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Review of the Current Illinois Health Coverage Marketplace: Background Research Report

September 2011

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A. Executive Summary

Under the federal Affordable Care Act[1] (ACA), each state is authorized to establish a Health Benefits Exchange (Exchange) for individuals and small employers to obtain health insurance. Deloitte Consulting LLP (Deloitte Consulting) has prepared this report as background research to support the State of Illinois (the State) in the development of its Exchange.

Results from the background research are intended to inform policy and operational decisions impacting the Exchange. Specifically, the State's goals for this report were to provide information on:

- Purchasers, and potential purchasers, in the health insurance marketplace, including insured, uninsured and underinsured Illinoisans.
- The health insurance carriers in the market, including products being offered, premiums being charged, and the affordability of health insurance at different income ranges.
- Future population projections by health insurance status and source of insurance under multiple market scenarios.

This information was developed from analysis of multiple data sources, including:

- State information from the Department of Healthcare and Family Services (HFS), Department of Insurance (DOI), and Department of Public Health (DPH);
- New primary research via surveys of the Illinois population (2011 Illinois Health Insurance Survey or IHIS) and of the State's major health insurance carriers (Carrier Survey);
- Existing secondary research; and,
- Deloitte Consulting's Healthcare Reform Impact Model.

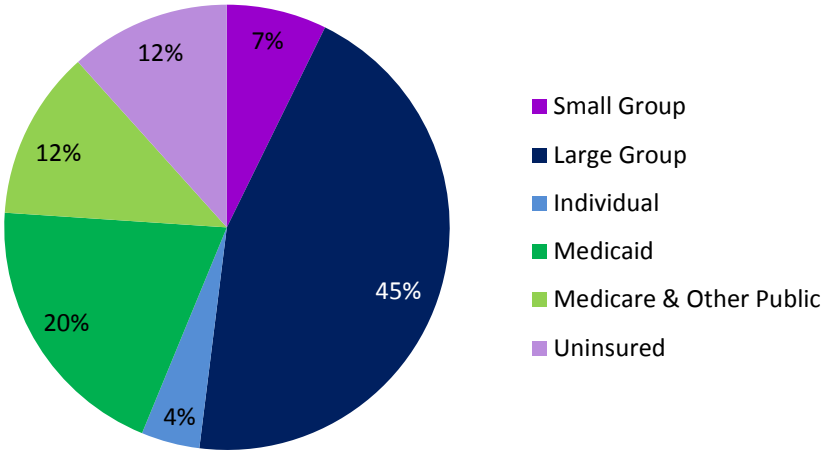
Below is a summary of major findings, organized as follows:

- Health Insurance Coverage
- Health Insurance Marketplace
- Affordability
- Market Projections

Health Insurance Coverage

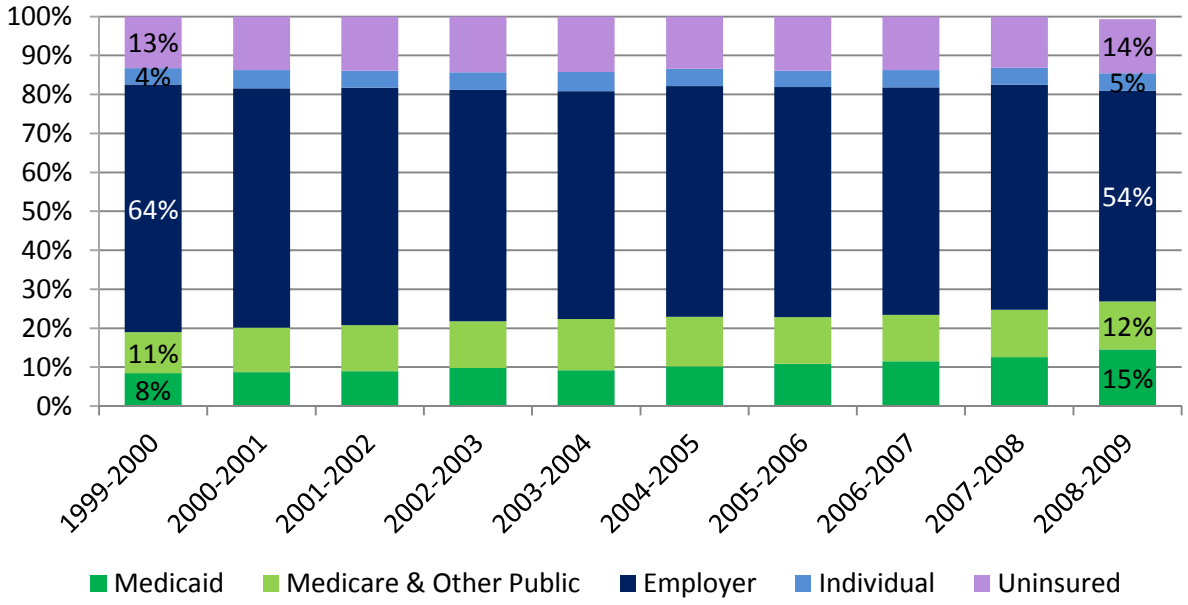
- Health Insurance Coverage – In 2011, an estimated 52% of the Illinois population is covered by employer-sponsored programs (including small group and large group plans), 4% purchase insurance in the individual market, 20% are covered by Medicaid (including All Kids, the State's program to cover all children and those dually eligible for Medicare benefits), 12% by Medicare and certain other public programs (e.g., military and veterans' programs), and 12% are uninsured. The figure below (Figure A.1) illustrates the baseline distribution of health insurance coverage.

Figure A.1: Estimated 2011 distribution of health insurance coverage across total Illinois population (Deloitte Consulting Health Reform Impact Model)[2]



- Historical Trends – Over a ten-year period ending 2008-2009, the uninsured population grew slightly (13% to 14%) as a percentage of the total State population, while the prevalence of employer coverage declined from 64% to 54% of the population, Medicaid grew from 8% to 15%, and Medicare (with other public programs) increased from 11% to 12% (Figure A.2). The growth in Medicaid was primarily due to economic conditions and specific policy expansions. In the adverse economic environment since 2009, some of these trends have accelerated, including the decline in employer sponsored coverage and the increase in Medicaid enrollment. The number of uninsured Illinoisans has declined somewhat since 2008-2009; this is attributable in large part to the growth in Medicaid enrollment.

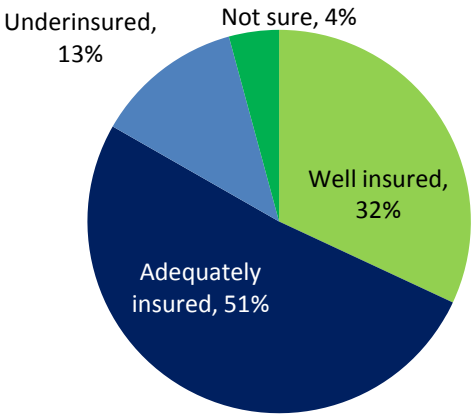
Figure A.2: Distribution of health insurance coverage across total Illinois population over the past decade, shown as two year averages (1999-2009 Urban Institute/Kaiser)[3]



- Insured and Uninsured Population Characteristics

  - Age - The young adult population (18-25 year olds) is the least likely to have health insurance (24% of young adults are uninsured)[4]. Insurance coverage prevalence increases as age increases[4].
  - Household Income - Insurance coverage increases as income increases[4]. Only 5% of persons living in households with incomes over 400% of the Federal Poverty Level (FPL) are uninsured whereas 34% of persons living in households with incomes less than 138% FPL are uninsured[4].
  - Geographic Regions – The adult (18-64) uninsurance rate ranges from 12% in the Urban Counties to 19% in the Rural Counties[4].
  - Insurance Adequacy - Of Illinoisans who are currently insured, the majority (83%) report that they are at least "adequately" insured while 13% report being underinsured. The remaining 4% are not sure (Figure A.3).

Figure A.3: Insurance adequacy in Illinois, adults age 18-64 (2011 IHIS)[4]



- Barriers to Coverage – Cost of health insurance is the most commonly reported reason for a person being uninsured (47%)[4]. The second most common reason is that health insurance is not offered by an employer (22%)[4].

Health Insurance Marketplace

- Market Concentration – The health carrier marketplace in Illinois is highly concentrated. Among the ten largest states, only Michigan has a higher degree of concentration, based on standard metrics used by the federal government for antitrust purposes (Figure A.4).

  The largest health carrier in Illinois owns a high market share, compared with leading carriers in other large states. Health Care Service Corporation (HCSC) has 49% of the statewide market share. This percentage is the second highest among the ten largest states, and compares with a median value of 25% for the leading carrier in the other nine largest states in the U.S. These market shares and concentration levels are calculated based on total health plan member counts, including all commercial (insured and self-insured), managed Medicare, and managed Medicaid members (if any).

Figure A.4: Health coverage market concentration for the top 10 most populous states based on enrollment estimates as of January 2011 in all fully and self-insured products (2011 HealthLeaders-InterStudy, 2011 HHI)[5,37]

Market Sorted by Population	Total Population	Top Carrier	Top Carrier % Share	Market Concentration
California	37,253,956	Kaiser	25%	Unconcentrated
Texas	25,145,561	HCSC	29%	Moderately Concentrated
New York	19,378,102	UnitedHealth Group	21%	Unconcentrated
Florida	18,801,310	UnitedHealth Group	22%	Unconcentrated
Illinois	12,830,632	HCSC	49%	Highly Concentrated
Pennsylvania	12,702,379	Highmark	28%	Unconcentrated
Ohio	11,536,504	WellPoint	23%	Unconcentrated
Michigan	9,883,640	BCBS of MI	51%	Highly Concentrated
Georgia	9,687,653	WellPoint	23%	Unconcentrated
North Carolina	9,535,483	BCBS of NC	38%	Moderately Concentrated

However, in no Metropolitan Statistical Area (MSA) in the State, does the market share of the area's largest carrier exceed about 56%, as shown in Figure A.5 below.

Figure A.5: Illinois health plan market concentration based on enrollment estimates as of January 2011 in all fully and self-insured products (2011 HealthLeaders-InterStudy)[5]

Market Sorted By Population	Total Population	Top Carrier	Top Carrier
Illinois	12,830,632	HCSC	49%
Chicago/Naperville/Joliet	7,883,147	HCSC	46%
Lake County–Kenosha, WI	869,888	HCSC	43%
Davenport	379,690	UnitedHealth Group	56%
Peoria	379,186	UnitedHealth Group	39%
Rockford	349,431	HCSC	44%
Champaign-Urbana	231,891	Health Alliance	53%
Springfield	210,170	HCSC	50%
Bloomington–Normal	169,572	HCSC	44%
Kankakee	113,449	HCSC	32%
Decatur	110,768	HCSC	48%
Danville	81,625	Health Alliance	37%

According to the Carrier Survey, only one carrier operates substantially statewide, having significant fully insured membership (in individual, small group, and large group markets) in nearly all counties in the State. (For this purpose, significant membership is defined as

more than 5% of the county total). Four other carriers have significant membership in between 26% and 37% of the counties across the State (as seen in Figure A.6).

Figure A.6: Geographic Coverage (% of Illinois counties covered with at least 5% market share in insured commercial market) for six top carriers in Illinois (2011 Carrier Survey) [6]

Carrier 1	Carrier 2	Carrier 3	Carrier 4	Carrier 5	Carrier 6
99%	9%	28%	26%	37%	33%

In addition to regional variations, market share concentration also varies by market segment. For example, statewide market share of the largest carrier in the individual market segment is higher than the 49% share shown above for all market segments combined[6].

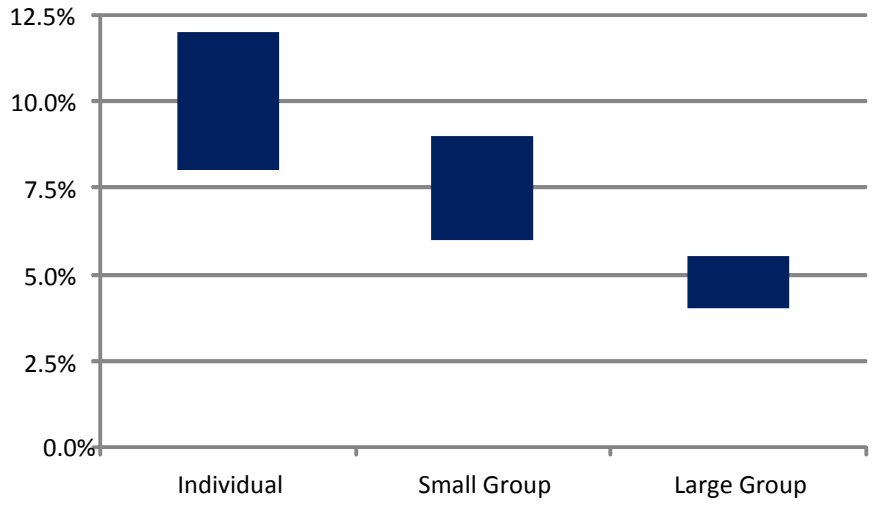
- Plan Designs – The Carrier Survey data indicates Preferred Provider Organizations (PPOs) dominate the Illinois individual and small group markets[6]. In the individual (non-group) segment of the market, 99% of reported membership is in PPOs and for the small group market, 84% of reported membership is in PPOs[6].

  The current market is characterized by a wide range of product options available to consumers and employers. Across the carriers surveyed, more than 500 distinct cost sharing combinations were observed across the items included and analyzed as part of the Carrier Survey (deductible, coinsurance, out-of-pocket (OOP) maximum, primary care provider (PCP) copays, specialist copays, inpatient copays, and emergency room (ER) copays)[6].

- Barriers to Market Competition – Illinois' insurance regulatory requirements and processes appear to be similar to those of other states[7,8,9]. Regulation does not currently appear to present any unusual barriers to competition or potential future market entry by new carriers. Other potential barriers or influences on competition are discussed in Section F.

- Agents – As of the beginning of 2011, there were over 54,000 agents licensed to sell health insurance in Illinois[10]. This represents 1 agent for every 240 persons in the State[10,11]. Agent compensation levels vary somewhat across carriers, with compensation levels declining (as a percentage of premium) as customer size increases (Figure A.7).

Figure A.7: Carrier-reported agent compensation as a percentage of premium by market (2011 Carrier Survey)[6]



In addition, there were 347 All Kids Application Agents in 2010 that helped enroll families into the All Kids and other Medicaid programs[12]. These agents are paid $50 per enrolled applicant.

Affordability

The report analyzes several measurements of affordability by comparing health care cost components to household income. Estimated premium and out-of-pocket cost sharing (OOP) costs for health insurance purchased through both the individual and small group markets are shown in Figure A.8 (as a percentage of household income, for households at 200% of FPL) and in Figure A.9 (in dollar values and as a percentage of income for households at 200% of FPL). For the purposes of this research, the State has defined an additional affordability measurement, total real out-of-pocket cost (TROOP), as the total of the estimated premium and OOP costs.

The affordability analysis in this report addresses the current market; ACA was intended to substantially improve affordability, particularly for lower income people, and it is expected that ACA provisions such as the Exchange and premium subsidies will substantially impact affordability when implemented in the future.

Note that for the small group premiums, employers typically pay a substantial portion of these costs on behalf of the employee. Federal government survey data indicate that the average employee contribution to small group health plan costs in Illinois for 2010 was $1,221 for

employee coverage, and $4,383 for family coverage[20]. However, it is reasonable to believe that employees ultimately bear much of the cost burden of these employer subsidies (in the form of lower wages than would otherwise be received).

OOP costs shown below reflect medical benefits, excluding pharmacy, and are based on in-network levels. OOP costs are substantially higher for out-of-network services.

Figure A.8: Average premium and OOP cost (excluding pharmacy) as a percent of household income at 200% FPL (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

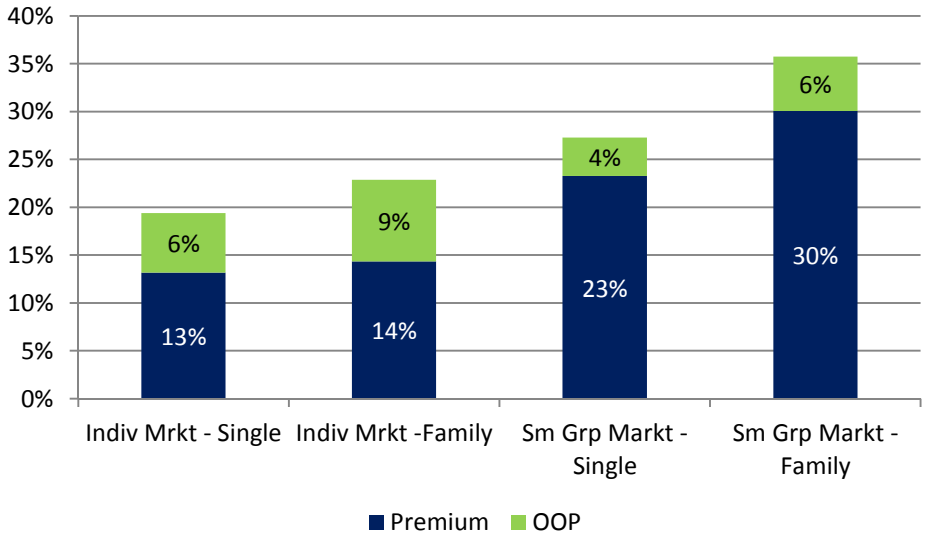


Figure A.9: Annual income, average OOP and average TROOP (excluding pharmacy) at 200% FPL (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

	Individual Market		Group Market	
	Single	Family of 4	Single	Family of 4
Annual Income	$21,660	$44,100	$21,660	$44,100
Average OOP	$1,347	$3,758	$868	$2,514
Average TROOP	$4,197	$10,088	$5,908	$15,764
Average TROOP % of Income	19%	23%	27%	36%

The differences between premium rates in the individual and small group market are due to differences in:

- benefit designs (group benefits typically pay a larger share of eligible medical expenses); this is estimated to account for 60% of the difference[13]; and
- underwriting (individual insurance underwriting often results in denial of coverage for persons in poor health) and other factors, such as member demographics and carrier administrative expenses. These factors are estimated to account for the remainder of the difference in premium rates.

- Out-of-Pocket (OOP) Costs – Figure A.8 and Figure A.9 shows the estimated average OOP costs for typical plan designs in each market. In many cases, the average OOP cost exceeds affordability thresholds specified by the State for low income individuals and families.

- Average Total Real Out-of-Pocket (TROOP) Costs – Average TROOP costs include both out-of-pocket costs and premiums for a typical plan design, and are illustrated by the total bars in Figure A.8 and the third row of Figure A.9. These costs range from 19% to 36% of household income for individuals and families at 200% FPL[13].

Market Projections

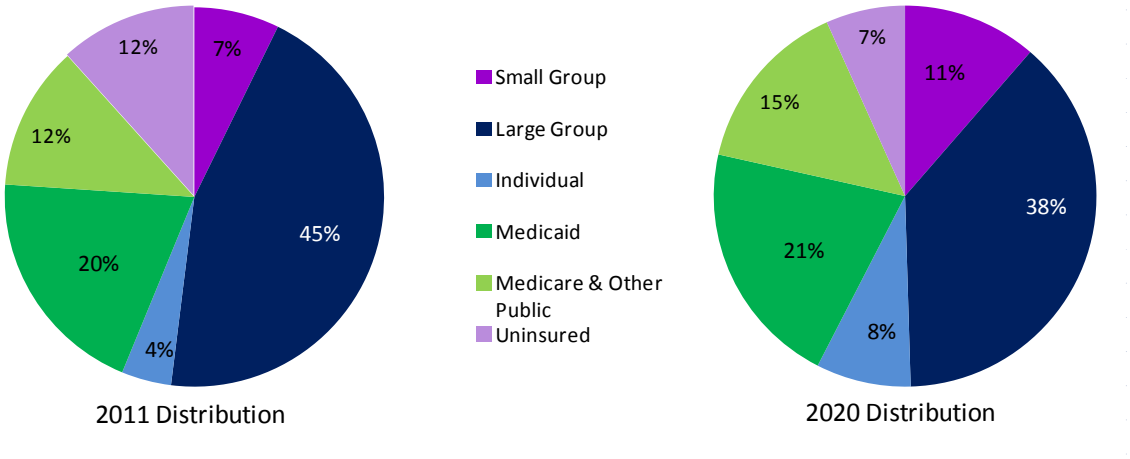
- Future Health Insurance Coverage – Health insurance coverage sources for the total population are projected to shift from 2011 to 2020 as follows (Figure A.10):

    - Small Group and Large Group Employer (including the Exchange) - declines from 52% to 49%,
    - Individual (including the Exchange) – grows from 4% to 8%,
    - Medicaid – increases significantly due to ACA eligibility expansion; but this increase is largely offset by assumed future improvement in economic conditions, resulting in net growth from 20% to 21% over the period,
    - Medicare – increases from 12% to 15%, and
    - Uninsured – declines from 12% to 7%.

  Note that persons eligible for both Medicaid and Medicare (i.e., “dual eligible”) are included in the Medicaid market in the population projections. As required by ACA, the definition of Small Group changes between 2011 and 2020. As of 2011, the Small Group market includes

employer plans with up to 50 employees while no later than 2016 the Small Group market must include employer plans with up to 100 employees. Projections reflect baseline assumptions developed with the State and summarized in Appendix D.

Figure A.10: Projected change in coverage distribution of total Illinois population (Deloitte Consulting Health Reform Impact Model)[14]



- Medicaid Enrollment – There are several factors that will tend to increase Medicaid enrollment: the expanded eligibility required under ACA, enhanced outreach by the State to eligible beneficiaries, and increased uptake of coverage by eligible Illinoisans. The "Prior Eligibles" in Figure A.11 below indicate those individuals who are currently eligible for Medicaid, prior to implementation of ACA eligibility expansion. Additional Medicaid enrollment due to ACA expanded eligibility requirements is labeled "New Eligibles" in Figure A.11 below. The dual eligible population (310,000 members in 2011) is expected to increase as the State's population ages and is included in the Medicaid numbers charted below.

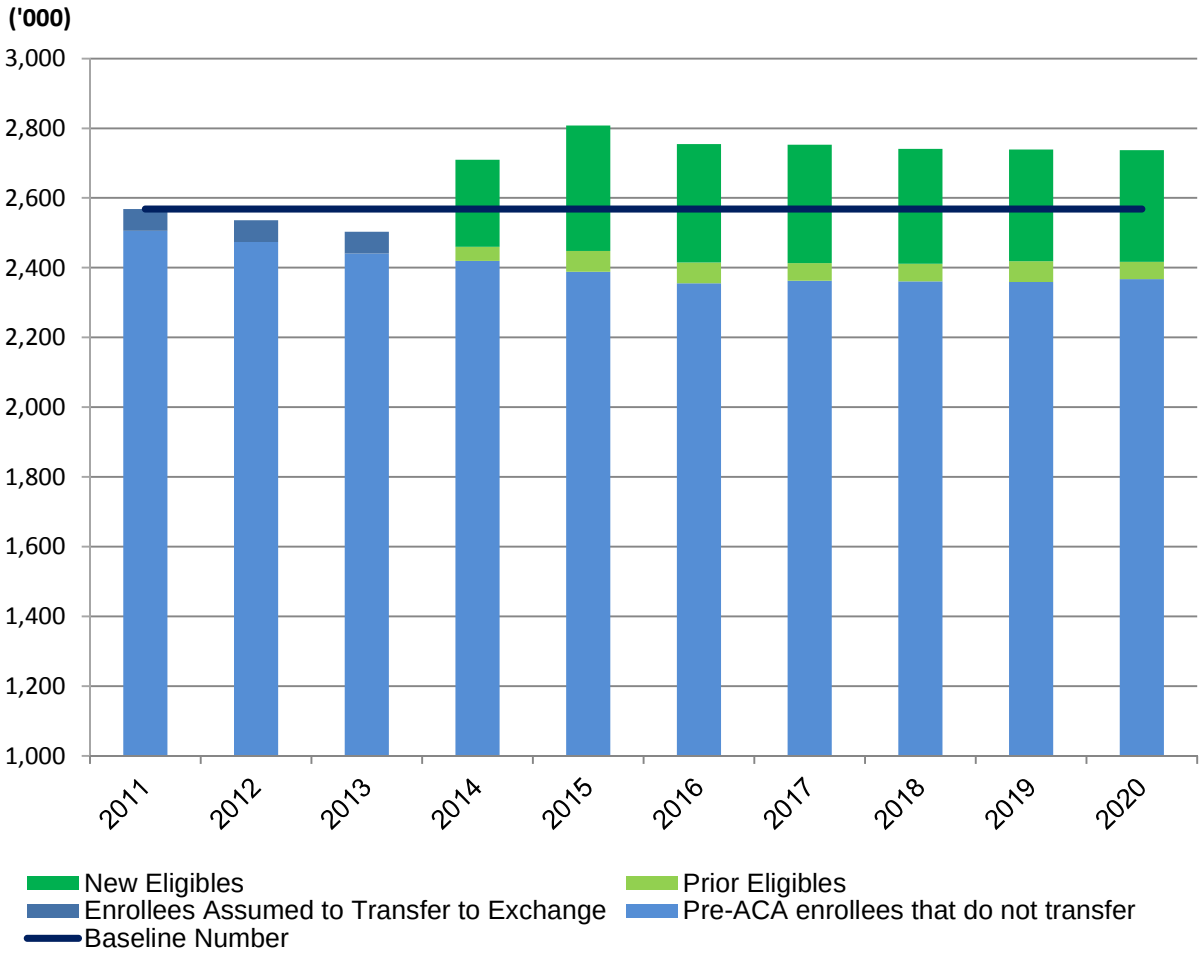
  However, Medicaid enrollment growth is offset by estimated reductions due to projected future economic recovery (future reductions in unemployment are projected, offsetting the significant increase in unemployment levels observed in recent years, and reversing the corresponding impact on Medicaid enrollment levels) as well as an assumed transfer of some persons from Medicaid and other State programs to the new Exchange (note that this transfer is an assumption regarding a policy decision the State has yet to make, and the States actual decision may differ).

  In addition to these factors, future growth of the total Medicaid population is limited to

some extent by the very high participation levels already achieved in Illinois, particularly with respect to eligible children, as determined from State enrollment data. In 2010, more than 95% of all Illinois children were estimated to have health insurance.[38]

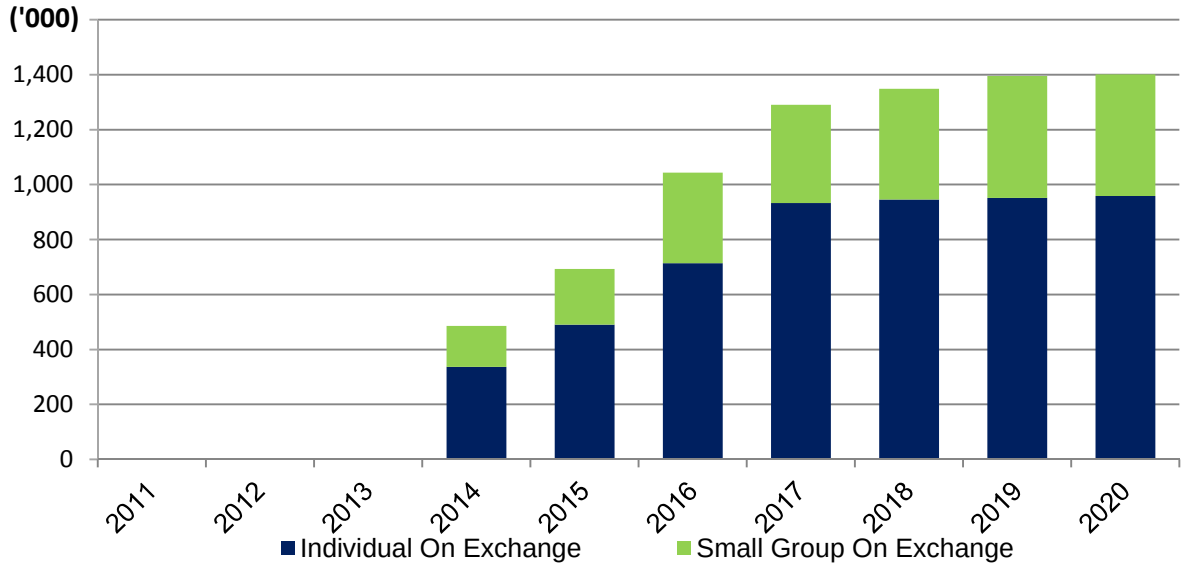
Given the uncertainty surrounding current and future economic growth in the U.S., it is important to note that all assumptions for the future of the economy incorporated in this reports projections are based on benchmarks published by the Congressional Budget Office.

Figure A.11: Projected growth in Medicaid, including Medicare dual eligibles (Deloitte Consulting Health Reform Impact Model)[14]



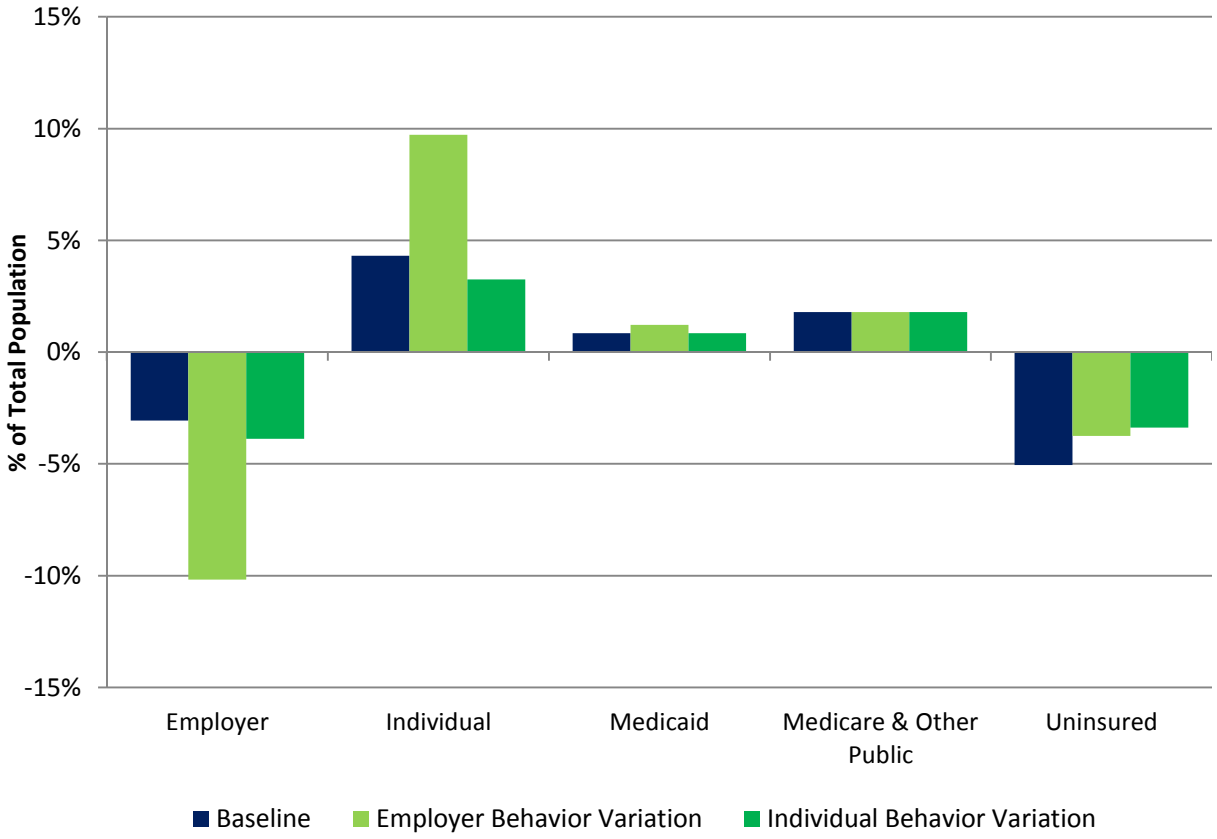
- Exchange Membership – health insurance enrollments through the Exchange are projected to ramp up over the first three years of operation. As of 2017, approximately 1.3 million people are projected to be purchasing health insurance through the Exchange (Figure A.12) as part of the individual market and the small group market (Small Business Health Options Program, or SHOP) according to the baseline assumptions.

Figure A.12: Projected exchange membership (Deloitte Consulting Health Reform Impact Model)[14]



- Multiple Scenarios – Market projections are influenced by future economic conditions, legislative and regulatory decisions, and behavior of market participants, and are therefore subject to a high degree of uncertainty. Additional scenarios were modeled to illustrate the impact of key assumptions and decisions on the future marketplace. The two additional scenarios are summarized and compared to the baseline below with the projected impacts reflected in Figure A.13:
    - Baseline Scenario - assumes ACA is implemented as written, and produces employer and individual behavior generally consistent with Congressional Budget Office projections.
    - Employer Behavior Variation - assumes a larger disruption to the existing employer-sponsored market compared to the Baseline by assuming more employers terminate or re-structure their traditional health benefits programs. The increased disruption is most pronounced in lower income industries and smaller employers. This scenario projects more uninsured and a larger individual market.
    - Individual Behavior Variation – illustrates reduced health insurance enrollment due to multiple factors, including the potential elimination of the ACA individual mandate penalty. The scenario also projects more uninsured than in the Baseline scenario.

Figure A.13: Changes in the enrollment by the year 2020, as percent of the total population – compared to 2011 (Deloitte Consulting Health Reform Impact Model)[14]



B. Project Overview and Research Methods

Overview

This report section provides background and describes the data used for the analyses. The information is summarized into the following areas:

- Background and Objectives,
- State Data Sources,
- 2011 Illinois Health Insurance Survey (IHIS),
- Carrier Survey,
- Secondary Research, and
- Market Projections.

Background and Objectives

Under the ACA, each state is authorized to establish an Exchange for individuals and small employers to obtain health insurance. Deloitte Consulting has prepared this report as background research to support the State, including DOI and other departments, in the development of its Exchange.

Results from the background research are intended to inform policy and operational decisions impacting the Exchange. Specifically, the State's goals for this report were to provide information on:

- Purchasers, and potential purchasers, in the health insurance marketplace, including insured, uninsured, and underinsured Illinoisans.
- The health insurance carriers in the market, including products being offered, premiums being charged, and the affordability of health insurance at different income ranges.
- Future population projections by health insurance status and source of insurance under multiple market scenarios.

This information was developed from analysis of multiple data sources, including:

- State information from the HFS, DOI, and DPH
- New primary research via surveys of the Illinois population (IHIS) and of the State's major health insurance carriers (Carrier Survey);
- Existing secondary research; and,
- Deloitte Consulting's Healthcare Reform Impact Model.

