest reductions in uninsured rates across all three Medicaid buy-in variations, ranging from 29.3-39.2 percent. Hispanic/Latino residents will also see significant declines, from 12.8 to 23.4 percent. Conversely, Black or African American residents will experience smaller declines in their uninsured rates – under 2 percent in the targeted and broad (Basic) variations and 7.6 percent under the broad (Enhanced) program.

Milliman's analysis further finds significant differences in the reduction in uninsured across geographic regions of the state. In the targeted buy-in and both broad buy-in program options, Rating Areas 2 and 3 would experience the most significant reductions in uninsured rates (between 10.1-21.2 percent), while Rating Areas 10, 11, and 13[‡‡‡] would experience the smallest reduction in uninsured rates (between 1.1-9.7 percent). These differences are largely due to differences in provider reimbursement rates.

Milliman also broke down the estimated numbers of enrollees with lower premiums and/or cost-sharing by race, ethnicity, and documented status. See Exhibit 41.

[‡‡‡] Rating area 2 includes McHenry county. Rating area 3 includes DuPage and Kaine counties. Rating area 10 includes Adams, Brown, Cass, Christian, Logan, Macon, Mason, Menard, Morgan, Moultrie, Pike, Sangamon, Schulyer, Scott and Shelby counties. Rating area 11 includes Bond, Calhoun, Clinton, Greene, Jersey, Macoupin, Montgomery, Randolph, and Washington counties. Rating area 13 includes Alexander, Clay, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Perry, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White and Williamson counties.

Exhibit 41. Number of Buy-in Enrollees with Reduced Premiums and Cost-sharing by Race, Ethnicity, and Documented Status*

	Medicaid Buy-in Variations					
	Targeted		Broad - Basic		Broad - Enhanced	
	Lower Premium	Lower Cost-Sharing	Lower Premium	Lower Cost-Sharing	Lower Premium	Lower Cost-Sharing
Non-Hispanic/Latino						
American Indian and Alaska Native	N/A	N/A	25.2%	0.0%	96.3%	100.0%
Asian	N/A	N/A	47.6%	0.0%	96.7%	100.0%
Black or African American	N/A	N/A	32.3%	0.0%	94.0%	100.0%
Native Hawaiian/Pacific Islander	N/A	N/A	59.9%	0.0%	92.7%	100.0%
White	N/A	N/A	56.2%	0.0%	94.9%	100.0%
Hispanic/Latino	N/A	N/A	17.0%	0.0%	95.2%	100.0%
Undocumented	N/A	N/A	11.5%	0.0%	94.3%	100.0%

* For a more detailed summary of the impact of the buy-in scenarios by race, ethnicity, and immigration status, see Appendix A. Modeling assumptions did not vary by race and ethnicity.
Note: The comparison for the targeted buy-in is listed as N/A because Milliman's analysis did not compare what individuals may be paying outside of the Marketplace (i.e., for employer-based or individual market insurance) to subsidized Marketplace coverage.

Under the Enhanced version of the broad Medicaid buy-in, enrollees would experience lower premiums and lower cost-sharing with few differences based on race or ethnicity. Under the Basic version of the broad buy-in, 56 percent of white and 48 percent of Asian enrollees would experience lower premiums, compared to 32 percent of Black or African American enrollees and 17 percent of Hispanic/Latino enrollees.

State Costs

As federal Medicaid matching funds would not be available for the Medicaid buy-in, the state would need to pick up any costs associated with the buy-in that are not covered by enrollee premiums and cost-sharing. Milliman estimates this to be $289 million in CY 2022 for the targeted buy-in, not including the administrative costs of the program, or approximately $4,817

per newly insured resident. See Exhibit 42. If the state limited enrollment among the Family Glitch population to spouses and dependents, the cost to the state would decline by $118 million. If eligibility was limited to those with incomes below 200 percent FPL, state costs would decline by $33 million. If the state limits enrollment of the family glitch population to spouses and dependents with household incomes below 200 percent FPL, the state cost would decline by $135 million. Additional state fiscal analysis is needed to determine administrative costs for the targeted buy-in.

For the Basic version of the broad buy-in, Milliman estimates a cost to the state of approximately $274 million in CY 2022, not including administrative costs, or approximately $3,800 per newly insured resident. For the Enhanced version, Milliman estimates a state CY 2022 cost of $1.052 billion, not including administrative costs, or $7,200 per newly insured resident. See Exhibit 42. These estimates assume that the state is able to obtain a 1332 waiver from the federal government, allowing it to draw down $4 million in pass through funds for the Basic variation and $984 million for the Enhanced variation. There would be no pass through funds available for the targeted buy in, as only those ineligible for APTCs would be enrolled. Additional state fiscal analysis is needed to determine administrative costs for the broad buy-in variations.

Exhibit 42. Medicaid Buy-in Program Costs Per Newly Insured Enrollee

Medicaid Buy-in Option	Estimated Enrollees Previously Uninsured	Estimated Required State Funding (Not Including Admin Costs) ($ Millions)	Approximate State Cost Per Newly Insured Enrollee (Not Including Admin Costs)
Targeted	60,000	$289	$4,800
Broad – Basic	72,000	$274	$3,800
Broad - Enhanced	146,000	$1052	$7,200

Notes: State funding requirements and costs per newly insured enrollees are approximate and do not include administrative costs. The buy-in options, in addition to reducing uninsurance, are also projected to reduce premiums and/or cost-sharing for enrollees, depending on their income.

The Interagency Working Group initially directed Milliman to model a Medicaid buy-in option that would be budget neutral to the state, but such a scenario resulted in higher enrollee premiums and/or cost-sharing than is currently available through the individual market. The estimated federal pass-through funding from a 1332 waiver was not enough to off-set the cost of subsidized coverage for individuals below 400% FPL who do not qualify for federal PTCs (populations included in the targeted and broad buy-ins) without increasing premiums and/or

cost sharing above Marketplace levels to off-set the cost to the state. Since increasing affordability is a primary goal of the feasibility study, this option is thus not discussed here.

Role of the Health Insurance Marketplace

This feasibility study assumes that the Medicaid buy-in, whether broad or targeted, will be offered off-Marketplace, and enrollees will not be part of the individual market risk pool. Transitioning to a SBM would thus not be a prerequisite for implementing a Medicaid buy-in program.[§§§] Under the targeted Medicaid buy-in option, there would be little impact on the individual market and the Marketplace because those eligible for the program are not eligible for APTCs on the Marketplace.

The broad Medicaid buy-in would have a greater effect, with an estimated 20-30 percent of buy-in enrollees transitioning from individual market coverage. These correspond to decreases in enrollment in the individual market of 26 to 74 percent, which may result in a sicker risk pool and an increase in premiums for those who remain in the individual market. Conversely, if the significant decreases in enrollment in the individual market resulted in a healthier risk pool, there would be a corresponding decrease in premiums for those who remained in the individual market. Reduced participation in the individual market under a broad buy-in may create a disincentive for insurers to continue to offer QHPs through the Marketplace. However, as no state has yet implemented any buy-in program, there is considerable uncertainty around its market impacts.

Role of an ACA 1332 Waiver

A 1332 waiver is unlikely to be applicable for the targeted Medicaid buy-in, as only those individuals ineligible for APTCs would be able to enroll. Under the broad buy-in options, if significant numbers of APTC-eligible individuals enroll, it could reduce federal APTC costs, enabling the state to generate pass through dollars through a waiver. The estimated state costs assume federal pass-through funding is approved through a 1332 waiver to offset the cost to the state of both broad buy-in programs. However, as noted above, large shifts of Marketplace enrollees to the buy-in could have a destabilizing effect on the individual market. If this results in higher Marketplace premiums and, at the same time, higher federal sending on APTCs for those individuals who remain in the Marketplace, federal pass-through dollars to the state would be reduced to maintain budget neutrality to the federal government.

[§§§] A fuller discussion of the role of a SBM in facilitating this policy option is provided in Chapter 5, "Transitioning to a State-based Marketplace."

Impact on the Market for Employer-sponsored Insurance

Under the targeted and both broad Medicaid buy-in options, a relatively modest percentage of individuals eligible for ESI are projected to decline the coverage and opt for the buy-in. Even under the Enhanced variation, where the buy-in benefits are relatively generous, Milliman estimates that only 8 percent of those enrolled in ESI would elect to shift to the buy-in. However, the availability of a broad Medicaid buy-in program could give some employers an incentive to discontinue offering group plans, leading to higher enrollment in the buy-in and higher costs to the state. Given the numbers of Illinoisans enrolled in ESI, even a small decline in employer offer rates could have a large impact. However, there is considerable uncertainty regarding these impacts, given that no state has yet implemented any sort of buy-in program.

Discussion

Benefits of a Medicaid Buy-in Program

Both the targeted and broad Medicaid buy-in programs would directly benefit populations identified by stakeholders as the most in need of intervention, including the undocumented and individuals caught in the family glitch with incomes below 400 percent FPL. These individuals would have access to a new affordable option with comprehensive benefits. The buy-in also leverages existing state infrastructure and lowers costs by reimbursing providers at Medicaid rates.

Risks Associated with a Medicaid Buy-in Program

A Medicaid buy-in program would need to be state subsidized. The targeted version is projected to cost the state $289 million in CY 2022, not including administrative costs, although the state could reduce outlays by further limiting eligibility. The Basic version of the broad buy-is projected to cost the state $274 million in CY 2022, with higher income enrollees helping to subsidize the cost to the state for lower income enrollees who are not eligible for federal subsidies. The Enhanced version is projected to cost the state $1.052 billion in CY 2022, not including administrative costs. Additional state fiscal analysis is needed to determine administrative costs.

A broad Medicaid buy-in program, if it siphons away significant numbers of healthy individuals currently enrolled in the individual market, could de-stabilize the Marketplace. This could lead to rising premiums and potentially fewer plan choices for individuals who rely on the individual market as a source of coverage. However, the relative morbidity of individuals likely to shift to a Medicaid buy-in, and how many, is difficult to predict given the lack of real world evidence on how individuals may respond.

Additionally, provider stakeholders maintain that the state's Medicaid rates are too low, which could limit their willingness to participate in a Medicaid buy-in program. However, they may be more willing to participate in a targeted Medicaid buy-in program, because many of the individuals who would be eligible for the targeted buy-in are currently uninsured and lack an affordable health insurance option. Getting them into coverage could help reduce providers' lost revenue due to bad debt.

Chapter 5. Transitioning to a State-based Marketplace

The ACA required the establishment of new health insurance Marketplaces in each state, either run by the state or operated by the federal government via HealthCare.gov. In addition to being the path through which individuals can receive financial assistance, the Marketplaces were designed to help organize insurance markets, promote competition, and help consumers more effectively compare their health plan options. States have flexibility to design and run their Marketplaces to meet the needs of their residents, while also meeting minimum standards and being financially self-sustaining. The Marketplaces are required to perform the following functions:

- *Eligibility and enrollment*. The Marketplace must provide a mechanism for consumers to receive a determination of their eligibility for APTCs and CSRs and enroll in a qualified health plan (or connect them to Medicaid or CHIP coverage, if eligible).
- *Plan management.* The Marketplace must certify that health plans meet licensure and other requirements for participation, review insurers' justifications for premium rates, and exercise oversight, including de-certifying non-compliant plans.
- *Consumer assistance*. The Marketplace must establish a web portal, call center, and Navigator program to help consumers find and enroll in public or private coverage.

The ACA required states to decide whether to operate their own Marketplace by 2012 for Plan Year 2014. There are currently three types of exchanges:

1. Federally Facilitated Marketplace (FFM): Federal government performs consumer assistance and eligibility and enrollment functions. Some states perform plan management as well as some consumer assistance, while others leave all functions to the federal government.
2. State-based Marketplace – Federal Platform (SBM-FP): State has legal authority to run a State-based Marketplace and is responsible for all consumer assistance functions, but the eligibility and enrollment functions are conducted by the federal government through HealthCare.gov.
3. State-based Marketplace (SBM): State has legal authority to run the Marketplace and is responsible for all Marketplace functions, including eligibility and enrollment.

Since 2013, Illinois has operated as an FFM. As such, the DOI has overseen the plan management functions and the "Get Covered Illinois" program ran a website with a Medicaid/Marketplace eligibility screening tool and a Consumer Checkbook tool to assist with health plan selection, a call center, a large statewide in-person assister program, and a large paid and earned media campaign. However, federal grants supporting the outreach and consumer assistance activities expired in 2017. As a result, DOI continues to oversee plan

management, but the consumer outreach and assistance program has been significantly smaller, with limited budget and staffing.

Illinois was not alone in its experience. By 2013, only 16 states and the District of Columbia had chosen to run their own Marketplaces. However, in recent years, several states have transitioned, or are considering a transition, from an FFM to an SBM.[132] See Exhibit 43.

Exhibit 43. States with Recent or Forthcoming Transitions to SBM Status, 2020-2022

State	Current Marketplace Model	Date of Transition to Full SBM
Nevada	SBM	Plan year 2020
New Jersey	SBM	Plan year 2021
Pennsylvania	SBM	Plan year 2021
Kentucky*	SBM-FP	Plan year 2022
New Mexico	SBM-FP	Plan year 2022
Maine	SBM-FP	Plan year 2022
Virginia	SBM-FP	Plan year 2023

*Kentucky established a SBM for plan year 2014, but reverted to a FFM beginning in plan year 2017. It is now in the midst of a transition back to full SBM status.

Since the transition to an SBM requires the state to take over a number of functions, states may first obtain legislative authority to become an SBM-FP for one plan year prior to moving to a full SBM. However, most of the benefits of transitioning the marketplace platform in relation to the other policy options outlined in this report are not achieved until Illinois becomes a full SBM. To receive federal approval for the transition, States must submit the Blueprint Application three months prior to open enrollment for the SBM-FP and fifteen months prior to open enrollment for the full SBM.

The primary factors driving states to switch from an FFM or SBM-FP to a full SBM are a greater ability to improve the consumer experience and exercise more control over their insurance market. SBM states can also more effectively target their marketing and consumer assistance efforts to specific populations who are eligible but not enrolled by directly accessing Marketplace enrollment data that HealthCare.gov does not share with states using the FFM. In addition, several of the recently transitioning states have benefited from significantly lower start-up costs than existed in 2013, and have been able to generate cost savings as a result. However, the transition involves some practical and political risks for state leaders and Marketplace enrollees, including glitches that can arise in switching to a new IT system and stakeholders that have grown used to the HealthCare.gov platform. Additionally, it is likely that the Biden administration will make additional investments in the FFM, as well as in consumer

outreach and assistance, that could help expand enrollment in the Marketplace without the state having to expend the resources necessary for a transition.

States Can Improve Eligibility and Enrollment Processes, User Experience

Transitioning to a full SBM can yield many immediate operational benefits, such as a better experience for consumers, insurers, and consumer assisters. SBMs are better positioned to coordinate with the state Medicaid agency and other relevant state agencies, such as unemployment benefit offices. For example, as millions of individuals filed unemployment claims in the spring and summer of 2020 due to COVID-19, Massachusetts' SBM worked with the unemployment agency to communicate with applicants about available subsidized coverage options. However, some SBMs have found it challenging to fully integrate Marketplace and Medicaid eligibility and enrollment (which cannot be integrated under an FFM). States may have more autonomy to improve these systems than when using the FFM, but that alone is not sufficient without strong interagency collaboration and a commitment to integration.[133] SBMs can use real-time data collection to monitor consumers' interactions with their website and call center and identify potential problem areas. During the open enrollment period, SBMs can use data about applicants' locations and enrollment decisions to more effectively target outreach campaigns and ad buys, or to adjust call center scripts. It can also help to have state-specific branding to improve public awareness and support of the Marketplace. SBMs also operate their own marketing and Navigator programs, allowing them to use data to identify and target resources to the populations most in need.

SBMs can determine their own open and special enrollment periods. Most SBMs have extended their annual open enrollment seasons considerably beyond the 6-week period offered by the FFM. At the beginning of the COVID-19 pandemic, all but one SBM chose to create a special enrollment period to enable uninsured individuals to sign up for coverage. In contrast, the federal government did not re-open HealthCare.gov in response to COVID-19.

Cost Efficiencies are also Drivers of State Decision-making

The prospect of cost efficiencies has been a compelling reason for some states to embrace a transition to an SBM. Beginning in 2014, the federal government charged a user fee of 3.5 percent of premium to operate the Marketplace in states using the FFM, although the fee dropped to 3 percent beginning in 2020. Prior to leaving office, the Trump administration dropped it again to 2.25 percent for 2022.[134] Insurers pay this user fee to the federal government as a percentage of premium based on enrollment. The user fee is intended to account for the operation of the enrollment platform and coverage of the expenses related to federal consumer assistance and marketing activities.

The user fee level varies depending on the type of Marketplace. As participants in the FFM, Illinois insurers paid the federal government $71,775,846 in user fees at the 3.5 percent level in 2019. For those with a SBM-FP, the amount collected by the federal government to operate the Marketplace has fluctuated over the years, but has generally been lower than the FFM user fee. (The federal government charged SBM-FPs no user fee in 2015 and 2016, 1.5 percent in 2017, 2 percent in 2018, 3 percent in 2019, and 2.5 percent in 2020 and 2021. For 2022, the Trump administration lowered the fee to 1.75 percent, but this could be reversed by the Biden administration). SBM-FPs may enact legislation to collect their own state assessments or user fees from insurers, on top of the reduced fee charged to SBM-FP states by the federal government. These additional state user fees or assessments can be used to defray the costs of operating state-run plan management, outreach, and consumer assistance. However, the cost of any additional state insurer user fee or assessment may be passed on to consumers in the form of additional premium increases if the total assessment is greater than the FFM user fee assessment. The federal government does not charge a user fee to states with full SBMs because SBMs are responsible for all marketplace operations and do not use the HealthCare.gov platform.

SBMs and SBM-FPs have different options with respect to the assessment of state-level user fees. Some SBMs collect state user fees only from insurers selling QHPs on the Marketplace. Others assess a broader set of insurers. Some states have written their legislation to provide SBMs with flexibility to adjust assessments over time; in other states the state user fee level is set in law.

One approach states have used to fund the operation of the SBM-FP or SBM is to pass legislation authorizing the SBM or SBM-FP to collect in user fees or assessments an amount equivalent to what would have been collected had the Marketplace remained an FFM, or in the case of a transition from SBM-FP to full SBM, an SBM-FP. In other words, for a FFM to SBM-FP transition, the combined user fee or assessment charged by the state in tandem with the federal government would be the equivalent of the user fee collected by the FFM. For example, if the federal FFM fee was 3 percent and the federal fee after transitioning to an SBM-FP fee was 2 percent, the state SBM-FP fee could be set at 1 percent. That way the combined federal and state fees after transitioning to an SBM-FP would be 3 percent, which is equal to the previous federal FFM fee.

Similarly, the state user fee charged by the SBM could equal the federal user fee charged by the FFM. Many states have set a state user fee equivalent to the projected federal user fee as a means to ensure the transition to a SBM-FP or full SBM does not lead to higher premiums. Alternately, Illinois could authorize a state user fee or insurer assessment at a level greater than

the projected FFM or SBM-FP user fee level, but insurers would likely pass along the additional cost to enrollees in the form of premium increases.

To transition to the SBM-FP, Illinois will need to pass legislation to fulfill requirements specified by the federal government, including:

- Authorization of a funding mechanism, such as a state user fee or a broader assessment;
- Revisions to the Navigator Certification Act; and
- Creation of a corporate governance structure for the Marketplace.

The feasibility of a transition to an SBM-FP or SBM is predicated on the passage of necessary legislation, as well as ensuring sufficient time is provided to develop the necessary staffing and infrastructure. The state's budget for administration of the Marketplace should be calculated prior to establishing the state user fee or assessment level. Additional state fiscal analysis is needed to determine implementation and ongoing administrative costs. An SBM with a lower administrative budget than the current federal fee can choose to assess a lower amount than the FFM to generate premium savings for consumers, or it could set the assessment at the same level as the FFM and use the surplus to fund other policies.

Several states undergoing a transition to a SBM have found they can operate it more cost efficiently than the FFM by leveraging lower cost, second-generation technology and a leaner bureaucracy. For example, Nevada projected that transitioning to its own technology platform would result in $19 million in savings (relative to using HealthCare.gov) through 2023.[135] Other officials reported their intention to direct cost-savings to programs that will benefit policyholders and expand coverage. Pennsylvania and New Jersey are capturing the difference in the user fees previously paid to the federal government and their operating costs, and using the funds to finance other state priorities, such as reinsurance. However, to the extent the Trump administration's reduced user fees for the FFM and SBM-FP remain in effect, it will reduce states' ability to generate cost-savings. Some national organizations are advocating for the Biden Administration to increase the FFM and SBM-FP user fees to support a more robust outreach and marketing effort in states using the FFM platform.[136]

SBMs Can Help States Implement Policy Goals: Considerations for Illinois

As referenced in earlier sections of this report, having a SBM can help state officials exercise greater control over their insurance market and implement coverage affordability programs. Currently, the federal government has limited ability to customize HealthCare.gov to meet a particular state's needs.

For example, FFM states cannot extend the annual open enrollment period or offer additional special enrollment opportunities. If a state wishes to require standardized benefit designs with lower cost-sharing for high-value services, HealthCare.gov cannot differentiate between these and non-standardized plans, making it difficult for consumers to make apples-to-apples comparisons. HealthCare.gov also is not designed to allow states to display further reduced premiums or cost-sharing subsidies beyond the federal subsidies.

SBM states are also leveraging their Marketplaces to advance health equity. For example, the governing board for D.C.'s Marketplace is creating a "Social Justice and Health Equity" Subcommittee to review policy and governance decisions with an equity lens,[137] and Washington's SBM has created a Health Equity Advisory Committee. It works with the Marketplace to improve language access for individuals with limited English proficiency, improve the cultural sensitivity of outreach efforts, and conducting diversity, equity, and inclusion training for staff, consumer assisters, and call center operators.[138]

Policy options for this feasibility study include: state-financed premium tax credits and/or CSR subsidies, a Basic Health Program (BHP), a public option plan, and a Medicaid buy-in. In each case, there may be advantages and disadvantages to transitioning to a SBM.

It is important to note that many of the flexibilities and the benefits referenced in this section are only achieved once the state moves to a full SBM. Since Illinois still utilizes the federal government IT platform for enrollment, those benefits may remain unavailable. If the state followed the example of other states and transitions to an SBM-FP for one year prior to the transition to a full SBM, the state would not be able to achieve these benefits for several years, given the time needed for federal approvals and building the necessary staff and infrastructure to conduct the required Marketplace functions.

State-financed Subsidies

All states that currently offer additional coverage subsidies also operate their own ACA Marketplace and enrollment portal. New Jersey implemented a state subsidy program during its first enrollment period as an SBM. While it is possible that the state could administer a subsidy program while remaining on HealthCare.gov, the federal platform cannot be customized to reflect operation of the state program. This means, among other considerations, that state subsidy eligibility would be bifurcated from the federal eligibility and enrollment process and that any subsidy offered by the state towards the purchase of a Marketplace plan would not be displayed on HealthCare.gov for consumers to see while shopping for and purchasing a plan. It is thus likely that adoption of a state-run Marketplace and enrollment

platform would greatly facilitate the implementation and effectiveness of a state subsidy program.

Notably, federal law prohibits individuals with undocumented immigration status from purchasing QHPs through the ACA Marketplace. While such eligibility rules are among the list of waivable provisions under the ACA's Section 1332 waiver program, the federal government has never assessed such a waiver.[139] Thus, to the extent a state program is designed to improve affordability for undocumented residents, it is possible that the program would need to provide state-subsidized coverage via an enrollment pathway outside of the ACA Marketplace structure. This is the approach Colorado is taking with respect to its program to provide subsidized coverage to undocumented residents beginning in 2023.

Basic Health Program

A BHP requires an eligibility and enrollment platform. In the two states with a BHP, they have leveraged their SBM to serve this function. Though each state's BHP is administered by the Medicaid program, it is the state's Marketplace that is the primary enrollment pathway for residents to access the BHP. It is unlikely Illinois could use HealthCare.gov to perform this function. To date the federal government has not been able to customize this platform to accommodate state-specific rules or reforms. Accordingly, without a SBM the state would need to modify existing Medicaid systems to support a BHP.

Public Option Plan

This feasibility analysis assumes that a public option plan would be offered through the Health Insurance Marketplace. Having an SBM is not a necessary prerequisite to implementing a public option plan. However, should the state want to give a public option plan priority placement on the Marketplace website, or devise customized consumer decision-support tools to encourage enrollment in such a plan, it would need to operate its own Marketplace. In addition, states operating their own Marketplace have access to more granular enrollment information than is currently available to those states using HealthCare.gov, data that could help inform future adjustments to any public option offering. If the state were approved to receive pass-through funding from a 1332 waiver for the public option, some state initiatives it may want to fund also may be implemented more effectively with an SBM.

Medicaid Buy-in Program

This feasibility study assumes that the Medicaid buy-in will be offered off-Marketplace, and enrollees will not be part of the individual market risk pool. Transitioning to a SBM would thus not be a prerequisite for implementing a Medicaid buy-in program. However, if the state does

transition to a SBM, a Medicaid buy-in, depending on its design, could have a significant impact. Specifically, if a broad Medicaid buy-in is open to enrollment to those eligible for the Marketplace, and they are given an incentive to shift to the buy-in because of lower premiums or cost-sharing, it could have a significant impact on Marketplace enrollment, and potentially the morbidity of the risk pool. A smaller pool of enrollees in the Marketplace can mean a smaller base from which to finance Marketplace operations.

Discussion

Benefits of Transitioning to a SBM

Illinoisans can reap several benefits from transitioning to an SBM. The state can customize and better invest in outreach and marketing efforts, coordinate with Medicaid and other state agencies, improve consumer assistance, and leverage its personnel and infrastructure to improve health equity. Additionally, the state would have access to eligibility and enrollment data not currently available through HealthCare.gov, enabling the state to have a better picture of the Marketplace population and how best to tailor outreach, enrollment, and retention efforts.

The 3 percent user fee to operate the Marketplace is currently collected by the federal government from insurers (that amount will drop to 2.25 percent in 2022, unless reversed by the Biden administration). If the state transitions to a SBM or SBM-FP, the state could pass legislation to capture all or a portion of those user fees to finance Marketplace operations (the user fee is estimated to generate approximately $61 million if it remains at 3 percent and slightly over $46 million if it is lowered to 2.25 percent). Several states have found that they can run their Marketplace more efficiently than the FFM under current user fee levels, allowing them to use the savings to fund other state priorities, such as coverage affordability programs, without needing to assess insurers an amount that would raise user fees above FFM levels. It is unclear whether this opportunity for cost efficiencies would remain feasible with the lowered user fee of 2.25 percent. Finally, several of the policy options considered in this feasibility study would either depend upon the state having an SBM or be more optimally implemented with a SBM.

Risks of Transitioning to a SBM

States undergoing a transition to a full SBM face several risks. A successful switch to a new eligibility and enrollment system requires sufficient lead-time, oversight, and staff resources. The Marketplace must also meet the needs of insurers whose participation is voluntary and consumers who deserve a seamless enrollment process.

Moving to a full SBM requires submission of a “Blueprint Application” to the federal government at least 15 months prior to the beginning of an SBM’s first open enrollment period. Additionally, several states have or are transitioning to an SBM-FP for one plan year prior to conversion to a full SBM. The Blueprint applications for both the SBM-FP and full SBM must demonstrate that the State is able to fulfill all requirements to receive approval from the federal government. Given that fulfilling some of these requirements will require the passage of legislation, this timeline could be further delayed depending on the legislative schedule and capacity.

Additionally, if the Biden administration does not increase the user fee for operation of the FFM, the state would need to ensure that it can support critical Marketplace functions within a smaller budget. The state could charge a higher amount, but insurers would likely pass that on to policyholders in the form of higher premiums.

At the same time, the risk-benefit analysis of continuing to use HealthCare.gov is heavily influenced by the federal administration and is likely to shift under President Biden. The Trump administration drastically reduced funding for Marketplace outreach and consumer assistance, shortened the open enrollment period, and imposed new documentation requirements on enrollees. States that use HealthCare.gov had little to no flexibility or funding to counter these moves and boost enrollment. However, these policies are being reassessed by the Biden administration and many, if not all, are anticipated to be reversed. For example, if the federal government once again makes significant investments in the FFM, it could help boost enrollment in Illinois. Over the longer term, subsequent federal administrations may choose to maintain these investments or return to Trump era approaches that would limit the FFM’s resources and effectiveness.

Chapter 6. State-Supported Marketing and Outreach

The ACA requires Marketplaces to provide outreach, education, and enrollment assistance to consumers eligible for Marketplace coverage or Medicaid. Within this framework, states have the opportunity, and sometimes the obligation, to implement and fund these important tasks. States that operate their own Marketplaces are responsible for administering a "navigator" program, for advertising their enrollment portals, and for informing residents about their coverage options. In states using the federally run Marketplace, the federal government is obligated to pay for marketing and outreach and, since 2017, has drastically reduced funding for these activities, limiting their effectiveness. While federal support is likely to rebound under the Biden administration, states may themselves prioritize marketing and outreach and finance these tasks to suit their residents' needs.

Evidence suggests states are likely to be well-served by these investments. National surveys have long documented the effectiveness of consumer assistance programs in facilitating Marketplace and Medicaid enrollment and the ongoing need for such services.[140] Applying for Marketplace or Medicaid coverage is time intensive and its complexity is a frequent challenge to consumers.[141] In a 2020 survey, 94 percent of consumers receiving enrollment assistance found it to be helpful, with about 40 percent reporting that it was unlikely that they would have gotten coverage in the absence of that assistance.[142] Among those who actively shopped for Marketplace or Medicaid coverage in the past year but did not receive help from an enrollment assister, 12 percent (or about 5 million consumers) sought out help but were not able to get it; two-thirds said they would be likely to seek help if it were available to them.[143] These findings are reinforced by feedback from a range of stakeholders who provided input on this study, who consistently emphasized they did not know where to go to find out if affordable coverage options were available to them. Consumer assisters, if adequately resourced, can play a critical role in facilitating enrollment, particularly as they are often trusted individuals within their communities and can effectively communicate with uninsured individuals about the value of health insurance coverage.

Lack of information about coverage options and the availability of financial assistance continue to be barriers to enrollment. In 2020, about two-thirds of consumers likely to use the Marketplace or Medicaid were unsure whether the ACA was still the law.[144] Just under half of consumers knew that enrollment in the Marketplace is generally limited to an annual open enrollment period; most did not know that Medicaid enrollment is year-round.[145] While only about 20 percent of consumers were aware of whether their state had expanded Medicaid, the vast majority said they would enroll in the program if they found out they were eligible.[146]

Consistent with these findings, other studies suggest that increases in outreach, education, and assistance reduce enrollment barriers and raise coverage take-up. Research has found that greater awareness of the ACA was strongly associated with higher application rates for Medicaid and the Marketplace.[147] Application assistance, meanwhile, has been found to be the strongest predictor of successful enrollment in coverage.[148] By contrast, reductions in federal advertising and other changes in political messaging at the outset of the Trump administration were found to have reduced Marketplace plan selections significantly.[149] Other work has revealed "strong and stable" associations between the volume of insurance advertising and gains in health insurance enrollment.[150] Government advertising — which is different both in content and its target audience from advertising conducted by private insurers — may be particularly effective in increasing Marketplace enrollment.[151] Public investments in such marketing efforts have been found to be cost effective and capable of providing a large return on investment by improving both the size and health of the individual market risk pool.[152]

Milliman estimates that, in the absence of any policy changes, by 2022 there will be nearly 330,000 Illinoisans who are eligible for Medicaid — with zero premiums and cost-sharing — or CHIP but who do not enroll. Another approximately 300,000 residents will be eligible for a subsidized Marketplace health plan but will instead forgo coverage. Taken together, more than two-thirds of the uninsured population in Illinois (more than 620,000 individuals) will be eligible for but unenrolled in subsidized — typically, heavily or fully subsidized — comprehensive health coverage.[153] See Exhibit 44. This suggests state outreach efforts to promote awareness of affordable coverage options, and to provide assistance with enrollment, could reach large numbers of uninsured residents and generate meaningful gains in coverage. Indeed, this was the state's experience in the initial years of the ACA: the Get Covered Illinois outreach program, established to assist Marketplace consumers, also enrolled a significant number of people in Medicaid, many of whom had not previously realized they were eligible.

Exhibit 44. Estimated CY 2022 Share of Uninsured Residents Eligible for Subsidized Health Coverage, by Income*

	Eligible for Medicaid/CHIP	Eligible for Marketplace Subsidies	Not Eligible for Medicaid/CHIP or Marketplace Subsidies	Total Uninsured
Up to 200% FPL	307,000 [56.1%]	121,000 [22.2%]	118,000 [21.6%]	546,000
201-400% FPL	20,000 [8.1%]	174,000 [72.1%]	48,000 [19.8%]	242,000
Over 400% FPL	--	--	119,000 [100%]	119,000
All Incomes	**326,000 [36.0%]**	**296,000 [32.6%]**	**285,000 [31.4%]**	**906,000**

* Exhibit displays Milliman's CY 2022 baseline population estimates under a 7.1% unemployment scenario. Values are rounded. Bracketed percentages reflect the share of the total uninsured, by income category. For more detail, see Appendix A.

Increased outreach and marketing would also advance health equity. See Exhibit 45. Milliman estimates that the vast majority of uninsured Black residents (approximately 90%) are eligible for Medicaid/CHIP or Marketplace subsidies. The share of documented immigrants who qualify for these programs but who lack coverage is projected to be nearly as large (about 87%). Though additional state investments aimed at facilitating enrollment in subsidized coverage programs are likely to offer affordability and coverage take-up benefits across demographic groups, these data suggest such investments are likely to be especially valuable for Illinoisans who face disproportionate challenges in accessing affordable coverage.

Exhibit 45. Estimated CY 2022 Share of Uninsured Residents Eligible for Subsidized Health Coverage, by Race, Ethnicity and Immigration Status*

	Eligible for Medicaid/CHIP	Eligible for Marketplace Subsidies	Not Eligible for Medicaid/CHIP or Marketplace Subsidies	Total Uninsured
Non-Hispanic/Latino				
Asian	17,000 [33.3%]	17,000 [32.9%]	17,000 [33.8%]	51,000
Black or African-American	79,000 [53.6%]	53,000 [36.0%]	15,000 [10.4%]	148,000
White	122,000 [35.8%]	129,000 [37.9%]	90,000 [26.4%]	342,000
Hispanic/Latino	97,000 [28.3%]	90,000 [26.3%]	156,000 [45.4%]	343,000
Documented immigrant				
Less than 5 Years	4,000 [13.0%]	22,000 [71.0%]	5,000 [16.0%]	31,000
5 or More Years	55,000 [40.1%]	65,000 [47.5%]	17,000 [12.3%]	137,000

* Exhibit displays Milliman's CY 2022 baseline population estimates under a 7.1% unemployment scenario. Values are rounded. Bracketed percentages reflect the share of the total uninsured, by demographic category. For more detail, see Appendix A.

Moreover, the state can increase equity by tailoring outreach and assistance to meet the needs of its diverse population. Marketing and awareness campaigns can be targeted to communities with a large share of uninsured residents, and to underserved or vulnerable populations, and should be developed to be culturally and linguistically appropriate for the audiences they are designed to reach. Consumer assistance efforts should be grounded in the communities they are intended to serve and work with trusted organizations and enterprises within those communities.

Assessing the Menu of Policy Options: Considerations for Illinois

All of the policy options modeled for this study are projected to reduce the number of Illinoisans without insurance and/or make coverage more affordable for enrollees, compared to existing individual market health insurance options. Most options would do both. As described more fully above, the magnitude of these benefits, and the estimated cost to the state of implementation, will vary significantly by policy. For example, the broad Medicaid Buy-in (Enhanced) program is expected to reduce the number of uninsured by 146,000, reduce premiums for 762,000 Illinois residents, and lower cost-sharing burdens for about 802,000 enrollees, at a cost to the state of approximately $1.052 billion. At the other end of the spectrum, a public option program that is budget neutral to the state for the cost of coverage (additional state fiscal analysis is needed to determine administrative costs) and is designed to reduce unsubsidized Marketplace premiums by 10 percent is projected to increase enrollment by about 6,000 and reduce premiums for about 106,000 individuals. For a summary of each policy option's cost per newly insured enrollee, see Exhibit 46.

Exhibit 46. Policy Options: State Costs[a] Per Newly Insured Enrollee

Policy Option	Estimated Enrollees Previously Uninsured	Estimated Required State Funding (Not Including Admin Costs) ($ Millions)	Approximate State Cost Per Newly Insured Enrollee (Not Including Admin Costs)
State Subsidies			
Massachusetts model	55,000	$364	$6,600
No FPL limit	9,000	$182	$20,500
California model	15,000	$113	$7,400
HEC proposal	106,000	$796	$7,500
Basic Health Program			
Minnesota model	23,000	--[b]	--[b]
New York model	27,000	--[b]	--[b]
Zero premium model	72,000	--[b]	--[b]
Public Option Plan			
10% premium reduction	6,000	--[c]	--[c]
20% premium reduction	13,000	--[c]	--[c]
30% premium reduction	20,000	--[c]	--[c]
Medicaid Buy-in			
Targeted	60,000	$289	$4,800
Broad – Basic	72,000	$274	$3,800[d]
Broad - Enhanced	146,000	$1052	$7,200[d]

Notes:

a. State funding requirements and costs per newly insured enrollees are approximate and do not include administrative costs. Additional state fiscal analysis is needed to determine administrative costs for each policy option.
b. It is estimated that there will be surplus funds under the BHP. Surplus funds are required to be used to reduce premiums and cost sharing for BHP enrollees and may be carried over from year to year. They may not be used to finance administrative costs.
c. The Public Option Plan estimates do not take into account the potential cost to the state if it takes on claims risk and do not include administrative costs.
d. Cost estimates for the Basic and Enhanced buy-in options assume that federal pass-through funding partially offsets the total program cost.
e. Several of these policy options, in addition to reducing the number of uninsured, are also projected to reduce premiums and/or cost-sharing for enrollees, depending on their income.

The distribution of gains, by income level, race, ethnicity, immigration status, and geography, are also expected to be different across options. For example, a BHP will improve coverage take-up and affordability among lower income Illinoisans at or below 200 percent FPL. Its effects on uninsurance are expected to be relatively similar across racial and ethnic categories, and the policy is projected to generate comparatively large increases in enrollment among

documented immigrants. A version of a premium subsidy program that would cap the amount of household income Illinoisans could be required to spend on premiums (the "No FPL limit" model would cap premium contributions at 10.1 percent of household income) would benefit the population above 400 percent FPL who do not currently receive federal premium assistance. Coverage and affordability gains under this scenario are comparatively small for people of color and documented immigrants.

The policies described in the study are not mutually exclusive and, if combined, may offer complementary benefits. As discussed more fully above, one option, to transition from HealthCare.gov to a SBM with a state-run enrollment platform, is a near prerequisite for an effective state subsidy program and at the least could be expected to greatly facilitate implementation of most of the options modeled in the study. Illinois could, as other states have done, pursue multiple policies, to be implemented concurrently or in sequence.

For example, the state might choose to adopt any of the modeled options and concurrently support its investment in the new initiative by increasing funding for marketing, outreach, and consumer assistance. Evidence suggests greater governmental spending on advertising and marketing are effective at reducing barriers to enrollment and increasing coverage take-up. Similarly, stakeholders who provided input on the study consistently emphasized the value provided by consumer assisters and recommended the state commit to greater funding for this work. This feedback is reinforced by research that has found that assisters often play an essential role in educating consumers about their coverage options and enabling successful enrollments in both Marketplace and Medicaid coverage. Accordingly, increased state support for assistance programs and for marketing and outreach may be particularly likely to enhance the effectiveness of any new coverage initiatives undertaken by the state, such as those modeled here. Increased consumer assistance could also support enrollment of uninsured individuals into the existing Medicaid program, which has no premiums or cost-sharing. As discussed, research has shown that enrollment in Medicaid not only improves health outcomes, but also protects families financially. The state also has the opportunity to use enhanced consumer assistance efforts to provide targeted outreach and support to under-resourced communities who are more likely to be uninsured and may need assistance in other languages or specialized assistance to due mixed immigration statuses within a family.

