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CLOSING THE GAP

Expanding Public Health Insurance Eligibility to Immigrants in Illinois

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This report was prepared in partial fulfillment of the requirements for the Master in Public Policy degree in the Department of Public Policy at the University of California, Los Angeles. It was prepared at the direction of the Department and of Healthy Illinois as a policy client. The views expressed herein are those of the authors and not necessarily those of the Department, the UCLA Luskin School of Public Affairs, UCLA as a whole, or the client.

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Executive Summary

In conversations on healthcare expansion and healthcare for all, the immigrant experience is often absent from the discussion. Immigrants without legal or long-term residency are even more likely to be purposefully excluded from public healthcare or healthcare assistance. Advocates such as Healthy Illinois, however, recognize that drawing boundaries to healthcare based on citizenship denies access to people in need. Previous research indicates that there are many individual and societal benefits to public healthcare expansion and our research contributes to this topic by analyzing the impacts of coverage expansion in Illinois.

Due to the Healthy Illinois campaign and network of health equity focused organizations, Illinois has made much progress on expanding Medicaid-like healthcare services to all low-income residents in Illinois, regardless of immigration status. For this report, we refer to "undocumented immigrants" and "legally residing immigrants" with less than five years of residency as federally ineligible immigrants. Currently, Illinois has three immigrant focused healthcare programs that are almost functionally identical to federal Medicaid: All Kids (ages 0-18), Health Benefits of Immigrant Seniors (ages 65+), and Health Care for Immigrant Adults (ages 42-64). As a result, immigrants who are federally ineligible for Medicaid between the ages of 0 to 18 and 42+ have access to state healthcare coverage. However, there is a gap in coverage for those ages 19 to 41.

As demonstrated by the extant literature on insurance and healthcare access for undocumented immigrants across states that have expanded Medicaid, there is a growing recognition that unequal access to healthcare across different groups of people, especially marginalized groups and purposeful exclusion of federally ineligible immigrants, represents a problem in equity of access and healthcare outcomes.[1] Healthy Illinois is committed to advocating for a closing of the eligibility gap of 19–41- year-old federally ineligible immigrants by expanding Medicaid-like insurance to all residents in Illinois, regardless of immigration status and of every age. To support this effort and analyze the effectiveness of the previous healthcare expansion programs, an applied policy project was conducted by a team of University of California-Los Angeles Masters of Public Policy students working with Healthy Illinois. Our research analyzes the current enrollment of immigrant adults in the Health Benefits for Immigrant Seniors (HBIS) and Health Benefits for Immigrant Adults (HBIA) programs.

Using enrollment data from the Illinois Department of Health and Family Services (HFS) and analyzing interviews from HBIS/A enrollees and healthcare providers, we identified important program data such as enrollment rates, insurance claims, program costs, health conditions affecting enrollees, and gaps in program or health resources. From that analysis, a few main findings emerged. The data shows that HBIA and HBIS have positive impacts, including ones that benefit Illinois overall. These programs provide important, and often lifesaving benefits to enrollees. These benefits include not only immediate access to medical treatments, but also improved quality of life for present and future generations and financial relief. HBIS/A programs also provide significant benefits to the Illinois healthcare system by reducing emergency room visits through health coverage and increased use of preventative care services.

Our preliminary program analysis revealed several program trends. First, there are enrollees in both HBIA and HBIS throughout the state. These programs benefit not only the densely populated Cook county, but the affected population resides throughout Illinois in every community. Second, there are more 42-54-year-olds enrolled in HBIA than any other age group enrolled in HBIA or HBIS. Several factors may contribute to this enrollment rate and we encourage the program administrators to consider potential program barriers for older populations. Third, enrollees credited community-based organizations in assisting them through the application process. These organizations are a critical part of the care network.

While reviewing available program information and specifically statements from potential enrollees and medical providers, we observed an additional healthcare gap. Not only is there a gap in program eligibility, but there is a gap between eligibility and coverage, as not all who are eligible for HBIS or HBIA are actually enrolled or utilizing the full range of health services available to them. Closing the gap also means closing both gaps, for all program expansions, current and potential. When examining how to better align eligibility and coverage, we recommended policy-based improvements aimed at increasing opportunities for program knowledge, application accessibility, and maintained coverage.

Based on data analysis informed by this research, we have provided Healthy Illinois with supporting data and recommendations for expanding Medicaid-like health care benefits to immigrant adults in the 19-41 age group. We conclude that in the absence of the federal government extending healthcare to immigrants, the Illinois government must provide this service to all regardless of immigration status and age. We recommend that Healthy Illinois be empowered to continue advocating for healthcare for all Illinois residents.

Acknowledgements

We would like to thank Tovia Siegal, Director of Healthy Illinois, Stephanie Altman, Senior Director of Policy at Shriver Center on Poverty Law, and our advisor Mark Peterson, Interim Chair for the UCLA Department of Public Policy, for their guidance and support throughout this report. Additionally, we would like to thank all the healthcare providers who participated in our study and provided valuable insight into the Illinois healthcare system.

Introduction

The history of the U.S. healthcare system reflects the exclusion of immigrants from social programs in the United States. Due to the Personal Responsibility and Work Opportunity Act of 1996, many immigrants, especially undocumented immigrants, are barred from access to most federal benefits, including federal health care programs and assistance, including Medicaid and the Children's Health Insurance Program (CHIP).[2] As of 2021, 25% of lawfully present immigrants and 46% of undocumented immigrants were without health insurance.[3] Most undocumented immigrants do not have access to preventative health services, only emergency care provided under emergency Medicaid.[4] As a result, many undocumented immigrants often delay or go without needed care, which can lead to worse health outcomes over the long term.[5] However, following the implementation of the Affordable Care Act in 2010, some states have extended healthcare to immigrants.

Illinois was among the first states to establish a universal health coverage program for federally ineligible immigrant groups. For this report, we refer to "undocumented immigrants" and "legally residing immigrants" with less than five years of residency as **federally ineligible immigrants (FII)**. With a population of 400,000 undocumented immigrants who are ineligible to apply for federal healthcare programs due to their residency status and non-employment- sponsored health insurance, Healthy Illinois – a coalition of clinics, grassroots organizations, immigrant service organizations, and policy and legal organizations – has led efforts to expand healthcare coverage.[6] Starting in July 2006, Healthy Illinois successfully advocated for the implementation of All Kids, which extended healthcare coverage to include dental and vision care to children ages up to 18 years old regardless of immigration status, enrolling up to 50,000 children during its first year.[7] In the following years, additional healthcare expansions were implemented to extend Medicaid-like healthcare coverage to federally ineligible immigrants (FII), which include undocumented immigrants and legally residing immigrants with less than five years of residency: Health Benefits for Immigrant **Seniors Program (HBIS)** and **Health Benefits For Immigrant Adults (HBIA)**.[8]

Administered by the Illinois Department of Health and Family Services, these programs are referred to as Medicaid-like programs because they function similarly to the Medicaid and State Children's Health Insurance Program (SCHIP) insurance programs but are funded entirely by the state.[9] Both programs cover standard healthcare services, such as hospital visits, doctor visits, and prescription drugs with up to three months of retroactive coverage upon enrolling.

HBIS offers health coverage to federally ineligible immigrants 65 years and older with incomes below the 100 percent Federal Poverty Level (FPL) regardless of their immigration status.[10] HBIA covers adults between the ages of 42 and 64 with incomes below 138 percent FPL, irrespective of their immigration status.[11] Early public data in 2021 revealed that around 9,000 federally ineligible immigrants were enrolled in HBIA, the program for non-senior adults – 6,500, or nearly three-quarters, were undocumented immigrants and approximately 2,500 legal permanent residents.[12]

While these programs provide health insurance for federally ineligible immigrants, ages 42 and older, 19-41-year-old FIIs are excluded. As of March 2023, two companion bills have been introduced in the Illinois House and Senate – HB 1570 and SB 122– that would close this coverage gap for FIIs ages 19-41 who have an income at or below 138 percent of the federal poverty level and who are otherwise ineligible for health insurance.[13] If the bill is signed into law, it would potentially cover 116,000 FIIs and effectively achieve universal healthcare insurance for all federally ineligible immigrants and children in Illinois.[14]

In partnership with our client Healthy Illinois, our team conducted a mixed-method research project to 1) analyze the health impact of HBIS and HBIA programs on enrolled immigrants while estimating the likely health impact of extending coverage to 19-41 immigrants and 2) provide policy recommendations based on a program evaluation of HBIS and HBIA to meet immigrant needs such as enrollment assistance and building trust among immigrant communities. With the beginning of a new legislative session, the introduction of HB 1570 and SB 122, support from legislators such as Senators Omar Aquino and Cristina H. Pacione-Zayas and representatives Elizabeth "Lisa" Hernandez and Daniel Didech along with other co-sponsors, and data from our analysis, there is a window of opportunity for advocates like Healthy Illinois to improve existing programs and build upon the success of the previous two programs.

State-landscape Analysis of Extending Healthcare to Immigrants

The development of the U.S. healthcare system reflects the general historical exclusion of immigrants from social programs in the United States. In 1996, the federal government passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) which restricted lawfully-present immigrants who had less than five years of US residency and undocumented immigrants from receiving any public benefits, including federally funded Medicaid and Medicare.[15] Only immigrants with temporary status, such as refugees and asylees, could be covered by federally subsidized health insurance plans.[16] Over the years, PRWORA set the justification and basis for excluding some immigrant populations from federal health insurance, with the only available option being purchasing expensive unsubsidized private health insurance on the market. An exclusive and inequitable narrative of U.S. healthcare was long- standing until the passage of the Patient Protection and Affordable Care Act (ACA) which gave states discretion in deciding whether to expand the healthcare eligibility of immigrant populations. Some states designed and implemented healthcare coverage for immigrants through their state budget process, while others did not.[17] The following section highlights a landmark study of the effect of expanding public health insurance, the Oregon Experiment, and Medicaid expansions in Massachusetts, California, and Illinois following the Affordable Care Act that helped close the health insurance gap by including immigrant populations through various means. These are significant examples in understanding how a healthcare expansion in Illinois would benefit immigrant health.

Oregon Health Care Experiment

One of the most robust studies in support of the Affordable Care Act was the Oregon Experiment. Prior to the ACA, Oregon implemented its own federal-state Medicaid program, Oregon Health Plan (OHP), which consisted of two programs – OHP Plus and OHP Standard. To be eligible to apply to the OHP Standard, one must be either an Oregon resident, a U.S. citizen, or a legal immigrants. Besides the identity status requirement, one must also meet all the following conditions: an income-level under the 100 percent FPL, ages 19 to 64, and be without health insurance for at least six months.[18] In 2004, due to state budget cuts, the program closed new enrollment.[19] However, in an effort to evaluate the effects of having Medicaid coverage and to determine an increase in enrollment, in 2008, Oregon Health Plan re-opened its enrollment on a lottery system to allow a limited number of people to enroll in OHP Standard and OHP Plus.[20] About 90,000 low-income adults signed up for the lottery.[21] Of those selected, approximately 10,000 individuals obtained Oregon Medicaid, and around 45,000 were not selected for Medicaid but were included in the study as a control group.[22]

In analyzing how much an individual utilized healthcare services, assessing health outcomes, and ascertaining financial hardship among other effects of having Medicaid coverage, the study found that health insurance increased the use of outpatient care by 35 percent, the use of prescription drugs by 15 percent and hospital admission by 30 percent.[23] Researchers also found that this program reduced the probability of people having to borrow money to pay medical bills by 40 percent.[24] The effects of having Medicaid showed that individuals no longer need to become bankrupt in order to receive basic health services or to treat any expensive chronic illness.

The results of the Oregon Health Experiment heavily influenced how the Affordable Care Act (2010) came to be. The results proved useful for other states to estimate the effects of expanding their own Medicaid programs. It showcases that expanding Medicaid can reduce health spending in the short run and make a difference to the uninsured – they utilize health services and are less likely to become financially insecure from paying expensive medical bills.[25] Most importantly, the study proved that when offered proper health insurance, people utilize healthcare services.

Affordable Care Act

Considering the health impact of the Oregon Experiment, in 2010, Congress passed the Patient Protection and Affordable Care Act (ACA) as a mandatory expansion of Medicaid eligibility by both income levels and age groups in all states. With ACA Medicaid expansion, non-disabled, non-elderly, and childless adults (ages 19 - 64) may be eligible for Medicaid. The ACA also expanded Medicaid coverage by reducing restrictions based on gender or family status. It also expanded Medicaid's income requirement to 138% of the federal poverty level (133% of the basic requirement plus a 5% income disregards due to state variations in income calculations).[26] However, in 2012 the U.S. Supreme Court ruled that the federal government could only lawfully withhold federal funding for the ACA expansion, not state funding for the existing Medicaid program, if a state declines to adopt the expansion.[27] As a result, states had the discretion to decide a) whether to expand Medicaid to their residents and b) how and to what extent to provide healthcare insurance services to newly eligible

populations. In states that did expand Medicaid under the ACA, the insured rate steadily increased among U.S.-born individuals and naturalized U.S. citizens as well as Emergency Department (ED) visits by 2.5 more visits than in the non- Medicaid expansion states.[28] The comparative study among expansion states and non-expansion states reflected an increase in Medicaid coverage of ED visits by 8.8 percent, accompanying a 5.3 percent decrease in the uninsured rate.[29] By 2018, approximately 12.2 million adults became newly eligible for Medicaid.[30] As of 2023, 40 states and Washington D.C. have adopted expanded Medicaid, while 11 states have yet to expand Medicaid coverage. Nonetheless, access to ACA-related health insurance programs still excluded immigrants based on their time of residency (ineligible for under five years of residency) and documentation status.[31]

The restrictions based on immigration status and residency have explicitly deepened a historical exclusion in the U.S. society and disparities in the U.S. healthcare system.[32] Even with state adaptation of ACA guidelines, states have broad discretion over implementing policies relevant to the well-being of immigrants, such as Medicaid.[33] For instance, non-expansive states may act passively in their Medicaid application review process and choose not to waive the five- year waiting period for eligible lawfully present immigrant children and pregnant women (such as refugees and asylums), or they may choose not to cover some basic but optional healthcare services including dental care and personal care services for people with disabilities.[34] Furthermore, in states with anti-immigrant policy climates, authorized immigrants have a lower Medicaid approval rate despite their eligible statuses and those who are eligible experience long waiting periods and hostility, leading to inaccessibility of healthcare services.[35] These explicit and implicit barriers blur the public recognition of healthcare coverage necessity and health equity for federally ineligible immigrants. With federally ineligible immigrants being excluded from receiving ACA benefits and legal permanent residents' five-year waiting period for ACA approval, this group would likely face greater burdens and unnecessary costs when the illnesses turn into chronic illnesses or emergent cases.[36] As a result, hospitals, health insurance plans, administrators, and health providers all sooner or later share the same burden from systematically inefficient preventive care and consequential overuse of health resources.[37]

Massachusetts Health Care Reform

Post ACA, Massachusetts created multiple healthcare programs by considering residency, age, and income aside from citizenship status to distribute a range of healthcare benefits. Medicaid expansion programs such as MassHealth and Health Safety Net were implemented for Massachusetts residents of any citizenship status with income eligibility to receive some health coverage.[38] The trajectory of Massachusetts' healthcare reform to include immigrants highlights how states amidst exclusionary federal healthcare reforms can provide coverage to immigrants and other vulnerable populations.

MassHealth required all Massachusetts residents to have some health coverage.[39] Documented immigrants such as long-term legal permanent residents (LPR) who met federal eligibility requirements and those with temporary protected status with incomes of less than 300% FPL were eligible for MassHealth. Legal permanent residents who did not meet federal requirements but did meet state eligibility requirements in accordance with ACA guidelines could apply for the Health Safety Net program, a state-funded program that covers outpatient services and includes most healthcare services with the exception of hospitalization.[40] However, HSN had several limitations. First, HSN recipients still had to pay

penalties for not fulfilling individual insurance mandates until the mandate was removed in 2019.[41] Second, the HSN program coverage was only available at Massachusetts community health centers and hospital clinics, which based on the recipient's geographic location, may not be accessible.[42] Third, HSN lacked the sustainability to maintain its quality healthcare accesses and services due to funding shortages since 2010.[43] While the uninsured rate fell to 3.1% from 12.5% (before the healthcare reform) after the implementation of MassHealth, this statistic does not include ineligible people such as undocumented immigrants, who made up 15% of the Massachusetts population at the time.[44] Undocumented immigrants were excluded from the Medicaid state expansion and are only eligible for emergency care.

