**To:** **The Illinois Department of Healthcare and Family Services (HFS) and Illinois Department of Insurance (DOI)**

**From:** **Protect Our Care Illinois Coalition**

**RE:** **Recommended Guiding Principles for the HFS/DOI Affordability Feasibility Study**

**DATE:** **November 3, 2020**

Thank you for holding a stakeholder meeting with Protect Our Care IL (POCIL) Coalition members about the HFS/DOI Healthcare Feasibility Affordability study mandated by Public Act 101-0649. We believe that everyone deserves access to equitable, affordable, comprehensive healthcare no matter their race, ethnicity, gender identity, sexual orientation, income, ability, or immigration status. People need access to health coverage and care to preserve and improve their health and well-being so they can work, take care of themselves and their families and be active members of their communities. We also believe that health care coverage is a right - not a privilege - and that any new health care policy that Illinois institutes should move the state toward universal coverage.

Achieving health justice requires focus in three separate but related areas: health coverage and affordability; access and quality; and the social determinants of health. All three are necessary to achieve equitable health outcomes and improve financial security.[1] As you continue to oversee the feasibility study exploring several options to make health insurance more affordable for low- and middle-income residents in Illinois and especially as you move into policy development, **we would like to propose the following guiding principles.**

1. Center racial equity in the study and in all policy proposals so that decisions increase fairness and opportunity, particularly for Black, Indigenous, Latinx, and other communities of color. For example:
    - Utilize a racial impact assessment of all proposed policies prior to final decision-making and implementation. Here is an example of the types of questions to ask.
    - When measuring "affordability" and evaluating the cost of health care, take the racial wealth gap into consideration. For example, cost-sharing (e.g., co-pays, deductibles, co-insurance) affects Black, Latinx and white households at similar incomes differently because white households have more resources on average to pay out-of-pocket costs.[2]
    - When modeling plan design, prioritize the use of essential community providers and ensure that a minimum percentage are providers of color and have lived experience in the communities they serve.

[1] "Advancing Health Justice: Building a System that Works for Everyone," Community Catalyst 2019.

[2] According to the Urban Institute, "In 2016, the median net worth of white families in the United States was $171,000 - 10 times that of Black families and 8 times that of Latinx families. Those gaps have grown over the past several decades and are expected to continue growing" and "An estimated 67 percent of Black households and 71 percent of Latinx households do not have enough saved to live above the poverty level for three months, compared with 49 percent of all households." State and Local Approaches to Chicago's Racial and Ethnic Wealth Inequity, December 2019.

- Ensure that any plan design prioritizes culturally competent care including language access for limited English speakers to make high quality care accessible.
- Recognize that the social determinants of health — racism, poverty, unequal access to care, housing, geography, employment, and education — must be confronted as they are significant contributing factors to health disparities, as well as obstacles to the coverage and quality objectives. For example, the All Kids program has had a "Welcome Mat" effect: all children are eligible regardless of immigration status and this framing has led to its success. This program has also been successful because community-based organizations are able to assist individuals in enrolling their children in the language and setting they feel comfortable and safe in.

2. Prioritize funding for community-based enrollment assisters who are critical to Illinois residents understanding their health care options in their preferred language and by a trusted messenger. In 2018, 62% (536,000) of the uninsured population in Illinois were eligible for but not enrolled in Medicaid or subsidized Marketplace coverage. A robust in-person assistance outreach and education program is essential for reaching these consumers.
    - Numerous studies have shown that "application assistance from navigators and others was the strongest predictor of enrollment," and that "supplementing or replacing diminishing federal funding for consumer outreach grant programs, workforce training, and support at the state or community level was found to be an important priority that can increase competencies in a diverse population."
    - The affordability study should consider the benefits of individual enrollment assistance and any policy proposals should include funding to cover the costs of grant-funded assisters and ongoing training and support of these assisters.
3. Create affordable comprehensive health coverage pathways for populations who are excluded from the Affordable Care Act (ACA) or are not eligible for Medicaid, and are effectively "locked out" of coverage including:
    - Undocumented/DACAmented immigrants – who comprise the majority of the uninsured in Illinois; and
    - People who fall into the "family glitch" - the ACA rule that bases eligibility for a family's premium subsidies on whether available employer-sponsored insurance is affordable for the employee only, even if it's not actually affordable for the whole family.
4. Prioritize options for low-income populations under 400% FPL.
5. Consider using an "affordability" threshold that is more generous than the ACA's definition of affordability -- which is currently that premiums paid for a self-only plan is 9.78% or less than the employee's household income.
    - For example, Illinois could consider eliminating premiums for all with income below 200% FPL.[3]
6. Prioritize a state-run exchange so that Illinoisans truly can have a "no wrong door" entry into the health system rather than a bifurcated ABE/HealthCare.gov system that causes confusion in enrollment, delays coverage, increases churn from Medicaid to the Marketplace and back, and disrupts continuity of coverage and care. A state-run exchange also gives the state greater

[3] "Health Care Affordability and COVID-19" Policy Brief, Community Catalyst, May 2020.

flexibility to develop policy proposals to better address affordability, such as standardized plans, state-based subsidies, and more tailored enrollment opportunities (e.g. state-specific Special Enrollment Periods).