The flexibility offered by a state subsidy program makes it a potentially strong choice to complement other state efforts. For example, modeling suggests that a public option is likely to produce modest enrollment gains and affordability improvements concentrated among Illinoisans at 400 percent FPL and above, where much of the recent declines in individual market enrollment have occurred. Were the state to pair a public option with a subsidy

program tailored to individuals at lower incomes, such as the Massachusetts model, it could achieve far broader and more equitable benefits. Washington intends to follow this approach by implementing a state subsidy program as a complement to its recently established public option. In a similar vein, New Jersey has begun offering state subsidies for lower and middle-income enrollees in order to support populations that are not helped by its reinsurance program. (Similar to a public option in its effects, reinsurance lowers unsubsidized premiums, which improves affordability for individuals who do not qualify for APTCs but provides no direct benefit to those at lower income levels.[154]) Likewise, Colorado's soon-to-be implemented subsidy program will broaden the state's commitment to improving coverage take-up and affordability beyond its existing reinsurance program, and will complement a public option, should the state ultimately adopt one.

Combining policy options may also enable the state to realize cost savings. Were the state to pair a BHP with one of the modeled subsidy programs, state subsidy costs would be reduced (because individuals at or below 200 percent FPL who otherwise would be eligible for a Marketplace subsidy instead would qualify for the BHP, at what is projected to be no cost to the state outside of administrative costs). Milliman estimates that combining a BHP with a Massachusetts or HEC model subsidy program would lower the cost to the state of implementing those programs by $125 million and $153 million, respectively, while producing the same gains in enrollment, affordability, and equity.

Appendices

Appendix A. Milliman Report

MILLIMAN CLIENT REPORT

Health Insurance Feasibility Study

State of Illinois Department of Healthcare and Family Services

April 1, 2021

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Executive summary

Milliman, Inc. (Milliman) was retained by the State of Illinois, Department of Healthcare and Family Services (HFS) to provide actuarial and consulting services to support, "a feasibility study to explore options to make health insurance more affordable for low-income and middle-income residents" as described in Public Act 101-0649.[1] To support this feasibility study, we developed estimates for four policy options provided by HFS in consultation with the Department of Insurance (Interagency Working Group):

1. Basic health program (BHP), as defined under Section 1331 of the Affordable Care Act (ACA)
2. Enhanced state-funded premium tax credits (PTCs) and cost sharing reductions (CSRs)
3. Marketplace public option
4. Medicaid buy-in

In this report, we present enrollment and funding estimates for the four policy options with regard to the forecasted calendar year (CY) 2022 health insurance landscape in Illinois, including the uninsured population. Results assume each policy option has reached a steady-state of enrollment, which may take a few years to achieve in reality. Take up rates, i.e. the percentage of eligible persons electing to enroll in coverage, are largely based upon historical enrollment patterns in Medicaid, the Individual ACA market, and similar insurance programs operated in other states. Results are presented for three or four variations of each policy option in order to illustrate how different design parameters may impact results. Although we have modeled each policy option (and variation thereof) independently, the state may choose to implement more than one policy option in order to impact different subgroups of the population. For example, enhanced state-funded PTCs/CSRs could be combined with a BHP or a Marketplace public option. Once the target policy option(s) are decided upon, further data collection and analysis will be needed to design specific program parameters, sensitivity test take up rate estimates, evaluate the impact of implementing multiple policy options concurrently, and develop a comprehensive understanding of the associated impacts across insurance coverage types.

Highlights of results for the policy option variations are provided in Figure 1 below. The results for each policy option are summarized in this executive summary. Additionally, we provide result highlights for the policy option variations using higher take up rate assumptions to illustrate potential variability of results. The sections of this report subsequent to the introduction and background section provide discussion of each policy option and associated modeling results as well as of the data, methodologies, and assumptions used in the modeling.

Figure 1 provides the following information for each policy option:

- *Estimated eligibles*: The estimated number of persons that meet the criteria to enroll in the insurance program. For each policy option, this varies based on household income requirements (household income falls within a specified range, cannot exceed a specified level, or is open to all income levels), exclusions (or lack thereof) for persons who have eligibility for other insurance programs, and citizenship or immigration status.
- *Estimated steady-state enrollees*: The estimated number of persons that will enroll in the insurance program once it reaches a steady month-to-month enrollment level (enrollment estimates immediately following policy option implementation would be lower).
- *Estimated enrollees previously uninsured [% of uninsured reduction]*: The estimated number of persons insured through the policy option that would be uninsured in the absence of the policy option, by household income. Additionally, the percentages below these enrollment estimates reflect the percentage reduction in the number of non-elderly uninsured for the income level. For example, under the BHP, Minnesota Model, 23,000 previously uninsured persons are estimated to be enrolled that have income up to 200% FPL, reducing the number of non-elderly uninsured persons from approximately 546,000 to 523,000, a 4.1% reduction.
- *Estimated enrollees with lower premiums relative to SLCS*: The estimated number of enrollees that will have lower premiums under the policy option than the premium they would pay for the second lowest cost Silver plan (SLCS) via the Marketplace.

[1] https://www.ilga.gov/legislation/publicacts/101/PDF/101-0649.pdf

- *Estimated enrollees with lower cost sharing*: The estimated number of enrollees with lower cost sharing in comparison to Silver level actuarial values, including CSRs for those eligible, via the Marketplace. Actual enrollee out-of-pocket cost sharing may be lower when provider reimbursement is less than Marketplace provider reimbursement.
- *Required state funding ($ Millions)*: The estimated annual state funding (on a CY 2022 basis) required for the policy option. These figures are net of estimated federal funding (if applicable) for each policy option. The estimates are based upon premium costs which include benefit expenses and associated administrative expenses. They do not include state expenses to implement and oversee the program, which are to be determined pending a full fiscal analysis.

FIGURE 1: CY 2022 PROJECTED STEADY-STATE RESULTS BY POLICY OPTION – 7.1% UNEMPLOYMENT SCENARIO

POLICY OPTION	ESTIMATED ELIGIBLES	ESTIMATED STEADY-STATE ENROLLEES	ESTIMATED ENROLLEES PREVIOUSLY UNINSURED [% UNINSURED REDUCTION][b] <=200% FPL	> 200% FPL	ALL FPLs	ESTIMATED ENROLLEES WITH LOWER PREMIUM vs SLCS[g]	COST SHARING[e]	REQUIRED STATE FUNDING EXCL ADMIN ($MILLIONS)[c]
Basic health program								
Minnesota Model	216,000	135,000	23,000 [4.1%]	- [0.0%]	23,000 [2.5%]	132,000	74,000	$ -[d]
New York Model	216,000	139,000	27,000 [5.0%]	- [0.0%]	27,000 [3.0%]	136,000	139,000	$ -[d]
Zero Premium Model	216,000	188,000	72,000 [13.2%]	- [0.0%]	72,000 [7.9%]	187,000	188,000	$ -[d]
State-Funded premium tax credit (PTC)/cost sharing reduction (CSR)								
Massachusetts Model	712,000	368,000	32,000 [5.8%]	24,000 [6.6%]	55,000 [6.1%]	327,000	238,000	$ 364
No FPL Limit for PTCs	712,000	324,000	- [0.0%]	9,000 [2.5%]	9,000 [1.0%]	107,000	-	$ 182
California Model	712,000	329,000	6,000 [1.2%]	9,000 [2.4%]	15,000 [1.7%]	230,000	-	$ 113
HEC Proposals[h]	712,000	424,000	53,000 [9.7%]	54,000 [14.9%]	106,000 [11.7%]	423,000	248,000	$ 796
Marketplace public option								
10% Premium Reduction	712,000	319,000	- [0.0%]	6,000 [1.7%]	6,000 [0.7%]	106,000	-	$ -[k]
20% Premium Reduction	712,000	328,000	- [0.0%]	13,000 [3.5%]	13,000 [1.4%]	116,000	-	$ -[k]
30% Premium Reduction	712,000	339,000	- [0.0%]	20,000 [5.7%]	20,000 [2.2%]	137,000	-	$ -[k]
Medicaid buy-in								
Targeted	535,000	128,000	43,000 [7.9%]	16,000 [4.6%]	60,000 [6.6%]	N/A	f	$ 289
Broad – Basic	6,235,000	430,000	40,000 [7.3%]	33,000 [9.0%]	72,000 [8.0%]	183,000	f	$ 274[j]
Broad – Enhanced	6,235,000	802,000	89,000 [16.3%]	57,000 [15.7%]	146,000 [16.1%]	762,000	802,000[i]	$ 1,052[j]

Notes:

a. Values have been rounded.
b. Of the approximately 906,000 non-elderly (age less than 65) uninsured, approximately 546,000 have household income up to 200% FPL and 360,000 have household income greater than 200% FPL.
c. Estimated state funding does not include costs for the state to implement and oversee the program, which are to be determined pending a full fiscal analysis.
d. We estimate that there will be surplus funds under the BHP of approximately $99 million for the Minnesota model, $59 million for the New York model, and $34 million for the Zero Premium model. Surplus funds are required to be used to reduce premiums and cost sharing for BHP enrollees and may be carried over from year to year.
e. Estimated enrollees with lower cost sharing is in comparison to Silver level actuarial values (as defined by the federal actuarial value calculator), including CSRs for those eligible, via the Marketplace.
f. Estimated enrollees with lower cost sharing is not available for the employer-sponsored insurance (ESI) market. For the Individual market and uninsured, cost sharing is the same actuarial value as Silver coverage via the Marketplace, including CSRs for those eligible.
g. Estimated enrollees with lower premiums in comparison to the estimated CY 2022 second lowest cost silver plan (SLCS) premium assuming that no policy options are implemented.
h. HEC proposals reflects PTCs and CSRs similar to levels in proposals by the United Stated House Energy & Commerce committee.
i. Estimated enrollees with lower cost sharing is for the Individual market and uninsured only. Estimated enrollees with lower cost sharing is not available for the ESI market.
j. State funding estimates assume that the state secures federal pass-through funding via a Section 1332 waiver of approximately $4 million for the Broad – Basic variation and approximately $984 million for the Broad – Enhanced variation.
k. Federal pass-through funding, contingent on the federal government considering the Marketplace public option an approvable 1332 waiver, may be available if the state chose to apply for a Section 1332 waiver. If approved, the federal pass-through funding could be used to support other state programs, such as PTCs, CSRs, and undocumented individuals. However, such benefits (depending upon design and eligibility requirements) may increase utilization of federal PTCs, reducing available pass-through funding.

Result highlights are additionally provided in Appendix B for the following demographic characteristics:

- B-1: income level
- B-2: adult versus child
- B-3: ethnicity and race
- B-4: immigration status
- B-5: individual ACA rating area

Note that some of the results in Appendix B are less reliable due to low population counts.

BASIC HEALTH PROGRAM

The BHP is a federal program authorized by section 1331 of the ACA. It allows states to provide health care coverage to certain individuals with household incomes up to 200% FPL. Federal funding is equal to approximately 95% of the PTCs that the federal government would pay for these individuals if they enrolled in individual insurance coverage via the Marketplace. The state must cover administrative costs of the program and any remaining cost of the health care coverage not covered by federal funding, enrollee premiums, and enrollee ***cost sharing***.

For this feasibility study, the Interagency Working Group directed us to develop estimates for a BHP in Illinois which has enrollee premiums and cost sharing consistent with the only two BHP programs that have been implemented in other states, Minnesota and New York. Enrollee premiums in these two programs are significantly less than what the enrollees have available to them via the Marketplace,[2] so a BHP can provide more affordable health insurance to its enrollees. The cost sharing of the New York plan is also less than what the enrollees have available to them via the Marketplace, helping to make using health care services more affordable for enrollees. We estimate that approximately 216,000 Illinoisans would be eligible for an Illinois BHP and approximately 135,000 to 139,000 would enroll if enrollee premiums and cost sharing are consistent with the Minnesota and New York BHPs. Approximately 23,000 to 27,000 of those enrollees would have been uninsured otherwise. As requested by the Interagency Working Group, we also developed estimates for an Illinois BHP that has no enrollee premiums, but cost sharing consistent with the New York BHP program. We estimate that enrollment in this program would be approximately 188,000, including approximately 72,000 enrollees who would have been uninsured otherwise.

We estimate that the cost to the state of Illinois in CY 2022 would be limited to oversight costs of the program. This estimate reflects underlying assumptions provided by the Interagency Working Group that: the state would administer the program in conjunction with its Medicaid managed care program; providers would be paid consistent with Medicaid reimbursement (inclusive of provider directed and pass-through payments); and covered services would be the same as Medicaid except that long term care and waiver services would not be covered. The cost to the state of the BHP will largely be dependent upon the difference in provider reimbursement underlying the BHP versus provider reimbursement underlying the Marketplace. State funding may be required if the difference in the provider reimbursement levels between the BHP and the Marketplace becomes smaller (reducing federal funding attributable to forgone Marketplace premium assistance), which may occur if competition among insurers increases in the Marketplace. Note, we have not considered any impact to Medicaid expenditures as a result of BHP implementation. It is possible that the BHP would increase Medicaid and CHIP participation rates through a “welcome mat” effect, i.e. individuals applying for BHP coverage are determined to be eligible for Medicaid coverage. Additionally, the state will need to consider whether Medicaid reimbursement levels will support adequate provider network access for BHP enrollees and the impact that additional enrollees at Medicaid reimbursement levels may have on provider revenue.

The Minnesota, New York, and zero premium programs modeled for this report are just three examples of potential program design. Further analysis is warranted to design enrollee premiums and cost sharing, and other program details, that would best meet the objectives established by Illinois.

[2] While many BHP-eligible consumers are eligible for zero out-of-pocket premium Bronze-level coverage available through the Marketplace, such coverage only pays for approximately 60% of average health care costs and generally has a deductible of $6,000 or more. Because such coverage is unlikely to provide adequate financial protection to BHP-eligible enrollees, we do not believe it is a reasonable comparison to BHP premium requirements.

STATE-FUNDED PTC/CSR

State-funded PTCs and CSRs supplement the federal PTCs and required CSRs currently available to enrollees via the Marketplace. PTCs help to make health insurance more affordable for enrollees (through reduced out-of-pocket premiums) and CSRs help to make using health care services more affordable for enrollees (by reducing cost sharing amounts). State-funded PTCs and CSRs can be designed to assist persons in varying amounts by level of income.

For this feasibility study, the Interagency Working Group directed us to develop estimates for state-funded PTCs/CSRs in Illinois using four variations of existing or proposed programs which target different income levels. Results for these variations can be reviewed to gain an understanding of how many persons could benefit, and to what extent, through state-funded PTCs/CSRs. Across the four variations, we estimate that an additional 9,000 to 106,000 uninsured persons in Illinois would gain health care coverage via the Individual ACA market, and up to approximately 248,000 persons could have more affordable health care services through lower cost sharing. The estimated cost to the state ranges from approximately $113 million to $796 million across the four variations considered. The wide range of these estimates reflects differences in the generosity of the subsidies across the four variations modeled.

The state has a great deal of latitude with state-funded PTCs/CSRs to define the persons who will benefit by level of income and the magnitude of the impact. Further analysis is warranted to design a program that would best meet the objectives established by Illinois.

MARKETPLACE PUBLIC OPTION

A state may be able to make health care coverage more affordable by participating as an insurer, either directly or via a contract with a private insurer, in the Individual ACA market, both on and off the Marketplace. The state may be able to offer lower premiums than would have otherwise been offered by insurers. Reduced provider reimbursement relative to current Marketplace levels would be the primary lever for a lower premium offering. If the SLCS premium is reduced as a result, federal PTCs will be reduced and enrollees receiving federal PTCs may need to change plans in order to avoid needing to pay more premium. Lower premium public option plans would provide higher income enrollees (generally those who have income in excess of 400% FPL) who are not receiving PTCs a more affordable health care coverage option.

For this feasibility study, the Interagency Working Group directed us to model scenarios of 10%, 20%, and 30% reductions to SLCS premiums. We estimate these premium reductions would increase enrollment of uninsured persons to the Individual ACA market by up to 20,000 and reduce reimbursement to hospitals and professionals for all enrollees in the Individual ACA market by up to 50%. Over 85% of the additional enrollment has household income over 400% FPL and are therefore not eligible for federal PTCs.

A Marketplace public option can be attractive because reduced premiums can be established to cover enrollee costs, requiring little or no incremental funding directly by the state. However, the competitive market dynamics of the state providing an option via the Marketplace (with reduced provider reimbursement) need to be carefully considered to develop a successful strategy for the state, other insurers, and providers.

MEDICAID BUY-IN

With a Medicaid buy-in, the state could make health care coverage more affordable by allowing enrollees to pay premiums for health care coverage under the state's Medicaid program infrastructure. However, the state would administer this program through its Medicaid managed care program and its associated provider reimbursement schedule. The buy-in would not be eligible for federal Medicaid matching funds, but some variations could be eligible for pass-through funding if a 1332 waiver were approved.

For this feasibility study, the Interagency Working Group directed us to model a targeted eligibility and two broad eligibility variations of a Medicaid buy-in program. All three variations reflect covered services that are the same as Medicaid except that long term care and waiver services are not covered. Figure 2 below highlights differences in eligibility, enrollee premiums, and enrollee cost sharing between the three variations, as specified by the Interagency Working Group.

FIGURE 2: MEDICAID BUY-IN VARIATIONS

VARIATION	ELIGIBILITY	ENROLLEE PREMIUMS[b]	ENROLLEE COST SHARING[c]
Targeted	Undocumented immigrant and households in the "***ACA family glitch***"[a], limited to households with income up to 400% FPL	Percentage of household income which is consistent with the maximum an enrollee would pay if eligible for Marketplace PTCs	Consistent with Silver level actuarial values (***AV***s) offered in the Marketplace, including CSR variations
Broad – Basic	Anyone not eligible for Medicare or comprehensive Medicaid coverage	30% less than the assumed CY 2022 SLCS premiums, or, if less, the percentage of household income which is consistent with the maximum an enrollee would pay if eligible for Marketplace PTCs	Consistent with Silver level AVs offered in the Marketplace, including CSR variations
Broad – Enhanced	Any one not eligible for Medicare or comprehensive Medicaid coverage	Consistent with Massachusetts up to 300% FPL. Over 300% FPL, 30% less than the assumed CY 2022 SLCS premiums or, if less, the percentage of household income which is consistent with the maximum an enrollee would pay if eligible for Marketplace PTCs.	Consistent with Massachusetts up to 300% FPL, 73% federal AV over 300% FPL

Notes:

a. The phrase "ACA family glitch" has been coined to identify families that have an offer of affordable ESI coverage for a single enrollee, per federal standards, but not for a family. These families are not eligible for federal PTCs via the Marketplace.

b. Enrollee premiums in these Medicaid buy-in variations are related to household income and SLCS premiums via the Marketplace. They are not related to the provider reimbursement underlying the cost of coverage for the Medicaid buy-in. Alternative variations are possible. Visual representations of enrollee premiums under the broad buy-in variations are provided in Figures 13A and 13B.

c. Enrollee cost sharing is based upon plan design elements that meet the applicable AV per the federal AV calculator. Under these plan designs, enrollees will pay a greater share of the cost in the Medicaid buy-in than they would in the Individual ACA market due to the differences in provider reimbursement.

For the targeted Medicaid buy-in variation, we estimate that approximately 535,000 Illinoisans would be eligible and approximately 128,000 would enroll. Approximately 60,000 of the enrollees would have previously been uninsured, while approximately 64,000 enrollees would come from employer-sponsored insurance (ESI) coverage. We estimate a cost to the state of approximately $289 million. No federal pass-through funding would be available through a Section 1332 waiver since enrollees would not be eligible for federal PTCs provided through the Marketplace.

For the broad Medicaid buy-in variations, we estimate that approximately 6.2 million Illinoisans would be eligible, and approximately 430,000 would enroll in the Broad - Basic variation while approximately 802,000 would enroll in the Broad - Enhanced variation. Of the enrollees, we estimate that approximately 15% to 20% would have previously been uninsured, approximately 20% to 30% would shift from Individual coverage, and approximately 50% to 65% would shift from ESI coverage. We estimate a cost to the state of approximately $274 million for the Broad - Basic variation and $1,052 million for the Broad - Enhanced variation. These estimates assume the state secures federal pass-through funding via a Section 1332 waiver of approximately $4 million for the Broad - Basic variation and $984 million for the Broad - Enhanced variation. These estimates of federal pass-through funding are equivalent to federal premium assistance that would otherwise be received by the Medicaid buy-in population enrolled in Marketplace coverage. The pass-through funding estimates do not consider changes in Marketplace premiums to the extent a Medicaid buy-in was implemented. Additionally, pass-through estimates do not consider other changes in federal spending that may be associated with a Medicaid buy-in. For example, if the Medicaid buy-in increases participation in existing Medicaid programs, this will increase both state and federal spending and may reduce available pass-through funding. Further analysis of these potential changes in state and federal spending should be considered in further financial evaluation of a Medicaid buy-in.

A Medicaid buy-in program can be an effective pathway to making health insurance coverage more affordable. Eligibility criteria and enrollee premiums and cost sharing must be balanced against federal funding that may be available as well as state funding constraints. Additionally, a Medicaid buy-in may materially reduce provider revenue (as persons shift from Individual and ESI coverage to the Medicaid buy-in), which may generate pressure to increase provider reimbursement for the whole Medicaid program, threaten provider financial viability, and create ancillary effects on other health insurance markets. For a broad Medicaid buy-in, a large number of enrollees may transition from Individual and ESI coverage. Transitions from Individual coverage may threaten the viability of the Individual ACA market due to low enrollment and adverse selection, Employers may increase contributions for and/or discontinue their ESI offerings. Further analysis is warranted to design a program that would best meet the objectives established by Illinois while balancing risks for providers, the Individual ACA market, and ESI coverage.

RESULTS WITH HIGHER TAKE UP RATES

Take up rates assumed in the modeling presented in this report are largely based upon historical enrollment patterns in Medicaid and the Individual ACA market. Take up rates may differ in the future due to economic conditions, employer contributions to integrated HRAs which can be used to pay health insurance premiums, and other factors. Highlights of the incremental changes in results for the policy option variations assuming higher take up rates are provided in Figure 3 below. For the higher take up rates, we increased the take up rates by 50%, e.g., a 10% take up rate was increased to 15%, while still limiting any take up rate to 100%. With these higher take up rates, we estimated the following increases in enrollment:

- Approximately 10% to 14% increase in BHP enrollees for total BHP enrollees of 149,000 to 215,000 (as opposed to 135,000 to 188,000 under the baseline take up rates)
- Approximately 9% to 17% increase in enrollees under the state-funded PTC/CSR variations for total enrollment between 354,000 and 496,000 (as opposed to enrollment ranging from 324,000 to 424,000 under the baseline take up rates)
- Approximately 10% increase in Marketplace public option enrollment for total enrollment of 350,000 to 372,000 (as opposed to enrollment ranging from to 319,000 to 339,000 under the baseline take up rates)
- Approximately 36% to 48% increase in Medicaid buy-in enrollees for total Medicaid buy-in enrollees of 189,000 to 1,092,000 (as opposed to 128,000 to 802,000 under the baseline take up rates)

We estimate that neither the BHP nor Marketplace public option would require additional state funding and that additional state funding of approximately $10 to $101 million would be needed for the state-funded PTC/CSR variations. The largest impact of higher take up rates would be with the Medicaid buy-in variations, with an additional cost to the state of approximately $70 to $413 million.

FIGURE 3: CY 2022 PROJECTED STEADY-STATE INCREASE/(DECREASE) IN RESULTS BY POLICY OPTION, HIGHER TAKE UP RATES

POLICY OPTION	ADDITIONAL ESTIMATED STEADY-STATE ENROLLEES	ESTIMATED ENROLLEES PREVIOUSLY UNINSURED [% UNINSURED REDUCTION][b]			ESTIMATED ENROLLEES WITH LOWER		REQUIRED STATE FUNDING
		<=200% FPL	> 200% FPL	ALL FPLs	PREMIUM vs SLCS[g]	COST SHARING[e]	EXCL ADMIN ($MILLIONS)[c]
Basic health program							
Minnesota Model	14,000	10,000	-	10,000	14,000	10,000	$ -[d]
	[10.4%]	[1.9%]	[0.0%]	[1.1%]			
New York Model	16,000	12,000	-	12,000	15,000	16,000	$ -[d]
	[11.5%]	[2.2%]	[0.0%]	[1.3%]			
Zero Premium Model	27,000	27,000	-	27,000	27,000	27,000	$ -[d]
	[14.4%]	[5.0%]	[0.0%]	[3.0%]			
State-Funded premium tax credit (PTC)/cost sharing reduction (CSR)							
Massachusetts	53,000	13,000	12,000	25,000	52,000	24,000	$ 38
	[14.4%]	[2.3%]	[3.2%]	[2.7%]			
No FPL Limit for PTCs	30,000	-	4,000	4,000	30,000	-	$ 23
	[9.3%]	[0.0%]	[1.2%]	[0.5%]			
California	34,000	2,000	4,000	6,000	34,000	-	$ 10
	[10.3%]	[0.4%]	[1.2%]	[0.7%]			
HEC Proposals[h]	72,000	22,000	27,000	49,000	72,000	36,000	$ 101
	[17.0%]	[4.0%]	[7.4%]	[5.4%]			
Marketplace public option							
10% Premium Reduction	32,000	-	3,000	3,000	30,000	-	$ 0
	[10.0%]	[0.0%]	[0.8%]	[0.3%]			
20% Premium Reduction	32,000	-	6,000	6,000	31,000	-	$ 0
	[9.8%]	[0.0%]	[1.7%]	[0.7%]			
30% Premium Reduction	33,000	-	10,000	10,000	31,000	-	$ 0
	[9.7%]	[0.0%]	[2.8%]	[1.1%]			
Medicaid buy-in							
Targeted	62,000	21,000	8,000	29,000	-	-	$ 119
	[48.4%]	[3.8%]	[2.3%]	[3.2%]			
Broad – Basic	203,000	19,000	16,000	35,000	80,000	-	$ 70
	[47.2%]	[3.5%]	[4.5%]	[3.9%]			
Broad - Enhanced	290,000	36,000	28,000	64,000	270,000	290,000[i]	$ 413
	[36.2%]	[6.5%]	[7.8%]	[7.1%]			

Notes:

a. Values have been rounded.
b. Of the approximately 906,000 non-elderly (age less than 65) uninsured, approximately 546,000 have household income up to 200% FPL and 360,000 have household income greater than 200% FPL.
c. Estimated state funding does not include costs for the state to implement and oversee the program, which are to be determined pending a full fiscal analysis.
d. We estimate that there will be surplus funds under the BHP of approximately $14 million for the Minnesota model, $13 million for the New York model, and $9 million for the Zero Premium model. Surplus funds are required to be used to reduce premiums and cost sharing for BHP enrollees and may be carried over from year to year.
e. Estimated enrollees with lower cost sharing is in comparison to Silver level actuarial values (as defined by the federal actuarial value calculator), including CSRs for those eligible, via the Marketplace.
f. Estimated enrollees with lower cost sharing is not available for the ESI market. For the Individual market and uninsured, cost sharing is the same as Silver coverage via the Marketplace, including CSRs for those eligible.
g. Estimated enrollees with lower premiums in comparison to the estimated CY 2022 SLCS premium assuming that no policy options are implemented.
h. HEC proposals reflects PTCs and CSRs similar to levels in proposals by the United Stated House Energy & Commerce committee.
i. Estimated enrollees with lower cost sharing is for the Individual market and uninsured only. Estimated enrollees with lower cost sharing is not available for the ESI market.

Introduction and background

Milliman was retained by HFS to provide actuarial and consulting services to support, "a feasibility study to explore options to make health insurance more affordable for low-income and middle-income residents" as described in Public Act 101-0649.[3] This report provides actuarial analyses regarding four policy options under consideration. It is intended to support and be included as an appendix in a final public document regarding the feasibility of these and other policy options. This report should not be viewed as a stand-alone document.

In this report, we present enrollment and funding estimates for four policy options, which were provided by the Interagency Working Group, with regard to the forecasted CY 2022 health insurance landscape in Illinois, including the uninsured population:

1. BHP, as defined under Section 1331 of the ACA
2. Enhanced state-funded PTCs and CSRs
3. Marketplace public option
4. Medicaid buy-in

Results are presented for three to four variations of each of these policy options to illustrate how different design parameters may impact results.

CY 2022 was chosen by the Interagency Working Group as the baseline year for this feasibility study because it is likely the earliest that any material policy change examined in this feasibility study could be implemented. Additionally, there is significant uncertainty regarding the duration of the COVID-19 pandemic and impacts to the state's health insurance markets. We believe CY 2022 enrollment figures serve as a better estimate of the long-term health insurance market enrollment in Illinois, as CY 2020 and CY 2021 enrollment are likely to be distorted by the economic impact of COVID-19 (e.g. higher unemployment levels).

We modeled each policy option variation reflecting an unemployment rate of 7.1%, which is consistent with the Congressional Budget Office's (CBO) July 2020 projection of the 2022 national unemployment rate.[4] For perspective, the reported Illinois unemployment rate in February 2020 was 3.4%,[5] nearly identical to the national unemployment rate of 3.5%.[6] The Illinois unemployment rate in October 2020 was 7.4%.

The four policy options analyzed are predominantly targeted to improve affordability of health insurance for uninsured persons and enrollees in the individual market. While the total non-elderly uninsured population in CY 2022 is projected to be approximately 906,000 persons assuming a 7.1% unemployment rate, 326,000 of these persons are estimated to be eligible for Medicaid. We estimate that the targeted population (which excludes uninsured persons eligible for Medicaid) will be approximately 580,000 uninsured persons who are not eligible for Medicare (due to age or disability status) or Medicaid (due to income level and/or immigration status) and 355,000 enrollees in the individual market in Illinois. Adults ages 19 to 64 comprise 90% or more of each group.

CLARIFICATION OF TERMINOLOGY

A glossary of terms has been included as Appendix G to this document. It includes key terminology used throughout the remainder of the report. Terms included in the glossary are in bold and italic font for their first occurrence in the report.

[3] https://www.ilga.gov/legislation/publicacts/101/PDF/101-0649.pdf

[4] https://www.cbo.gov/publication/56442

[5] https://data.bls.gov/timeseries/LASST170000000000003

[6] https://www.bls.gov/opub/ted/2020/mobile/north-dakota-had-the-lowest-unemployment-rate-in-february-2020.htm

CY 2022 POPULATION ESTIMATES

Before modeling the policy options presented in this report, it was necessary to develop estimates of the CY 2022 Illinois population. A summary of these estimates by insurance coverage type under four different unemployment scenarios are presented in Figure 4 below.

FIGURE 4: CY 2022 POPULATION ESTIMATES BY INSURANCE COVERAGE TYPE PRIOR TO POLICY OPTIONS

INSURANCE COVERAGE TYPE	3.4% UNEMPLOYMENT	5.5% UNEMPLOYMENT	7.1% UNEMPLOYMENT	8.5% UNEMPLOYMENT
Individual	349,000	349,000	355,000	363,000
Employer	6,470,000	6,411,000	6,347,000	6,286,000
Medicaid	2,443,000	2,492,000	2,524,000	2,554,000
Medicare	1,955,000	1,955,000	1,955,000	1,955,000
Dual (Medicaid and Medicare)	383,000	383,000	383,000	383,000
TRICARE/Veterans	80,000	80,000	80,000	80,000
Uninsured[b]	889,000	900,000	925,000	948,000
Statewide	**12,569,000**	**12,569,000**	**12,569,000**	**12,569,000**

Notes:

a. Values have been rounded.
b. The Individual insurance coverage type is referred to as Direct in the appendices. The Individual insurance coverage type includes approximately 40,000 enrollees in non-ACA compliant individual coverage, with the balance of enrollees in ACA-compliant individual coverage.
c. Uninsured includes both elderly (ages 65 and over) and non-elderly (age less than 65) uninsured. We estimate that there are approximately 19,000 elderly uninsured, with the remaining uninsured under each economic scenario being non-elderly.

The 3.4% unemployment scenario (tied to the Illinois unemployment rate in February 2020) was developed as a baseline; enrollment for each insurance coverage type was calibrated with publicly available information as well as information provided by HFS. We have the following observations and comments about the 3.4% unemployment scenario estimates:

- The total CY 2022 population is estimated to be approximately (0.8%) lower than the estimate of approximately 12,672,000 for July 2019,[7] consistent with the estimated (1.1%) decrease from 2014 to 2018.
- Population changes by insurance coverage type between CY 2020 and CY 2022 are influenced by the general aging of the population.
    - CY 2022 Medicare and dual eligible (persons eligible for both Medicare and Medicaid) enrollment are estimated to increase by 3.0% and 3.5%, respectively, from first quarter 2020 enrollment levels of approximately 1,891,000 and 371,000, respectively.
    - CY 2022 ***Individual market*** enrollment (persons purchasing coverage directly from an insurer) is estimated to decrease by 1.6% from the estimated CY 2020 enrollment of approximately 355,000.
    - CY 2022 Medicaid enrollment (excluding Dual eligibles) is estimated to decrease by approximately 2.1% from the first quarter 2020 enrollment of approximately 2,494,000.
- The estimated uninsured population of approximately 889,000 is fairly consistent with the 835,000 estimate noted in Public Act 101-0649, considering at least a two year difference in the estimates.

The three other unemployment scenarios were developed from the 3.4% unemployment scenario to reflect the higher unemployment levels expected for CY 2022 in comparison to January-February 2020. These unemployment rates provide a range around the CBO's July 2020 projection of the 2022 national unemployment rate of 7.1%.[8] We present results for the 7.1% unemployment economic scenario in this report. We also note that the estimated uninsured not eligible for Medicaid and enrollees in the individual market who would be impacted by the policy options will be higher if the unemployment rate is higher than 7.1% and lower if the unemployment rate is less than 7.1%.

[7] https://www.census.gov/quickfacts/IL

[8] https://www.cbo.gov/publication/56442

The policy options considered in this report apply to persons differently depending on their age, household income level, and immigration status, so it was necessary to develop CY 2022 population estimates at a more detailed level to support modeling of the policy options. Additionally, Public Act 101-0649 specifies that the feasibility study results are to include results by geography, ethnicity, race, and income level. Summaries of the population estimates for the 3.4% and 7.1% unemployment economic scenarios are provided in Appendix A for the following demographic characteristics:

- A-1: age and ***federal poverty level*** (***FPL***) by insurance type
- A-2: geographic region by insurance type
- A-3: ethnicity and race by insurance type
- A-4: immigration status by age and FPL.

Additionally, Appendix A-5 includes the demographic characteristics of the non-elderly uninsured population in three cohorts: eligible for Medicaid; not eligible for Medicaid but eligible for Marketplace subsidies; and not eligible for either Medicaid or Marketplace subsidies. Each of these cohorts represents roughly 1/3 of the non-elderly uninsured. Assuming a 7.1% unemployment rate, we estimate that the non-elderly uninsured in CY 2022 will be comprised of approximately 326,000 persons eligible for Medicaid, 296,000 persons not eligible for Medicaid but eligible for Marketplace subsidies, and 285,000 persons not eligible for either Medicaid or Marketplace subsidies, for total non-elderly uninsured population of approximately 906,000. The demographic composition of a particular cohort should be considered when developing policy options, as well as marketing and enrollment assistance programs aimed at the cohort, in order to achieve health equity objectives established by Illinois.

The development of the CY 2022 population estimates is discussed in the Data, Methodology, and Assumptions section of this report.

Basic health program

Per Section 1331 of the ACA, United States citizens with household income between 138% and 200% FPL and documented immigrants with income up to 200% FPL can be eligible for a state's BHP. If Illinois were to implement a BHP with premiums and cost sharing comparable to what is offered in the Minnesota and New York BHPs, we estimate that approximately 216,000 Illinoisans would be eligible and approximately 135,000 to 139,000 would enroll. If Illinois were to implement a BHP with no premiums but cost sharing comparable to what is offered in the New York BHP, we estimate that enrollment would increase to approximately 188,000. It is assumed that nearly all of the approximately 116,000 BHP-eligible persons currently enrolled in Individual ACA coverage would enroll in the BHP because they would no longer be eligible for Marketplace premium assistance and they would pay lower premiums and may have richer benefits under the BHP. We estimate that approximately 23% to 27% of the 100,000 eligible uninsured would enroll in an option comparable to what is offered in Minnesota and New York, with participation of those needing to pay no premium being higher than those that would be subject to a BHP premium. We estimate that approximately 72% of the eligible uninsured would enroll in a BHP with no premiums for any enrollees. Enrollees in the BHP will be adults ages 19-64; children with household income up to 200% FPL are eligible for Medicaid/CHIP. BHP eligibility is consistent with Marketplace PTC eligibility, resulting in persons with access to affordable ESI, as defined by the ACA, and undocumented persons not being eligible for the BHP.[9]

BHP enrollees would benefit from lower premiums and may have reduced cost sharing in comparison to what they would have otherwise received via the Marketplace. Figure 5 below presents a comparison of premiums and ***actuarial values*** available via the Marketplace, the Minnesota BHP, the New York BHP, and the zero premium BHP. It is important to note, however, that roughly 20% of the Marketplace enrollees with household income up to 200% FPL are enrolled in Bronze plans that require a lower out-of-pocket premium (often $0) than the maximum premiums noted in Figure 5. Bronze plan enrollees may choose to be uninsured rather than pay BHP premiums. The potentially lower cost sharing in a BHP in comparison to a Bronze plan will not be enough incentive for some to pay the BHP premiums. Consistent with enrollment studies that have shown reduction in enrollment of 10% or more when a modest premium was implemented for Medicaid,[10] we estimate that approximately 2,000 enrollees in the Marketplace would elect to be uninsured and not enroll in the BHP if there is a premium.

FIGURE 5: BASIC HEALTH PROGRAM MONTHLY OUT-OF-POCKET ADULT PREMIUMS AND COST SHARING ACTUARIAL VALUES

	MONTHLY OUT-OF-POCKET ENROLLEE PREMIUM				COST SHARING ACTUARIAL VALUE			
FPL RANGE	MINNESOTA	NEW YORK	ZERO PREMIUM	MARKETPLACE	MINNESOTA	NEW YORK	ZERO PREMIUM	MARKETPLACE
Up to 138%	$ 0	$ 0	$ 0	$ 23 - $ 31	94% AV	100% AV	100% AV	94% AV
138% up to 150%	$ 25	$ 26	$ 0	$ 47 - $ 68	94% AV	100% AV	100% AV	94% AV
150%-200%	$ 37 - $ 80	$ 46	$ 0	$ 68 - $ 143	94% AV	91% AV	91% AV	87% AV

Notes:

a. Values have been rounded.
b. Adults with household income up to 138% FPL are limited to documented immigrants still in the five-year waiting period for Medicaid eligibility.
c. Minnesota premiums from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4139A-ENG and were modified to $0 up to 138% FPL for Illinois modeling.
d. Minnesota cost sharing benefit design: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4858A-ENG
e. New York premiums from https://www.nyhealthinsurer.com/new-york-essential-plan/ and include dental and vision coverage to be consistent with modeled benefits.
f. New York cost sharing benefit design: https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20H%20-%20EP%20Benefits%20and%20Cost-Sharing_.pdf
g. Out-of-pocket Marketplace premiums based on projected CY 2022 federal poverty level and premium tax credit percentages.
h. New York cost sharing actuarial values were estimated using the CY 2021 CMS actuarial value calculator. Minnesota cost sharing actuarial value is based on the state's actuary's assessment of actual cost sharing percentages.