Findings within this report have been validated with additional sources to the extent they were reliable and available. In some cases, results obtained from different sources may be inconsistent or contradictory; this may be due to differences methodology, source data used, time periods considered, etc. In cases where differences appear significant, the data sources are disclosed and potential reasons are noted.

Certain Medicaid beneficiaries receive partial benefits (e.g. family planning services) only; data shown in this report reflect participants receiving full Medicaid benefits.

Some results have been adjusted so that rounded subtotals displayed in the report add to 100% of the total numbers.

This report documents the details and findings from the background research.

State Data Sources

a. Overview and Methodology

Data and analyses were provided by various State departments. The specific data requests are included as Appendix A of this report.

b. Data Listing

Below is a summary of the information provided by each of the State departments. Also, State websites and published reports were utilized to gather additional information and data (e.g., Illinois Comprehensive Health Insurance Plan (ICHIP) data was collected and analyzed from the ICHIP website).

Department	Summary of Data Provided	Sample Data Analyses
HFS	Recent history of Medicaid enrollment and claims experience	• Recent growth in Medicaid enrollment by aid category • Population projections starting point
	Summary of Medicaid and related program eligibility criteria	• Overview of current market • Input to population projections
	10 years of historical information on active All Kids Application Agents (AKAA)	• Agent Analysis (AKAA specific), their locations in the State and levels of activity
	State Employee Carrier Network Information	• Carrier network coverage across the State

Department	Summary of Data Provided	Sample Data Analyses
DPH	10 years of historical data from the Behavioral Risk Factor Surveillance System (BRFSS).	• Population characteristics • Validation for external data • Uninsured analysis – mental health
	Summarized Information from the all-payer State Inpatient Database.	• Regional differences in coverage distributions
	Health Maintenance Organization (HMO) Network Approval information	• Overview of current market • Regulatory Barriers to Carriers
DOI	Historical health premium volumes and policy counts for fully insured business	• Overview of current market • Validation of market share information
	Agent and broker Licensing Information	• Distribution Analysis – Access to Agents
	Compliance and regulatory requirements for establishing an insurance company or HMO in Illinois.	• Overview of current market • Regulatory Barriers to market entry for insurance carriers
	Insurance complaints information	• Overview of current market • Barriers to individuals obtaining health insurance
	Sample rate filing information	• Regulatory Barriers
	Various DOI reports	• Overview of current market • Analyses of High Risk Pool • Input into population projections

2011 Illinois Health Insurance Survey (IHIS)

a. Overview and Methodology

To describe current health insurance coverage, health care related expenditures and attitudes of residents, a population survey was designed and administered. Harris Interactive, Inc. was contracted to administer a web-based survey in June-July of 2011. An overview of the survey methodology is as follows:

- Survey was conducted in both English and Spanish. The survey questions, as well as the weighted survey results, can be found in Appendix B of this report (in English).
- Survey criteria required completion by any adult in the household who was a current resident of the State (as evaluated by the person's current zip code), over the age of 18 and under the age of 65.

- 2,051 respondents met the survey criteria and completed the survey. The respondents were tracked to ensure that a sufficient number of uninsured individuals with incomes below 200% of the FPL were included in the sample.

b. Representativeness of the Sample

The survey targeted a representative sample of Illinois residents based on several demographic characteristics, including age, gender, education, race, insured status, and income. A weighting factor was applied to each survey respondent to match the targeted population.

With over 2,000 completed responses, the survey provides results at a sufficient level of detail and statistical significance to draw conclusions about the population and health insurance market in the State.

For example, IHIS results show that 16% of the Illinois population aged 18-64 is uninsured. The margin of error for this statistic at 95% confidence is 2%. This means that there is a 95% probability that a similar survey reaching the entire population of the State would indicate the uninsured population in this age group is between 14% and 18%.

Carrier Survey

a. Overview and Methodology

The Carrier Survey requested information directly from the largest health insurance carriers in the State to provide data on the insurance market. The State issued a Data Call to these carriers under its insurance regulatory authority. There were two Data Calls – the original request for information on products, enrollment, and plan designs which was executed by Wakely Consulting Group. The addendum to the Data Call was a request for member location information which was executed by Deloitte Consulting working together with Wakely Consulting Group. The data submitted covered the following areas:

- Individual underwriting experience, providing estimates of the proportions of cases denied, approved, with exclusions, etc.
- Small Group underwriting experience, providing estimates of case distribution relative to the rating band,
- Summarized health insurance product experience, including exposure (counts of member months), claims and premium differentiated by market (individual or small group), product type (PPO, HMO, etc.), and various plan design characteristics (e.g. deductible, coinsurance, PCP copay),

- Distribution (e.g., agents/brokers) compensation information, including commission schedules, bonus definitions, and total compensation levels by market, and
- Regional exposure, providing fully insured group and member distribution by zip code for each of the fully-insured individual, small group and large group markets.

The two requests sent to carriers are included as Appendix C of this report.

b. Representativeness of the Sample

The DOI requested information from the top six carriers based on the volume of individual and fully insured small group enrollment in the State. The information represents a large subset of the Illinois marketplace, and:

- Does not include self-funded or large group business. Note that the second survey requests enrollment by zip code and market and does include insured large group business.
- Was limited to comprehensive coverage insurance plans only. In other words, it excludes products such as mini-med products.
- Requests detailed plan design information for the top 80% of each carrier's enrollment. Products with lower enrollment, but materially different cost sharing, could be omitted.
- Focuses on in-network benefit designs and on limits for single members. Out-of-network benefits were excluded. Generalizing analysis to family limits required additional assumptions outlined in the relevant sections of the report.
- Did not specifically request information on lifetime or annual limits, or specific policy exclusions, which may impact member cost sharing.
- The pharmacy information submitted by the carriers was not included in the plan design analysis or included in the out-of-pocket cost estimates developed in the report. Carriers' coverage of pharmacy appear to vary (e.g., as a separate policy, as a discounted program, or included with the medical benefits).

Secondary Research

a. Overview and Methodology

In order to provide a broader picture of the Illinois marketplace, and to validate or test findings from the primary research outlined above, the background research project considered various external resources. These include a cross-section of:

- Deloitte Consulting's Models, Databases and Publications,
- Other external datasets, and
- Market Publications.

b. Data Listing

Below is a brief summary of the key secondary research utilized (Figure B.1).

Figure B.1: Summary of secondary data research

Tool/Resource	Examples of Data Utilized
Deloitte Consulting's Models, Databases & Publications	• Deloitte Consulting's Health Reform Impact Model described further in subsequent sections of this report • Health insurance benefits modeling used to calculate the total relative cost of coverage based on specific plan designs • *Thomson Reuters MarketScan® Research Databases*, a commercial claims database capturing utilization and expenditures at the participant-level across service categories for over 2 million individuals under the age of 65 in Illinois • The Deloitte Center for Health Solutions' 2009 Survey of Healthcare Consumers
External Datasets	• U.S. Census Bureau: Current Population Survey (CPS) • U.S. Census Bureau: American Community Survey (ACS) • U.S. Census Bureau: Annual Social and Economic Supplement (ASEC) • U.S. Census Bureau: Survey of Income and Program Participants (SIPP) • U.S. Census Bureau: Small Area Health Insurance Estimates (SAHIE) • U.S. Department of Health and Human Services: Medical Expenditure Panel Survey (MEPS) • Kaiser Family Foundation(KFF)/Urban Institute: State Health Facts information

Tool/Resource	Examples of Data Utilized
Market Publications	• HealthLeaders-InterStudy: Managed Market Surveyor and Managed Market Surveyor Rx • Illinois Comprehensive Health Insurance Plan (CHIP): Illinois Comprehensive Health Insurance Plan 2009 Annual Report • America's Health Insurance Plans (AHIP): Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits • Kaiser Family Foundation (KFF): Survey of People Who Purchase Their Own Insurance • Kaiser Family Foundation (KFF) and Health Research & Educational Trust: Employer Health Benefits 2010 Annual Survey • SK&A: Nationwide Physician Specialty Report

Market Projections

a. Overview and Methodology

Deloitte Consulting's Health Reform Impact Model is an analytical tool that uses baseline demographic and cost data to project market results for multiple years under alternative future scenarios based on specific assumptions. The model projects information by state and various market segments. In general, persons having insurance coverage available from two different sources are classified based on the primary source of coverage. However, to facilitate comparison with State Medicaid data and other research, persons dually eligible for both Medicare and Medicaid are classified as Medicaid enrollees (even though Medicare generally provides primary coverage for these persons).

The model utilizes a variety of data sources (e.g., Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, U.S. Census Bureau, Kaiser Family Foundation) to develop baseline information for use in projection estimates.

Projections incorporate a variety of estimates, including assumptions pertaining to future economics, legislative outcomes, behavioral reactions, and strategic decisions. Due to the subjective nature of any future projections, results are highly uncertain, and multiple scenarios are modeled to illustrate some of the potential variation.

b. Results and their Interpretation

Results from population projections are dependent upon:

- The underlying data - As an example, Aliens Not Lawfully Present in the US cannot (by law) purchase coverage on the Exchange or receive affordability credits and this group represents a significant share of the population uninsured (approximately

300,000) and insured (approximately 200,000) in Illinois[15]. However, this is a segment of the population where data is limited and may be inaccurate.

- The assumptions used in the projections - As an example, estimates around the speed and robustness of economic recovery significantly impact public program enrollment. Estimates on when the economy will recover vary widely.

Market projections are subject to a high degree of uncertainty and should be understood in the context of the multiple assumptions and estimates used to develop the projection. This report uses a scenario-based approach to help illustrate the sensitivity of results to specific assumptions that could impact the distribution of coverage in the Illinois market.

C. Baseline Population

Overview

This report provides baseline information about the State that will be helpful to understand as results are presented throughout the report. This section is organized into the following areas:

- Age and Gender,
- Race,
- Employment Status,
- Household Income,
- Public Programs,
- Geographic Regions,
- Health Insurance Coverage, and
- Historical Trends in Coverage.

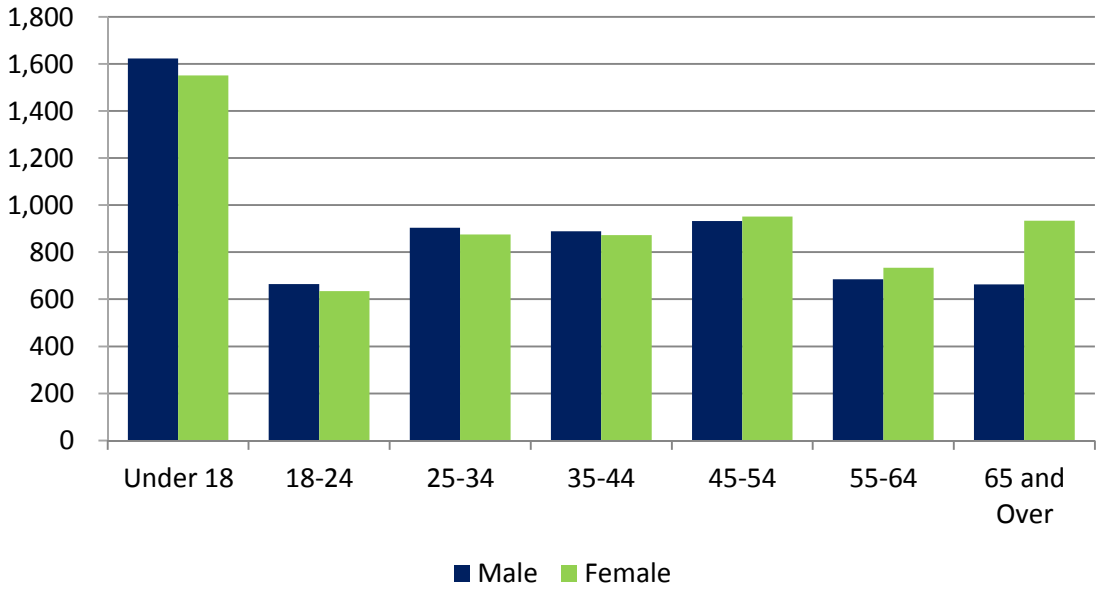
Key findings from this section include:

- As of 2009, approximately half of the Illinois working age population was employed full time, while 30% worked part time and approximately 20% did not work in the prior 12 months[11].
- As of 2009, nearly 70% of single parent households have incomes below $25,000 per year[16].
- The Chicago Suburbs/Collar Counties contain 42% of the State's population, translating to over 5 million people[11].
- According to the State Medicaid data, 28% of the population in Chicago is in the Medicaid program whereas 18% of the Chicago Suburbs/Collar Counties area is in Medicaid[17].
- As of 2011, 52% of Illinois residents obtain health insurance through employer sponsored coverage[18].
- The uninsured rate has been estimated at 12% for the entire population (2011)[2], 14% for those over 18 years old (2009)[16], and 16% for those between 18 and 64 years old (2011)[4].
- The distribution of coverage by source in Illinois has shifted over the last decade as employer sponsored coverage has declined and government sponsored coverage has grown[3].

Age and Gender

The Illinois non-elderly (under age 65) population is evenly distributed by gender. The non-elderly adult population is close to equally divided across male and female. The 65 year old and older age group population is smaller and contains more females than males (refer to Figure C.1 below).

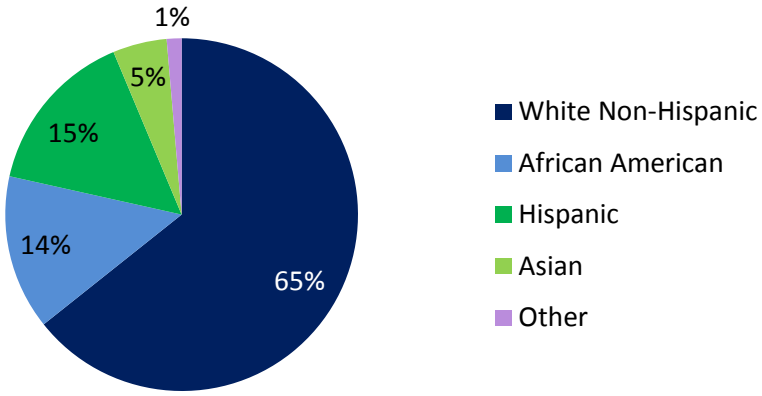
Figure C.1: Distribution of total Illinois population (in thousands) by age and gender (2009 ACS) [11]



Race

White Non-Hispanics make up the majority (65%) of the Illinois population, followed by Hispanics and African Americans. According to the 2009 ACS population study, Hispanics are 15% of the population and African Americans are 14% of the population. Note that throughout this report, the African American and Asian categories exclude Hispanic persons (who may be of any race).

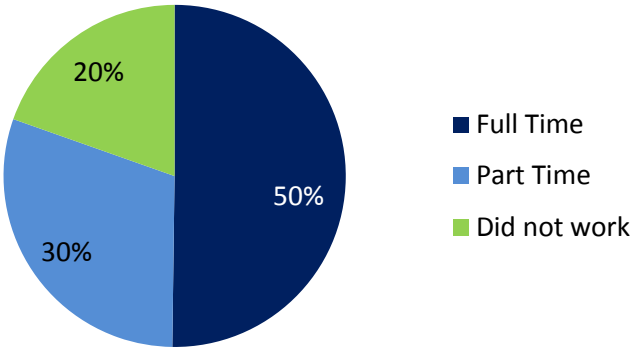
Figure C.2: Total Illinois population by race (2009 ACS) [11]



Employment Status

Approximately half of the Illinois working age population was employed full time, while 30% worked part time and 20% did not work in the prior 12 months. For purposes of the ACS survey, full time employment is defined as persons who usually worked 35 hours or more per week. Part time employment is defined based on persons who worked less than full time, year round.

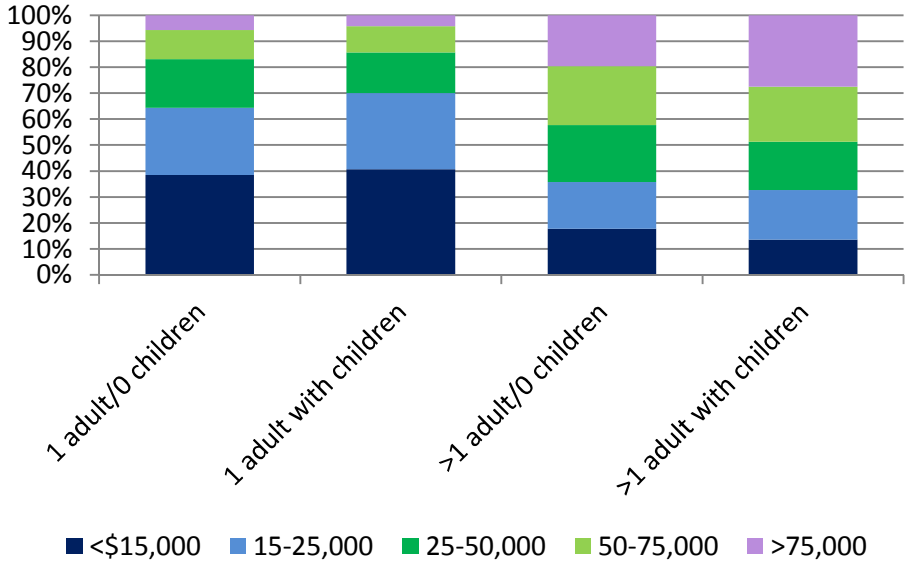
Figure C.3: Distribution of employment status (18-64) for Illinois (2009 ACS) [11]



Household Income

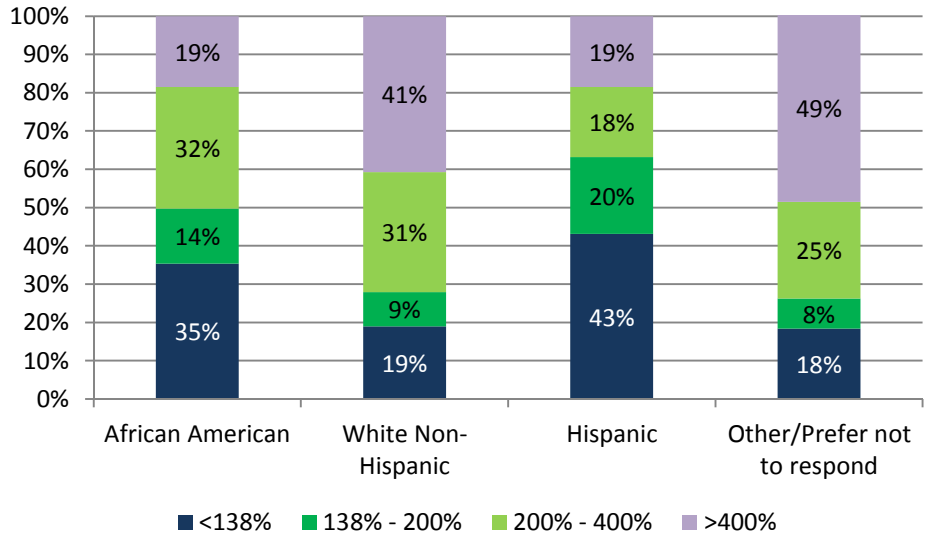
As of 2009, nearly 70% of single parent households in Illinois have household incomes of less than $25,000. In contrast, half of households with more than one adult and one or more children have incomes over $50,000 annually. The below chart (Figure C.4) summarizes the differences in household income for various household compositions.

Figure C.4: Distribution by household size and income for the over 18 Illinois population (2009 BRFSS) [16]



63% of the Hispanic population in Illinois currently live in households below 200% FPL while only 28% of the White Non-Hispanic population live in households below 200% FPL. On the other hand, 41% of White Non-Hispanics in Illinois are above 400% FPL while only 19% of African Americans and Hispanics in Illinois are above 400% FPL. (Figure C.5)

Figure C.5: Illinois population distribution (18-64) by race and income level (2011 IHIS)[4]



Public Programs

According to State data, approximately one in five people are on Medicaid (21% of the Illinois population). Using data provided by HFS, the below table (Figure C.6) shows the distribution of Medicaid enrollment by region and as a percentage of the region's total population. This reflects a higher percentage than the survey data provided by Urban Institute/Kaiser (shown as 15% of the Illinois population in 2008-2009). These differences are primarily due to the fact that the HFS data includes State-only sponsored programs and due to differences in survey methodology and timing (Medicaid enrollment has grown significantly in recent years). The Medicaid population is approximately 28% of the total population in Chicago, while in the Chicago Suburbs/Collar Counties Medicaid membership is only 18% of the total population.

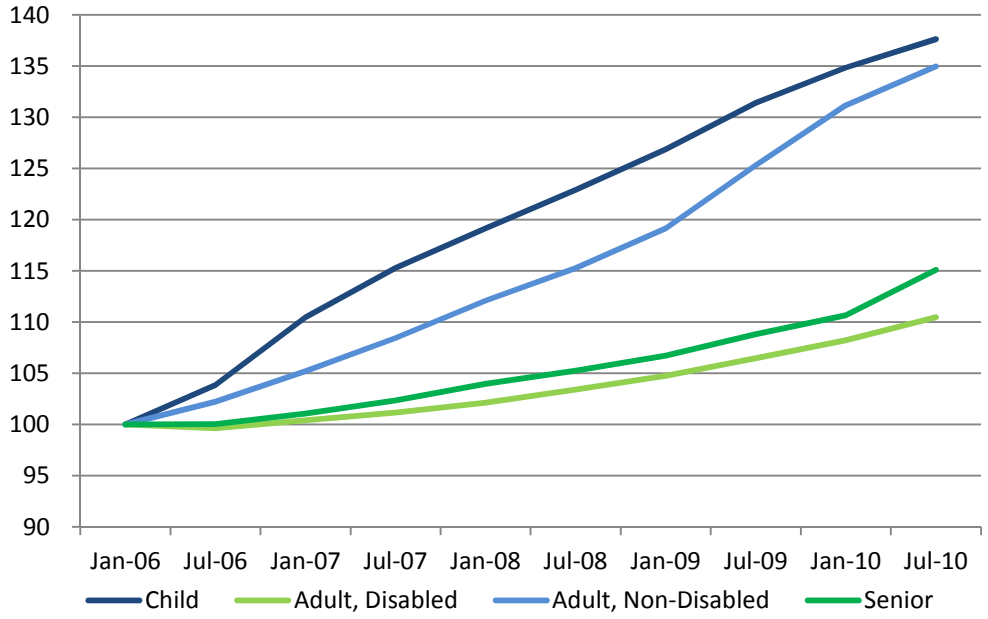
Figure C.6: Medicaid enrollment by region and percentage of total Illinois population (July 2010 HFS & 2009 ACS) [11,17]

Region	Medicaid Enrollment*	Enrollment Distribution	Enrollment as a % of the Region Population
Chicago	817,104	31%	28%
Chicago Suburbs/Collar Counties	933,576	35%	18%
North Central Counties	116,805	4%	23%
Urban Counties	365,328	14%	21%
Rural Counties	417,168	16%	20%
No Location	8,016	0%	N/A
Total	**2,657,986**	**100%**	**21%**

** Medicaid includes All Kids and Family Care Programs, as well as dual eligibles. It does not include programs that cover partial benefits.*

Medicaid enrollment has increased over the past five years, driven primarily by increases in enrollment of children and non-disabled adults. The following table (Figure C.7) shows changes in Medicaid enrollment, including enrollment in other State health insurance programs, since January 2006, as provided by HFS. Values have been normalized such that the January 2006 values are set to 100. Enrollment for children and non-disabled adults (less than or equal to 65 years old) has increased over time whereas enrollment growth for disabled adults (less than or equal to 65 years old) and seniors (those over 65 years old) has been less pronounced.

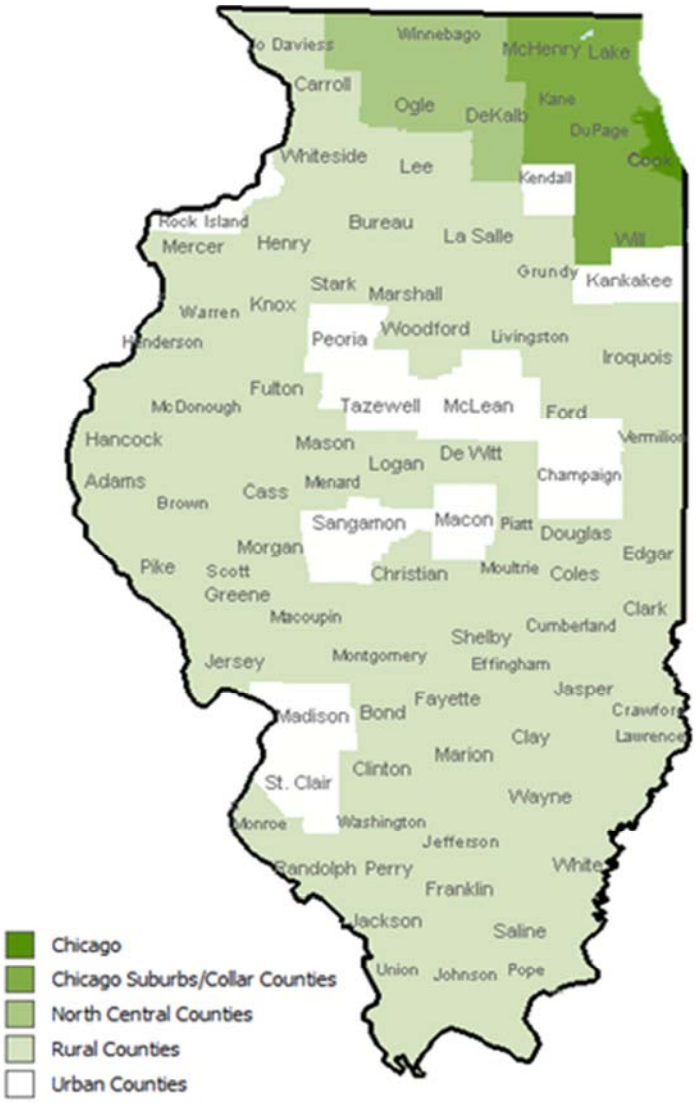
Figure C.7: Historical Medicaid enrollment based on the change from January 2006 (July 2010 HFS) [17]



Geographic Regions

Geographic breakdowns in this report are based on the IL BRFSS [16], which stratifies its survey data by Chicago, other parts of Cook County, Collar Counties, Urban Counties and Rural Counties. This report includes a separate region for the North Central region and combines non-Chicago Cook county and the Collar Counties to make up the 'Chicago Suburbs/Collar Counties' region. Geographic breakdowns in this report reflect the following five regions:

Figure C.8: Map of counties and regions (based on 2009 BRFSS)[16]



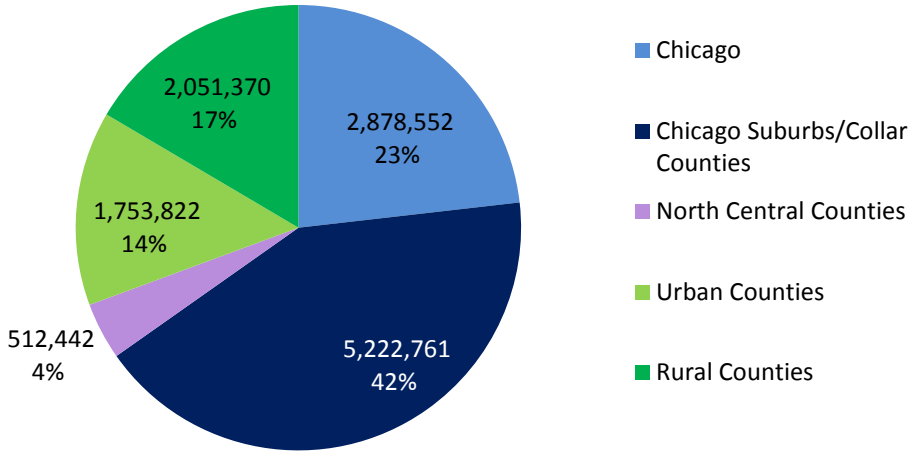
The following table depicts this same county–to-region mapping in list form.

Figure C.9: List of counties and regions (based on 2009 BRFSS)[16]

Region	Counties
Chicago	Part of Cook County- City of Chicago
Chicago Suburbs/Collar Counties	Suburban Cook County, DuPage, Kane, Lake, McHenry, Will
North Central Counties	Boone, De Kalb, Ogle, Stephenson, Winnebago
Urban Counties	Champaign, Kankakee, Kendall, Macon, Madison, Mclean, Peoria, Rock Island, Sangamon, Saint Clair, Tazewell
Rural Counties	Adams, Alexander, Bond, Brown, Bureau, Calhoun, Carrol, Cass, Christian, Clark, Clay, Clinton, Coles, Crawford, Cumberland, DeWitt, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Jo Daviess, Johnson, Knox, La Salle, Lawrence, Lee, Livingston, Logan, Macoupin, Marion, Marshall, Mason, Massac, McDonough, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Saline, Schuyler, Scott, Shelby, Stark, Union, Vermillion, Wabash, Warren, Washington, Wayne, White, Whiteside, Williamson, Woodford

The Chicago Suburbs/Collar Counties have the largest portion of the population (42%) in Illinois representing over 5 million people. The City of Chicago has 23% of the total population, which translates to approximately 2.9 million people. In contrast, the North Central Counties has about 500,000 people, representing 4% of the total population (Figure C.10).

Figure C.10: Total Illinois population by region (2009 ACS) [11]



The median income is lowest in rural areas. According to the 2005-2009 ACS data, the population in the Collar Counties have the highest median income (refer to Figure C.11).

Figure C.11: Median household income averaged by region (2005-2009 ACS) [19]

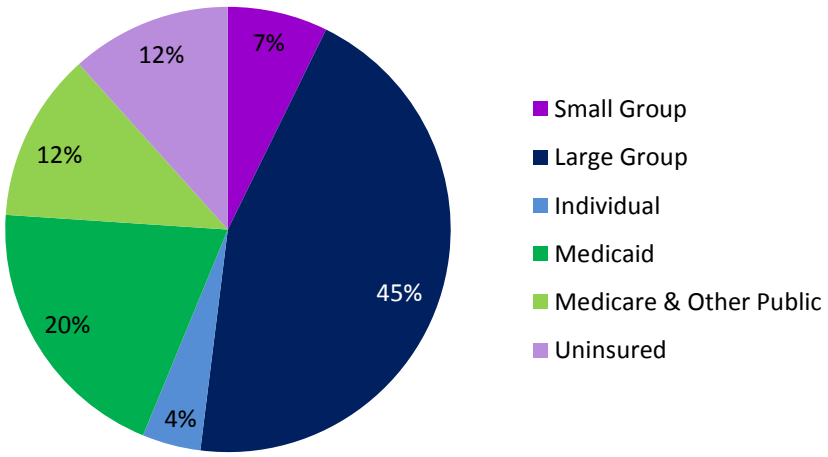
Region	2005-2009 ACS*
Collar Counties	$75,229
Cook County	$53,903
North Central Counties	$49,704
Urban Counties	$50,141
Rural Counties	$43,880
Statewide	$56,530

*Amounts shown in 2009 inflation-adjusted dollars

Health Insurance Coverage

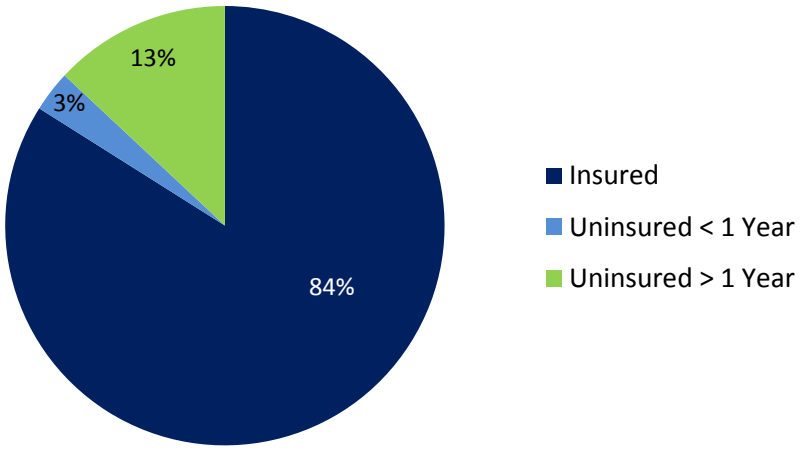
The majority (52%) of Illinois residents obtain health insurance through employer sponsored coverage. Employer sponsored coverage includes small group and large group plans, provided through insurance policies or self-funded by employers. The overall distribution of health insurance coverage in 2011 for the Illinois population is shown below in Figure C.12. Health insurance purchased through the individual market represents 4% while Medicaid covers 20% and Medicare & Other Public Programs cover 12% of the total population. The dual eligibles are included in the Medicaid enrollment. The uninsured represent 12% of the population.

Figure C.12: Estimated 2011 distribution of health insurance coverage across total Illinois population (Deloitte Consulting Health Reform Impact Model)[2]



As of 2011, IHIS results indicate that 84% of the Illinois 18-64 year old adult population is currently insured. 3% of Illinoisans in this age group are currently uninsured, but had health insurance in the past year while 13% is uninsured and has not had health insurance for at least one year (refer to Figure C.13).