7. Consider in the study and policy proposals that adults with disabilities are almost twice as likely as nondisabled adults to report unmet health care needs due to problems with accessibility.[4] Thus, consider accessibility as a social determinant of health throughout plan design. Ensure that health plans and the services and facilities associated with them meet the needs of people with multiple disabilities and are compliant with the accessibility and nondiscrimination standards established by multiple state and Federal laws including, Section 504 of the Rehabilitation Act, The Americans with Disabilities Act and the ACA.
8. Ensure that the healthcare plans and services proposed adequately cover the full range of cost for home and community-based services (HCBS) and the equipment and supplies associated with HCBS care such as complex rehabilitation technology, incontinence supplies and more.
9. Study the impact that a reinsurance program could have on insurance premiums.
10. Study the impact that providing the Department of Insurance with the authority to reject unreasonable or discriminatory rate increases could have on insurance premiums. Available data suggests that independent scrutiny of rate filings has been an effective tool at reducing requested rates, especially in states with prior approval requirements:
    - Rate review reduced total nationwide premiums by $1.2 billion in 2012.
    - In California, rate review saved an estimated $349 million between 2011 and 2014.
    - In Colorado, rate review saved consumers $125 million over five years.
    - In Oregon, rate review saved at least $69 million in premiums in 2014 due in part to the identification of calculation errors identified during the rate review process.
11. Improve the Medicaid enrollment and redetermination system (which will, in turn, reduce the number of uninsured and churn).
    - Presumptive eligibility was implemented in response to the COVID pandemic emergency and succeeded in getting applicants onto coverage faster and greatly reducing the Medicaid application backlog. The state should permanently establish presumptive eligibility for adults under Medicaid.
    - Self-attestation and attestation by service providers and assisters have been allowed during the COVID pandemic. The state should make these policies permanent to the extent allowable under federal law.
    - Study implementing a real time eligibility determination system.
    - Build on recommendations in the HFS December 2019 Ex Parte Renewal Report, as required by Public Act 101-0209. For example, study the impact of increasing the use of automated Medicaid redetermination processes (sometimes called ex-parte or Form A) and how it would impact continuity of coverage and affordability for those individuals and families.

[4] Center for Medicare and Medicaid Services, Office of Minority Health (2017). Increasing the Physical Accessibility of Healthcare Facilities. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Brief-Physical-AccessibilityBrief.pdf

- Consider different policy changes in estimating the use of automated Medicaid redetermination such as by allowing a self-attestation of zero income for cases who have no electronically verifiable income or by electronically verifying assets.
- Study the administrative cost and the cost of disruption of regular and ongoing health care of Medicaid enrollees due to the current levels of Medicaid churn and cancellation due to failure to return requested documentation.
- Translate the redetermination notice in the top 5 languages spoken in Illinois. Research from UIC has shown that Medicaid recipients who are limited English proficient (LEP) are 5 times more likely to lose Medicaid coverage for not being able to read the notice.

12. Study the costs and benefits of the Illinois Medicaid Managed Care system including the impact on enrollee costs, enrollee access to care, and state costs for the following:
    - Care Coordination
    - Managed Care Networks
    - Prior authorizations or other utilization management practices
    - Restrictions on prescriptions and therapies due to step therapy requirements, preferred drug lists, and other limitations
13. Clearly delineate the accountability structure for the Affordability study going forward by outlining opportunities for diverse stakeholder and public input and laying out who is responsible for ensuring recommendations in the study are enacted.
14. Clearly state that the study and the policy proposals included are limited and not able to address all racial health inequities being sure to name that structural racism is embedded in our current health coverage, care and delivery systems.
15. Ensure the following questions are addressed for each policy proposal included in the study:
    - How will the plan(s) move Illinois toward universal coverage?
    - How will the plan(s) improve quality of healthcare services?
    - How will the plan(s) improve the quality of health for Illinoisans?
    - How will the plan(s) improve access to health care, particularly for people who have historically been locked out of coverage?
    - How will the plan(s) improve affordability for people under 400% FPL?
    - How will the plan(s) be structured so there is investment in equitable social determinants of health (SDOH)?
    - How will the plan(s) reduce racial health inequities in Illinois?
    - What impact will the plan(s) have on costs for consumers? The state? Other stakeholders?

Thank you for your consideration of our guiding principles. If you have any questions, please do not hesitate to contact Logan Charlesworth, Protect Our Care IL Coalition Manager info@protectourcareil.org.