[9] https://www.healthcare.gov/glossary/affordable-coverage/

[10] https://pubmed.ncbi.nlm.nih.gov/24879608/

It is anticipated by the Interagency Working Group that if Illinois offered a BHP, the state would administer the program in conjunction with its Medicaid managed care program, and provider reimbursement and covered services would be the same as Medicaid except that long term care and waiver services would not be covered. Per the BHP regulations, federal funding is equal to approximately 95% of the PTCs that enrollees would be eligible for if they enrolled via the Marketplace.[11] We estimate that the federal funding plus enrollee premiums and cost sharing would cover the cost of covered services for enrollees, such that there would be surplus funds of approximately $34 to $99 million. Surplus funds are required to be used to reduce premiums and cost sharing for BHP enrollees and may be carried over from year to year.[12] The level of provider reimbursement that the state chooses to use for the BHP will also impact the amount of surplus funds and could potentially create a cost to the state for the BHP if provider reimbursement is increased. Administrative expenses and any deficit under a BHP are required to be funded by the state. We have not reflected costs for the state to oversee the program in the estimates included in this report.

The surplus/deficit under a BHP will vary each year and largely be driven by the difference in Marketplace provider reimbursement rates underlying the SLCS premiums and Medicaid provider reimbursement rates. The larger the differential is between Marketplace and Medicaid provider reimbursement levels, the higher the surplus or lower the deficit. The competitive environment of the Individual ACA market also influences the SLCS premiums and therefore BHP federal funding. We recommend that a state consider different scenarios for Marketplace and for Medicaid provider reimbursement and the competitive environment over a multi-year period to develop an understanding of the range of surplus potential or deficit to be funded by the state under a BHP. Additionally, the state will need to consider whether Medicaid reimbursement levels will support adequate provider network access for BHP enrollees and the impact that additional enrollees at Medicaid reimbursement levels may have on provider revenue. Providers may experience an increase in revenue from persons who were previously uninsured and a decrease in revenue from persons who were previously enrolled in the Marketplace where provider reimbursement is higher than Medicaid reimbursement levels.

Since federal funding of a BHP is a function of the PTCs that enrollees would be eligible for if they enrolled via the Marketplace, a state must be cognizant of the impact, if any, on the federal PTCs if other policy options are also implemented. A change in the federal PTCs will result is a similar change to federal BHP funding.

Since many BHP enrollees are currently enrolled in Marketplace coverage, a state should also consider the impact that a BHP could have on the Individual ACA market due to the removal of BHP enrollees from the Individual ACA risk pool. We estimate that enrollment in the Individual ACA market would decrease by roughly 35% and overall premiums would increase by approximately 4% to 6% for a given age. The increase in premiums will occur because the enrollees that would transition from the Marketplace to the BHP are generally younger and healthier than the remaining enrollees.[13]

The increased Marketplace premiums will have a larger impact on those not receiving federal PTCs (generally above 400% FPL). Enrollees receiving PTCs could potentially be impacted with reductions in subsidies as well. This will depend upon the magnitude of the CSR loading that insurers have included in Silver plan premiums via the Marketplace to cover CSR subsidies. If the removal of the CSR loading more than offsets the overall increase in premiums, federal PTCs will decrease as the SLCS premiums decrease. Consequently, enrollees in non-Silver plans who are receiving federal PTCs would need to pay more out-of-pocket premium to maintain their same level of coverage (if they purchase a plan other than the SLCS plan). The premium adjustment factor in the federal BHP funding formula is expected to offset the impact of the Silver CSR loading, negating the impact on BHP funding.[11] We did not reflect any reductions in enrollment in the Individual ACA market for households with income above 200%

[11] The BHP federal funding formula also includes adjustments for population health, income reconciliation, and metal tier selection, which we reflected in the modeling. We did not reflect the premium adjustment factor in our estimates because the SLCS premiums used in this analysis include the Silver CSR loading in the Marketplace currently. If a BHP is implemented, the reduction in SLCS premiums due to the removal of the Silver CSR loading is expected to be offset by the premium adjustment factor. Details about the federal funding formula for 2022 are available in the November 3, 2020 Federal Register.

[12] Additional detail is available in the March 12, 2014 Federal Register, Section 600.705 BHP trust fund.

[13] Enrollee premiums in the Marketplace are much lower for lower levels of household income than for higher levels of household income due to federal premium tax credits. In the Illinois individual market, we observed that lower premiums (which apply to the lower levels of household income) attract a broader mix of healthy and unhealthy enrollees, while higher premiums (which apply to the higher levels of household income) attract more unhealthy enrollees. Removing enrollees with lower levels of household income from the Marketplace leaves the enrollees with higher levels of household income which, in total, are not as healthy as enrollees with lower levels of household income.

FPL as a result of higher premiums or reduced federal PTC amounts as part of the BHP modeling; our modeling was limited to the BHP.

Detailed results from our modeling of the three Illinois BHPs specified by the Interagency Working Group are available in Appendix C:

- C-1: Underlying parameters for BHP scenarios
- C-2: Minnesota Model
- C-3: New York Model
- C-4: Zero Premium Model

State-funded PTC/CSR

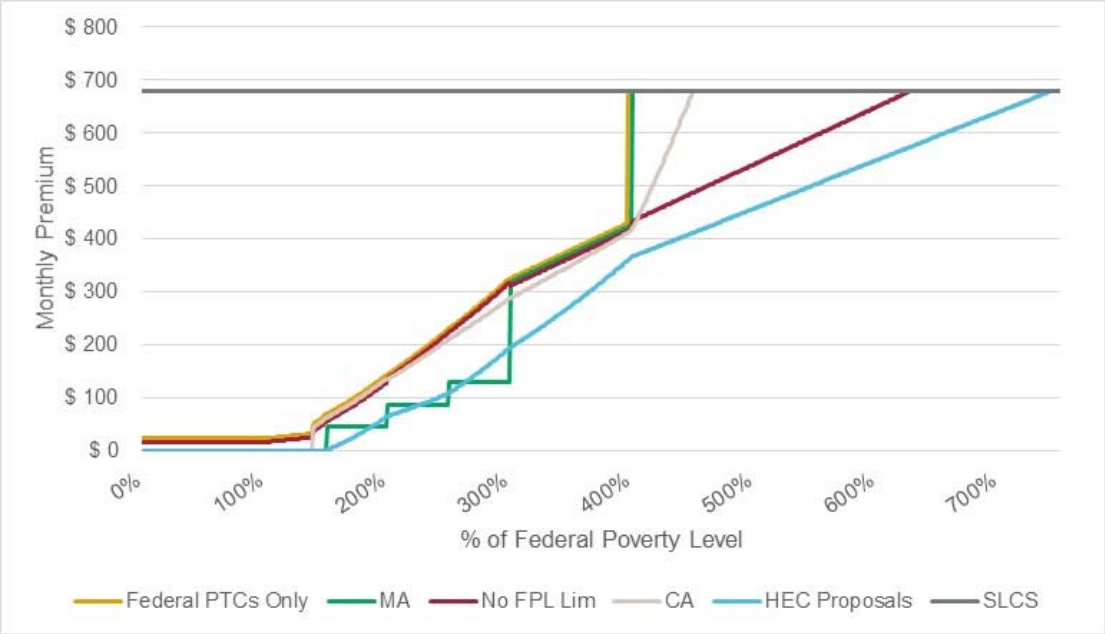
Some states, such as Massachusetts and California, provide state-funded PTCs and CSRs to Marketplace enrollees to supplement the federal PTCs and required CSRs currently available. The additional PTCs make coverage more affordable, which benefits existing Marketplace enrollees and also encourages subsidy-eligible uninsured persons to enroll. The uninsured are generally healthier than current enrollees in the Individual ACA market, so the morbidity of the risk pool may be reduced with this additional enrollment, leading to reductions in premiums. All enrollees not receiving PTCs benefit from lower premiums (in fact, a premium cycle can perpetuate whereby lower premiums lead to additional enrollees that are healthier which reduces the morbidity of the risk pool and results in even lower premiums.) The additional CSRs lower cost sharing amounts for eligible enrollees, thereby reducing a barrier that enrollees may have to using their health care coverage (as well as incenting enrollment from persons who would otherwise choose to remain uninsured).

States have flexibility to provide PTCs and CSRs to enrollees in whatever amount they choose and to vary the assistance by income level. This broad flexibility is limited by how much in total funding a state is able to provide. A state should set objectives based upon the current status of affordability of health care insurance to determine who will be eligible and the amount of the PTCs and/or CSRs offered. To illustrate how state-funded PTCs and CSRs can be designed to impact affordability of health care coverage via the Marketplace, the Interagency Working Group directed us to model the impact in Illinois of four programs:

- Massachusetts' program (MA), which provides enhanced state-funded PTCs and CSRs to enrollees with household income up to 300% FPL
- State-funded PTCs to enrollees with household income above the current federal limit of 400% FPL (No FPL limit)
- California's program (CA), which provides enhanced state-funded PTCs between 200% and 400% FPL and state-only PTCs between 400% and 600% FPL
- Enhanced state-funded PTCs relative to levels prescribed by the current ACA, state-funded PTCs beyond 400% FPL, and enhanced state-funded CSRs up to 400% FPL, based on levels in proposals by the United Stated House Energy & Commerce committee (HEC)

Figures 6A and 6B provide a visual comparison of the federal and state-funded PTCs by household income level across the four programs from the perspective of an enrollee. Figure 6A reflects an enrollee of age 40 in southeast Illinois while Figure 6B reflects an enrollee of age 40 in Chicago. The figures illustrate the average monthly enrollee SLCS premium for each program relative to enrollee premiums with only the federal PTCs. The SLCS premiums (before subsidies), denoted by the horizontal line in the figure, vary by rating area and age. Other out-of-pocket premiums, which are based upon enrollee income, do not vary by rating area and age (to the extent the enrollee's out-of-pocket premium for the SLCS has reached the maximum prescribed under the ACA). As a result of age rating, the value of federal PTCs and state-funded PTCs (to the extent not structured as a flat dollar amount per person) increases with age. Additionally, the value of federal PTCs and state-funded PTCs is higher in higher cost rating areas relative to lower cost rating areas. Enrollees in different rating areas may have different perspectives on how much premium is affordable due to differences in cost of living or other factors.

FIGURE 6A: ESTIMATED CY 2022 MONTHLY ENROLLEE SLCS PREMIUM BY FEDERAL POVERTY LEVEL UNDER EACH PTC PROGRAM – SINGLE 40-YEAR OLD, SOUTHEAST ILLINOIS, NON-TOBACCO USER

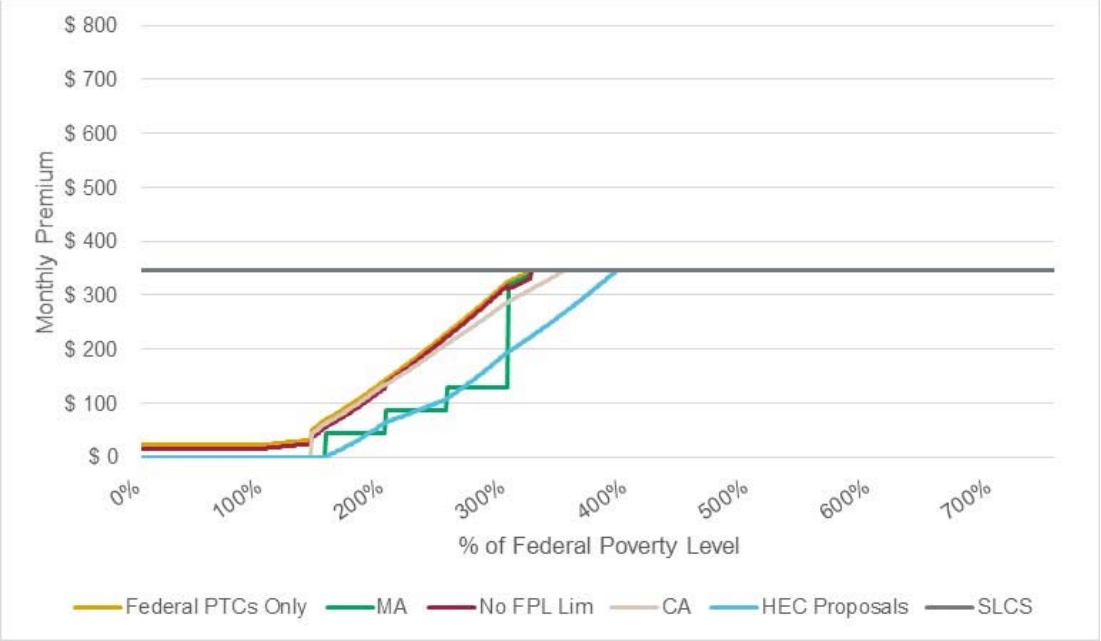


Notes:

a. Lines are offset slightly for illustrative purposes where premiums are identical. All programs ultimately reach the level of the monthly SLCS premium ($678).

b. Illustrated premiums are for SLCS. Enrollees can choose to enroll in more expensive plans and pay the difference, and enrollees can choose to enroll in less expensive plans and not pay as much.

FIGURE 6B: ESTIMATED CY 2022 MONTHLY ENROLLEE SLCS PREMIUM BY FEDERAL POVERTY LEVEL UNDER EACH PTC PROGRAM – SINGLE 40-YEAR OLD, CHICAGO, NON-TOBACCO USER



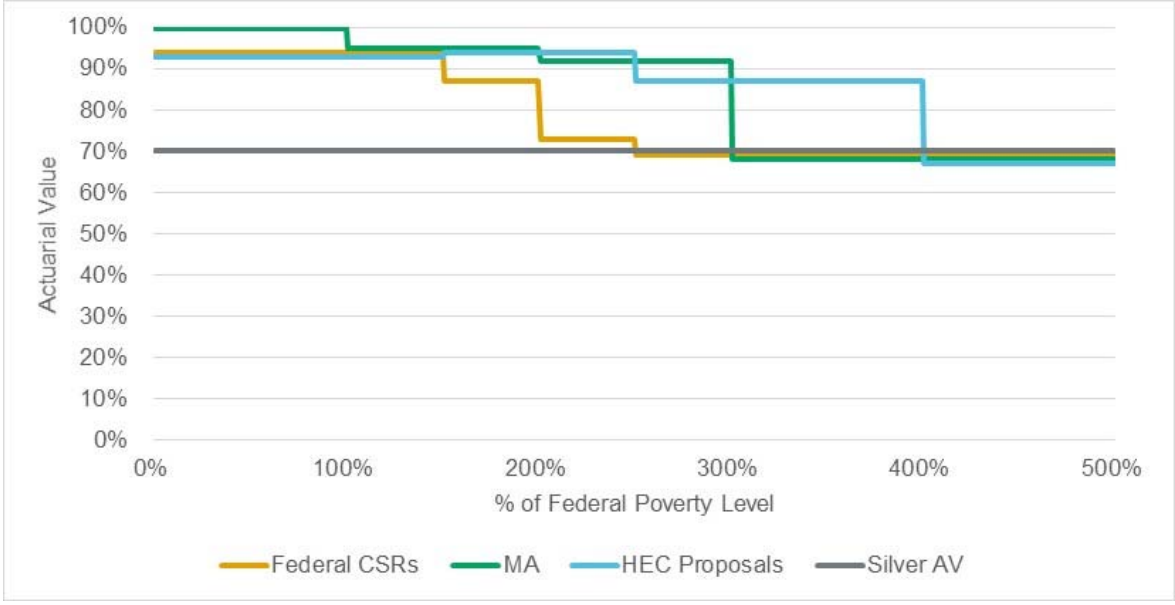
Notes:

a. Lines are offset slightly for illustrative purposes where premiums are identical. All programs ultimately reach the level of the monthly SLCS premium ($345).

b. Illustrated premiums are for SLCS. Enrollees can choose to enroll in more expensive plans and pay the difference, and enrollees can choose to enroll in less expensive plans and not pay as much.

A visual comparison of the federal and state-funded CSRs by household income level across the four programs is provided in Figure 7 below. The higher the ***actuarial value (AV)*** on the vertical axis, the lower the amount of cost sharing enrollees pay, on average. The nominal AV for a standard Silver plan without CSR is 70% in the Individual ACA market. The MA program provides additional CSRs at the Silver plan level for those up to 300% FPL while the HEC proposal provides additional CSRs at the Silver plan level for those with household income between 150% and 400% FPL. The No FPL limit and CA programs do not provide additional CSRs, so all AVs are consistent with the federal levels.

FIGURE 7: ESTIMATED COST SHARING REDUCTION ACTUARIAL VALUES BY FEDERAL POVERTY LEVEL UNDER EACH PTC/CSR PROGRAM



Notes:

a. Lines are offset slightly for illustrative purposes where actuarial values overlap.
b. No FPL Limit and California models use federal CSR definitions and are, therefore, not illustrated.
c. Federal AVs based on https://www.law.cornell.edu/uscode/text/42/18071.
d. Massachusetts AVs estimated using the CY 2021 Actuarial Value Calculator for Connector Care plan designs: https://www.mahealthconnector.org/wp-content/uploads/ConnectorCare-Overview-2020.pdf.
e. House Energy & Commerce CSR source: https://www.congress.gov/116/bills/hr1425/BILLS-116hr1425pcs.pdf
f. Illustrated AVs are for Silver coverage, including CSRs for those eligible. Enrollees can choose to enroll in Bronze (60% AV), Gold (80% AV), and in some rating areas, Platinum (90% AV) coverage.

Highlights of results from our modeling of the four programs are provided in Figure 8 below. Across all four programs, we expect all Individual ACA enrollees to continue to enroll because the state-funded PTCs/CSRs will have a minimal impact or reduce the cost of their current coverage selections. Enrollment rates of Individual non-ACA enrollees and the uninsured vary across the programs based upon the percentage reduction in their SLCS out-of-pocket premium via the Marketplace, and, to a lesser extent, the percentage reduction in cost sharing. Enrollment rates are highest for those who would not need to pay any premium due to the enhanced state-funded PTCs. Enrollment rates decrease sharply when a premium is introduced then decrease slowly as premiums increase. For example, the decrease in enrollment when increasing monthly premiums from $0 to $10 is much greater than when increasing monthly premiums from $40 to $50. More detailed results are available in Appendix D:

- D-1: Underlying parameters for state-funded PTC/CSR scenarios
- D-2: MA
- D-3: No FPL limit
- D-4: CA
- D-5: HEC Proposals

FIGURE 8: CY 2022 PROJECTED STEADY-STATE RESULTS BY STATE-FUNDED PTC/CSR PROGRAM

PROGRAM	ESTIMATED ENROLLEES	ESTIMATED ENROLLEES PREVIOUSLY UNINSURED UP TO 200% FPL	ESTIMATED ENROLLEES PREVIOUSLY UNINSURED OVER 200% FPL	ESTIMATED ENROLLEES WITH LOWER PREMIUM	ESTIMATED ENROLLEES WITH LOWER COST SHARING	STATE FUNDING PTCs (MILLIONS)	STATE FUNDING CSRs (MILLIONS)
Massachusetts	368,000	32,000	24,000	327,000	238,000	$ 151.0	$ 213.0
No FPL Limit for PTCs	324,000	-	9,000	107,000	-	$ 182.0	$ 0.0
California	329,000	6,000	9,000	230,000	-	$ 113.0	$ 0.0
HEC Proposals	424,000	53,000	54,000	423,000	248,000	$ 511.0	$ 285.0

Notes:

a. We estimate approximately 712,000 Illinoisans are eligible for Marketplace coverage.

b. Estimates of state funding are overstated to the extent that enrollees choose Bronze rather than Silver plans. The state would not fund CSRs for Bronze enrollees and may not need to fund the full amount of PTCs.

c. If the state also implemented a BHP, enrollees in the Marketplace would be limited to those with household income above 200% FPL. We estimate that state funding requirements would be reduced by approximately $125 million for the Massachusetts program and $153 million for the HEC program if a BHP was implemented. There would be minimal change to the state funding requirement for the other two programs.

In modeling the four programs, we assume that all enrollees are in Silver plans, both without and with additional state funded PTCs/CSRs. However, as shown in Figure 9, approximately 40% of enrollees currently eligible for PTCs are in lower cost Bronze plans, with a higher portion of enrollment in Bronze plans for higher FPLs than lower FPLs. Of those in Bronze plans, we expect that a material number of enrollees in the lower FPL ranges are not paying any premiums because the federal PTCs cover the full premium amount. If the additional PTCs are enough, enrollees in $0 Bronze plans may be able to enroll in plans with lower cost sharing for no incremental out-of-pocket cost. We have not reflected these $0 Bronze enrollees in our estimates of the number of enrollees that will have lower cost sharing under the four programs so the estimates in Figures 1, 3, and 8 may be understated. Additionally, the estimates of the state funding needed for CSRs is overstated in our modeling to the extent that enrollees that are eligible for state-funded CSRs elect to enroll in a Bronze plan.

FIGURE 9: ENROLLEES IN BRONZE PLANS – MARKETPLACE ENROLLEES WITH INCOME BETWEEN 100% AND 400% FPL

FPL RANGE	% OF ENROLLEES IN BRONZE PLANS, CY 2020	ESTIMATED ENROLLEES IN BRONZE PLANS, CY 2022
100%-150%	14%	6,000
150%-200%	24%	16,000
200%-250%	46%	20,000
250%-300%	58%	15,000
300%-400%	64%	25,000
Composite	40%	82,000

Notes:

a. CY 2020 percentage of enrollees in Bronze plans are based upon 2020 OEP State, Metal Level, and Enrollment Status Public Use File https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files.

b. CY 2022 estimated enrollees in Bronze plans assumes enrollment in Bronze plans consistent with CY 2020 and in the absence of new policy options that might be available.

In the Marketplace today, insurers are effectively bidding for the SLCS premiums in each rating area. Enrollees with household income up to 133% FPL pay 2.1% of their income for these plans. The MA, CA, and HEC programs provide additional PTCs such that enrollees with household income at lower FPLs (up to 150% FPL for MA and HEC, and up to 138% FPL for CA) pay no premium for the SLCS plan[14]. These programs create an environment where insurers are effectively bidding to be the insurer that provides low income enrollees with an option for a $0 Silver plan premium. This may lead to premiums that are a few percentage points lower given the high level of enrollment in plans where enrollees do not need to pay any out-of-pocket premium. We have not reflected any additional premium reduction in our modeling to reflect such an enhanced competitive environment.

To the extent additional premium reductions materialize due to the enhanced competitive environment, enrollees not receiving PTCs would benefit. The federal government would also pay lower PTCs per enrollee receiving PTCs. Enrollees receiving PTCs who are enrolled in a plan that is more expensive than the SLCS may need to change plans in order to avoid paying more premium. State funding of PTCs that are based upon income would decrease for enrollees not receiving federal PTCs. For enrollees receiving federal PTCs, state funding of PTCs is always a percentage of income and not related to premium.

In addition to funding PTCs and/or CSRs, a state will need to determine how best to operationalize the program and the administrative costs of doing so. We have not reflected such administrative costs in the estimates in this report. For each of the four PTC/CSR programs we modeled, we estimate that there would not be any funding via a 1332 waiver. Federal pass-through funding requires a reduction of federal PTC expenditures under the waiver. The increase in federal funding of PTCs due to higher Marketplace enrollment is estimated to more than offset the reduction in federal funding of PTCs due to the reduced SLCS premiums resulting from the lower average morbidity in the risk pool.

[14] California consumers with household income up to 139% FPL have premiums capped at $1 per month.

Marketplace public option

A state may be able to make health care coverage more affordable by participating as an insurer in the Individual ACA market, both on and off the Marketplace, if it can offer lower premiums than available via other insurers. A state may also contract with private health insurance plans or a third-party administrator to provide a public option plan. For the purpose of this report, these proposals are referred to as a 'marketplace public option'.

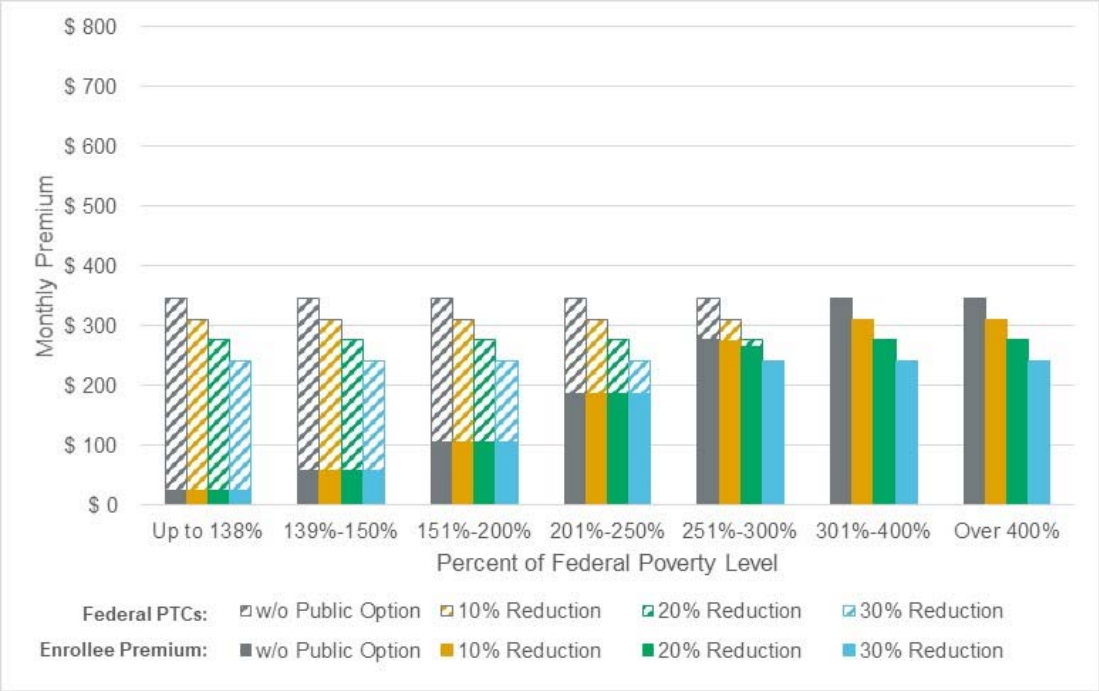
To the extent a public option has a lower premium relative to other qualified health plans offered in the Marketplace, the majority of enrollees receiving PTCs would not realize premium savings because their premiums are already limited to a specified percentage of their household income (premium savings would accrue to the federal government). In fact, if the public option plan leads to lower PTCs, it is possible that the availability of Bronze plans with no premium will be reduced and enrollees receiving PTCs could be subject to substantial premium increases if they do not change plans. This potential disruption is the same as the disruption that occurs when the insurer who has the SLCS changes from year to year, but it may be to a greater degree depending upon the magnitude of the premium reduction. However, lower premiums would make health care coverage more affordable to higher income enrollees who are not receiving PTCs and may encourage uninsured persons not eligible for PTCs to enroll.

To illustrate potential impacts of a Marketplace public option, the Interagency Work Group requested that we model scenarios of 10%, 20%, and 30% reductions to SLCS premiums. Figures 10A and 10B provide a visual comparison of the federal PTCs and premiums by household income level across the three scenarios. Figure 10A reflects an enrollee of age 40 in southeast Illinois while Figure 10B reflects an enrollee of age 40 in Chicago. The figures illustrate the average monthly enrollee premium and federal PTCs for each scenario and in comparison to enrollee premiums and federal PTCs without a Marketplace public option. The SLCS premiums (before subsidies) vary by rating area and age. Subsidized out-of-pocket premiums, which are based upon enrollee income, do not vary by rating area and age (to the extent the enrollee's out-of-pocket premium for the SLCS has reached the maximum prescribed under the ACA). A result of age rating is that the value of federal PTCs increases with age. Additionally, the value of federal PTCs is higher in higher cost rating areas relative to lower cost rating areas.

FIGURE 10A: PUBLIC OPTION SLCS PREMIUMS, FEDERAL PTCS, AND ENROLLEE OUT-OF-POCKET PREMIUMS BY FPL – SINGLE 40-YEAR OLD, SOUTHEAST ILLINOIS, NON-TOBACCO USER

Note: Values reflect the average within each FPL range.

FIGURE 10B: PUBLIC OPTION SLCS PREMIUMS, FEDERAL PTCS, AND ENROLLEE OUT-OF-POCKET PREMIUMS BY FPL – SINGLE 40-YEAR OLD, CHICAGO, NON-TOBACCO USER



Note: Values reflect the average within each FPL range.

We estimate that the premium reductions would lead to additional enrollment of approximately 6,000 uninsured persons in the Marketplace for the 10% reduction scenario, approximately 13,000 for the 20% reduction scenario, and approximately 20,000 for the 30% reduction scenario. Due to the relatively modest enrollment gains under these scenarios[15] and that the least healthy of the uninsured would be more likely to enroll, we estimate that the additional enrollment would not improve the overall risk pool morbidity.

Additionally, since over 80% of premiums for health care coverage are paid to providers of health care services, provider reimbursement is a significant lever a state may use to achieve the lower premiums in a Marketplace public option. Figure 11 below includes estimates of the level of provider reimbursement, as a percentage of Medicare provider reimbursement, needed to achieve the premium reduction under each scenario. The state will need to consider whether these provider reimbursement levels will support adequate provider network access for enrollees. A state may be able to use other levers to support provider participation, and it may be able to achieve some of the target premium reduction without reducing provider reimbursement.

[15] Modest enrollment gains may be optimistic based upon experience in other states. Seven states (Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin) implemented reinsurance programs for the Individual ACA market under Section 1332 waivers in 2018 or 2019. Reinsurance programs have an impact on SLCS premiums similar to a Marketplace public option. All seven states had enrollment decreases in the year that the reinsurance program was implemented. Reduction in federal spending for advertising, enrollment assisters, and other Marketplace supports and other factors may have contributed to these enrollment decreases in 2018 and 2019, so we cannot concretely determine the change in enrollment due to a reinsurance program.

FIGURE 11: MARKETPLACE PUBLIC OPTION ESTIMATED PROVIDER REIMBURSEMENT BY SCENARIO

METRIC	WITHOUT PUBLIC OPTION	10% REDUCTION	20% REDUCTION	30% REDUCTION
Estimated provider reimbursement as a % of Medicare	145% - 185%	120% - 160%	100% - 140%	75% - 115%

Notes:

a. Provider reimbursement as a % of Medicare applies to inpatient hospital, outpatient hospital, and professional services in composite. Reimbursement for pharmacy and other miscellaneous services were assumed to be the same under the scenarios.

b. Provider reimbursement as a % of Medicare was estimated for the Individual ACA market in composite. Provider reimbursement underlying plans within a metallic tier that have less than average premiums may be lower.

c. Provider reimbursement as a % of Medicare varies by rating area as well as between inpatient hospital, outpatient hospital, and professional services. In comparison to the composites shown in this figure, reimbursement for inpatient hospital and professional services are typically a lower % of Medicare and reimbursement for outpatient hospital services are typically a higher % of Medicare.

As can be seen in the detailed modeling results available in Appendix E, over 85% of the additional enrollment due to lower premiums available through a Marketplace public option would be of persons who have household income over 400% FPL and are not eligible for federal PTCs. Enrollees up to 400% FPL will benefit from the lower premiums if they enroll in the public option, to the extent that their SLCS premiums (which vary by age and rating area) are lower than the maximum premium based upon household income (this scenario is most likely for young adults with income between 300% and 400% FPL and those in rating areas with lower premiums). If the SLCS premium is reduced due to the Marketplace public option, PTCs will be reduced and enrollees receiving PTCs may need to change plans in order to avoid needing to pay more premium.

A Marketplace public option which offers lower premiums may lead other insurers to seek ways to reduce premiums to maintain/attract enrollment because Marketplace enrollees are very price sensitive. Our analysis of the 2019 Individual ACA enrollment in Illinois indicates that approximately 42% of total enrollees with more than one insurer option were in Bronze plans, and approximately 46% to 47% of Silver and Gold enrollees with more than one insurer option were enrolled in the lowest cost plan for their chosen metal level. The price sensitivity that enrollees demonstrate can result in large market shares for the lowest cost insurer(s).

A Marketplace public option may also cause other insurers to exit the Marketplace if they are unable to offer competitive premiums. Just as the SLCS premium can vary by county and year, the competitive dynamic can differ from rating area to rating area and from year to year. If a state wants to maintain choice for enrollees and competition in the Marketplace, it is critical to establish the level of provider reimbursement in each rating area such that lower premiums are achieved without reducing the number of insurers. Additional analysis specific to each rating area is warranted to determine the level of provider reimbursement that can achieve these objectives. This analysis needs to be done each year, just as other insurers do when assessing their competitive position and establishing premiums. Additionally, depending upon the magnitude, reductions in provider reimbursement for the Individual ACA market may strain provider revenue or lead to pressure to increase provider reimbursement for Medicaid and/or the ESI.

Operationally, a state can develop insurer operations (including contracting with a third-party administrator similar to state employee health insurance) and directly participate in the Marketplace, or a state may choose to contract with health insurer(s), similar to Medicaid managed care. If the state were to contract with a health insurer, the competitive dynamic of the Marketplace could be impacted if the health insurer also has its own Marketplace offering.

Federal pass-through funding via a Section 1332 waiver may be available to support state administrative costs of a Marketplace public option if the total federal funding of PTCs is reduced as a result of the state's program (and if all other guardrails required under a Section 1332 waiver are met). For the three scenarios modeled, we estimate there will be a decrease of approximately $285 to $573 million in federal PTCs due to the reduction in SLCS premiums. Hence, federal pass-through funding, contingent on the federal government considering the Marketplace public option an approvable 1332 waiver, may be available if the state chose to apply for a Section 1332 waiver. If approved, the federal pass-through funding could be used to support other state programs, such as PTCs, CSRs, and undocumented persons. However, such benefits (depending upon design and eligibility requirements) may increase utilization of federal PTCs, reducing available pass-through funding.

Detailed results from our modeling of the Marketplace public option variations are available in Appendix E:

- E-1: Underlying parameters for Marketplace public option scenarios
- E-2: 10% premium reduction
- E-3: 20% premium reduction
- E-4: 30% premium reduction

Medicaid buy-in

For a Medicaid buy-in, the state could make health care coverage more affordable by allowing enrollees to pay premiums for health care coverage under the state's Medicaid program infrastructure. The state would administer this program through its Medicaid managed care program and its associated provider reimbursement schedule. We modeled three variations of a Medicaid buy-in, as prescribed by the Interagency Working Group. The first variation sets limits on eligibility for the Medicaid buy-in while the other two expand eligibility to all Illinois residents not eligible for Medicare or comprehensive Medicaid benefits. Enrollee premiums and cost sharing differ between the three Medicaid buy-in variations modeled. The buy-in would not be eligible for federal Medicaid matching funds, but some variations could be eligible for federal pass-through funding via a Section 1332 waiver.

In designing a Medicaid buy-in program, a state will need to balance eligibility criteria and enrollee premiums and cost sharing against federal funding that may be available as well as state funding constraints. Additionally, a broad Medicaid buy-in may materially reduce provider revenue (as persons shift from Individual and ESI coverage to the Medicaid buy-in), which may generate pressure to increase provider reimbursement for the whole Medicaid program, threaten provider financial viability, and create ancillary effects on other health insurance markets. For a broad Medicaid buy-in, a large number of enrollees may transition from Individual and ESI coverage. Transitions from Individual coverage may threaten the viability of the Individual ACA market due to low enrollment and adverse selection. Some employers may increase employee contributions for and/or discontinue their ESI offerings in response to a Medicaid buy-in. There is considerable uncertainty regarding the impacts that a broad Medicaid buy-in would have because such a program has not been implemented to date.

Underlying parameters for the Medicaid buy-in scenarios are provided in Appendix F-1.

TARGETED ELIGIBILITY VARIATION

For the targeted eligibility variation, the Interagency Work Group specified that eligibility would be limited to Illinois residents:

- not eligible for comprehensive Medicaid benefits
- with household income up to 400% FPL, and
- either: 1. are an undocumented immigrant, or 2. have an offer of affordable ESI coverage for a single enrollee but not for a family (commonly referred to as the ***ACA family glitch***).

These population subgroups are not eligible for federal PTCs via the Marketplace so this variation would have little to no impact on the Individual ACA market. As specified by the Interagency Work Group, covered services were assumed to be the same as Medicaid except that long term care and waiver services are not covered, and that cost sharing would equal the Silver level AVs that enrollees would be eligible for via the Marketplace based only upon their FPL, including CSR variations. Silver level AVs are based upon the federal AV calculator, so enrollees will pay a greater share of the cost in the Medicaid buy-in than they would in the Individual ACA market due to the differences in provider reimbursement. The Interagency Work Group also specified that enrollee premiums would equal the federal maximums for SLCSs based on their FPL so that premiums would be consistent with what enrollees would pay for the SLCS if they were eligible for federal PTCs via the Marketplace. Premiums for the targeted buy-in are only defined as a percentage of household income based on FPL; they are not based upon the cost of coverage or another benchmark.

We estimate that approximately 535,000 persons would be eligible for the Medicaid buy-in under the targeted eligibility variation and approximately 128,000 would enroll. Of the approximately 187,000 uninsured who are eligible for the targeted eligibility buy-in, we estimate that approximately 60,000 (32%) would enroll, comparable to the enrollment rate of those eligible for Marketplace coverage since the premiums will be the same as the Marketplace. Of the approximately 343,000 enrolled in ESI and eligible for the targeted eligibility buy-in, we estimate that approximately 64,000 (19%) would enroll. ***Take up rates*** for lower FPL ranges of ESI enrollees are expected to be a little higher than the uninsured take up rates because these persons have already shown a willingness to pay for coverage. Take up rates for higher FPL ranges are expected to be lower because ESI may offer a lower premium.

Low take up from ESI coverage is consistent with what states, including Illinois, observed when expanding Medicaid eligibility to adults with household income up to 138% FPL.

Since there is not any federal funding available for providing health care coverage to enrollees eligible for this targeted buy-in, the state would fund the cost of the program that is in excess of the enrollee premiums. We estimate this will be approximately $289 million, plus the oversight costs of the program. If employees with an affordable offer of employee-only coverage are not eligible to enroll, but their spouses and dependents are, we estimate that enrollment and required state funding would be lower by approximately 51,000 and $119 million, respectively. Alternatively, if household income is required to be up to 200% FPL rather than 400% FPL, we estimate that enrollment and required state funding would be lower by approximately 39,000 and $33 million, respectively. Finally, if employees with an affordable offer of employee-only coverage are not eligible to enroll, but their spouses and dependents are, and household income is required to be up to 200% FPL rather than 400% FPL, we estimate that enrollment and required state funding would be lower by approximately 74,000 and $135 million, respectively. Figure 12 illustrates these estimates for the modeled targeted eligibility Medicaid buy-in as well as three eligibility variants.

FIGURE 12: TARGETED MEDICAID BUY-IN ELIGIBILITY VARIANTS

	TARGETED MEDICAID BUY-IN VARIANT			
METRIC	AS MODELED	SPOUSE AND DEPENDENT FAMILY GLITCH	<=200% FPL ONLY	SPOUSE AND DEPENDENT FAMILY GLITCH & <= 200% FPL
Estimated Eligibles	535,000	317,000	254,000	149,000
Estimated Enrollees	128,000	76,000	88,000	54,000
Required State Funding (millions)	$ 289.0	$ 170.0	$ 256.0	$ 153.5
Estimated Enrollees Previously Uninsured	60,000	37,000	43,000	28,000
Percent Reduction in Uninsured	6.6%	4.1%	4.8%	3.1%

In our modeling, we have not assumed any change (relative to the baseline health insurance market) in required employee contributions to participate in ESI coverage. It is possible that employers would increase the required contributions for spouses and child dependents to incent a shift to the targeted buy-in (reducing ESI costs). Many of the dependent children are eligible for and would therefore shift to CHIP rather than the targeted buy-in. Additionally, we have assumed there will continue to not be any employer penalty for failure to offer affordable family coverage.

Detailed results from our modeling of the targeted eligibility Medicaid buy-in variation are available in Appendix F-2.