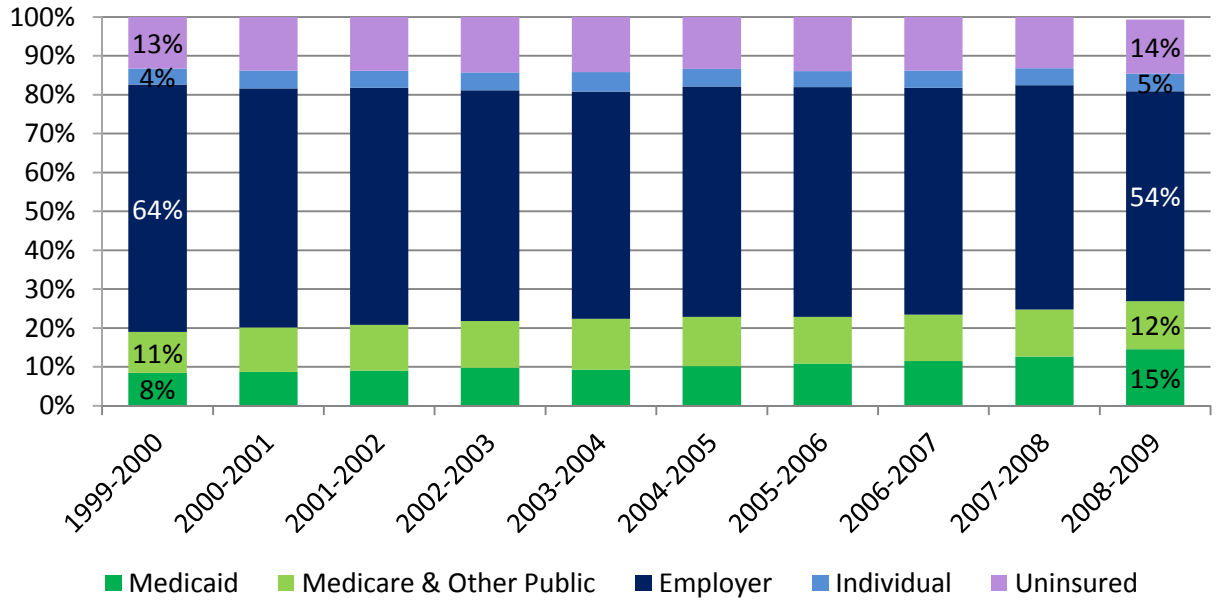
Figure C.13: Illinois (18-64) population by insured status (2011 IHIS) [4]



Historical Trends in Coverage

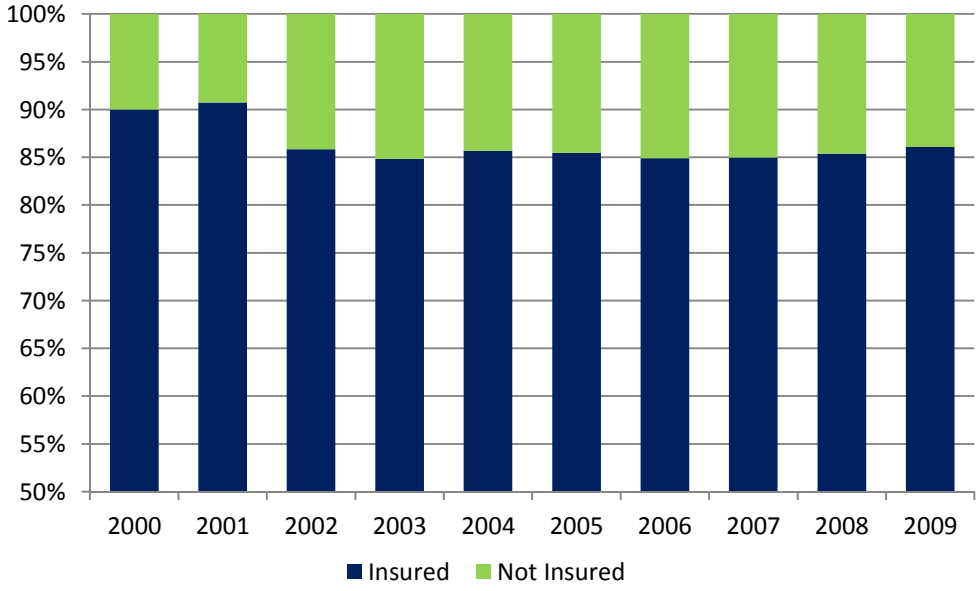
Coverage in Illinois has shifted somewhat from commercial toward government sponsorship over the last decade. By 2008-2009, Medicaid enrollment has expanded to cover 15% of the State population, largely offsetting a reduction in employer sponsored insurance. Rates of uninsured have held fairly steady over time (refer to Figure C.14 below). Dual eligibles are included in Medicaid.

Figure C.14: Distribution of health insurance coverage across total Illinois population, shown as two year averages (1999-2009 Urban Institute/Kaiser)[3]



According to the BRFSS study, nearly 90% of the Illinois adult population had insurance coverage as of 2000. By 2009, the insured rate reduced to the approximately 86%, reflecting a large increase in the number of uninsured (uninsured went from approximately 10% of the population to 14% of the population). The Urban Institute/Kaiser data above also show an increase in the uninsured rate, however the magnitude of the increase in uninsured is much larger in the BRFSS data (5 percentage point increase) versus the Urban Institute/Kaiser data (1 percentage point increase).

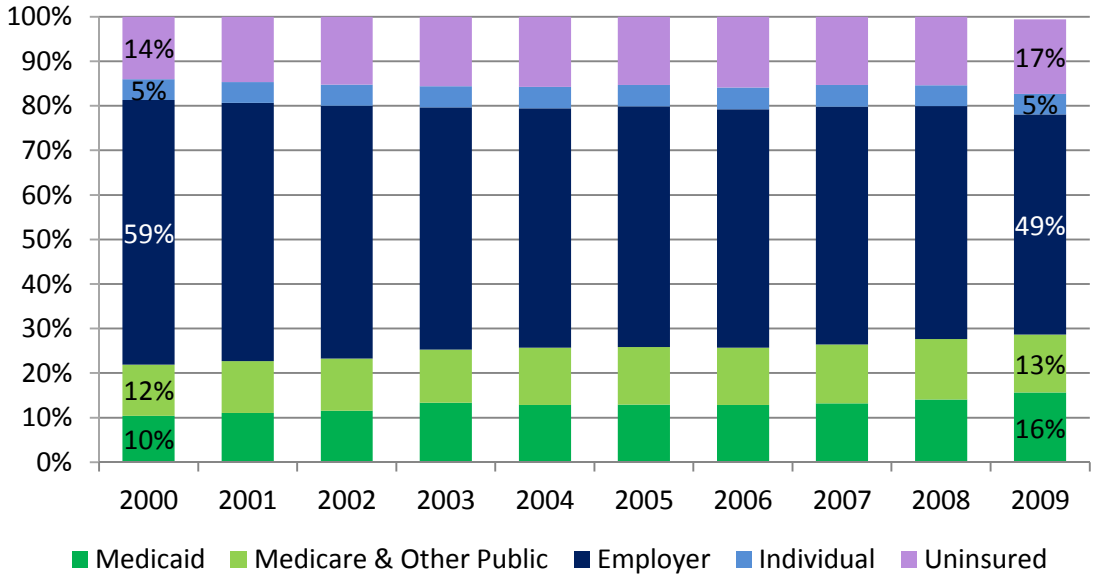
Figure C.15: Historical distribution of the over 18 population by insurance coverage across Illinois (2000-2009 BRFSS) [16]



Coverage trends for Illinois are slightly different from those for the U.S. population. Trends in the U.S. are comparable to Illinois, though somewhat different in magnitude

In Illinois, residents are more likely to access coverage through employer-based arrangements (55%) versus the U.S. (49%) as of 2009. Government sponsored insurance represents a growing share of the coverage nationwide, with Medicare enrollment growing as the population continues to age and Medicaid enrollment growing due to economic conditions and program expansions.

Figure C.16: Distribution of health insurance coverage across the U.S. (2000-2009 Urban Institute/Kaiser)[3]



D. Characteristics of the Insured and Uninsured

Overview

This section of the report describes key characteristics of the insured and uninsured populations and is organized as follows:

- Age and Gender,
- Race,
- Employment Status,
- Household Income,
- Public Programs,
- Geographic Regions,
- Barriers to Coverage for Individuals, and
- Specific Populations of Interest.

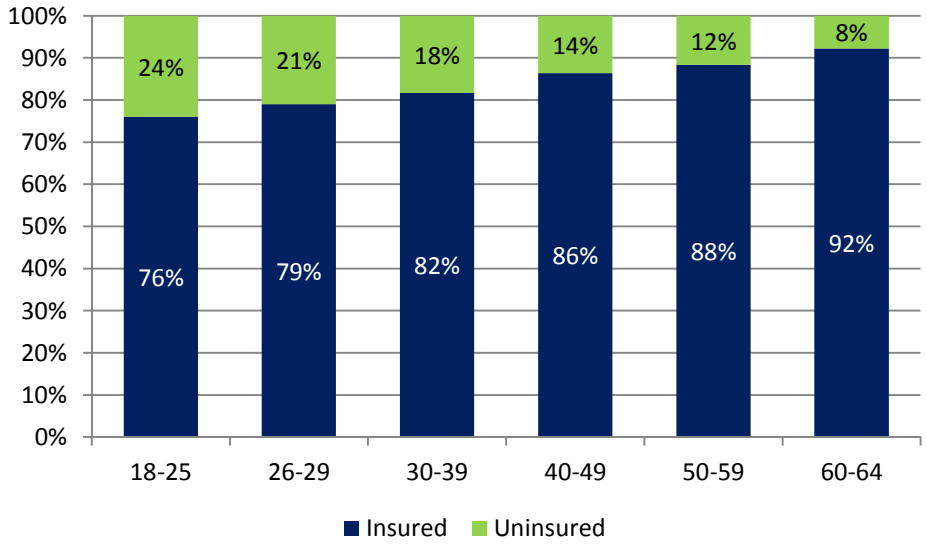
Key findings in this section include:

- The young adult population segment (18 to 25 year olds) is the most likely to be uninsured (24%) while the 60 to 64 year olds have the lowest uninsured rate (8%) among the age groups surveyed[4].
- Among the largest racial groups in Illinois, Hispanics have the highest uninsured rate (27%) with African Americans second (23%), while White Non-Hispanics have the lowest uninsured rate (13%)[4].
- As income increases, Illinoisans are increasingly likely to have health insurance coverage[4].
- Self-identified health status improves with increases in household income[16].
- Insured Illinoisans indicate that the most important factors in selecting a health plan are the cost of premiums and the out-of-pocket costs associated with doctor visits[4].
- The top two reasons reported by the uninsured for not having health insurance are:
    - insurance is too expensive,
    - insurance is not offered by an employer[4].
- The incidence of Frequent Mental Distress (FMD) is increasing over time, both in the total population and for the uninsured segment[16].

Age and Gender

Older Illinoisans are more likely to have health insurance. The young adult population segment (18 to 25 year olds) is the most likely to be uninsured (24%) while the 60 to 64 year olds have the lowest uninsured rate (8%) among the age groups surveyed.

Figure D.1: Distribution of Illinois (18-64) population by age (2011 IHIS)[4]



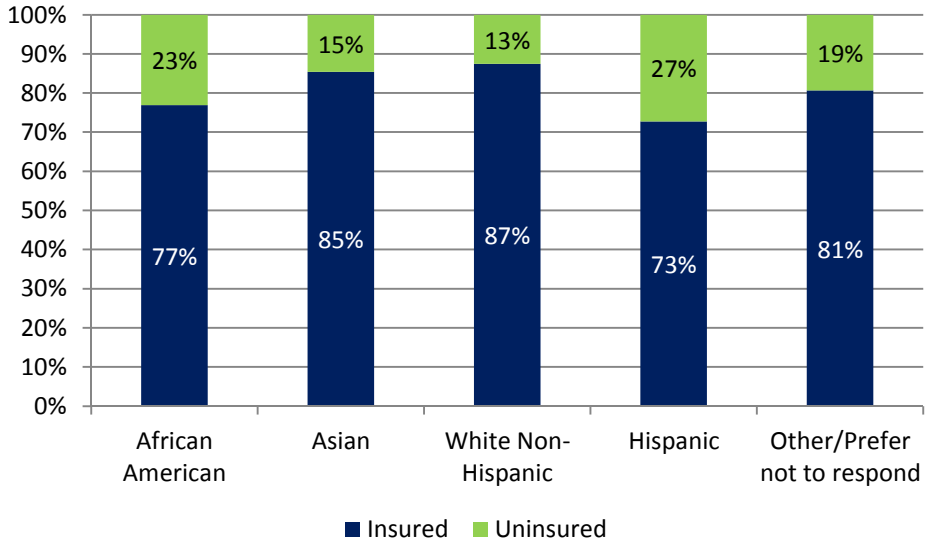
No statistically significant differences were found between the uninsured rates for males and females in Illinois. According to the IHIS, approximately the same rate of uninsurance exists for both males and females (16%)[4].

In 2010, more than 95% of all Illinois children were estimated to have health insurance. [38] According to a recent study performed by the State, nearly all children in Illinois were covered by some type of insurance.

Race

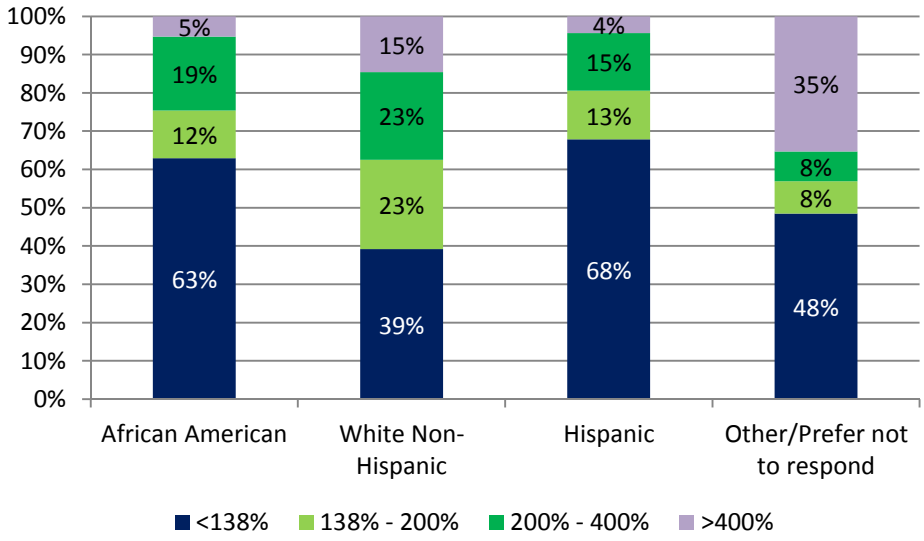
Among the largest racial groups, Hispanics in Illinois have the highest uninsured rate (27%) while White Non-Hispanics have the lowest uninsured rate (13%). According to the IHIS, 27% of Hispanics and 23% of African Americans in Illinois do not have health insurance, while only 13% of White Non-Hispanics are uninsured (Figure D.2*)*.

Figure D.2: Illinois population distribution (18-64) of race by insured status (2011 IHIS) [4]



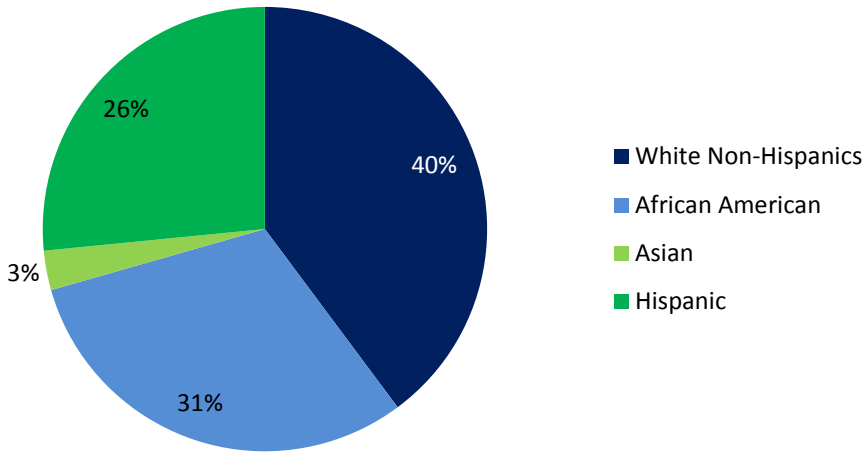
Over 75% of uninsured Hispanics and African Americans have incomes below 200% FPL. In contrast, only 62% of uninsured White Non-Hispanics live in households below 200% FPL, suggesting that this group is somewhat more often uninsured by choice, as opposed to reasons of financial constraints.

Figure D.3: Illinois uninsured (18-64) population distribution of race by income level (2011 IHIS)[4]



White Non-Hispanics make up the largest share of Medicaid enrollment, followed by African Americans and Hispanics. However, Hispanics and African Americans are disproportionately over-represented in the Medicaid population, while White Non-Hispanics are under-represented in Medicaid (as compared with their representation in the total State population).

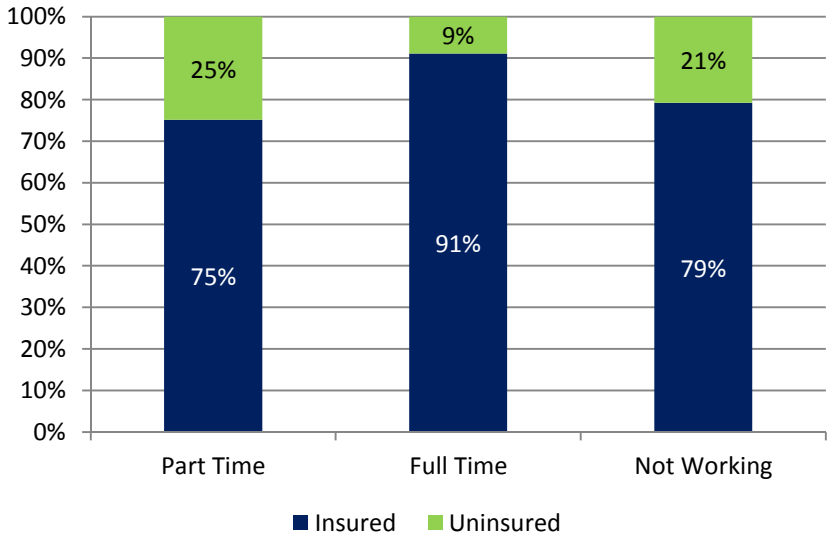
Figure D.4: Medicaid enrollment distribution across Illinois by race (July 2010 HFS)[17]



Employment Status

Per IHIS, fully employed respondents are more likely to have health insurance. Approximately 91% of the adult survey respondents working full time are insured while 75% of those working part time are insured, and 79% of those currently not working are insured. Respondents could be insured through another person's coverage (e.g., parent or spouse).

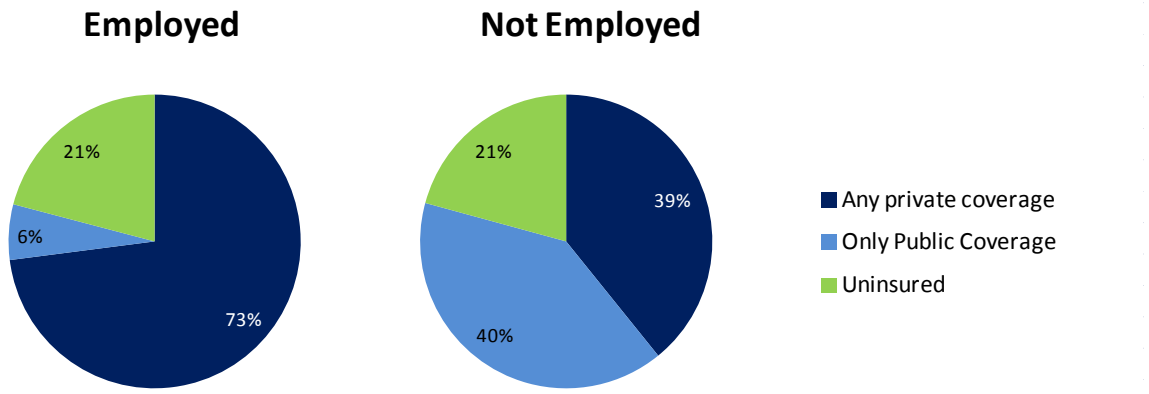
Figure D.5: Illinois population (18-64) insured status by employment status (2011 IHIS)[4]



The majority of employed persons are insured through private coverage while a large portion of those not currently working obtain health insurance through public programs. According to MEPS, persons who are currently employed are more likely to obtain health insurance through a private source (employer, individual market, etc.) than through any other source[20].

Those not currently working are significantly more likely than their employed counterparts to obtain insurance through public programs (Medicaid, Medicare, etc.) as only 6% of the employed population nationwide obtains insurance via public programs while 40% of those not currently working have public health insurance coverage[20].

Figure D.6: U.S. adult (16+) insured population's type of insurance by employment status (2010 MEPS)[20]



Most of the insured population in Illinois is working in services, education, health services, and retail industries. The service industries include business, personal, legal services, finance, insurance, real estate, technology, communication, transportation, government and public service, health services, etc. (Figure D.7).

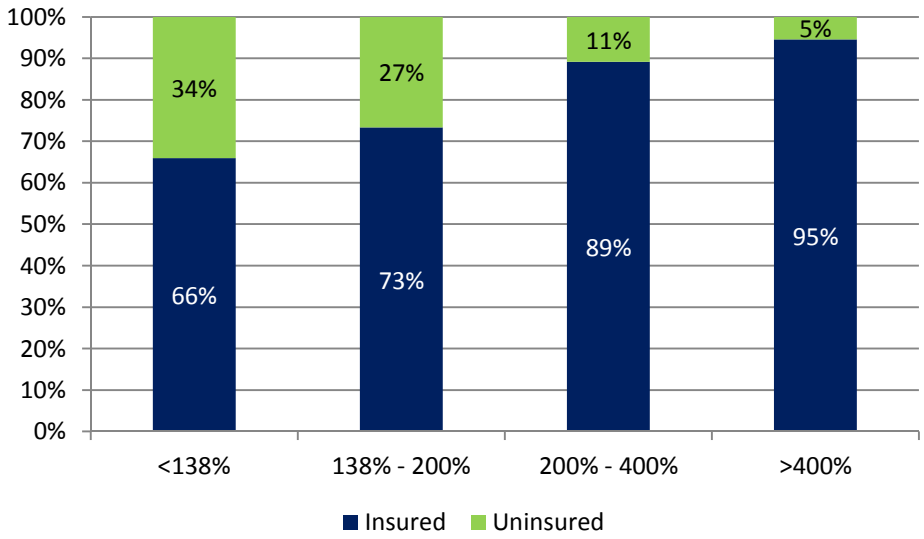
Figure D.7: Illinois insured adult (18-64) population by industry (2011 IHIS)[4]

Industry	% Population
Business services, personal services, legal services, finance, insurance, real estate, technology, communication, transportation	22%
Construction	3%
Education, social services	13%
Government, public service, military	5%
Health services	10%
Manufacturing	8%
Non-profits, religious organizations	4%
Retail, restaurant	10%
Arts, entertainment, recreation	3%
Other	22%

Household Income

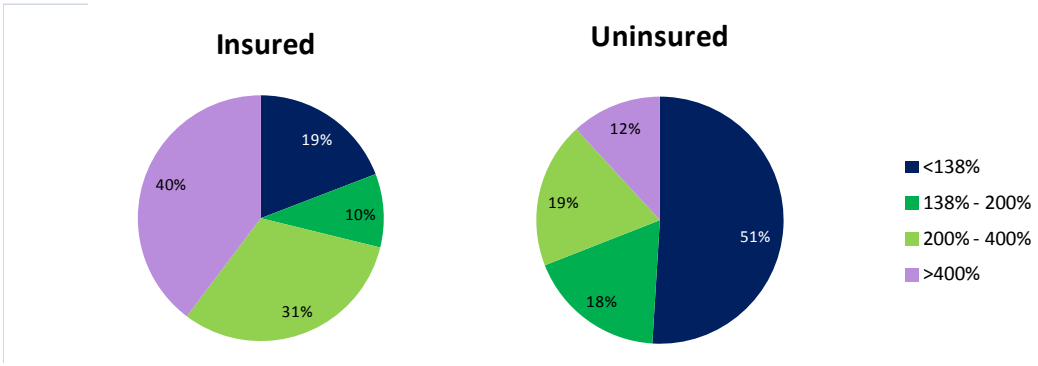
As income increases, Illinoisans are increasingly likely to have health insurance coverage. According to IHIS (Figure D.8), 34% of those having incomes below 138% FPL are uninsured, while only 5% of those above 400% are uninsured.

Figure D.8: Illinois population (18-64) by insured status and income level (2011 IHIS) [4]



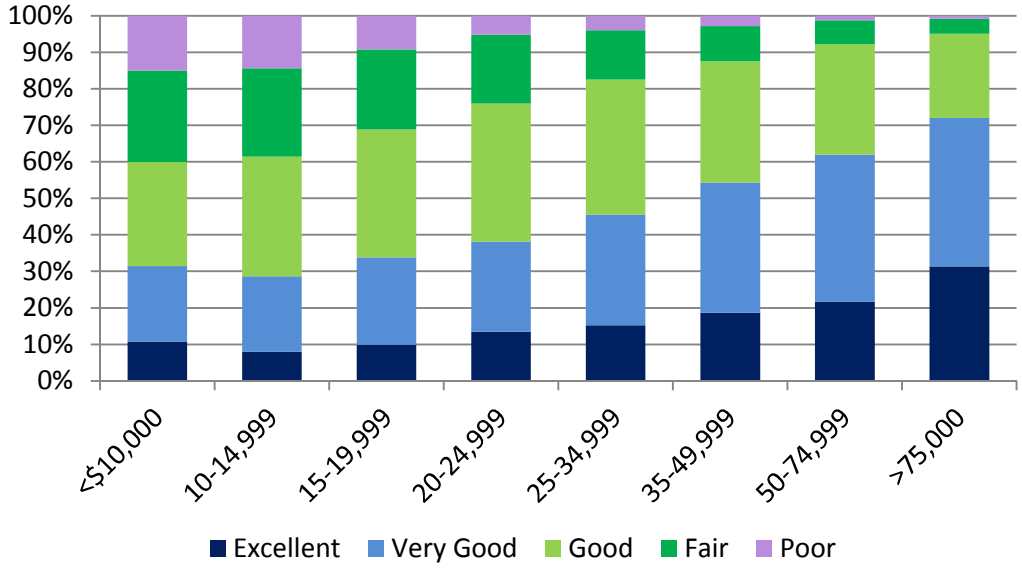
The uninsured are much more likely to be in lower income categories than insured persons. According to the IHIS, 31% of uninsured respondents have household incomes of more than 200% FPL while 71% of the insured respondents' household incomes exceed 200% FPL (Figure D.9.

Figure D.9: Illinois population (18-64) by income and insured status (2011 IHIS)[4]



Self-identified health status improves with increases in household income. According to the BRFSS results, respondents with higher income report better health status (Figure D.10).

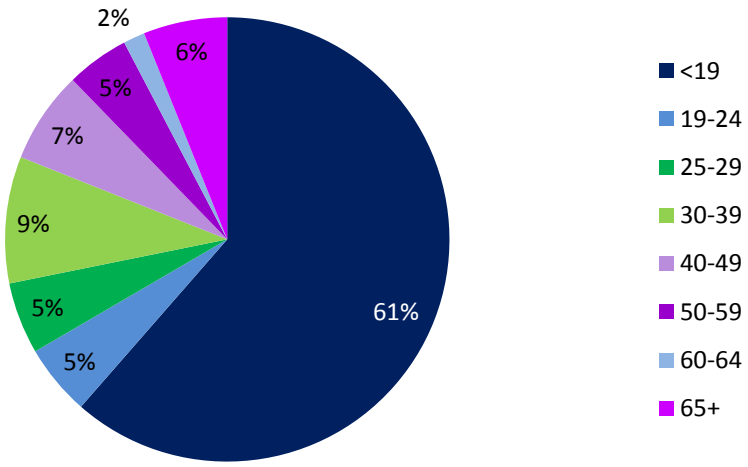
Figure D.10: Self-identified general health rating for the Illinois adult over 18 population by FPL (2009 BRFSS)[16]



Public Programs

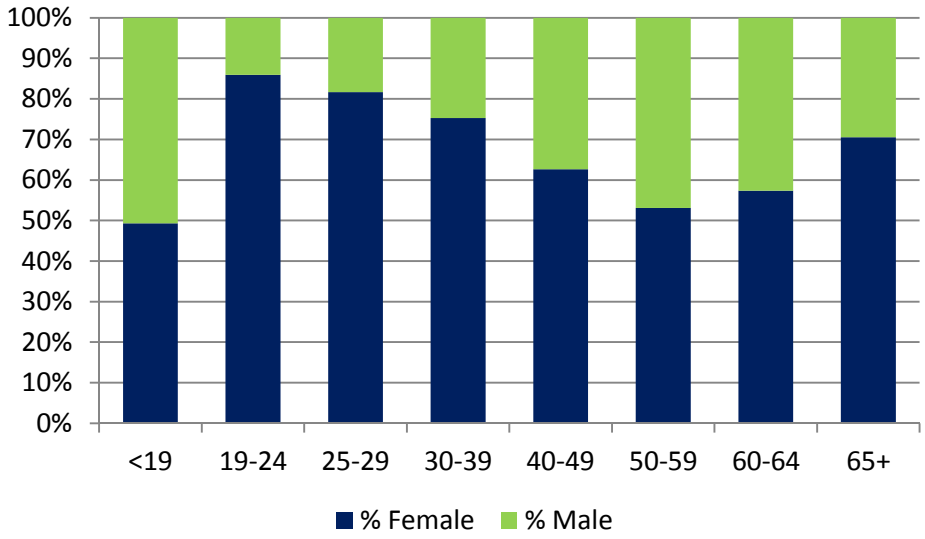
The majority of the current Illinois Medicaid enrollees are children under the age of 19. According to Medicaid enrollment data provided by HFS, 61% of the State's Medicaid enrollment is children. Included in Medicaid are the All Kids and Family Care programs and dual eligibles. The partial benefit programs have been excluded. Nearly 6% of the State's Medicaid enrollment is persons over age 65, who are typically also eligible for Medicare (i.e. dually eligible for both Medicare and Medicaid).

Figure D.11: Total Illinois Medicaid enrollment distribution by age (July 2010 HFS) [17]



The Medicaid population is dominated by females across age groups, with the exception of children. For ages older than 18, females are far more likely to be enrolled in Medicaid than males.

Figure D.12: Total Illinois Medicaid enrollment distribution by age and gender (July 2010 HFS) [17]

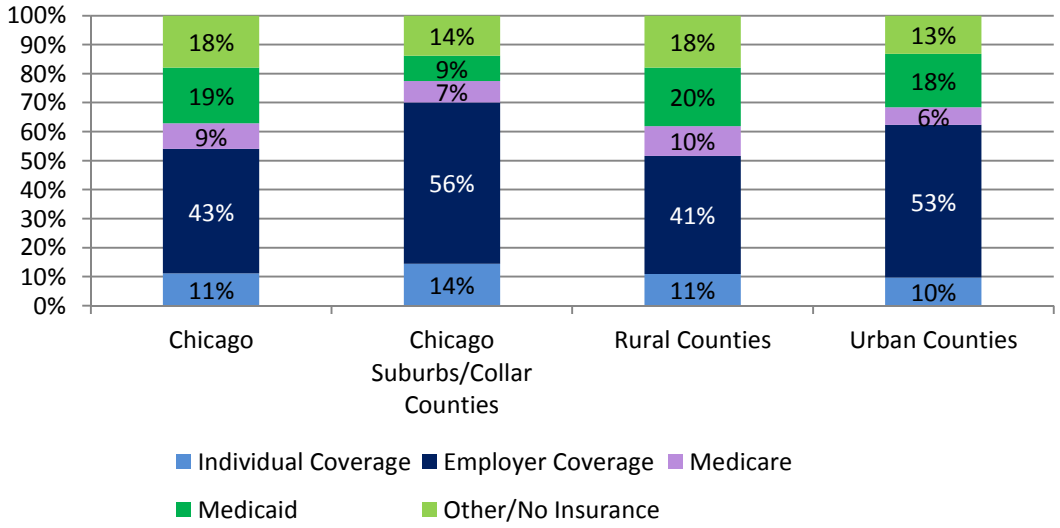


20% of the total uninsured population age 18-64 has a household member currently covered under Medicaid[4]. This statistic can be attributed largely to Medicaid-eligible children living in uninsured persons' households.

Geographic Regions

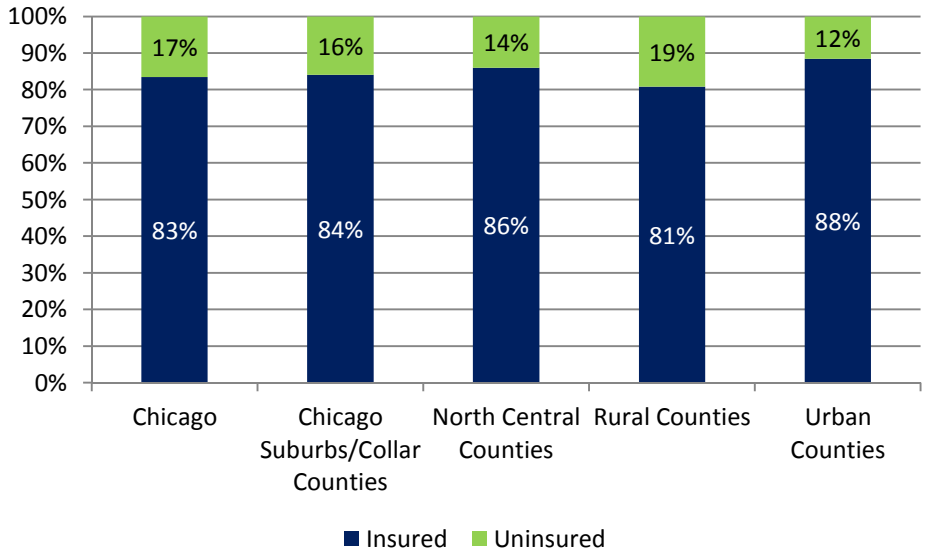
Health insurance coverage type varies by region. According to the IHIS, the Chicago Suburbs/Collar Counties' population primarily obtains insurance coverage via the employer market (56%), while far fewer obtain coverage through Medicaid (9%) or Medicare (7%). In contrast, less than half (43%) of the Chicago population obtains coverage via the employer market while 19% access insurance through Medicaid and 9% receive coverage through Medicare. (Figure D.13).