To this day, undocumented immigrants are only eligible for MassHealth Limited – a limited version of Medicaid that exclusively covers emergency healthcare services. By 2017, Massachusetts Medicaid Policy Institute reported an estimated gap of 630,000 people that were not eligible for any health program under MassHealth, with the majority of them being undocumented immigrants.[45] That said, important for our analysis, the case study of Massachusetts reform outlines how citizenship status influences individuals' coverage options under different policies. Through a series of reforms, including the expansion of public programs and the creation of a health insurance exchange, Massachusetts has clearly demonstrated the potential for reducing the number of uninsured, including immigrants through legislative action and shared responsibility. Massachusetts healthcare reform is a critical case for our project when creating and evaluating solutions to extend healthcare to 19-41-year-old undocumented immigrants.

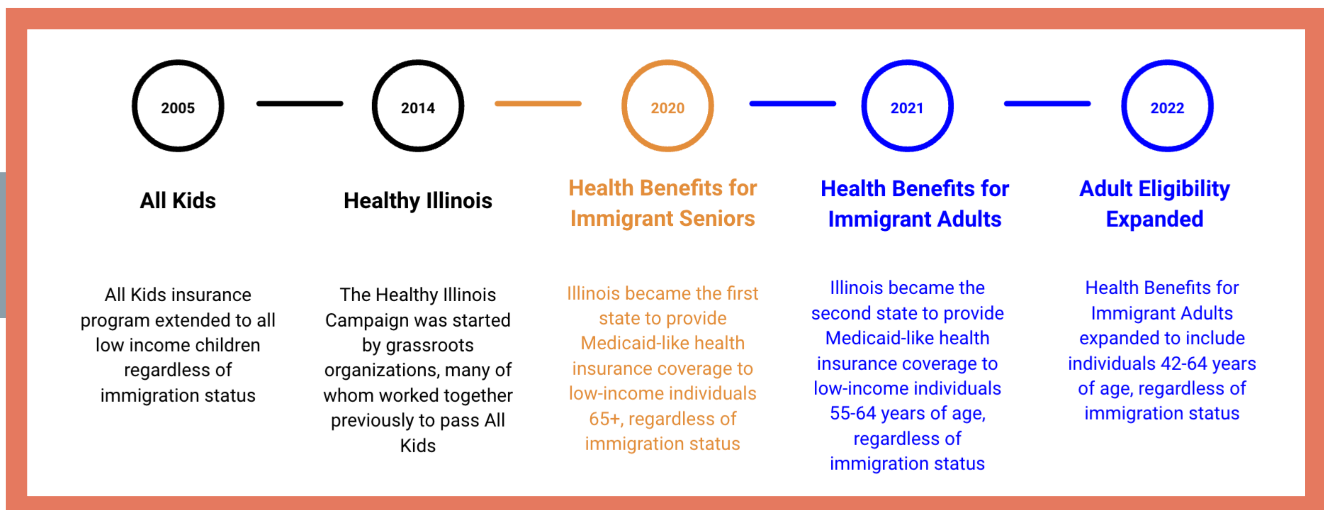
California Medi-Cal

Of the Medicaid expansions, California has been a leader in expanding Medicaid eligibility to federally ineligible immigrants and serves as a model for our research to build solutions for the Illinois healthcare system. In 2016 California created the Health4All Kids program, which expanded Medi-Cal eligibility to all California children (under the age of 19) in low-income families, regardless of their immigration status, including federally ineligible immigrant children.[46] This expansion led to a 34% decrease in uninsured undocumented children in California and reduced the health disparities among low-income children between undocumented and documented/citizen children by 56%.[47] This expansion effectively helped close the health coverage gap between low-income undocumented children and U.S. citizen children of California. In 2019, following the Health4All Kids expansion, California implemented the Younger Adults Expansion program, which expanded Medi-Cal eligibility to adults ages 19-25 years old regardless of immigration status. It was the first step in increasing access to preventative care for the nation's most uninsured population. Studies confirm that the program has significantly increased the percentage of early diagnosis of many chronic illnesses, such as cancers.[48] By September 2021, this expansion brought 96,193 young adults into the Medicaid program, further reducing the uninsured rate statewide.[49] The last Medi-Cal expansion occurred in 2022 and increased full-scope Medi-Cal eligibility to low-income individuals ages 50 and older, regardless of immigration status.[50] Since this recent expansion is fairly new, there is limited data on the impact of the program. Still, we can expect that healthcare costs have decreased for enrollees ages 50 and over since this age group tends to utilize healthcare services more than the younger age groups. Most recently, California has approved, through their 2023 budget, a Medi-Cal expansion to the remaining group of 26-49-year-old FII, effectively closing their coverage gap.[51] The expansion is set to be implemented in 2024.[52]

California offers an exciting study for expanding healthcare coverage for immigrants and in relation to closing the health coverage gap in Illinois. It is different from Illinois in the sense that California has a larger immigrant population and a higher cost of living. Yet, although more expensive for the state to fund, California continues to expand its Medicaid program to all of its residents, regardless of immigration status.

Illinois Healthcare Expansions

To expand access to healthcare coverage and services for the benefit of eligible and ineligible immigrant groups and promote the state's overall welfare, Illinois has developed its own Medicaid-like healthcare programs to include low-income populations not covered by the federal Medicaid program.[53] In July 2006, Illinois implemented a healthcare reform launching the nation's first universal coverage program for children, All Kids. It is built upon the state's Medicaid and State Children's Health Insurance Program (SCHIP) and is exclusively funded by the state.[54] All Kids offers health coverage, including regular medical check-ups, immunizations, hospital stays, prescription drugs, vision care, dental care, and eyeglasses to all uninsured children, regardless of their family income level or immigration status. In particular, All Kids also covers special services like medical equipment, speech therapy, and physical therapy. Within a year of its launch, approximately 50,000 previously ineligible undocumented children in Illinois enrolled to receive health insurance.[55]



Building upon All Kids, Healthy Illinois has led efforts to expand healthcare coverage to other federally ineligible immigrants.[56] Immigrant healthcare expansion bills were introduced in 2020, 2021, and 2022. These expansions ended up passing through the legislated budget process each of the last three years (for 65+, 55+, and 42+ respectively) via a Budget Implementation Bill (BIMP), similar to the congressional omnibus budget resolution acts at the national level. As a result, the Illinois state legislature granted funding for the Department of Health and Family Services to create and administer the Health Benefits for Immigrant Seniors Program (HBIS) and Health Benefits for Immigrant Adults (HBIA).

For both programs, eligible undocumented immigrants could apply online through the statewide Applications for Benefit Eligibility (ABE) portal that administers a variety of state programs, including Medicaid and Supplemental Nutrition Assistance Program (SNAP), or apply through mail.[57] Applicants can also go in person to an application assistant or community service agency – with agents available in 59 languages – that can assist with the application process and answer any concerns they may have.[58]

As the table below summarizes, HBIS offers health coverage to federally ineligible immigrants 65 years and older with incomes below the 100 percent Federal Poverty Level (FPL), regardless of their immigration status. The 100 percent FPL corresponds to the Medicaid eligibility level in state without Medicaid expansion, even though U.S. citizen seniors are able to qualify for Medicare.[59] In 2022, 100 percent FPL equaled an annual income at or below $13,590 for a single individual and $18,310 for a couple.[60] The income threshold for HBIS is extremely low for immigrant seniors, especially considering that seniors on Medicare have expansive coverage that is not dependent on income (income affects how much individuals pay for different plans but does not affect eligibility).[61]

HBIA covers adults ages 42- 64 with incomes below 138 percent FPL, regardless of their immigration status. Following the 2022 FPL guidelines, 138 percent equals an annual income at or below $18,754 for a single individual and $25,268 in combined income for a household size of two.[62] The income requirements for both programs are in line with Medicaid income eligibility requirements for U.S. citizens, as per the ACA.

HBIA and HBIS programs cover healthcare services such as hospital visits, doctor visits, and prescription drugs but do not cover nursing facility services or home and community-based services (HCBS) as an alternative to facility services. Health care providers (e.g., hospitals) are reimbursed for providing services for immigrants enrolled in either program at the same rate if services provided were for Medicaid or CHIP enrollees. Additionally, the authorizing Illinois state legislation requires the rules for HBIS/A to be "at least as restrictive as the rules for medical assistance."[63]

Unlike the federal Medicaid or CHIP programs that exclude immigrants based on their status, HBIA and HBIS are explicitly designed to include immigrants who have historically been excluded, such as legal permanent residents who have resided in Illinois for less than five years (i.e., green card holders), and undocumented immigrants who meet other program requirements.[64] Within three years, about 16,000 federally ineligible immigrants have enrolled in HBIS. In addition, within eight months, nearly 35,000 federally ineligible immigrants have enrolled in HBIA. Yet, policymakers believe the number of enrollees has been underestimated due to unreliable Census data for immigration status and the rollout of the programs during the SARS-CoV-2 (COVID-19) pandemic.[65]

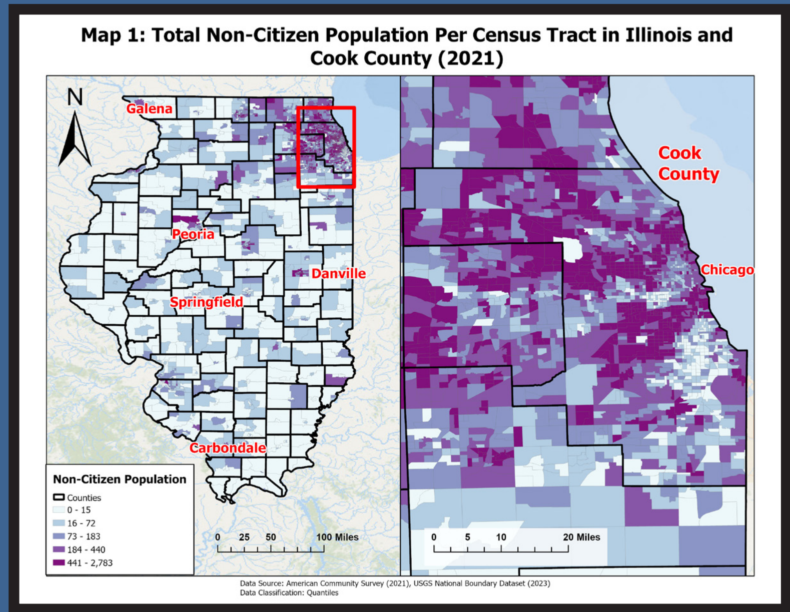
Eligibility Breakdown of HBIS and HBIA

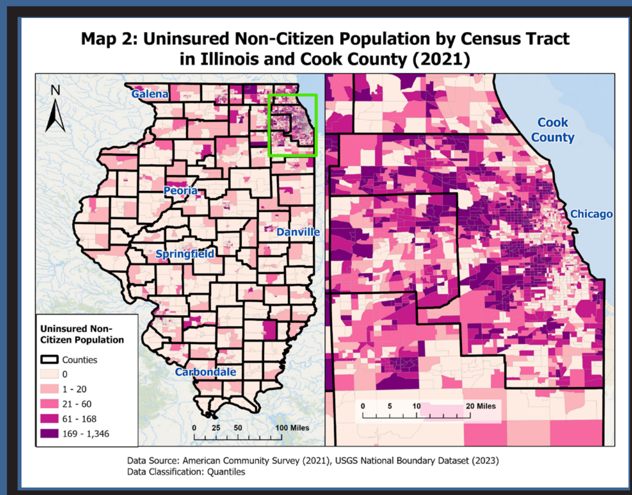
Eligibility Breakdown of HBIS and HBIA		
Requirement	**Medicaid**	**Health Benefits for Illinois Adults/Seniors**
Income	Seniors: under 100% FPL Adults: under 138% FPL	Seniors: under 100% FPL Adults: under 138% FPL
Reimbursement	Providers are reimbursed at a state approved rate for various services	Providers are reimbursed at a state approved rate for various services
Funding	Federal + state govt.	State govt.
Covers services	Doctor and hospital visits, rehabilitative services, home health, mental health and substance use disorder services, dental and vision services, prescription drugs, and long-term care services	Doctor and hospital visits, rehabilitative services, home health, mental health and substance use disorder services, dental and vision services, and prescription drugs. **No long-term care services.**
Residency	Citizens, refugees/asylees, legal permanent resident for **more than** five years	Legal permanent resident (LPR) for **less than** five years, and undocumented immigrants

With a total of about 12.8 million people, Illinois has the fourteenth largest immigrant population, including 14 percent of its population being foreign-born.[66] Of the immigrant population, an estimated 400,000 are undocumented and ineligible to apply for federal healthcare programs due to their residency status and non-employment-sponsored health insurance.[67]

Using the American Community Survey data from 2021 for the following categories: total number of federally ineligible immigrants (**Map 1**); total number of federally ineligible immigrants who are non-citizens without health insurance (**Map 2**); and total population with limited English proficiency (**Map 3**); we proxied the location of Illinois' FII population. As a disclaimer, the ACS does not separate data on non-citizen foreign-born populations by their legal status, therefore the maps below include federally ineligible immigrants and all other non-citizen foreign-born individuals. Within the foreign-born population, non-citizens include immigrants with various citizenship status, including undocumented immigrants. However, it is not possible to distinguish between documented and undocumented populations using ACS data.[68]

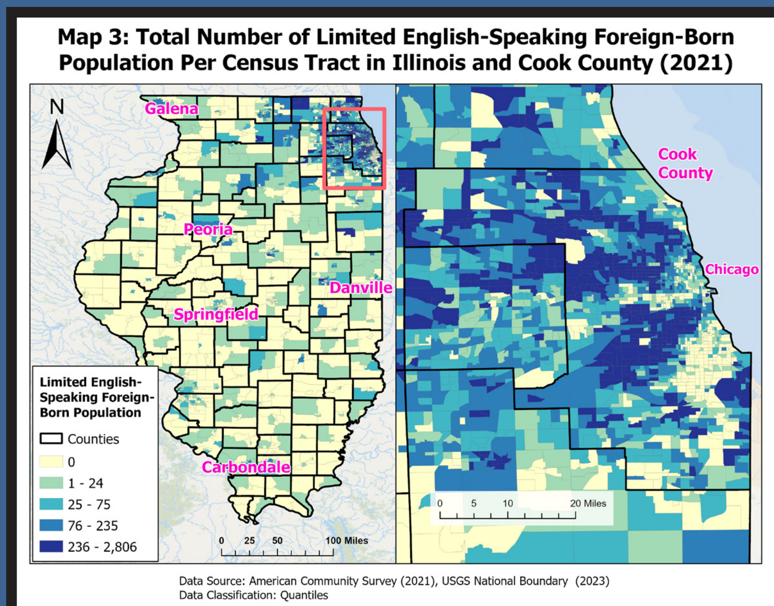
Maps 1-3 suggest a near 100% correlation between immigration status and insurance status: if someone is an immigrant in Illinois, they very likely do not have health insurance. This is consistent with research that indicates legal status is a social determinant of health in addition to lack of English proficiency by acting as barriers to accessing health insurance and overall leading to health disparities within the FII population.[69] Second, they also show a similar pattern with higher concentrations of immigrant populations living in Cook County and Northeast Illinois, with some FIIS sparsely located throughout the state.