BROAD ELIGIBILITY VARIATION

For the broad eligibility Medicaid buy-in, the following parameters were specified by the Interagency Work Group:

- Any Illinois resident that is not eligible for Medicare or comprehensive Medicaid benefits is eligible
- Covered services are the same as Medicaid except that long term care and waiver services are not covered

Enrollee premiums and cost sharing vary between the Broad - Basic and Broad - Enhanced Medicaid buy-in variations as described in Figure 13. The enrollee premiums for the Basic variation are consistent with the targeted buy-in, which has eligibility limited to those with household income up to 400% FPL, except that enrollees in the Broad - Basic variation will pay a lower premium if it's less than the federal maximums as a percentage of household income.

FIGURE 13: BROAD MEDICAID BUY IN ENROLLEE PREMIUMS AND COST SHARING

Variation	ENROLLEE PREMIUMS	ENROLLEE COST SHARING
Broad – Basic	30% less than the assumed CY 2022 SLCS premiums in each rating area or, if less, the percentage of household income which is consistent with the maximum an enrollee would pay if eligible for Marketplace PTCs	Consistent with Silver level AVs offered in the Marketplace, including CSR variations
Broad - Enhanced	Consistent with Massachusetts up to 300% FPL, Above 300% FPL, 30% less than the assumed CY 2022 SLCS premiums in each rating area, or, if less, the percentage of household income which is consistent with the maximum an enrollee would pay if eligible for Marketplace PTCs	Consistent with Massachusetts up to 300% FPL, 73% AV over 300% FPL

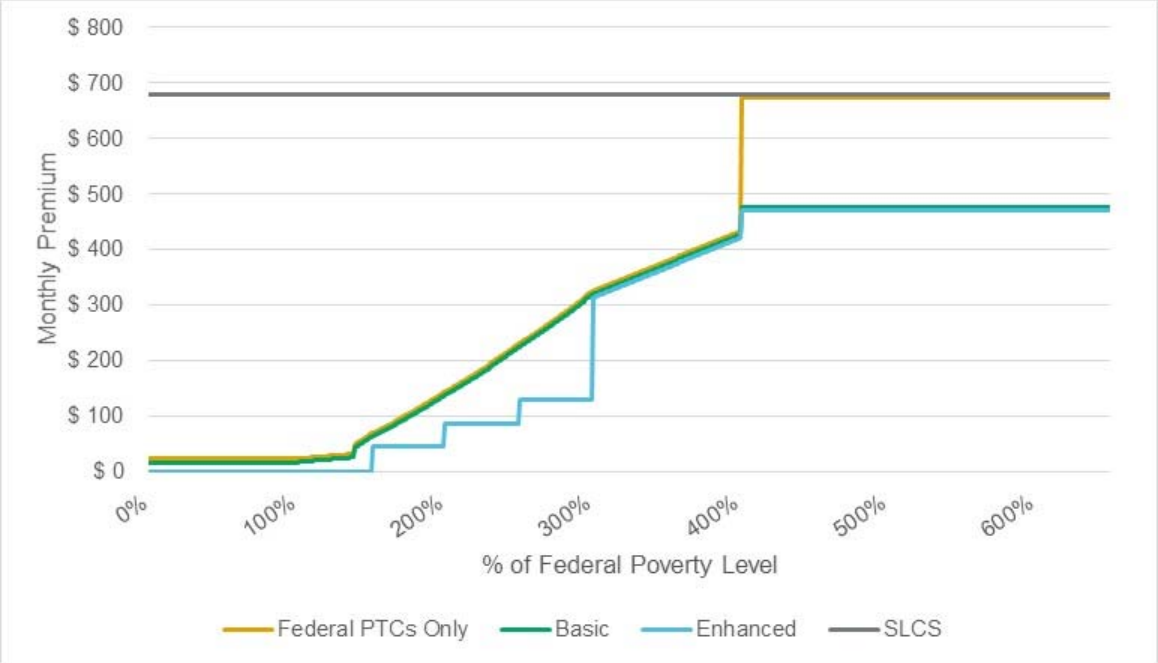
Notes:

a. Enrollee premiums in these Medicaid buy-in variations are related to household income and SLCS premiums on the Marketplace. They are not related to the provider reimbursement underlying the cost of coverage for the Medicaid buy-in. Alternative variations are possible.

b. Enrollee cost sharing is based upon plan design elements that meet the applicable AV per the federal AV calculator. Under these plan designs, enrollees will pay a greater share of the cost in the Medicaid buy-in than they would in the Individual ACA market due to the differences in provider reimbursement.

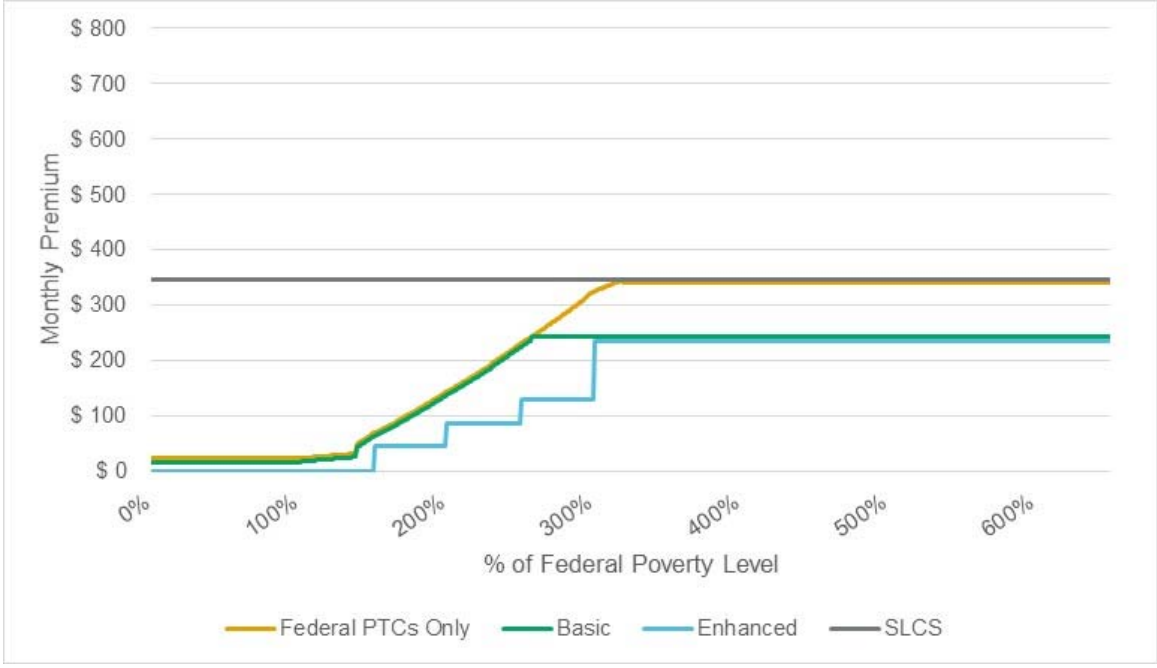
Figures 14A and 14B provide a visual comparison of enrollee premiums by household income level in the broad Medicaid buy-in variations, along with comparison to the enrollee premiums via the Marketplace if the person is eligible for federal PTCs. Figure 14A reflects an enrollee of age 40 in southeast Illinois while Figure 14B reflects an enrollee of age 40 in Chicago. The Marketplace SLCS premiums (before subsidies) and the Medicaid broad buy-in premiums (before subsidies) vary by rating area and age. Other out-of-pocket premiums, which are based upon enrollee income, do not vary by rating area and age (to the extent the enrollee's out-of-pocket premium has reached the maximum prescribed by the program).

FIGURE 14A: ESTIMATED CY 2022 MONTHLY ENROLLEE PREMIUMS BY FEDERAL POVERTY LEVEL FOR BROAD MEDICAID BUY-IN PROGRAMS – SINGLE 40-YEAR OLD, SOUTHEAST ILLINOIS, NON-TOBACCO USER



Note: Lines are offset slightly for illustrative purposes where premiums are identical.

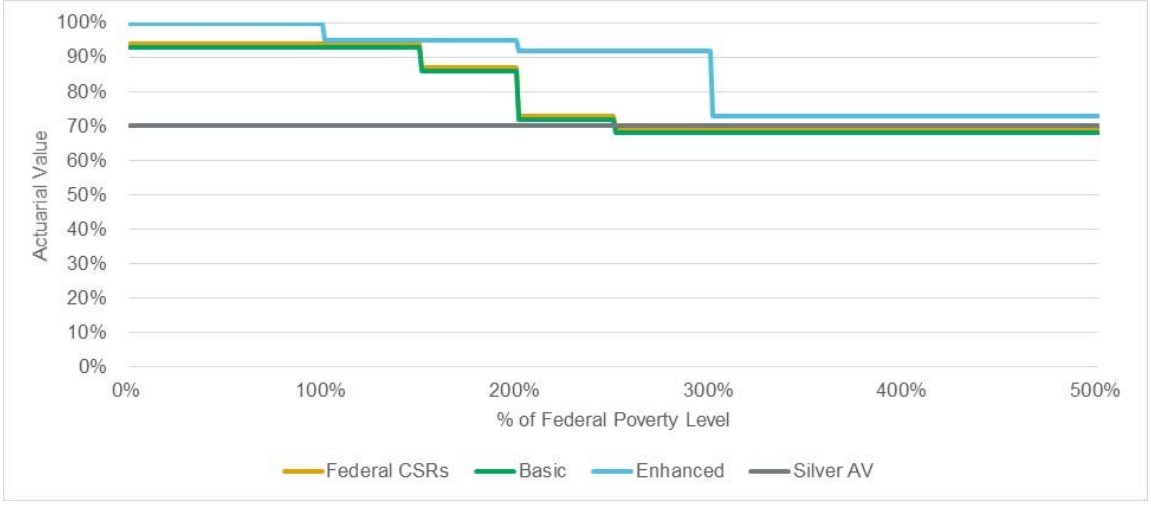
FIGURE 14B: ESTIMATED CY 2022 MONTHLY ENROLLEE PREMIUM BY FEDERAL POVERTY LEVEL FOR BROAD MEDICAID BUY-IN PROGRAMS – SINGLE 40-YEAR OLD, CHICAGO, NON-TOBACCO USER



Note: Lines are offset slightly for illustrative purposes where premiums are identical.

Figure 15 below provides a visual comparison of the cost sharing AVs by household income level for the broad Medicaid buy-in variations, along with comparison to cost sharing AVs via the Marketplace for enrollees eligible for Marketplace coverage. The higher the AV on the vertical axis, the lower the amount of cost sharing enrollees pay, on average. The Broad – Basic buy-in variation follows the cost sharing available via the Marketplace while the Broad – Enhanced buy-in variation offers lower cost sharing.

FIGURE 15: ESTIMATED COST SHARING ACTUARIAL VALUES BY FEDERAL POVERTY LEVEL UNDER EACH BROAD BUY-IN PROGRAM



Notes:

a. Lines are offset slightly for illustrative purposes where actuarial values overlap.
b. Federal AVs based on https://www.law.cornell.edu/uscode/text/42/18071.

We estimate that approximately 6.2 million Illinoisans would be eligible for the broad Medicaid buy-in variations. Of the approximately 580,000 eligible uninsured, we estimate that approximately 72,000 (12%) would enroll in the Broad - Basic variation and approximately 146,000 (25%) would enroll in the Broad - Enhanced variation. Previously uninsured persons are estimated to comprise approximately 15% to 20% of the enrollees in the broad Medicaid buy-in variations.

Of the approximately 5.3 million eligibles enrolled in ESI, we estimate that approximately 267,000 (5%) would elect to enroll in the Broad - Basic variation and approximately 398,000 (8%) would elect to enroll in the Broad - Enhanced variation. These estimates reflect an assumption that employers continue to offer coverage as they do today. The enrollment from ESI would predominantly have lower levels of household income where their premiums for the broad Medicaid buy-in are capped based upon household income because those capped premiums could be more affordable than ESI premiums. While the take up rates from ESI are small, enrollees from ESI coverage are estimated to comprise approximately 50% to 65% of the enrollees in the broad Medicaid buy-in variations. As ESI provides health insurance coverage to more than half of Illinoisans before modeling policy options, even small reductions in ESI coverage may have significant impacts to other insurance markets such as a Medicaid buy-in. To the extent that employers increase required contributions or discontinue offering ESI coverage, the enrollment in a broad Medicaid buy-in program may be substantially higher and have a corresponding increase in the cost to the state.

Of the approximately 350,000 eligibles enrolled in Individual coverage, we estimate that approximately 91,000 (26%) would elect to enroll in the Broad – Basic variation and approximately 259,000 (74%) would elect to enroll in the Broad – Enhanced variation. Enrollees from Individual coverage are estimated to comprise approximately 20% to 30% of the enrollees in the broad Medicaid buy-in variations. The large decreases in enrollment in Individual coverage may threaten the viability of the Individual ACA market due to low enrollment and/or adverse selection. The enrollment estimates assume that persons who would pay the same premiums for the broad Medicaid buy-in as they would in the Individual ACA market would remain in the Individual ACA market because enrollees in the Individual ACA market have flexibility to choose other levels of cost sharing and premiums. These enrollees could alternatively choose to enroll in the broad Medicaid buy-in.

We estimate the total cost of the Medicaid buy-in to be approximately $1,981 million for the Broad - Basic variation and approximately $3,716 million for the Broad - Enhanced variation. The cost to the state is estimated to be approximately $274 million for the Broad - Basic variation and approximately $1,052 million for the Broad - Enhanced variation. These estimates assume federal pass-through funding (contingent upon a Medicaid buy-in being considered an approvable Section 1332 waiver by the federal government) of approximately $4 million and $984 million, respectively. These estimates of federal pass-through funding are equivalent to federal premium assistance that would otherwise be received by the Medicaid buy-in population enrolled in Marketplace coverage. The pass-through funding estimates do not consider changes in Marketplace premiums to the extent a Medicaid buy-in was implemented. Additionally, pass-through estimates do not consider other changes in federal spending that may be associated with a Medicaid buy-in. For example, if the Medicaid buy-in increases participation in existing Medicaid programs, this will increase both state and federal spending and reduce available pass-through funding. Further analysis of these potential changes in state and federal spending should be considered in the final financial evaluation of a Medicaid buy-in. Note, however, that if the Individual ACA market is no longer viable due to a broad Medicaid buy-in, there would not be a benchmark premium on which to base federal funding. An alternative benchmark premium would be needed.

Provider revenue is an additional consideration for a Medicaid buy-in, particularly a broad buy-in where only 15% to 20% of estimated enrollees are expected to be uninsured previously. The remaining 80% to 85% are transitioning from Individual and ESI coverage where provider reimbursement is significantly more than Medicaid provider reimbursement. We estimate that provider reimbursement may be reduced by approximately $1 to $2 billion, which is a reduction of approximately 35% to 40% attributable to these enrollees in the broad Medicaid buy-in variations. This reduction may generate pressure to increase provider reimbursement for the whole Medicaid program, threaten provider financial viability, and create ancillary effects on other health insurance markets.

As noted above, enrollee premiums for the broad Medicaid buy-in variations were specified to be 30% less than the assumed CY 2022 SLCS premiums, subject to maximums as a percentage of household income. If premiums were 20% less rather than 30% less, we estimate that enrollment would decrease by approximately 38,000 for the Broad – Basic variation and by 39,000 for the Broad – Enhanced variation. We estimate that the cost to the state would decrease by approximately $40 million and $57 million, respectively. The majority of enrollees in the broad Medicaid buy-in program have their premiums limited to a percentage of household income so are not sensitive to changes in the buy-in premiums. The enrollment reduction is therefore primarily in the higher FPL ranges where enrollee premiums and cost sharing cover more than the cost of coverage. Figure 16 illustrates estimates for the modeled broad eligibility Medicaid buy-in as well as the premium variants.

FIGURE 16: BROAD MEDICAID BUY-IN PREMIUM VARIANTS

	BROAD MEDICAID BUY-IN VARIANT			
METRIC	BASIC AS MODELED	BASIC - 20% BELOW SLCS	ENHANCED AS MODELED	ENHANCED - 20% BELOW SLCS
Estimated Eligibles	6,235,000	6,235,000	6,235,000	6,235,000
Estimated Enrollees	430,000	392,000	802,000	763,000
Required State Funding ($ millions)	$ 274.0	$ 234.0	$ 1,052.0	$ 995.0
Estimated Enrollees Previously Uninsured	72,000	65,000	146,000	139,000
Percent Reduction in Uninsured	8.0%	7.2%	16.1%	15.4%

There is a great deal of uncertainty regarding how many eligible persons will elect to enroll in a broad Medicaid buy-in because there is no historical precedence available for consumer behavior of such an option, particularly for persons with household income in the higher FPL ranges. If enrollment of higher income persons is higher than modeled, the cost to the state of a broad Medicaid buy-in may decrease because enrollee premiums and cost sharing more than cover the cost of coverage at the higher FPL ranges, helping to offset the cost of the Medicaid buy-in for lower income persons. For example, when we increased the take up rates by 50%, e.g., a 10% take up rate was increased to 15%, for those with household income over 300% FPL, we estimated an increase in enrollment of approximately 12% to 21% for the broad Medicaid buy-in variations and a lower cost to the state of approximately $110 to $145 million. Conversely, if enrollment of higher income persons is lower than modeled, the cost to the state may increase. Additional sensitivity testing is warranted in further financial evaluation of a Medicaid buy-in. A Medicaid buy-in could potentially be implemented in conjunction with another policy option or on a phase-in basis in order to mitigate risk to the state and other stakeholders.

Detailed results from our modeling of the broad eligibility Medicaid buy-in variations are available in Appendix F-3 and Appendix F-4.

Data, methodology, and assumptions

In this section of the report, we first discuss the data, methodology, and assumptions used to develop the CY 2022 population estimates to support modeling the policy options. This is followed by discussion of key assumptions we used to model the policy options.

OVERVIEW OF POPULATION ESTIMATES

To develop the CY 2022 population estimates, we began with the Illinois population reported in the 2018 American Community Survey (ACS) available from the United States Census Bureau.[16] We made demographic adjustments to move the population forward to CY 2022; the demographic adjustments were based upon historical patterns between the 2014 and 2018 ACS population estimates. We then made adjustments to reflect the 3.4% unemployment economic scenario. Lastly, adjustments were made to reflect the higher unemployment economic scenarios. Our approach to developing the CY 2022 population estimates is discussed in more detail in the next subsections of this report.

STARTING POPULATION AND DEMOGRAPHIC ADJUSTMENTS

To develop the CY 2022 population estimates, we began with the Illinois population reported in the 2018 ACS stratified by:

- Insurance coverage type [Individual, ESI (includes both fully-insured and self-funded group plans), Government (e.g., TRICARE, Veterans Affairs), Medicaid (excluding persons also enrolled in Medicare), Medicare (excluding persons also enrolled Medicaid), Uninsured, and Dual (persons enrolled in both Medicare and Medicaid)]
- Gender [male, female] and age group [0-18, 19-34, 35-49, 50-64, and 65+]
- Household income FPL % [up to 138%, 139%-150%, 151%-200%, 201%-250%, 251%-300%, 301%-400%, 401%-600%, over 600%]
- Ethnicity [Hispanic/Latino, non-Hispanic Latino] and race [American Indian and Alaska Native, Asian, Black or African American, Native Hawaiian and Other Pacific Islander, White, Other]
- Geographic region [Northwestern Illinois, Cook County, Collar Counties, Central Illinois, Southern Illinois]
- Commercial rating areas [Rating Area 1 through Rating Area 13]

We mapped the counties on the 2018 ACS data to be consistent with the five geographic regions used for managed care rate development in the Illinois Medicaid program as well as the 13 rating areas utilized for Individual and Small Group markets in Illinois.

We additionally utilized logic from the Center for Migration Studies of New York (CMS NY)[17] to further stratify the 2018 ACS data by immigration status [citizen, documented immigrant, undocumented immigrant] and, for immigrants, years since entry [0-4, 5+]. Citizen versus non-citizen status is available on the 2018 American Community Survey which was used as the base data. Using CMY NY's logic, we inferred documented versus undocumented immigration status based upon occupation, student status, being an immediate relative of a citizen, receiving public benefits, and age at immigration. We utilized information from the Yearbooks of Immigration Statistics from the Department of Homeland Security[18] to estimate the total number of documented immigrants.

[16] https://www.census.gov/programs-surveys/acs

[17] https://journals.sagepub.com/doi/10.1177/233150241400200403

[18] https://www.dhs.gov/immigration-statistics/yearbook

To adjust the 2018 population for demographic changes between 2018 and 2022, we developed multiplicative adjustment factors by gender and age group, by ethnicity and race, and by geographic region. The multiplicative adjustment factors were based upon the change in these demographic characteristics as indicated by population changes between the 2014 and 2018 ACS population estimates. In other words, we assumed the period from 2018 to 2022 would see the same annualized rate of change in demographic characteristics as observed from 2014 to 2018.

3.4% UNEMPLOYMENT ECONOMIC SCENARIO

Once the demographics of the CY 2022 population were estimated, we made adjustments to the 2018 enrollment levels from the ACS data to reflect the enrollment and economic environment of January-February 2020 prior to the COVID-19 pandemic. The unemployment rate in Illinois was 3.4% at this time.[3] The primary effects of the adjustments were to:

- move enrollees from Individual to Medicaid insurance coverage
- redistribute enrollees in the Individual, Medicaid, and Dual insurance coverages by FPL level

By combining publicly available reporting of insurance market enrollment with the ACS estimates and consistent with other state analyses, we have observed that Illinois Medicaid enrollment is understated in ACS while Individual enrollment is overstated in ACS. Enrollment of children in ESI is also often overstated. We hypothesize that these discrepancies are related to members within a family being enrolled in different insurance coverage types and some misunderstanding of their coverage by participants in the ACS. We adjusted our CY 2022 population estimates to reflect available enrollment reporting for early 2020.

For the Individual market, we first estimated enrollment in the Marketplace and off-Marketplace segments. February 2020 effectuated Marketplace enrollment was reported as 273,180,[19] so we estimated 2020 Marketplace enrollment would average approximately 250,000 members based upon prior year enrollment patterns. We estimated off-Marketplace enrollment to average approximately 106,000 members during 2020, comprised of approximately 65,000 members in ACA-compliant plans and approximately 41,000 members in non-ACA compliant plans. We developed these estimates based upon 2017 through 2019 reporting of total Individual enrollment per supplemental healthcare exhibits included in insurers' NAIC annual statements and ACA-compliant enrollment per annual risk adjustment transfer reports.[20] Our estimates were consistent with values reported by insurers to the Illinois Department of Insurance.

To estimate the demographic composition of Individual enrollment, we used 2019 values reported by insurers to the Illinois Department of Insurance. For Medicaid, we used January through March 2020 enrollment reported by HFS,[21] as well as more detailed enrollment by gender, age group, and geographic region provided to us by HFS.

We adjusted the 2020 enrollment stratifications for Individual and Medicaid to CY 2022 using the same annualized demographic projection factors as noted above (changes in demographic characteristics indicated by differences in the 2014 and 2018 ACS population estimates). We combined the Individual and Medicaid adjusted CY 2022 stratified enrollment with our CY 2022 population estimates for the other insurance coverage types. We made final adjustments to the ESI enrollment such that the composite population stratification estimates across all insurance coverage types equaled the total estimated demographic-adjusted population. This resulted in a small net decrease in ESI enrollment of approximately 37,000 enrollees, comprised of a decrease of approximately 145,000 children and an increase of approximately 108,000 adults.

As a final step, we redistributed Individual, Medicaid, and Dual enrollment by FPL %. For the Individual enrollment, we used 2020 Marketplace open enrollment reporting for the Marketplace segment[22] and assumed the following distribution for off-Marketplace and non-ACA enrollment.

[19] www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Early-2020-2019-Effectuated-Enrollment-Report.pdf

[20] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs

[21] https://www.illinois.gov/hfs/info/factsfigures/Pages/DetailedManagedCareEnrollment.aspx

[22] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files

FIGURE 17: OFF-MARKETPLACE FPL DISTRIBUTION

FPL RANGE	POPULATION DISTRIBUTION
Up to 250%	0.0%
251%-300%	3.0%
301%-400%	2.0%
401%-600%	30.0%
Over 600%	65.0%

Note: Off-Marketplace includes both individual ACA and individual non-ACA enrollment.

For Medicaid adults, Medicaid children, and Duals, we used detailed enrollment information provided to us by HFS, Illinois Medicaid eligibility requirements,[23] and our actuarial judgment to estimate the distribution of enrollment by FPL %.

HIGHER UNEMPLOYMENT ECONOMIC SCENARIOS

We used Milliman's COVID-19 Advanced Population Shift Model (CAPS) to model population shifts between FPL levels and insurance coverage types based upon expected economic levels in CY 2022.

- **Employment loss.** The overall rate of employment loss is a key input into CAPS. CAPS then varies the rate of employment loss by employer size, industry, and employee income levels, with smaller employers, lower income levels, and industries such as hospitality and travel being more susceptible to job losses.
- **Income loss.** CAPS models the reduction in household income due to employment loss and other reasons, such as reduced hours or lower commissions, to estimate eligibility for Medicaid coverage and subsidies for Individual ACA coverage.
- **Insurance market transitions.** CAPS then models population transitions from primarily ESI or Individual coverages to Medicaid, Individual, or uninsured.
    - The largest amount of transitions is estimated to occur from persons losing ESI and then transitioning to the Individual or Medicaid markets, as well as potentially becoming uninsured. Additional insurance coverage transitions are estimated to occur among the pre-COVID Individual market enrollees. As a portion of these enrollees experience job loss and lose income, some will become eligible for Medicaid and leave the Individual market.
    - Take-up rates for each coverage type vary by health status, age, and pre-COVID insurance coverage. For example, among the population losing ESI coverage as a result of economic effects from COVID-19, we have assumed that persons with higher than average morbidity are more likely to enroll in Individual coverage relative to persons with lower than average morbidity.
    - Take-up rates for Individual ACA coverage also vary by income level, with households eligible for premium subsidies in the Marketplace more likely to enroll relative to households not eligible for a premium subsidy.

For the three higher unemployment scenarios included in this report we reflected assumed CY 2022 unemployment rates of approximately 5.5%, 7.1%, and 8.5% in Illinois. This range contains the Congressional Budget Office's (CBO) most recent projection of the 2022 national unemployment rate of 7.1%[24] and is intended to capture what we believe to be the most likely range of unemployment rates post-pandemic in CY 2022. Pre-COVID, Illinois' unemployment rate (3.4%) was nearly identical to the national unemployment rate (3.5%).[25]

[23] https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html

[24] https://www.cbo.gov/publication/56442

[25] https://www.bls.gov/opub/ted/2020/mobile/north-dakota-had-the-lowest-unemployment-rate-in-february-2020.htm

KEY ASSUMPTIONS

We used the following assumptions when modeling the policy options:

Second lowest cost silver plan (SLCS) premiums. We used the 2021 SLCS premiums and assumed no trend for 2022. While a CY 2022 trend of 4.7% would be consistent with the proposed 2022 BHP funding formula and CMS' March 2020 National Health Expenditure (NHE) projections, Table 17,[26] it would not account for the Marketplace landscape in Illinois, where an increase in the number of insurers has resulted in lower premiums for CY 2021. We have, therefore, selected a premium trend of 0% for CY 2022. We have additionally assumed that the rating areas and age curve used for Individual ACA market premiums in CY 2022 are the same as in CY 2021. The resulting CY 2022 SLCS premiums are illustrated in the following table. The requirement that a family does not pay more than three premiums for children ages 0 to 18 was reflected in the analysis.

FIGURE 18: CY 2022 PROJECTED SECOND LOWEST COST SILVER PLAN MONTHLY PREMIUMS, ENROLLEE AGE 21

RATING AREA	MONTHLY PREMIUM
Rating Area 1	$ 270
Rating Area 2	$ 325
Rating Area 3	$ 308
Rating Area 4	$ 311
Rating Area 5[b]	$ 419
Rating Area 6[c]	$ 457
Rating Area 7	$ 447
Rating Area 8	$ 433
Rating Area 9	$ 433
Rating Area 10	$ 438
Rating Area 11	$ 460
Rating Area 12	$ 325
Rating Area 13	$ 531

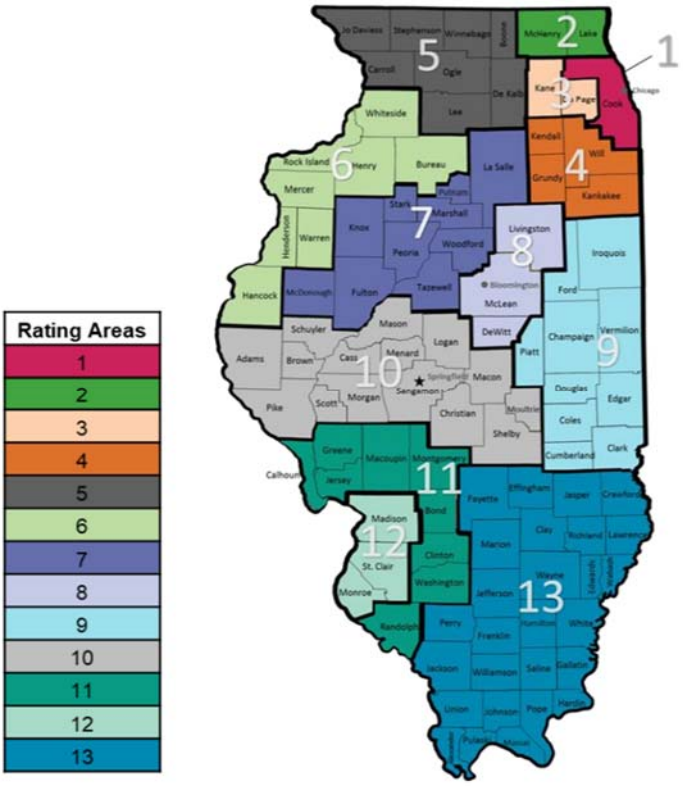
Notes:

a. Values have been rounded.
b. Projected monthly premium for DeKalb County is $501. Remaining counties in rating area 5 are as listed above.
c. Projected monthly premium for Henry, Mercer, and Rock Island Counties is $331. Remaining counties in rating area 6 are as listed above.

[26] https://www.federalregister.gov/public-inspection/2020-24147/basic-health-program-federal-funding-methodology-for-program-year-2022

The SLCS premiums correspond with the Illinois commercial rating areas, as illustrated in the map below.

FIGURE 19: ILLINOIS COMMERCIAL RATING AREAS



Federal premium tax credit (PTC) percentages. We estimated the required contribution percentages for determining federal premium tax credits for 2022 as the 2014 percentages increased by an estimated ratio of premium to income growth of approximately 1.059. This ratio is based upon the projected change from 2013 to 2021 in premium growth of approximately 44.1% and income growth of approximately 36.1% per the CMS' March 2020 National Health Expenditure (NHE) projections, Table 17 and Table 1, respectively.[27] The estimated 2022 federal PTC percentages are illustrated in the following table. The federal PTC percentages represent the maximum percentage of an enrollee's household income that they must contribute toward coverage of the SLCS plan in the Marketplace. The initial percentage applies to the low end of the corresponding FPL range while the final percentage applies to the high end of the corresponding FPL range. Linear interpolation is used to determine the applicable percentage for income levels within the FPL range. Premium tax credits were estimated at the household level and allocated to persons in a household in proportion to their SLCS premiums.

[27] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

FIGURE 20: CY 2022 PROJECTED FEDERAL PREMIUM TAX CREDIT PERCENTAGES

FPL RANGE	INITIAL PERCENTAGE	FINAL PERCENTAGE
Up to 133%	2.1%	2.1%
133% up to 150%	3.2%	4.2%
150% up to 200%	4.2%	6.7%
200% up to 250%	6.7%	8.5%
250% up to 300%	8.5%	10.1%
300% up to 400%	10.1%	10.1%
Over 400%	Not Eligible	Not Eligible

Note: The initial percentage applies to the low end of the corresponding FPL range while the final percentage applies to the high end of the corresponding FPL range. Linear interpolation is used to determine the applicable percentage for income levels within the FPL range. Note, these ranges do not reflect the 5% income disregard for Medicaid eligibility.

Federal poverty levels (FPLs). We estimated that the FPLs used for 2022 coverage determinations will be approximately 0.9% higher than those used for 2021 coverage determinations. This increase is based upon the CBO's projected change in the CPI-U from 2020 to 2021 as of July 2020.[28] CBO's July 2020 projections reflect impacts from COVID-19. The 2021 and estimated 2022 FPLs are illustrated in the following table.

FIGURE 21: PROJECTED FEDERAL POVERTY LEVELS

HOUSEHOLD SIZE	2021 COVERAGE DETERMINATIONS	ESTIMATED 2022 COVERAGE DETERMINATIONS
Single	$12,760	$12,870
Additional household member	$4,480	$4,520

Cost of Coverage. We estimated the cost of covered health care benefits in CY 2022 based upon draft CY 2021 Medicaid capitation rates[29], inclusive of pass-through and directed payments to providers, for the non-disabled children and adults and the ACA expansion populations. We increased the capitation rates by 5%. We believe that 5% is a reasonable estimate for trend and program changes from CY 2021 to CY 2022 based upon our development of the capitation rates for CY 2021 and prior years. Additional adjustments were made to reflect assumed covered benefits and provider reimbursement levels specific to each policy option. These estimates were risk-adjusted from a Medicaid basis to an Individual market basis in order to reflect the morbidity of the prospective enrolled population. 2019 HHS-HCC risk scores, Silver metal level, were used for this purpose, and the CAPS model was used to estimate the relative morbidity between the Individual, uninsured, and ESI insurance coverage types. An adjustment corresponding to the take up rate was additionally applied to the resulting cost of coverage in order to reflect the morbidity of the population which chooses to take up the policy option versus that which declines coverage. This selection adjustment reflects that persons who chose to enroll are likely to have higher morbidity than those who chose not to enroll.

Cost Sharing. We estimated cost sharing per member per month (PMPM) based upon CY 2019 Medicaid utilization for the non-disabled children and adults and the ACA expansion populations. The Medicaid utilization was used in conjunction with cost sharing plan designs which correspond to the Marketplace Silver plan offerings at the various CSR levels as well as cost sharing plan designs for the proposed policy options. The resulting PMPM values vary by age, gender, and FPL bucket, depending on the eligibility for each of the policy options. The cost of coverage and cost sharing estimates were reduced proportionately to reflect utilization dampening due to cost sharing.

[28] https://www.cbo.gov/system/files/2020-07/56442-CBO-update-economic-outlook.pdf

[29] Final CY 2021 Medicaid capitation rates are not yet available as of the time of this report but will not be materially different than the draft rates.

ESI Affordability. We estimated the percentage of families with unaffordable ESI using the 2018 Current Population Survey's Annual Social and Economic Supplements data.[30] We identified records for families (versus individuals) using the IPUMS CPS household unit definitions.[31] We then determined the proportion of families where annual health insurance premiums exceeded the 2018 ACA affordability threshold of 9.56% of annual income (excluding supplemental security payments). Note, this methodology is not consistent with the ACA definition of employer coverage affordability as it is based on the family premiums; the ACA definition of employer coverage affordability is based upon employee-only premiums. ESI affordability was only used for purposes of estimating the population in the "ACA family glitch" when modeling eligibility for the targeted Medicaid buy-in in this report. The table below illustrates the ESI affordability estimates.

FIGURE 22: ESTIMATED PERCENTAGE OF FAMILIES WITH UNAFFORDABLE ESI BY CURRENT INSURANCE COVERAGE TYPE

FPL RANGE	EMPLOYER	UNINSURED	INDIVIDUAL
Up to 138%	45.0%	22.5%	0.0%
139% - 250%	30.0%	15.0%	0.0%
250% - 400%	10.0%	5.0%	0.0%
Over 400%	4.0%	2.0%	0.0%

Note: These unaffordability percentages are only applied to those not eligible for Medicaid.

Medicaid Eligibility. Medicaid/CHIP eligibility was defined in the 2018 ACS data using the following set of criteria:

- Ages 0-18:
  - Currently enrolled in Medicaid/CHIP or as a Medicaid/Medicare dual eligible, or
  - FPL does not exceed 318%
- Ages 19+:
  - Currently enrolled in Medicaid or as a Medicaid/Medicare dual eligible, or
  - [Either a citizen or has been a documented immigrant for at least 5 years, and
  - FPL does not exceed 138%], or
  - [Pregnant woman and
  - FPL does not exceed 213%]

Marketplace reimbursement as a % of Medicare. We used group claims experience underlying the Milliman *Health Cost Guidelines* to estimate provider reimbursement as a % of Medicare. The group claims experience was repriced to Medicare reimbursement levels and trended to 2019. We aligned the resulting allowed claims per member per month (PMPM) estimates with allowed claims PMPM estimates by rating area based upon 2019 EDGE server files from individual market issuers in Illinois.

Take Up Rates. Take up rates vary by population cohort for each policy option variation and scenario. Take up rates are based upon estimated take up rates for a population with comparable choices as well as assumed premium elasticity, and to a lesser extent, cost sharing elasticity. Take up rates increase as enrollee premiums and cost sharing decrease, while take up rates decrease as enrollee premiums and cost sharing increase.

We considered the following when estimating take up rates:

[30] https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html

[31] IPUMS-CPS, University of Minnesota, www.ipums.org

- An estimated take up rate of approximately 95% for children eligible for Medicaid/CHIP in Illinois based upon the data used in this analysis.[32] There are no premiums if household income is up to approximately 155% FPL and up to $40 monthly premium per child if household income is up to 318% FPL.
- An estimated take up rate of approximately 83% for adults eligible for Medicaid in Illinois based upon the data used in this analysis.[33] Household income may be up to 138% FPL, or 213% FPL for pregnant women, and there are no premiums.
- Estimated take up rates of Individual market coverage that vary by FPL range, gender, age group, and family status in Illinois based upon the data used in this analysis. In composite across all FPL and demographic categories, the estimated take up rate for Individual market coverage is approximately 46%.
- Individual market take up rates by FPL versus maximum Marketplace premium by FPL. The take up rate for a given FPL range should be at least as high as a lower FPL range if premiums for the higher FPL range decrease to the level of the lower FPL range.

We have not reflected the potential that ESI enrollees may retire or otherwise leave employment because Marketplace or other new alternative coverage is more affordable due to a policy option. Expanding Medicaid eligibility to adults up to 138% FPL with no premiums had no discernable impact on ESI enrollment in Illinois and other states so lower Marketplace premiums are not likely to have a material impact on ESI enrollment. However, enrollment from ESI could be substantial if employers drop coverage due to a policy option.

There is a great deal of uncertainty regarding the take up rates used for the policy option variations included in this report. We recommend further sensitivity testing to develop a broad understanding of the potential range of outcomes due to differences in take up rates.

[32] The estimated take up rate is similar to that reported at https://www.kff.org/medicaid/state-indicator/medicaidchip-child-participation-rates/

[33] The estimated take up rate is similar to that reported at https://www.kff.org/medicaid/state-indicator/medicaidchip-parent-participation-rates/

Limitations and qualifications

The information contained in this report has been prepared for the State of Illinois, Department of Healthcare and Family Services (HFS) and their consultants and advisors. This report provides actuarial analyses regarding policy options under consideration in a health insurance feasibility study. It is intended to support a final public document regarding the feasibility of the policy options and should not be viewed as a stand-alone document. The information presented may not be appropriate for any other purpose.

This draft work product may not be provided to third parties without Milliman's prior written consent. Any distribution of this report should be in its entirety. Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for HFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts for advice appropriate to their own specific needs.

We have developed certain models to estimate the values included in this report. The intent of the models was to estimate enrollment and financial impacts of certain policy options under consideration in Illinois' health care affordability/accessibility feasibility study. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by HFS, individual market issuers in Illinois, and other publicly available information for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Our data and information reliance includes:

- 2018 American Community Survey extracts
- 2018 Current Population Survey extracts
- HFS Medicaid detail enrollment and claims extracts
- 2020 Affordable Care Act Health Insurance Marketplace enrollment reports
- Illinois Health Reform Issuer Inquiry Reports
- EDGE server files from individual market issuers in Illinois
- CMS' HHS-HCC Risk Adjustment Model

The models, including all input, calculations, and output may not be appropriate for any other purpose.