Figure D.13: Regional Illinois population by type of insurance coverage (2011 IHIS)[4]



The uninsured rates vary between 12% and 19% across geographic regions. The highest rate of uninsurance according to the IHIS is in the Rural Counties (19%) while the lowest rate of uninsurance is in the Urban Counties (12%) (Figure D.14)

Figure D.14: Regional distribution of Illinois population (18-64) by insured status (2011 IHIS)[4]



Other Considerations

a. Cost

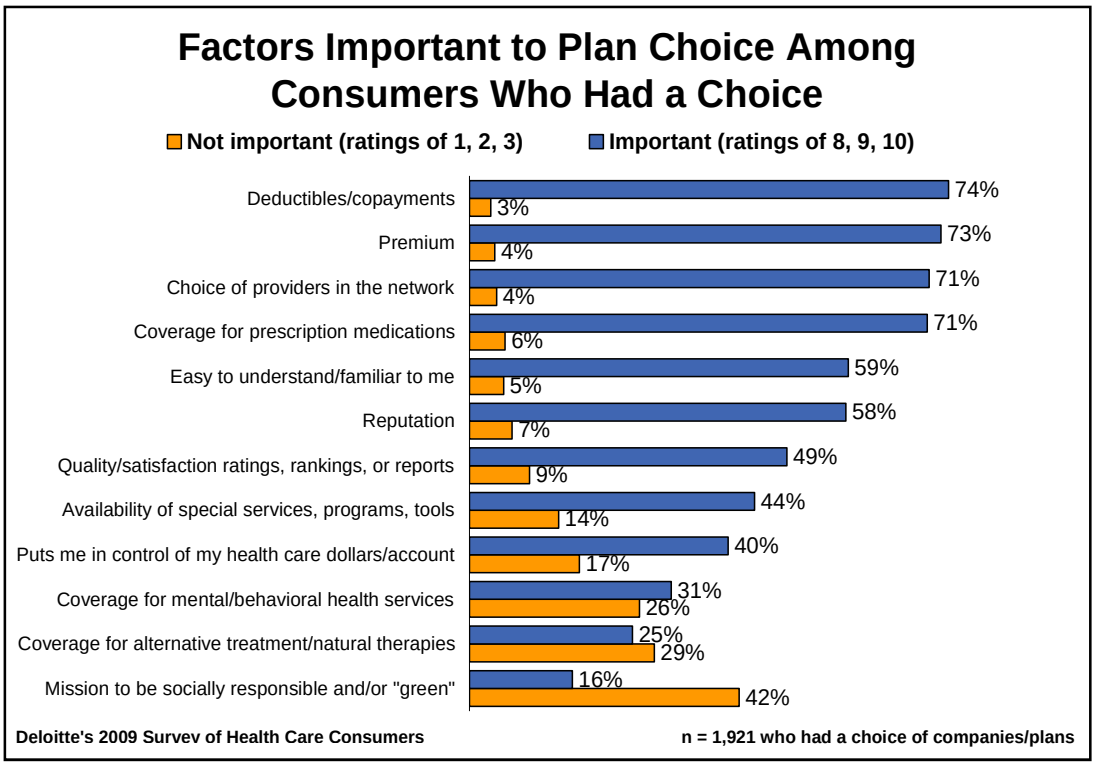
The most important factors in the selection of a health plan for the Illinois population are the cost of premium and the out-of-pocket costs associated with doctor visits. Also significant were the reputation or reliability of the health plan when it comes to paying claims, as well as having a choice of providers in the network. In the below Figure D.15, each question was rated separately as the respondent was asked to identify how important a given factor is in choosing primary health insurance. For the purposes of this question, a '1' indicates the factor is 'Not at all important' while a '5' indicates the factor is 'Extremely important'.

Figure D.15: Illinois population's (18-64) importance rating when selecting a health plan (2011 IHIS)[4]

Question	Average Rating
What I have to pay each month to buy the insurance (premium)	4.44
What I have to pay out-of-pocket when I visit a doctor (cost sharing via deductible/co-pay)	4.29
Reputation or reliability in paying claims	4.21
Choice of providers in the network	4.20
Puts me in control of my health care dollars	4.08
Easy to understand/familiar to me	4.06
Coverage for generic medications	4.05
Quality of customer service that I receive from the Insurance Company	4.04
Coverage for prescription brand name medications	3.97
Quality or satisfaction ratings, rankings, or reports of the particular plan: If you were to purchase health insurance today, how important would each of these factors be in choosing your primary health insurance?	3.82
Coverage for mental/behavioral health services	3.68
Coverage for alternative treatment approaches or natural therapies	3.52

The most important factors in selecting a health plan for the U.S. insured population include out-of-pocket costs (copays/deductible and premium), accessibility of providers in network, and coverage of prescription drugs. These same factors are at the top of the list for Illinoisans. The Deloitte Center for Health Solutions' 2009 Study of Healthcare Consumers rated each of the following categories on a ten point scale with '1' being least important and '10' being most important.

Figure D.16: U.S. important factors when selecting a health plan (2009 Study of Healthcare Consumers, Deloitte Center for Health Solutions)[21]



b. Satisfaction

Consumer satisfaction with health insurance varies across several key characteristics. Satisfaction is highest for mental health coverage, quality of medical care, and generic medication benefits.

The two most important features when selecting a health plan are the two characteristics the insured population is least satisfied with in their current insurance. Illinoisans are least satisfied with the amount they pay in premium (3.06 average rating), followed by the amount they pay for cost sharing (3.12 average rating), and amount of control they have over their health care dollars (3.13 average rating) (Figure D.17). For this topic, respondents were asked to rate how satisfied he/she is with each of the below factors for his/her current health insurance. A rating of '1' indicates the respondent is 'Not at all satisfied' while a rating of '5' is 'Extremely satisfied'

Figure D.17: Insured population (18-64) satisfaction with health plan characteristics (2011 IHIS) [4]

Health Plan Characteristic	Average Rating
Mental Health Coverage	3.72
Quality of Care	3.61
Generic Rx Coverage	3.60
Choice of Doctors	3.51
Alternative Treatment Coverage	3.50
Quality of Customer Service	3.36
Benefits & Services	3.23
Brand Rx Coverage	3.16
Easy to Understand	3.16
Control of Health Care Dollars	3.13
Cost Sharing	3.12
Premium	3.06

The most common complaint filed by health insurance consumers with the Illinois DOI was unsatisfactory claims settlement, followed closely by the denial of a claim. Claim related issues represent the top three items, amounting to over 75% of the complaints. Figure D.18 displays the number of complaints by general complaint categories over 2009 – 2011.

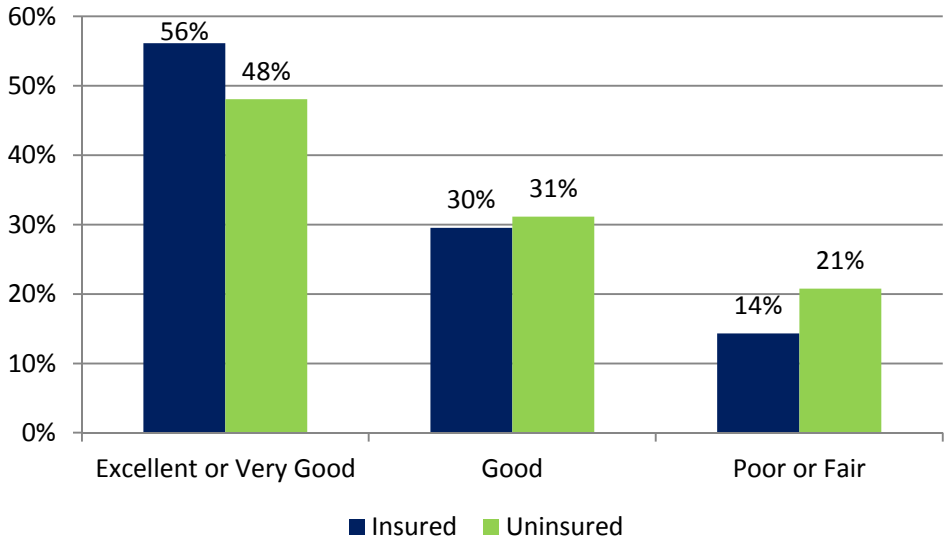
Figure D.18: Distribution of Illinois consumer complaints filed with the DOI (2009-2011 Illinois DOI) [22]

Description of Complaint	Count of Complaints 2009 - 2011	% of Complaints
Unsatisfactory Settlement	909	35%
Denial of Claim	871	33%
Claim Delay/Unpaid	245	9%
Service Delays	161	6%
Premium & Rating	143	5%
Other	94	4%
Refusal to Insure	66	3%
Provider Relations	53	2%
Post Claim Underwriting	43	2%
Cancellation	33	1%
Premium Notice/Billing Problem	13	0%
Total	**2,631**	**100%**

c. Health Status

The uninsured population in Illinois self-reports as being less healthy than those who are insured. (Figure D.19). The IHIS results are consistent with the findings shown from BRFSS.

Figure D.19: Distribution of Illinois population by general health rating and insured status for adults 18+ (2009 BRFSS) [16]



IHIS results also indicate that 37% of the uninsured have been diagnosed with a chronic condition while 52% of the insured have been diagnosed with a chronic condition[4]. However, the higher rate of diagnoses for the insured population is influenced by their insurance and better access to medical services. These findings suggest that the uninsured are somewhat less healthy, on average, than the insured. As the uninsured obtain new coverage on the Exchange in 2014 and later years, their average health status may tend to increase average health costs; however, there are a number of additional factors which will tend to exacerbate this effect (e.g. guaranteed issue requirements under ACA) or mitigate it (e.g. ACA subsidies which will motivate some healthier individuals to join the Exchange)..

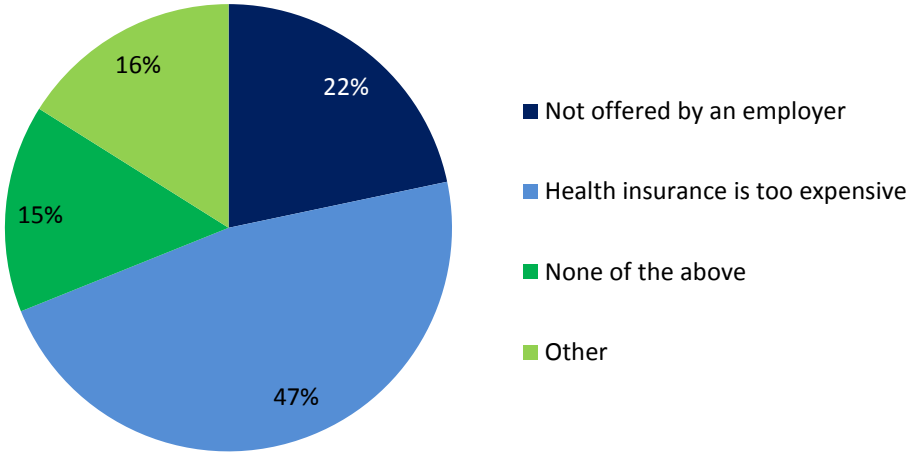
Barriers to Coverage for Individuals

Barriers to individuals purchasing and maintaining health insurance coverage are analyzed in this section, using information drawn from various research work.

a. Cost of Insurance and Employers Offering Coverage

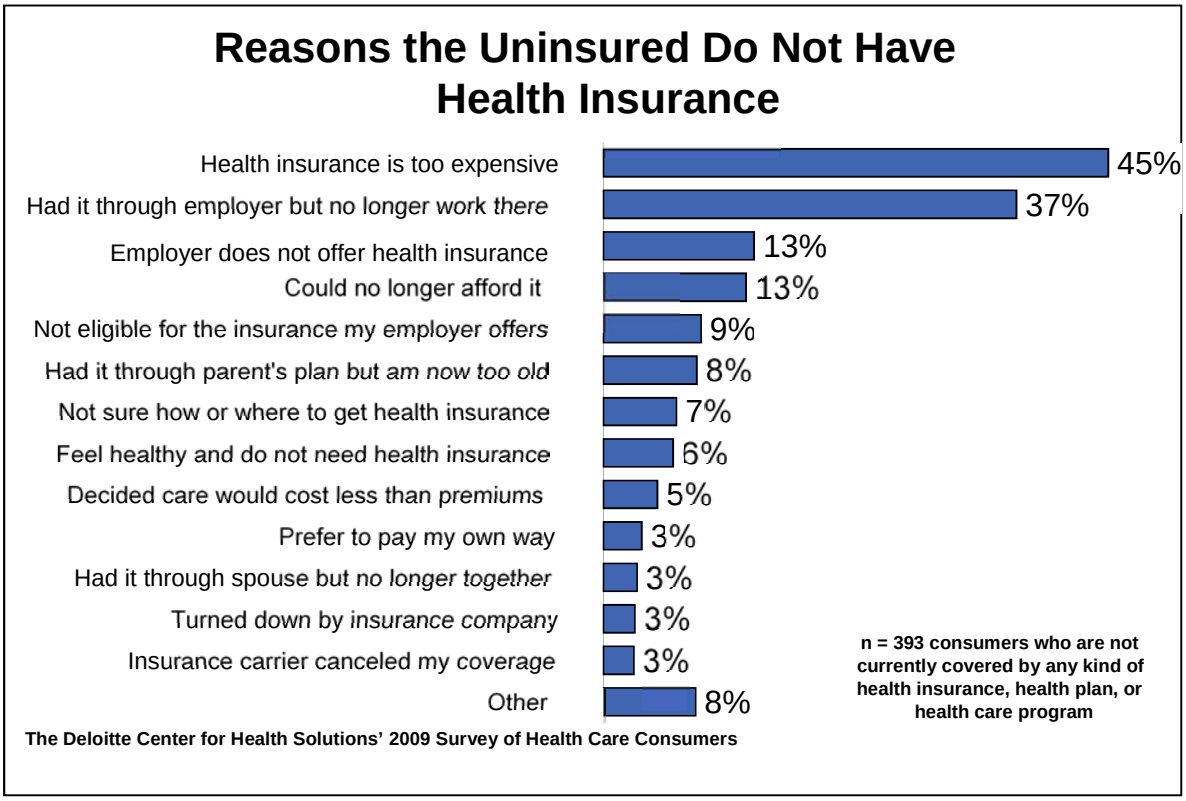
The top two reported reasons the uninsured in Illinois do not have health insurance are because insurance is too expensive and/or because it is not offered by an employer. In the IHIS, 47% of uninsured respondents answered that the reason why he/she does not currently have health insurance is because it is too expensive. The second most frequent answer given by 22% of respondents was that health insurance was not offered by an employer (Figure D.20).

Figure D.20: Illinois adult 18-64 population, reasons for being uninsured (2011 IHIS)[4]



Consistent with the Illinois IHIS, major reasons the uninsured in the U.S. do not have health insurance is because insurance is too expensive and it is not offered by an employer.

Figure D.21: Reasons the uninsured in the U.S. do not have insurance (2009 Consumer Survey, Deloitte Center for Health Solutions)[21]



b. <u>Health Status</u>

According to the Carrier Survey information, 9% of policies for the individual market (HMO and PPO) were issued with specific conditions excluded as part of the underwriting process[6].

These prior-existing conditions exclusions present barriers to coverage for people - mostly because they will not be fully covered for certain existing medical conditions (see Section E)[6]. Some people may choose not to purchase insurance if a significant health condition is excluded from the policy.

However, the State does operate several high risk pools to offer insurance to individuals that have trouble finding insurance, including the Traditional High Risk Pool that covers pre-

existing conditions[23].

c. Additional Comments

- **Age and Gender -** Older Illinoisans are more likely to have health insurance. The younger populations (18-25 year olds) have the highest rate of uninsurance[4]. This is influenced by relative income levels and employment rates, as well as differences in the perceived need for health insurance. Based on the research, there are no apparent differences between males and females in their rate of uninsurance[4].

- **Household Income** –according to the IHIS, the majority of the uninsured (69%) are under 200% FPL and as income rises, the percentage insured increases[4].

Specific Populations of Interest

The State identified two specific segments of the population for additional background research:

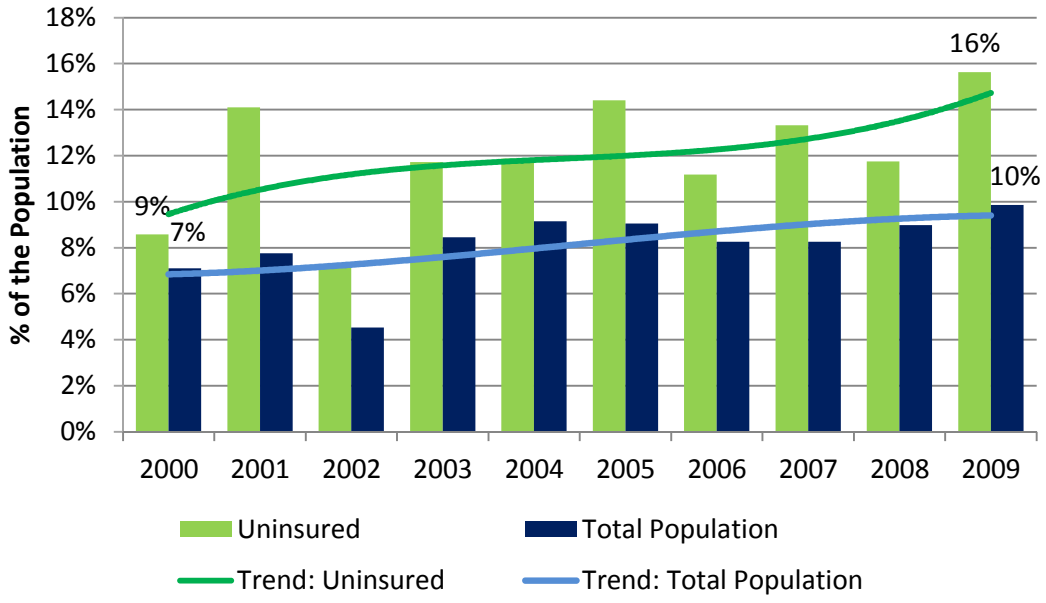
- The uninsured that suffer from mental illness and
- The ex-prisoner population.

a. Uninsured that Suffer from Mental Illness

The incidence of Frequent Mental Distress (FMD) is increasing over time, both in the total population and among the uninsured. FMD is defined as those who have 14 or more mentally unhealthy days in the last 30 days, per the Center for Disease Control[16]. BRFSS investigates this by asking respondents each year to identify the number of days their mental health was not good in the past 30 days. While the actual rate of FMD incidence has varied from year to year, the percentage of the population with FMD has generally increased over time (Figure D.22).

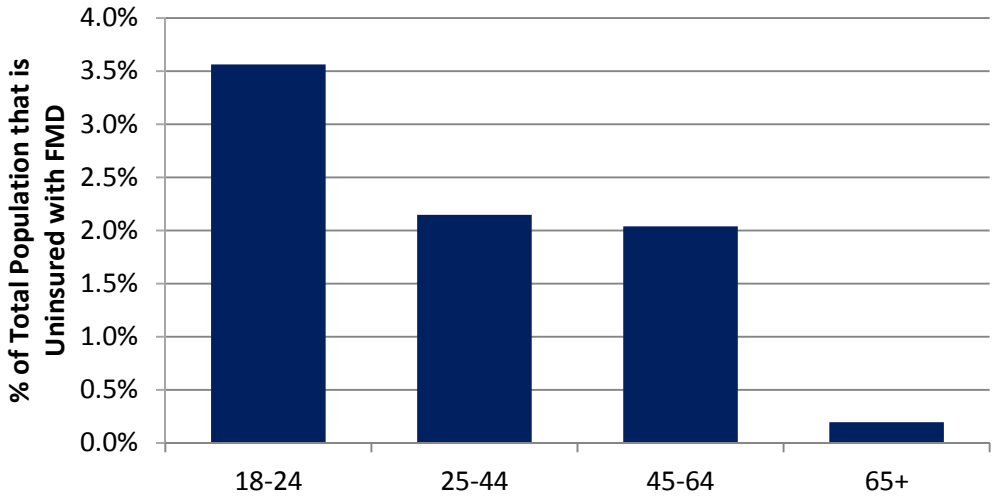
The reported increase in 2009 for the uninsured population is particularly pronounced (Figure D.23). For all periods, the incidence of FMD is higher in the uninsured than the total population.

Figure D.22: Trends in the incidence of FMD in the Illinois adult 18+ population over time (2000-2009 BRFSS)[16]



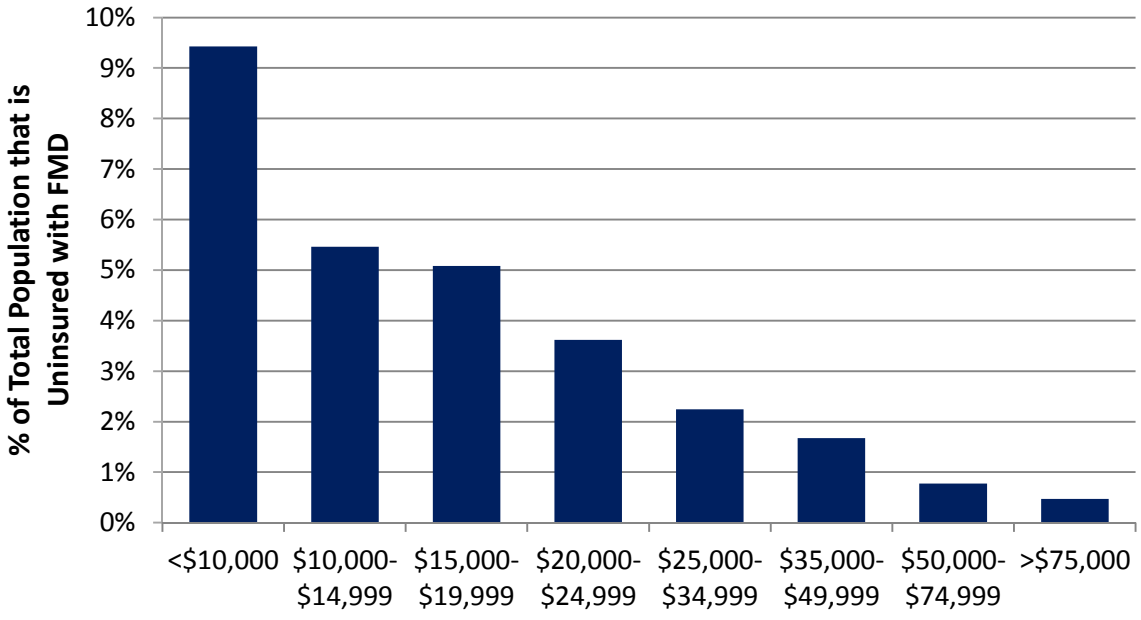
Within the uninsured population, FMD is more common at the younger ages. The incidence of FMD is higher for 18 to 24 year olds than for older age groups (Figure D.23). (Given the low level of uninsured over the age of 65 the value for that age group may not be reliable.)

Figure D.23: Differences in the incidence of FMD in the uninsured population by age group (2007-2009 BRFSS) [16]



Within the uninsured population, FMD is more prevalent at lower income levels, with incidence decreasing rapidly as income increases (Figure D.24).

Figure D.24: Incidence of FMD in the uninsured population by income level (2007-2009 BRFSS) [16]



b. Ex-Prisoner Population

The ex-prisoner population is less likely to be employed than the population as a whole. This group also tends to have depressed earnings when employed relative to the average.

- The PEW Charitable Trust found that employment was lower (indicated as average number of weeks worked) for the ex-prisoner population nationally, and that hourly wages and annual earnings reduced as well (Figure D.25).

Figure D.25: Estimated effect of incarceration on male wages, weeks worked and annual earnings predicted at age 45 (2009 The Pew Charitable Trusts)[24]

Population	Wages	Weeks worked	Annual Earnings
If not incarcerated	$16.33/hr.	48 weeks	$39,100
Post-Incarceration	$14.57/hr.	39 weeks	$23,500

- A significant proportion of ex-prisoners have been found to return to prison within a relatively short period from the time of their release. The PEW Center on the States in collaboration with the Association of State Correctional Administrators (ACSA), found three year recidivism rates of 52% for Illinois, higher than the U.S. average of 43%[25].

- The PEW Charitable Trust similarly found that the impact on earnings is longer term in nature and prevents upward income mobility.

Figure D.26: Percent of ex-prisoner men in the top and bottom of the earnings distribution in 2006 who were in the bottom in 1986 (2009 Pew Charitable Trusts)[24]

Population	Remain in Bottom of Earnings Distribution	Progress Upward in Earnings Distribution
Not incarcerated	33%	16%
Incarcerated	67%	2%

Soon-to-be-released prisoner population has a higher prevalence of diseases. The RAND research brief "Prisoner Reentry: What Are the Public Health Challenges?" reported that incidence for numerous diseases are higher in the soon-to-be-released prisoner population, when compared to U.S. average (Figure D.27) [26].

Figure D.27: Health status of soon-to-be-released offenders compared to the U.S. population (1996 The RAND Corporation)[26]

Category	Condition	Prevalence Relative to U.S. population
Infectious Diseases	Active Tuberculosis	4 times greater
	Hepatitis C	9 - 10 times greater
	AIDS	5 times greater
	HIV Infection	8-9 times greater
Chronic Diseases	Asthma	Higher
	Diabetes/hypertension	Lower
Mental Illness	Schizophrenia/Psychotic Disorder	3 - 5 times greater
	Bipolar Disorder	1.5 - 3 times greater
	Major Depression	Roughly equal

E. Characteristics of the Underinsured

Overview

The underinsured population is a subset of the insured population. The underinsured have health insurance, but the insurance is not considered fully adequate. The State developed several different definitions of underinsured, each of which is analyzed in this section:

- Consumers' confidence about adequacy of health insurance coverage,
- Those enrolled in a 'mini-med' policy, and
- Those who currently have a pre-existing condition that is specifically excluded from their policy.

In Section G (Assessment of Affordability of Coverage), there is further analysis relevant to the issue of underinsurance. In that section, we focus on specific cost related issues, such as:

- Estimating the out-of-pocket costs and comparing to household income to determine whether out-of-pocket costs are more than 10% of household income (more than 5% of household income for families below 200% FPL).
- Providing findings on those who have had problems paying medical bills or who have delayed care due to cost.

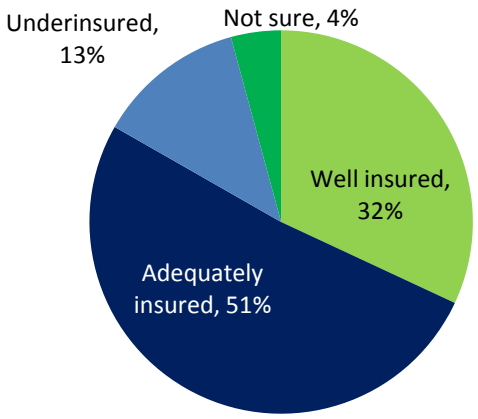
Key findings detailed in this section include:

- Approximately 13% of Illinois households self-identify as being underinsured[4].
- According to a summary from the U.S. Department of Health and Human Services (HHS), approximately 1.2% of the U.S. population is enrolled in a health plan approved for waiver of the annual limits requirements[27].
- 8.6% of the Illinois population has been denied coverage and/or had health benefits limited due to a pre-existing condition, according to the IHIS[4].

Health Insurance Adequacy

Approximately 13% of the insured Illinois population self-identifies as being underinsured. According to the 2011 IHIS, approximately half of the population feels 'well insured' with another 32% feeling 'adequately insured', for a total of 83% feeling their insurance coverage is at least adequate. A small portion of the population (4%) is not sure about their level of insurance.

Figure E.1: Illinois adult, 18-64, population distribution of insurance adequacy (2011 IHIS) [4]



Mini-Med Policies

According to a summary from the U.S. Department of Health and Human Services (HHS), approximately 1.2% of the U.S. population is enrolled in a health plan approved for waiver of the annual limits requirements[27]**.** Between now and 2014, employers and insurers must get permission (or a waiver) to continue to provide these types of limited coverage. The HHS waiver list includes employers based in Illinois, as well as employers based in other states that have Illinois employees[27].

Below is a table summarizing the waivers filed with HHS as of 1/26/2011, where employer-based plans represent 97% of all waivers (including self-insured plans, collectively-bargained plans, and health reimbursement arrangements)(Figure E.2). The remaining 3% are health insurers and state governments.

Figure E.2: Summary of waivers by coverage type in the U.S. (January 2011 U.S. HHS Listing)[27]

Source of Health Plan Coverage/Waiver Type	Number of Waivers	Percentage of All Waivers
Employment-Based Plans		
Self-Insured Employer Plans	*359*	49%
Collectively-Bargained Employer-Based Plans	*182*	25%
Health Reimbursement Arrangements (HRAs)	*171*	23%
Health Insurers	16	2%
State Governments (OH, MA, NJ, TN)	4	1%
Total Number of Waivers	**732**	**100%**

Policies with Exclusions

8.6% of the Illinois adult population, age 18-64, has been denied coverage and/or had health benefits limited due to a pre-existing condition, according to the IHIS[4]. Note that these denials and limitations occur mainly in the individual market, rather than under group plans. The percentage includes respondents who may have group or other coverage currently, but report having coverage denied or limited in the past.

The percentage of individual market policies issued with specific exclusions was 9% according to the Carrier Survey[6]. 9% of policies in the individual market were issued with specific underwriting prior-existing condition exclusions[6]. Application denials averaged 12% according to the Carrier Survey[6]. The prevalence of pre-existing conditions exclusions and denial rates vary significantly among carriers in the individual market[6].

F. Characteristics of the Health Insurance Marketplace

Overview

This section provides an overview of the health insurance marketplace in Illinois and is organized as follows:

- A description of the current market for commercial coverage including common plan designs,
- Information on the State's high risk pools,
- Identification of potential barriers to competition in the market, and
- Descriptive statistics on the distribution channels (e.g., agents, brokers) for coverage as they exist today.

Key findings in this section include:

- The Illinois health carrier market is highly concentrated among a small number of leading carriers.
- The largest carrier in the State has a market share of about 49% of total enrollment across all health plan market segments, including insured and self-insured. This is significantly higher than the market share of leading carriers in most other large states [5].
- The top two carriers in each Metropolitan Statistical Area in Illinois represent over 60% of each area's enrollment[5].
- The data indicates that PPOs dominate the fully insured individual and small group market[6].
- The market offers hundreds of products/plan designs[6].
- The top barriers to coverage are cost and availability of insurance being offered by employers[7,8,9].
- Individuals in the State-funded high risk pools represent less than 1% of the total population[23].
- Agents' total compensation measured as a percentage of premium decreases as customer size increases[6].
- As would be expected, consumers travel longer distances to access care in the more rural areas of Illinois[29]. Medicare insured members tend to travel shorter distances than persons with other types of coverage[29].

Current Carrier Marketplace

Analyzed below are several aspects of the current carrier marketplace including the carriers and their market concentrations, products and plan designs, and provider networks.

a. Carriers and Market Concentration

The health insurance marketplace in Illinois includes one carrier that is much larger than any competitor in the State. Health Care Service Corporation (HCSC) has 49% of the statewide market share (in terms of enrolled membership). This compares with a median value of 25% for the leading carrier in the other nine largest states in the U.S. The top two carriers in the State have 63% of the membership (Figure F.1). The percentage market share calculations below include membership in insured and self-insured plans, including managed Medicare and managed Medicaid (if any) for the ten states.

In comparison to the other largest states in the country, Illinois is second only to Michigan in the market share concentration achieved by the largest carrier. The 49% share shown for HCSC excludes business attributable to associated Blue Cross and Blue Shield plans based in other states, and may differ from other market share estimates for that reason. In addition, market shares vary by market segment and are also affected by differences in time periods and methodology.

The health carrier marketplace in Illinois is 'highly concentrated' based on standard metrics and thresholds used by the federal Department of Justice (DOJ) for antitrust enforcement purposes. This analysis uses the Herfindahl-Hirschman Index (HHI), a weighted average market share metric. DOJ guidelines define an unconcentrated market as one with an HHI below 1,500, a moderately concentrated market as one with an HHI between 1,500 and 2,500, and a highly concentrated market as one with an HHI above 2,500. With a statewide HHI of approximately 2,800, Illinois is somewhat above the threshold for highly concentrated markets. Michigan is also determined to be 'highly concentrated', while Texas and North Carolina are 'moderately concentrated' and the remaining large states are 'unconcentrated'.

Figure F.1: Health plan market concentration for the top 10 most populous states based on enrollment estimates as of January 2011 in all fully and self-insured products (2011 HealthLeaders-InterStudy, January 2011 HHI)[5, 37]

Market Sorted By Population	Total Population	Top Carrier	% Share		2011 Herfindahl –Hirschman Index (HHI)	
			Top Carrier	Top 2 Carriers	Index	Classification
California	37,253,956	Kaiser Foundation	25%	49%	1,455	Unconcentrated
Texas	25,145,561	HCSC	29%	47%	1,544	Moderately Concentrated
New York	19,378,102	UnitedHealth Group	21%	37%	1,056	Unconcentrated
Florida	18,801,310	UnitedHealth Group	22%	42%	1,219	Unconcentrated
Illinois	12,830,632	HCSC	49%	63%	2,795	Highly Concentrated
Pennsylvania	12,702,379	Highmark	28%	43%	1,344	Unconcentrated
Ohio	11,536,504	WellPoint	23%	39%	1,280	Unconcentrated
Michigan	9,883,640	BCBS of MI	51%	59%	2,840	Highly Concentrated
Georgia	9,687,653	WellPoint	23%	44%	1,332	Unconcentrated
North Carolina	9,535,483	BCBS of NC	38%	57%	2,104	Moderately Concentrated

In no Metropolitan Statistical Area (MSA) does the largest carrier's market share exceed approximately 56%. The largest carrier varies by region, and the largest market share in each region is most often between 40% and 50%[5] (Figure F.2).

The top two carriers represent over 60% of each MSA's enrollment (all segments, fully insured and self-insured). As shown in a study by HealthLeaders-InterStudy, HCSC has almost 50% market share and is the carrier with either the highest or second highest enrollment in most of Illinois' Metropolitan Statistical Areas (MSA) markets (Figure F.2).