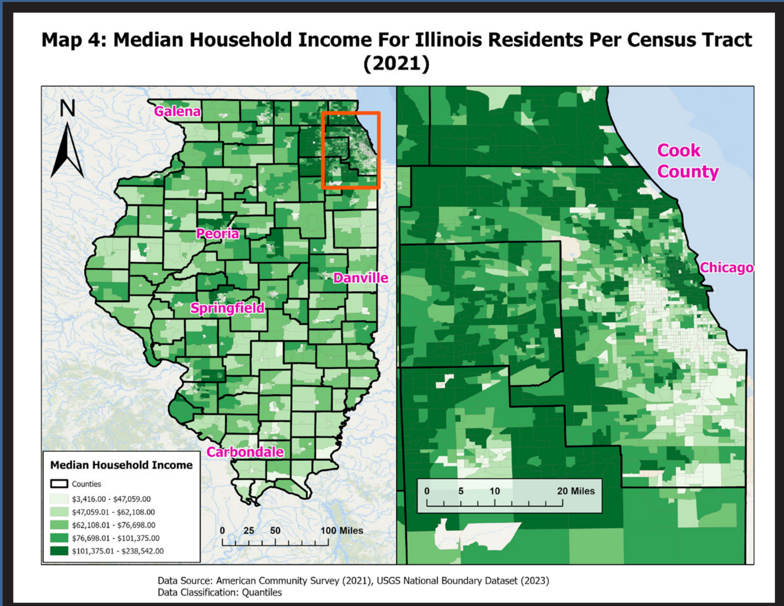
From our geospatial analysis, we also learned that most of the immigrant (non-citizen) population without health insurance live in urban areas such as Cook County and surrounding Collar Counties as represented by the area in the green square (**Map 2**). These are areas indicated by darker shades of purple and are most likely urban areas with elected officials that better represent immigrants versus elected officials in rural parts of Illinois, which is the entire area outside the green square.

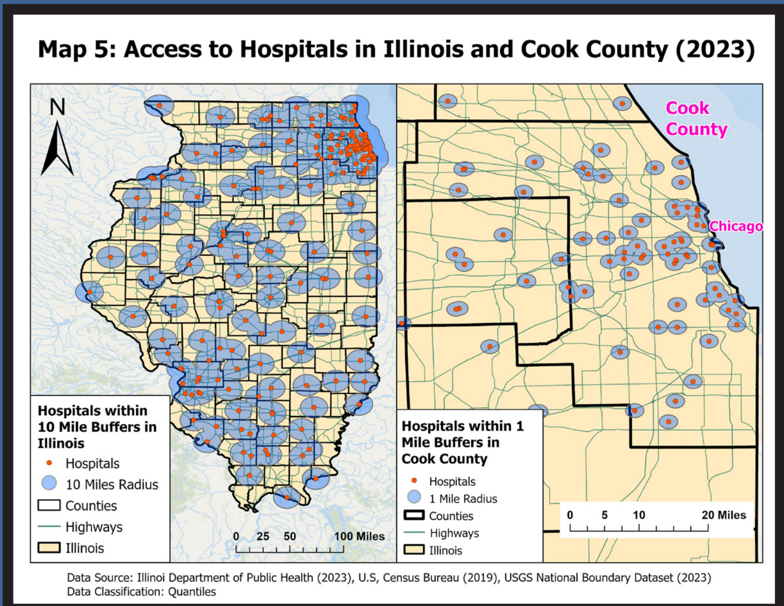
The immigrants that live in the rural counties often have the least amount of healthcare resources.[70] Thus HBIS/HBIA wouldn't just benefit urban counties where the highest immigrant population resides. The healthcare expansion would benefit the whole state. These rural areas with high immigrant populations that have no health insurance are what the Department of Health and Family Services need to reach to enroll these populations into HBIS or HBIA.



Combined with **Maps 1-3, Map 4** shows immigrant populations living in areas associated with poverty, consistent with previous research that documented how immigrants are more likely to be overrepresented in low-wage sector jobs, have lower incomes, and face increased challenges affording employer-sponsored health coverage when it is available or individual plans through the market.[71] Finally, **Map 5** shows the distribution of public hospitals across the state with a large concentration near Cook County, specifically Chicago and the population center, suggesting that accessibility in terms of transportation for FIIs in Cook County may not be a salient issue.

These geospatial visualizations provide us with a better sense of where federally ineligible immigrants live and how their environment impacts their health status and health outcomes. In the following sections, we discuss findings from Illinois' HBIS and HBIA Medicaid-like programs as well as the current window of opportunity in the Illinois' legislature to extend health insurance access to 19-41 federally ineligible immigrants.





Policy Window to Expand Illinois Healthcare Eligibility

The mechanism for closing the eligibility gap is legislative action. The state legislature holds the authority over the state public health code, where the current eligibility guidance stands. The legislature also controls the state budget, which must be adjusted to authorize funding for an additional expansion. The work of advocacy groups like Healthy Illinois and strong supportive political majorities in the legislature has created a policy window for passing healthcare expansion bills.[72] In the previous legislative session, a similar expansion bill was introduced but not passed. However, the legislative sponsors from previous efforts still consider it an important part of their political agenda and are trying to pass an expansion bill again.

The expansion policy can be enacted through various existing legislative mechanisms. HBIS was enacted via a "Budget Implementation Bill" (BIMP) and used language from an independent House Bill (HB 4981). The state budget bills, known as Public Act 101-0636, codified the expansion by authorizing and appropriating funds to HBIS. Similarly, authorizing language in the FY2022 BIMP and budget bills created the HBIA program. Lawmakers can use the same mechanisms to pass the 19-41 expansion. The current legislative makeup is also favorable for passing this policy, as there are Democratic supermajorities in each house. Current Governor J.B. Pritzker (D) was also supportive of the previous expansion efforts and spoke to "healthcare, including mental health and substance use treatment as well as reproductive health services" as being key policy and budget priorities for his administration.[73] Expanding coverage depends on the medical treatments that the newly eligible population would use and state administrative costs. The state's projected cost for the 19-41 age group was $203.8 million in 2022. It has not provided updated cost estimates in 2023.[74]

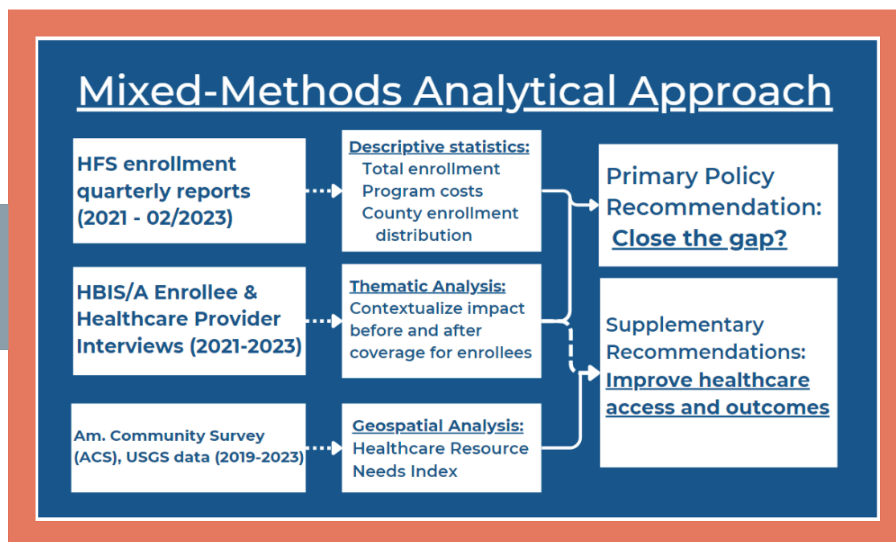
This policy would be difficult to dislodge once established due to its popularity and impact on enrollees and the public health system. Although it is generally difficult to revoke public benefits after implementation, these specific healthcare expansions benefit a population without much political leverage due to a lack of citizenship and lower economic mobility. This healthcare expansion is, however, supported by a broad stakeholder group of healthcare and social justice advocates. The Healthy Illinois Campaign is endorsed by healthcare providers and networks, community organizations, non-profit institutions, representatives of academic and law enforcement institutions, faith institutions, and civic leaders.[75] The full details are available in Appendix A. Many healthcare providers support further eligibility expansions, and they can wield more political leverage for people experiencing poverty and being undocumented.

Methodology

For this report, Healthy Illinois requested the following analysis of HBIS and HBIA programs to aid its goal of expanding public healthcare eligibility to all federally ineligible immigrants. Using a mixed-method approach, we executed our analysis in two phases:

1. ***Health impact analysis:*** using HBIS and HBIA quarterly enrollment alongside interview data from enrollees and health care providers, we analyzed enrollment trends, program costs, medical expenditures, and overall, what FIIs are using health insurance for.

2. ***Program assessment and policy recommendations:*** Using results from our health impact analysis and limited enrollment data by HFS, we identified areas of improvement. They include: making enrollment data available and accurate for the public to determine whether Illinois lawmakers should extend public health insurance eligibility to 19-41-year-old FII.



We used our health impact analysis and program assessment results to inform our policy options and, subsequently, our policy recommendations. To analyze the health impacts HBIS and HBIA have on federally ineligible immigrants' lives while also identifying how currently available data can further be deconstructed for a more accurate depiction of FIIs' accessibility to healthcare, we inform the policy decision of whether the state of Illinois should extend public health insurance to FIIs ages 19-41 through a Medicaid-like program, or whether they should do nothing and continue with the current state of excluding 19-41-year-old from health coverage.

As a reminder, this report's immigrant population consists of undocumented immigrants and legally-residing immigrants with less than five years of residency, whom we refer to collectively as 'federally ineligible immigrants' (FII). While we acknowledge that Medicaid-like programs extend eligibility to both groups, approximately 75% of the population are undocumented immigrants who will never qualify for public health insurance without some policy or political intervention. With that, unless the legal status is specifically stated, it is assumed that the results of this analysis refer to both populations within FII.

Phase 1: Health Impact Analysis

For the health impact analysis, we used a mixed-methods approach combining enrollment trends, geospatial analysis, and common themes/patterns identified from the following data sources:

1. Publicly released Department of Health & Family Services (HFS) quarterly reports of HBIA and HBIS enrollment data from December 2021 - current (last report was February 2023)[76]

2. Focus group discussion and semi-structured in-depth interviews of enrollees conducted by Healthy Illinois

3. Focus group discussion and semi-structured in-depth interviews of Illinois medical providers[77]

4. US Census, USGS, and American Community Survey (ACS) shapefile and data tables[78]

Using HFS quarterly reports, we analyzed enrollment data longitudinally to examine enrollment patterns, programs costs, county-level, race, and language breakdown across both programs, update current total estimates, and filtered by both program and age groups between HBIS and HBIA. We examined 1) the total number of enrollees, 2) the incremental change of enrollees per quarterly report, 3) reimbursement payments by HFS to medical providers, 4) distribution of HFS claims by type (e.g., inpatient, outpatient, pharmacy, other), 5) per capita enrollee costs, and 6) demographic data including enrollee race, ethnicity, and preferred language.

Using HFS quarterly reports and ACS data, we conducted a geospatial analysis to examine the distribution of enrollees by county across Illinois to see where HBIS and HBIA enrollment has been successful across the state and where outreach is needed. We created a needs-based index using social determinants of health (e.g., median household income and English language proficiency) and logistical considerations (e.g., proximity to hospitals) to make supplementary policy recommendations regarding allocating resources for improving HBIS and HBIA enrollment.

While HFS quarterly reports provide a general overview of how many federally ineligible immigrants are enrolling into the programs and program costs, the lack of available granular public data leaves us without information about what federally ineligible immigrants' lives were like before enrolling in HBIS and HBIA, and how access to medical insurance has affected their lives, health conditions, and medical treatments received, among other relevant issues. To provide a more holistic picture of the impact of HBIS and HBIA, we analyzed public media statements, focus group discussions, and pre-recorded in-depth interviews of enrollees by Healthy Illinois, as well as interviews we conducted with healthcare providers. Our interviews with healthcare providers were 30-45 minutes, conducted via Zoom, and recorded. A full list of medical providers is available in Appendix E.

Using the available interview data, we conducted a thematic analysis where we identified the following themes:

- Background information on the lives and experiences of HBIS and HBIA enrollees before health insurance versus after health insurance to give context to the HFS quarterly reports in terms of what the state money has been spent on and how it has impacted enrollees and their families
- Health conditions of enrollees, including pre-existing conditions as well as conditions diagnosed via HBIS and HBIA enrollment
- Medical treatments and services HBIS and HBIA enrollees have received since they have had access to public health insurance
- Themes around the financial stress and burden associated with medical insurance and treatment are for FII populations and how HBIS and HBIA have impacted their lives
- What the strengths and weaknesses of HBIS and HBIA are to this point and how this can inform policy implementation

Phase 2: Program assessment and policy recommendations

In addition to our policy evaluation of determining whether eligibility should be expanded to 19–41-year-old FIIs, we analyze the current strengths and weaknesses of HBIS and HBIA to identify areas where the programs have been successful, areas for improvement, and what current available data does and does not tell us. From ensuring eligibility leads to actual enrollment to the availability of quality enrollment data, we use our geospatial analysis to conduct a need-based analysis highlighting which regions have the greatest disconnect between eligibility and enrollment and likely need more education outreach resources.

Our policy recommendations thus also focus on how to improve outreach and enrollment, improve access to healthcare and treatment, address issues federally ineligible immigrants have in navigating the HBIS and HBIA applications and healthcare system, and equitable data gathering practices and dissemination to make the system more efficient and effective at providing coverage now and in the future.

Limitations

The Challenge of Data Limitations in Assessing Coverage Impact

One of the most significant challenges to assessing the potential efficacy of expanding the Health Benefits for Illinois programs to include all adults is the limited available quantitative data for the existing programs. Because both programs are in their early stages, there are only about two years of data for HBIS, which launched in 2020, and one year for HBIA, which was implemented in 2022. In addition, the lack of disaggregation of enrollment data leaves more questions than answers. For instance, no data on diseases or treatments received for HBIS/A enrollees exist. Information on the health conditions for which patients receive treatment under HBIS/A, and their prevalence among the non-citizen population, would allow for a more thorough evaluation of the relationship between the programs and health outcomes. Regarding All Kids, while data are disaggregated by citizenship status, they are not by age or any other characteristic. If there were data on the types of medical conditions affecting this group, one could analyze how losing healthcare access at age 19 would affect their medical treatment needs as older adults. As the quote below reveals, FIIs are phasing out of All Kids; however, without detailed data, the exact number in any given year is unknown.

"I had All Kids in the past when my family came to the US, but then they took away my coverage when I turned 19. No coverage during the entire pandemic. I have had recent problems and had to visit the hospital and ER. I have used charity care from nonprofit hospitals ...."

– Federally ineligible immigrant[79]

Finally, considering that HBIS/A rolled out during the COVID-19 pandemic, the pandemic likely influenced enrollment numbers and the deployment of outreach and education to potential eligible immigrants. All these factors may limit our ability to confidently identify the programs' health and economic impacts on Illinois undocumented immigrants.

Estimating the Number of Undocumented Immigrants in Illinois

In analyzing the impact of the programs, we acknowledge that there is limited data on the number of undocumented immigrants in Illinois. Databases such as the American Community Survey (ACS) and National Health Interview Survey (NHIS) and National Health Interview Survey (NHIS) do not separate data on noncitizen foreign-born populations by their legal status, making it difficult to obtain an accurate number of the immigrant population in any state and how many may be eligible for social safety net programs.[80] Given their precarious residency status, many undocumented immigrants do not participate in traditional population counting methodologies, such as filling out the U.S./ census or any survey asking for their immigration status.[81] This project's estimated number of undocumented individuals for this project comes from advocacy and research collaborators with Healthy Illinois. For example, researchers at the Urban Institute developed a methodology to estimate households "likely" to be undocumented based on certain characteristics reported in the American Community Survey for 2013-2017. While the estimate that we use in our report derives from this well-vetted method, there is no complete method for determining the exact population of undocumented immigrants without a margin of error.[82]

By understanding the limitations of our current research, our project revealed the dearth of data for conducting ongoing evaluations of the various immigrant healthcare coverage expansions. Future policy choices, including the continuation or expansion of the existing programs, would be enhanced by establishing a program of data gathering and program evaluation. For enrollment data, the gaps and limitations we have already observed are opportunities to improve the system of program data collection. For instance, in identifying and addressing areas where data gathering practices can be improved (i.e., disaggregating data by year, status, and age), there is the opportunity to arrive at more confident and accurate data analysis in the future. Similarly, the information obtained through in-depth interviews with HBIS/A enrollees and healthcare providers adds to the quantitative data analysis to leverage the stories of how undocumented immigrants have used the program and identify what areas of the program are working well and where it could be improved.