The Milliman CAPS model is premised on assumptions of the latest unemployment data, changes to family and individual incomes, economic recovery post-2020 and others. Knowledge of future economic impacts related to COVID-19 shut-downs and potential state and federal regulatory actions to alleviate financial distress is incomplete. New information about state and federal regulatory actions, including length of "stay-at-home" orders and non-essential business closures, unemployment benefit extensions and the creation of additional state and federal relief programs is still emerging and rapidly changing. Consequently, our model results will evolve as new information becomes available and new actions are taken by the authorities and other stakeholders. Due to constantly developing data on COVID-19 and to economic outlooks for 2020 through 2022, as well as the inherent difficulty of predicting individual and governmental actions far into the future, any analysis using the CAPS model is subject to a substantially greater than usual level of uncertainty. Note that the population model is NOT an economic forecasting model. Judgements about the economy and related unemployment are inputs to the model, not outputs.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. In particular, we note that there is substantial uncertainty regarding the impact of the COVID-19 pandemic on the population estimates included in this report due to economic, mortality, morbidity, and other influences. There is also substantial uncertainty regarding the enrollment choices that persons will make when new health insurance options are available to them.

The services provided for this project were performed under the contract between Milliman and HFS dated April 9, 2019.

QUALIFICATIONS

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

APPENDIX A

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Baseline Population - 3.4% Unemployment
Appendix A-1: Population Estimates by Age and FPL

	Individual	Employer	Medicaid	Medicare	Dual	Government	Uninsured	Total
Adult								
By FPL:								
Below 138%	18,000	448,000	1,099,000	380,000	327,000	10,000	318,000	*2,601,000*
139%-150%	32,000	62,000	9,000	56,000	7,000	1,000	28,000	*196,000*
151%-200%	61,000	294,000	39,000	233,000	30,000	9,000	123,000	*789,000*
201%-250%	41,000	383,000	< 1,000	198,000	15,000	6,000	102,000	*746,000*
251%-300%	29,000	346,000	< 1,000	153,000	< 1,000	5,000	58,000	*591,000*
301%-400%	32,000	689,000	< 1,000	246,000	< 1,000	9,000	67,000	*1,043,000*
401%-600%	42,000	1,145,000	< 1,000	328,000	< 1,000	13,000	63,000	*1,591,000*
Over 600%	56,000	1,645,000	< 1,000	354,000	< 1,000	10,000	35,000	*2,101,000*
All FPLs	***311,000***	***5,012,000***	***1,149,000***	***1,949,000***	***379,000***	***62,000***	***794,000***	***9,656,000***
Child								
By FPL:								
Below 138%	< 1,000	113,000	1,024,000	1,000	4,000	1,000	36,000	*1,179,000*
139%-150%	< 1,000	15,000	42,000	1,000	< 1,000	< 1,000	3,000	*60,000*
151%-200%	< 1,000	100,000	173,000	2,000	< 1,000	2,000	13,000	*290,000*
201%-250%	< 1,000	114,000	28,000	1,000	< 1,000	4,000	9,000	*156,000*
251%-300%	< 1,000	129,000	13,000	< 1,000	< 1,000	2,000	9,000	*152,000*
301%-400%	9,000	228,000	15,000	1,000	< 1,000	3,000	9,000	*265,000*
401%-600%	13,000	344,000	< 1,000	1,000	< 1,000	4,000	10,000	*371,000*
Over 600%	16,000	416,000	< 1,000	1,000	< 1,000	2,000	6,000	*440,000*
All FPLs	***38,000***	***1,458,000***	***1,294,000***	***6,000***	***4,000***	***18,000***	***95,000***	***2,913,000***
All Ages								
By FPL:								
Below 138%	18,000	561,000	2,124,000	381,000	330,000	11,000	354,000	*3,779,000*
139%-150%	32,000	77,000	51,000	57,000	7,000	1,000	30,000	*256,000*
151%-200%	61,000	393,000	212,000	235,000	30,000	11,000	136,000	*1,079,000*
201%-250%	41,000	497,000	28,000	199,000	15,000	10,000	112,000	*901,000*
251%-300%	29,000	474,000	13,000	153,000	< 1,000	7,000	67,000	*743,000*
301%-400%	41,000	917,000	15,000	246,000	< 1,000	12,000	76,000	*1,307,000*
401%-600%	55,000	1,489,000	< 1,000	329,000	< 1,000	16,000	73,000	*1,962,000*
Over 600%	72,000	2,061,000	< 1,000	355,000	< 1,000	12,000	41,000	*2,541,000*
All FPLs	***349,000***	***6,470,000***	***2,443,000***	***1,955,000***	***383,000***	***80,000***	***889,000***	***12,569,000***

Note: Values have been rounded.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Baseline Population - 7.1% Unemployment
Appendix A-1: Population Estimates by Age and FPL

	Individual	Employer	Medicaid	Medicare	Dual	Government	Uninsured	Total
Adult								
By FPL:								
Below 138%	18,000	488,000	1,179,000	432,000	332,000	13,000	350,000	*2,812,000*
139%-150%	34,000	63,000	8,000	56,000	6,000	1,000	28,000	*196,000*
151%-200%	66,000	300,000	32,000	231,000	27,000	9,000	124,000	*788,000*
201%-250%	43,000	411,000	< 1,000	206,000	13,000	6,000	98,000	*776,000*
251%-300%	29,000	332,000	< 1,000	144,000	< 1,000	4,000	55,000	*564,000*
301%-400%	32,000	665,000	< 1,000	232,000	< 1,000	8,000	63,000	*1,001,000*
401%-600%	41,000	1,080,000	< 1,000	311,000	< 1,000	12,000	66,000	*1,511,000*
Over 600%	55,000	1,568,000	< 1,000	337,000	< 1,000	10,000	37,000	*2,006,000*
All FPLs	***317,000***	***4,908,000***	***1,220,000***	***1,949,000***	***379,000***	***62,000***	***820,000***	***9,654,000***
Child								
By FPL:								
Below 138%	< 1,000	130,000	1,064,000	1,000	4,000	2,000	41,000	*1,242,000*
139%-150%	< 1,000	16,000	36,000	1,000	< 1,000	< 1,000	3,000	*56,000*
151%-200%	< 1,000	104,000	151,000	1,000	< 1,000	3,000	13,000	*273,000*
201%-250%	< 1,000	128,000	27,000	1,000	< 1,000	4,000	10,000	*169,000*
251%-300%	< 1,000	122,000	11,000	< 1,000	< 1,000	2,000	9,000	*144,000*
301%-400%	10,000	218,000	14,000	1,000	< 1,000	3,000	9,000	*254,000*
401%-600%	13,000	326,000	< 1,000	1,000	< 1,000	4,000	12,000	*354,000*
Over 600%	16,000	396,000	< 1,000	< 1,000	< 1,000	2,000	8,000	*422,000*
All FPLs	***38,000***	***1,439,000***	***1,304,000***	***6,000***	***4,000***	***18,000***	***105,000***	***2,915,000***
All Ages								
By FPL:								
Below 138%	18,000	618,000	2,243,000	434,000	336,000	14,000	391,000	*4,054,000*
139%-150%	34,000	79,000	44,000	57,000	6,000	1,000	31,000	*252,000*
151%-200%	66,000	405,000	184,000	232,000	27,000	11,000	138,000	*1,061,000*
201%-250%	43,000	538,000	27,000	206,000	13,000	10,000	107,000	*945,000*
251%-300%	29,000	453,000	12,000	144,000	< 1,000	6,000	64,000	*709,000*
301%-400%	42,000	883,000	14,000	233,000	< 1,000	11,000	73,000	*1,255,000*
401%-600%	53,000	1,406,000	< 1,000	312,000	< 1,000	16,000	78,000	*1,865,000*
Over 600%	71,000	1,965,000	< 1,000	338,000	< 1,000	12,000	44,000	*2,429,000*
All FPLs	***355,000***	***6,347,000***	***2,524,000***	***1,955,000***	***383,000***	***80,000***	***925,000***	***12,569,000***

Note: Values have been rounded.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Baseline Population
Appendix A-2: Population Estimates by Geographic Region

3.4% Unemployment

Region	Individual	Employer	Medicaid	Medicare	Dual	Government	Uninsured	Total
Region 1 - Northwestern Illinois	45,000	739,000	322,000	287,000	45,000	8,000	83,000	*1,529,000*
Region 2 - Central Illinois	34,000	635,000	271,000	230,000	41,000	6,000	72,000	*1,290,000*
Region 3 - Southern Illinois	27,000	565,000	266,000	227,000	52,000	26,000	75,000	*1,238,000*
Region 4 - Cook County	145,000	2,445,000	1,152,000	697,000	187,000	13,000	459,000	*5,097,000*
Region 5 - Collar Counties	98,000	2,093,000	431,000	506,000	60,000	27,000	200,000	*3,415,000*
Statewide	***349,000***	***6,477,000***	***2,443,000***	***1,947,000***	***384,000***	***80,000***	***889,000***	***12,569,000***

7.1% Unemployment

Region	Individual	Employer	Medicaid	Medicare	Dual	Government	Uninsured	Total
Region 1 - Northwestern Illinois	46,000	722,000	334,000	287,000	45,000	8,000	87,000	*1,529,000*
Region 2 - Central Illinois	34,000	622,000	280,000	231,000	41,000	6,000	75,000	*1,290,000*
Region 3 - Southern Illinois	27,000	551,000	276,000	228,000	52,000	26,000	78,000	*1,238,000*
Region 4 - Cook County	147,000	2,389,000	1,186,000	701,000	185,000	13,000	475,000	*5,097,000*
Region 5 - Collar Counties	101,000	2,062,000	447,000	508,000	60,000	28,000	209,000	*3,415,000*
Statewide	***355,000***	***6,347,000***	***2,524,000***	***1,955,000***	***383,000***	***80,000***	***925,000***	***12,569,000***

Note: Values have been rounded.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Baseline Population
Appendix A-3: Population Estimates by Ethnicity and Race

3.4% Unemployment

Ethnicity	Individual	Employer	Medicaid	Medicare	Dual	Government	Uninsured	Total
Non-Hispanic/Latino	***33,000***	***920,000***	***724,000***	***124,000***	***54,000***	***8,000***	***340,000***	***2,203,000***
American Indian and Alaska Native	< 1,000	7,000	4,000	1,000	1,000	< 1,000	1,000	*15,000*
Asian	< 1,000	4,000	1,000	1,000	< 1,000	< 1,000	< 1,000	*7,000*
Black or African American	1,000	11,000	16,000	< 1,000	1,000	< 1,000	3,000	*33,000*
Native Hawaiian and Other Pacific Islander	< 1,000	2,000	2,000	< 1,000	< 1,000	< 1,000	1,000	*5,000*
White	21,000	628,000	448,000	92,000	34,000	6,000	210,000	*1,440,000*
Other	11,000	267,000	252,000	30,000	18,000	1,000	124,000	*703,000*
Hispanic/Latino	***316,000***	***5,558,000***	***1,719,000***	***1,822,000***	***330,000***	***73,000***	***549,000***	***10,366,000***
American Indian and Alaska Native	< 1,000	6,000	6,000	2,000	1,000	< 1,000	1,000	*17,000*
Asian	52,000	468,000	88,000	75,000	26,000	3,000	51,000	*764,000*
Black or African American	23,000	561,000	711,000	205,000	93,000	13,000	147,000	*1,753,000*
Native Hawaiian and Other Pacific Islander	< 1,000	4,000	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	*5,000*
White	231,000	4,352,000	806,000	1,522,000	201,000	52,000	330,000	*7,493,000*
Other	10,000	166,000	108,000	18,000	9,000	5,000	20,000	*334,000*
All Ethnicities and Races	***349,000***	***6,477,000***	***2,443,000***	***1,947,000***	***384,000***	***80,000***	***889,000***	***12,569,000***

7.1% Unemployment

Ethnicity	Individual	Employer	Medicaid	Medicare	Dual	Government	Uninsured	Total
Hispanic/Latino	33,000	902,000	733,000	125,000	53,000	8,000	348,000	*2,203,000*
American Indian and Alaska Native	< 1,000	7,000	4,000	1,000	1,000	< 1,000	1,000	*15,000*
Asian	< 1,000	4,000	1,000	1,000	< 1,000	< 1,000	< 1,000	*7,000*
Black or African American	1,000	11,000	16,000	< 1,000	1,000	< 1,000	4,000	*33,000*
Native Hawaiian and Other Pacific Islander	< 1,000	2,000	2,000	< 1,000	< 1,000	< 1,000	1,000	*5,000*
White	21,000	615,000	455,000	93,000	34,000	6,000	216,000	*1,440,000*
Other	11,000	263,000	254,000	30,000	18,000	2,000	126,000	*703,000*
Not Hispanic/Latino	322,000	5,444,000	1,791,000	1,830,000	329,000	73,000	577,000	*10,366,000*
American Indian and Alaska Native	< 1,000	6,000	6,000	2,000	1,000	< 1,000	1,000	*17,000*
Asian	53,000	459,000	93,000	76,000	26,000	3,000	54,000	*764,000*
Black or African American	22,000	542,000	727,000	207,000	91,000	13,000	150,000	*1,753,000*
Native Hawaiian and Other Pacific Islander	< 1,000	4,000	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	*5,000*
White	237,000	4,271,000	855,000	1,527,000	202,000	52,000	350,000	*7,493,000*
Other	10,000	162,000	110,000	18,000	8,000	4,000	21,000	*334,000*
All Ethnicities and Races	***355,000***	***6,347,000***	***2,524,000***	***1,955,000***	***383,000***	***80,000***	***925,000***	***12,569,000***

Note: Values have been rounded.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Baseline Population - 3.4% Unemployment
Appendix A-4a: Individual and Uninsured Population Estimates by Immigration Status, Age, and FPL

	Individual					Uninsured				
	Total	Citizens	Documented Immigrants (< 5 Years)	Documented Immigrants (5+ Years)	Undocumented Immigrants	Total	Citizens	Documented Immigrants (< 5 Years)	Documented Immigrants (5+ Years)	Undocumented Immigrants
Adult										
By FPL:										
Below 138%	18,000	< 1,000	18,000	< 1,000	< 1,000	318,000	181,000	11,000	52,000	*74,000*
139%-150%	32,000	24,000	2,000	6,000	< 1,000	28,000	15,000	1,000	5,000	*7,000*
151%-200%	61,000	44,000	3,000	14,000	< 1,000	123,000	62,000	3,000	26,000	*32,000*
201%-250%	41,000	31,000	2,000	9,000	< 1,000	102,000	60,000	4,000	17,000	*22,000*
251%-300%	29,000	20,000	1,000	5,000	3,000	58,000	30,000	2,000	11,000	*16,000*
301%-400%	32,000	25,000	1,000	4,000	2,000	67,000	41,000	2,000	10,000	*13,000*
401%-600%	42,000	31,000	1,000	7,000	3,000	63,000	40,000	4,000	11,000	*9,000*
Over 600%	56,000	45,000	1,000	8,000	2,000	35,000	22,000	2,000	5,000	*5,000*
All FPLs	***311,000***	***221,000***	***28,000***	***53,000***	***9,000***	***794,000***	***450,000***	***29,000***	***136,000***	***178,000***
Child										
By FPL:										
Below 138%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	36,000	32,000	2,000	1,000	*1,000*
139%-150%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	3,000	2,000	< 1,000	< 1,000	*< 1,000*
151%-200%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	13,000	11,000	1,000	1,000	*< 1,000*
201%-250%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	9,000	9,000	< 1,000	< 1,000	*< 1,000*
251%-300%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	9,000	8,000	1,000	< 1,000	*< 1,000*
301%-400%	9,000	9,000	< 1,000	< 1,000	< 1,000	9,000	9,000	< 1,000	< 1,000	*< 1,000*
401%-600%	13,000	12,000	< 1,000	1,000	< 1,000	10,000	9,000	1,000	< 1,000	*< 1,000*
Over 600%	16,000	15,000	< 1,000	< 1,000	< 1,000	6,000	6,000	< 1,000	< 1,000	*< 1,000*
All FPLs	***38,000***	***36,000***	***1,000***	***1,000***	***< 1,000***	***95,000***	***86,000***	***5,000***	***2,000***	***2,000***
All Ages										
By FPL:										
Below 138%	18,000	< 1,000	18,000	< 1,000	< 1,000	354,000	213,000	13,000	53,000	*75,000*
139%-150%	32,000	24,000	2,000	6,000	< 1,000	30,000	17,000	1,000	5,000	*8,000*
151%-200%	61,000	44,000	3,000	14,000	< 1,000	136,000	73,000	4,000	26,000	*33,000*
201%-250%	41,000	31,000	2,000	9,000	< 1,000	112,000	69,000	4,000	17,000	*22,000*
251%-300%	29,000	20,000	1,000	5,000	3,000	67,000	37,000	3,000	11,000	*16,000*
301%-400%	41,000	34,000	1,000	5,000	2,000	76,000	50,000	2,000	10,000	*13,000*
401%-600%	55,000	44,000	1,000	7,000	3,000	73,000	49,000	5,000	11,000	*9,000*
Over 600%	72,000	60,000	1,000	8,000	2,000	41,000	28,000	2,000	6,000	*5,000*
All FPLs	***349,000***	***256,000***	***29,000***	***54,000***	***9,000***	***889,000***	***536,000***	***34,000***	***139,000***	***180,000***

Note: Values have been rounded.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Baseline Population - 7.1% Unemployment
Appendix A-4b: Individual and Uninsured Population Estimates by Immigration Status, Age, and FPL

	Individual					Uninsured				
	Total	Citizens	Documented Immigrants (< 5 Years)	Documented Immigrants (5+ Years)	Undocumented Immigrants	Total	Citizens	Documented Immigrants (< 5 Years)	Documented Immigrants (5+ Years)	Undocumented Immigrants
Adult										
By FPL:										
Below 138%	18,000	< 1,000	18,000	< 1,000	< 1,000	350,000	200,000	12,000	57,000	*80,000*
139%-150%	34,000	26,000	2,000	7,000	< 1,000	28,000	15,000	1,000	5,000	*7,000*
151%-200%	66,000	47,000	3,000	15,000	< 1,000	124,000	63,000	3,000	26,000	*32,000*
201%-250%	43,000	32,000	2,000	9,000	< 1,000	98,000	58,000	4,000	16,000	*20,000*
251%-300%	29,000	20,000	1,000	5,000	3,000	55,000	28,000	2,000	10,000	*15,000*
301%-400%	32,000	25,000	1,000	4,000	2,000	63,000	39,000	2,000	10,000	*13,000*
401%-600%	41,000	31,000	1,000	6,000	3,000	66,000	42,000	4,000	11,000	*9,000*
Over 600%	55,000	45,000	1,000	8,000	2,000	37,000	23,000	2,000	6,000	*5,000*
All FPLs	***317,000***	***225,000***	***28,000***	***54,000***	***9,000***	***820,000***	***468,000***	***30,000***	***141,000***	***182,000***
Child										
By FPL:										
Below 138%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	41,000	37,000	2,000	1,000	*1,000*
139%-150%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	3,000	2,000	< 1,000	< 1,000	*< 1,000*
151%-200%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	13,000	12,000	1,000	1,000	*< 1,000*
201%-250%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	10,000	9,000	< 1,000	< 1,000	*< 1,000*
251%-300%	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	9,000	8,000	1,000	< 1,000	*< 1,000*
301%-400%	10,000	9,000	< 1,000	< 1,000	< 1,000	9,000	9,000	< 1,000	< 1,000	*< 1,000*
401%-600%	13,000	12,000	< 1,000	1,000	< 1,000	12,000	10,000	1,000	< 1,000	*< 1,000*
Over 600%	16,000	15,000	< 1,000	< 1,000	< 1,000	8,000	7,000	< 1,000	< 1,000	*< 1,000*
All FPLs	***38,000***	***36,000***	***1,000***	***1,000***	***< 1,000***	***105,000***	***95,000***	***5,000***	***3,000***	***2,000***
All Ages										
By FPL:										
Below 138%	18,000	< 1,000	18,000	< 1,000	< 1,000	391,000	237,000	14,000	59,000	*81,000*
139%-150%	34,000	26,000	2,000	7,000	< 1,000	31,000	17,000	1,000	5,000	*8,000*
151%-200%	66,000	47,000	3,000	15,000	< 1,000	138,000	75,000	4,000	27,000	*33,000*
201%-250%	43,000	32,000	2,000	9,000	< 1,000	107,000	67,000	4,000	16,000	*20,000*
251%-300%	29,000	20,000	1,000	5,000	3,000	64,000	36,000	3,000	10,000	*15,000*
301%-400%	42,000	35,000	1,000	4,000	2,000	73,000	48,000	2,000	10,000	*13,000*
401%-600%	53,000	43,000	1,000	7,000	3,000	78,000	52,000	5,000	11,000	*9,000*
Over 600%	71,000	59,000	1,000	8,000	2,000	44,000	31,000	2,000	6,000	*5,000*
All FPLs	***355,000***	***261,000***	***29,000***	***55,000***	***9,000***	***925,000***	***562,000***	***35,000***	***143,000***	***184,000***

Note: Values have been rounded.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Baseline Population
Appendix A-5: Demographic Composition of Uninsured Population

	3.4% Unemployment				7.1% Unemployment			
Demographic	**Eligible for Medicaid**	**Not Eligible for Medicaid but Eligible for Marketplace Subsidies**	**Not Eligible for Medicaid and Not Eligible for Marketplace Subsidies**	**Total Uninsured**	**Eligible for Medicaid**	**Not Eligible for Medicaid but Eligible for Marketplace Subsidies**	**Not Eligible for Medicaid and Not Eligible for Marketplace Subsidies**	**Total Uninsured**
Up to 200% FPL	277,000	119,000	112,000	508,000	307,000	121,000	118,000	546,000
201%-400% FPL	19,000	182,000	51,000	252,000	20,000	174,000	48,000	242,000
Over 400% FPL	-	-	111,000	111,000	-	-	119,000	119,000
Adult	225,000	293,000	258,000	776,000	249,000	287,000	265,000	802,000
Child	71,000	8,000	16,000	95,000	77,000	8,000	19,000	105,000
Not Hispanic/Latino								
American Indian and Alaska Native	<1,000	<1,000	<1,000	<1,000	<1,000	<1,000	<1,000	<1,000
Asian	15,000	17,000	16,000	48,000	17,000	17,000	17,000	51,000
Black or African American	74,000	56,000	15,000	145,000	79,000	53,000	15,000	148,000
Native Hawaiian and Other Pacific Islander	<1,000	<1,000	-	<1,000	<1,000	<1,000	-	<1,000
White	108,000	130,000	84,000	322,000	122,000	129,000	90,000	342,000
Other	9,000	6,000	6,000	20,000	10,000	6,000	6,000	21,000
Hispanic/Latino								
American Indian and Alaska Native	<1,000	<1,000	<1,000	1,000	<1,000	<1,000	<1,000	1,000
Asian	<1,000	-	-	<1,000	<1,000	-	-	<1,000
Black or African American	2,000	1,000	<1,000	3,000	2,000	<1,000	<1,000	4,000
Native Hawaiian and Other Pacific Islander	<1,000	-	1,000	1,000	<1,000	-	1,000	1,000
White	61,000	57,000	90,000	208,000	67,000	55,000	92,000	214,000
Other	26,000	34,000	61,000	121,000	28,000	33,000	62,000	123,000
Citizen	241,000	213,000	76,000	530,000	265,000	208,000	82,000	556,000
Documented Immigrant (< 5 Years)	4,000	22,000	5,000	30,000	4,000	22,000	5,000	31,000
Documented Immigrant (5+ Years)	50,000	66,000	16,000	132,000	55,000	65,000	17,000	137,000
Undocumented Immigrant	2,000	-	177,000	178,000	2,000	-	181,000	182,000
Rating Area 1	143,000	155,000	151,000	449,000	157,000	152,000	155,000	465,000
Rating Area 2	14,000	19,000	23,000	57,000	15,000	19,000	24,000	59,000
Rating Area 3	26,000	23,000	44,000	93,000	29,000	23,000	46,000	98,000
Rating Area 4	14,000	17,000	16,000	47,000	15,000	17,000	17,000	49,000
Rating Area 5	14,000	17,000	8,000	38,000	15,000	16,000	8,000	39,000
Rating Area 6	6,000	6,000	3,000	16,000	7,000	6,000	3,000	16,000
Rating Area 7	14,000	9,000	5,000	28,000	16,000	9,000	5,000	29,000
Rating Area 8	4,000	3,000	1,000	7,000	4,000	3,000	1,000	8,000
Rating Area 9	11,000	10,000	5,000	26,000	12,000	10,000	5,000	27,000
Rating Area 10	14,000	10,000	6,000	31,000	16,000	10,000	7,000	33,000
Rating Area 11	8,000	5,000	2,000	14,000	9,000	5,000	2,000	15,000
Rating Area 12	14,000	13,000	5,000	31,000	15,000	12,000	6,000	33,000
Rating Area 13	15,000	15,000	5,000	34,000	16,000	14,000	5,000	36,000

Note: Values have been rounded.

APPENDIX B

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-1: Summary of Results by Income Level

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Basic Health Program							
Minnesota Model							
Up to 200% FPL	216,000	135,000	23,000	132,000	74,000	(4.1%)	12.3%
201%-400% FPL	-	-	-	-	-	0.0%	10.4%
Over 400% FPL	-	-	-	-	-	0.0%	3.3%
New York Model							
Up to 200% FPL	216,000	139,000	27,000	136,000	139,000	(5.0%)	12.3%
201%-400% FPL	-	-	-	-	-	0.0%	10.4%
Over 400% FPL	-	-	-	-	-	0.0%	3.3%
Zero Premium Model							
Up to 200% FPL	216,000	188,000	72,000	187,000	188,000	(13.2%)	12.3%
201%-400% FPL	-	-	-	-	-	0.0%	10.4%
Over 400% FPL	-	-	-	-	-	0.0%	3.3%
State-Funded PTC/CSR							
Massachusetts							
Up to 200% FPL	216,000	147,000	32,000	146,000	147,000	(5.8%)	12.3%
201%-400% FPL	275,000	130,000	22,000	90,000	90,000	(9.3%)	10.4%
Over 400% FPL	221,000	91,000	1,000	91,000	-	(1.0%)	3.3%
No FPL Limit for PTCs							
Up to 200% FPL	216,000	116,000	-	-	-	0.0%	12.3%
201%-400% FPL	275,000	107,000	< 1,000	6,000	-	(0.0%)	10.4%
Over 400% FPL	221,000	101,000	9,000	101,000	-	(7.5%)	3.3%
California							
Up to 200% FPL	216,000	122,000	6,000	24,000	-	(1.2%)	12.3%
201%-400% FPL	275,000	112,000	5,000	112,000	-	(1.9%)	10.4%
Over 400% FPL	221,000	94,000	4,000	94,000	-	(3.4%)	3.3%
HEC Proposals							
Up to 200% FPL	216,000	169,000	53,000	169,000	101,000	(9.7%)	12.3%
201%-400% FPL	275,000	147,000	40,000	147,000	147,000	(16.6%)	10.4%
Over 400% FPL	221,000	107,000	13,000	107,000	-	(11.4%)	3.3%
Marketplace Public Option							
10% Premium Reduction							
Up to 200% FPL	216,000	115,000	-	-	-	0.0%	12.3%
201%-400% FPL	275,000	107,000	< 1,000	9,000	-	(0.2%)	10.4%
Over 400% FPL	221,000	97,000	6,000	97,000	-	(4.7%)	3.3%
20% Premium Reduction							
Up to 200% FPL	216,000	115,000	-	-	-	0.0%	12.3%
201%-400% FPL	275,000	108,000	1,000	11,000	-	(0.6%)	10.4%
Over 400% FPL	221,000	105,000	11,000	105,000	-	(9.4%)	3.3%
30% Premium Reduction							
Up to 200% FPL	216,000	115,000	-	< 1,000	-	0.0%	12.3%
201%-400% FPL	275,000	110,000	3,000	22,000	-	(1.2%)	10.4%
Over 400% FPL	221,000	114,000	17,000	114,000	-	(14.7%)	3.3%
Medicaid Buy-In							
Targeted							
Up to 200% FPL	254,000	88,000	43,000	-	-	(7.9%)	12.3%
201%-400% FPL	281,000	39,000	16,000	-	-	(6.8%)	10.4%
Over 400% FPL	-	-	-	-	-	0.0%	3.3%
Broad - Basic							
Up to 200% FPL	768,000	149,000	40,000	< 1,000	-	(7.3%)	12.3%
201%-400% FPL	1,902,000	115,000	15,000	17,000	-	(6.3%)	10.4%
Over 400% FPL	3,565,000	166,000	17,000	166,000	-	(14.6%)	3.3%
Broad - Enhanced							
Up to 200% FPL	768,000	372,000	89,000	368,000	372,000	(16.3%)	12.3%
201%-400% FPL	1,902,000	255,000	38,000	220,000	255,000	(15.8%)	10.4%
Over 400% FPL	3,565,000	175,000	18,000	175,000	175,000	(15.5%)	3.3%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-2: Summary of Results by Age

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Basic Health Program							
Minnesota Model							
Adult	216,000	135,000	23,000	132,000	74,000	(2.8%)	10.7%
Child	-	-	-	-	-	0.0%	3.6%
New York Model							
Adult	216,000	139,000	27,000	136,000	139,000	(3.4%)	10.7%
Child	-	-	-	-	-	0.0%	3.6%
Zero Premium Model							
Adult	216,000	188,000	72,000	187,000	188,000	(9.0%)	10.7%
Child	-	-	-	-	-	0.0%	3.6%
State-Funded PTC/CSR							
Massachusetts							
Adult	647,000	336,000	55,000	305,000	238,000	(6.9%)	10.7%
Child	65,000	31,000	< 1,000	22,000	-	(0.2%)	3.6%
No FPL Limit for PTCs							
Adult	647,000	291,000	8,000	83,000	-	(1.0%)	10.7%
Child	65,000	33,000	1,000	23,000	-	(1.1%)	3.6%
California							
Adult	647,000	297,000	14,000	198,000	-	(1.8%)	10.7%
Child	65,000	32,000	< 1,000	32,000	-	(0.7%)	3.6%
HEC Proposals							
Adult	647,000	388,000	103,000	388,000	237,000	(12.8%)	10.7%
Child	65,000	36,000	4,000	36,000	11,000	(3.5%)	3.6%
Marketplace Public Option							
10% Premium Reduction							
Adult	647,000	286,000	5,000	82,000	-	(0.6%)	10.7%
Child	65,000	33,000	1,000	24,000	-	(1.2%)	3.6%
20% Premium Reduction							
Adult	647,000	293,000	10,000	90,000	-	(1.3%)	10.7%
Child	65,000	35,000	3,000	26,000	-	(2.4%)	3.6%
30% Premium Reduction							
Adult	647,000	302,000	16,000	106,000	-	(2.0%)	10.7%
Child	65,000	37,000	4,000	31,000	-	(3.9%)	3.6%
Medicaid Buy-In							
Targeted							
Adult	515,000	127,000	59,000	-	-	(7.4%)	10.7%
Child	20,000	< 1,000	< 1,000	-	-	(0.3%)	3.6%
Broad - Basic							
Adult	5,269,000	388,000	69,000	147,000	-	(8.6%)	10.7%
Child	966,000	43,000	3,000	36,000	-	(2.9%)	3.6%
Broad - Enhanced							
Adult	5,269,000	754,000	142,000	722,000	754,000	(17.7%)	10.7%
Child	966,000	48,000	3,000	40,000	48,000	(3.3%)	3.6%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-3: Summary of Results by Ethnicity and Race

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Basic Health Program							
Minnesota Model							
Non-Hispanic/Latino	***172,000***	***116,000***	***16,000***	***114,000***	***63,000***	***(2.8%)***	***6.8%***
American Indian and Alaska Native	-	-	-	-	-	0.0%	6.1%
Asian	34,000	28,000	2,000	27,000	11,000	(3.9%)	7.8%
Black or African American	27,000	12,000	4,000	12,000	8,000	(2.4%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	-	-	-	-	0.0%	6.8%
White	104,000	71,000	10,000	70,000	43,000	(2.8%)	5.8%
Other	7,000	5,000	< 1,000	5,000	2,000	(2.3%)	6.7%
Hispanic/Latino	***44,000***	***19,000***	***7,000***	***18,000***	***11,000***	***(2.1%)***	***16.8%***
American Indian and Alaska Native	-	-	-	-	-	0.0%	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	(0.9%)	11.0%
Native Hawaiian and Other Pacific Islande	-	-	-	-	-	0.0%	22.8%
White	26,000	11,000	4,000	11,000	6,000	(2.1%)	16.1%
Other	18,000	7,000	3,000	7,000	5,000	(2.2%)	18.7%
New York Model							
Non-Hispanic/Latino	***172,000***	***119,000***	***18,000***	***116,000***	***119,000***	***(3.3%)***	***6.8%***
American Indian and Alaska Native	-	-	-	-	-	0.0%	6.1%
Asian	34,000	28,000	2,000	27,000	28,000	(4.7%)	7.8%
Black or African American	27,000	13,000	4,000	12,000	13,000	(2.8%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	-	-	-	-	0.0%	6.8%
White	104,000	73,000	11,000	71,000	73,000	(3.3%)	5.8%
Other	7,000	5,000	< 1,000	5,000	5,000	(2.7%)	6.7%
Hispanic/Latino	***44,000***	***20,000***	***9,000***	***19,000***	***20,000***	***(2.5%)***	***16.8%***
American Indian and Alaska Native	-	-	-	-	-	0.0%	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	(0.9%)	11.0%
Native Hawaiian and Other Pacific Islande	-	-	-	-	-	0.0%	22.8%
White	26,000	12,000	5,000	11,000	12,000	(2.5%)	16.1%
Other	18,000	8,000	3,000	8,000	8,000	(2.7%)	18.7%
Zero Premium Model							
Non-Hispanic/Latino	***172,000***	***153,000***	***49,000***	***153,000***	***153,000***	***(8.7%)***	***6.8%***
American Indian and Alaska Native	-	-	-	-	-	0.0%	6.1%
Asian	34,000	32,000	5,000	32,000	32,000	(10.7%)	7.8%
Black or African American	27,000	21,000	12,000	21,000	21,000	(8.2%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	(17.0%)	6.8%
White	104,000	93,000	30,000	93,000	93,000	(8.7%)	5.8%
Other	7,000	6,000	1,000	6,000	6,000	(6.5%)	6.7%
Hispanic/Latino	***44,000***	***35,000***	***23,000***	***35,000***	***35,000***	***(6.7%)***	***16.8%***
American Indian and Alaska Native	-	-	-	-	-	0.0%	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	(0.9%)	11.0%
Native Hawaiian and Other Pacific Islande	-	-	-	-	-	0.0%	22.8%
White	26,000	21,000	14,000	21,000	21,000	(6.4%)	16.1%
Other	18,000	14,000	9,000	14,000	14,000	(7.6%)	18.7%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-3: Summary of Results by Ethnicity and Race

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
State-Funded PTC/CSR							
Massachusetts							
Non-Hispanic/Latino	***587,000***	***323,000***	***39,000***	***287,000***	***202,000***	***(6.9%)***	***6.8%***
American Indian and Alaska Native	< 1,000	< 1,000	< 1,000	< 1,000	-	(0.3%)	6.1%
Asian	70,000	48,000	4,000	45,000	37,000	(7.5%)	7.8%
Black or African American	82,000	30,000	10,000	28,000	24,000	(6.4%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	(1.0%)	6.8%
White	416,000	234,000	25,000	205,000	134,000	(7.2%)	5.8%
Other	17,000	10,000	< 1,000	9,000	7,000	(4.8%)	6.7%
Hispanic/Latino	***125,000***	***45,000***	***16,000***	***40,000***	***36,000***	***(4.7%)***	***16.8%***
American Indian and Alaska Native	1,000	< 1,000	< 1,000	< 1,000	< 1,000	(11.0%)	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	2,000	< 1,000	< 1,000	< 1,000	< 1,000	(5.7%)	11.0%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	-	(0.2%)	22.8%
White	80,000	28,000	10,000	25,000	21,000	(4.7%)	16.1%
Other	43,000	15,000	6,000	14,000	14,000	(4.8%)	18.7%
No FPL Limit for PTCs							
Non-Hispanic/Latino	***587,000***	***294,000***	***8,000***	***100,000***	***-***	***(1.4%)***	***6.8%***
American Indian and Alaska Native	< 1,000	< 1,000	< 1,000	< 1,000	-	(0.1%)	6.1%
Asian	70,000	45,000	< 1,000	10,000	-	(1.0%)	7.8%
Black or African American	82,000	22,000	< 1,000	5,000	-	(0.5%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	-	< 1,000	-	0.0%	6.8%
White	416,000	218,000	7,000	82,000	-	(2.0%)	5.8%
Other	17,000	9,000	< 1,000	2,000	-	(0.8%)	6.7%
Hispanic/Latino	***125,000***	***30,000***	***< 1,000***	***7,000***	***-***	***(0.2%)***	***16.8%***
American Indian and Alaska Native	1,000	< 1,000	< 1,000	< 1,000	-	(0.0%)	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	2,000	< 1,000	< 1,000	< 1,000	-	(0.0%)	11.0%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	-	(0.1%)	22.8%
White	80,000	19,000	< 1,000	6,000	-	(0.3%)	16.1%
Other	43,000	10,000	< 1,000	1,000	-	(0.2%)	18.7%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-3: Summary of Results by Ethnicity and Race

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
State-Funded PTC/CSR (cont.)							
California							
Non-Hispanic/Latino	***587,000***	***296,000***	***11,000***	***208,000***	***-***	***(1.9%)***	***6.8%***
American Indian and Alaska Native	< 1,000	< 1,000	< 1,000	< 1,000	-	(0.6%)	6.1%
Asian	70,000	46,000	2,000	33,000	-	(3.3%)	7.8%
Black or African American	82,000	23,000	2,000	15,000	-	(1.4%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	-	< 1,000	-	0.0%	6.8%
White	416,000	217,000	7,000	156,000	-	(2.0%)	5.8%
Other	17,000	9,000	< 1,000	5,000	-	(1.2%)	6.7%
Hispanic/Latino	***125,000***	***33,000***	***4,000***	***22,000***	***-***	***(1.2%)***	***16.8%***
American Indian and Alaska Native	1,000	< 1,000	< 1,000	< 1,000	-	(1.5%)	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	2,000	< 1,000	< 1,000	< 1,000	-	(1.7%)	11.0%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	-	(0.1%)	22.8%
White	80,000	21,000	3,000	15,000	-	(1.3%)	16.1%
Other	43,000	11,000	1,000	6,000	-	(1.2%)	18.7%
HEC Proposals							
Non-Hispanic/Latino	***587,000***	***365,000***	***77,000***	***365,000***	***207,000***	***(13.7%)***	***6.8%***
American Indian and Alaska Native	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	(2.6%)	6.1%
Asian	70,000	52,000	7,000	52,000	24,000	(12.9%)	7.8%
Black or African American	82,000	39,000	18,000	39,000	28,000	(12.0%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	< 1,000	(17.1%)	6.8%
White	416,000	264,000	51,000	263,000	149,000	(14.8%)	5.8%
Other	17,000	11,000	2,000	11,000	6,000	(9.1%)	6.7%
Hispanic/Latino	***125,000***	***59,000***	***29,000***	***59,000***	***42,000***	***(8.6%)***	***16.8%***
American Indian and Alaska Native	1,000	< 1,000	< 1,000	< 1,000	< 1,000	(13.9%)	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	2,000	< 1,000	< 1,000	< 1,000	< 1,000	(7.6%)	11.0%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	-	(0.3%)	22.8%
White	80,000	37,000	18,000	37,000	25,000	(8.6%)	16.1%
Other	43,000	20,000	11,000	20,000	15,000	(8.7%)	18.7%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-3: Summary of Results by Ethnicity and Race