Figure F.2: Illinois Insurance market concentration based on enrollment estimates as of January 2011 in all fully and self-insured products (2011 HealthLeaders-InterStudy)[5]

Market Sorted By Population	Total Population	Top Carrier	% Share	
			Top Carrier	Top 2 Carriers
Illinois	12,830,632	HCSC	49%	63%
Chicago/Naperville/Joliet	7,883,147	HCSC	46%	64%
Lake County–Kenosha, WI	869,888	HCSC	43%	65%
Davenport	379,690	UnitedHealth Group	56%	68%
Peoria	379,186	UnitedHealth Group	39%	62%
Rockford	349,431	HCSC	44%	62%
Champaign-Urbana	231,891	Health Alliance	53%	66%
Springfield	210,170	HCSC	50%	60%
Bloomington–Normal	169,572	HCSC	44%	65%
Kankakee	113,449	HCSC	32%	62%
Decatur	110,768	HCSC	48%	60%
Danville	81,625	Health Alliance	37%	65%

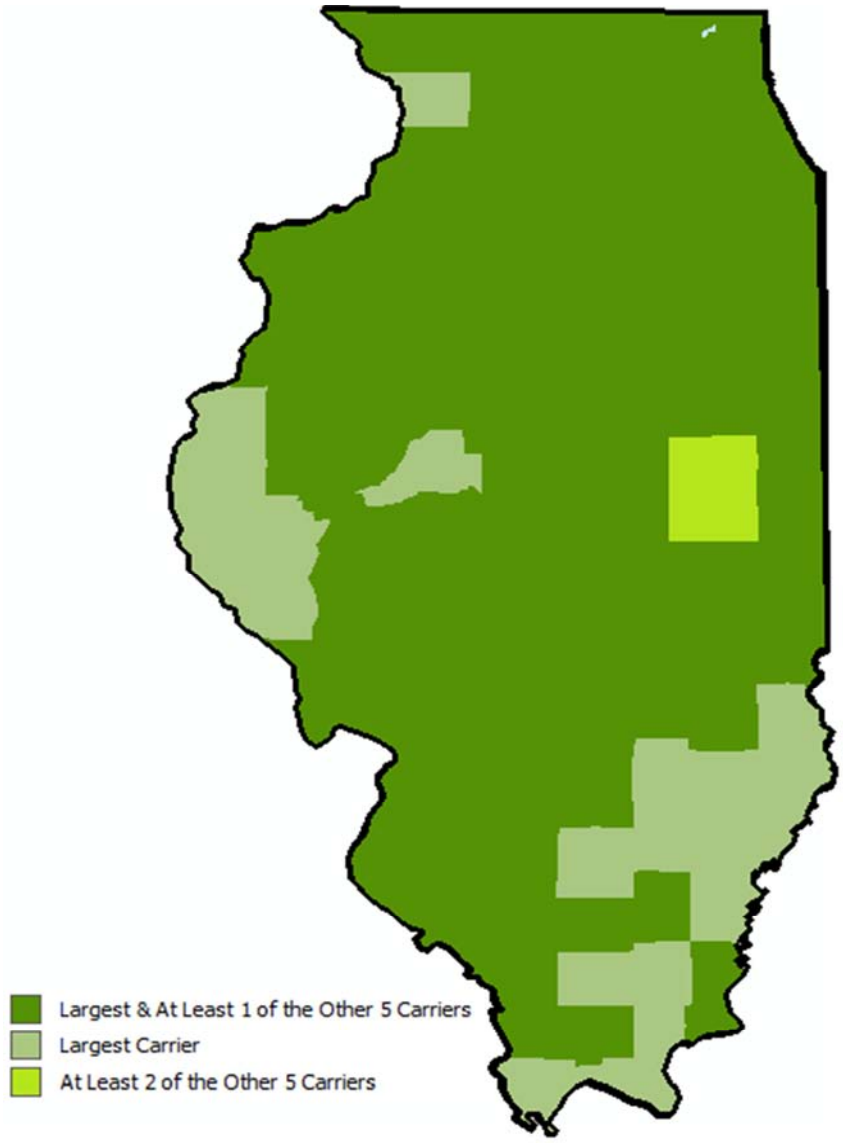
According to the Carrier Survey, only one carrier covers substantially all counties. Four other carriers cover between 26% and 37% of the counties across the State. These numbers are based on counties where each carrier has at least 5% of the fully insured commercial (individual, small group, and large group) membership (as seen in Figure F.3).

Figure F.3: Geographic coverage (% of Illinois counties covered with at least 5% market share in insured commercial market) for six top carriers in Illinois (2011 Carrier Survey) [6]

Carrier 1	Carrier 2	Carrier 3	Carrier 4	Carrier 5	Carrier 6
99%	9%	28%	26%	37%	33%

At least two carriers compete in most counties of the State. As shown in Figure F.4 below, at least two carriers compete significantly in each county. For this purpose, a significant competitor means a carrier having at least a 5% market share in the county's insured commercial enrollment (including individual, small group and large group) The light green areas represent those areas primarily covered by the top carrier (due to other carriers each covering less than 5% of the county's membership).

Figure F.4: Geographic coverage (at least 5% market share in insured commercial market) by the top 6 carriers by county (2011 Carrier Survey)[6]



There have been some recent exits from the carrier marketplace (or major market segments). The most recent Office of Consumer Health Insurance report (2009) highlighted some of these events including the largest recent market exit, Unicare, which withdrew from the commercial group and individual markets in 2009-2010, impacting 183,000 individuals[30]. Historical review of these reports indicated four market exits in 2007, one market exit in 2008, and four market exits (in addition to Unicare) in 2009[30].

b. Products and Common Plan Design

The data indicates for the top carriers, PPOs dominate the fully insured commercial market. This is especially true in the individual market where virtually all membership included in the Carrier Survey information is enrolled in PPO products (refer to Figure F.5 below).

Figure F.5: Distribution of enrollment by product type (2011 Carrier Survey)[6]

Plan Type	Small Group	Individual
PPO	84%	99%
HMO	11%	1%
Other (e.g., Point of Service)	5%	0%

The market offers over 500 different benefit designs. Across the carriers surveyed, more than 500 distinct cost sharing combinations were observed in the individual and small group commercial markets across the features included and analyzed as part of the Carrier Survey (deductible, coinsurance, out-of-pocket (OOP) maximum, PCP copays, specialist copays, inpatient copays, and emergency room (ER) copays)[6]. Note that participating carriers provided detailed information only on their top products by enrollment, representing at least 80% of enrollment for the carrier.

The most common plan designs in each of the individual and small group markets (excluding HMOs) are shown below, along with the market share of that plan design (Figures F.6 and F.7).

Figure F.6 & F.7: Top Illinois fully insured products by enrollment in the individual and small group commercial markets (none of the top plans included a hospital inpatient copay, excludes pharmacy) (2011 Carrier Survey)[6]

Individual Market						
Deductible	Coinsurance	OOP Max	ER Copay	PCP Copay	Specialist Copay	% of Total
$5,000	0%	$5,000	NA	NA	NA	6.7%
$2,500	20%	$5,500	NA	$30	$30	5.8%
$1,000	20%	$2,000	NA	$20	$20	5.2%
$1,000	20%	$4,000	NA	$30	$30	4.8%
$2,500	20%	$3,500	NA	$20	$20	4.0%
$2,500	20%	$3,500	NA	NA	NA	3.6%
$2,600	0%	$2,600	NA	NA	NA	3.5%
$1,000	20%	$2,000	NA	NA	NA	3.2%
$500	20%	$1,500	NA	$20	$20	3.0%
$500	20%	$3,500	NA	$30	$30	2.9%

Small Group Market						
Deductible	Coinsurance	OOP Max	ER Copay	PCP Copay	Specialist Copay	% of Total
$1,000	20%	$3,000	$150	$30	$50	6.5%
$2,500	0%	$5,000	NA	NA	NA	5.8%
$500	10%	$1,500	$150	$20	$40	4.5%
$2,500	0%	$2,500	NA	NA	NA	4.2%
$2,500	20%	$4,500	$150	$30	$50	3.8%
$500	20%	$2,500	$150	$30	$50	3.5%
$1,500	20%	$3,500	$150	$30	$50	3.3%
$1,000	10%	$2,000	$150	$20	$40	3.0%
$500	20%	$2,500	$150	$20	$40	2.8%
$2,500	20%	$5,000	NA	NA	NA	2.4%

Considering only the deductible, coinsurance and out-of-pocket maximum allows for grouping of like plans and produces a more consolidated view of popular plan designs. This summarized version of plan designs across non-HMO plans still show variability across the product options selected within the individual and small group markets, even when only considering the more popular options.

Figure F.8 & F.9: Deductible, coinsurance and out-of-pocket maximum combinations with more than 120,000 member months' exposure (excludes cases with copay cost sharing only; amounts shown apply to covered medical expenses other than pharmacy) (2011 Carrier Survey)[6]

Individual Market			
Deductible	Coinsurance	Out-of-Pocket Maximum	% of Total Enrollment*
$2,500	20%	$3,500	10.1%
$1,000	20%	$2,000	8.8%
$2,500	20%	$5,500	8.8%
$1,000	20%	$4,000	7.3%
$5,000	0%	$5,000	6.8%
$1,750	20%	$4,750	5.9%
$500	20%	$3,500	5.2%
$5,000	20%	$8,000	4.6%
$500	20%	$1,500	4.6%
$2,600	0%	$2,600	3.5%
$5,000	20%	$6,000	3.3%

Small Group Market			
Deductible	Coinsurance	Out-of-Pocket	% of Total Enrollment*
$1,000	20%	$3,000	10.1%
$500	20%	$2,500	7.6%
$500	10%	$1,500	7.2%
$2,500	0%	$5,000	5.8%
$2,500	0%	$2,500	5.4%
$1,500	20%	$3,500	4.9%
$2,500	20%	$4,500	4.8%
$1,000	10%	$2,000	3.8%
$250	10%	$1,250	3.1%
$2,500	20%	$5,000	2.4%

**Member Months reflect only cases where detailed plan design information was provided*

c. Provider Networks

According to SK&A's Nationwide Physician Specialty Report, there were over 32,000 physicians in Illinois as of June 2011, representing roughly one physician per 400 people in the population. This proportion for Illinois is in line with the United States in total. The 10 most prevalent specialties are listed in the table below (Figure F.10).

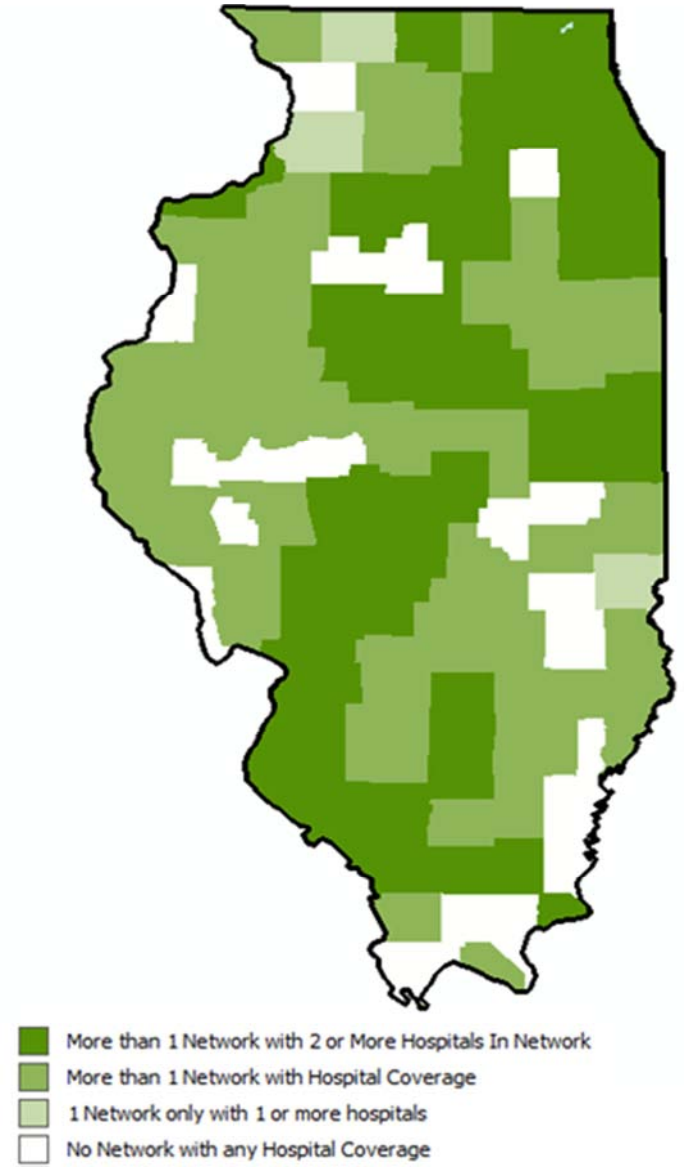
Figure F.10: Top 10 physician specialties in Illinois (2011 SK&A)[31]

Physician Type	Count
Family Practitioner	4,052
Internist	3,607
Pediatrician	2,079
Obstetrician/ Gynecologist	1,836
Orthopedic Surgeon	1,414
Cardiovascular Disease	1,301
Ophthalmologist	1,301
Psychiatrist	1,196
Podiatrist	1,090
Diagnostic Radiologist	1,016

Another way to view coverage access is to analyze the level of choice (i.e., number of options) within health plan networks.

Within their chosen provider network, the majority of State employees are able to select from two or more hospitals. Information from carriers offering to provide health insurance coverage to the State employee population was utilized to review network coverage across the State. From this information, it was clear that the majority of residents had options to select between multiple networks each of which would offer access to more than one hospital within their county.

Figure F.11: Distribution of provider networks by hospital choices available (2009 State Employee Bid)[28]



As expected, consumers travel longer distances to access care in the more rural areas of Illinois. However, even in rural areas, average travel distances are generally reasonable. Using the State's All Payer Discharge database, we analyzed distances consumers traveled for inpatient services, approximated as the distance between the patient home zip code and the provider zip code for each discharge on record. In the more rural areas, consumers had to travel close to 20 miles on average for an inpatient service compared to approximately 5 miles in Chicago (Figure F.12). Those with Medicare insurance consistently traveled the shortest distance compared to others in the all payer data base (Figure F.13).

Figure F.12: Estimated average distance traveled for inpatient care (2010 State Discharge Data)[29]

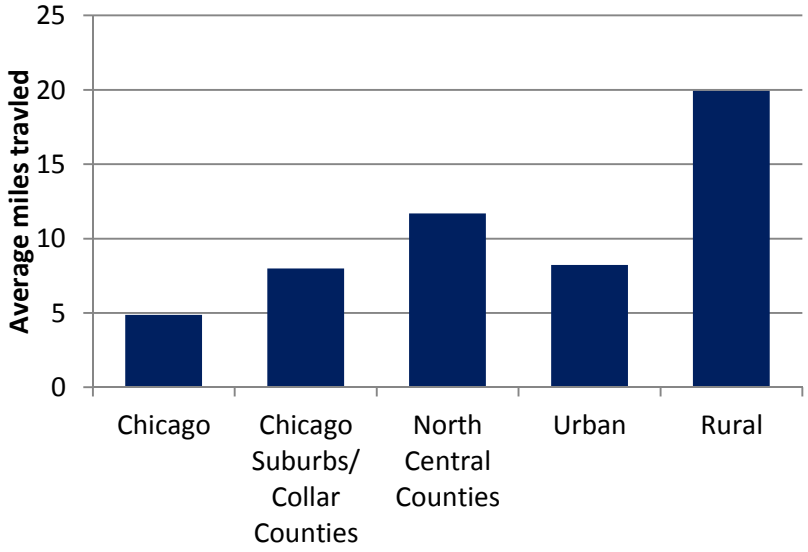
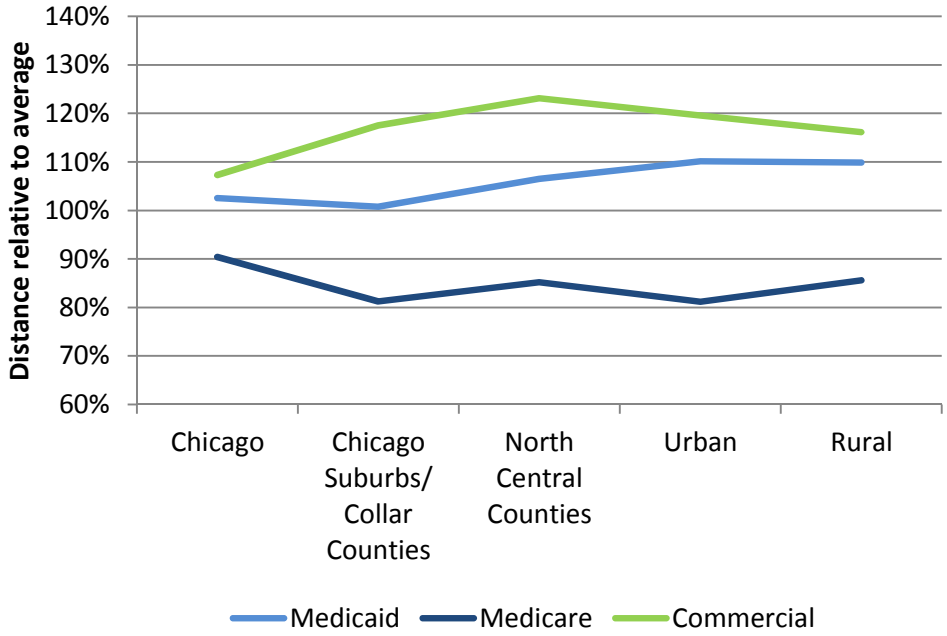
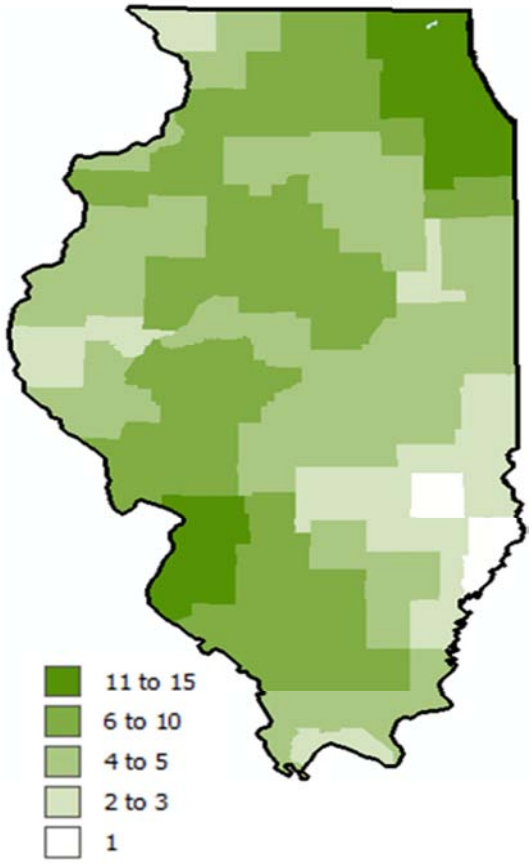


Figure F.13: Inpatient relative distance compared to all payers average distance by region (2010 State Discharge Data)[29]



Currently there are HMOs approved in all counties in Illinois with wider selections available in the more populous areas of the State. There are a number of HMOs approved for business across the State. In Figure F.14 below, the map depicts the number of approved HMOs in each county per data provided by DPH.

Figure F.14: Prevalence of approved HMOs by county (April 2011 DPH)[32]



High Risk Pools

Illinois has three high risk pools currently in place to provide coverage for higher cost individuals. Illinois' Comprehensive Health Insurance Plan (ICHIP) includes three high risk pools, including the Federally-funded Pre-existing Condition Insurance Plan established in September 2010 as part of ACA. This plan had 1,357 enrollees as of May 31, 2011[33]. In addition, there are two other State-funded high risk pools:

- The Traditional Pool for those unable to obtain coverage due to a pre-existing medical condition (2009 Enrollment of 4,565 individuals, and an enrollment cap of 5,950 individuals[23]) and
- The HIPAA pool for those losing access to group coverage (2009 Enrollment of 11,520 individuals[23]).

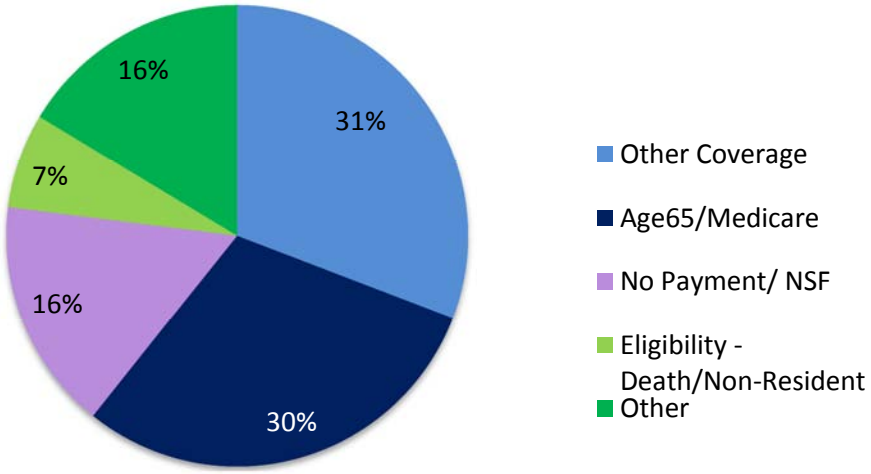
The individuals in the State-funded high risk pools represent less than 1% of the total population. The geographic distribution of high risk pool members is relatively similar to the population distribution of the overall State. The Chicago Suburbs/Collar Counties do have a higher concentration of those in the high risk pools, as seen from the higher observed penetration rates for Lake and DuPage Counties.

Figure F.15: High risk pool enrollment (under 65) as a percentage of the Illinois population by county (2009 ICHIP) [23,11]

County	Enrollment	Percentage of Population
Cook	6,202	0.19%
DuPage	1,778	0.31%
Lake	1,574	0.37%
Will	743	0.18%
Kane	596	0.20%
McHenry	466	0.24%
Winnebago	431	0.24%
Peoria	226	0.21%
Sangamon	204	0.17%
All Other counties	3,865	0.17%
Total	16,085	0.21%

Individuals tend to leave the high risk pools when access to other coverage becomes available. 61% of the documented reasons for terminating from the high risk pool are transfers to other coverage and turning 65 (presumably to transfer to Medicare). While transfers produce the majority of terminations, 16% of individuals terminate specifically for cost or affordability reasons (Figure F.16).

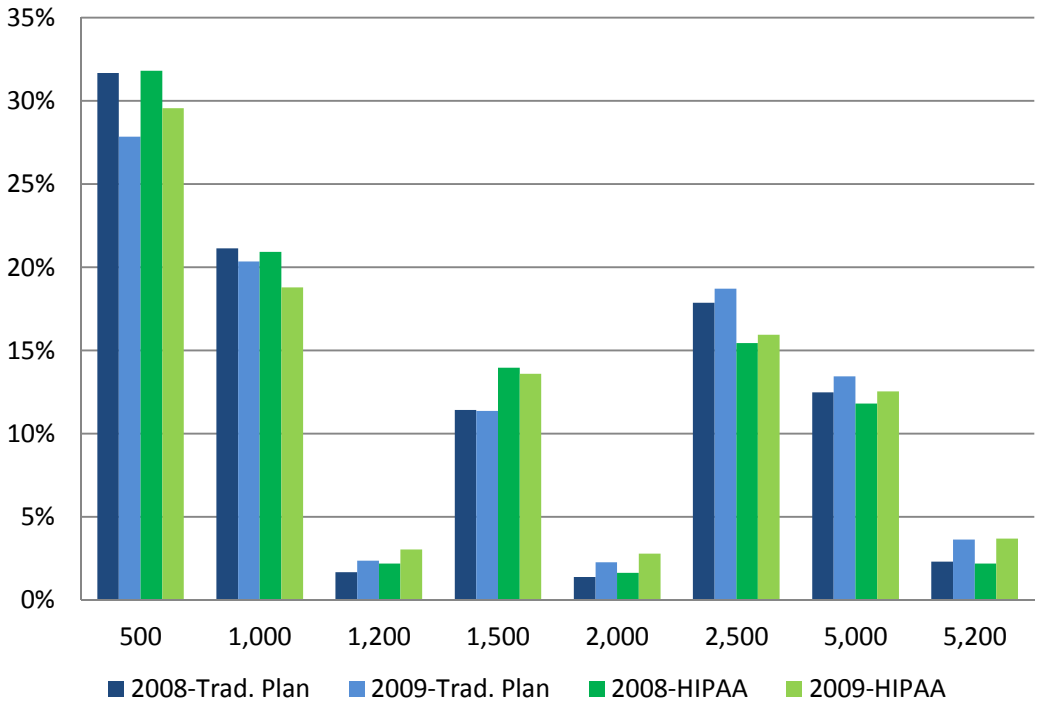
Figure F.16: Distribution of reasons for leaving a high risk pool (2009 ICHIP Annual Report) [23]



The selected cost sharing in the high-risk pool plans closely resembles the cost sharing in the small group market. The observed cost sharing in the State-paid High Risk Pools was compared to the common plan designs from the Carrier Survey information.

- The median deductible for the high risk pool in 2009 was $1,200 with a median out-of-pocket maximum of $2,700[23], only slightly higher than the $1,000 and $2,500 levels found for small group deductibles[6] and out-of-pocket maximums, respectively.
- The following charts provide additional detail on the distribution of coverage by deductible (the deductible amount is included in the out-of-pocket maximum). Although $500 is the most popular deductible option, there is also significant membership at the $2,500 and even $5,000 deductible levels. The information also indicates a slight shift in 2009 toward higher deductibles.

Figure F.17: Distributions by traditional & HIPAA plans by deductible over time (2008 & 2009 Illinois Comprehensive Health Insurance Plan Annual Report)[23]



Barriers to Entry for Additional Carriers

In general, it does not appear that Illinois presents unusual regulatory barriers to market entry for carriers. Although Illinois does exhibit somewhat greater market concentration (measured by market share of the largest carrier) than other large states, all of the major national carriers have a presence in Illinois, and several have substantial market shares in regions of the State. Following are a review of the regulatory environment and comments on other issues relevant to market entry and competition.

a. Regulatory Framework

Based on information provided by the DOI and DPH, which oversee the insurer and HMO markets, we did not find evidence that the Illinois regulatory environment is a major hurdle to the entry of new carriers in the marketplace. Below is a summary of the major components of the regulatory framework considered and their potential impact on new entrants.

The insurance licensing and HMO approval process is not excessively or unusually burdensome to market entrants/participants. These processes do not appear to be overly burdensome when compared to other states[7]. Furthermore, Representatives of the DOI indicated that the vast majority of license applications are approved, with most exceptions being cases where foundational requirements (e.g. required capital or audited financial statements) had not been met.

The product approval and rate review processes do not significantly limit the attractiveness of the Illinois market. The DOI website provided the process of the product approval and rate review[34, 35]. The requirements imposed (e.g., Health Insurance Portability and Accountability Act (HIPAA) requirements, reviews for compliance with mandated benefits) do not appear to limit the relative attractiveness of Illinois as a market for new entrants. Illinois, like other states, is strengthening its rate review process in accordance with the requirements of ACA, which requires states to enhance the review of rate increases (especially those deemed to be unreasonable) and improve documentation and communication of the rate review process.

Consumer protections, rating and underwriting restrictions are generally consistent with the majority of other states. Illinois has introduced a number of regulations to limit the ability of carriers to select and rate for risk or limit their exposure to pre-existing conditions. These regulations tend to be consistent with the regulatory approaches in most other states[8,9]. Some specific examples include:

- Pre-existing conditions[8,9] - The Illinois small group market applies a 6 month look-back (similar to 46 other states as of January 2011) and a 12 month maximum exclusion period (which is aligned with 36 other states and is the longest of all states). In the individual market, Illinois has a 24 month look-back period (longer than 28 other states) and a 24 month exclusion period (longer than 31 other states). The longer the time period, the more opportunity the carrier has to control its risk.
- Rate differentiation[8,9] - In the small group market, Illinois allows for rating bands with deviations of up to 25% from the manual rate, which means premiums can be reduced or increased by up to 25% to allow for variations in health status. As of January 2011, 35 other states apply rate bands in the small group market while 11 states applying more stringent adjusted community rating rules where no additional rate modification is allowed for health status. In the individual market, Illinois does not restrict rating, giving carriers more flexibility to vary premiums.
- Groups of one[8,9] - Illinois does not allow group insurance for employers having only one employee. This is consistent with the practice in 37 other states, and allows carriers to assess the risk for these policies under individual market rating rules.

Other regulatory requirements align well with majority practice. Based on National Association of Insurance Commissioner (NAIC) documentation of health insurance regulation, Illinois tends to be consistent with national market practices in terms of documentation requirements, capital and surplus requirements, public records, etc[7]. Costs related to additional fees, taxes levied and benefit mandates (e.g. Annual Statement filing fee, Certificate of Authority Renewal Fee, Financial Regulation Fee, Fire Marshal's Tax), likely have limited bottom-line impact on carrier financials and would not significantly impact the entry of new carriers into the market.

b. Other Considerations

In addition to regulatory barriers, other market characteristics may impact the willingness of new carriers to enter the market or existing competition.

Market concentration among a few incumbents may deter new entrants and decrease competition in certain geographic areas. The market is mature with Health Care Service Corporation (HCSC) being the dominant market player in the State[6].

Network discounts significantly impact product pricing. The largest existing market players have the ability to exert more influence in provider negotiations, because of their market power. This is typically most evident in the largest MSA markets. Differences in provider discounts directly impact pricing to the consumer. In a price-competitive market any pricing

disadvantage may prove to be a significant barrier to the entry of new market participants and impact competition in the State.

Key attributes include brand value, credibility and community presence of the existing carriers in the market. The largest market players have brand awareness and consumer loyalty due to their presence in the market and active community involvement. Overcoming this hurdle is a significant challenge for a new market participant, especially if this company does not yet have a good presence in the large group self-insured market or another health care related market.

Establishing distribution systems in the agent channel could present a hurdle to a new market entrant, increasing the risk of investment in the new market. Compensation for agents frequently includes bonuses determined by total enrollment with a carrier and retention of those individuals and groups. Persuading agents to put this compensation at risk (by moving enrollees to the new carrier) would require additional investment by the new carrier. Moreover, agents may also expect to see a history of good service, before moving significant parts of their block to a newer carrier, leading to longer investment periods for the new carrier.

Investment costs to develop a new market may reduce potential return on investment and deter new carriers. Entering a new market requires significant investments. These include marketing and administrative investments to set up a new carrier or new market presence, premium commissions required to attract agents to the new carrier, and the risk of anti-selection as agents may initially place poorly performing groups with the new carrier. These costs can be significant, especially in early years, and can deter new carriers.

New Minimum Medical Loss Ratio (MLR) requirements under ACA impact start-up carriers disproportionately. The new minimum loss ratio requirements limit the amount an insurer can spend on non-medical costs as a percentage of premium – once the limit is exceeded a rebate becomes payable to the policyholders. In initial years, especially in the individual market, policies tend to have lower medical costs which result in the carrier having more margin from which to fund business development costs and overhead. Under the new ACA regulations, the fixed expenses and market development costs will have to be funded from capital, as high non-medical costs paid from premium would trigger rebates to members, thus increasing the investment required to develop a new market.

Agents

The term 'agent' is used throughout this report to define those selling health insurance, through a brokerage agency, consulting firm or employed by an insurer In Illinois. All Kids Application Agents provide assistance to enrollees in some of the State supported programs for families, including the All Kids program that covers children throughout the State. The DOI licenses and regulates agents and HFS licenses and regulates the AKAAs.

a. Agents

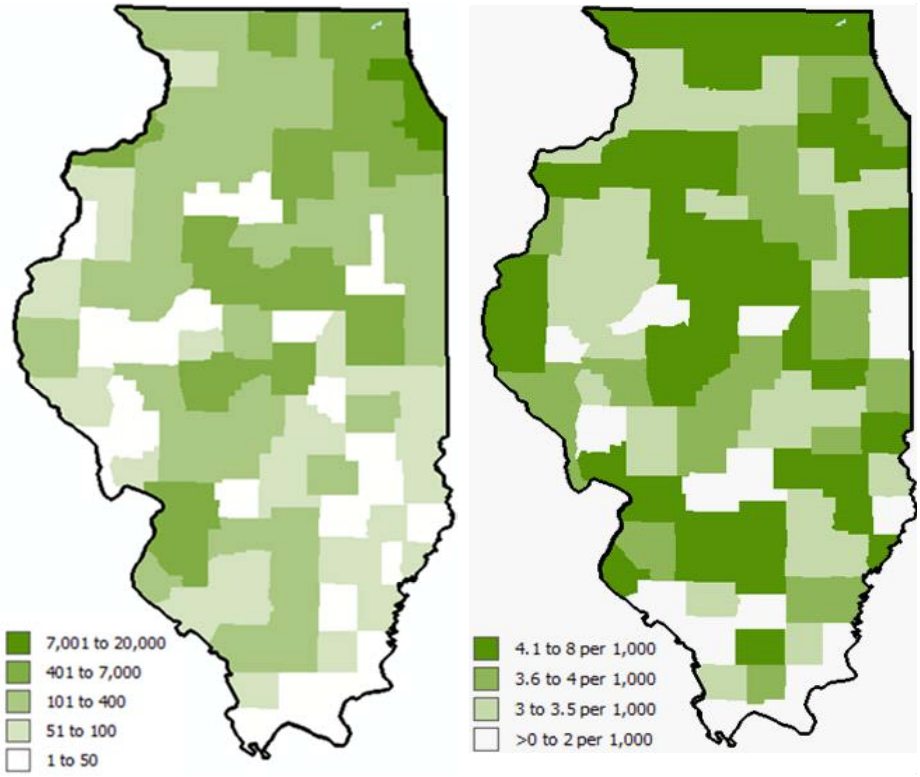
As of the beginning of 2011, there were over 54,000 agents licensed to sell health insurance in Illinois. Almost all agents licensed to sell health insurance are also accredited to sell other types of insurance, such as casualty, fire, and life insurance (Figure F.18).

Figure F.18: Number of health insurance agents by number of license lines (2011 DOI)[10]

	Health Only	2 Lines	3 Lines	4 or More Lines	Total
Number of Agents	517	15,267	12,904	25,952	54,640
% of Health Agents	1%	28%	24%	47%	100%

As would be expected, most of the agents live in urban areas where the concentration of people is high. The map on the left below (Figure F.19) shows the distribution of agents across the State. After adjusting for the population size, the map on the right below shows the concentration of agents per 1,000 people.

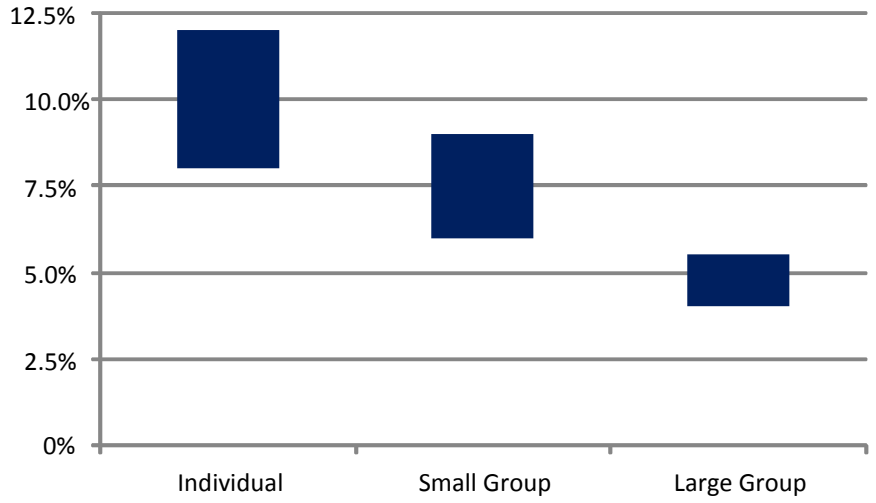
Figure F.19: Health insurance agents by county (left map) and agents per 1,000 persons (right map) (2010 DOI)[10]



Agents typically receive both commissions and bonuses as part of their compensation package[6]. Commission structures and bonus levels vary depending on whether the agent is selling health insurance to individuals, small employer groups, or large employer groups. Compensation includes both commissions and bonuses.

While agent compensation levels vary across carriers, compensation, measured as a percentage of premium, decreases as customer size increases. In Figure F.20, the range of compensation paid by market size is illustrated; demonstrating the higher percentage of premium paid for smaller policies and lower percentage of premium for larger policies. Also shown is the larger range of compensation for the smaller policies as compared to a tighter range of compensation for the larger policies. These compensation levels include both commissions and bonuses as reported through the Carrier Survey.