Health Impact Analysis of HBIS and HBIA Programs

Our health impact analysis is part of the program evaluation to inform the policy decision about whether or not to fill the 19-41 gap. Using publicly available quarterly data from the Department of Health and Family Services (HFS), our longitudinal and cross-sectional quantitative analysis of HFS reports examines HBIA and HBIS enrollment patterns, program and per capita costs, and distribution of costs by medical claim type.

Enrollment Trends

Interviews with advocates for HBIS had originally expected enrollment figures to be a much smaller number, around 4,000 or so based on estimates they had received.[83] However, enrollment data revealed that as of the latest February 2023 HFS report, there are around 35,000 enrollees in HBIA and 16,000 enrollees in HBIS for a near total of 51,000 federally-ineligible immigrants enrolled (**Figure 1**).

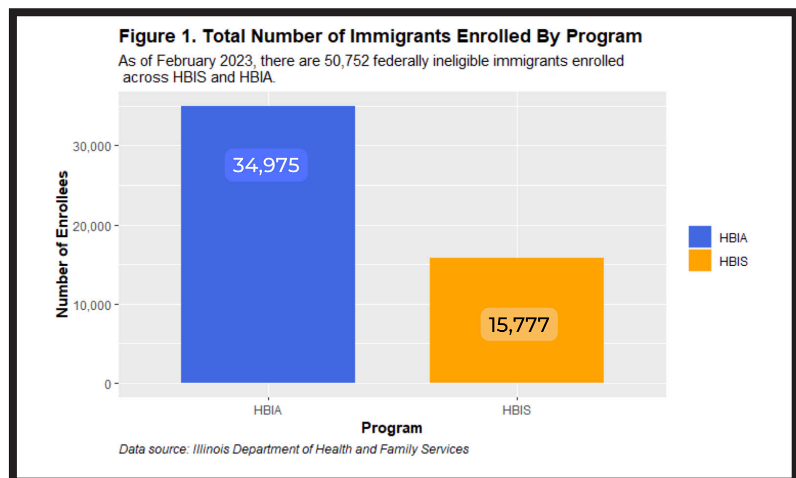


Figure 1. Total Number of Immigrants Enrolled By Program
As of February 2023, there are 50,752 federally ineligible immigrants enrolled across HBIS and HBIA.
Data source: Illinois Department of Health and Family Services

When sub-setting by age, there are 21,880 42–54-year-old FIIs enrolled making it the largest age group to be enrolled. The second largest age group is 65+ year olds at 15,777 enrollees followed by 13,095 55–64-year- old enrollees (**Figure 2**).

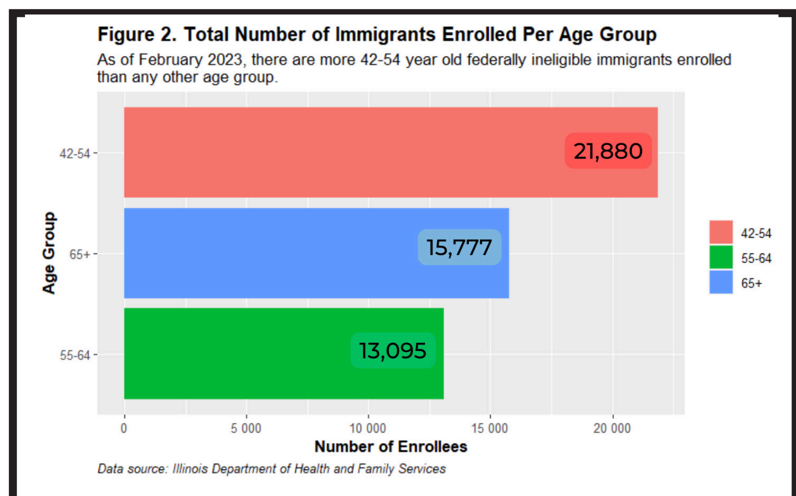


Figure 2. Total Number of Immigrants Enrolled Per Age Group
As of February 2023, there are more 42-54 year old federally ineligible immigrants enrolled than any other age group.
Data source: Illinois Department of Health and Family Services

Consistent with our geospatial analysis of FIIs living in Cook County, a high number of HBIS and HBIA enrollees were also concentrated in Cook County. **Map 6** shows areas with fewer HBIS/A enrollees, indicated by a lighter blue or orange while areas with larger numbers of HBIS/A enrollees are indicated by a darker shade of blue or orange.

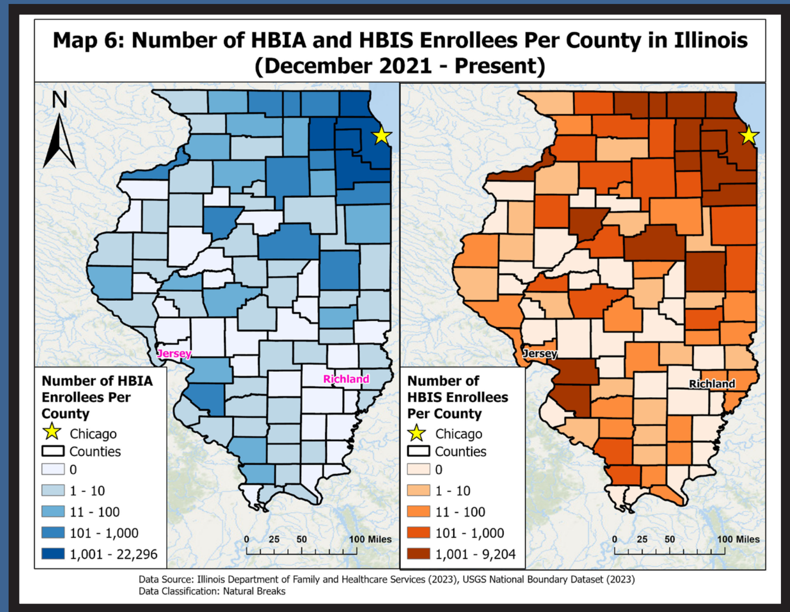


Table 1 and Table 2 represent the percentage and the raw number of quarterly changes in HBIS enrollment in Cook County. For **Table 1**, within the first quarterly report spanning from December 2020-March 2021, 2,999 federally ineligible immigrants were enrolled in HBIS. By the second quarterly report, 855 more federally eligible immigrants enrolled, representing a 29.5% increase in enrollment. Over the past two years, the incremental percentage increase across quarterly reports has levelled off to 2-3%.

Table 1: HBIS Enrollment in Cook County: December 2020-Present

Month	Cumaltive Total	Cumaltive Total Difference	Percent Change
Dec 2020	0	0	-
Mar 2021	2999	2999	-
May 2021	3884	885	29.51 %
Jul 2021	4862	978	25.18 %
Sep 2021	5525	663	13.64 %
Nov 2021	5833	308	5.57 %
Jan 2022	6325	492	8.43 %
Apr 2022	7019	694	10.97 %
May 2022	7312	293	4.17 %
Aug 2022	8113	801	10.95 %
Oct 2022	8393	280	3.45 %
Dec 2022	8639	246	2.93 %
Feb 2023	9204	565	6.54 %

Note:
Source: Illinois Department of Health and Family Services

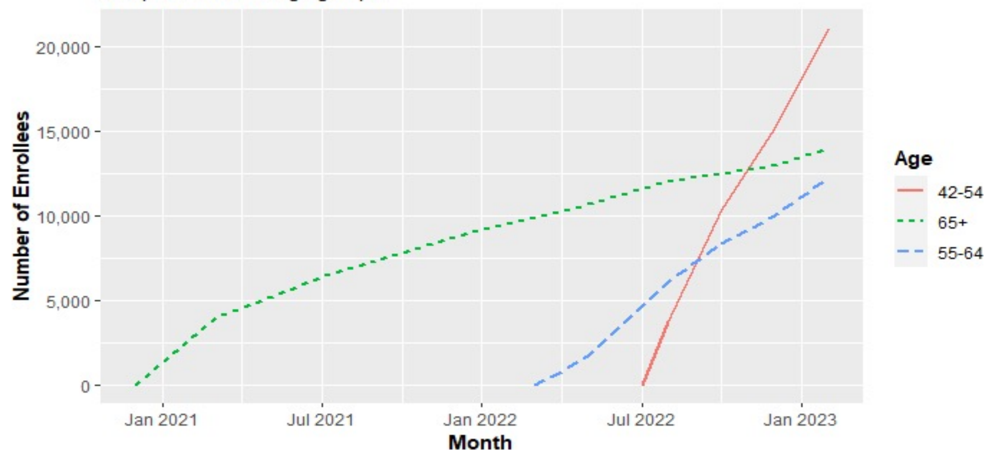
Table 2 shows the first two quarterly reports for HBIA spanning from April 2022 -May 2022 representing only enrollment change for the initial 55-64-year-old HBIA group, which began in March 2022. Since the expansion to include 42-54-year-old undocumented immigrants in HBIA began in July 2022, the table shows no enrollment change for that month, therefore we excluded it from our table. By August 2022, a month after HBIA was implemented, 5,753 newly eligible immigrants aged 42-64 enrolled in HBIA, representing a 421% change. Two months later, nearly the same amount of newly eligible undocumented immigrants enrolled. To date, the enrollment percentage change has remained around 30%.

Table 2: HBIA Enrollment in Cook County: April 2022-Present

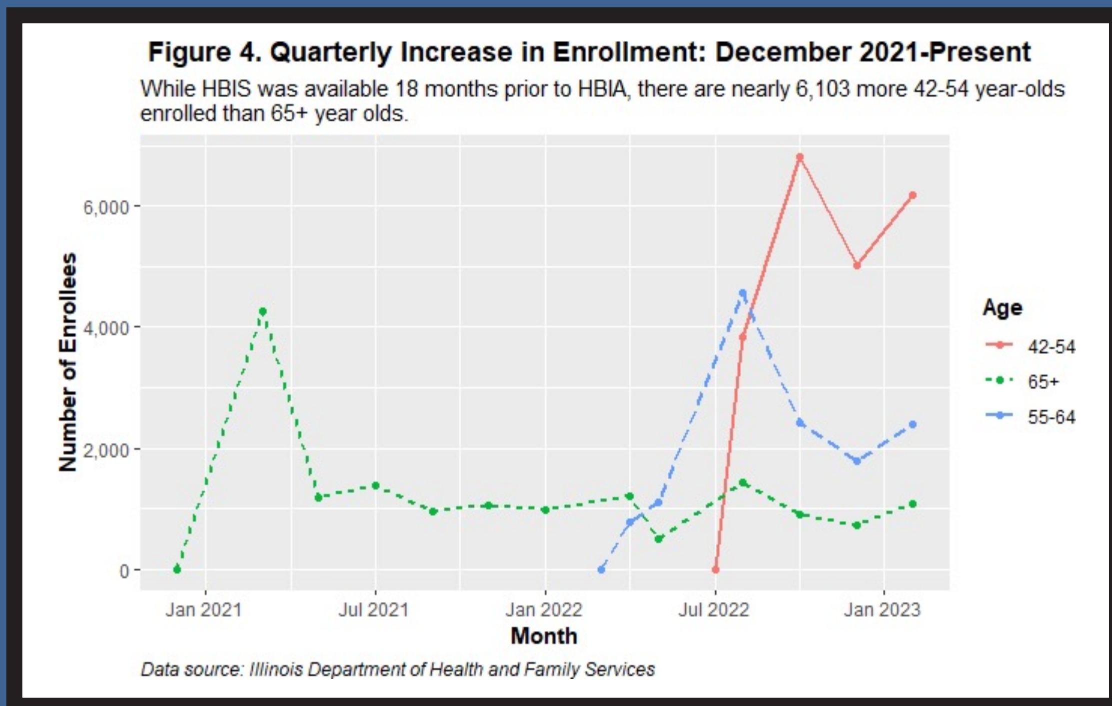
Month	Cumaltive Total	Cumaltive Total Difference	Percent Change
Apr 2022	587	0	-
May 2022	1,366	779	132.71 %
Jul 2022	1,366	0	0 %
Aug 2022	7,119	5,753	421.16 %
Oct 2022	12,875	5,756	80.85 %
Dec 2022	17,200	4,325	33.59 %
Feb 2023	22,296	5,096	29.63 %

Note:
Considering enrollment for 42-54 year old federally-ineligible immigrants under HBIA began in July 2022, we have excluded this month for accuracy purposes.

When comparing overall enrollment trends across quarterly reports, we see different enrollment patterns based on the age group, which helps explain the total enrollment numbers reported in the previous figures. Based on **Figure 3**., we see a negative relationship between age and enrollment rate, where the older the population, the slower the enrollment rate. In comparing the different age groups, we see that, despite enrollment starting a full 18 months prior for 65+ versus 42–54- year-olds, there are nearly 50% or 6,103 more 42-54 year-olds enrolled than 65-plus-year-olds.

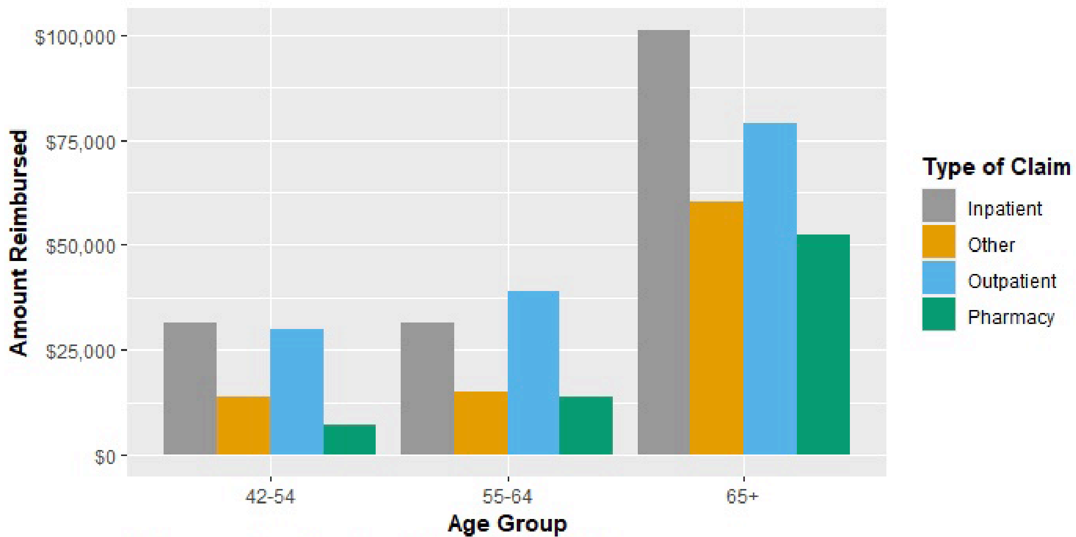


Based on **Figure 4**, it suggests that the total number of new enrollees added per quarter has stabilized for the HBIS population at around 1,100, absent additional enrollment outreach efforts. Due to the newness of HBIA (i.e., it began in July 2022), we have yet to state whether its quarterly enrollment increase has stabilized. These figures suggest that within the following two quarterly reports, the 42-55-year-old population within HBIA will likely overtake the 55-64 and 65-plus-year-old populations combined in terms of the total enrollee population. Additionally, these trends suggest that if a Medicaid expansion occurs for 19-41-year-old FIIs, they will likely represent an even larger and higher enrollment rate than HBIA enrollees.