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Marketplace Public Option							
10% Premium Reduction							
Non-Hispanic/Latino	***587,000***	***289,000***	***5,000***	***98,000***	***-***	***(0.9%)***	***6.8%***
American Indian and Alaska Native	< 1,000	< 1,000	< 1,000	< 1,000	-	(0.9%)	6.1%
Asian	70,000	45,000	< 1,000	10,000	-	(0.9%)	7.8%
Black or African American	82,000	21,000	< 1,000	6,000	-	(0.5%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	-	< 1,000	-	0.0%	6.8%
White	416,000	213,000	4,000	80,000	-	(1.2%)	5.8%
Other	17,000	9,000	< 1,000	3,000	-	(0.7%)	6.7%
Hispanic/Latino	***125,000***	***30,000***	***< 1,000***	***7,000***	***-***	***(0.3%)***	***16.8%***
American Indian and Alaska Native	1,000	< 1,000	< 1,000	< 1,000	-	(0.9%)	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	2,000	< 1,000	< 1,000	< 1,000	-	(0.5%)	11.0%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	-	(0.8%)	22.8%
White	80,000	19,000	< 1,000	6,000	-	(0.3%)	16.1%
Other	43,000	10,000	< 1,000	1,000	-	(0.2%)	18.7%
20% Premium Reduction							
Non-Hispanic/Latino	***587,000***	***297,000***	***11,000***	***107,000***	***-***	***(1.9%)***	***6.8%***
American Indian and Alaska Native	< 1,000	< 1,000	< 1,000	< 1,000	-	(1.8%)	6.1%
Asian	70,000	46,000	< 1,000	11,000	-	(1.8%)	7.8%
Black or African American	82,000	22,000	1,000	7,000	-	(1.0%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	-	< 1,000	-	0.0%	6.8%
White	416,000	219,000	8,000	87,000	-	(2.3%)	5.8%
Other	17,000	9,000	< 1,000	3,000	-	(1.4%)	6.7%
Hispanic/Latino	***125,000***	***31,000***	***2,000***	***9,000***	***-***	***(0.6%)***	***16.8%***
American Indian and Alaska Native	1,000	< 1,000	< 1,000	< 1,000	-	(2.5%)	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	2,000	< 1,000	< 1,000	< 1,000	-	(1.1%)	11.0%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	-	(1.5%)	22.8%
White	80,000	20,000	1,000	7,000	-	(0.7%)	16.1%
Other	43,000	10,000	< 1,000	2,000	-	(0.4%)	18.7%
30% Premium Reduction							
Non-Hispanic/Latino	***587,000***	***306,000***	***17,000***	***126,000***	***-***	***(3.0%)***	***6.8%***
American Indian and Alaska Native	< 1,000	< 1,000	< 1,000	< 1,000	-	(2.8%)	6.1%
Asian	70,000	47,000	2,000	12,000	-	(3.0%)	7.8%
Black or African American	82,000	23,000	2,000	8,000	-	(1.6%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	-	< 1,000	-	0.0%	6.8%
White	416,000	226,000	13,000	101,000	-	(3.7%)	5.8%
Other	17,000	10,000	< 1,000	4,000	-	(2.2%)	6.7%
Hispanic/Latino	***125,000***	***33,000***	***3,000***	***11,000***	***-***	***(1.0%)***	***16.8%***
American Indian and Alaska Native	1,000	< 1,000	< 1,000	< 1,000	-	(4.4%)	7.9%
Asian	-	-	-	-	-	0.0%	2.0%
Black or African American	2,000	< 1,000	< 1,000	< 1,000	-	(2.0%)	11.0%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	< 1,000	-	(2.4%)	22.8%
White	80,000	21,000	2,000	9,000	-	(1.1%)	16.1%
Other	43,000	10,000	< 1,000	2,000	-	(0.7%)	18.7%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-3: Summary of Results by Ethnicity and Race

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Medicaid Buy-In							
Targeted							
Non-Hispanic/Latino	***256,000***	***52,000***	***16,000***	***-***	***-***	***(2.8%)***	***6.8%***
American Indian and Alaska Native	< 1,000	< 1,000	< 1,000	-	-	(2.4%)	6.1%
Asian	54,000	14,000	4,000	-	-	(7.5%)	7.8%
Black or African American	33,000	7,000	2,000	-	-	(1.6%)	9.9%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	-	-	(1.5%)	6.8%
White	160,000	29,000	8,000	-	-	(2.4%)	5.8%
Other	8,000	2,000	1,000	-	-	(6.9%)	6.7%
Hispanic/Latino	***279,000***	***75,000***	***44,000***	***-***	***-***	***(12.8%)***	***16.8%***
American Indian and Alaska Native	< 1,000	< 1,000	< 1,000	-	-	(1.1%)	7.9%
Asian	< 1,000	< 1,000	-	-	-	0.0%	2.0%
Black or African American	1,000	< 1,000	< 1,000	-	-	(6.8%)	11.0%
Native Hawaiian and Other Pacific Islande	< 1,000	< 1,000	< 1,000	-	-	(22.2%)	22.8%
White	172,000	44,000	24,000	-	-	(11.0%)	16.1%
Other	104,000	31,000	20,000	-	-	(15.9%)	18.7%
Broad - Basic							
Non-Hispanic/Latino	***5,280,000***	***312,000***	***26,000***	***163,000***	***-***	***(4.6%)***	***6.8%***
American Indian and Alaska Native	6,000	< 1,000	< 1,000	< 1,000	-	(4.2%)	6.1%
Asian	492,000	40,000	5,000	19,000	-	(9.4%)	7.8%
Black or African American	487,000	35,000	3,000	11,000	-	(1.8%)	9.9%
Native Hawaiian and Other Pacific Islande	4,000	< 1,000	-	< 1,000	-	0.0%	6.8%
White	4,144,000	227,000	17,000	128,000	-	(4.9%)	5.8%
Other	148,000	9,000	2,000	5,000	-	(8.1%)	6.7%
Hispanic/Latino	***954,000***	***119,000***	***46,000***	***20,000***	***-***	***(13.5%)***	***16.8%***
American Indian and Alaska Native	7,000	< 1,000	< 1,000	< 1,000	-	(2.5%)	7.9%
Asian	3,000	< 1,000	-	< 1,000	-	0.0%	2.0%
Black or African American	10,000	< 1,000	< 1,000	< 1,000	-	(8.7%)	11.0%
Native Hawaiian and Other Pacific Islande	2,000	< 1,000	< 1,000	< 1,000	-	(23.7%)	22.8%
White	631,000	73,000	25,000	14,000	-	(11.8%)	16.1%
Other	301,000	43,000	20,000	5,000	-	(16.5%)	18.7%
Broad - Enhanced							
Non-Hispanic/Latino	***5,280,000***	***599,000***	***65,000***	***570,000***	***599,000***	***(11.6%)***	***6.8%***
American Indian and Alaska Native	6,000	< 1,000	< 1,000	< 1,000	< 1,000	(5.3%)	6.1%
Asian	492,000	86,000	10,000	84,000	86,000	(18.7%)	7.8%
Black or African American	487,000	73,000	11,000	68,000	73,000	(7.6%)	9.9%
Native Hawaiian and Other Pacific Islande	4,000	< 1,000	< 1,000	< 1,000	< 1,000	(0.7%)	6.8%
White	4,144,000	421,000	42,000	399,000	421,000	(12.2%)	5.8%
Other	148,000	19,000	3,000	17,000	19,000	(14.4%)	6.7%
Hispanic/Latino	***954,000***	***203,000***	***80,000***	***193,000***	***203,000***	***(23.4%)***	***16.8%***
American Indian and Alaska Native	7,000	1,000	< 1,000	1,000	1,000	(11.0%)	7.9%
Asian	3,000	< 1,000	-	< 1,000	< 1,000	0.0%	2.0%
Black or African American	10,000	2,000	< 1,000	2,000	2,000	(16.3%)	11.0%
Native Hawaiian and Other Pacific Islande	2,000	< 1,000	< 1,000	< 1,000	< 1,000	(39.2%)	22.8%
White	631,000	125,000	46,000	119,000	125,000	(21.5%)	16.1%
Other	301,000	73,000	33,000	70,000	73,000	(26.8%)	18.7%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
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CY 2022 Policy Modeling Results by Demographic
Appendix B-4: Summary of Results by Immigration Status

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Basic Health Program							
Minnesota Model							
Citizen	137,000	82,000	12,000	81,000	54,000	(2.2%)	6.3%
Documented Immigrant (< 5 Years)	34,000	29,000	7,000	28,000	3,000	(21.5%)	23.1%
Documented Immigrant (5+ Years)	45,000	24,000	4,000	23,000	17,000	(2.8%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%
New York Model							
Citizen	137,000	85,000	15,000	84,000	85,000	(2.6%)	6.3%
Documented Immigrant (< 5 Years)	34,000	29,000	7,000	29,000	29,000	(23.3%)	23.1%
Documented Immigrant (5+ Years)	45,000	25,000	5,000	23,000	25,000	(3.5%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%
Zero Premium Model							
Citizen	137,000	119,000	46,000	119,000	119,000	(7.7%)	6.3%
Documented Immigrant (< 5 Years)	34,000	31,000	9,000	31,000	31,000	(26.7%)	23.1%
Documented Immigrant (5+ Years)	45,000	38,000	17,000	38,000	38,000	(11.5%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%
State-Funded PTC/CSR							
Massachusetts							
Citizen	531,000	272,000	37,000	240,000	160,000	(6.7%)	6.3%
Documented Immigrant (< 5 Years)	52,000	36,000	8,000	34,000	33,000	(26.7%)	23.1%
Documented Immigrant (5+ Years)	129,000	60,000	10,000	53,000	44,000	(7.1%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%
No FPL Limit for PTCs							
Citizen	531,000	244,000	7,000	91,000	-	(1.3%)	6.3%
Documented Immigrant (< 5 Years)	52,000	27,000	< 1,000	2,000	-	(0.5%)	23.1%
Documented Immigrant (5+ Years)	129,000	52,000	2,000	13,000	-	(1.2%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%
California							
Citizen	531,000	243,000	7,000	170,000	-	(1.2%)	6.3%
Documented Immigrant (< 5 Years)	52,000	34,000	7,000	29,000	-	(21.6%)	23.1%
Documented Immigrant (5+ Years)	129,000	52,000	2,000	31,000	-	(1.2%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%
HEC Proposals							
Citizen	531,000	312,000	73,000	312,000	187,000	(13.1%)	6.3%
Documented Immigrant (< 5 Years)	52,000	37,000	10,000	37,000	9,000	(31.5%)	23.1%
Documented Immigrant (5+ Years)	129,000	75,000	24,000	75,000	52,000	(17.4%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
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Appendix B-4: Summary of Results by Immigration Status

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Marketplace Public Option							
10% Premium Reduction							
Citizen	531,000	240,000	5,000	91,000	-	(0.9%)	6.3%
Documented Immigrant (< 5 Years)	52,000	27,000	< 1,000	2,000	-	(0.8%)	23.1%
Documented Immigrant (5+ Years)	129,000	51,000	< 1,000	13,000	-	(0.7%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%
20% Premium Reduction							
Citizen	531,000	248,000	10,000	99,000	-	(1.8%)	6.3%
Documented Immigrant (< 5 Years)	52,000	28,000	< 1,000	3,000	-	(1.7%)	23.1%
Documented Immigrant (5+ Years)	129,000	53,000	2,000	14,000	-	(1.5%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%
30% Premium Reduction							
Citizen	531,000	256,000	16,000	117,000	-	(2.9%)	6.3%
Documented Immigrant (< 5 Years)	52,000	28,000	< 1,000	3,000	-	(2.8%)	23.1%
Documented Immigrant (5+ Years)	129,000	54,000	3,000	17,000	-	(2.4%)	13.8%
Undocumented Immigrant	-	-	-	-	-	0.0%	40.3%
Medicaid Buy-In							
Targeted							
Citizen	164,000	25,000	3,000	-	-	(0.6%)	6.3%
Documented Immigrant (< 5 Years)	9,000	3,000	1,000	-	-	(3.3%)	23.1%
Documented Immigrant (5+ Years)	39,000	8,000	2,000	-	-	(1.4%)	13.8%
Undocumented Immigrant	323,000	92,000	53,000	-	-	(29.3%)	40.3%
Broad - Basic							
Citizen	5,033,000	274,000	10,000	148,000	-	(1.7%)	6.3%
Documented Immigrant (< 5 Years)	123,000	12,000	< 1,000	3,000	-	(1.6%)	23.1%
Documented Immigrant (5+ Years)	650,000	47,000	2,000	21,000	-	(1.4%)	13.8%
Undocumented Immigrant	429,000	97,000	60,000	11,000	-	(31.8%)	40.3%
Broad - Enhanced							
Citizen	5,033,000	512,000	42,000	485,000	512,000	(7.1%)	6.3%
Documented Immigrant (< 5 Years)	123,000	47,000	8,000	46,000	47,000	(20.4%)	23.1%
Documented Immigrant (5+ Years)	650,000	105,000	12,000	102,000	105,000	(8.4%)	13.8%
Undocumented Immigrant	429,000	138,000	83,000	130,000	138,000	(39.2%)	40.3%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-5: Summary of Results by Individual ACA Rating Area

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Basic Health Program							
Minnesota Model							
Rating Area 1	108,000	65,000	11,000	63,000	38,000	(2.5%)	10.9%
Rating Area 2	18,000	11,000	2,000	11,000	6,000	(3.0%)	7.0%
Rating Area 3	18,000	11,000	2,000	11,000	7,000	(2.1%)	8.1%
Rating Area 4	11,000	7,000	< 1,000	7,000	4,000	(1.4%)	6.0%
Rating Area 5	13,000	9,000	< 1,000	9,000	5,000	(2.2%)	7.5%
Rating Area 6	5,000	3,000	< 1,000	3,000	< 1,000	(2.7%)	6.5%
Rating Area 7	10,000	8,000	< 1,000	8,000	4,000	(2.6%)	6.6%
Rating Area 8	2,000	< 1,000	< 1,000	< 1,000	< 1,000	(2.5%)	5.9%
Rating Area 9	8,000	5,000	< 1,000	5,000	2,000	(3.6%)	7.3%
Rating Area 10	8,000	5,000	< 1,000	4,000	3,000	(3.0%)	7.5%
Rating Area 11	3,000	2,000	< 1,000	2,000	1,000	(2.5%)	6.9%
Rating Area 12	5,000	3,000	< 1,000	3,000	2,000	(2.8%)	7.7%
Rating Area 13	8,000	4,000	1,000	4,000	2,000	(3.3%)	7.8%
New York Model							
Rating Area 1	108,000	67,000	14,000	64,000	67,000	(2.9%)	10.9%
Rating Area 2	18,000	11,000	2,000	11,000	11,000	(3.6%)	7.0%
Rating Area 3	18,000	11,000	2,000	11,000	11,000	(2.4%)	8.1%
Rating Area 4	11,000	7,000	< 1,000	7,000	7,000	(2.0%)	6.0%
Rating Area 5	13,000	10,000	< 1,000	10,000	10,000	(2.2%)	7.5%
Rating Area 6	5,000	4,000	< 1,000	3,000	4,000	(3.2%)	6.5%
Rating Area 7	10,000	8,000	< 1,000	8,000	8,000	(3.2%)	6.6%
Rating Area 8	2,000	1,000	< 1,000	1,000	1,000	(3.6%)	5.9%
Rating Area 9	8,000	6,000	1,000	6,000	6,000	(4.2%)	7.3%
Rating Area 10	8,000	5,000	1,000	5,000	5,000	(3.9%)	7.5%
Rating Area 11	3,000	2,000	< 1,000	2,000	2,000	(3.2%)	6.9%
Rating Area 12	5,000	3,000	1,000	3,000	3,000	(3.2%)	7.7%
Rating Area 13	8,000	5,000	1,000	5,000	5,000	(3.8%)	7.8%
Zero Premium Model							
Rating Area 1	108,000	92,000	37,000	92,000	92,000	(7.9%)	10.9%
Rating Area 2	18,000	15,000	6,000	15,000	15,000	(9.9%)	7.0%
Rating Area 3	18,000	15,000	6,000	15,000	15,000	(6.2%)	8.1%
Rating Area 4	11,000	10,000	3,000	10,000	10,000	(6.3%)	6.0%
Rating Area 5	13,000	12,000	3,000	12,000	12,000	(7.2%)	7.5%
Rating Area 6	5,000	5,000	1,000	5,000	5,000	(9.0%)	6.5%
Rating Area 7	10,000	10,000	2,000	10,000	10,000	(8.2%)	6.6%
Rating Area 8	2,000	2,000	< 1,000	2,000	2,000	(10.2%)	5.9%
Rating Area 9	8,000	7,000	2,000	7,000	7,000	(9.1%)	7.3%
Rating Area 10	8,000	7,000	3,000	7,000	7,000	(9.1%)	7.5%
Rating Area 11	3,000	3,000	1,000	3,000	3,000	(8.0%)	6.9%
Rating Area 12	5,000	4,000	2,000	4,000	4,000	(7.1%)	7.7%
Rating Area 13	8,000	7,000	4,000	7,000	7,000	(9.9%)	7.8%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-5: Summary of Results by Individual ACA Rating Area

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
State-Funded PTC/CSR							
Massachusetts							
Rating Area 1	322,000	156,000	27,000	142,000	109,000	(5.8%)	10.9%
Rating Area 2	54,000	32,000	4,000	28,000	19,000	(6.2%)	7.0%
Rating Area 3	76,000	39,000	4,000	35,000	21,000	(4.0%)	8.1%
Rating Area 4	47,000	25,000	3,000	22,000	13,000	(6.2%)	6.0%
Rating Area 5	40,000	23,000	3,000	21,000	16,000	(7.3%)	7.5%
Rating Area 6	16,000	9,000	1,000	7,000	5,000	(7.6%)	6.5%
Rating Area 7	28,000	17,000	2,000	16,000	13,000	(7.0%)	6.6%
Rating Area 8	7,000	4,000	< 1,000	4,000	2,000	(8.0%)	5.9%
Rating Area 9	26,000	14,000	2,000	12,000	10,000	(8.5%)	7.3%
Rating Area 10	29,000	14,000	2,000	12,000	9,000	(7.4%)	7.5%
Rating Area 11	13,000	8,000	< 1,000	6,000	5,000	(6.5%)	6.9%
Rating Area 12	25,000	11,000	2,000	10,000	6,000	(7.2%)	7.7%
Rating Area 13	30,000	15,000	3,000	12,000	9,000	(8.3%)	7.8%
No FPL Limit for PTCs							
Rating Area 1	322,000	131,000	2,000	38,000	-	(0.4%)	10.9%
Rating Area 2	54,000	29,000	< 1,000	10,000	-	(1.1%)	7.0%
Rating Area 3	76,000	37,000	1,000	16,000	-	(1.1%)	8.1%
Rating Area 4	47,000	23,000	< 1,000	10,000	-	(1.4%)	6.0%
Rating Area 5	40,000	21,000	< 1,000	6,000	-	(1.7%)	7.5%
Rating Area 6	16,000	8,000	< 1,000	2,000	-	(1.8%)	6.5%
Rating Area 7	28,000	16,000	< 1,000	3,000	-	(2.0%)	6.6%
Rating Area 8	7,000	4,000	< 1,000	2,000	-	(2.0%)	5.9%
Rating Area 9	26,000	13,000	< 1,000	4,000	-	(1.7%)	7.3%
Rating Area 10	29,000	13,000	< 1,000	4,000	-	(2.7%)	7.5%
Rating Area 11	13,000	7,000	< 1,000	2,000	-	(1.2%)	6.9%
Rating Area 12	25,000	10,000	< 1,000	4,000	-	(1.3%)	7.7%
Rating Area 13	30,000	13,000	1,000	5,000	-	(3.3%)	7.8%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-5: Summary of Results by Individual ACA Rating Area

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
State-Funded PTC/CSR (cont.)							
California							
Rating Area 1	322,000	136,000	7,000	89,000	-	(1.5%)	10.9%
Rating Area 2	54,000	30,000	1,000	21,000	-	(1.8%)	7.0%
Rating Area 3	76,000	37,000	1,000	28,000	-	(1.5%)	8.1%
Rating Area 4	47,000	23,000	< 1,000	16,000	-	(1.6%)	6.0%
Rating Area 5	40,000	21,000	< 1,000	15,000	-	(1.8%)	7.5%
Rating Area 6	16,000	8,000	< 1,000	6,000	-	(1.5%)	6.5%
Rating Area 7	28,000	16,000	< 1,000	9,000	-	(1.8%)	6.6%
Rating Area 8	7,000	4,000	< 1,000	3,000	-	(0.6%)	5.9%
Rating Area 9	26,000	13,000	< 1,000	11,000	-	(3.4%)	7.3%
Rating Area 10	29,000	13,000	< 1,000	9,000	-	(1.5%)	7.5%
Rating Area 11	13,000	7,000	< 1,000	5,000	-	(1.7%)	6.9%
Rating Area 12	25,000	10,000	< 1,000	8,000	-	(1.6%)	7.7%
Rating Area 13	30,000	13,000	1,000	10,000	-	(3.0%)	7.8%
HEC Proposals							
Rating Area 1	322,000	179,000	49,000	179,000	114,000	(10.6%)	10.9%
Rating Area 2	54,000	36,000	8,000	36,000	20,000	(12.9%)	7.0%
Rating Area 3	76,000	45,000	9,000	45,000	24,000	(9.1%)	8.1%
Rating Area 4	47,000	28,000	6,000	28,000	14,000	(11.9%)	6.0%
Rating Area 5	40,000	27,000	6,000	27,000	15,000	(15.3%)	7.5%
Rating Area 6	16,000	10,000	3,000	10,000	5,000	(15.5%)	6.5%
Rating Area 7	28,000	20,000	4,000	20,000	11,000	(13.2%)	6.6%
Rating Area 8	7,000	5,000	< 1,000	5,000	2,000	(12.1%)	5.9%
Rating Area 9	26,000	16,000	4,000	16,000	9,000	(14.9%)	7.3%
Rating Area 10	29,000	17,000	5,000	17,000	10,000	(14.8%)	7.5%
Rating Area 11	13,000	9,000	2,000	9,000	6,000	(11.7%)	6.9%
Rating Area 12	25,000	14,000	4,000	14,000	7,000	(13.8%)	7.7%
Rating Area 13	30,000	18,000	6,000	18,000	11,000	(17.4%)	7.8%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-5: Summary of Results by Individual ACA Rating Area

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Marketplace Public Option							
10% Premium Reduction							
Rating Area 1	322,000	132,000	3,000	41,000	-	(0.6%)	10.9%
Rating Area 2	54,000	29,000	< 1,000	10,000	-	(0.6%)	7.0%
Rating Area 3	76,000	37,000	< 1,000	17,000	-	(0.9%)	8.1%
Rating Area 4	47,000	22,000	< 1,000	10,000	-	(1.0%)	6.0%
Rating Area 5	40,000	20,000	< 1,000	5,000	-	(0.4%)	7.5%
Rating Area 6	16,000	7,000	< 1,000	2,000	-	(0.8%)	6.5%
Rating Area 7	28,000	15,000	< 1,000	3,000	-	(0.6%)	6.6%
Rating Area 8	7,000	4,000	< 1,000	2,000	-	(0.5%)	5.9%
Rating Area 9	26,000	12,000	< 1,000	3,000	-	(0.7%)	7.3%
Rating Area 10	29,000	12,000	< 1,000	4,000	-	(1.1%)	7.5%
Rating Area 11	13,000	7,000	< 1,000	2,000	-	(0.6%)	6.9%
Rating Area 12	25,000	9,000	< 1,000	4,000	-	(0.8%)	7.7%
Rating Area 13	30,000	12,000	< 1,000	3,000	-	(0.8%)	7.8%
20% Premium Reduction							
Rating Area 1	322,000	136,000	6,000	46,000	-	(1.2%)	10.9%
Rating Area 2	54,000	29,000	< 1,000	11,000	-	(1.2%)	7.0%
Rating Area 3	76,000	38,000	2,000	18,000	-	(1.8%)	8.1%
Rating Area 4	47,000	23,000	< 1,000	10,000	-	(2.0%)	6.0%
Rating Area 5	40,000	20,000	< 1,000	6,000	-	(0.9%)	7.5%
Rating Area 6	16,000	8,000	< 1,000	3,000	-	(1.6%)	6.5%
Rating Area 7	28,000	16,000	< 1,000	3,000	-	(1.2%)	6.6%
Rating Area 8	7,000	4,000	< 1,000	2,000	-	(1.0%)	5.9%
Rating Area 9	26,000	13,000	< 1,000	3,000	-	(1.4%)	7.3%
Rating Area 10	29,000	13,000	< 1,000	4,000	-	(2.2%)	7.5%
Rating Area 11	13,000	7,000	< 1,000	2,000	-	(1.2%)	6.9%
Rating Area 12	25,000	10,000	< 1,000	4,000	-	(1.6%)	7.7%
Rating Area 13	30,000	12,000	< 1,000	4,000	-	(1.6%)	7.8%
30% Premium Reduction							
Rating Area 1	322,000	141,000	9,000	58,000	-	(2.0%)	10.9%
Rating Area 2	54,000	30,000	1,000	12,000	-	(1.9%)	7.0%
Rating Area 3	76,000	40,000	3,000	20,000	-	(2.9%)	8.1%
Rating Area 4	47,000	24,000	2,000	12,000	-	(3.3%)	6.0%
Rating Area 5	40,000	21,000	< 1,000	6,000	-	(1.4%)	7.5%
Rating Area 6	16,000	8,000	< 1,000	3,000	-	(2.5%)	6.5%
Rating Area 7	28,000	16,000	< 1,000	4,000	-	(1.9%)	6.6%
Rating Area 8	7,000	4,000	< 1,000	2,000	-	(1.6%)	5.9%
Rating Area 9	26,000	13,000	< 1,000	4,000	-	(2.2%)	7.3%
Rating Area 10	29,000	13,000	1,000	5,000	-	(3.5%)	7.5%
Rating Area 11	13,000	7,000	< 1,000	2,000	-	(1.9%)	6.9%
Rating Area 12	25,000	10,000	< 1,000	5,000	-	(2.5%)	7.7%
Rating Area 13	30,000	12,000	< 1,000	4,000	-	(2.5%)	7.8%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
CY 2022 Policy Modeling Results by Demographic
Appendix B-5: Summary of Results by Individual ACA Rating Area

Policy Option	Estimated Eligibles	Estimated Enrollees	Estimated Enrollees Previously Uninsured	Estimated Enrollees with Lower Premium	Estimated Enrollees with Lower Cost Sharing	Percent Reduction in Uninsured	Baseline Percent Uninsured
Medicaid Buy-In							
Targeted							
Rating Area 1	260,000	66,000	35,000	-	-	(7.4%)	10.9%
Rating Area 2	52,000	13,000	6,000	-	-	(10.4%)	7.0%
Rating Area 3	78,000	20,000	10,000	-	-	(10.1%)	8.1%
Rating Area 4	38,000	9,000	4,000	-	-	(8.0%)	6.0%
Rating Area 5	23,000	5,000	2,000	-	-	(4.4%)	7.5%
Rating Area 6	8,000	2,000	< 1,000	-	-	(2.9%)	6.5%
Rating Area 7	14,000	3,000	< 1,000	-	-	(2.0%)	6.6%
Rating Area 8	5,000	< 1,000	< 1,000	-	-	(2.5%)	5.9%
Rating Area 9	13,000	3,000	< 1,000	-	-	(2.1%)	7.3%
Rating Area 10	11,000	2,000	< 1,000	-	-	(1.1%)	7.5%
Rating Area 11	6,000	1,000	< 1,000	-	-	(1.3%)	6.9%
Rating Area 12	13,000	3,000	< 1,000	-	-	(2.0%)	7.7%
Rating Area 13	14,000	2,000	< 1,000	-	-	(1.3%)	7.8%
Broad - Basic							
Rating Area 1	2,446,000	198,000	41,000	91,000	-	(8.8%)	10.9%
Rating Area 2	599,000	38,000	7,000	16,000	-	(11.6%)	7.0%
Rating Area 3	874,000	59,000	13,000	28,000	-	(12.9%)	8.1%
Rating Area 4	563,000	35,000	5,000	16,000	-	(9.8%)	6.0%
Rating Area 5	290,000	19,000	2,000	5,000	-	(4.9%)	7.5%
Rating Area 6	133,000	8,000	< 1,000	3,000	-	(3.7%)	6.5%
Rating Area 7	251,000	13,000	< 1,000	3,000	-	(2.7%)	6.6%
Rating Area 8	84,000	5,000	< 1,000	2,000	-	(4.8%)	5.9%
Rating Area 9	188,000	11,000	< 1,000	3,000	-	(2.7%)	7.3%
Rating Area 10	237,000	12,000	< 1,000	4,000	-	(2.6%)	7.5%
Rating Area 11	115,000	6,000	< 1,000	2,000	-	(1.7%)	6.9%
Rating Area 12	232,000	14,000	< 1,000	6,000	-	(2.8%)	7.7%
Rating Area 13	224,000	13,000	< 1,000	3,000	-	(2.0%)	7.8%
Broad - Enhanced							
Rating Area 1	2,446,000	363,000	79,000	349,000	363,000	(17.0%)	10.9%
Rating Area 2	599,000	68,000	12,000	64,000	68,000	(21.1%)	7.0%
Rating Area 3	874,000	96,000	21,000	90,000	96,000	(21.2%)	8.1%
Rating Area 4	563,000	59,000	9,000	55,000	59,000	(17.3%)	6.0%
Rating Area 5	290,000	43,000	5,000	40,000	43,000	(12.9%)	7.5%
Rating Area 6	133,000	16,000	2,000	16,000	16,000	(12.1%)	6.5%
Rating Area 7	251,000	31,000	3,000	29,000	31,000	(9.3%)	6.6%
Rating Area 8	84,000	9,000	< 1,000	8,000	9,000	(12.6%)	5.9%
Rating Area 9	188,000	26,000	3,000	24,000	26,000	(11.0%)	7.3%
Rating Area 10	237,000	26,000	3,000	24,000	26,000	(9.5%)	7.5%
Rating Area 11	115,000	13,000	1,000	12,000	13,000	(8.2%)	6.9%
Rating Area 12	232,000	26,000	3,000	25,000	26,000	(10.0%)	7.7%
Rating Area 13	224,000	28,000	3,000	27,000	28,000	(9.7%)	7.8%

Notes:

(1) Values have been rounded.

(2) Percent reduction in uninsured for each demographic cohort is based on estimated enrollees previously uninsured relative to the cohort's total non-elderly uninsured in the absence of the modeled policy.

(3) Baseline percent uninsured for each demographic cohort represents the projected CY 2022 statewide population, regardless of whether the individuals are eligible for the policy option.

APPENDIX C

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
Basic Health Program (BHP)
Appendix C-1: Highlights of methodology and assumptions used in modeling

Modeling Component	Description of Assumptions and Methodology
Eligibility	Per the Affordable Care Act (ACA), US citizens with income of 138% to 200% FPL and documented immigrants with income of 0% to 200% FPL can be eligible for the BHP.
Cost of coverage	Estimates based upon 2021 Medicaid capitation rates for the non-disabled children and adults and the ACA expansion populations with one year of trend at 5% Estimates reflect Medicaid covered benefits except long term care and waiver services Risk adjustment was applied to reflect estimated morbidity differences between the BHP and Medicaid populations
Federal BHP funding	Estimates based upon assumed 2022 Second Lowest Cost Silver (SLCS) plan premiums, federal premium tax credit percentages, and federal poverty levels Enrollees assumed to have 2022 income at the same multiple of the FPL as in the baseline population

Enrollee monthly premiums

ADULT / CHILD	FPL RANGE	MINNESOTA	NEW YORK	ZERO PREMIUM
Adult	Below 100%	$ 0	$ 0	$ 0
Adult	100%-138%	$ 0	$ 0	$ 0
Adult	138%-150%	$ 25	$ 26	$ 0
Adult	150%-159%	$ 37	$ 46	$ 0
Adult	160%-169%	$ 44	$ 46	$ 0
Adult	170%-179%	$ 52	$ 46	$ 0
Adult	180%-189%	$ 61	$ 46	$ 0
Adult	190%-199%	$ 71	$ 46	$ 0
Adult	200%	$ 80	$ 46	$ 0
Child	All	$ 0	$ 0	$ 0

Sources:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4139A-ENG
Note: Minnesota modified to no premiums below 139% FPL for Illinois BHP modeling
https://www.nyhealthinsurer.com/new-york-essential-plan/
Note: New York premiums include dental and vision coverage to be consistent with modeled benefits

Enrollee cost sharing

Minnesota *https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4858A-ENG*
New York *https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20H%20-%20EP%20Benefits%20and%20Cost-Sharing_.pdf*
Zero Premium *Set equal to New York cost sharing*
Estimated average value per enrollee based upon utilization underlying 2021 Medicaid capitation rates for the non-disabled children and adults and the ACA expansion populations
Risk adjustment was applied to reflect estimated morbidity differences between the BHP and Medicaid populations

State funding

Calculated as [cost of coverage] plus [state administrative costs] less the sum of ([federal BHP funding] less [enrollee premiums] less [enrollee cost sharing])

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Basic Health Program
Appendix C-2: Minnesota Premiums and Cost Sharing

							Annual amounts per enrollee for the Marketplace			Annual amounts per enrollee under Basic Health Program				
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	Cost of Coverage	Federal Funding	State Funding	Enrollee Cost Sharing	Enrollee Premium
Adult	Below 138%	Direct	17,869	17,485	100%	17,485	$ 4,700	$ 4,481	$ 219	$ 3,840	$ 4,180	$ (732)	$ 392	$ 0
Adult	139%-150%	Direct	34,185	33,038	99%	32,686	$ 7,478	$ 6,849	$ 629	$ 6,213	$ 6,189	$ (903)	$ 626	$ 300
Adult	151%-200%	Direct	65,603	65,337	95%	61,770	$ 6,863	$ 5,707	$ 1,156	$ 5,850	$ 5,116	$ (459)	$ 555	$ 638
Adult	201%-250%	Direct	42,515	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	251%-300%	Direct	28,967	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	301%-400%	Direct	32,099	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	401%-600%	Direct	40,659	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Over 600%	Direct	54,860	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Below 138%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	401%-600%	Direct	12,678	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Over 600%	Direct	15,868	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Below 138%	Uninsured	349,531	9,666	66%	6,423	$ 4,469	$ 4,266	$ 203	$ 2,552	$ 3,890	$ (1,582)	$ 245	$ 0
Adult	139%-150%	Uninsured	27,992	16,392	22%	3,574	$ 7,399	$ 6,703	$ 696	$ 4,839	$ 5,985	$ (1,920)	$ 474	$ 300
Adult	151%-200%	Uninsured	124,115	74,091	17%	12,645	$ 6,020	$ 4,805	$ 1,215	$ 4,588	$ 4,399	$ (870)	$ 436	$ 623
Adult	201%-250%	Uninsured	97,757	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	251%-300%	Uninsured	55,033	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	301%-400%	Uninsured	63,129	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	401%-600%	Uninsured	66,227	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Over 600%	Uninsured	36,535	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	401%-600%	Uninsured	11,604	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Over 600%	Uninsured	7,565	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Total	**1,279,879**	**216,011**	**62%**	**134,584**	**$ 6,552**	**$ 5,698**	**$ 854**	**$ 5,374**	**$ 5,152**	**$ (733)**	**$ 523**	**$ 432**
		Direct	354,902	115,861	97%	111,941	$ 6,705	$ 5,849	$ 856	$ 5,642	$ 5,283	$ (631)	$ 550	$ 440
		Uninsured	924,977	100,150	23%	22,643	$ 5,798	$ 4,952	$ 846	$ 4,050	$ 4,505	$ (1,238)	$ 388	$ 395
					Totals (in Millions)		**$ 881.8**	**$ 766.9**	**$ 115.0**	**$ 723.3**	**$ 693.4**	**($ 98.7)**	**$ 70.4**	**$ 58.2**

Note: State funding surplus funds are required to be used to reduce premiums and cost sharing for BHP enrollees and may be carried over from year to year.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Basic Health Program
Appendix C-3: New York Premiums and Cost Sharing

							Annual amounts per enrollee for the Marketplace			Annual amounts per enrollee under Basic Health Program				
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	Cost of Coverage	Federal Funding	State Funding	Enrollee Cost Sharing	Enrollee Premium
Adult	Below 138%	Direct	17,869	17,485	100%	17,485	$ 4,700	$ 4,481	$ 219	$ 3,840	$ 4,180	$ (340)	$ 0	$ 0
Adult	139%-150%	Direct	34,185	33,038	99%	32,700	$ 7,478	$ 6,849	$ 629	$ 6,213	$ 6,189	$ (305)	$ 17	$ 312
Adult	151%-200%	Direct	65,603	65,337	95%	62,126	$ 6,864	$ 5,706	$ 1,158	$ 5,847	$ 5,115	$ (266)	$ 446	$ 552
Adult	201%-250%	Direct	42,515	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	251%-300%	Direct	28,967	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	301%-400%	Direct	32,099	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	401%-600%	Direct	40,659	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Over 600%	Direct	54,860	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Below 138%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	401%-600%	Direct	12,678	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Over 600%	Direct	15,868	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Below 138%	Uninsured	349,531	9,666	72%	6,978	$ 4,485	$ 4,284	$ 201	$ 2,556	$ 3,905	$ (1,350)	$ 1	$ 0
Adult	139%-150%	Uninsured	27,992	16,392	29%	4,735	$ 7,368	$ 6,685	$ 683	$ 4,824	$ 5,973	$ (1,474)	$ 13	$ 312
Adult	151%-200%	Uninsured	124,115	74,091	21%	15,354	$ 6,004	$ 4,737	$ 1,267	$ 4,592	$ 4,363	$ (679)	$ 357	$ 552
Adult	201%-250%	Uninsured	97,757	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	251%-300%	Uninsured	55,033	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	301%-400%	Uninsured	63,129	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	401%-600%	Uninsured	66,227	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Over 600%	Uninsured	36,535	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	401%-600%	Uninsured	11,604	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Over 600%	Uninsured	7,565	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Total	**1,279,879**	**216,011**	**65%**	**139,379**	**$ 6,540**	**$ 5,676**	**$ 864**	**$ 5,343**	**$ 5,136**	**$ (425)**	**$ 243**	**$ 391**
		Direct	354,902	115,861	97%	112,312	$ 6,706	$ 5,848	$ 858	$ 5,641	$ 5,282	$ (289)	$ 252	$ 396
		Uninsured	924,977	100,150	27%	27,067	$ 5,851	$ 4,961	$ 890	$ 4,108	$ 4,526	$ (991)	$ 205	$ 368
					Totals (in Millions)		**$ 911.5**	**$ 791.1**	**$ 120.4**	**$ 744.8**	**$ 715.8**	**($ 59.3)**	**$ 33.8**	**$ 54.4**

Note: State funding surplus funds are required to be used to reduce premiums and cost sharing for BHP enrollees and may be carried over from year to year.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Basic Health Program
Appendix C-4: Zero Premium and New York Cost Sharing

							Annual amounts per enrollee for the Marketplace			Annual amounts per enrollee under Basic Health Program				
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	Cost of Coverage	Federal Funding	State Funding	Enrollee Cost Sharing	Enrollee Premium
Adult	Below 138%	Direct	17,869	17,485	100%	17,485	$ 4,700	$ 4,481	$ 219	$ 3,840	$ 4,180	$ (340)	$ 0	$ 0
Adult	139%-150%	Direct	34,185	33,038	100%	33,038	$ 7,478	$ 6,849	$ 629	$ 6,203	$ 6,189	$ (3)	$ 17	$ 0
Adult	151%-200%	Direct	65,603	65,337	100%	65,337	$ 6,863	$ 5,706	$ 1,157	$ 5,802	$ 5,115	$ 244	$ 442	$ 0
Adult	201%-250%	Direct	42,515	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	251%-300%	Direct	28,967	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	301%-400%	Direct	32,099	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	401%-600%	Direct	40,659	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Over 600%	Direct	54,860	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Below 138%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	-	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	401%-600%	Direct	12,678	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Over 600%	Direct	15,868	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Below 138%	Uninsured	349,531	9,666	72%	6,978	$ 4,485	$ 4,284	$ 201	$ 2,556	$ 3,905	$ (1,350)	$ 1	$ 0
Adult	139%-150%	Uninsured	27,992	16,392	71%	11,711	$ 6,844	$ 6,208	$ 636	$ 4,486	$ 5,600	$ (1,125)	$ 11	$ 0
Adult	151%-200%	Uninsured	124,115	74,091	72%	53,141	$ 6,005	$ 4,929	$ 1,076	$ 4,416	$ 4,486	$ (408)	$ 338	$ 0
Adult	201%-250%	Uninsured	97,757	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	251%-300%	Uninsured	55,033	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	301%-400%	Uninsured	63,129	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	401%-600%	Uninsured	66,227	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Over 600%	Uninsured	36,535	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	401%-600%	Uninsured	11,604	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Over 600%	Uninsured	7,565	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Total	**1,279,879**	**216,011**	**87%**	**187,691**	**$ 6,437**	**$ 5,552**	**$ 886**	**$ 5,095**	**$ 5,024**	**$ (183)**	**$ 254**	**$ 0**
		Direct	354,902	115,861	100%	115,861	$ 6,712	$ 5,847	$ 865	$ 5,620	$ 5,280	$ 86	$ 254	$ 0
		Uninsured	924,977	100,150	72%	71,830	$ 5,994	$ 5,075	$ 919	$ 4,247	$ 4,611	$ (616)	$ 252	$ 0
					Totals (in Millions)		**$ 1,208.2**	**$ 1,042.0**	**$ 166.2**	**$ 956.2**	**$ 943.0**	**($ 34.4)**	**$ 47.6**	**$ 0.0**

Note: State funding surplus funds are required to be used to reduce premiums and cost sharing for BHP enrollees and may be carried over from year to year.