Figure F.20: Carrier-reported agent compensation as a percentage of premium by market (2011 Carrier Survey)[6]



Commission levels for the individual market are consistently based on premiums, but amount and structure of commissions vary across carriers[6]. All carriers indicated that commissions are structured as a percentage of premium. This means that a 10% commission on a $200 monthly premium per enrolled member results in $20 in commission per month. Additional information on the commissions for the individual market includes:

- The majority of carriers (four of six surveyed) indicated higher first year commissions of 10% to 20% of premium, compared to renewal commissions of 4% to 10% of premium[6]. Some carriers vary the level of first year commissions based on the overall enrollment of the producer[6].

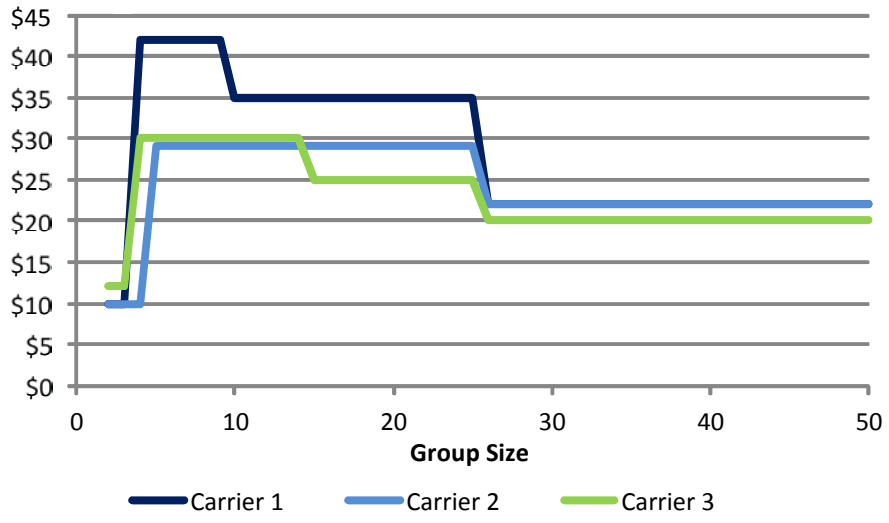
- Recent changes in commission levels varied across carriers (with some increases and some decreases)[6].

Small group market commission structures are changing from a percentage of premium basis to a fixed dollar amount per enrolled employee. The Carrier Survey information shows that two thirds of the carriers now pay commissions based on a fixed dollar amount per enrolled employee while the other third of the carriers pay a percentage of premium[6]. Additional insights on commission in the small group market include**:**

- All but one of the surveyed carriers indicated flat commissions over time of the policy, meaning there are no increased commissions for the first year[6].

- Commissions vary by employer group size, where the smallest employer groups (typically those having fewer than 5 employees) have the lowest commission fees and the next group size (e.g., 5 to 10 employees) has the highest commission fees on a per enrolled employee basis. Thereafter the commission fee reduces as employer group size increases. The figure below demonstrates these relationships for three of the carriers (Figure F.21).

Figure F.21: Carrier-reported agent commission by group size (2011 Carrier Survey)[6]



In the large group market, commission levels lower as the employer group size increases. For example, one carrier stated that commissions for employer group sizes between 101 and 250 employees were 2% of premium while for an employer group size of 251 to 500 employees, the commissions were 1% of premium[6].

A number of carriers have transitioned to enrollment-based commissions for the 51-99 group sizes, with premium-based commissions being most prevalent thereafter[6]. For example, some carriers offer a commission of $15 per enrolled employee (with no additional payment related to enrolled dependents) for group sizes of 51-99 and offer 1.25% of premium for group sizes over 100 employees[6].

Bonuses in the small group and large group markets are based on a combination of retaining business and enrolling new business[6].

b. All Kids Application Agents

AKAAs have been successful at enrolling individuals into coverage, but the volume of enrollment has decreased in recent periods[12]. All Kids application agents (AKAAs) are authorized to support the enrollment of individuals into multiple State administered programs including All Kids, FamilyCare and Moms & Babies.

The AKAAs are "community-based organizations, including faith-based organizations, day care centers, local governments, unions, medical providers and licensed insurance agents. Most, but not all, AKAAs receive a $50 Technical Assistance Payment (TAP) for each complete application that results in new coverage"[12].

The volume of new enrollments has decreased over time most likely due to two external factors, namely lower numbers of eligible children yet to be enrolled in the program, and the introduction of a web-based enrollment option[12]. The table below shows the total number of agents, the total number of applications processed, and the resulting average number of applications submitted per agent per year.

Figure F.22: AKAAs enrollment activity over time (HFS 2002-2010)[12]

	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total AKAAs	449	461	476	474	496	507	449	403	347
Total Enrollments	37,934	42,915	41,194	40,799	43,040	37,808	32,433	27,156	22,869
Average Enrollments per AKAA	84	93	87	86	87	75	72	67	66

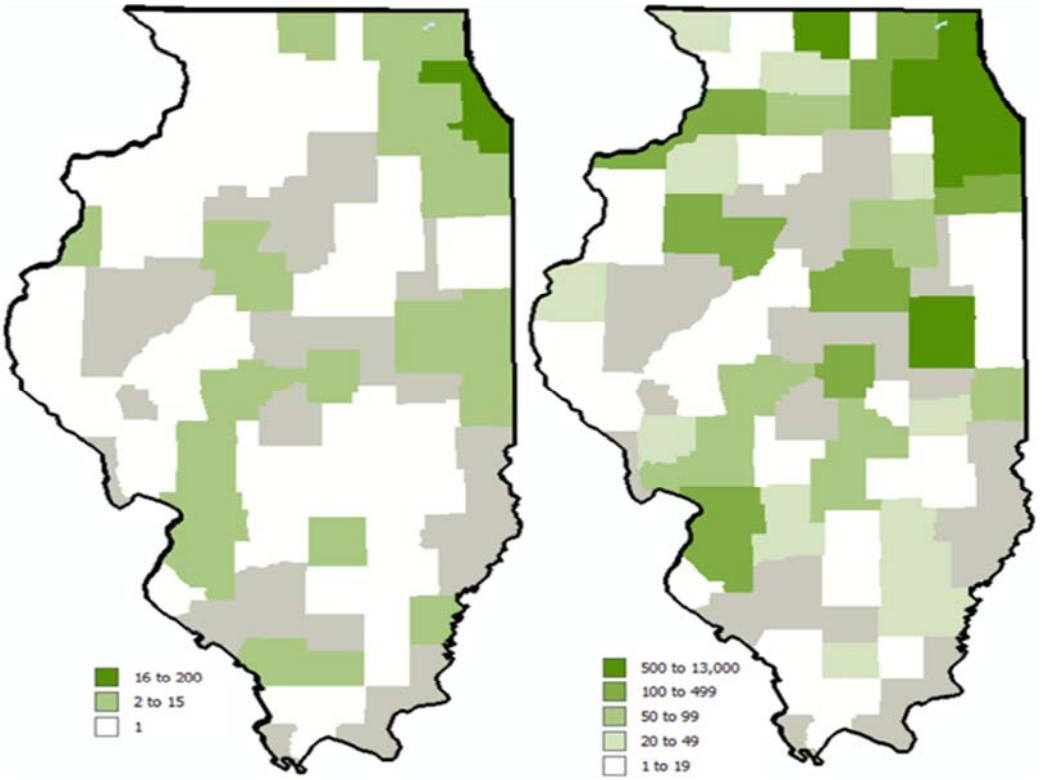
A small number of AKAAs represent a large proportion of the membership enrolled. The table below (Figure F.23) shows that fewer than 20% of AKAAs have consistently enrolled over 100 applicants per year (17% of the agents enrolled over 100 of the applicants in 2010). Over half of the AKAAs enroll fewer than 25 applicants over the last 9 years.

Figure F.23: Distribution of AKAAs processing enrollments (HFS 2002-2010)[12]

	2002	2003	2004	2005	2006	2007	2008	2009	2010
1 To 24 Enrollments	59%	57%	57%	57%	59%	60%	59%	58%	56%
25 To 99 Enrollments	24%	24%	24%	24%	23%	21%	23%	24%	27%
Over 100 Enrollments	17%	19%	19%	19%	18%	19%	18%	18%	17%

The active AKAAs are distributed across the State, but access may still be limited in some areas. The map below shows the distribution both of AKAAs and AKAA enrollments across the State for 2010. There are some areas of the State where the distribution of AKAAs (Figure F.24) is less than proportional to the enrollments (Figure F.22 & F.23).

Figure F.24: Number of AKAAs (map on left) and approved All Kids enrollments (map on right) (HFS 2010)[12]



G. Assessment of Affordability of Coverage

Overview

One of the main items identified as a barrier to health insurance coverage for individuals is cost. This section provides additional information regarding how health care costs relate to income and impact other financial decisions within the household. Different measures identified by the State are considered:

- Average premium as a percentage of income,
- Average out-of-pocket spending as compared to a pre-determined percentage of income,
- The sum of premium and cost sharing, and
- Consumers' confidence in their ability to pay for health care costs.

The key findings from this section include:

- Average monthly premiums in Illinois in 2010 were $208 per member for the individual market and $365 per member for the small group market[6].
- According to State-defined affordability thresholds, , the average out-of-pocket costs for the individual market were determined to be unaffordable based on the threshold specified by the State for the low income population segments (less than 200% FPL). Average out-of-pocket costs for the higher income population segments were determined to be affordable based on the threshold[13].
- According to State-defined affordability thresholds, , the average out-of-pocket costs for the small group market were estimated to be affordable for the low income singles but unaffordable for the families. The estimated out-of-pocket costs for the higher income singles and families were deemed affordable[13].
- A single person with income at 200% FPL is estimated to spend 19% of household income to cover the premium and estimated out-of-pocket costs for a policy purchased in the individual market[13].
- A family of four with income at 200% FPL is estimated to spend 23% of their household income to cover the premium and estimated out-of-pocket costs for a policy purchased in the individual market[13].
- The higher Illinoisans' incomes are, the more confident they are that they will be able to pay for their families' medical costs[4].
- 28% of the Illinois population delayed visiting the doctor because of cost in the past 12 months[4].

Premium Levels Compared to Income

2010 average monthly premiums were $208 for the individual market and $365 for the small group market. Based on the Carrier Survey data, the average premium per member (across individual purchasers and family purchasers) is:

- $208 per month (approximately $2,500 annually)[6] in the individual market and
- $365 per month (approximately $4,375 annually)[6] in the small group (fully insured) market.

The differences between premiums in the individual and small group market are due to differences in:

- benefit designs (group benefits typically pay a larger share of eligible medical expenses); this is estimated to account for 60% of the difference[13]; and
- underwriting (individual insurance underwriting often results in denial of coverage for persons in poor health) and other factors, such as member demographics and carrier administrative expenses. These factors are estimated to account for the remainder of the difference in premium rates.

Annual premium estimates for individuals and families were developed using estimated single to family ratio and family size values. These estimates are shown in Figure G.1 below.

Figure G.1: Estimated average annual premiums (2011 Carrier Survey)[6]

	Single	Family
Small Group Market	$5,040	$13,250
Individual Market	$2,850	$6,330

Note that the single premiums are higher than the per member premiums from the Carrier Survey because persons with single coverage are generally adults, not children.

Average premium as a percentage of income ranges widely across income levels. Expressing each of these premiums as a percentage of income at different income levels provides a measurement of affordability. Note no adjustments are included for any potential difference in premium levels by income. In each of the tables below the columns highlighted in blue represent sections on the income curve where the populations are considered low income (i.e. 200% of FPL). Family premiums were compared against income for a family of four. The last row of each of these tables (Figure G.2) contains the estimated premium as a percentage of income.

Figure G.2: Average annual premium levels in the individual and fully insured small group market relative to income (2011 Carrier Survey)[6]

Individual Market	Premium:		$2,850
Single	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent	$21,660	$32,490	$43,320
Premium % of Income	13%	9%	7%
Individual Market	**Premium:**		**$6,330**
Family of 4	**Income Level**		
% of FPL (Family of 4)	200%	300%	400%
Annual $ Income Equivalent (Family of 4)	$44,100	$66,150	$88,200
Premium % of Income	14%	10%	7%

Small Group Market	Premium:		$5,040
Single	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent	$21,660	$32,490	$43,320
Premium as % of Income	23%	16%	12%
Small Group Market	**Premium:**		**$13,250**
Family of 4	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent (Family of 4)	$44,100	$66,150	$88,200
Premium % of Income	30%	20%	15%

There are approximately 515,000 members in the individual market and 900,000 members in the small group market for 2011 in Illinois[2].

When interpreting the small group numbers, note that the impact of the premium is shared by employers who make contributions to the cost of coverage. Survey data from MEPS indicate that the average employee contribution to small group health plan costs in Illinois for 2010 was $1,221 for employee coverage, and $4,383 for family coverage[20]. In addition, even the portion of premium that is subsidized by employers impacts worker affordability, since money spent on health insurance is not available to spend on employee wages.

High Out-of-Pocket Spending

In the individual market, average out-of-pocket costs for the low income population exceed the specified affordability threshold. Average out-of-pocket costs for the higher income populations are below the threshold. Out-of-pocket (OOP) costs related to deductibles, copayments, and coinsurance were defined as unaffordable if these costs are higher than 5% for low income individuals or 10% for higher income individuals. For this purpose, low income is defined as income at or below 200% of FPL and is highlighted in blue below (Figure G.4). Out-of-pocket expenditures were estimated based on the following common plan design for the Illinois individual market (Figure G.3). The plan design was then applied to a representative MarketScan® data base in order to estimate average OOP costs.

Figure G.3: Typical Illinois individual plan design (2011 Carrier Survey)[6]

Individual Market Plan Design
• $2,500 Deductible • $3,500 OOP max • 20% coinsurance • $21 PCP Copay • $34 Specialist Copay • No ER copay – included in coinsurance • Family OOP Limit Capped at 2 x Single • No pharmacy costs included • Only in-network benefits valued

Comparing the affordability threshold of 5% or 10% (row 3 of each table), to the Average OOP % of Income (row 4 of each table), shows that the costs are above the threshold for the lower income population. In no instance did income levels above 200% of FPL result in an average out-of-pocket cost of more than 10% of income.

Figure G.4: Average out-of-pocket expenditure (excluding pharmacy) relative to income levels in the individual market (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

Individual Market	Average OOP:		$1,347
Single	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent	$21,660	$32,490	$43,320
Affordability Threshold	5%	10%	10%
Average OOP % of Income	6%	4%	3%

Individual Market	Average OOP:		$3,758
Family of 4	**Income Level**		
% of FPL	200%	300%	400%
Annual $ Income Equivalent (Family of 4)	$44,100	$66,150	$88,200
Affordability Threshold	5%	10%	10%
Average OOP % of Income	9%	6%	4%

Average out-of-pocket costs are estimated to be unaffordable for the low income population segments according to the specified affordability threshold. Average out-of-pocket costs for the higher income population segments were deemed affordable. As shown in Figure G.6 below, the small group market had results similar to the individual market. As in the individual market analysis, a typical plan design (Figure G.5) specific to the small group market was established based on common plan designs found in the Carrier Survey. The plan design was then applied to a representative MarketScan® data base in order to estimate average OOP costs.

Figure G.5: Typical Illinois small group plan design (2011 Carrier Survey)[6]

Small Group Market Plan Design
• $1,000 Deductible • $2,500 OOP max • 10% coinsurance • $22 PCP Copay • $34 Specialist Copay • $150 ER Copay • Family OOP Limit Capped at 2 x Single • No pharmacy costs included • Only in-network benefits valued

Figure G.6: Average out-of-pocket expenditure (excluding pharmacy) relative to income levels in the small group market (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

Group Market	Average OOP:		$868
Single	Income Level		
% of FPL	200%	300%	400%
Annual Income	$21,660	$32,490	$43,320
Affordability Threshold	5%	10%	10%
Average OOP % of Income	4%	3%	2%

Group Market	Average OOP:		$2,514
Family of 4	Income Level		
% of FPL	200%	300%	400%
Annual Income	$44,100	$66,150	$88,200
Affordability Threshold	5%	10%	10%
Average OOP % of Income	6%	4%	3%

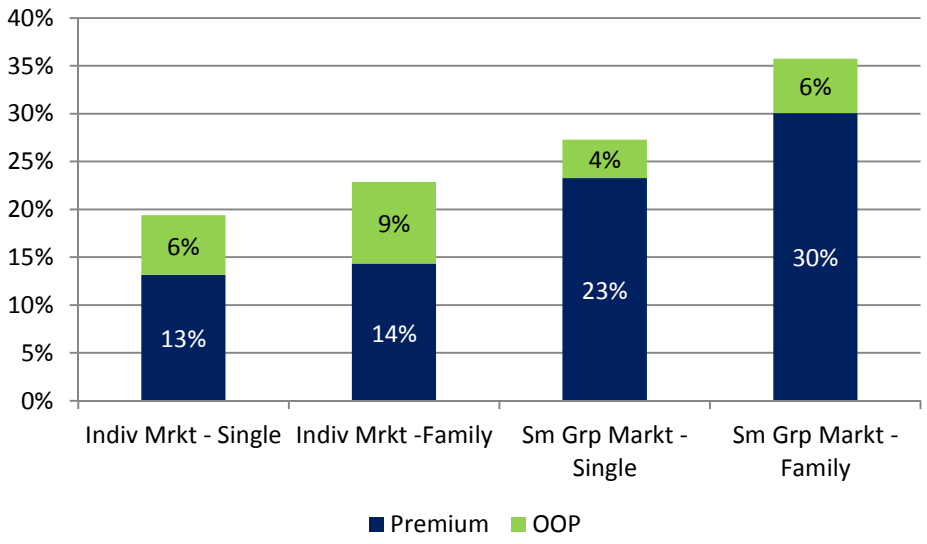
Average Total Real Out-of-Pocket (TROOP) Costs

For purposes of this research, the State defined TROOP as the sum of premiums and out-of-pocket cost sharing, representative of the total cost of health care. Using the premiums and out-of-pocket costs calculated above, affordability was analyzed for a household at 200% FPL (Figure G.7).

- A single person with income at 200% FPL is estimated to spend 19% of household income to cover the premium and average out-of-pocket costs for a policy purchased in the individual market.
- A family of four with income at 200% FPL is estimated to spend 23% of household income to cover the premium and average out-of-pocket costs for a policy purchased in the individual market.

Estimated costs for policies purchased through small employers are also shown in the figure below and have not been adjusted for the portion of the premium that may be subsidized by the employer.

Figure G.7: Average premium levels and estimated OOP (excluding pharmacy) in the individual and fully insured small group market relative to 200% FPL (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]



Average TROOP costs range widely across markets, policy types and level of claims costs. The below table (Figure G.8) provides a summary of the range (i.e., various percentiles) of the possible out-of-pocket costs, including the premium. The range of costs illustrated is large; ranging from $6,330 to $13,820 for family coverage purchased in the individual market (last row).

These expected cost ranges are for the same typical plan design described in the previous section. In practice, the TROOP will vary even more across individuals, as similar claims levels across different plan designs may result in significantly different TROOP exposure.

The average (or mean) TROOP values are provided in the last column.

Figure G.8: Distribution of potential TROOP expenditure (excluding pharmacy) at different claims levels based on modified MarketScan® experience and average plan design (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

Estimated TROOP $	Percentile on the TROOP distribution					Mean
	5th	25th	50th	75th	95th	
Small Group Market: Single	$5,040	$5,160	$5,710	$6,390	$7,670	$5,908
Small Group Market: Family	$13,250	$14,450	$15,490	$16,880	$18,950	$15,764
Individual Market: Single	$2,850	$2,960	$3,580	$5,560	$6,540	$4,197
Individual Market: Family	$6,330	$7,720	$9,860	$12,560	$13,810	$10,088

In addition, table (Figure G.9) summarizes annual income and average OOP and TROOP costs by individual and small group market and percentage of FPL. TROOP costs consume a substantial portion of total household income (as shown in the last row of each table), particularly for lower income levels and family households. As stated above, the premium estimates have not been adjusted to reflect employer subsidies.

Figure G.9: Annual income, average OOP and average TROOP (excluding pharmacy) by income level (2011 Carrier Survey & Deloitte Consulting Benefits Model Analysis)[6,13]

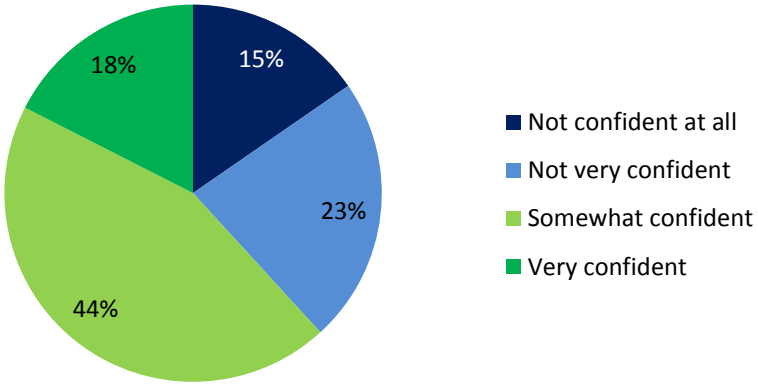
	Individual Market					
	Single			Family of 4		
% of FPL	200%	300%	400%	200%	300%	400%
Annual Income	$21,660	$32,490	$43,320	$44,100	$66,150	$88,200
Average OOP	$1,347	$1,347	$1,347	$3,758	$3,758	$3,758
Average TROOP	$4,197	$4,197	$4,197	$10,088	$10,088	$10,088
Average TROOP % of Income	19%	13%	10%	23%	15%	11%

	Group Market					
	Single			Family of 4		
% of FPL	200%	300%	400%	200%	300%	400%
Annual Income	$21,660	$32,490	$43,320	$44,100	$66,150	$88,200
Average OOP	$868	$868	$868	$2,514	$2,514	$2,514
Average TROOP	$5,908	$5,908	$5,908	$15,764	$15,764	$15,764
Average TROOP % of Income	27%	18%	14%	36%	24%	18%

Consumer Confidence in Affordability

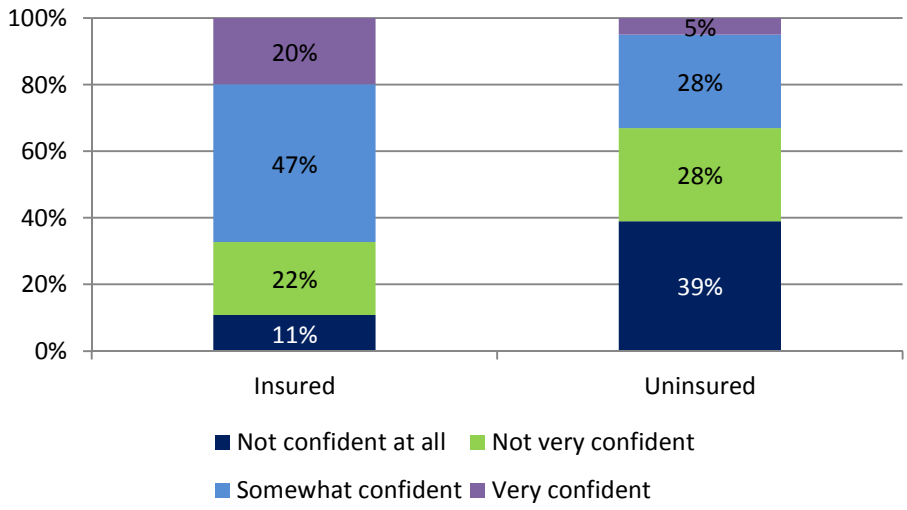
Most (62%) Illinoisans are at least 'somewhat confident' in their ability to pay the medical expenses their family incurs. This question was asked in IHIS of all survey respondents, regardless of whether they are insured.

Figure G.10: Illinois population by confidence in ability to pay medical expenses (2011 IHIS)[4]



Approximately one-third of the uninsured are at least somewhat confident that they will be able to pay for their families' medical costs . As would be anticipated, the IHIS finds that the amount of confidence a respondent has in his/her ability to pay for medical expenses is far higher for those with insurance than it is for those without insurance (Figure G.11).

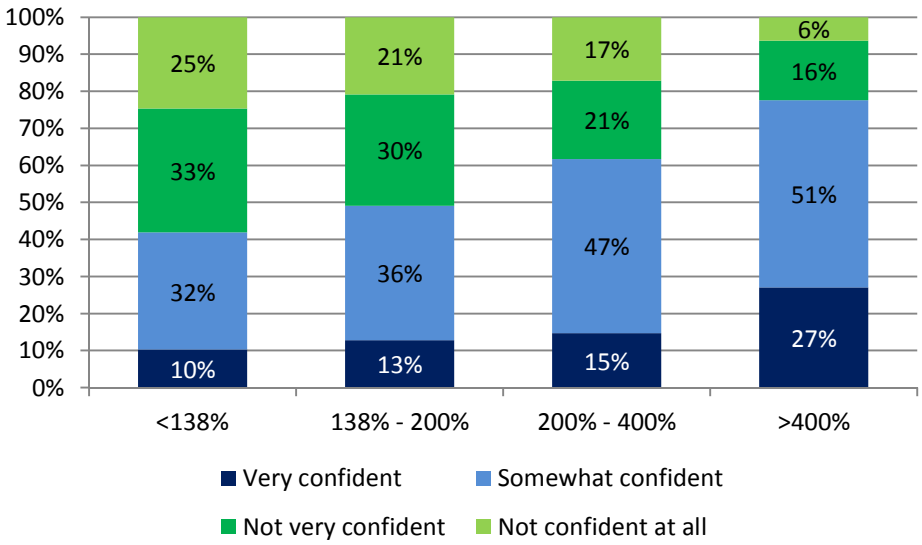
Figure G.11: Illinois population's financial confidence to pay medical expenses by insured status (2011 IHIS)[4]



The higher Illinoisans' incomes are, the more confident they are that they will be able to pay for their families' medical costs. According to the IHIS, the amount of confidence a respondent has in his ability to pay for medical expenses is far higher for those above 400%

FPL than it is for those below 138% FPL (Figure G.12). Even among Illinoisans over 400% FPL, approximately 27% are "very confident" on this issue.

Figure G.12: Illinois population's financial confidence to pay medical expenses by income (2011 IHIS)[4]



28% of the Illinois population delayed visiting the doctor in the last 12 months because of cost. Also, 15% of respondents had serious problems paying or were unable to pay medical bills and 15% had to choose between paying for health care or prescriptions and paying for other essential needs (such as rent, mortgage, utilities). Respondents could answer multiple times (Figure G.13).

Figure G.13: Illinois population's restrictions to healthcare access (2011 IHIS)[4]

Action	% Respondents
Delayed visiting a doctor or other provider due to the cost	28%
Had serious problems paying or were unable to pay medical bills	15%
Had to choose between paying for health care or prescriptions and paying for other essential needs (such as rent, mortgage, utilities)	15%
Ran up credit card or other debt your household is still paying off due to medical costs	10%
Delayed visiting a doctor because I didn't know where to find one and/or the doctor I could find was too far away	7%
Delayed visiting a doctor due to a current disability or physically difficulties getting to the office	5%
None of these	60%

H. Projected Population

Approach and Assumptions

The Deloitte Consulting Health Reform Impact model was used to produce State-level projections of coverage patterns in future years under multiple scenarios. The model projects the future population counts by coverage type considering:

- The current population in Illinois and breakdowns by demographic category and income,
- Observed current (pre-reform) market participant behaviors and coverage distribution,
- Assumptions on how the population will grow and change over time, and
- Assumptions on how behaviors and coverage will change due to the introduction of ACA.

The key assumptions and data sources used in the projections are outlined in Appendix D, as approved and finalized by the State.

The key findings from this section include:

- Illinois is aging, with a decreasing proportion of the population projected to be of working age, and a growing proportion of those eligible for Medicare[14].
- The distribution of the population by FPL band stays relatively constant in the future[14].
- Medicaid is expected to remain relatively flat in terms of enrollment —despite some economic recovery—as eligibility expands under ACA, people currently eligible enter the program, and some members are assumed to shift to the Exchange[14].
- Income distribution of the uninsured population changes as the major changes due to ACA are reflected[14].
- There are large shifts in health insurance coverage over the 2014-2016 time period. Sensitivity is reflected in the modeling of different scenarios reflecting different assumptions of market behavior[14].
- The Exchange is projected to become the dominant marketplace for individual health insurance, reflecting over 1 million people in 2017. Another 357,000 people are estimated to be part of the SHOP in the same year[14].

Market Projection Results

In this section, summary projection results are shown, with a discussion of the drivers of the results.

a. Definition of the Baseline Scenarios and Alternatives

Results from projections are sensitive to assumptions. To gauge these sensitivities and to better understand potential drivers of future coverage, the State considered two alternatives to the Baseline. These scenarios are described below and contrasted with the Baseline in Figure H.1.

- Baseline - assumes ACA is implemented as written, and produces employer and individual behavior generally consistent with the Congressional Budget Office projections.
- Employer Behavior Variation - assumes a larger disruption to the existing employer-sponsored market compared to the Baseline by assuming more employers drop coverage. The scenario projects more uninsured and a larger individual market.
- Individual Behavior Variation - illustrates less pronounced reactions of individual market participants compared to the Baseline by assuming individuals are less likely to purchase coverage. This scenario projects less enrollment and more uninsured, primarily due to the absence of an individual mandate.

Figure H.1: Employer behavior variation scenario of the population projections (Deloitte Consulting Health Reform Impact Model)[14]

Assumptions (EEs = Employees)	Reduction in Coverage Offered	
	Baseline	Employer Behavior Variation
Employers >100 EEs	5%	15%
Employers with 51-99 EEs	7.5%	25%
Employers with <=50 EEs	10%	35%
Income Bias in Reduction	No bias	2:1 reduction for low vs. high income industries

Figure H.2: Individual behavior variation scenario of the population projections (Deloitte Consulting Health Reform Impact Model)[14]

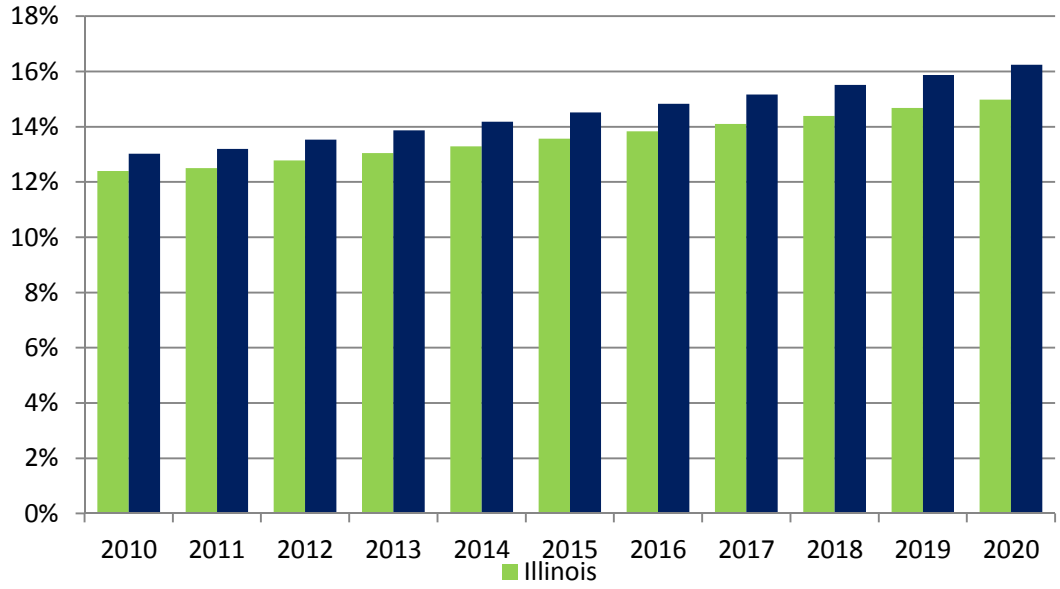
Assumptions	Baseline	Individual Behavior Variation
Cost Sensitivity	Model standard by income	50% of model standard
Impact of Individual Mandate	Model standard for compliance with mandate	Reduced enrollment reflecting elimination of the ACA individual mandate penalty
Individual market Maximum Take-Up	Model standard by income	Consistent with adult Medicaid take-up

b. Changes in the Age and Income Distributions

The type of coverage that people access is driven, among other things, by age (e.g. Medicare is predominantly for over 65 year olds, All Kids is for under 19 year olds) and income level (e.g. Medicaid eligibility thresholds). Independent of the provisions in ACA, this will continue to be the case.

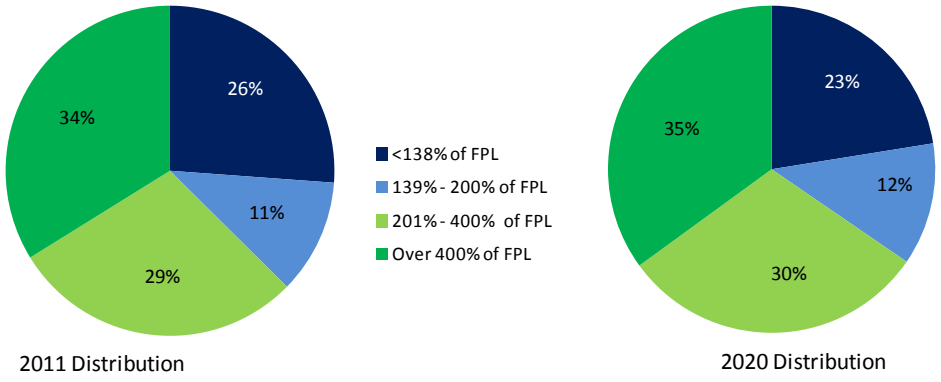
Illinois is aging, with a decreasing proportion of the population projected to be of working age, and a growing proportion eligible for Medicare. Based on U.S. Census projections, the share of the population over the age of 65 is anticipated to grow by approximately 20% (from approximately 12.5% to 15% of the population) over the next decade. This mimics the aging projected for the U.S. population in aggregate (Figure H.3).

Figure H.3: Growing elderly share of the Illinois and U.S. populations (Deloitte Health Reform Impact Model)[14]



The distribution of the population by income band changes most significantly in the <138% FPL category. Those that have incomes under 138% of FPL are estimated to be 26% of the population today, and 23% in 2020. As shown in Figure H.4, the distribution of the population by income band for the other categories stays relatively constant when comparing estimates in 2011 to 2020.

Figure H.4: Change in income distribution over the projection period due to modeled economic recovery (Deloitte Consulting Health Reform Impact Model)[14]



c. Changes in Public Programs

Medicaid is expected to have a net growth in enrollment as eligibility expands under ACA and people currently eligible enter the program. However, the impact of these effects will be partially offset by assumed economic growth and an assumed shift of enrollment from Medicaid to the Exchange.