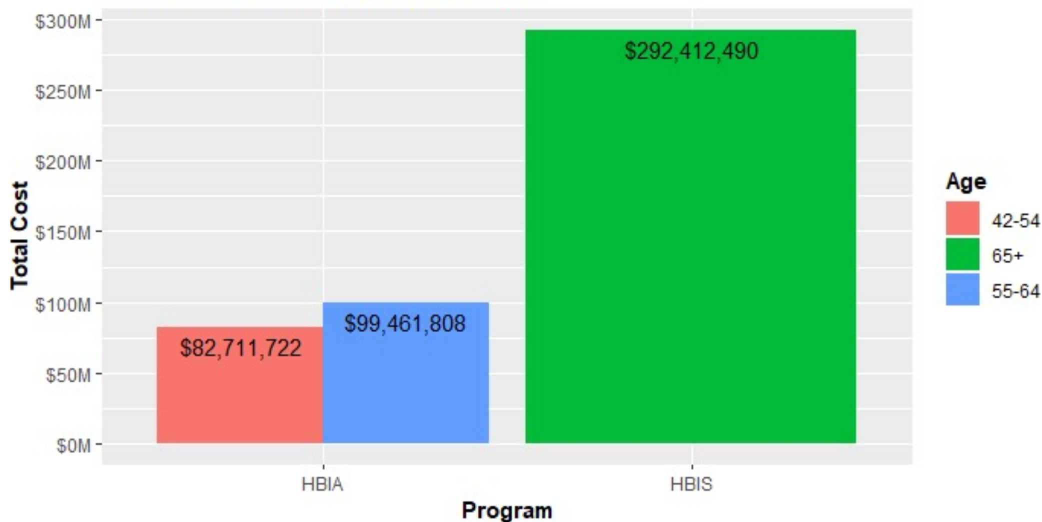


Insurance

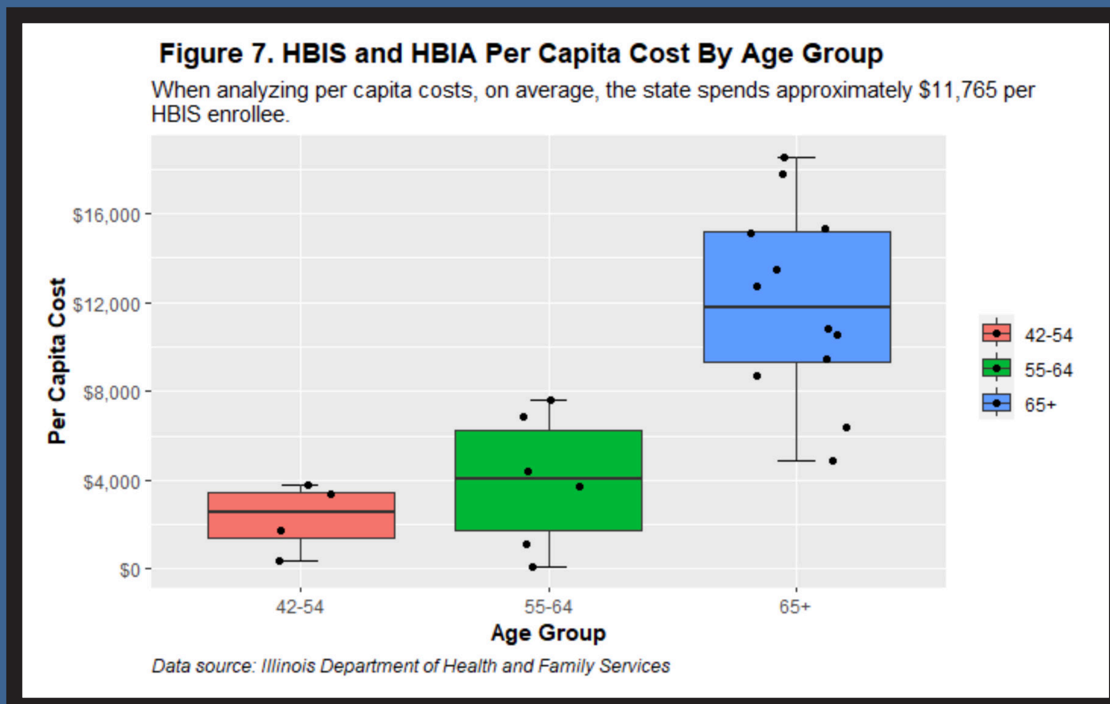
When disaggregating data by type of claim and age, we see that HBIS enrollees use their health insurance for inpatient and other services. Inpatient claims may include being under the care of doctors or nurses at medical facilities such as hospitals. Outpatient claims may include visits and procedures usually associated with primary care providers or outpatient settings for some surgeries. Other claims may include dental services, and pharmacy claims may refer to covering costs for provider-administered drugs. As shown in **Figure 5**, the rate of inpatients increases relative to outpatient services for FIIs ages 65 and over. Overall, claims data reveals federally ineligible immigrants' pent-up demand for healthcare services and the necessity to extend healthcare coverage to this vulnerable population. However, these results should be considered cautiously due to the inconsistency of HFS disaggregating claim type data and no available information on how HFS defines claim type data.



Using claims data to calculate the total amount spent on HBIS/A programs, the state has spent more than twice as much on HBIS than HBIA, with $292,412,490 and $182,173,530 respectively – a $110,238,960 difference between programs (**Figure 6**.).



By age group in HBIA, the state has reimbursed Medicaid providers for providing healthcare services to 42-54-year-old, $82,711,722 and $99,461,808 for HBIA enrollees ages 55-64 (**Figure 7**). When analyzing per capita costs, the state spends approximately $11,765 per HBIS enrollee. Within the HBIA program, the state spends approximately $4,061 per 55-64-year-old enrollee and approximately $2,558 per 42-54-year-old enrollee. The significantly higher per capita costs reveal the overall accumulation of severe untreated health conditions present in populations without access to health insurance, such as FII, in addition to the independent effects of advanced age. It is important to note that the HBIS programs only cover FIIs ages 65 and over who are below 100% of the FPL, leaving many still in need and without access to Medicare.



Preferred Language for HBIS and HBIA Enrollees

In addition to total enrollment and cost, we examined the preferred language of enrollees based on the most recent HFS report (see Appendix F, Table 3 for complete list). As of the most recent report, a total of over 48 different languages were reported by HBIS/A enrollees. Of the 50,000+ enrollees, 34.7% selected English and 57.8% selected Spanish as their preferred language. The remaining 8% of the HBIS/A enrollee population have their preferred language distributed across at least 46 other languages. We cannot estimate completely how many languages are represented due to 201 enrollees having their preferred language reported as ‘other’ by HFS.

Thematic Analysis: Who are the Enrollees?

While enrollment data shows us an aggregate view of the FII enrollee population, it does not give us any granularity into their life experiences, such as how they have been living without health insurance and what impact having health insurance has had on their well-being and health outcomes. To identify common themes, we conducted a thematic analysis of qualitative data, including public media statements, focus group discussions from enrollees, and interviews with healthcare providers.

Common Health Conditions and Diseases Treated

Table 4 shows a list of medical conditions and treatments that were constantly mentioned as federally ineligible immigrants' health experiences. The most frequent mentions were chronic diseases such as diabetes, heart disease, cancer, and osteoarthritis/joint pain. In accordance with the literature, high rates of chronic diseases are associated with undocumented immigrants and uninsured individuals.[84] Given that this list was made from a combination of both enrollee and provider interviews, we can infer that all the diseases and conditions mentioned are an accurate representation.

Table 4: List of Health Conditions and Medical Treatments From HBIS and HBIS Enrollee, Illinois Medical Provider Interview

Health Conditions:		
Alzheimer's disease	*COVID-19*	*Cancer*
Heart disease (generic)	*Kidney disease*	*Joint Replacement (osteoarthritis)*
Parkinson's Disease	*Fibromyalgia*	*Stress*
Vision	*Type 2 Diabetes*	*Dental*
Mental Health Issues	*Non-specific chronic organ diseases*	
Medical Treatments:		
Diagnostic tests	*Regular check-up*	*Joint replacement*
Glasses	*Dental surgery*	*Medication*
Surgery	*Hospitalization*	*Chemotherapy*
Radiation treatment	*Organ transplant*	*Immunotherapy*
Medical devices and supplies	*Register dietician*	*Appointments with Specialists*

Pent-up demand in accessing healthcare services

Many enrollees spoke about their health conditions and difficulties in accessing health services prior to enrolling into the Medicaid-like programs. For example, a federally ineligible immigrant shares his frustrations of not being able to afford health services due to their immigration status:[85]

"I believe immigration status is a huge part of not getting medical service here. We have to reach into our pockets and need to make it so healthcare is a universal right - not only because of immigration status but for all human beings."

HBIS/A programs represented an answer to accessing healthcare services. Once FIIs enrolled, they were able to afford medicines and surgery costs they either initially delayed accessing or were denied due to lack of health insurance. For example, in an interview with a daughter of an HBIS enrollee, Susan, revealed that, prior to enrolling her mom into HBIS, she was struggling to afford her mother's medicine needed for her post-surgery recovery. Once enrolled in HBIS, the program covered the costs of her mom's medicine. She says:[86]

"Debido a su condición, mi madre todavía necesita muchas citas médicas y medicina. Y como no tenemos seguro médico, los gastos médicos siguen para mi familia. Esto [HBIS] nos ayudó bastante"

"Due to her condition, my mom still needed to attend doctor's visits and take medicine. Since we are not eligible for health insurance, our family incurred a lot of costs. The HBIS program helped us a lot."

Similarly, Lina's mom disclosed that upon being approved into the HBIS program, she was able to receive the cancer treatment she was initially denied due to not having health insurance. Her daughter states: [87]

"The operation came just in time to save my mom's life thanks to the new health program. It is so hard and stressful to worry about your parents' health all the time as they get older and know that you cannot help them."

While some were able to benefit from the health expansion programs, other FIIs like Ocampo– a 55-year-old undocumented immigrant who delayed surgery due to costs related to lack of health insurance – shares that while he felt fortunate that his daughter had the time and financial stability to care for him, others may not have the same luck. He adds that if HBIA had been available sooner, he would have been eligible for and possibly receive treatment and/or surgery for his condition sooner. He claims:[88]

"Unfortunately, there are many more undocumented elders that live alone, or whose families cannot afford or do not have the ability to care for them as they age."

Healthcare providers also pointed out how pent-up demand for healthcare services by immigrant communities disproportionately at risk for chronic illnesses may have contributed to high initial enrollment numbers. Given the size of the 19-41-year-old population, we could expect maybe double the number of enrollees (or more) per month compared to the HBIA 42-65 population. In restricting healthcare for FIIs, many are stuck between deciding whether to front out-of-pocket expenses for needed health services or delay receiving care that could lead to worsening health outcomes and more expensive treatment options. This scenario is one that for years immigrants have lived in, and in recent years, following the ACA expansion, some states have begun extending healthcare coverage.

A medical care provider at Esperanza Health Center describes a conversation with a patient detailing her healthcare experience before and after enrolling into HBIA:[89]

"She was just telling me how she was hoping she would get approved because she really needed surgery and was expressing how expensive it is without any sort of medical insurance. It was about $5,000 and she could not afford the procedure.... I found out she was approved. So now she can get that procedure that she would not have gotten before HBIA. It is cases like this that, you know, we appreciate that this program is here and helping. You know, patients' lives."

As these stories of HBIS/A enrollees show, within the first two years of the programs being available, federally ineligible immigrants are already experiencing positive health impacts. From avoiding out-of-pocket costs to receiving much-needed medication and surgery, we can see how removing citizenship status as a barrier to accessing healthcare can work towards positive health outcomes.

The role of community-based organizations

In conjunction with pent-up demand for extending health insurance to federally ineligible immigrants, community-based organizations have been a critical link in enrolling FIIs into HBIS/A programs. In our thematic analysis, some enrollees admitted that if it were not for the staff at community-based organizations who assisted them in navigating errors in their applications, they might not have applied altogether. For example, Ms. Gonzalez, an HBIA enrollee, sought assistance from Ms. Villanueva, a Benefits & Enrollment Specialist at Pillars Community Health, a community-based organization located in Cook County, after she was initially denied for inputting a wrong household income. Ms. Villanueva recalls:

> "Household and income rules for the programs are complex and easy to misunderstand. I was very worried when she was denied but I contacted the Shriver Center and together we were able to get the correct information to the state agency who reversed the decision and expedited her coverage. Ms. Gonzalez is very relieved and is going to be able to schedule her pre-surgery appointments for December."

As shown, CBOs are an important link in building trust between immigrant communities and government programs. Additionally, FIIs reported feeling comfortable in contacting community partners to help them in reapplying if their applications were denied.[90] However, the responsibility of enrolling FIIs into HBIS/A programs should not fall solely on community-based organizations. Stephanie Altman, a lawyer and Director of Policy at the Shriver Center on Poverty Law, suggests:[91]

> "It takes more trusted partners, one on one community organizations, neighbors talking to neighbors, you know, people who not only speak your language and are culturally competent to communicate that you can enroll in the [HBIA and HBIS] programs."

A Feeling of Relief

Doctors, health advocates, and enrollees themselves say HBIA and HBIS have been nothing short of life-changing. Dr. Kimberly Dixon, Head of Geriatric Medicine at Stroger Hospital, conveys:[92]

"I recently informed one of my patients — an 80-year-old undocumented woman —that she qualified for coverage under the [HBIS] program. She burst into tears.'

Similarly, Patricia Morrison, an enrollment assistant at a community health center at Esperanza Health Center, describes an enrollee's reaction to finding out they were eligible for HBIA. Specifically, they mention the 'three months backtrack' benefit in both programs, where enrollees could have their surgery and medicine for post-surgeries covered if it occurred within three months of their program approval. She states:[93]

"They are grateful that through this program we are able to backtrack three months. So, if they ever had a hospital bill that they were not able to pay and were approved, that [HBIA program] will cover those charges"

Stories like these are prevalent across interviews with HBIS enrollees and healthcare providers. HBIS/A represented a sigh of relief to FIIs because it allowed them to access healthcare services, that they were previously ineligible for and eased the financial burden related to health expenses. Across our thematic analysis, FIIs and medical providers stressed the importance of extending health insurance to historically marginalized groups and strong support for including 19-41-year-old FIIs in the final Medicaid expansion.

Where are the health equity and resource gaps?

While HBIS/A has been wildly popular amongst enrollees, there is still room for improvement. As defined by HBIS/A enrollees and Illinois Medical providers. Table 5 is a list of issues associated with HBIS/A programs including either coverage gaps associated with HBIS/A, or healthcare access and navigation issues in utilizing services. The major theme for coverage gaps is associated with the carve-outs for long-term care, home care, and sub-acute rehab that were inexplicably omitted from HBIS/A. Sub-acute rehab refers to skilled rehabilitation care that is usually associated with a hospital stay or acute care under supervision of long-term care.[94] A medical care provider who participates in the HBIS/A program reveals that, while a hospital stay - as acute care - is covered, any required rehabilitation is currently not covered.[95] In terms of healthcare access, issue areas were associated with 1) a lack of

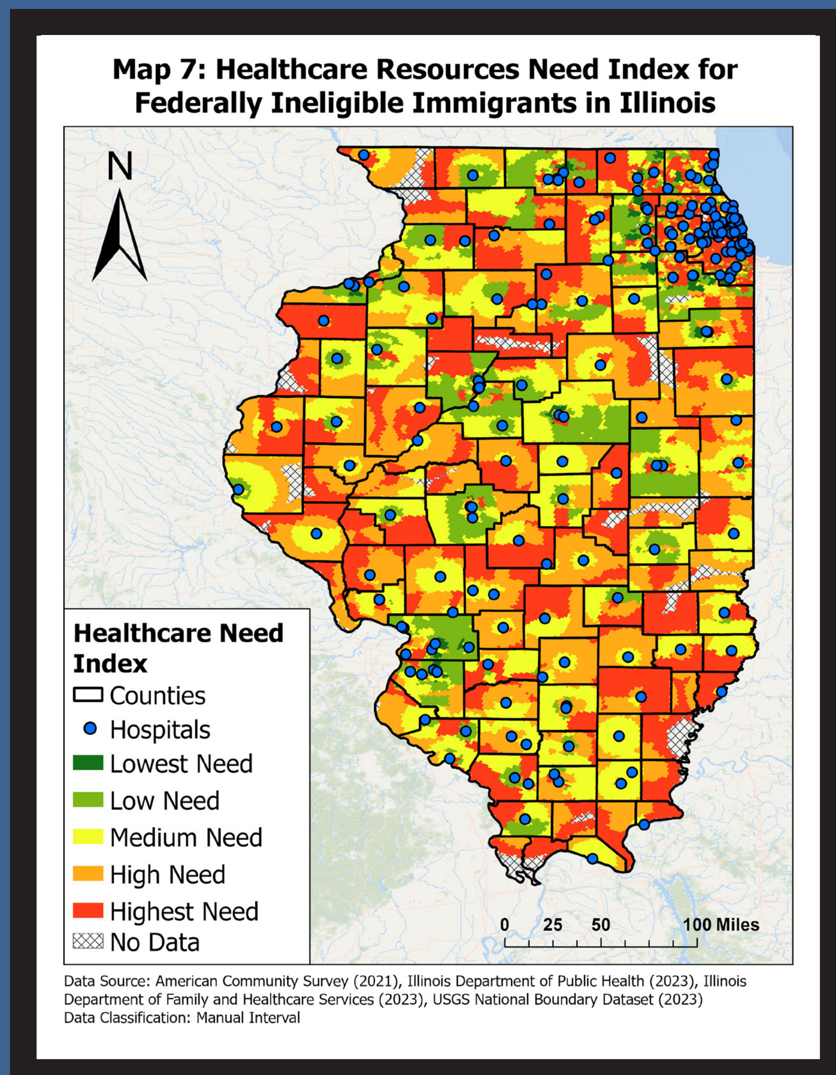
awareness that the program exists 2) under-utilization of services due to fear of speaking against mistreatment 3) navigation issues surrounding the complexity of the healthcare system and 4) lack of in-language resources after enrollment. A list of representative quotes that highlight some of these major themes can be found in Appendix G.

