Illinois Health and Hospital Association

On April 2, the Departments of Healthcare and Family Services (HFS) and Insurance (DOI) released a report entitled Feasibility Report for Coverage Affordability Initiatives in Illinois. This report was in response to Public Act 101-0649, the Health Care Affordability Act, which in part required the agencies to complete a feasibility study to explore options to make health insurance more affordable for low-income and middle-income residents in Illinois. The report outlines a menu of options, rather than recommendations, for policymakers to consider, taking into account the likelihood of the options helping the state achieve its overarching goals of reducing the numbers of uninsured, increasing affordability, and improving health equity. The report also outlines the estimated costs, utilization, and the benefits and risks of each option.

The following six options were included in the report:

- Basic Health Program
- State Premium and Cost-sharing Subsidies
- Public Option Plan
- Medicaid Buy-in
- Transition to a State-based Marketplace
- State-supported Marketing and Outreach

Basic Health Program

Permitted under the Affordable Care Act (ACA), states may administer a Basic Health Plan Program (BHP) instead of Marketplace coverage for individuals with incomes between 138% and 200% of the federal poverty level (FPL) who would otherwise be eligible for Advance Premium Tax Credits (APTCs), or documented immigrants under 138% FPL who are not yet eligible for Medicaid. Coverage must be at least as affordable and comprehensive as Marketplace coverage with the federal government providing the state 95% of what would
have been spent on APTCs had the enrollees received them through the Marketplace. Forecasting through three different models, it is estimated that 135,000 to 188,000 individuals would opt for coverage through this program, reducing the number of uninsured by 23,000 to 72,000. The majority of other individuals opting for this plan would be those currently enrolled in a Bronze level plan on the Marketplace due to the more favorable cost-sharing components of such a plan for most eligible individuals. In addition, assuming reimbursement rates were kept at current Medicaid levels, the out-of-pocket cost to the state under the BHP would be minimal. Two other states, Minnesota and New York, have implemented a BHP.

State Premium and Cost-sharing Subsidies

In this option, states are permitted to build on the federal government's APTCs and Costsharing Reductions (CSRs) to lower premiums and/or cost-sharing for Marketplace enrollees. The report looks at four scenarios based on other state implemented programs and proposed limits from the U.S. House Energy and Commerce Committee.

In all four scenarios, there will be increased enrollment in comprehensive individual market coverage relative to existing policy and the number of uninsured could be decreased by as many as 106,000. It is also estimated that up to 423,000 individuals would experience lower premiums and approximately 248,000 would see reduced cost-sharing. Such an option, however, would require significant state investment and a funding source. Estimated state cost for the first year would range between $113 million and $796 million. Five other states,

California, Colorado, Massachusetts, New Jersey, and Vermont have all committed state money to premium or cost-sharing assistance programs using a variety of funding sources including general revenue funds, other state funds, a federal Section 1115 waiver, and assessments on health insurers and hospitals.

Public Option Plan

Under this scenario, a government-backed health plan would compete on the Marketplace with private plans. The public option could reduce costs through lower administrative costs or by paying lower provider rates. In addition, the public option plan offered (both on and off Marketplace) must meet the same standards as the Marketplace plans. Three scenarios were included in the report looking at 10%, 20%, and 30% reduction in premiums from the second lowest Silver Plan (SLCSP).

Each scenario saw an increase in newly insured residents ranging from 6,000 with the 10% plan up to 20,000 with the 30% plan. The program would be budget neutral to the state with the only costs coming from implementation and oversight expenditures. The report notes that the major benefactors of a public option will be the White population in Illinois as 85% of new enrollees will be people with household incomes over 400% FPL, thus not making any significant strides in improving health equity. The report also notes that provider
reimbursement may need to be increased to meet network adequacy demands if there is insufficient incentives for provider participation. Should such an adjustment be needed, the program would no longer be budget neutral, losing one of the key factors to support such a program. Currently, only the state of Washington has implemented a public option; however, other states are currently considering legislative action implementing such a plan.