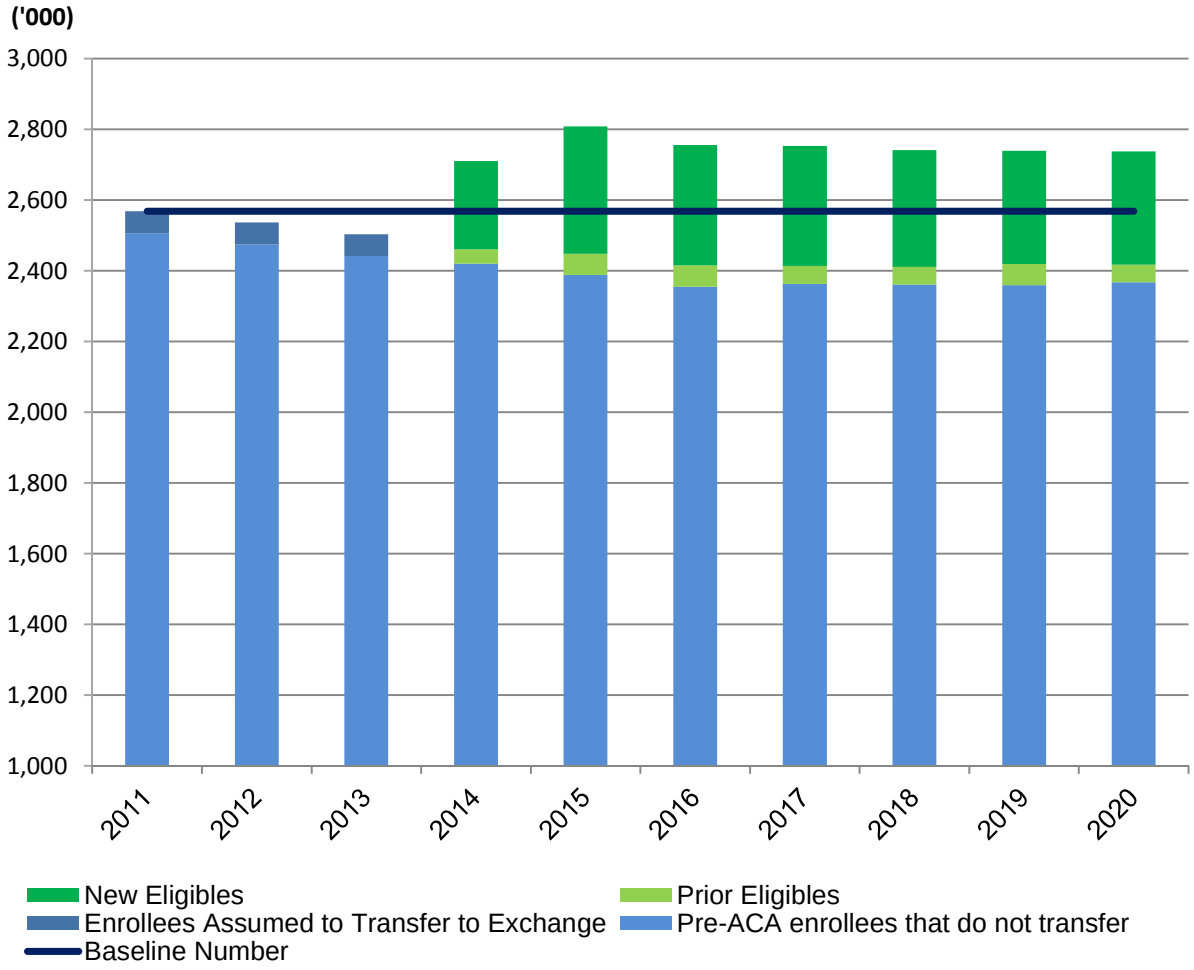
Under the Baseline scenario, the change in Public Program (e.g., Medicare, Medicaid) enrollment is projected as follows:

- Medicare enrollment is projected to grow in line with the growth in the over age 65 year old population. The dual eligible population (310,000 members in 2011) is included in the Medicaid market for consistency with other data.
- Medicaid enrollment is projected to grow due to enhanced outreach and uptake of coverage - independent of changes in the eligibility. The "Prior Eligibles" in Figure H.5 below indicate those individuals who are currently eligible for Medicaid, prior to implementation of ACA eligibility expansion. Additional Medicaid enrollment due to ACA expanded eligibility requirements is labeled as "New Eligibles" in Figure H.5 below.

This growth is offset by projected reductions in enrollment from the baseline due to the projected economic recovery (reduced unemployment and real wage growth) as well as an assumed transfer of 62,000 Medicaid adults and those covered through State programs to the Exchange (referenced below as "Enrollees Assumed to Transfer to Exchange). The impacts of these offsets to the starting estimates are shown in the Figure H.5 below.

Given the uncertainty surrounding current and future economic growth in the U.S., it is important to note that all assumptions for the future of the economy incorporated in this reports projections are based on benchmarks published in 2010 by the Congressional Budget Office.[14]

Figure H.5: Growth in Medicaid projections* (Deloitte Consulting Health Reform Impact Model)[14]

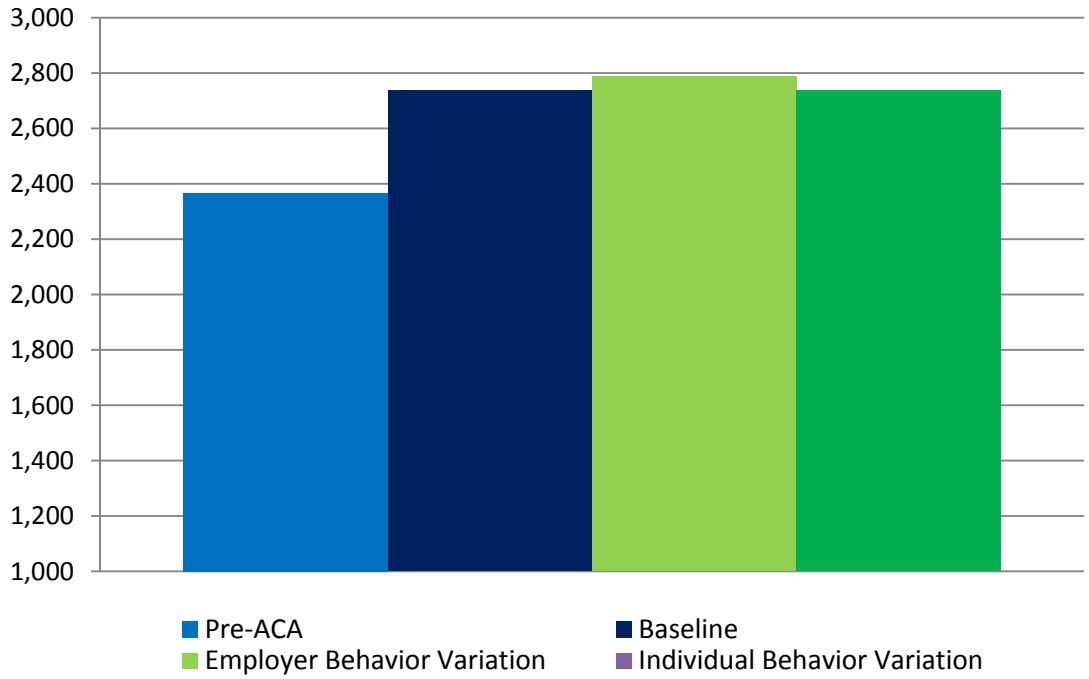


*Medicare dual eligibles are included in Medicaid projections

Comparing results across the different scenarios, the projected Medicaid enrollment is fairly stable, with minor changes only in the Employer Behavior Variation. Where employers exit the health insurance benefits market in higher numbers, modest increases are reflected in Medicaid as some working families in lower income households losing employer sponsored coverage are projected to enroll in Medicaid.

The comparison of 2020 Medicaid enrollment across the three scenarios is shown below. These scenarios did not impact Medicare projected enrollment.

Figure H.6: 2020 Medicaid projected enrollment under alternate scenarios, in (000's) (Deloitte Consulting Health Reform Impact Model)[14]

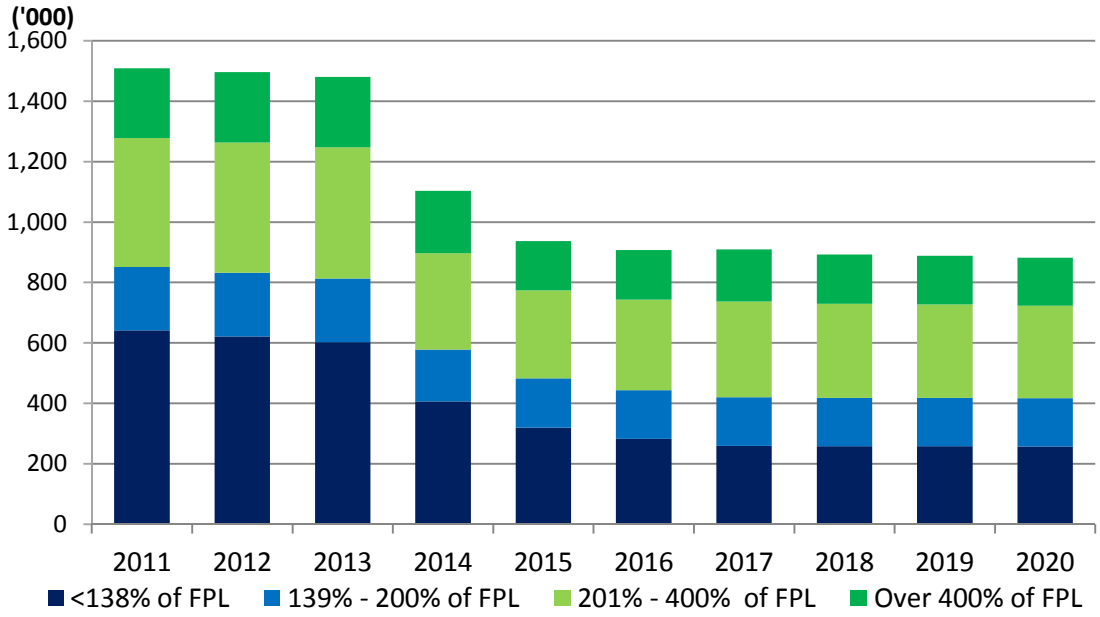


d. Changes in Uninsured

Income distribution of the uninsured population changes as the major provisions of ACA take effect. The uninsured population in Illinois is projected to decline across all income levels under the Baseline scenario assumptions (Figure H.7). These reductions are due to changes affecting people at the various income levels:

- At the lower income levels, this is mostly from the Medicaid expansion under ACA,
- At intermediate income levels this is mostly due to the ACA premium subsidies, and
- At the top income levels the individual mandate is the major driver for increased coverage levels projected.

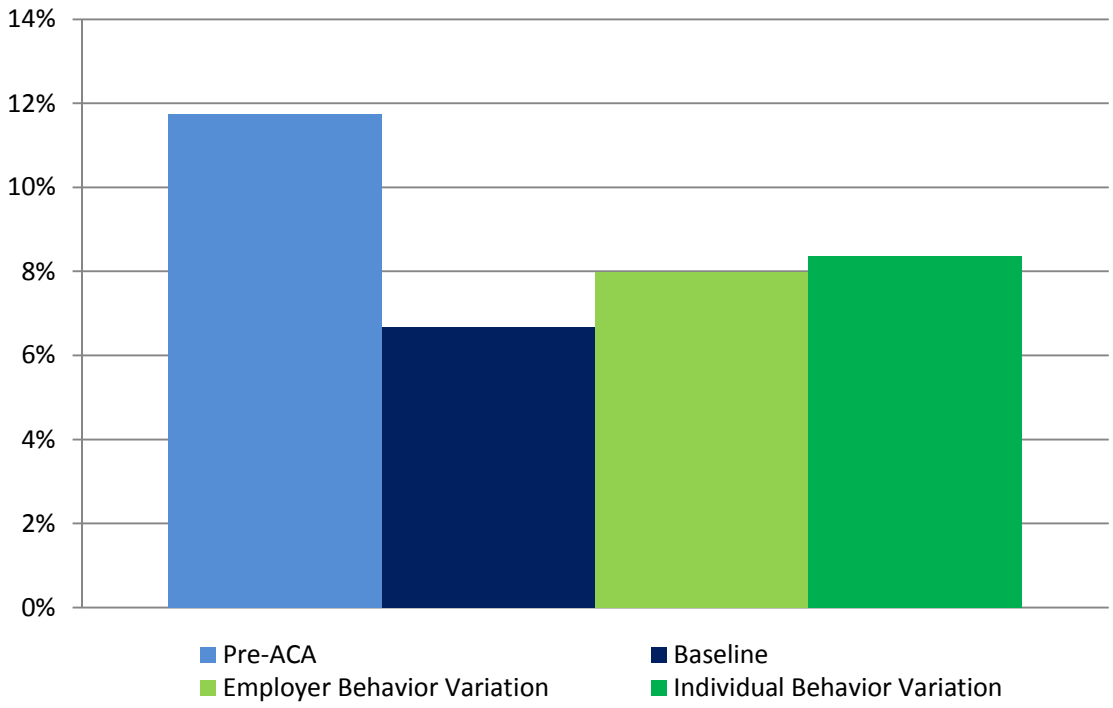
Figure H.7: Projected changes in the income distribution of the uninsured over time (Deloitte Consulting Health Reform Impact Model)[14]



The Employer Behavior Variation Scenario and Individual Behavior Variation Scenario both yield smaller reductions in the uninsured population. In comparing the alternative scenario results to the Baseline results, the uninsured population levels have (Figure H.8):

- Increased in the Employer Behavior Variation Scenario, where employers exit the market in higher numbers – as some working families go without coverage upon losing employer subsidies for coverage.
- Increased in the Individual Behavior Variation Scenarios as reduced take-up rates are projected from reduced compliance with the ACA individual mandate and reduced cost sensitivity (which reduces the impacts of subsidies and penalties).

Figure H.8: 2020 uninsured population as a percentage of total State population under alternate scenarios (Deloitte Consulting Health Reform Impact Model)[14]

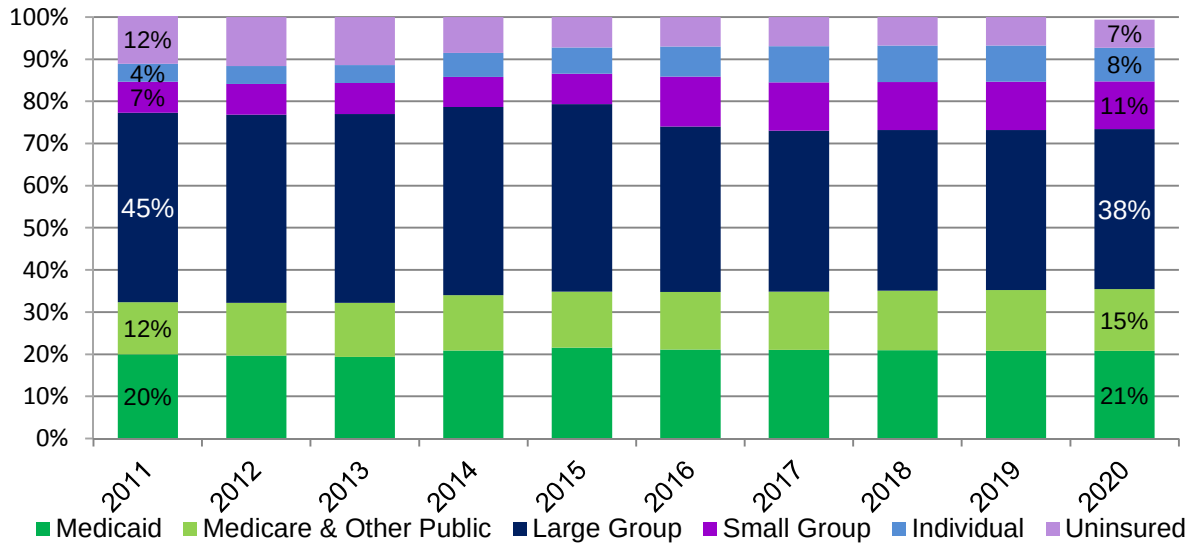


e. Composition of the market

Large shifts in coverage over the 2014-2016 time period. There are many shifts in coverage sources anticipated between 2011 and 2020 as shown in the Figures H.9 and H.10-H.14 below, in total and by income band. The primary shifts projected in the Baseline include:

- Shift from employer sponsored insurance, individual market and uninsured to Medicaid with the expansion of Medicaid eligibility and enhanced outreach/take-up rates of coverage.
- Shift from Medicaid to individual and employer sponsored coverage as economic conditions improve.
- Shift from employer sponsored insurance to the individual market and uninsured as some employers exit the market.
- Shifts from fully insured to self-insured employer sponsored insurance as employers are projected to react to additional taxation of the fully insured market and more restrictive rating requirements.
- Shift from uninsured to individual market as premium and cost sharing subsidies and the individual mandate take effect.

Figure H.9: Projected changes in coverage distribution over time (Deloitte Consulting Health Reform Impact Model)[14]



The small group market is assumed to be defined as up to 50 employees through 2015, then in 2016 the definition of small group will be expanded to include groups up to 100 employees.

Figure H.10: Change in coverage distribution over time for the total Illinois population (Deloitte Consulting Health Reform Impact Model)[14]

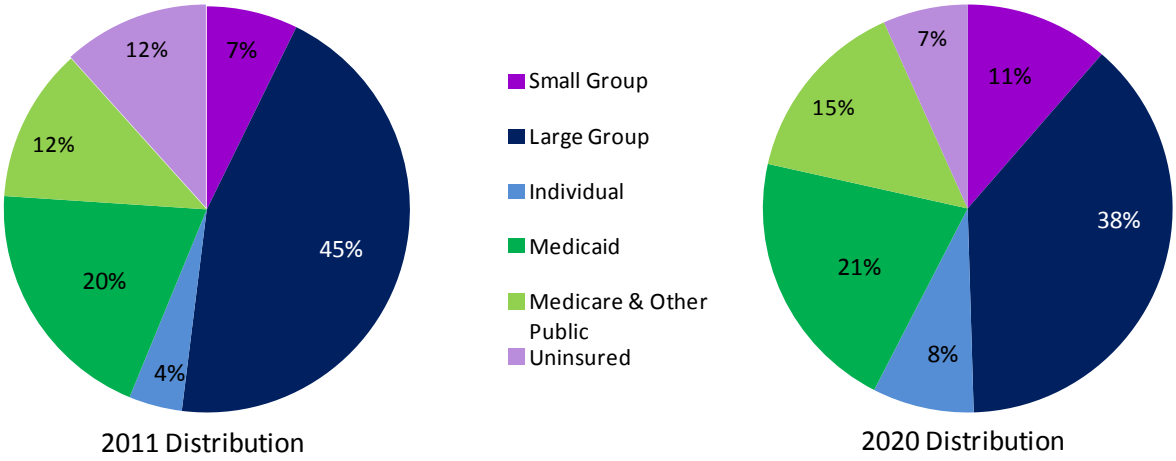


Figure H.11: Change in coverage distribution over time for the Illinois population below 138% of FPL (Deloitte Consulting Health Reform Impact Model)[14]

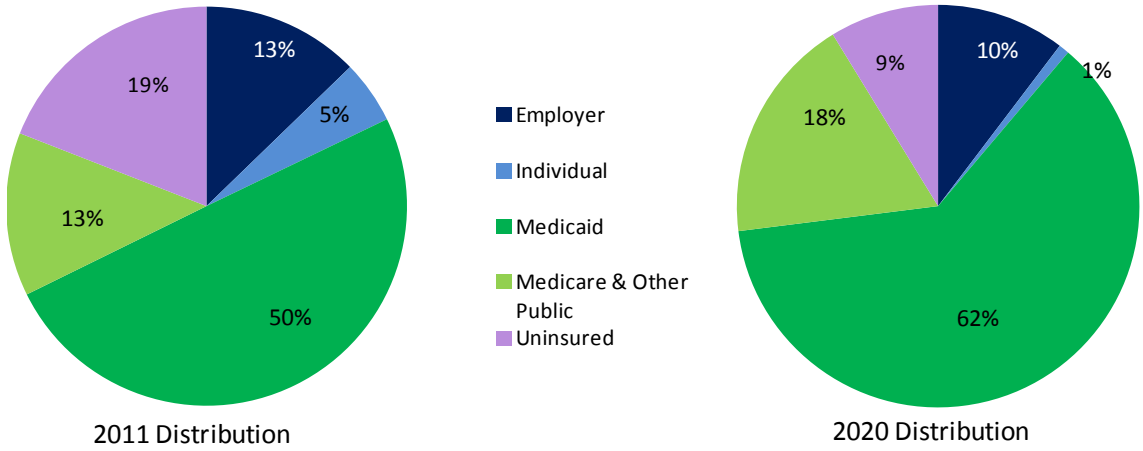


Figure H.12: Change in coverage distribution for the total Illinois population 139-200% of FPL (Deloitte Consulting Health Reform Impact Model)[14]

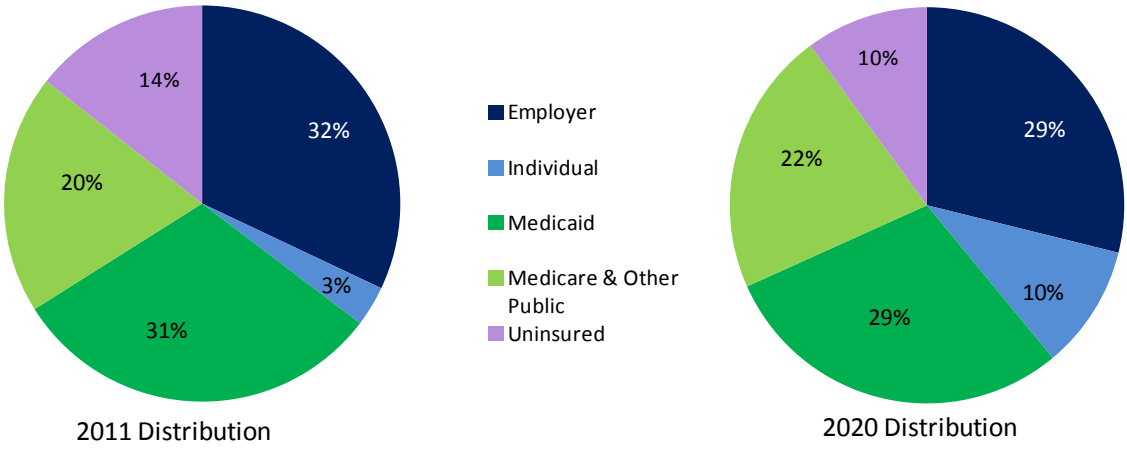


Figure H.13: Change in coverage distribution for the total Illinois population 201-400% of FPL (Deloitte Consulting Health Reform Impact Model)[14]

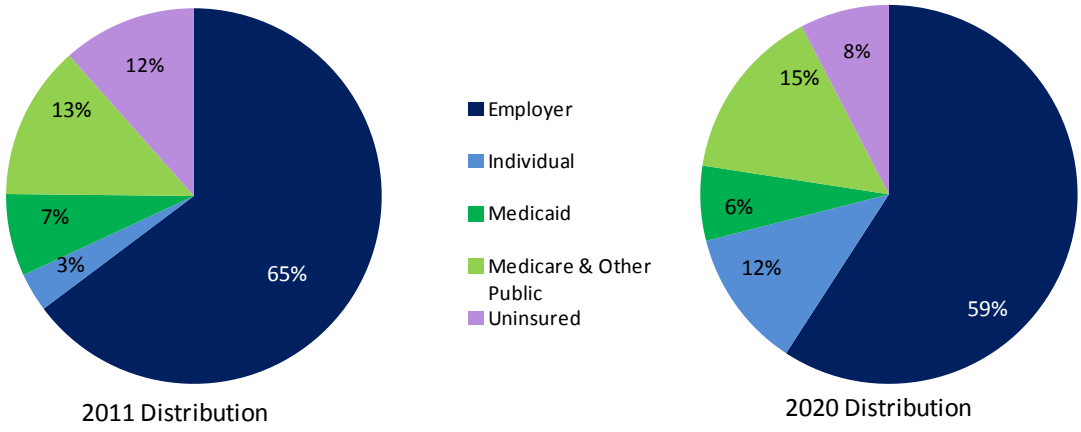
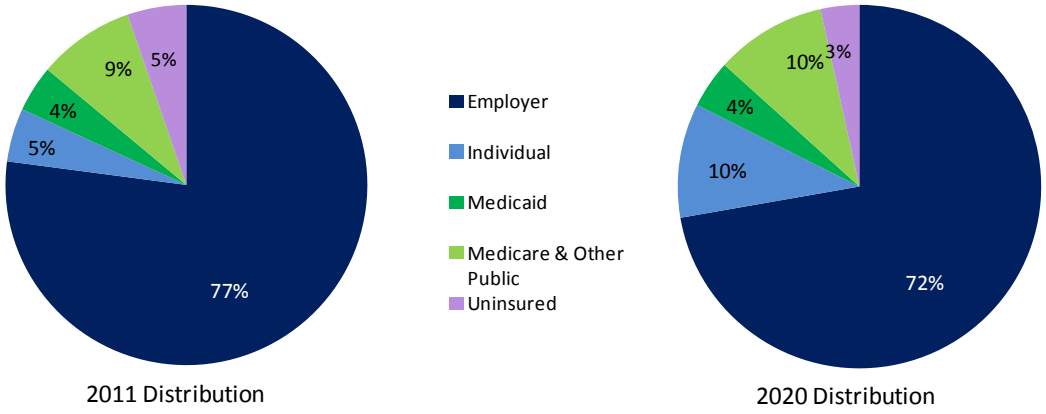


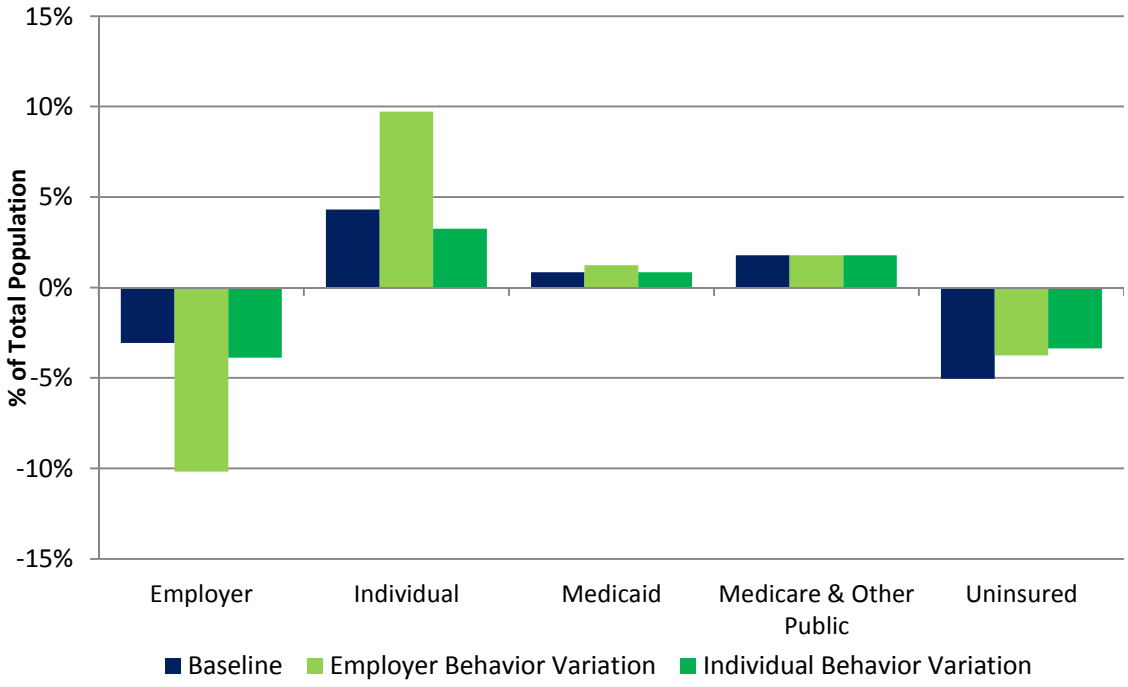
Figure H.14: Change in coverage distribution for the total Illinois population over 400% of FPL (Deloitte Consulting Health Reform Impact Model)[14]



Comparing across the different scenarios illustrates the sensitivity of results to market participant behavior. The Baseline scenario assumes behavior largely as anticipated when reform was introduced. This is contrasted to the other two scenarios as follows (Figure H.15):

- The Employer Behavior Variation Scenario - projects greater uninsured and a larger individual market if employers exit the market in larger numbers.
- The Individual Behavior Variation Scenario - projects reduced enrollment in coverage (especially individual coverage) and a resultant increase in the uninsured. This could happen if the individual mandate is weakened or eliminated or if, for whatever reasons, individual take-up rate is materially lower than assumed.

Figure H.15: Changes in coverage components as percentage of the total population as of 2020 (Deloitte Consulting Health Reform Impact Model)[14]

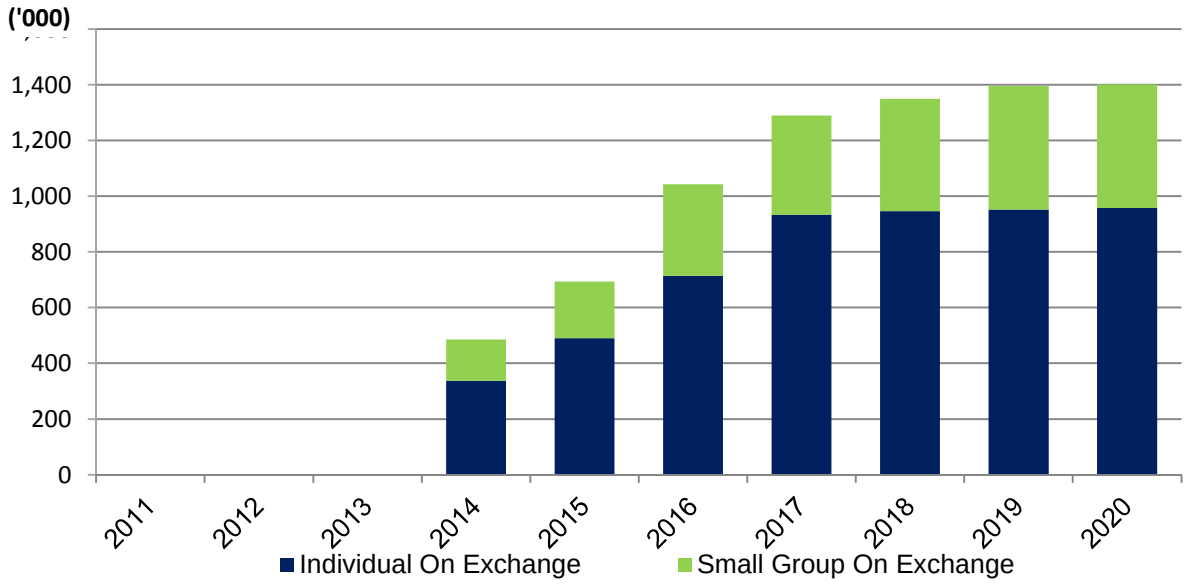


The Exchange is projected to become the dominant marketplace for individual health insurance. In the various projections, a strong Exchange is assumed. In other words, the projections assume that the large majority of those eligible for premium subsidies will purchase coverage through the Exchange (Figure H.16).

The small employer exchange, or Small Business Health Options Program (SHOP), is estimated to grow to approximately 357,000 members by 2017. The modeling also assumes that the Exchange will provide a viable alternative marketplace for those above 400% of FPL and that a majority share of this population will also purchase coverage through the Exchange.

The off-Exchange marketplace is assumed to continue to exist, mainly as a market where higher-income individuals as well as Aliens Not Lawfully Present in the U.S. can purchase coverage.

Figure H.16: Projected Exchange membership (Deloitte Consulting Health Reform Impact Model)[14]



Appendix A: Data Requests Submitted to State Agencies

Illinois Department of Insurance

1. Agent and Broker Data

Summary:

This data request pertains to the agent and broker database maintained by the DOI.

Agent and Broker Data	
Field	Comments
Unique Identifier	This field should be a unique identifier for each agent. Using name is ok, but a simple numbering convention (1,2,3, etc.) is also reasonable.
Zip Code	IL zip codes
Line of Insurance (LOI) License	This field should list the license held by the agent. If licenses are within the data as a code or are non-descriptive, please provide a data dictionary with a description of the license.

2. Historical Insurer & HMO Premium

Summary:

The following data request pertains to Annual Statement data that could be used to show changes over time in the health insurance market.

Historical Insurer & HMO Premium
Request
Please provide an updated version of the sample report, [Sample Data.pdf], for both insurers and HMOs and include all 10 years of available data. If possible, please provide these historical premium exhibits split between individual product premium and group product premium. This level of granularity may not be available from all Statutory annual statements, but we do believe it is captured in Orange Blanks (Life & Health).
Additional Notes: The DOI ultimately provided historical premium for companies filing Life blanks with the NAIC for the 5 year period ending in 2010. We relied on a vendor data set for historical premium from Health blank filers for the 10 year period ending in 2010.

3. Complaint Database

Summary:

The following data request pertains to the complaint database maintained by the DOI.

Complaint Database	
Field	Comments
Year Complaint Submitted	Data should include, if possible, historical complaints for the most recent 5 years.
Year Complaint Resolved	This data item may not be available in some or all cases. Please ignore if not available.
Regional Field	If a field capturing the location of the party registering the complaint, for example zip code, is available please include.
Gender	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Race/Ethnicity	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Age of Insured Person	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Marital Status	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Sources of Income	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Number of Persons in Household	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Job Status	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Spouse Job Status	We are requesting this field based on the online complaint submission website's demographic questions. Please ignore this field if not available within the database.
Relationship Close Code	Based on the sample code files provided

Complaint Database	
Field	Comments
Coverage Code	Based on the sample code files provided
Reason Code	Based on the sample code files provided
Contributing Factors	Based on the sample code files provided
Against Close Code	Based on the sample code files provided
Disposition Code	Based on the sample code files provided
Count of Complaints	Based on the sample code files provided

Illinois Department of Public Health

1. Behavioral Risk Factor Surveillance System

Summary: This data request pertains to the Illinois Behavioral Risk Factor Surveillance System.