Table 5: List of Health System Issues From HBIS and HBIA Enrollees, Illinois Medical Care Providers Interview data

HBIS and HBIA Coverage Issues	**Enrollee Access and Navigation Issues**	
Long-term care facilitates not covered by HBIS	*Eligible FII unaware of program and are not enrolling*	*Lack of services in language makes navigating system difficult*
Sub-Acute rehab not covered by HBIS or HBIA	*Enrollees unaware of benefits once enrolled and underutilizing services*	*Erroneous billing issues and billing complications add significant stress*
Lack of long-term and rehab services leading to delays/avoiding procedures by enrollees	*Enrollees are afraid to lose coverage and do not speak up about mistreatment*	*Lack of culturally competent healthcare providers hurts enrollee health experience/trust with system*
Confusion about difference between Medicaid And HBIA/S long-term and sub-acute treatment coverage leading to ***significant provider-side medical waste***	*Significant treatment delays due underfunded healthcare system*	*Accessing services difficult due to complicated system which hurts enrollee utilization of services after enrollment*
Confusion about difference between Medicaid And HBIA/S Long-Term and sub-acute treatment coverage leading to ***poor health outcomes for enrollees***		*Poor coordination of follow-up services to enrollees hurts outcomes and health experience*

In addition to healthcare system issues with HBIS/A identified by enrollees and medical providers we identified geographic disparities associated with the distribution of healthcare resources across the state of Illinois in the context of the FII population using rastors and spatial analysis. We created a high-need index using the following indicators: 1) distance from hospitals limiting access to health services, 2) dense populations of FII that are uninsured in spite of living in close proximity to hospitals such as in 'Cook and Collar' Countie, 3) areas with low-income households, 4) areas with low English-proficiency, and finally 5) areas with low HBIS/A enrollment (**Map 7**).[96]

As you can see in the map, there's a concentration of hospitals in Cook and Collar counties, while the presence of hospitals in the rest of Illinois is **scattered**. This is explained by the fact that Cook County and its bordering 'Collar Counties' of DuPage, Kane, Lake, McHenry, and Will Counties have approximately two thirds of the state's entire population and also the majority of its healthcare system resources.[97] In addition to the presence of CBO's, access to healthcare facilities like hospitals is essential to making healthcare accessible for all and analyzing the health impact of these programs. By focusing on the red and orange areas on this map, HFS and lawmakers can redirect their resources towards areas where FIIs have not been enrolled and/or have limited access to healthcare facilities. This would ensure that the design and implementation of the current programs and potential expansion is equitable for all.



Discussion

Our research revealed several themes related to the question of whether to expand healthcare eligibility to federally ineligible immigrants ages 19-41. Addressing the needs of the most vulnerable populations is an integral value of this research project and the values of Healthy Illinois. Supported by previous state Medicaid expansions, extending health coverage to federally ineligible immigrants – a population that experiences the compounded vulnerabilities of low-income, non-citizen, and non-English speaking status– is important for achieving health equity and reducing health disparities. The discussion below synthesizes our research findings to reveal the benefits of HBIS and HBIA programs on immigrant health, issue areas within the existing programs, such as navigating the application process, and the role of community-based organizations in deploying outreach and enrollment services to FIIs.

Health Benefits to Immigrant Communities

Quality of Life for Present and Future Generations

HBIS and HBIA programs have tangibly impacted the quality of life for FII and their families. HBIS/A recipients and their providers have expressed that the programs greatly increase the rate of medical treatment, reduce stress, provide financial relief, and ensure overall medical protection. Accessing these services through the programs has helped enrollees and family members with paying for medical bills or relieved them of the stress of caring for someone with a medical condition that they could not afford to treat without HBIS/A. Given the history of excluding immigrants from receiving healthcare, immigrants have high rates of chronic illnesses, face barriers to paying out-of-pocket healthcare expenses and have legitimate fears about enrolling in social safety programs even if they are eligible that may improve their health and general well-being. A 2018 study revealed that 18 out of 27 million emergency room visits could have been avoided if primary care treatments or diagnosis treatment were available to emergency room patients who were undocumented immigrants.[98] As a result, federally ineligible immigrants do not receive or delay receiving healthcare services that can affect their health both in the short and long term.

In the short term, enrollees can access healthcare, such as treatment and medicine, to immediately address pre-existing conditions. In the long-term, the etiology of many chronic, costly, and preventable health conditions such as obesity and associated comorbidities such as cancer and type 2 diabetes are a product of intergenerational health issues.[99] Diabetes and its complications are largely preventable, with 90% of type 2 diabetes attributed solely to obesity and a sedentary lifestyle.[100] Some health conditions, such as stunting and anemia, take a minimum of three generations to ameliorate if each generation has proper nutrition, access to healthcare, housing, etc., and are healthy and free of medical conditions six months prior to conception.[101] In the context of Illinois, even with All Kids monitoring maternal and child health during and after pregnancy, parents' health coverage gaps have extended to their children and put them at risk for the development of costly, chronic, preventable diseases. Considering that immigrants have historically been excluded from social welfare programs such as Medicaid, a lack of health

coverage anywhere for the current generation of immigrants equals a lack of health coverage overall. Furthermore, it will continue to impact immigrants and their children indefinitely. Thus, health insurance over the entire life course is the only way to reduce the long-term disease burden and long-term health costs associated with costly intergenerational diseases.

Financial Relief

Extending healthcare coverage at no cost for services represents the positive effect of removing a barrier to accessing healthcare. Previous literature and our thematic analysis revealed how prior to HBIS/A, many were delaying seeking services for their condition and/or overall avoided using health services due to high copays for check-ups, diagnostic tests, or pharmaceutical services. In the absence of state-provided health insurance, individuals are left to use marketplace insurance rates, charity care, or go without insurance completely. Under marketplace insurance or charity care, not all healthcare services are provided, such as bariatrics or preventative screenings.[102] Medical costs can range significantly based on the treatment or service. However, any out-of-pocket expenses can be a financial burden for those earning less than 138 percent of the federal poverty guidelines. A nationally represented sample of low- income (less than 138 percent of the federal poverty) individuals ages 19-64 Medical debt was specifically referenced as a concern for recipients, who fear that they may never be able to pay off collections, often deterring recipients from seeking out medical care.[103] Therefore, extending healthcare coverage to immigrants can assist in removing barriers and mitigating worsening health outcomes.

Program Evaluation

While the immigrant healthcare expansions had many positive effects, our research found several areas concerning how the programs were deployed and used by enrollees. These areas represent opportunities for program improvement of HBIA and HBIS.

Lack of Application Assistance

Enrollees may apply for HBIS/A via an online application, phone application, or with a case manager or other application assistant. Online applications generally come with a barrier to potentially eligible immigrants who typically lack ways to approach online technology or the technical literacy necessary to navigate the online application on their own, especially for older adults.[104] As our research showed, caseworkers and enrollment assistants revealed that federally ineligible immigrants encountered confusion and submitted erroneous applications when entering the application online. As a result, this led to delayed applications of up to 60 days or denied applications. Some FIIs admitted that had they not sought help to correct their application, they may have not applied all together.[105]

The key point of entry into the programs is the application and there are many ways the application process can present barriers, such as the format and language versions of the application. While HFS supports enrollment assistance, our qualitative analysis noted that when FIIs seek application assistance, they experience long wait times for appointments or issues finding appropriate language assistance through the agency. Focus group participants commented that they “need an education that is culturally and linguistically

appropriate," noting the cultural differences around diet and illness between different ethnic groups. Additionally, potential participants noted a need for better phone customer service and language accommodations are needed.[106] Illinois could allocate funding to translate communication materials through community-based organizations to verify that translations are accurate as well as culturally appropriate.

Vulnerabilities of Seniors

Our quantitative analysis of HFS enrollment data showed that HBIS enrollees have higher per capita costs and a slower enrollment rate than HBIA enrollees. Considering that HBIA has only been available for less than a year and was implemented through the same mechanisms as HBIS, the higher enrollment trend for HBIA can be explained by the press coverage and media roll-out for HBIS preceding HBIA, as well as community organizations continuous educational outreach and enrollment assistance. The slower enrollment rate of HBIS indicates that special enrollment efforts must be directed specifically at senior immigrant populations.

Seniors living alone are especially vulnerable because they lack familial support and resources that can help with navigating care. These individuals require extra assistance to enroll in HBIS, understand program materials, make and travel to appointments, and monitor their overall health status. Our geospatial analysis revealed that counties with low HBIS enrollment numbers might overlap with limited hospital and CBO resources to provide health services. Isolated FIIs who are seniors must receive additional support to enroll in HBIS and receive healthcare.

Gap Between Eligibility and Coverage

Through statements from enrollees and providers when discussing problems related to accessing healthcare, whether in regards to the application process or navigating care, current HBIS/A enrollees indicated they are unaware of the benefits provided under the programs and/or are not accessing the full range of services. HBIS enrollees interviewed demonstrated that they were represented and/or connected to HBIS/A by their children who spoke English and gathered information through technology and their networks. Therefore, we can infer that seniors without a younger generation family network would most likely rely on referrals from medical care providers to access HBIS/A, which requires them to take the initiative to visit doctors despite their uninsured statuses and possible mobility issues as older adults.

Location represents an additional layer of complexity for HBIS and HBIA enrollees to receive care. HBIS/A and the potential expansion serve FII in all areas of the state because, as a Medicaid-like coverage, it must be accepted by all Medicaid providers, such as hospitals in the state. Due to the large number of hospitals and federally ineligible immigrants concentrated in Cook County, Cook County has higher enrollment numbers than any other counties.

Additionally, prior to HBIS and HBIA, Cook County Medicaid providers assisted low-income

immigrants regardless of citizenship status. Therefore, when HBIS and HBIA programs became available, they were able to easily enroll their patients into the new programs without any barriers. On the other side, due to scattered availability of hospitals in the rest of Illinois, not all FIIs have equal geographic access to healthcare. Similarly, the availability of CBOs, who can help offer public assistance to disadvantaged communities, is concentrated in Cook County and varies throughout the rest of Illinois. Based on HFS reports and comparable geospatial analysis, we know approximately which populations and regions are the most underrepresented and need the most help.

It is essential to deploy resources to counties where there are senior federally ineligible immigrants who are not yet enrolled in the program, where there is a lack of hospitals for HBIS/A to access care as well as where there are few community-based organizations to assist with the application process. Additionally, we can infer that including younger FIIs in Medicaid- like programs may assist with guiding them and sharing information about the health services offered. Closing the health insurance gap also includes closing the gap between eligibility and coverage, for all program expansions, current and potential.

Maintaining Coverage through a Redetermination Process

Like Medicaid, HBIS/A recipients must "redetermine" or re-enroll in the program on an annual basis to verify their eligibility. However, the redetermination process for Medicaid and HBIS/A enrollees has been on hold for the past three years due to the COVID-19 pandemic and the public health emergency (PHE) declaration from the federal government.[107] The PHE included a continuous coverage provision for Medicaid barre termination from Medicaid throughout the duration of the PHE and waived any requirement to verify program eligibility. Since the Illinois immigrant expansion programs were implemented for the first time during the PHE, there has been no requirement to recertify program eligibility for the past three years.

However, in December 2022, Congress passed the Consolidated Appropriations Act of 2023, which effectively ends the Medicaid continuous enrollment requirement and reinstates the standard redetermination process beginning in 2023 for Medicaid. Considering that Illinois law requires HBIS/A rules to "be at least as restrictive as the rules" for Medicaid, redetermination will begin for HBIS/A.[108]

A redetermination process for HBIS/A programs could present many of the same barriers as accessing health coverage in the first place: providing verification documents, proof of income, lack of language translation, submitting applications online or by mail etc. Medical care provider interviews on the redetermination process for Medicaid show that it has a negative impact on the total number of enrollees, as the process removes both those who are no longer income eligible as well as those who failed to meet the administrative requirements of reverification.[109] An Illinois case study from 2016 found that "about 25 percent of all Medicaid clients were disenrolled in one year" the majority of whom were most likely still eligible.[110] The federal government estimates that up to six million people nationally could lose access to Medicaid once redeterminations begin again due to administrative challenges alone and not because of a change in income.[111] The likelihood that a Medicaid customer loses coverage is compounded by language blocks - participants

with limited English proficiency can be five times more likely to lose their Medicaid benefits during redetermination compared to English proficient participants.[112] Since many HBIS/A participants shared that they have limited English proficiency and technical literacy skills needed to navigate the application process, the effect of redetermination on program retention could be much more severe.

Community-based Organizations as Critical Resources

Cited by numerous studies and interviews with enrollees and providers, the role of community-based organizations (CBOs) and community clinics in building trust among immigrants and extending resources cannot be ignored. For instance, a 2019 Well-Being and Basic Needs Survey (WBNS) revealed that more than one in every seven adults from immigrant families reported avoiding non-cash government benefits, with half of the population in this category avoiding Medicaid due to fear of immigration-related consequences.[113] Similarly, HBIS/A enrollees spoke about their skepticism towards the programs prior to contacting CBOs for program information and enrollment assistance. They also described community-based organizations and health centers as having more empathetic staff, time to work with individuals on a variety of health needs, and being trustworthy.[114] However, as our interviews with healthcare providers revealed, much of enrollment support and educational outreach was done without state funding.

By investing in community-based partnerships for program-related marketing, misinformation about programs can be reduced, more eligible undocumented immigrants can enroll into programs, and trust can be built with impacted communities.

Benefits to Healthcare System

Reducing Emergency Room Visits Through Health Coverage

Under the health system in Illinois, health coverage and healthcare for FII is costing the state significantly greater resources due to a lack of eligibility and access to preventative healthcare treatment for FII. As our qualitative analysis revealed, many FIIs shared that prior to acquiring health insurance through HBIS/A they declined or delayed costly medical care for both acute and chronic conditions until their situation got so severe that they sought emergency room care. Interviews with healthcare providers confirmed that they are already serving FII through charity-based care or emergency room assistance. This burden may limit the number of patients Medicaid providers such as hospitals can attend due to funding, while also putting a costly financial burden on FIIs who rely on emergency room assistance. According to a study, approximately $32 billion dollars could potentially be saved by extending primary care services to federally ineligible immigrants to avoid incurring costs through emergency room visits.[115] Additionally, research estimates that the average inpatient stay costs more than $22,000, while the average outpatient visit costs around $500.[116] Instead this money could be better spent on improving preventative elements of the Illinois healthcare system.[117] As shown in **Figure 5**, inpatient costs make up a significant percentage of all age group's medical expenditures, particularly for HBIS enrollees due to both their advanced and greater number of years without medical insurance compared to the HBIA population.

When examining the per capita costs between different age groups, we see a significantly smaller per capita cost between the 42-55-year-old age group (**~$4,000**) compared to the 65+ age group ~(**$12,000**). We expect this inverse relationship between cost and age to extend to the 19- 41 age group. For example, it can be anticipated that higher per capita costs will be incurred during the first initial year of expanding health insurance to 19-41-year-olds representing pent-up demand. As the program continues, emergency room visits and program costs may decrease as having healthcare access during earlier years will contribute to healthier lives.