APPENDIX D

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
State-Funded Premium Tax Credits (PTCs) and Cost Share Reductions (CSRs)
Appendix D-1: Highlights of methodology and assumptions used in modeling

Modeling Component	Description of Assumptions and Methodology
Eligibility	Not eligible for Medicaid and US citizen or documented immigrant, consistent with the Marketplace Note: Modeling does not reflect the potential for enrollees from ESI who may retire or otherwise leave employment because Marketplace coverage is now more affordable due to state-funded PTCs/CSRs.
SLCS plan premiums	Estimates based upon assumed 2022 Second Lowest Cost Silver (SLCS) plan premiums
Federal Premium Tax Credits (PTCs)	Estimates based upon assumed 2022 federal premium tax credit percentages and federal poverty levels. Enrollees assumed to have 2022 income at the same multiple of the FPL as in the baseline population
Enrollee premium	Calculated as [SLCS plan premium] less [federal PTCs] less [state PTCs, when applicable]. Based on income standard, not reflecting enrollees in Bronze for lower premium.
State funding estimates	State PTC and State CSR amounts are overstated to the extent that enrollees choose Bronze rather than Silver Plans. The state would not fund CSRs for Bronze enrollees and may not need to fund the full amount of PTCs.
State-funded PTC/CSR programs	
Massachusetts	Enrollees are responsible for monthly premiums, and the state pays the remainder after federal premium tax credits. Individuals above 300% FPL are not eligible for additional state funding. Enrollee cost sharing illustrated in the table below. Details for Plan Types 1-3 are available in the link below the table.
No FPL Limit for PTCs	Enrollees are responsible for an income-based percentage portion of the SLCS premium as illustrated in the table below. Percentages correspond with the federal premium tax credit percentages. Individuals up to 400% FPL receive federal premium tax credits for the remainder of the SLCS premium. The state pays the remainder of the SLCS premium for individuals over 400% FPL.
California Contribution Limit	Enrollees are responsible for an income-based percentage of the SLCS premium as illustrated in the table below. Percentages are lower than the federal premium tax credit percentages to allow for additional state funding. Individuals between 138% and 200% FPL and those above 600% FPL are not eligible for additional state funding. Eligible individuals receive federal premium tax credits according to federal definitions. The state PTC pays the remainder of the SLCS premium up to the state-defined out-of-pocket limit.
House Energy & Commerce Proposa	Enrollees are responsible for an income-based percentage of the SLCS premium as illustrated in the table below. Percentages are lower than the federal premium tax credit percentages to allow for additional state funding. Eligible individuals receive federal premium tax credits according to federal definitions. The state pays the remainder of the SLCS premium.. Enrollee cost sharing defined consistently with federal Marketplace standards, with lower cost sharing as noted in the table below.

CY 2022 PREMIUM TAX CREDIT PERCENTAGES

	FEDERAL PTC		MASSACHUSETTS		NO FPL LIMIT		CALIFORNIA		HOUSE ENERGY & COMMERCE PROPOSALS	
FPL RANGE	INITIAL	FINAL	INITIAL	FINAL	INITIAL	FINAL	INITIAL	FINAL	INITIAL	FINAL
Up to 100%	2.1%	2.1%	0.0%	0.0%	2.1%	2.1%	0.0%	0.0%	0.0%	0.0%
100 up to 138%	2.1%	2.1%	0.0%	0.0%	2.1%	2.1%	0.0%	0.0%	0.0%	0.0%
138% up to 150%	3.2%	4.2%	0.0%	0.0%	3.2%	4.2%	N/A	N/A	0.0%	0.0%
150% up to 200%	4.2%	6.7%	2.8%	2.1%	4.2%	6.7%	N/A	N/A	0.0%	3.0%
200% up to 250%	6.7%	8.5%	4.1%	3.2%	6.7%	8.5%	6.2%	7.8%	3.0%	4.0%
250% up to 300%	8.5%	10.1%	4.8%	4.0%	8.5%	10.1%	7.8%	8.9%	4.0%	6.0%
300% up to 400%	10.1%	10.1%	N/A	N/A	10.1%	10.1%	8.9%	9.7%	6.0%	8.5%
400% up to 450%	N/A	N/A	N/A	N/A	10.1%	10.1%	9.7%	14.0%	8.5%	8.5%
450% up to 500%	N/A	N/A	N/A	N/A	10.1%	10.1%	14.0%	16.0%	8.5%	8.5%
500% up to 600%	N/A	N/A	N/A	N/A	10.1%	10.1%	16.0%	18.0%	8.5%	8.5%
Above 600%	N/A	N/A	N/A	N/A	10.1%	10.1%	N/A	N/A	8.5%	8.5%

Notes:

The initial percentage applies to the low end of the corresponding FPL range while the final percentage applies to the high end of the corresponding FPL range. Linear interpolation is used to determine the applicable percentage for income levels within the FPL range.

Federal percentages forecasted to 2022 from current 2021 levels: https://www.currentfederaltaxdevelopments.com/blog/2020/7/21/irs-releases-2021-aca-premium-tax-credit-percentages.

Massachusetts percentages calculated from monthly premiums: https://www.mahealthconnector.org/wp-content/uploads/ConnectorCare-Overview-2020.pdf.

No FPL Limit scenario extends federal scenario beyond 400% FPL.

California percentages source: https://board.coveredca.com/meetings/2020/May%202020%20Meeting/Proposed%202021%20State%20Subsidy%20Program-Program%20Design%20Document%20-%20REDLINE.pdf

House Energy & Commerce percentage source: https://www.congress.gov/116/bills/hr1425/BILLS-116hr1425pcs.pdf

CY 2022 COST SHARE REDUCTION ACTUARIAL VALUES

FPL RANGE	FEDERAL CSR	MASS	NO FPL LIMIT	CALIFORNIA	HEC PROPOSALS
Up to 100%	94% AV Silver	MA 100% AV	94% AV Silver	94% AV Silver	94% AV Silver
100 up to 138%	94% AV Silver	MA 95% AV	94% AV Silver	94% AV Silver	94% AV Silver
138% up to 150%	94% AV Silver	MA 95% AV	94% AV Silver	94% AV Silver	94% AV Silver
150% up to 200%	87% AV Silver	MA 95% AV	87% AV Silver	87% AV Silver	94% AV Silver
200% up to 250%	73% AV Silver	MA 92% AV	73% AV Silver	73% AV Silver	94% AV Silver
250% up to 300%	Standard Silver	MA 92% AV	Standard Silver	Standard Silver	87% AV Silver
300% up to 400%	Standard Silver	Standard Silver	Standard Silver	Standard Silver	87% AV Silver
400% up to 450%	Standard Silver	Standard Silver	Standard Silver	Standard Silver	Standard Silver
450% up to 500%	Standard Silver	Standard Silver	Standard Silver	Standard Silver	Standard Silver
500% up to 600%	Standard Silver	Standard Silver	Standard Silver	Standard Silver	Standard Silver
Above 600%	Standard Silver	Standard Silver	Standard Silver	Standard Silver	Standard Silver

See Notes section in above table for sources.

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix D-2: Massachusetts Premium Tax Credit (PTC) and Cost Share Reduction (CSR) Model

							Annual amounts per enrollee without state funding			Annual amounts per enrollee with additional state funding				
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	SLCS Premium	Federal PTC	State PTC	State CSR	Enrollee premium
Adult	Below 138%	Direct	17,869	17,485	100%	17,485	$ 4,700	$ 4,481	$ 219	$ 4,688	$ 4,470	$ 219	$ 255	$ 0
Adult	139%-150%	Direct	34,185	33,038	100%	33,038	$ 7,478	$ 6,849	$ 629	$ 7,460	$ 6,831	$ 629	$ 123	$ 0
Adult	151%-200%	Direct	65,603	65,337	100%	65,337	$ 6,863	$ 5,706	$ 1,157	$ 6,847	$ 5,689	$ 515	$ 515	$ 642
Adult	201%-250%	Direct	42,515	42,157	100%	42,157	$ 7,259	$ 5,423	$ 1,836	$ 7,242	$ 5,406	$ 721	$ 1,660	$ 1,115
Adult	251%-300%	Direct	28,967	25,642	100%	25,642	$ 7,653	$ 5,128	$ 2,525	$ 7,654	$ 5,106	$ 839	$ 2,120	$ 1,709
Adult	301%-400%	Direct	32,099	29,996	99%	29,829	$ 7,755	$ 4,450	$ 3,305	$ 3,282	$ 0	$ 0	$ 0	$ 3,282
Adult	401%-600%	Direct	40,659	37,305	85%	31,678	$ 7,030	$ 0	$ 7,030	$ 6,622	$ 0	$ 0	$ 0	$ 6,622
Adult	Over 600%	Direct	54,860	52,096	69%	36,001	$ 7,278	$ 0	$ 7,278	$ 6,855	$ 0	$ 0	$ 0	$ 6,855
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	9,598	99%	9,537	$ 3,084	$ 1,446	$ 1,638	$ 1,638	$ 0	$ 0	$ 0	$ 1,638
Child	401%-600%	Direct	12,678	12,660	85%	10,750	$ 2,815	$ 0	$ 2,815	$ 2,652	$ 0	$ 0	$ 0	$ 2,652
Child	Over 600%	Direct	15,868	15,773	69%	10,900	$ 2,845	$ 0	$ 2,845	$ 2,680	$ 0	$ 0	$ 0	$ 2,680
Adult	Below 138%	Uninsured	349,531	9,666	71%	6,905	$ 4,489	$ 4,289	$ 201	$ 4,479	$ 4,278	$ 201	$ 151	$ 0
Adult	139%-150%	Uninsured	27,992	16,392	67%	11,033	$ 6,927	$ 6,290	$ 636	$ 6,910	$ 6,274	$ 636	$ 90	$ 0
Adult	151%-200%	Uninsured	124,115	74,091	18%	13,686	$ 6,014	$ 4,803	$ 1,211	$ 5,999	$ 4,788	$ 607	$ 449	$ 604
Adult	201%-250%	Uninsured	97,757	72,190	20%	14,136	$ 5,882	$ 3,862	$ 2,021	$ 5,868	$ 3,848	$ 956	$ 1,571	$ 1,065
Adult	251%-300%	Uninsured	55,033	38,863	21%	8,104	$ 6,723	$ 3,820	$ 2,903	$ 6,724	$ 3,802	$ 1,311	$ 1,977	$ 1,610
Adult	301%-400%	Uninsured	63,129	48,036	0%	127	$ 3,491	$ 33	$ 3,458	$ 3,281	$ 0	$ 0	$ 0	$ 3,281
Adult	401%-600%	Uninsured	66,227	54,589	1%	656	$ 5,906	$ 0	$ 5,906	$ 5,563	$ 0	$ 0	$ 0	$ 5,563
Adult	Over 600%	Uninsured	36,535	30,179	1%	363	$ 5,625	$ 0	$ 5,625	$ 5,298	$ 0	$ 0	$ 0	$ 5,298
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	8,248	0%	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	401%-600%	Uninsured	11,604	11,320	1%	131	$ 2,731	$ 0	$ 2,731	$ 2,572	$ 0	$ 0	$ 0	$ 2,572
Child	Over 600%	Uninsured	7,565	7,565	1%	91	$ 2,810	$ 0	$ 2,810	$ 2,646	$ 0	$ 0	$ 0	$ 2,646
		Total	**1,279,879**	**712,227**	**52%**	**367,585**	**$ 6,586**	**$ 3,902**	**$ 2,684**	**$ 6,090**	**$ 3,493**	**$ 411**	**$ 579**	**$ 2,186**
		Direct	354,902	341,087	92%	312,355	$ 6,680	$ 3,791	$ 2,890	$ 6,099	$ 3,312	$ 353	$ 533	$ 2,435
		Uninsured	924,977	371,140	15%	55,230	$ 6,053	$ 4,532	$ 1,521	$ 6,034	$ 4,517	$ 740	$ 840	$ 777
								Totals (in Millions)		**$ 2,238.0**	**$ 1,284.0**	**$ 151.0**	**$ 213.0**	**$ 804.0**

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix D-3: No FPL Limit on Premium Tax Credits (PTCs) and Cost Share Reduction (CSR) Model

							Annual amounts per enrollee without state funding			Annual amounts per enrollee with additional state funding				
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	SLCS Premium	Federal PTC	State PTC	State CSR	Enrollee premium
Adult	Below 138%	Direct	17,869	17,485	100%	17,485	$ 4,700	$ 4,481	$ 219	$ 4,620	$ 4,401	$ 0	$ 0	$ 219
Adult	139%-150%	Direct	34,185	33,038	100%	33,038	$ 7,478	$ 6,849	$ 629	$ 7,351	$ 6,722	$ 0	$ 0	$ 629
Adult	151%-200%	Direct	65,603	65,337	100%	65,337	$ 6,863	$ 5,706	$ 1,157	$ 6,747	$ 5,590	$ 0	$ 0	$ 1,157
Adult	201%-250%	Direct	42,515	42,157	100%	42,157	$ 7,259	$ 5,423	$ 1,836	$ 7,137	$ 5,301	$ 0	$ 0	$ 1,836
Adult	251%-300%	Direct	28,967	25,642	100%	25,555	$ 7,652	$ 5,127	$ 2,525	$ 7,518	$ 4,982	$ 0	$ 0	$ 2,536
Adult	301%-400%	Direct	32,099	29,996	99%	29,817	$ 7,756	$ 4,452	$ 3,305	$ 7,624	$ 4,323	$ 0	$ 0	$ 3,301
Adult	401%-600%	Direct	40,659	37,305	92%	34,167	$ 7,195	$ 0	$ 7,195	$ 7,662	$ 0	$ 3,379	$ 0	$ 4,283
Adult	Over 600%	Direct	54,860	52,096	69%	35,881	$ 7,314	$ 0	$ 7,314	$ 7,371	$ 0	$ 497	$ 0	$ 6,874
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	9,598	99%	9,536	$ 3,084	$ 1,446	$ 1,638	$ 3,032	$ 1,393	$ 0	$ 0	$ 1,639
Child	401%-600%	Direct	12,678	12,660	88%	11,184	$ 2,845	$ 0	$ 2,845	$ 3,009	$ 0	$ 819	$ 0	$ 2,190
Child	Over 600%	Direct	15,868	15,773	68%	10,796	$ 2,848	$ 0	$ 2,848	$ 2,836	$ 0	$ 73	$ 0	$ 2,763
Adult	Below 138%	Uninsured	349,531	9,666	0%	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	139%-150%	Uninsured	27,992	16,392	0%	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	151%-200%	Uninsured	124,115	74,091	0%	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	201%-250%	Uninsured	97,757	72,190	0%	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	251%-300%	Uninsured	55,033	38,863	0%	10	$ 3,367	$ 214	$ 3,152	$ 3,197	$ 0	$ 0	$ 0	$ 3,197
Adult	301%-400%	Uninsured	63,129	48,036	0%	36	$ 3,477	$ 23	$ 3,454	$ 3,419	$ 0	$ 0	$ 0	$ 3,419
Adult	401%-600%	Uninsured	66,227	54,589	12%	6,365	$ 8,354	$ 0	$ 8,354	$ 9,002	$ 0	$ 4,845	$ 0	$ 4,156
Adult	Over 600%	Uninsured	36,535	30,179	4%	1,287	$ 10,677	$ 0	$ 10,677	$ 11,478	$ 0	$ 4,370	$ 0	$ 7,108
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	8,248	0%	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	401%-600%	Uninsured	11,604	11,320	10%	1,129	$ 3,338	$ 0	$ 3,338	$ 3,598	$ 0	$ 1,573	$ 0	$ 2,024
Child	Over 600%	Uninsured	7,565	7,565	1%	55	$ 3,537	$ 0	$ 3,537	$ 3,696	$ 0	$ 570	$ 0	$ 3,125
		Total	**1,279,879**	**712,227**	**45%**	**323,835**	**$ 6,737**	**$ 3,655**	**$ 3,082**	**$ 6,734**	**$ 3,573**	**$ 561**	**$ 0**	**$ 2,600**
		Direct	354,902	341,087	92%	314,953	$ 6,702	$ 3,758	$ 2,944	$ 6,681	$ 3,674	$ 455	$ 0	$ 2,552
		Uninsured	924,977	371,140	2%	8,881	$ 7,999	$ 0	$ 7,998	$ 8,612	$ 0	$ 4,309	$ 0	$ 4,303
								Totals (in Millions)		**$ 2,181.0**	**$ 1,157.0**	**$ 182.0**	**$ 0.0**	**$ 842.0**

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix D-4: California Premium Tax Credit (PTC) and Cost Share Reduction (CSR) Model

							Annual amounts per enrollee without state funding			Annual amounts per enrollee with additional state funding				
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	SLCS Premium	Federal PTC	State PTC	State CSR	Enrollee premium
Adult	Below 138%	Direct	17,869	17,485	100%	17,485	$ 4,700	$ 4,481	$ 219	$ 4,599	$ 4,380	$ 219	$ 0	$ 0
Adult	139%-150%	Direct	34,185	33,038	100%	33,038	$ 7,478	$ 6,849	$ 629	$ 7,318	$ 6,689	$ 0	$ 0	$ 629
Adult	151%-200%	Direct	65,603	65,337	100%	65,337	$ 6,863	$ 5,706	$ 1,157	$ 6,716	$ 5,559	$ 0	$ 0	$ 1,157
Adult	201%-250%	Direct	42,515	42,157	100%	42,157	$ 7,259	$ 5,423	$ 1,836	$ 7,104	$ 5,268	$ 143	$ 0	$ 1,693
Adult	251%-300%	Direct	28,967	25,642	100%	25,642	$ 7,653	$ 5,128	$ 2,525	$ 7,503	$ 4,961	$ 257	$ 0	$ 2,285
Adult	301%-400%	Direct	32,099	29,996	100%	29,996	$ 7,758	$ 4,453	$ 3,305	$ 7,589	$ 4,295	$ 223	$ 0	$ 3,072
Adult	401%-600%	Direct	40,659	37,305	88%	32,926	$ 7,154	$ 0	$ 7,154	$ 7,383	$ 0	$ 2,043	$ 0	$ 5,340
Adult	Over 600%	Direct	54,860	52,096	69%	35,752	$ 7,278	$ 0	$ 7,278	$ 7,021	$ 0	$ 0	$ 0	$ 7,021
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	9,598	100%	9,598	$ 3,084	$ 1,446	$ 1,638	$ 3,018	$ 1,379	$ 113	$ 0	$ 1,526
Child	401%-600%	Direct	12,678	12,660	86%	10,899	$ 2,829	$ 0	$ 2,829	$ 2,834	$ 0	$ 353	$ 0	$ 2,482
Child	Over 600%	Direct	15,868	15,773	69%	10,824	$ 2,845	$ 0	$ 2,845	$ 2,745	$ 0	$ 0	$ 0	$ 2,745
Adult	Below 138%	Uninsured	349,531	9,666	67%	6,498	$ 4,471	$ 4,268	$ 203	$ 4,376	$ 4,173	$ 203	$ 0	$ 0
Adult	139%-150%	Uninsured	27,992	16,392	0%	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	151%-200%	Uninsured	124,115	74,091	0%	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	201%-250%	Uninsured	97,757	72,190	3%	1,829	$ 5,981	$ 4,190	$ 1,791	$ 5,853	$ 4,062	$ 138	$ 0	$ 1,653
Adult	251%-300%	Uninsured	55,033	38,863	4%	1,417	$ 6,816	$ 4,207	$ 2,608	$ 6,674	$ 4,061	$ 269	$ 0	$ 2,344
Adult	301%-400%	Uninsured	63,129	48,036	2%	1,122	$ 6,790	$ 3,625	$ 3,165	$ 6,643	$ 3,482	$ 233	$ 0	$ 2,927
Adult	401%-600%	Uninsured	66,227	54,589	6%	3,366	$ 8,636	$ 0	$ 8,636	$ 9,229	$ 0	$ 4,281	$ 0	$ 4,948
Adult	Over 600%	Uninsured	36,535	30,179	1%	218	$ 5,625	$ 0	$ 5,625	$ 5,426	$ 0	$ 0	$ 0	$ 5,426
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	8,248	3%	258	$ 3,019	$ 1,346	$ 1,673	$ 2,954	$ 1,279	$ 127	$ 0	$ 1,549
Child	401%-600%	Uninsured	11,604	11,320	4%	409	$ 3,764	$ 0	$ 3,764	$ 3,995	$ 0	$ 1,474	$ 0	$ 2,521
Child	Over 600%	Uninsured	7,565	7,565	1%	54	$ 2,810	$ 0	$ 2,810	$ 2,710	$ 0	$ 0	$ 0	$ 2,710
		Total	**1,279,879**	**712,227**	**46%**	**328,826**	**$ 6,659**	**$ 3,743**	**$ 2,916**	**$ 6,554**	**$ 3,639**	**$ 342**	**$ 0**	**$ 2,572**
		Direct	354,902	341,087	92%	313,655	$ 6,694	$ 3,778	$ 2,916	$ 6,581	$ 3,673	$ 304	$ 0	$ 2,604
		Uninsured	924,977	371,140	4%	15,171	$ 5,935	$ 3,017	$ 2,917	$ 5,988	$ 2,935	$ 1,138	$ 0	$ 1,915
								Totals (in Millions)		**$ 2,155.0**	**$ 1,197.0**	**$ 113.0**	**$ 0.0**	**$ 846.0**

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix D-5: House Energy & Commerce Proposals Premium Tax Credit (PTC) and Cost Share Reduction (CSR) Model

							Annual amounts per enrollee without state funding			Annual amounts per enrollee with additional state funding				
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	SLCS Premium	Federal PTC	State PTC	State CSR	Enrollee premium
Adult	Below 138%	Direct	17,869	17,485	100%	17,485	$ 4,700	$ 4,481	$ 219	$ 4,773	$ 4,554	$ 219	$ 0	$ 0
Adult	139%-150%	Direct	34,185	33,038	100%	33,038	$ 7,478	$ 6,849	$ 629	$ 7,594	$ 6,965	$ 629	$ 0	$ 0
Adult	151%-200%	Direct	65,603	65,337	100%	65,337	$ 6,863	$ 5,706	$ 1,157	$ 6,970	$ 5,813	$ 822	$ 410	$ 335
Adult	201%-250%	Direct	42,515	42,157	100%	42,157	$ 7,259	$ 5,423	$ 1,836	$ 7,372	$ 5,536	$ 988	$ 1,719	$ 848
Adult	251%-300%	Direct	28,967	25,642	100%	25,642	$ 7,653	$ 5,128	$ 2,525	$ 7,792	$ 5,243	$ 1,162	$ 1,763	$ 1,387
Adult	301%-400%	Direct	32,099	29,996	100%	29,996	$ 7,758	$ 4,453	$ 3,305	$ 7,888	$ 4,567	$ 868	$ 1,781	$ 2,452
Adult	401%-600%	Direct	40,659	37,305	94%	34,913	$ 7,175	$ 0	$ 7,175	$ 7,884	$ 0	$ 4,174	$ 0	$ 3,710
Adult	Over 600%	Direct	54,860	52,096	70%	36,575	$ 7,336	$ 0	$ 7,336	$ 7,320	$ 0	$ 925	$ 0	$ 6,395
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	9,598	100%	9,598	$ 3,084	$ 1,446	$ 1,638	$ 3,132	$ 1,493	$ 418	$ 958	$ 1,221
Child	401%-600%	Direct	12,678	12,660	91%	11,532	$ 2,845	$ 0	$ 2,845	$ 3,126	$ 0	$ 1,234	$ 0	$ 1,892
Child	Over 600%	Direct	15,868	15,773	70%	10,976	$ 2,852	$ 0	$ 2,852	$ 2,778	$ 0	$ 174	$ 0	$ 2,604
Adult	Below 138%	Uninsured	349,531	9,666	67%	6,498	$ 4,471	$ 4,268	$ 203	$ 4,541	$ 4,338	$ 203	$ 0	$ 0
Adult	139%-150%	Uninsured	27,992	16,392	67%	10,918	$ 6,936	$ 6,300	$ 636	$ 7,044	$ 6,408	$ 636	$ 0	$ 0
Adult	151%-200%	Uninsured	124,115	74,091	48%	35,531	$ 6,077	$ 5,074	$ 1,003	$ 6,171	$ 5,168	$ 764	$ 335	$ 239
Adult	201%-250%	Uninsured	97,757	72,190	30%	21,938	$ 5,974	$ 4,201	$ 1,773	$ 6,067	$ 4,294	$ 956	$ 1,621	$ 817
Adult	251%-300%	Uninsured	55,033	38,863	25%	9,893	$ 6,637	$ 4,081	$ 2,556	$ 6,751	$ 4,183	$ 1,177	$ 1,671	$ 1,391
Adult	301%-400%	Uninsured	63,129	48,036	14%	6,649	$ 6,601	$ 3,407	$ 3,194	$ 6,720	$ 3,502	$ 877	$ 1,802	$ 2,341
Adult	401%-600%	Uninsured	66,227	54,589	16%	8,929	$ 7,922	$ 0	$ 7,922	$ 8,807	$ 0	$ 5,231	$ 0	$ 3,576
Adult	Over 600%	Uninsured	36,535	30,179	8%	2,408	$ 9,667	$ 0	$ 9,667	$ 10,667	$ 0	$ 4,624	$ 0	$ 6,042
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	8,248	19%	1,537	$ 3,002	$ 1,327	$ 1,675	$ 3,049	$ 1,371	$ 456	$ 973	$ 1,222
Child	401%-600%	Uninsured	11,604	11,320	17%	1,897	$ 3,111	$ 0	$ 3,111	$ 3,461	$ 0	$ 1,707	$ 0	$ 1,753
Child	Over 600%	Uninsured	7,565	7,565	3%	249	$ 3,343	$ 0	$ 3,343	$ 3,592	$ 0	$ 792	$ 0	$ 2,801
		Total	**1,279,879**	**712,227**	**59%**	**423,697**	**$ 6,589**	**$ 3,821**	**$ 2,768**	**$ 6,758**	**$ 3,898**	**$ 1,207**	**$ 672**	**$ 1,653**
		Direct	354,902	341,087	93%	317,249	$ 6,699	$ 3,735	$ 2,963	$ 6,861	$ 3,810	$ 1,184	$ 653	$ 1,867
		Uninsured	924,977	371,140	29%	106,448	$ 6,263	$ 4,077	$ 2,186	$ 6,451	$ 4,159	$ 1,276	$ 728	$ 1,016
								Totals (in Millions)		**$ 2,863.0**	**$ 1,651.0**	**$ 511.0**	**$ 285.0**	**$ 700.0**

APPENDIX E

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
Marketplace Public Option
Appendix E-1: Highlights of methodology and assumptions used in modeling

Modeling Component	Description of Assumptions and Methodology
Eligibility	Not eligible for Medicaid and US citizen or documented immigrant, consistent with the Marketplace Note: Modeling does not reflect the potential for enrollees from ESI who may retire or otherwise leave employment because Marketplace coverage is now more affordable due to state-funded PTCs/CSRs.
SLCS plan premiums	
Without Marketpace Public Option	Estimates based upon assumed 2022 Second Lowest Cost Silver (SLCS) plan premiums
With Marketplace Public Option	Estimates reflect a 10% to 30% decrease from the assumed 2022 SLCS plan premiums
Federal Premium Tax Credits (PTCs)	Estimates based upon assumed 2022 federal premium tax credit percentages and federal poverty levels. Enrollees assumed to have 2022 income at the same multiple of the FPL as in the baseline population
Enrollee Premium	Calculated as [SLCS plan premium] less [federal PTCs].

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix E-2: Marketplace Public Option - 10% Reduction SLCS Premiums

							Annual amounts per enrollee w/o Marketplace public option			Annual amounts per enrollee with Marketplace public option		
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC per Enrollee	Enrollee Premium	SLCS Premium	Federal PTC per Enrollee	Enrollee Premium
Adult	Below 138%	Direct	17,869	17,485	99%	17,344	$ 4,698	$ 4,480	$ 219	$ 4,113	$ 3,894	$ 219
Adult	139%-150%	Direct	34,185	33,038	99%	32,719	$ 7,447	$ 6,817	$ 629	$ 6,518	$ 5,889	$ 629
Adult	151%-200%	Direct	65,603	65,337	99%	64,519	$ 6,796	$ 5,636	$ 1,160	$ 5,949	$ 4,789	$ 1,160
Adult	201%-250%	Direct	42,515	42,157	99%	41,919	$ 7,215	$ 5,376	$ 1,839	$ 6,314	$ 4,476	$ 1,838
Adult	251%-300%	Direct	28,967	25,642	100%	25,561	$ 7,651	$ 5,112	$ 2,539	$ 6,680	$ 4,178	$ 2,501
Adult	301%-400%	Direct	32,099	29,996	99%	29,832	$ 7,754	$ 4,446	$ 3,309	$ 6,775	$ 3,527	$ 3,248
Adult	401%-600%	Direct	40,659	37,305	86%	32,225	$ 7,030	$ 0	$ 7,030	$ 6,154	$ 0	$ 6,154
Adult	Over 600%	Direct	54,860	52,096	71%	36,765	$ 7,278	$ 0	$ 7,278	$ 6,371	$ 0	$ 6,371
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	9,598	99%	9,540	$ 3,084	$ 1,445	$ 1,639	$ 2,687	$ 1,055	$ 1,632
Child	401%-600%	Direct	12,678	12,660	86%	10,936	$ 2,815	$ 0	$ 2,815	$ 2,464	$ 0	$ 2,464
Child	Over 600%	Direct	15,868	15,773	71%	11,131	$ 2,845	$ 0	$ 2,845	$ 2,490	$ 0	$ 2,490
Adult	Below 138%	Uninsured	349,531	9,666	0%	-	N/A	N/A	N/A	N/A	N/A	N/A
Adult	139%-150%	Uninsured	27,992	16,392	0%	-	N/A	N/A	N/A	N/A	N/A	N/A
Adult	151%-200%	Uninsured	124,115	74,091	0%	-	N/A	N/A	N/A	N/A	N/A	N/A
Adult	201%-250%	Uninsured	97,757	72,190	0%	5	$ 3,120	$ 440	$ 2,680	$ 2,491	$ 0	$ 2,491
Adult	251%-300%	Uninsured	55,033	38,863	0%	161	$ 3,555	$ 268	$ 3,287	$ 2,935	$ 0	$ 2,935
Adult	301%-400%	Uninsured	63,129	48,036	1%	415	$ 3,571	$ 65	$ 3,506	$ 3,091	$ 0	$ 3,091
Adult	401%-600%	Uninsured	66,227	54,589	4%	2,361	$ 6,175	$ 0	$ 6,175	$ 5,405	$ 0	$ 5,405
Adult	Over 600%	Uninsured	36,535	30,179	7%	2,024	$ 6,471	$ 0	$ 6,471	$ 5,664	$ 0	$ 5,664
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	8,248	0%	16	$ 2,607	$ 433	$ 2,175	$ 2,081	$ 0	$ 2,081
Child	401%-600%	Uninsured	11,604	11,320	5%	596	$ 2,727	$ 0	$ 2,727	$ 2,387	$ 0	$ 2,387
Child	Over 600%	Uninsured	7,565	7,565	8%	607	$ 2,807	$ 0	$ 2,807	$ 2,457	$ 0	$ 2,457
		Total	**1,279,879**	**712,227**	**45%**	**318,677**	**$ 6,628**	**$ 3,662**	**$ 2,966**	**$ 5,798**	**$ 3,072**	**$ 2,726**
		Direct	354,902	341,087	92%	312,492	$ 6,653	$ 3,734	$ 2,919	$ 5,820	$ 3,132	$ 2,688
		Uninsured	924,977	371,140	2%	6,185	$ 5,354	$ 13	$ 5,341	$ 4,679	$ 0	$ 4,679
					Totals (in Millions)		**$ 2,112.1**	**$ 1,166.9**	**$ 945.2**	**$ 1,847.7**	**$ 979.0**	**$ 868.8**

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix E-3: Marketplace Public Option - 20% Reduction SLCS Premiums

							Annual amounts per enrollee w/o Marketplace public option			Annual amounts per enrollee with Marketplace public option		
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC per Enrollee	Enrollee Premium	SLCS Premium	Federal PTC per Enrollee	Enrollee Premium
Adult	Below 138%	Direct	17,869	17,485	99%	17,344	$ 4,698	$ 4,480	$ 219	$ 3,667	$ 3,448	$ 219
Adult	139%-150%	Direct	34,185	33,038	99%	32,719	$ 7,447	$ 6,817	$ 629	$ 5,812	$ 5,182	$ 629
Adult	151%-200%	Direct	65,603	65,337	99%	64,519	$ 6,796	$ 5,636	$ 1,160	$ 5,304	$ 4,144	$ 1,160
Adult	201%-250%	Direct	42,515	42,157	99%	41,919	$ 7,215	$ 5,376	$ 1,839	$ 5,629	$ 3,792	$ 1,837
Adult	251%-300%	Direct	28,967	25,642	100%	25,562	$ 7,651	$ 5,112	$ 2,539	$ 5,951	$ 3,490	$ 2,461
Adult	301%-400%	Direct	32,099	29,996	99%	29,838	$ 7,754	$ 4,445	$ 3,309	$ 6,031	$ 2,844	$ 3,188
Adult	401%-600%	Direct	40,659	37,305	89%	33,081	$ 7,030	$ 0	$ 7,030	$ 5,487	$ 0	$ 5,487
Adult	Over 600%	Direct	54,860	52,096	73%	37,960	$ 7,278	$ 0	$ 7,278	$ 5,680	$ 0	$ 5,680
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	9,598	99%	9,541	$ 3,084	$ 1,445	$ 1,639	$ 2,393	$ 776	$ 1,617
Child	401%-600%	Direct	12,678	12,660	89%	11,226	$ 2,815	$ 0	$ 2,815	$ 2,197	$ 0	$ 2,197
Child	Over 600%	Direct	15,868	15,773	73%	11,493	$ 2,845	$ 0	$ 2,845	$ 2,220	$ 0	$ 2,220
Adult	Below 138%	Uninsured	349,531	9,666	0%	-	N/A	N/A	N/A	N/A	N/A	N/A
Adult	139%-150%	Uninsured	27,992	16,392	0%	-	N/A	N/A	N/A	N/A	N/A	N/A
Adult	151%-200%	Uninsured	124,115	74,091	0%	-	N/A	N/A	N/A	N/A	N/A	N/A
Adult	201%-250%	Uninsured	97,757	72,190	0%	22	$ 3,210	$ 555	$ 2,655	$ 2,285	$ 0	$ 2,285
Adult	251%-300%	Uninsured	55,033	38,863	1%	403	$ 3,683	$ 374	$ 3,308	$ 2,688	$ 0	$ 2,688
Adult	301%-400%	Uninsured	63,129	48,036	2%	924	$ 3,672	$ 172	$ 3,499	$ 2,799	$ 0	$ 2,799
Adult	401%-600%	Uninsured	66,227	54,589	8%	4,626	$ 6,197	$ 0	$ 6,197	$ 4,836	$ 0	$ 4,836
Adult	Over 600%	Uninsured	36,535	30,179	14%	4,079	$ 6,513	$ 0	$ 6,513	$ 5,084	$ 0	$ 5,084
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	8,248	1%	105	$ 2,637	$ 474	$ 2,162	$ 1,877	$ 0	$ 1,877
Child	401%-600%	Uninsured	11,604	11,320	10%	1,188	$ 2,727	$ 0	$ 2,727	$ 2,128	$ 0	$ 2,128
Child	Over 600%	Uninsured	7,565	7,565	16%	1,233	$ 2,807	$ 0	$ 2,807	$ 2,191	$ 0	$ 2,191
		Total	**1,279,879**	**712,227**	**46%**	**327,782**	**$ 6,598**	**$ 3,561**	**$ 3,037**	**$ 5,145**	**$ 2,554**	**$ 2,591**
		Direct	354,902	341,087	92%	315,202	$ 6,648	$ 3,702	$ 2,946	$ 5,184	$ 2,656	$ 2,529
		Uninsured	924,977	371,140	3%	12,579	$ 5,339	$ 30	$ 5,309	$ 4,154	$ 0	$ 4,154
					Totals (in Millions)		**$ 2,162.7**	**$ 1,167.2**	**$ 995.5**	**$ 1,686.4**	**$ 837.2**	**$ 849.3**

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix E-4: Marketplace Public Option - 30% Reduction SLCS Premiums

							Annual amounts per enrollee w/o Marketplace public option			Annual amounts per enrollee with Marketplace public option		
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC per Enrollee	Enrollee Premium	SLCS Premium	Federal PTC per Enrollee	Enrollee Premium
Adult	Below 138%	Direct	17,869	17,485	99%	17,344	$ 4,698	$ 4,480	$ 219	$ 3,208	$ 2,989	$ 219
Adult	139%-150%	Direct	34,185	33,038	99%	32,719	$ 7,447	$ 6,817	$ 629	$ 5,084	$ 4,454	$ 629
Adult	151%-200%	Direct	65,603	65,337	99%	64,519	$ 6,796	$ 5,636	$ 1,160	$ 4,637	$ 3,479	$ 1,158
Adult	201%-250%	Direct	42,515	42,157	99%	41,919	$ 7,215	$ 5,376	$ 1,839	$ 4,909	$ 3,085	$ 1,824
Adult	251%-300%	Direct	28,967	25,642	100%	25,565	$ 7,651	$ 5,111	$ 2,540	$ 5,194	$ 2,785	$ 2,409
Adult	301%-400%	Direct	32,099	29,996	100%	29,855	$ 7,752	$ 4,443	$ 3,309	$ 5,249	$ 2,149	$ 3,100
Adult	401%-600%	Direct	40,659	37,305	91%	34,079	$ 7,030	$ 0	$ 7,030	$ 4,800	$ 0	$ 4,800
Adult	Over 600%	Direct	54,860	52,096	76%	39,355	$ 7,278	$ 0	$ 7,278	$ 4,969	$ 0	$ 4,969
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	9,598	100%	9,557	$ 3,083	$ 1,444	$ 1,639	$ 2,050	$ 474	$ 1,576
Child	401%-600%	Direct	12,678	12,660	91%	11,565	$ 2,815	$ 0	$ 2,815	$ 1,922	$ 0	$ 1,922
Child	Over 600%	Direct	15,868	15,773	76%	11,915	$ 2,845	$ 0	$ 2,845	$ 1,942	$ 0	$ 1,942
Adult	Below 138%	Uninsured	349,531	9,666	0%	-	N/A	N/A	N/A	N/A	N/A	N/A
Adult	139%-150%	Uninsured	27,992	16,392	0%	-	N/A	N/A	N/A	N/A	N/A	N/A
Adult	151%-200%	Uninsured	124,115	74,091	0%	-	N/A	N/A	N/A	N/A	N/A	N/A
Adult	201%-250%	Uninsured	97,757	72,190	0%	213	$ 3,421	$ 971	$ 2,450	$ 2,130	$ 0	$ 2,130
Adult	251%-300%	Uninsured	55,033	38,863	2%	722	$ 3,757	$ 449	$ 3,308	$ 2,390	$ 0	$ 2,390
Adult	301%-400%	Uninsured	63,129	48,036	4%	1,701	$ 3,783	$ 322	$ 3,461	$ 2,492	$ 0	$ 2,492
Adult	401%-600%	Uninsured	66,227	54,589	13%	7,236	$ 6,203	$ 0	$ 6,203	$ 4,235	$ 0	$ 4,235
Adult	Over 600%	Uninsured	36,535	30,179	21%	6,432	$ 6,526	$ 0	$ 6,526	$ 4,455	$ 0	$ 4,455
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	8,248	3%	261	$ 2,675	$ 538	$ 2,136	$ 1,665	$ 0	$ 1,665
Child	401%-600%	Uninsured	11,604	11,320	16%	1,867	$ 2,727	$ 0	$ 2,727	$ 1,862	$ 0	$ 1,862
Child	Over 600%	Uninsured	7,565	7,565	26%	1,949	$ 2,807	$ 0	$ 2,807	$ 1,917	$ 0	$ 1,917
		Total	**1,279,879**	**712,227**	**48%**	**338,771**	**$ 6,562**	**$ 3,448**	**$ 3,114**	**$ 4,469**	**$ 2,041**	**$ 2,428**
		Direct	354,902	341,087	93%	318,392	$ 6,643	$ 3,665	$ 2,978	$ 4,524	$ 2,171	$ 2,353
		Uninsured	924,977	371,140	5%	20,379	$ 5,299	$ 60	$ 5,239	$ 3,600	$ 0	$ 3,600
					Totals (in Millions)		**$ 2,223.0**	**$ 1,168.1**	**$ 1,054.9**	**$ 1,513.9**	**$ 691.4**	**$ 822.6**

APPENDIX F

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
Medicaid Buy-In
Appendix F-1: Highlights of methodology and assumptions used in modeling

Modeling Component	Description of Assumptions and Methodology
Eligibility	Number of eligible lives estimated as per baseline population modeling for the following variations:
Cost of coverage	Estimates based upon 2021 Medicaid capitation rates for the non-disabled children and adults and the ACA expansion populations with one year of trend at 5% Estimates reflect Medicaid covered benefits except long term care and waiver services Risk adjustment was applied to reflect estimated morbidity differences between the BHP and Medicaid populations
Enrollee premium and cost sharing	Enrollees assumed to have 2022 income at the same multiple of the FPL as in the baseline population Premiums are consistent with federal affordability standards Enrollee cost sharing estimated average value per enrollee based upon utilization underlying 2021 Medicaid capitation rates for the non-disabled children and adults and the ACA expansion populations Risk adjustment was applied to reflect estimated morbidity differences between the BHP and Medicaid populations

ELIGIBILITY FOR MEDICAID BUY-IN VARIATIONS

VARIATION	ELIGIBILITY
Targeted	Undocumented immigrant and households in the "ACA family glitch", limited to households with income below 400% FPL
Broad – Basic	Anyone not eligible for Medicare or comprehensive Medicaid coverage
Broad – Enhanced	Anyone not eligible for Medicare or comprehensive Medicaid coverage

Note: The phrase "ACA family glitch" has been coined to identify families that have an offer of affordable ESI coverage for a single enrollee, per federal standards, but not for a family. These families are not eligible for federal PTCs on the Marketplace.