Illinois Behavioral Risk Factor Surveillance System	
Field	Comments
Year	Please include survey results from 2000 to 2009.
Zip Code	If available, please delineate by zip code.
County	
Area	Based on the survey, possible values are Chicago, Suburban Cook County, Collar Counties, Urban Counties, Rural Counties
Age Group	Based on the survey topic - Demographics
Sex of Respondents	Based on the survey topic - Demographics
Race	Based on the survey topic - Demographics
Hispanic or Latino	Based on the survey topic - Demographics
Income Level	Based on the survey topic - Demographics
Education Level	Based on the survey topic - Demographics
Household Type	Based on the survey topic - Demographics
Have a Health Plan	Based on the survey topic - Health Care Utilization
Have Primary Care Provider	Based on the survey topic - Health Care Utilization
Avoided Doctor Due to Cost	Based on the survey topic - Health Care Utilization
Last Routine Checkup	Based on the survey topic - Health Care Utilization
General Health	Based on the survey topic - Health Status
Days Mental Health Not Good	Based on the survey topic - Health Status
Days Physical Health Not Good	Based on the survey topic - Health Status
Days Health Kept from Doing Usual Activities	Based on the survey topic - Health Status
Get Social / Emotional Support	Based on the survey topic - Quality of Life/Disability
How Satisfied You are with Your Life	Based on the survey topic - Quality of Life/Disability
Unweighted Count	Unweighted count is the number of actual survey

Illinois Behavioral Risk Factor Surveillance System	
Field	Comments
	respondents stratified by the above fields. Note: This field was not specifically provided. Rather it could be obtained by counting the number of rows with a desired stratification of the above fields.
Weighted Count	Weighted count is the count of respondents extrapolated to the population as a whole, stratified by the above fields.

Illinois Department of Healthcare and Family Services

1. Medical Data Warehouse

Summary: The following data request pertains to the medical data warehouse and various enrollment and claims experience data.

Medical Warehouse Database		
Field	Comments	Additional Notes
Zip Code		
Year	Year of enrollment from 2001 to 2010	2006 - 2010 provided; 2010 claims adjudicated through June 3, 2011 and are incomplete.
4 + 1 Category	Per our phone discussion, the categories for members are 1)Children 2)Adults, non-disability (19-64) 3)Adults with disabilities (19-64) 4)Elderly, 65+ and 5) Partial benefits	Enrollment Codes were linked to additional table below to determine if full or partial benefits and if disabled.
Medicaid Program or Category of Aid	This field should show specific Medicaid programs. We would expect to see field values consistent with those provided by Megan Moore in the file [SUMMARY OF MEDICAL ELIGIBILITY GROUPS 05.2011(1.0).docx], column "Program Name". For example, "Family Care", "All Kids Assist", "All Kids Share", etc....	Enrollment Code descriptions were provided from linking code provided on main file to additional table below.
Age	<18, 18-25, 26-29, 30-39, 40-49, 50-59, 60-64, 65+	
Gender	Male/Female	
Race	White, African, Asian, Hispanic, Other	D=did not respond, M=multi
Employment Status	Employed Yes/No, or Full time/Part time, if known	Not available
Count of Unique Members	This field should show a count of the number of members stratified by the previous fields. Specifically, the number of members enrolled for a	Members counted as of Jan 1 and July 1 each year.

Medical Warehouse Database		
Field	Comments	Additional Notes
	given year, demographic characteristics, 4+1 Category and Medicaid Program.	
Member Months	This field should show the total number of member months stratified by the previous fields. Specifically, the number of members enrolled for a given year, demographic characteristics, 4+1 Category and Medicaid Program.	Not provided
Gross Claim Cost	This field should show the total cost stratified by the previous fields. This includes both the costs paid by the Program and cost sharing by the individual	Not available as copays are not tracked.
Net Claim Cost	This field should show the total cost stratified by the previous fields. This includes both the costs paid by the Program and cost sharing by the individual	Net paid provided. These are costs allocated to an individual person for an individual health event. Bulk payments are not included.

Additional Medicaid Programs Data			
Enrollment (Detail Report Group) Code	**Enrollment Detail Report Group Description**	**Benefits Type Code**	**Disabled Indicator**
110	Illinois Cares Rx	Partial	N
120	Breast and Cervical Cancer (BCC)	Full	N
130	Illinois Healthy Women (IHW)	Partial	N
140	MPE - Pregnant Women	Partial	N
150	General Assistance adults	Partial	N
160	Emergency services only (excludes Labor & Delivery)	Partial	N
170	All Kids Rebate	Partial	N
180	Family Care Rebate	Partial	N
190	Chronic Renal	Partial	N
200	QMB Only	Partial	N
210	SLMB Only	Partial	N
220	QI-1 Only	Partial	N
230	Mental Health Screening Only	Partial	N
240	AABD - Age 65 years old and older	Full	Y
250	AABD - Blind/Disabled under Age 65 years	Full	Y
260	HBWD	Full	Y
270	All Kids Income <= 133%	Full	N
280	All Kids - Age 6 to 18 years old & Income	Full	N
290	All Kids - Age 6 to 18 years old & Income	Full	N
300	All Kids - income > 133% <= 150% FPL	Full	N
310	All Kids - income > 150% <= 200% FPL	Full	N

Additional Medicaid Programs Data			
Enrollment (Detail Report Group) Code	Enrollment Detail Report Group Description	Benefits Type Code	Disabled Indicator
320	All Kids - income > 200% <= 300% FPL	Full	N
330	All Kids - income > 300% <= 400% FPL	Full	N
340	All Kids - income > 400% <= 500% FPL	Full	N
350	All Kids - income > 500% <= 600% FPL	Full	N
360	All Kids - income > 600% <= 700% FPL	Full	N
370	All Kids - income > 700% <= 800% FPL	Full	N
380	All Kids - income > 800% FPL	Full	N
390	DCFS - Foster Care	Full	N
400	DCFS - Adoption Assistance	Full	N
410	DCFS - Subsidized Guardianship	Full	N
420	DJJ Non-Incarcerated Children	Full	N
425	DCFS - Other cases enrolled and administered	Full	N
430	Moms & Babies	Full	N
440	Unborn Child SPA	Full	N
450	FamilyCare Assist w cash	Full	N
460	FamilyCare Assist w/o cash	Full	N
470	FamilyCare - income <= 133% FPL	Full	N
480	FamilyCare - income > 133% <= 150% FPL	Full	N
490	FamilyCare - income > 150% <= 185% FPL	Full	N
500	FamilyCare - income > 185% <= 400% FPL -	Full	N
510	General Assistance - age <= 18 years old	Full	N
520	RRA	Full	N
530	TMA	Full	N
540	Veterans Care	Full	N
550	Warriors Assistance	Partial	N
560	Pending Asylees or Torture Victims	Full	N
570	Presumptive Eligibility	Full	N
999	Unknown	Full	N

2. All Kids Application Agents

Summary: The following data request pertains to All Kids Application Agent data (number of approved applications, location of agent).

All Kids Application Agents
Request
We note that the sample file provided shows the number of approved applications by agent for the period 4/01/2010 - 3/31/2011. If possible, please provide similar files for the prior 12 month periods, up to 10 periods as available. For example, 4/1/2009 - 3/31/2010, 4/1/2008 - 3/31/2009, 4/1/2007 - 3/31/2008, etc. In addition, we have the following questions to clarify the sample data provided. 1) Within the sample file what does "Active" mean - registered, enrolled at least one person? 2) Is the list of AKAAs provided in the sample file a truncated list? The lowest number of approved applications by an agent is 21. We would expect to see some agents with between 1 and 20 approved applications. If this is a truncated list, can you provide the complete list?
Additional notes from the State: 1) The State provided approvals for the period April 2002 through March 2011. 2) An Active AKAA is one who submitted an application during the time period of the report. AKAA activity has declined over the years, mainly due to the popularity of the web based application. Prior to the web based application, the majority of the State's applications came through AKAAs.

3. Discharge Data

Summary: The following data request pertains to the Illinois all payer hospital discharge data set.

Illinois Discharge Data - Inpatient	
Field	Comments
Year	2008, 2009, 2010
Patient Age Band	<18, 18-25, 26-29,30-34, 35-39, ….,60-64, 65+
Patient Zip code	
Provider Zip code	
Diagnosis	Primary only
Primary Payer Type	Private Insurance, Medicaid, Medicare, Self Pay, Other
Secondary Payer Type	Private Insurance, Medicaid, Medicare, Self Pay, Other
Sum of discharges	
Sum of days	

Illinois Discharge Data - Outpatient	
Field	Comments
Year	2008, 2009, 2010
Patient Age Band	<18, 18-25, 26-29,30-34, 35-39, ….,60-64, 65+
Patient Zip code	
Provider Zip code	
Diagnosis	Primary only
Primary Payer Type	Private Insurance, Medicaid, Medicare, Self Pay, Other
Secondary Payer Type	Private Insurance, Medicaid, Medicare, Self Pay, Other
Sum of Cases	

Appendix B: 2011 Illinois Health Insurance Survey Questions and Results

IHIS Questions and Weighted Results

Note to Survey Respondents: It may be beneficial to track down your health insurance card and other relevant health insurance information before beginning this survey. If you don't currently have insurance, that's OK as you will go through a related set of questions on this topic.

Q258 - COUNTRY - SHORT LIST

In which country or region do you currently reside?

Country of Residence	% Respondents
United States of America	100%

Q268 - GENDER

Are you...?

Gender	% Respondents
Male	50%
Female	50%

Q270 - YEAR OF BIRTH

In what year were you born? Please enter your response as a four-digit number (for example, 1977).

Age Bands	% Respondents
18-25	18%
26-29	9%
30-39	20%
40-49	23%
50-59	18%
60-64	12%

Q326- Concatenated zip/postal code

What is your zip code (zip codes were later grouped into geographic regions)?

Region	% Respondents
Chicago	21%
Chicago Suburbs/Collar Counties	43%
North Central Counties	5%
Rural Counties	19%
Urban Counties	12%

Q602 - Number of Adults (18 or older) live in your household

Including yourself, how many people age 18 or older live in your household? If you live in more than one household, please answer for only one of the households.

# Adults in Household	% Respondents
1	23%
2	48%
3	17%
4	8%
5	2%
6	1%
7+	1%

Q603 – Number of Children (under age 18) live in your household

How many people under the age of 18 live in your household? If you live in more than one household, please answer for only one of the households.

# Children in Household	% Respondents
0	63%
1	17%
2	13%
3	5%
4	1%
5+	1%

Q610 - Total 2010 household income

Which of the following income categories best describes your total 2010 household income before taxes (income ranges varied by household size)?

1 Person	
Less than $15,000	26%
$15,000 to $21,999	7%
$22,000 to $31,999	14%
$32,000 to $42,999	10%
$43,000 to $99,999	28%
$100,000 or more	4%
Decline to answer	11%
% Population	**19%**

5 Persons	
Less than $25,000	9%
$25,000 to $35,999	28%
$36,000 to $51,999	11%
$52,000 to $76,999	16%
$77,000 to $102,999	12%
$103,000 or more	15%
Decline to answer	9%
% Population	**6%**

2 Persons	
Less than $20,000	12%
$20,000 to $28,999	6%
$29,000 to $43,999	11%
$44,000 to $57,999	15%
$58,000 to $99,999	27%
$100,000 or more	14%
Decline to answer	15%
% Population	**30%**

6 Persons	
Less than $25,000	18%
$25,000 to $40,999	21%
$41,000 to $58,999	11%
$59,000 to $88,999	15%
$89,000 to $117,999	12%
$118,000 or more	16%
Decline to answer	7%
% Population	**5%**

3 Persons	
Less than $25,000	19%
$25,000 to $36,999	12%
$37,000 to $54,999	14%
$55,000 to $72,999	11%
$73,000 to $99,999	15%
$100,000 or more	15%
Decline to answer	14%
% Population	**19%**

7 Persons	
Less than $25,000	30%
$25,000 to $45,999	24%
$46,000 to $66,999	25%
$67,000 to $99,999	18%
$100,000 to $132,999	1%
Decline to answer	2%
% Population	**2%**

4 Persons	
Less than $30,000	19%
$30,000 to $43,999	13%
$44,000 to $65,999	15%
$66,000 to $87,999	15%
$88,000 to $99,999	10%
$100,000 or more	17%
Decline to answer	11%
% Population	**18%**

8+ Persons	
Less than $25,000	27%
$25,000 to $50,999	25%
$51,000 to $73,999	15%
$74,000 to $110,999	17%
$111,000 to $147,999	3%
$148,000 or more	7%
Decline to answer	6%
% Population	**1%**

Q625 - Health Insurance

We will now ask you some questions about health insurance. Are you currently covered by any kind of health insurance, health plan, or health care program? Please select one.

Health Insurance Status	% Respondents
Yes, I am currently covered	84%
No, I am not currently covered, but I had coverage within the past year	3%
No, I am not currently covered and have not had health insurance coverage at any time during the past year	13%

Q705 - Number of individuals

Including yourself, how many individuals in your household have the following types of coverage?

Type of coverage	Average Number of Individuals with Coverage
Purchased individual or family coverage directly from an insurance company	0.4
Obtained it through an employer (either your own or your spouse/partner's)	1.5
Enrolled in Medicare	0.2
Enrolled in Medicaid, All Kids, or other Illinois health programs	0.4
Enrolled in military health care (TRICARE, VA, CHAMP-VA)	0.1
Other source	0.1
Do not have insurance	0.3

Q711- Additional insurance

Does anyone in your household have any of the following additional types of insurance programs? Please select all that apply.

Type of coverage	Average Number of Individuals with Coverage
Long term care coverage	0.2
Dental care coverage	0.6
Vision or eye care coverage	0.5
Supplemental insurance to cover what my primary insurance/spouse's insurance does not cover (e.g., Medigap policies and other plans)	0.1
Prescription drug coverage under an additional policy I had to purchase (e.g., Medicare Part D and other policies, programs)	0.2
Not sure what additional coverage I have	0.1
Other	0.1
No Additional insurance	0.3

Q750- Insurance Plan

We will now ask you some questions regarding your insurance plan.

Thinking about the health insurance coverage you have and the medical costs you could afford to pay out of pocket, do you consider yourself to be… Please select one.

Insured Level	% Respondents
Well insured	32%
Adequately insured	51%
Underinsured	13%
Not sure	4%

Q756 - Satisfaction

Thinking of your current insurance plan, how satisfied are you with each of the following factors? Please rate each factor.

	Not at all satisfied (1)	Somewhat satisfied (2)	Satisfied (3)	Very Satisfied (4)	Extremely satisfied (5)	Does not apply (6)
What I have to pay out-of-pocket to buy the insurance (premium)	16%	22%	30%	13%	11%	8%
What I have to pay out-of-pocket when I visit a doctor (cost sharing via deductible/co-pay)	11%	22%	33%	16%	14%	4%
Benefits and services covered by your insurance policy	7%	21%	35%	21%	14%	2%
Quality of health care service you receive	2%	12%	35%	26%	23%	2%
Choice of doctors in the network	5%	13%	35%	23%	21%	3%
Coverage for prescription brand name medications	11%	19%	35%	17%	14%	4%
Coverage for generic medications	3%	13%	35%	23%	23%	3%
Coverage for alternative treatment approaches or natural therapies	13%	17%	29%	11%	7%	23%
Coverage for mental/behavioral health services	7%	14%	34%	13%	10%	22%
Puts me in control of my health care dollars	11%	22%	34%	14%	11%	8%
Easy to understand/familiar to me	7%	20%	39%	19%	13%	2%
Quality of customer service that I receive from the Insurance Company	5%	18%	40%	18%	12%	7%

Q760 – Uninsured Barriers to Coverage

Which of the following describes why you do not currently have health insurance? Please select all that apply.

Barrier to Coverage	% Respondents
I do not have access to health insurance offered by an employer	22%
I applied for health insurance but was turned down by the insurance company	5%
Health insurance is too expensive	47%
I feel healthy and do not need health insurance	6%
I do not have insurance due to religious/cultural observance	1%
I am not able to conveniently access a doctor that would be covered under any available health insurance	1%
I am not able to find a doctor who speaks my language that would be covered under any available health insurance	0.4%
I can pay the bills myself without insurance	4%
None of the above	15%

Q766 - Primary Health Insurance- Importance

If you were to purchase health insurance today, how important would each of these factors be in choosing your primary health insurance? Please rate each factor.

	Not at all important (1)	Somewhat important (2)	Important (3)	Very important (4)	Extremely important (5)	Does not apply (6)
What I have to pay each month to buy the insurance (premium)	0%	2%	15%	23%	56%	4%
What I have to pay out-of-pocket when I visit a doctor (cost sharing: deductible/co-pay)	1%	3%	17%	27%	49%	3%
Reputation or reliability in paying claims	1%	3%	21%	29%	43%	3%
Quality or satisfaction ratings, rankings, or reports of the particular plan	1%	9%	31%	28%	28%	3%
Choice of providers in the network	1%	4%	20%	27%	45%	3%
Coverage for prescription brand name medications	2%	7%	24%	28%	36%	3%
Coverage for generic medications	1%	5%	24%	28%	38%	4%

	Not at all important (1)	Somewhat important (2)	Important (3)	Very important (4)	Extremely important (5)	Does not apply (6)
Coverage for alternative treatment approaches or natural therapies	7%	16%	29%	19%	21%	8%
Coverage for mental/behavioral health services	8%	14%	28%	17%	22%	11%
Puts me in control of my health care dollars	0%	4%	26%	30%	36%	4%
Easy to understand/familiar to me	1%	4%	25%	32%	36%	2%
Quality of customer service that I receive from the Insurance Company	0%	5%	26%	31%	35%	3%

Q770- Chronic Conditions

A "chronic condition" is any disease or health problem that has lasted for 3 months or more. Examples include arthritis, diabetes, cancer, heart disease, high blood pressure, high cholesterol, asthma, allergies, back pain, depression, alcohol or drug dependence, and others. Have you been diagnosed by a doctor or other medical professional as having one or more chronic conditions? Please select one.

Chronic Condition	% Respondents
Yes	50%
No	50%

Q775 - Denied Coverage

Have you ever been denied coverage and/or had health benefits limited due to a pre-existing condition? Please select one.

Denied Coverage Due to Pre-X	% Respondents
Yes	9%
No	91%

Q780 - Poor Health

In general, would you consider any member of your family to have poor health? Please select one.

Poor Health	% Respondents
Yes	23%
No	77%

Q785 – Level of Confidence

Generally, how confident are you that you and your family have enough money to pay for the usual medical costs that you and your family require?

Level of Confidence	% Respondents
Very confident	15%
Somewhat confident	23%
Not very confident	44%
Not confident at all	18%

Q790 - Household Behavior

In the past 12 months, has your household done any of the following? Please select all that apply.

Barrier to Coverage	% Respondents
Had to choose between paying for health care or prescriptions and paying for other essential needs (such as rent, mortgage, utilities)	11%
Had serious problems paying or were unable to pay medical bills	11%
Ran up credit card or other debt your household is still paying off due to medical costs	7%
Delayed visiting a doctor or other provider due to the cost	20%
Delayed visiting a doctor due to a current disability or physically difficulties getting to the office	4%
Delayed visiting a doctor because I didn't know where to find one and/or the doctor I could find was too far away	5%
None of these	43%

Q800 - Health Insurance Premiums

Approximately how much do you pay for your household health insurance premiums, not including the health care costs you pay directly out of your own pocket? You may enter the amount you pay per month or per year. If you are not sure what this number is, please look it up in your insurance documents. Please enter just one number:

Premium Time Period	Average	Median
Average Premium Per Month	$244	$147
Average Premium Per Year	$2,455	$1,800

Q805 - Number of Adults and Children Covered by Premium

How many adults over 18 (including yourself) and how many children under 18 are covered by this premium?

Persons	Average
Average Number of Adults	1.6
Average Number of Children	0.5

Q810- Out of Pocket Costs

Even with insurance, most people have to pay additional costs for their insurance above and beyond their premiums. How much have you and your family paid for health care costs, such as co-pays, deductibles, and any other expenses not covered by your insurance, out of your own pocket in the past 12 months? Please do not include the amount you pay for health insurance premiums, since this was provided in the previous answer.

	Average	Median
Out of Pocket Spend Per Year	$1,170	$700

Q815 - Maximum Benefit

Thinking about your current insurance plan, what is the maximum amount of benefit your policy will cover for medical care per year? If you are not sure what this number is, please look it up in your insurance documents.

Maximum Benefit	% Respondents
Less than $20,000	10%
$20,000 to $99,999	12%
$100,000 to $999,999	13%
$1,000,000 to $4,999,999	12%
$5,000,000 or more	7%
Don't know	46%

Q820 – Premium afford to pay

Thinking about an insurance plan in which you could enroll in the future, approximately how much could you afford to pay for the following: Your household health insurance premiums, not including the health care costs you would pay directly out of your own pocket? You may enter the amount you could afford to pay per month or per year.

Please enter just one number:

Premium Time Period	Average	Median
Average Premium Per Month	$196	$118
Average Premium Per Year	$2,231	$1,104

Q822- Out of pocket

Thinking about an insurance plan in which you could enroll in the future, approximately how much could you afford to pay for the following: "Out of pocket" health care costs for you, such as co-pays, deductibles, and any other expenses not covered by your insurance, over 12 months? Please do not include the amount you would pay for health insurance premiums.

	Average	Median
Out of Pocket Spend Per Year	$1,085	$421

Our next series of questions is for classification purposes and will help us properly analyze responses to this survey.

Q900 - Race

Which of the following best describes your race? Please select one.

Race	% Respondents
African American	14%
Asian	2%
White Non-Hispanic	68%
Hispanic	12%
Other	1%
Prefer not to respond	3%

Q905 - Current Employment Status

What best describes your current employment status? Please select one.

Employment Status	% Respondents
Part time (<30 hours per week on average over the course of a month)	16%
Full time	46%
Not currently working	38%

Q910 - Industry

Which of the following best describes the industry in which you work? Please select one.

Industry	% Respondents
Agriculture, forestry, mining	2%
Business services, personal services, legal services, finance, insurance, real estate, technology, communication, transportation	20%
Construction	3%
Education, social services	12%
Government, public service, military	5%
Health services	10%
Manufacturing	8%
Non-profits, religious organizations	3%
Retail, restaurant	11%
Arts, entertainment, recreation	3%
Other	23%

Appendix C: Carrier Survey Data

The Carrier Survey requested information directly from the largest health insurance carriers in the State to provide data on the insurance market. The State submitted a Data Call to these carriers under its insurance regulatory authority. The Initial Carrier Survey was executed by Wakely Consulting Group and Deloitte Consulting executed the Addendum to the Carrier Survey, on behalf of the State. The following table summarizes the two data requests sent to the participating carriers, labeled Initial and Addendum.

Initial Carrier Survey Data Request	
Request	**Detailed Data Elements**
Illinois Small Group and Individual Experience for 2010 ***Note that different levels of detail were requested based on the following indicator:*** ** Data element collected for products that make up at least 80% of enrollees in the small group market and at least 80% of enrollees in the individual market for a particular carrier.* *** Data elements collected for products not captured in the 80% of enrollment in small group and individual markets.* **** Data elements collected for all products*.	Carrier*** Line of Business*** Type of Product* In-network Deductible* In-network Coinsurance* In-network Maximum Out-of-Pocket* Inpatient per admit copay* Inpatient per day copay* Emergency Room Cost-Sharing* PCP Office Visit* Specialist Office Visit Cost-Sharing* Generic Prescription Drug Cost-Sharing* Preferred Brand Prescription Drug Cost-Sharing* Non-Preferred Brand Prescription Drug Cost-Sharing* Closed or Open status as of 1/1/2011* 2010 Member Months*** 2010 Earned Premiums*** 2010 Incurred Claims net of cost sharing (paid) including incurred but not reported (IBNR)*** 2010 Incurred Claims gross of cost sharing (allowed) including IBNR**\

Initial Carrier Survey Data Request (cont.)	
Request	**Detailed Data Elements**
Illinois Individual Underwriting Experience	2010 Policies and 2010 Written (Annualized) Premium by: 2010 Applications 2010 Standard Issues 2010 Preferred Issues 2010 Sub-standard Issues 2010 Denied 2010 Non-Issued at Policyholder discretion 2010 Issued with Underwriting Condition Exclusion Current Rating Factors and Persistency at End of Year by Duration.
Illinois Small Group Underwriting Experience	By Group Size: 2010 Group Months 2010 Employee Months 2010 Member Months 2010 Earned Premium Average Health Status Adjustment Factor 2010 Earned Premium or # of Groups by Health Status Factor Adjustment
Agent Compensation	For Each Commission Schedule: Company Name NAIC Company Code State Market Product Commission Schedule Applies to What Class of Producers Date Commission Schedule First Went Into Effect Date Commission Schedule Terminated First Year Commission - % of Premium Renewal Commission - % of Premium First Year Commission - Fixed Amount Renewal Commission - Fixed Amount Incentive or Bonus Programs Total Compensation in Dollars Total Compensation - % of Premium

Addendum Carrier Survey Data Request	
Request	**Detailed Data Elements**
Illinois Fully Insured Product Exposure by Zip Code for 2010	For Each Plan: Carrier Line of Business Type of Product Group Zip Code Member Zip Code 2010 Member Months 2010 Earned Premiums

Appendix D: Projection Assumptions

Item	Definition/Description	Sources and Assumptions
Total Population		
Total Illinois Population	Population projections for years 2011-2020 (breakdowns by state, age, and income)	Age Distribution from Census Projections. Income distribution per Urban/Kaiser Family Foundation (KFF) values, derived from Census projections (CPS). www.statehealthfacts.org
Aliens Not Lawfully Present	Projections on the number of persons residing in Illinois who are Aliens not Lawfully Present in the United States, and their health insurance coverage from 2011-2020.	Baseline counts of this population group per PEW Hispanic Center. http://pewhispanic.org/unauthorized-immigration/ Current coverage levels per PEW and Center for Immigration Studies (CIS) http://www.cis.org/articles/2009/hr3200.pdf Baseline level of increase corresponds with population growth. Those with commercial coverage are assumed to retain it. Exchange and Medicaid expansion are assumed not to apply to this population group, as per ACA.
Legal/ACA		
Individual Mandate	Size, basis and timing of penalties for those without health care coverage	ACA provisions – without adjustment
Employer Pay or Play	Size, basis and timing of fees assessed on employers not providing health care coverage	ACA provisions – without adjustment
Exchange availability: Individuals	Date at which Exchange established, and subsidies etc. can be processed	Assume strong exchange beginning on Jan 1, 2014.
Exchange availability: Groups	Date at which SHOP established, and group sizes allowed over time.	Assume SHOP for groups <50 on Jan 1, 2014 Assume SHOP for groups <100 on Jan 1, 2016 No SHOP for groups > 100 in projection period

Economy		
Unemployment	Unemployment rate projections from 2011-2020 by state	Timing of employment recovery per CBO Budget Office Economic Outlook http://www.cbo.gov/ftpdocs/120xx/doc12039/01-26_FY2011Outlook.pdf Eventual unemployment level: Per Bureau of Labor Statistics http://www.bls.gov/lau/
Real Wage Growth	Year over year increase in wages, adjusted for inflation.	CBO Budget Office Economic Outlook
Commercial Coverage		
Group Coverage Offer Rates	% of those eligible to purchase coverage through their employer by group size	Compound assumptions (decreases with establishment of Exchange and Guaranteed Issue requirements, increases with Pay-or-play). Net assumption produces a gradual reduction of approximately 7% in offer rates by the year 2017.
Group Coverage Take Rates	% of those offered group coverage that accept group coverage, by group size	Increase over time as a function of the individual mandate
Group ASO Share	% of those with group coverage on self-insured plans, by group size.	Moderate increase in ASO with introduction of ACA industry fees applicable to insured business only Larger shift to ASO with community rating of larger groups when the small group market is extended up to 100 employee groups
Individual Take Rates	Individual Enrollment as % of (Individual + Uninsured)	Derived through decision modeling based on the price sensitivity, considering estimated value of subsidies, cost of penalties, underwriting and rating restrictions
Individual Market Maximum Take Rates	Maximum take rate by Income	Consistent with Adult Medicaid Take rates
Medicare		
Medicare Beneficiary Projection	Number of persons enrolled in Medicare for 2011-2020, including dual eligibles.	Increase in Medicare beneficiaries proportional to population growth for the over age 65 population.
Medicaid		
Medicaid Beneficiary Projection	Number of persons enrolled in Medicaid and All Kids over the projection period.	Changes each year due to population growth and economic factors including unemployment rates and real wage growth rate assumptions Eligibility calculated based on Illinois income distribution data from KFF

Effective Income Limit Floor	The minimum income level at which federal law requires eligibility for Medicaid	ACA without adjustment. 138% of FPL (i.e. 133% + 5% income disregard)
Shift of Membership from State Programs To Exchanges	Assumed Exchange take up from individuals on Medicaid or State Programs prior to reform	Assume that a subset of adults on Medicaid and State Programs with incomes above 138% of FPL (62K) transfer to the Exchange. This reflects an assumption of movement that may change once policy decisions are finalized.
Take Rates - Prior Eligibles	The proportion of people who enroll for Medicaid from among those already eligible prior to the implementation of ACA.	Assume that 20% of those not taking up coverage today, will do so in the future. (Excludes disabled individuals). Assume All Kids children stay on Medicaid.
Take Rates - New Eligibles	The % of people who enroll for Medicaid from among those who will be newly eligible due to ACA.	Assume that 60% take coverage (includes currently uninsured as well as current Group and Individual market enrollees) Take up Rate per Urban Institute: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf

Endnotes

Note: The following endnotes contain web links where applicable. The links in this report may have moved or been deleted after this report became final.

[1] Patient Protection and Affordable Care Act (Public Law 111-148) and amendment - Healthcare and Education Reconciliation Act of 2010 (Public Law 111-162)

[2] 2011 Population Coverage Sources: Medicare – CMS Eligibility Files reduced for Duals and Medicare Secondary Payer (2%) to Employer Coverage. The Duals and Medicare Secondary Payer source is Kaiser Family Foundation (KFF). Medicaid – HFS enrollment files provided by the State reduced for 5% commercial overlap. Commercial overlap is based on discussions with the State. Commercial – Consistent with KFF values for 2009 (including "Other Coverage"), reflecting Healthleaders-InterStudy changes in the marketplace between 2009 and 2011. Additional breakdowns of commercial (small group/large group/individual) are from Medical Expenditure Panel Survey (MEPS). Uninsured – Difference between total population from the US Census Bureau and the previously mentioned markets.

[3] The Kaiser Family Foundation. *The Kaiser Commission on Medicaid and the Uninsured, Excerpts from Health Insurance Coverage in America Chartbooks, 2000 – 2009.* Provided to Deloitte Consulting directly from Kaiser Family Foundation. 24 June 2011.

[4] 2011 Illinois Health Insurance Survey. Developed by Deloitte Consulting with the State of Illinois, and administered by Harris Interactive, Inc. in June and July 2011. See Appendix B of this report for survey questions and results.

[5] HealthLeaders-InterStudy, *Managed Market Surveyor & Managed Market Surveyor Rx Data*, January 2011. www.healthleaders-interstudy.com. 1 July 2011.

[6] 2011 Carrier Survey. State Issued Data Call. Executed by Wakely Consulting Group. See Appendix C for data collected as a part of survey. July 2011.

[7] National Association of Insurance Commissioners and The Center for Insurance Policy And Research. *Uniform Certificate of Authority Application State Charts*. http://www.naic.org/industry_ucaa.htm

[8] The Kaiser Family Foundation, statehealthfacts.org. Data Source: *Illinois Protections in Individual Insurance Markets*. http://www.statehealthfacts.org/profileind.jsp?cat=7&sub=87&rgn=16

[9] The Kaiser Family Foundation, statehealthfacts.org. Data Source: *Illinois Protections in Small Group Markets*. http://www.statehealthfacts.org/profileind.jsp?cat=7&sub=86&rgn=16

[10] Department of Insurance, *Agent and Broker Licensing Information Data.* Provided to Deloitte Consulting directly from State as a part of project data requests. See Appendix A for data request. 14 June 2011.

[11] U.S. Census Bureau, *2009 American Community Survey Data 1-Year Estimates*, factfinder.census.gov. 27 July 2011.

[12] Department of Healthcare and Family Services, *All Kids Application Agents (AKAA) Data.* Provided to Deloitte Consulting directly from State as a part of project data requests. See Appendix A for data request. 8 June 2011.

[13] Deloitte Consulting Assessment of Affordability of Coverage. Based on analysis of *Thomson Reuters MarketScan® Research Databases* Illinois specific experience, the 2011 Carrier Survey[6], 2009 ACS Data[11], and various reports from the Kaiser Family Foundation.

[14] Deloitte Consulting Health Reform Impact model Results. Used to produce State-level projections of coverage patterns in future years. Model is based on assumptions from multiple sources. See Appendix D for a summary of assumptions used within the model.

[15] Jeffrey S. Passel and D'Vera Cohn. *A Portrait of Unauthorized Immigrants in the United States*. Washington, DC: Pew Hispanic Center, April 2009. http://pewhispanic.org/files/reports/107.pdf

[16] Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey (BRFSS) Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000-2009. 23 June 2011.

[17] Department of Healthcare and Family Services, *Medicaid Enrollment and Claims Experience Data.* Provided to Deloitte Consulting directly from State as a part of project data requests. See Appendix A for data request. 21 June 2011.

[18] The Kaiser Family Foundation, statehealthfacts.org. Data Source: *Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements)*. 27 July 2011.
http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=16&ind=125&sub=39

[19] U.S. Census Bureau, *2009 American Community Survey Data 5-Year Estimates*, factfinder.census.gov. 27 July 2011.

[20] U.S. Department of Health and Human Services, *Medical Expenditure Panel Survey (MEPS) Data*.

1. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/hlth_insr/2010/alltables.pdf. Table 5 - Health insurance coverage of the civilian noninstitutionalized population: Population estimates by type of coverage and selected population characteristics, United States, first half of 2010. 27 July 2011.
2. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tiic2.pdf. Table II.C.2(2010) - Average total employee contribution (in dollars) per enrolled employee for single coverage at private-sector establishments that offer health insurance by firm size and State: United States, 2010. August 2011.
3. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tiid2.pdf. Tabl e II.D.2(2010) - Average total employee contribution (in dollars) per enrolled employee for family coverage at private-sector establishments that offer health insurance by firm size and State: United States, 2010. August 2011

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http://www.deloitte.com/us/2009consumersurvey. 27 July 2011.

[22] Department of Insurance, *Insurance Complaints Information Data.* Provided to Deloitte Consulting directly from State as a part of project data requests. See Appendix A for data request. 13 June 2011.

[23] Illinois Comprehensive Health Insurance Plan (ICHIP), *Illinois Comprehensive Health Insurance Plan 2009 Annual Report* and *Illinois Comprehensive Health Insurance Plan 2008 Annual Report*.
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2009: http://www.chip.state.il.us/downloads/09anrept.pdf. 27 July 2011.

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