Preventative Care

Preventative care through access to public health insurance will reduce costs by either delaying the onset of or eliminating the prevalence of many of the conditions that afflict FII. Table X shows a list of chronic preventable health conditions like type 2 diabetes, osteoarthritis, cancer, and general cardiovascular damage that were frequently mentioned in interviews. When these diseases progress untreated, the results are long and costly hospital stays. As shown in Table X in our data, inpatient costs make up a significant percentage of all age group's medical expenditures, particularly for HBIS enrollees due to their advanced and greater number of years without medical insurance as compared to the HBIA population.

While hospitalization and inpatient services are a near-inevitability throughout the course of life, ***the frequency, magnitude, duration, and onset of costly hospitalizations and long-term disease management can vary greatly from person to person, depending on their access to preventative healthcare***. Therefore, through preventative treatment, HFS can reduce disease prevalence and the number of individuals that require costly inpatient treatment while encouraging FIIs not to delay seeking healthcare services.

Eréndira Rendón, an organizer with our client Healthy Illinois, shares:[118]

> "The state and federal governments need to find ways to provide comprehensive healthcare for this population [federally ineligible immigrants] before it hits crisis levels due to leaving chronic illnesses unattended which in turn leads to overuse of emergency care and overall strains safety- net hospitals and ends up costing the state more. This could be a problem for Illinois as the number of seniors living in the U.S. without authorization is set to grow exponentially over the next decade."

Policy Options and Recommendations for Closing the Healthcare Gap

The central issue addressed in this report is whether to expand health insurance to the remaining 19–41-year-old federally ineligible population by analyzing the health impact from previous Medicaid-like expansions to estimate the efficacy and health impact of closing the eligibility gap. Our research was also informed by evidence from other previous healthcare expansions in different states. Based on our findings, our policy options are to close the gap by increasing eligibility to all age groups, increasing eligibility to another age subset within the 19- 41 FII population, or doing nothing and maintaining the status quo.

Policy Options

Our mixed-method research project revealed that the effect of the HBIS/A programs is a positive impact on quality of life, health equity, reduced economic burden, and intergenerational health for enrollees. A possible consideration may be extending eligibility to a subset of 19-41 FIIs. However, this would still leave an excluded population and a coverage gap. There is no evidence-based reason to suggest continuing the exclusion of 19-41 FIIs. For example, certain medical conditions may present themselves at later life stages; however, access to preventative care in earlier stages could help treat conditions and diseases to avoid worse health outcomes.

Therefore, the only option that fully addresses the problems created by a coverage gap is implementing a final Medicaid expansion to 19-41 FIIs to achieve universal coverage for immigrants and improve health outcomes.

Primary Recommendation : Expand Medicaid-like eligibility to 19-41 FIIs

Through our preliminary analysis of publicly available HBIS/A data and interviews with healthcare providers and enrollees, we recommend that expanding eligibility to 19-41 FIIs will close the health coverage gap and extend positive health impacts from previous Medicaid-like programs to them. The previous expansions show that eligibility expansion can be implemented through the current policy window and is supported by existing healthcare networks. As our study shows, HBIS enrollees are more costly than younger FII populations in HBIA, which implies that the state could benefit from more utilization of preventative care, early management of chronic conditions, and healthcare access outside of emergency room settings. This recommendation is an equitable policy that directs resources to a vulnerable population that are excluded from government healthcare.

Supplementary Recommendations

Part of analyzing the efficacy and health impact of HBIS/A programs on immigrant health, a theme of disconnect between eligibility and coverage emerged. An additional dimension to the healthcare gap besides restriction in eligibility is a disconnect between eligibility and coverage. In other words, simply because one is eligible for HBIS/A does not mean that they are 1) enrolled or 2) receiving adequate coverage. To mitigate the existing deficiencies, we offer a number of supplemental program recommendations directly informed by the findings of our research. These program improvement opportunities speak to important relationships and goals rather than the mechanisms for achieving them. Healthy Illinois and stakeholders may consider these program recommendations as part of their overall advocacy efforts.

Implement Equitable Data Gathering and Dissemination Practices

1) HBIS/A program administrators should partner with public universities and advocacy groups to provide in-depth program analysis of HBIS/A programs: In the process of analyzing available public HBIS/A data, we have identified a series of challenges due to absence of and quality of data. As currently reported, enrollee data is not disaggregated by census tract or zip code, only by county level. With a more detailed geographical breakdown, zip code or census-level data gives more precision in targeting resources and can speak to the relationship between geography and social determinants of health. Similarly, we recommend HFS disaggregating All Kids program data by age in public reports. Currently, it is impossible to determine the various ages of immigrant All Kids participants and subsequently how many All Kids enrollees will age out of public health insurance in any given year. This information would be valuable to show how many low-income youths are at risk of losing healthcare access.

These equitable dissemination practices can be achieved by partnering with graduate research universities and other advocacy organizations that have the capacity to provide continued detailed program analysis. For example, researchers with the necessary tools for data disaggregation could assist HFS in making monthly reports available in various format options and create a web page with information on how categories or variables are defined and measured. Currently, only a PDF format of the monthly HBIS/A reports is available, and there is no information on measures or how terminology is defined. By making the data available in various formats (e.g., Excel) and having a section on the web page with information on how categories or variables are defined and measured, the data would be more useful for future policymakers.

Leverage Community-Based Organizations (CBO) to Improve Accessibility

1) Leverage Community-Based Organizations (CBO) to Improve Accessibility: Establishing trust between government programs and immigrant communities is essential for immigrants' health and well-being because they are a critical link in navigating individuals through the application process and healthcare system. By investing in community-based partnerships for program related marketing, education, and outreach (MEO), misinformation about HBIS/A can be reduced, enrollment among eligible undocumented immigrants can

increase, and Illinois can continue to invest in social infrastructure that helps build trust among impacted communities and reduce health disparities.

2) All HBIS-and-HBIA-related materials should be translated into all languages, and community participation should be used to vet for culturally competent materials and processes: One of the biggest barriers to accessing any government program is the lack of materials translated into languages used by those eligible for the program. Through geospatial analysis of state records coupled with a joint county and community outreach effort, languages with participants that are underrepresented in the data can be better reached, which would improve the equity and effectiveness of the program. Community-based organizations are a valuable resource for patients navigating care and the healthcare system. They should be adequately supported for this work. By inviting trusted community organizations to validate translated materials, concerns over eligibility and what services are covered under HBIS/A would be addressed, and it would help build trust in the programs.

Simplify the Redetermination Process

1) Simplify the Redetermination Process: The redetermination process may present a chilling effect for federally ineligible immigrants who out of distrust of the government and immigration- related consequences may choose to not submit verification documents and first-time applicants may avoid applying altogether. Since HBIS/A recipients have yet to go through redetermination, we can only estimate the effect on program attrition to be similar to that of Medicaid, or more extreme due to more extensive language issues (immigrants almost by definition have a primary language other than English) and fears of revealing their location as undocumented. Options for improving this process include automatic redeterminations under specific conditions, a simple process for renewals with limited documentation required, and limiting the number of redeterminations that happen annually. Additionally, Illinois could consider continuous coverage for certain patient groups such as children, postpartum women, or the elderly.[119]

Conclusion

In expanding healthcare coverage to the 19- 41-year-old FII group, our study predicts a positive chain of effect throughout the Illinois healthcare system in the long run. Based on our analysis of HBIS and HBIA, enrollees and healthcare providers spoke unequivocally about the health impact of accessing preventative care services in regards to treating chronic diseases.

Early diagnosis rate of chronic illnesses such as cancers, diabetes, and heart diseases through preventive care offered by Medicaid would significantly reduce costs for both the individual and state in covering expenses for medication, surgeries and other treatments, hospitalization, and/or emergency care. Therefore, a healthcare expansion to 19-41 federally ineligible immigrants would not only boost resources for early diagnosis of chronic illnesses for a historically uninsured population but also extend their lives. In analyzing the available enrollment data, we also identified areas for improvement for HFS to disaggregate data such as by citizenship status, age, and providing definitions for terminology used. Together, we can work towards achieving universal healthcare coverage for all in Illinois.

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Appendix A - Healthy Illinois Campaign Endorsers

Universities & Law Enforcement

Rev. Dennis H. Holtschneider, President, *DePaul University* **Donna M. Carroll**, President*, Dominican University* **John Pelissero**, President, *Loyola University*

Christine Wiseman, President, *St. Xavier University* **William J. Carroll**, President, *Benedictine University* **James Gaffney**, President, *Lewis University*

Arvid Johnson, President, *University of St. Francis* **Eva Serrano**, Director of Latino Initiatives, *Aurora University* **Sheriff Mark Curran**, Lake County

Faith & Civic Leaders

Rev. MSGR Michael Boland, C.E.O. *Catholic Charities of the Arch Diocese of Chicago*

Bishop Wayne N. Miller, Metropolitan Chicago Synod, *Evangelical Lutheran Church of America* **Bishop John R. Manz**, *Archdiocese of Chicago*, Vicariate IV

Bishop Alberto Rojas, *Archdiocese of Chicago*, Vicariate III **Jesse Ruiz, Interim CEO**, *Chicago Board of Education*

Sam Toia, President and CEO, *Illinois Restaurant Association* **Carmen Velazquez**, Founder, *Alivio Medical Center*

Sr. Carol Cook, *Sisters of Charity, Blessed Virgin Mary* **Sr. Gwen Farry**, *Sisters of Charity, Blessed Virgin Mary* **Fr. Corey Brost**, *Clerics of St. Viator*

Br. Michael Gosch, JPIC Coordinator, *Clerics of St. Viator* **Br. Leo V. Ryan**, *Clerics of St. Viator*

Sr. Rose Therese, JPIC Coordinator, *Holy Spirit Missionary Sister-USA* **Rev. Dr. Larry GreenField**, Executive Minister, *American Baptist Church of Metro Chicago*

Rabbi Seth Limmer, *Chicago Sinai Congregation* **Rev. Thomas G. Mescall**, *St. Adrian Catholic Church*

Rev. Lyle Gundrum, *St. Clare of Montefalco Catholic Church* **Rev. William Lego**, *St. Turibius Catholic Church*

Rev. Michael Mann, Associate Director of Mission & Advocacy, *Northern Illinois* **Alderman Carlos Rosa**, Chicago

Jaime di Paulo, Executive Director, *Little Village Chamber of Commerce* **Alderwoman Sue Sadlowski Garza**, Chicago

Faith Institutions

St. Agnes of Bohemia Catholic Church Good Shepard Parish Catholic Church St. Adrian Catholic Church Unity Church in Chicago

St. Nicolai United Church-Christ St. Peters Church Catholic Church Queen of the Universe Catholic Church Urban Village Church-Hyde Park & Woodlawn

St. Leonards Catholic Church, Berwyn St. Nicholas of Tolentine Catholic Church St. Turibius Catholic Church The Holy Spirit Missionary Sisters-USA

The 8th Day Center for Justice St. Ann's Catholic Church St. Procopius Catholic Church St. Clare of Montifalco Catholic Church

Universalist Unitarian Church of Joliet United Church of Christ in Aurora Mt Zion Tabernacle in Joliet First Presbyterian in Elgin

Kneseth Israel Congregation in Elgin Universalist Unitarian Church of DeKalb Universalist Unitarian Church of Naperville Catholic Diocese of Joliet

Our Lady of Mount Carmel – Joliet

Appendix B - Example of HFS Quarterly Reports (February 2023)

Immigrant Adults 42-54
(Report Run Date:02/08/2023)
Data as of 02/02/2023

MangPCd	MangPCdDesc
NI	Benefit Coverage for Immigrant Adults

Active_Closed_Status	Customer_Count	Claims Paid Amount
Active	21,090	$79,468,209.82
Closed	790	$3,243,511.78
Total	**21,880**	**$82,711,721.60**

Fiscal_Year	Claims Paid Amount
2023	82,711,721.60

Type_Of_Claim	Claims Paid Amount
Inpatient	$31,526,002.65
Outpatient	$29,886,843.81
Pharmacy	$7,314,372.76
Other	13,984,502.38
Total	**82,711,721.60**

Record_Type	Claims Paid Amount
Cook County Health System	$42,314,504.97
Other	$40,397,216.63
Total	**$82,711,721.60**

Race	Customer_Count - Active
American Indian or Alaskan Native	161
Asian Indian	307
Black or African American	363
Chinese	65
Filipino	50
Guamanian or Chamorro	2
Korean	30
Native Hawaiian	3
Other Asian	251
Other Pacific Islander	1,047
Unknown	7,570
Vietnamese	25
White	11,216
Total	**21,090**

Ethnicity	Customer_Count - Active
Another Hispanic, Latino, or Spanish origin	5,678
Cuban	18
Mexican, Mexican American, Chicano/a	9,439
Non-Hispanic/Latino	2,235
Puerto Rican	34
Unknown	3,686
Total	**21,090**

County	Customer_Count - Active
Homeless	150
Out Of Illinois	4
Adams	11
Boone	103
Bureau	34
Carroll	2
Cass	23
Champaign	173
Christian	2
Clinton	3
Coles	15
Cook	13,694
Crawford	3
Cumberland	1
De Witt	1
DeKalb	61
Douglas	5
DuPage	1,361
Edgar	1
Effingham	5
Fayette	1
Ford	5
Franklin	2
Grundy	21
Hancock	1
Henry	8
Iroquois	7
Jackson	35
Jefferson	4
Jo Daviess	6
Johnson	2
Kane	1,275
Kankakee	137
Kendall	63
Knox	4
La Salle	65
Lake	1,641
Lawrence	1
Lee	1
Livingston	3
Macon	2
Madison	59
Marshall	1
Massac	2
McDonough	1
McHenry	253
McLean	93
Monroe	1
Morgan	3
Ogle	23
Peoria	84
Perry	3
Pike	1
Pulaski	1
Putnam	3
Randolph	4
Rock Island	174
Saline	2
Sangamon	7
Schuyler	1
St. Clair	76
Stephenson	24
Tazewell	2
Union	14
Vermilion	3
Wabash	1
Warren	13
Washington	1
Whiteside	17
Will	829
Williamson	2
Winnebago	454
All Counties	**21,090**
Cook & Collar	17,412
% of total	83

Language_Pref	Customer_Count - Active
African French	4
Albanian	2
Arabic	134
Armenian	1
Bengali	3
Chinese - Cantonese	32
Chinese - Mandarin	30
Czech	2
English	6,821
Farsi	3
French	19
Greek	1
Gujarati	44
Haitian Creole	1
Hindi	29
Italian	2
Korean	17
Lithuanian	3
Maltese	1
Other	39
Polish	113
Portuguese	4
Punjabi	1
Romanian	8
Russian	41
Serbian	4
Sign Language	1
Slovak	1
Spanish	13,614
Tagalog	1
Thai	1
Tigrinya	1
Turkish	11
Ukrainian	57
Urdu	28
Vietnamese	19
Total	**21,090**

Immigrant Adults 55-64
(Report Run Date:02/08/2023)
Data as of 02/02/2023

MangPCd	MangPCdDesc
NI	Benefit Coverage for Immigrant Adults

Active_Closed_Status	Customer_Count	Claims Paid Amount
Active	12,275	$90,523,277.11
Closed	820	$8,938,530.55
Total	**13,095**	**$99,461,807.66**

Fiscal_Year	Claims Paid Amount
2022	14,490,801.24
2023	84,971,006.42

Type_Of_Claim	Claims Paid Amount
Inpatient	$31,522,000.51
Outpatient	$38,906,428.55
Pharmacy	$13,937,680.92
Other	15,095,697.68
Total	**99,461,807.66**

Record_Type	Claims Paid Amount
Cook County Health System	$55,236,018.64
Other	$44,225,789.02
Total	**$99,461,807.66**

Race	Customer_Count - Active
American Indian or Alaskan Native	107
Asian Indian	374
Black or African American	349
Chinese	124
Filipino	110
Guamanian or Chamorro	1
Korean	30
Native Hawaiian	3
Other Asian	202
Other Pacific Islander	600
Samoan	1
Unknown	4,776
Vietnamese	23
White	5,575
Total	**12,275**

Ethnicity	Customer_Count - Active
Another Hispanic, Latino, or Spanish origin	1,780
Cuban	14
Mexican, Mexican American, Chicano/a	5,642
Non-Hispanic/Latino	1,956
Puerto Rican	34
Unknown	2,849
Total	**12,275**