ENROLLEE PREMIUM AND COST SHARING FOR MEDICAID BUY-IN VARIATIONS

VARIATION	ENROLLEE PREMIUMS[a]	ENROLLEE COST SHARING[b]
Targeted	Federal maximums for the SLCS plan as a percentage of household income (table below)	Consistent with Silver level actuarial values offered in the Marketplace, including CSR variations
Broad – Basic	30% less than the assumed CY 2022 SLCS premiums, subject to the federal maximums as a percentage of household income	Consistent with Silver level AVs offered in the Marketplace, including CSR variations
Broad – Enhanced	Consistent with Massachusetts up to 300% FPL (table below), 30% less than the assumed CY 2022 SLCS premiums, subject to the federal maximums as a percentage of household income over 300% FPL	Consistent with Massachusetts up to 300% FPL (table below), 73% AV calculator over 300% FPL

Notes:
a. Enrollee premiums in these Medicaid buy-in variations are related to household income and SLCS premiums on the Marketplace. They are not related to the provider reimbursement underlying the cost of coverage for the Medicaid buy-in. Alternative variations are possible.
b. Enrollee cost sharing is based upon plan design elements that meet the applicable AV per the federal AV calculator. Under these plan designs, enrollees will pay a greater share of the cost in the Medicaid buy-in than they would in the Individual ACA market due to the differences in provider reimbursement.

PROJECTED CY 2022 PREMIUM TAX CREDIT PERCENTAGES

FPL RANGE	LOW END	HIGH END
Up to 133%	2.1%	2.1%
133% up to 150%	3.2%	4.2%
150% up to 200%	4.2%	6.7%
200% up to 250%	6.7%	8.5%
250% up to 300%	8.5%	10.1%
300% up to 400%	10.1%	10.1%

MONTHLY PREMIUMS AND COST SHARING FOR BROAD - ENHANCED VARIATION UNDER 300% FPL

FPL RANGE	MASSACHUSETTS PREMIUM	MASSACHUSETTS COST SHARING
Up to 100%	$ 0	MA 100% AV
100 up to 138%	$ 0	MA 95% AV
138% up to 150%	$ 0	MA 95% AV
150% up to 200%	$ 45	MA 95% AV
200% up to 250%	$ 87	MA 92% AV
250% up to 300%	$ 130	MA 92% AV

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix F-2: Medicaid Buy-In Targeted

							Annual amounts per enrollee without Medicaid Buy-In			Annual amounts per enrollee with Medicaid Buy-in			
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	Cost of Coverage	State Funding	Enrollee Cost Sharing	Enrollee Premium
Adult	Below 138%	Direct	17,869	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	139%-150%	Direct	34,185	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	151%-200%	Direct	65,603	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	201%-250%	Direct	42,515	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	251%-300%	Direct	28,967	3,007	84%	2,518	$ 6,493	$ 0	$ 6,493	$ 5,418	$ 789	$ 2,311	$ 2,318
Adult	301%-400%	Direct	32,099	1,805	84%	1,508	$ 6,118	$ 0	$ 6,118	$ 4,939	$ (642)	$ 2,197	$ 3,384
Adult	401%-600%	Direct	40,659	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Over 600%	Direct	54,860	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Direct	9,598	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	401%-600%	Direct	12,678	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Over 600%	Direct	15,868	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Below 138%	Uninsured	349,531	80,604	35%	28,355	$ 4,882	$ 0	$ 4,882	$ 3,012	$ 2,605	$ 202	$ 205
Adult	139%-150%	Uninsured	27,992	8,915	43%	3,841	$ 4,976	$ 0	$ 4,976	$ 4,435	$ 3,536	$ 283	$ 616
Adult	151%-200%	Uninsured	124,115	40,449	27%	11,040	$ 5,701	$ 0	$ 5,701	$ 4,734	$ 3,126	$ 639	$ 969
Adult	201%-250%	Uninsured	97,757	26,160	27%	7,112	$ 5,597	$ 0	$ 5,597	$ 4,985	$ 1,704	$ 1,719	$ 1,561
Adult	251%-300%	Uninsured	55,033	15,922	29%	4,696	$ 5,378	$ 0	$ 5,378	$ 4,243	$ 146	$ 1,867	$ 2,231
Adult	301%-400%	Uninsured	63,129	14,009	31%	4,393	$ 5,923	$ 0	$ 5,923	$ 4,801	$ (83)	$ 1,979	$ 2,905
Adult	401%-600%	Uninsured	66,227	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Over 600%	Uninsured	36,535	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Uninsured	9,460	560	48%	271	$ 3,019	$ 0	$ 3,019	$ 2,075	$ (767)	$ 1,114	$ 1,728
Child	401%-600%	Uninsured	11,604	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Over 600%	Uninsured	7,565	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Below 138%	Employer	488,111	39,730	48%	19,235	N/A	N/A	N/A	$ 2,547	$ 2,179	$ 171	$ 198
Adult	139%-150%	Employer	63,405	14,132	43%	6,131	N/A	N/A	N/A	$ 5,100	$ 4,121	$ 342	$ 638
Adult	151%-200%	Employer	300,224	69,851	28%	19,706	N/A	N/A	N/A	$ 5,259	$ 3,373	$ 745	$ 1,141
Adult	201%-250%	Employer	410,643	87,735	14%	12,290	N/A	N/A	N/A	$ 5,359	$ 1,786	$ 2,102	$ 1,470
Adult	251%-300%	Employer	331,629	38,465	8%	3,082	N/A	N/A	N/A	$ 4,451	$ 43	$ 2,336	$ 2,072
Adult	301%-400%	Employer	665,085	74,113	4%	2,801	N/A	N/A	N/A	$ 4,596	$ (704)	$ 2,494	$ 2,806
Adult	401%-600%	Employer	1,080,433	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adult	Over 600%	Employer	1,568,117	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Below 138%	Employer	129,544	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	139%-150%	Employer	15,788	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	151%-200%	Employer	104,375	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	201%-250%	Employer	127,561	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	251%-300%	Employer	121,752	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	301%-400%	Employer	217,861	19,389	4%	684	N/A	N/A	N/A	$ 3,029	$ (264)	$ 1,593	$ 1,700
Child	401%-600%	Employer	325,529	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child	Over 600%	Employer	396,481	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Total	**7,626,418**	**534,846**	**24%**	**127,662**	**N/A**	**N/A**	**N/A**	**$ 4,161**	**$ 2,262**	**$ 894**	**$ 1,005**
		Direct	354,902	4,812	84%	4,026	$ 6,352	$ 0	$ 6,352	$ 5,239	$ 253	$ 2,268	$ 2,717
		Uninsured	924,977	186,619	32%	59,708	$ 5,232	$ 0	$ 5,232	$ 3,881	$ 2,248	$ 735	$ 899
		Employer	6,346,539	343,415	19%	63,928	N/A	N/A	N/A	$ 4,355	$ 2,402	$ 957	$ 996
								Totals (in Millions)		**$ 531.0**	**$ 289.0**	**$ 114.0**	**$ 128.0**

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix F-3: Medicaid Buy-In Broad - Basic

							Annual amounts per enrollee without Medicaid Buy-In			Annual amounts per enrollee with Medicaid Buy-in				
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	Cost of Coverage	Federal Funding	State funding	Enrollee Cost Sharing	Enrollee Premium
Adult	Below 138%	Direct	17,869	17,485	0%	-	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Adult	139%-150%	Direct	34,185	33,038	0%	-	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Adult	151%-200%	Direct	65,603	65,337	0%	-	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Adult	201%-250%	Direct	42,515	42,157	1%	605	$ 3,613	$ 933	$ 2,680	$ 3,377	$ 933	$ (1,418)	$ 1,332	$ 2,529
Adult	251%-300%	Direct	28,967	28,649	10%	2,899	$ 3,745	$ 456	$ 3,289	$ 3,613	$ 456	$ (1,224)	$ 1,715	$ 2,667
Adult	301%-400%	Direct	32,099	31,801	14%	4,520	$ 4,006	$ 338	$ 3,667	$ 3,517	$ 338	$ (1,544)	$ 1,770	$ 2,953
Adult	401%-600%	Direct	40,659	39,867	70%	28,051	$ 7,065	$ 0	$ 7,065	$ 5,044	$ 0	$ (2,602)	$ 2,223	$ 5,423
Adult	Over 600%	Direct	54,860	53,862	60%	32,305	$ 7,305	$ 0	$ 7,305	$ 5,491	$ 0	$ (2,497)	$ 2,381	$ 5,607
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	301%-400%	Direct	9,598	9,598	8%	762	$ 2,408	$ 431	$ 1,977	$ 2,204	$ 431	$ (973)	$ 1,061	$ 1,686
Child	401%-600%	Direct	12,678	12,678	84%	10,693	$ 2,816	$ 0	$ 2,816	$ 2,153	$ 0	$ (1,143)	$ 1,134	$ 2,161
Child	Over 600%	Direct	15,868	15,868	69%	10,973	$ 2,845	$ 0	$ 2,845	$ 2,218	$ 0	$ (1,132)	$ 1,166	$ 2,184
Adult	Below 138%	Uninsured	349,531	89,893	31%	27,609	$ 4,472	$ 0	$ 4,472	$ 3,027	$ 0	$ 2,617	$ 203	$ 207
Adult	139%-150%	Uninsured	27,992	27,364	12%	3,149	$ 4,252	$ 0	$ 4,252	$ 4,422	$ 0	$ 3,521	$ 277	$ 624
Adult	151%-200%	Uninsured	124,115	122,335	7%	8,898	$ 5,019	$ 0	$ 5,019	$ 4,640	$ 0	$ 3,048	$ 627	$ 966
Adult	201%-250%	Uninsured	97,757	96,642	6%	5,493	$ 4,796	$ 3	$ 4,792	$ 4,908	$ 0	$ 1,626	$ 1,671	$ 1,611
Adult	251%-300%	Uninsured	55,033	54,341	9%	4,735	$ 4,662	$ 32	$ 4,630	$ 4,159	$ 0	$ 132	$ 1,817	$ 2,209
Adult	301%-400%	Uninsured	63,129	62,587	8%	4,861	$ 4,975	$ 36	$ 4,938	$ 4,628	$ 0	$ (91)	$ 1,915	$ 2,804
Adult	401%-600%	Uninsured	66,227	63,934	12%	7,981	$ 5,825	$ 0	$ 5,825	$ 6,952	$ 0	$ (539)	$ 3,020	$ 4,471
Adult	Over 600%	Uninsured	36,535	35,486	18%	6,513	$ 5,942	$ 0	$ 5,942	$ 6,817	$ 0	$ (651)	$ 2,907	$ 4,561
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	301%-400%	Uninsured	9,460	8,395	2%	196	$ 2,733	$ 322	$ 2,411	$ 2,483	$ 0	$ (689)	$ 1,314	$ 1,857
Child	401%-600%	Uninsured	11,604	11,604	12%	1,444	$ 2,733	$ 0	$ 2,733	$ 1,997	$ 0	$ (1,134)	$ 1,033	$ 2,098
Child	Over 600%	Uninsured	7,565	7,565	18%	1,346	$ 2,807	$ 0	$ 2,807	$ 1,901	$ 0	$ (1,249)	$ 995	$ 2,155
Adult	Below 138%	Employer	488,111	52,311	45%	23,559	N/A	N/A	N/A	$ 2,494	$ 0	$ 2,123	$ 169	$ 202
Adult	139%-150%	Employer	63,405	62,844	35%	22,246	N/A	N/A	N/A	$ 5,088	$ 0	$ 4,075	$ 343	$ 670
Adult	151%-200%	Employer	300,224	296,897	21%	63,446	N/A	N/A	N/A	$ 5,439	$ 0	$ 3,468	$ 776	$ 1,195
Adult	201%-250%	Employer	410,643	405,068	10%	40,749	N/A	N/A	N/A	$ 5,648	$ 0	$ 1,834	$ 2,161	$ 1,653
Adult	251%-300%	Employer	331,629	327,466	7%	21,663	N/A	N/A	N/A	$ 4,731	$ 0	$ 18	$ 2,396	$ 2,317
Adult	301%-400%	Employer	665,085	656,676	3%	22,340	N/A	N/A	N/A	$ 4,684	$ 0	$ (759)	$ 2,463	$ 2,980
Adult	401%-600%	Employer	1,080,433	1,063,262	2%	22,045	N/A	N/A	N/A	$ 4,757	$ 0	$ (1,043)	$ 2,523	$ 3,276
Adult	Over 600%	Employer	1,568,117	1,539,363	2%	34,105	N/A	N/A	N/A	$ 4,868	$ 0	$ (922)	$ 2,562	$ 3,227
Child	Below 138%	Employer	129,544	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	139%-150%	Employer	15,788	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	151%-200%	Employer	104,375	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	201%-250%	Employer	127,561	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	251%-300%	Employer	121,752	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	301%-400%	Employer	217,861	178,239	4%	6,498	N/A	N/A	N/A	$ 3,035	$ 0	$ (255)	$ 1,590	$ 1,700
Child	401%-600%	Employer	325,529	325,529	1%	4,421	N/A	N/A	N/A	$ 2,413	$ 0	$ (558)	$ 1,216	$ 1,755
Child	Over 600%	Employer	396,481	396,481	2%	6,379	N/A	N/A	N/A	$ 2,432	$ 0	$ (565)	$ 1,210	$ 1,787
		Total	**7,626,418**	**6,234,622**	**7%**	**430,486**	**N/A**	**N/A**	**N/A**	**$ 4,602**	**$ 9**	**$ 636**	**$ 1,594**	**$ 2,363**
		Direct	354,902	350,340	26%	90,809	$ 5,820	$ 41	$ 5,779	$ 4,365	$ 41	$ (2,097)	$ 1,968	$ 4,451
		Uninsured	924,977	580,145	12%	72,225	$ 4,812	$ 6	$ 4,807	$ 4,344	$ 0	$ 1,489	$ 1,181	$ 1,674
		Employer	6,346,539	5,304,136	5%	267,452	N/A	N/A	N/A	$ 4,752	$ 0	$ 1,334	$ 1,579	$ 1,840
									Totals (in Millions)	**$ 1,981.0**	**$ 4.0**	**$ 274.0**	**$ 686.0**	**$ 1,017.0**

Illinois Department of Healthcare and Family Services
Healthcare Reform Feasibility Analysis
2022 Estimated Expenditures
Appendix F-4: Medicaid Buy-In Broad - Enhanced

							Annual amounts per enrollee without Medicaid Buy-In			Annual amounts per enrollee with Medicaid Buy-in				
Age	FPL	Insurance Type	Total Population	Eligibles	Take-up rate	Enrollees	SLCS Premium	Federal PTC	Enrollee Premium	Cost of Coverage	Federal Funding	State funding	Enrollee Cost Sharing	Enrollee Premium
Adult	Below 138%	Direct	17,869	17,485	95%	16,690	$ 4,739	$ 4,517	$ 222	$ 3,620	$ 4,517	$ (914)	$ 17	$ 0
Adult	139%-150%	Direct	34,185	33,038	99%	32,646	$ 7,519	$ 6,890	$ 629	$ 5,820	$ 6,890	$ (1,355)	$ 285	$ 0
Adult	151%-200%	Direct	65,603	65,337	91%	59,407	$ 7,013	$ 5,830	$ 1,183	$ 5,340	$ 5,830	$ (1,277)	$ 246	$ 540
Adult	201%-250%	Direct	42,515	42,157	92%	38,946	$ 7,394	$ 5,527	$ 1,867	$ 5,094	$ 5,527	$ (1,861)	$ 384	$ 1,044
Adult	251%-300%	Direct	28,967	28,649	80%	22,930	$ 7,896	$ 5,224	$ 2,672	$ 5,020	$ 5,224	$ (2,139)	$ 376	$ 1,559
Adult	301%-400%	Direct	32,099	31,801	15%	4,638	$ 4,091	$ 430	$ 3,661	$ 3,581	$ 430	$ (1,206)	$ 1,400	$ 2,958
Adult	401%-600%	Direct	40,659	39,867	71%	28,198	$ 7,063	$ 0	$ 7,063	$ 5,042	$ 0	$ (2,173)	$ 1,794	$ 5,421
Adult	Over 600%	Direct	54,860	53,862	60%	32,500	$ 7,303	$ 0	$ 7,303	$ 5,487	$ 0	$ (2,047)	$ 1,928	$ 5,606
Child	Below 138%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	139%-150%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	151%-200%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	201%-250%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	251%-300%	Direct	-	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	301%-400%	Direct	9,598	9,598	9%	821	$ 2,456	$ 504	$ 1,952	$ 2,263	$ 504	$ (710)	$ 789	$ 1,680
Child	401%-600%	Direct	12,678	12,678	85%	10,771	$ 2,816	$ 0	$ 2,816	$ 2,148	$ 0	$ (831)	$ 818	$ 2,161
Child	Over 600%	Direct	15,868	15,868	70%	11,071	$ 2,845	$ 0	$ 2,845	$ 2,215	$ 0	$ (810)	$ 842	$ 2,184
Adult	Below 138%	Uninsured	349,531	89,893	55%	49,508	$ 4,474	$ 518	$ 3,956	$ 2,894	$ 0	$ 2,842	$ 53	$ 0
Adult	139%-150%	Uninsured	27,992	27,364	51%	14,071	$ 6,181	$ 4,395	$ 1,786	$ 4,434	$ 0	$ 4,222	$ 211	$ 0
Adult	151%-200%	Uninsured	124,115	122,335	21%	25,467	$ 5,544	$ 2,666	$ 2,877	$ 4,590	$ 0	$ 3,838	$ 214	$ 538
Adult	201%-250%	Uninsured	97,757	96,642	20%	19,760	$ 5,636	$ 2,620	$ 3,016	$ 4,922	$ 0	$ 3,527	$ 355	$ 1,040
Adult	251%-300%	Uninsured	55,033	54,341	24%	12,961	$ 5,886	$ 2,248	$ 3,638	$ 4,402	$ 0	$ 2,526	$ 322	$ 1,554
Adult	301%-400%	Uninsured	63,129	62,587	8%	5,217	$ 5,040	$ 205	$ 4,835	$ 4,644	$ 0	$ 285	$ 1,543	$ 2,816
Adult	401%-600%	Uninsured	66,227	63,934	13%	8,380	$ 5,830	$ 0	$ 5,830	$ 6,949	$ 0	$ 49	$ 2,425	$ 4,475
Adult	Over 600%	Uninsured	36,535	35,486	19%	6,859	$ 5,957	$ 0	$ 5,957	$ 6,798	$ 0	$ (106)	$ 2,332	$ 4,572
Child	Below 138%	Uninsured	41,377	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	139%-150%	Uninsured	2,691	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	151%-200%	Uninsured	13,436	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	201%-250%	Uninsured	9,546	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	251%-300%	Uninsured	8,979	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	301%-400%	Uninsured	9,460	8,395	4%	304	$ 2,814	$ 658	$ 2,156	$ 2,590	$ 0	$ (166)	$ 988	$ 1,768
Child	401%-600%	Uninsured	11,604	11,604	14%	1,607	$ 2,723	$ 0	$ 2,723	$ 1,982	$ 0	$ (849)	$ 741	$ 2,090
Child	Over 600%	Uninsured	7,565	7,565	20%	1,511	$ 2,807	$ 0	$ 2,807	$ 1,861	$ 0	$ (997)	$ 704	$ 2,154
Adult	Below 138%	Employer	488,111	52,311	69%	36,035	N/A	N/A	N/A	$ 2,336	$ 0	$ 2,293	$ 43	$ 0
Adult	139%-150%	Employer	63,405	62,844	68%	43,010	N/A	N/A	N/A	$ 4,551	$ 0	$ 4,329	$ 222	$ 0
Adult	151%-200%	Employer	300,224	296,897	32%	95,564	N/A	N/A	N/A	$ 5,084	$ 0	$ 4,298	$ 248	$ 538
Adult	201%-250%	Employer	410,643	405,068	17%	70,608	N/A	N/A	N/A	$ 5,498	$ 0	$ 4,028	$ 431	$ 1,039
Adult	251%-300%	Employer	331,629	327,466	15%	47,488	N/A	N/A	N/A	$ 4,736	$ 0	$ 2,804	$ 380	$ 1,552
Adult	301%-400%	Employer	665,085	656,676	4%	23,848	N/A	N/A	N/A	$ 4,693	$ 0	$ (245)	$ 1,946	$ 2,991
Adult	401%-600%	Employer	1,080,433	1,063,262	2%	23,493	N/A	N/A	N/A	$ 4,757	$ 0	$ (525)	$ 1,983	$ 3,299
Adult	Over 600%	Employer	1,568,117	1,539,363	2%	36,218	N/A	N/A	N/A	$ 4,866	$ 0	$ (384)	$ 2,009	$ 3,241
Child	Below 138%	Employer	129,544	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	139%-150%	Employer	15,788	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	151%-200%	Employer	104,375	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	201%-250%	Employer	127,561	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	251%-300%	Employer	121,752	-	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$ 0	N/A	N/A
Child	301%-400%	Employer	217,861	178,239	4%	7,592	N/A	N/A	N/A	$ 3,041	$ 0	$ 183	$ 1,152	$ 1,705
Child	401%-600%	Employer	325,529	325,529	2%	5,736	N/A	N/A	N/A	$ 2,406	$ 0	$ (265)	$ 883	$ 1,788
Child	Over 600%	Employer	396,481	396,481	2%	8,264	N/A	N/A	N/A	$ 2,423	$ 0	$ (268)	$ 879	$ 1,811
		Total	**7,626,418**	**6,234,622**	**13%**	**802,121**	**N/A**	**N/A**	**N/A**	**$ 4,633**	**$ 1,227**	**$ 1,312**	**$ 655**	**$ 1,439**
		Direct	354,902	350,340	74%	258,619	$ 6,688	$ 3,805	$ 2,882	$ 4,902	$ 3,805	$ (1,581)	$ 720	$ 1,957
		Uninsured	924,977	580,145	25%	145,646	$ 5,237	$ 1,631	$ 3,606	$ 4,207	$ 0	$ 2,736	$ 475	$ 996
		Employer	6,346,539	5,304,136	8%	397,857	N/A	N/A	N/A	$ 4,614	$ 0	$ 2,671	$ 679	$ 1,264
									Totals (in Millions)	**$ 3,716.0**	**$ 984.0**	**$ 1,052.0**	**$ 526.0**	**$ 1,154.0**

APPENDIX G

Appendix G: Glossary of Terms

Health Insurance Feasibility Study

State of Illinois Department of Healthcare and Family Services

April 1, 2021

We have consistently used terminology in this report as discussed below.

Individual market: In the individual health insurance market, individuals and families purchase health insurance coverage directly from an insurer. Enrollees in the individual market are not enrolled in health care coverage through employer-sponsored insurance (ESI) or government programs, such as Medicare and Medicaid. The individual market is also referred to as the direct market.

There are three segments of the individual market: Marketplace, Off-Marketplace; and Non-ACA. *Marketplace* refers to health insurance coverage that complies with the ACA rating requirements and is purchased via the Marketplace, which is also commonly referred to as a health insurance exchange. Enrollees must purchase health insurance coverage via the Marketplace in order to receive any federal PTCs or CSRs for which they are eligible. *Off-Marketplace* coverage has the same rating and benefit coverage requirements as Marketplace coverage but it is purchased directly from an insurer. Off-Marketplace enrollees do not receive federal PTCs or CSRs. In this report, we refer to the Marketplace and Off-Marketplace segments collectively as the *Individual ACA market* because they form a single risk pool for purposes of establishing premiums. The *Individual non-ACA market* does not comply with the ACA rating requirements and is a separate risk pool from the Individual ACA market.

ACA family glitch: This phrase has been coined to identify families that have an offer of affordable ESI coverage for a single enrollee, per federal standards, but not for a family. These families are not eligible for federal PTCs on the Marketplace.

Federal Poverty Level (FPL): Household income as a percentage of the federal poverty level (FPL) is used to define eligibility criteria for Medicaid, federal PTCs/CSRs, and other programs. For reference, the 2020 FPL for a single person household is $12,760 and increases $4,480 for each additional household member.

Adults: The vast majority of Illinois adults ages 65 and older are eligible for health care coverage through Medicare. The policy options included in this report do not consider this population, so adults generally refers to people between the ages of 19 and 64, inclusive.

Cost sharing: In health care insurance, cost sharing refers to the out-of-pocket costs an enrollee incurs when they receive health care services. Deductibles, coinsurance, and copays are the common forms of cost sharing. Once an enrollee's cumulative cost sharing for a plan year exceeds the out-of-pocket maximum, the insurer covers 100% of the cost of health care services.

Actuarial value (AV): Actuarial value (AV) is the average percentage of the cost of health care services paid for by an insurer for a combination of cost sharing elements. 100% AV means that the insurer pays all costs for health care services and the enrollee has no cost sharing. Higher AVs indicate that enrollees pay less cost sharing, on average, than lower AVs.

Second-lowest cost silver plan (SLCS): Federal PTCs are based upon the premium for the SLCS on the Marketplace in each rating area/county. The federal PTCs are equal to the SLCS premium less a percentage of household income, as specified by the premium tax credit percentages table.

Take up rate. In this report, we refer to the percentage of eligible enrollees participating in a program as the 'take up rate' (e.g., if 50,000 persons were eligible and 25,000 enrolled, the take-up rate would be 50%). Take up rates vary by population cohort based upon premium elasticity (the sensitivity of consumer insurance participation attributable to the change in premium rates), and to a lesser extent, cost sharing elasticity (the sensitivity of consumer insurance participation attributable to the degree of insurance plan design cost sharing). Enrollment rate and participation rate are other terms synonymous with take up rate.

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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Appendix B. List of Acronyms

AABD	Aid to Aged, Blind, and Disabled
ACA	Affordable Care Act
APTC	Advance Premium Tax Credit
ARP	American Rescue Plan Act
AV	Actuarial Value
BHP	Basic Health Program
CHIP	Children's Health Insurance Program
CSR	Cost-sharing Reductions
CY	Calendar Year
DOI	Department of Insurance
DPH	Department of Public Health
ESI	Employer-sponsored Insurance
FFM	Federally Facilitated Marketplace
FFS	Fee-for-Service
FPL	Federal Poverty Level
HCBS	Home and Community Based Services
HEC	U.S. House Energy & Commerce Committee
HFS	Department of Health & Family Services
HMO	Health Maintenance Organization
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer
MAC	Medicaid Advisory Committee
MCO	Managed Care Organization
MLR	Medical Loss Ratio
PCCM	Primary Care Case Management
POS	Point of Service Plan
PPO	Preferred Provider Organization
QHP	Qualified Health Plan
REIA	Racial Equity Impact Assessment
SBM	State-Based Marketplace
SBM-FP	State-Based Marketplace on the Federal Platform
SFY	State Fiscal Year
SLCSP	Second Lowest-Cost Silver Plan
TPA	Third Party Administrator

Appendix C. Glossary of Key Terms

Actuarial Value	The percentage of total average costs for covered benefits that a plan will cover. However, a given individual could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on their actual health care needs and the terms of your insurance policy.
Advance Premium Tax Credits	A tax credit that qualifying individuals can take in advance to lower their monthly premiums for plans sold in the Health Insurance Marketplace.
Coinsurance	The percentage of costs of a covered health care service an enrollee pays after they have paid their deductible.
Copayment	A fixed dollar amount an enrollee pays for a covered health care service after they have paid their deductible.
Cost-sharing Reductions	A discount that lowers the amount that qualifying individuals have to pay for deductibles, copayments, and coinsurance for plans sold in the Health Insurance Marketplace. Individuals who qualify must enroll in a plan in the Silver category to get the cost-sharing reductions.
Deductible	The amount an enrollee pays for covered health care services before the health plan starts to pay. After the enrollee pays their deductible, they would pay only a copayment or coinsurance for covered services. They health plans pays the rest.
Essential Health Benefits	A set of 10 categories of services health insurance plans must cover under the ACA. These include ambulatory services, hospital care, prescription drugs, maternity care, behavioral health and substance use treatment, rehabilitative and habilitative services, pediatric care, including oral and vision services, and more.
Family Glitch	Individuals with an “affordable” offer of employer-sponsored insurance are not eligible for APTCs, regardless of whether they’ve enrolled in such insurance. The federal government determines whether an employer’s offer of coverage is affordable solely based on the premium an employee must

	pay for self-only coverage, not how much the employee has to pay to add their family to the plan, which is often considerably more than the premium for self-only coverage. This leaves many spouses and dependents ineligible for APTCs, even though the offer of ESI is not practically affordable.
Federally Facilitated Marketplace	A Health Insurance Marketplace operated by the federal government.
Federal Poverty Level	A measure of income issued every year by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits, including premium subsidies and cost-sharing reductions for Marketplace health insurance, and Medicaid and CHIP coverage.
Medical Loss Ratio	A ratio that represents the proportion of enrollee premiums devoted to paying medical claims. Under the ACA, individual market insurers must maintain a medical loss ratio of 80 percent or pay rebates to policyholders.
Navigator Program	An individual or organization that's trained and able to provide free assistance to consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. The ACA requires the Health Insurance Marketplace to operate a Navigator program.
Plan Year	A 12-month period of benefits under a health insurance plan or policy. In the individual market, the plan year is required to run from January 1-December 31.
Qualified Health Plan	A health plan that is issued by a state-licensed insurer and certified by the Health Insurance Marketplace. Requirements for certification include providing essential health benefits, following established limits on cost-sharing, and meeting other requirements specified by the ACA.
Rating Area	A region within a state within which insurers may not vary premium rates based on geographic differences in claims costs.

Section 1115 Waiver	Section 1115 of the Social Security Act gives the U.S. Department of Health & Human Services the authority to approve state-level experimental, pilot, or demonstration projects that are determined by the Department to be likely to assist in promoting the objectives of the Medicaid program.
Section 1332 Waiver	Section 1332 of the ACA gives the U.S. Department of Health & Human Services the authority to approve state-level waivers of certain provisions of the ACA so long as they can demonstrate that the coverage will be at least as comprehensive and affordable as coverage under the ACA, it will not cover fewer people, and will not impose any additional costs on the federal government.
Second Lowest-Cost Silver Plan	A plan in the Silver-level tier with the second-lowest monthly premium in a given rating area. The government determines an individual's APTC by calculating the percentage of household income that would be required for the individual to purchase the second lowest-cost Silver plan.
Silver Loading	In October 2017 the Trump administration discontinued reimbursing insurers for cost-sharing reductions. Most states allowed plans to increase Silver plan premiums to make up the costs, beginning in 2018. This "Silver loading" policy resulted in increased premiums for the SLCSP, resulting in increased APTCs for eligible consumers below 400 percent FPL.
State-Based Marketplace	A Health Insurance Marketplace authorized to be operated by the state.
State-Based Marketplace on the Federal Platform	A Health Insurance Marketplace authorized to be run by the state but using the federal HealthCare.gov platform for eligibility and enrollment functions.
State Partnership Marketplace	A Federally Facilitated Marketplace whose functions are performed in partnership with a state.
Third Party Administrator	An entity that performs functions associated with developing and maintaining a health insurance plan, such as claims processing, network development, utilization review, and benefit design. However, the financial risk for paying medical

claims rests with the health plan, not the Third Party Administrator.

Appendix D. Stakeholder Engagement

90-Minute Stakeholder Meeting Attendees

- AIDS Foundation Chicago
- Shriver Center
- Shriver Center consumer board member
- EverThrive
- Legal Council for Health Justice
- Healthy Illinois Campaign
- Protect Our Care Illinois
- Heartland Alliance
- Access Living
- Cancer Society Cancer Action Network
- Health & Medicine Policy Research Group
- The Leukemia and Lymphoma Society
- Illinois Health and Hospital Association
- AMITA Health
- Touchette Regional Hospital
- Memorial Medical Center
- Jackson Park Hospital
- Community Behavioral Health Association
- Illinois Association of Behavioral Health
- Illinois Association of Rehabilitation Facilities
- Grand Prairie Services
- Chestnut Health Systems, Bloomington, IL
- Trinity Services
- Haymarket Center
- Gateway Foundation
- Cornerstone Services
- Illinois Primary Health Care Association
- Erie Family Health Center
- SIU Center for Family Medicine
- Access Community Health Network
- Lake County Health Department and Community Health Center
- Howard Brown Health
- Heartland Health Services
- Heartland Alliance
- Illinois State Medical Society
- Illinois Academy of Family Physicians
- Illinois Life & Health Insurance Council
- Health Alliance
- United Healthcare

- Blue Cross Blue Shield of Illinois
- Centene
- Aetna
- Illinois Association of Medicaid Health Plans
- Cook County Health (CountyCare)
- Molina
- SEIU

Two virtual community member listening sessions on 10/28 and 10/29

- Uninsured (5 individuals) – one uninsured attendee had kids on All Kids
- Medicaid (3 individuals)
- Employer health insurance covered under ERISA (1 individual)
- Marketplace (4 individuals) – one Marketplace enrollee had kids on All Kids; one Marketplace enrollee was a small business owner who offered employees insurance until it became too expensive
- Private insurance/COBRA (previously on an employer health plan) (1 individual)

Public Meetings

- 1 virtual Medicaid Advisory Committee (MAC) Meeting
    - November 6, 2020: https://www.illinois.gov/hfs/SiteCollectionDocuments/MedicalAdvisoryCommitteeAgendaNovember62020.pdf
- 2 MAC Public Education Subcommittee Meetings
    - October 1, 2020:
    - https://www.illinois.gov/hfs/SiteCollectionDocuments/October12020PublicEdSubCommMeetingMinutes.pdf
    - December 3, 2020: https://www.illinois.gov/hfs/SiteCollectionDocuments/December3PubEdMeetingMaterials.pdf

Formal Letters

- Protect Our Care Illinois
- America's Health Insurance Plans
- Illinois Health and Hospital Association
- Illinois Life & Health Insurance Council
- Illinois Academy of Family Physicians
- Cook County Health
- The Coalition of Insurance Agents and Brokers of Illinois

Emails with Information

- American Cancer Society Cancer Action Network, Inc.

Appendix E. Feasibility Study Development

To conduct the feasibility study, the Interagency Working Group, comprised of state staff from HFS, DOI, and the Governor's office worked with:

- Manatt Health, a national consulting firm, which developed a project work plan that incorporated best practices and lessons learned from their work on feasibility studies in New Mexico and Colorado. The Robert Wood Johnson Foundation funded this work through State Health and Value Strategies (SHVS), a state technical assistance center located at Princeton University

- HFS leveraged its existing actuarial contract with Milliman and DOI leveraged its existing actuarial contract with Oliver Wyman.
    - Milliman conducted the actuarial modeling for the study with consultation from Oliver Wyman, state staff, and a team of subject matter experts brought in by the University of Illinois Office of Medicaid Innovation.

- HFS used its existing Intergovernmental Agreement with the University of Illinois Office of Medicaid Innovation to receive assistance from the Office of Medicaid Innovation staff and a team of subject matter experts OMI brought in for the study, including:
    - Sabrina Corlette, regulatory expert from Georgetown University's McCourt School of Public Policy (drafted feasibility study report)
    - Justin Giovannelli, regulatory expert from Georgetown University's McCourt School of Public Policy (drafted feasibility study report)
    - Ben Sommers, health economist and physician from Harvard University;
    - Ezra Golberstein, health economist from the University of Minnesota;
    - Tekisha Everette, health and racial equity consultant from TDE Consulting;
    - Mike Robinson, senior staff from Lambent Risk Management Services, an Illinois Business Enterprise Program (BEP) certified insurance broker firm
    - Manny Ribot, senior staff from Lambent Risk Management Services, an Illinois BEP certified insurance broker firm

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