Medicaid Buy-in

Under this option, the state would make Medicaid or Medicaid-like coverage available to residents not currently eligible. The report evaluates three different scenarios:

- Targeted – Available to those not eligible for Medicare or Medicaid, up to 400% FPL who are either an undocumented immigrant or in the family glitch, a scenario in which APTCs are not available to a family because one adult is eligible for individual coverage through their job, but no coverage is available for their family.
- Broad (Basic) – Available to all residents not eligible for Medicare or Medicaid with premium caps set at 30% lower than estimated premiums for a 2022 SLCSP, and premium contributions capped consistent with federal maximums based on household income.
- Broad (Enhanced) – Same principles as the basic Broad plan with more generous premium and cost-sharing assistance.

The report estimates that 535,000 to 6.2 million residents would be eligible for coverage under these scenarios with the undocumented immigrant lack of insurance rates being reduced 30%- 40% depending on the scenario. Such a program would cost the state between $274 million and $1.052 billion in the first year, assuming federal approval for pass-through funding. Besides the significant cost, it is estimated that a broad-based option would siphon 80%-85% of the enrollees from individual or employer-sponsored insurance risking the stability of the
Marketplace. No other states have implemented such a program.

Transitioning to a State-based Marketplace

In this option, the state would take over the Health Insurance Marketplace from the federal government and be responsible for eligibility, enrollment, consumer outreach and assistance, and plan management functions. Taking over the Marketplace function could lead to greater efficiencies, provide opportunity to improve consumer experience, and allow for more control over the insurance market. States that have transitioned to this model frequently pass legislation allowing for the collection of an assessment fee from insurers. This is what the
federal government does to cover the cost of operating the Marketplace. Those states which have transitioned to a state-based marketplace have found efficiencies and other cost savings that have allowed for investment in other programs such as reinsurance. Additionally, the report outlines that premium and subsidy assistance as well as a public option would be enhanced through a state-based marketplace, while a Medicaid buy-in program would not work as well. Seven states, Kentucky, Maine, New Jersey, New Mexico, Nevada, and Virginia, are all
in the process of switching to a state-based marketplace.

State-Supported Marketing and Outreach

In this scenario the state would increase its investment in outreach, education, and enrollment assistance to consumers eligible for Marketplace coverage and Medicaid. The report notes that national surveys show a high level of efficacy of consumer assistance programs in facilitating Marketplace and Medicaid enrollment. These investments have been found to be cost effective and capable of providing a significant return on investment through improving the size and health of the individual market risk pool. The report notes that two-thirds of the uninsured population, including those uninsured at lower incomes and the majority of Black residents are
already eligible for subsidized coverage through Medicaid or the Marketplace. As such it suggests that this investment could produce substantial affordability and coverage benefits in a way that increases health equity.

IHA's Position

IHA has and will continue to raise significant concerns that making drastic changes, such as a public option or a Medicaid buy-in program, would need close examination and analysis of many questions and unintended consequences given the complexity of healthcare and the ongoing challenges associated with Medicaid Managed Care. Of particular concern is the detrimental financial impact that hospitals and other providers will likely face with the significant shift a Medicaid buy-in would cause through individuals currently insured on the
non-group market or through an employer-sponsored plan moving to the Medicaid program. Such a shift would not only bring significant instability to the insurance marketplace in Illinois, but would also create a payer mix scenario in which many hospitals would find impossible to operate.

IHA believes the best use of state resources is to focus efforts on shoring up the current system as this will likely have more meaningful and immediate impact on improving access for affordable care. For example, the report's final option to enhance investment in marketing and outreach to those uninsured who are currently eligible will likely make a significant impact on healthcare affordability and health equity as approximately 65% of those uninsured are either eligible for Medicaid or APTCs. In addition, state investment in premium and cost-sharing
subsidies will have a significant positive impact for patients who have coverage but cannot use it because of the high deductibles. Finally, IHA supports mechanisms to expand healthcare access to the undocumented population which is estimated to be approximately 17% of the uninsured population in the state.

IHA will continue to be actively engaged on this key issue, advocating that common sense improvements to the current system should be made prior to consideration of any drastic changes to the insurance marketplace. If you have questions, please contact IHA.