County	Customer_Count - Active
Homeless	96
Out Of Illinois	4
Boone	40
Bureau	14
Calhoun	1
Carroll	1
Cass	16
Champaign	99
Christian	1
Clinton	2
Coles	13
Cook	8,602
De Witt	1
DeKalb	25
Douglas	5
DuPage	688
Edgar	2
Effingham	2
Fayette	1
Ford	3
Franklin	3
Grundy	8
Henry	2
Iroquois	4
Jackson	21
Kane	638
Kankakee	85
Kendall	38
Knox	5
La Salle	40
Lake	809
Lawrence	2
Logan	1
Macon	6
Madison	31
McDonough	3
McHenry	110
McLean	31
Ogle	12
Peoria	20
Pike	2
Randolph	2
Rock Island	89
Sangamon	20
St. Clair	40
Stephenson	9
Tazewell	5
Union	5
Vermilion	4
Wabash	1
Warren	4
Whiteside	9
Will	388
Williamson	2
Winnebago	208
All Counties	12,275
Cook & Collar	10,426
% of total	85

Language_Pref	Customer_Count - Active
African French	7
Albanian	9
Amharic	2
Arabic	85
Bengali	7
Bosnian	3
Chinese - Cantonese	46
Chinese - Mandarin	59
English	3,975
Farsi	6
French	10
Greek	1
Gujarati	76
Haitian Creole	2
Hindi	30
Khmer	2
Korean	28
Lithuanian	6
Maltese	1
Mandingo	1
Other	60
Polish	216
Portuguese	4
Punjabi	3
Romanian	14
Russian	57
Serbian	1
Spanish	7,391
Swahili	1
Tagalog	14
Thai	2
Turkish	3
Ukrainian	90
Urdu	47
Vietnamese	17
Total	**12,275**

Senior Expansion Program
(Report Run Date:02/08/2023)
Data as of 02/02/2023

MangPCd	MangPCdDesc
6I	100% FPL or lower- No Spenddown. age >65 and non-citizen
7I	Over 100% FPL -with Spenddown. age >65 and non citizen

Active_Closed_Status	Customer_Count	Claims Paid Amount
Active	13,946	$ 249,436,269.65
Closed	1,831	$ 42,976,220.42
Total	**15,777**	**$ 292,412,490.07**

Fiscal_Year	Claims Paid Amount
2021	53,836,663.11
2022	129,037,221.77
2023	109,538,605.19

Active_Closed_Status	MangP	Customer_Count	Claims Paid Amount
Active	6I	13,395	$ 241,337,484.81
Active	7I	551	$ 8,098,784.84
Closed	6I	1,713	$ 41,139,759.55
Closed	7I	118	$ 1,836,460.87
Total	**Total**	**15,777**	**$ 292,412,490.07**

Spenddown_Status	Customer_Count - Active
Met Spenddown	525
Unmet Spenddown	26
Total	**551**

Type_Of_Claim	Claims Paid Amount
Inpatient	$ 101,089,631.78
Outpatient	$ 78,850,381.12
Pharmacy	$ 52,251,931.19
Other	$ 60,220,545.98
Total	**$ 292,412,490.07**

Record_Type	Claims Paid Amount
Cook County Health System	$ 115,978,341.80
Other	$ 176,434,148.27
Total	**$ 292,412,490.07**

Race	Customer_Count - Active
American Indian or Alaskan Native	166
Asian Indian	924
Black or African American	618
Chinese	287
Filipino	241
Guamanian or Chamorro	2
Korean	55
Native Hawaiian	2
Other Asian	379
Other Pacific Islander	549
Samoan	1
Unknown	4,804
Vietnamese	49
White	5,869
Total	**13,946**

Ethnicity	Customer_Count - Active
Another Hispanic, Latino, or Spanish origin	1,664
Cuban	26
Mexican, Mexican American, Chicano/a	4,863
Non-Hispanic/Latino	3,835
Puerto Rican	89
Unknown	3,469
Total	**13,946**

County	Customer_Count - Active
Homeless	**120**
Out Of Illinois	2
Adams	4
Boone	41
Brown	1
Bureau	10
Carroll	1
Cass	7
Champaign	100
Christian	1
Clark	3
Clinton	1
Coles	11
Cook	9,204
Crawford	2
Cumberland	1
De Witt	2
DeKalb	30
Douglas	6
DuPage	1,133
Effingham	6
Fayette	2
Ford	1
Franklin	2
Fulton	1
Grundy	8
Henry	3
Iroquois	7
Jackson	8
Jasper	1
Jefferson	1
Jersey	2
Johnson	1
Kane	714
Kankakee	41
Kendall	73
Knox	7
La Salle	13
Lake	1,048
Lee	10
Macon	8
Madison	38
McDonough	1
McHenry	192
McLean	55
Morgan	5
Ogle	7
Peoria	89
Perry	1
Piatt	1
Randolph	1
Richland	1
Rock Island	50
Saline	1
Sangamon	26
St. Clair	23
Stephenson	12
Tazewell	12
Union	7
Vermilion	11
Wabash	1
Warren	3
Washington	2
White	1
Whiteside	4
Will	551
Williamson	4
Winnebago	203
Woodford	6
All Counties	13,946
Cook & Collar	11,794
% of total	85

Language_Pref	Customer_Count - Active
African French	10
Albanian	34
Amharic	4
Arabic	146
Bengali	5
Bosnian	5
Chinese - Cantonese	72
Chinese - Mandarin	160
Croatian	1
Czech	1
English	5,624
Farsi	25
French	35
German	1
Greek	1
Gujarati	169
Haitian Creole	5
Hindi	90
Hungarian	2
Indonesian	1
Italian	3
Khmer	3
Korean	51
Kurdish	1
Lithuanian	13
Mandingo	1
Other	102
Polish	446
Portuguese	17
Punjabi	11
Romanian	26
Russian	126
Serbian	26
Slovak	2
Spanish	6,361
Tagalog	55
Thai	8
Tigrinya	2
Turkish	11
Ukrainian	139
Urdu	107
Uzbek	2
Vietnamese	42
Total	13,946

Appendix C - Interview Questions for Healthcare Providers

Process

- Email healthcare providers to schedule interview
- Method: Sending interviewees a calendar invite with Zoom information including link and number to call
- Zoom recording will be sent to Nangha's email
- On the day of the interview log in 10 minutes early to assess any technical difficulties
- Make sure computer and phone are fully charged

Goal

- The goal of the interviews is to invite healthcare providers to share their experiences in providing care or recent enrollees

Introduction/Confidentiality Statement:

Thank you for taking time to participate in our research project about the impact of HBIA and HBIS on accessing healthcare for undocumented immigrants in Illinois. *Our goal for this interview is to understand your experience with HBIA and HBIS enrollees but also in general about healthcare access for undocumented immigrants in Illinois. This interview will take about 30-45 minutes and will be recorded. Recordings are only for our personal review and will not be shared with anyone.*

Your responses are important to us and will not be linked to your name. All information gathered will be used confidentially and anonymously in our report set to be published in April 2023.

If at any moment you wish to stop the interview, please let me know. Do you have any questions before we begin? Okay, let 's get started!

The following interview questions cover three main themes:

General information

The goal here is to 1) obtain general information about who are the providers and 2) general conditions they treat from enrollees.

1. Who is the provider?
   a. Years experience
   b. Field, title
   c. What services do they provide?
   d. Where are they located?
   e. Where have they worked previously?
2. Describe the community that you serve (use the following probes/examples):
   a. Ethnicity
   b. Age range
   c. Social determinants of health
   d. Where do they live typically?
   e. How do they live?

Appendix C - Interview Questions for Healthcare Providers

3. What acute illnesses/diseases do you regularly treat for HBIA/S enrollees?
4. What chronic conditions do you regularly treat for HBIA/S enrollees?

Understanding HBIA/S experience and impact

The goal here is to obtain information about 1) scenarios with how providers have interacted with enrollees and 2) what enrollees have told their providers about the program.

5. Describe some of the experiences you have had treating HBIA/S populations thus far
   a. Success?
   b. Failures?
   c. Gray areas?
6. Describe some of the experiences you have heard from HBIA/S enrollees associated with eligibility, access, and healthcare treatment
   a. What are some of the barriers that enrollees have described in obtaining health insurance and healthcare?
7. How have the enrollees said HBIA/S has impacted their lives?
   a. Physical health?
   b. Mental health?
   c. Stress, worry?
   d. Economic impact?
8. From a professional position, describe the impact HBIA/S has had on the lives of the enrollees
   a. Short-term
   b. Prediction for long-term impact
   c. Quality of life

Extrapolating impact to extend coverage

The goal here is to 1) include health care providers perspectives in the framing of the expansion including anything they believe is missing from the programs based on their interactions with recent enrollees and 2) address system barriers that may have come up in their process to provide care.

9. What can you say about the potential impact of expanding healthcare eligibility to 19-41 year-old population, eliminating age-eligibility gaps for federally ineligible immigrants
   a. Individual
      i. Short-term impact
      ii. Long-term impact
      b. Public health
      i. Short-term
      i. long-term

10. What can be done to improve the effectiveness of HBIA/S in terms of:
    a. Increase enrollment
    b. Improve healthcare access
    c. Improve healthcare treatment
    d. other

Appendix C - Interview Questions for Healthcare Providers

11. What recommendations do you have for prospective bills/budget that would expand access to the 19-41 to improve effectiveness?
12. How does expanding access to the 19-41 FII population address issues of health equity in the state of Illinois?
13. What can you say about the potential impact to public health and the public healthcare system in Illinois as a result of HBIA/S and prospective eligibility expansion?
14. Is there anything else you would like to add that was not addressed in these questions?
15. Do you have any questions for us?

Appendix D - Data Sources Table

Source	Description	Notes
American Community Survey (ACS)	The American Community Survey (ACS) releases new data every year through a variety of data tables that you can access with different data tools.	Will be used for general landscape tabulations.
HFS Quarterly HBIS and HBIA Data	The Illinois Department of Healthcare and Family Services releases data on enrollment in the coverage programs Healthy Illinois has passed. The data is broken down by: • ae groups (65+, 55-64, 42-54) • self-reported race and ethnicity • preferred language • county of residence and; • total claims filed	Includes data from before the beginning o f t he program and is updated every quarter.
Pre -Conduct e d Enrollee Interviews by Healthy Illinois	The Healthy Illinois Campaign has interviews with enrollees and could access more if necessary. • Most are in text, some audio – some anonymous or pseudo name, Spanish and English interviews	In total we have 10 testimonies/interviews.
Interviews with health care providers	APP team conducted hour -long thematic interviews aimed at understanding provider experiences (such as a clinician or clinic staff) based on interactions with enrollees in the Health Benefits for Immigrant Adults/Seniors programs.	In total we have 5 interviews.
Media Mentions	A list of articles where HBIA, HIBS, and Healthy Illinois articles are mentioned.	

Appendix E - List of Interviewed Medical Providers

Appendix E		
Healthcare Provider Name	**Title and Organization**	**Role Description**
Stephanie Atman	Legal representation, Shriver Center	Provides national leadership in advancing laws and policies that secure justice to improve the lives and opportunities of people living in poverty, connecting applicants to eligible healthcare programs
Padraic Stanley	Program Manager of Community Integration, RUSH Hospital	Health Promotion & Disease Prevention at Department of Social Work & Community Health and Chair of Rush Immigrant Health Working Group
Lucia Camacho	Manager, Esperanza Health Centers	Manager directly overseeing the Patients Benefits Navigators and connected to Community Health Workers also doing eligibility screening
Catherine Plonka	Director, Medical, Family Medicine, Advocate Aurora Health	Director who allocates medical resources and provided navigations in a large healthcare system in Illinois
Mara Ruff	Vice President, External Affairs at Sinai Hospital	Managing a major safety net hospital in Chicago in her practice

Appendix F - Preferred Languages of HBIA/S Enrollees

Table 3: Preferred Language of HBIA/S Enrollees, 2023

Language	65+	55-64	42-54	Total	Percent (%)
African French	10	7	4	21	0.044
Albanian	34	9	2	45	0.095
Amharic	4	2	0	6	0.013
Arabic	146	85	134	365	0.772
Armenian	0	0	1	1	0.002
Bengali	5	7	3	15	0.032
Bosnian	5	3	0	8	0.017
Chinese Cantonese	72	46	32	150	0.317
Chinese Mandarin	160	59	30	249	0.527
Croatian	1	0	0	1	0.002
Czech	1	0	2	3	0.006
English	5624	3975	6821	16420	34.737
Farsi	25	6	3	34	0.072
French	35	10	19	64	0.135
German	1	0	0	1	0.002
Greek	1	1	1	3	0.006
Gujarati	169	76	44	289	0.611
Haitian Creole	5	2	1	8	0.017
Hindi	90	30	29	149	0.315
Hungarian	2	0	0	2	0.004
Indonesian	1	0	0	1	0.002
Italian	3	0	2	5	0.011
Khmer	3	2	0	5	0.011
Korean	51	28	17	96	0.203
Kurdish	1	0	0	1	0.002
Laotian	0	0	0	0	0.000
Lithuanian	13	6	3	22	0.047
Maltese	0	1	1	2	0.004
Mandingo	1	1	0	2	0.004
Other	102	60	39	201	0.425
Polish	446	216	113	775	1.640
Portuguese	17	4	4	25	0.053
Punjabi	11	3	1	15	0.032
Romanian	26	14	8	48	0.102
Russian	126	57	41	224	0.474
Serbian	26	1	4	31	0.066
Sign Language	0	0	1	1	0.002
Slovak	2	0	1	3	0.006
Spanish	6361	7391	13614	27366	57.893
Swahili	0	1	0	1	0.002
Tagalog	55	14	1	70	0.148
Thai	8	0	0	8	0.017
Tigrinya	2	0	1	3	0.006
Turkish	11	3	11	25	0.053
Ukrainian	139	90	57	286	0.605
Urdu	107	47	28	182	0.385
Uzbek	2	0	0	2	0.004
Vietnamese	0	17	19	36	0.076

Appendix G: Representative Quotes Surrounding Major Healthcare System Complaints Identified by HBIS and HBIA enrollees, Illinois Medical Providers

Healthcare System Issue	Representative Quote:
Carve outs for long-term care and rehab services significantly impact healthcare quality and outcomes	"…Like all the services that Medicaid doesn't cover, like, how it doesn't cover home and community based services. It doesn't cover long-term care, any sort of facility- based care. People are like, 'Oh, well, the majority of people don't need those services,' but, like the people who need them really need them. **And so, like the people who need them if they don't have access to them, they're kind of just like shit out of luck. We have this amazing access, but then, when we are faced with a patient with really complex care needs that needs home health or needs some sort of facility based care, then we're back at we're back in 2017 again.** We're back trying to pull on social workers and care managers when, like the structural resources aren't there. We have to look into church networks. families, charity care like what you know we have to look into donations…"
Provider confusion around home care services due to similarities with Medicaid program causes significant medical waste and poor health outcomes	And then it also for a while was creating a lot of confusion on the inpatient floors because people would check in, be admitted to the hospital or **establish their care at Rush [Hospital] and show this card, and the people doing the intake wouldn't know it was any different than traditional medicaid,** and so they would put it in the chart as traditional Medicaid and whole care team would just assume that this person has Medicaid and they would come up with this whole discharge plan. **The majority of discharge plans include some sort of home health, follow up or homemaker services for follow-up. And then, a day or 2 until discharge, the insurance verification came back, and it turns out that have these things in their care plan they don't qualify for, so then the entire care team is like scrambling to try to find some semblance of an ethical discharge**, so that the patient does have to stay in the hospital for longer than they need to, **which is expensive for the patient, expensive for medicaid, expensive for the hospital, the hospitals penalized for it, [hospital] leadership gets all up and up…"**
Provider confusion around sub-acute services due to similarities with Medicaid program causes significant medical waste and poor health outcomes	"And then the other issue was **that the plan does cover acute rehab., but it doesn't cover sub-acute rehab. We would make referrals to acute rehab facilities, and they would deny the patient because if they were in acute rehab, and didn't recover enough to be discharged home, the hospital would not be able to discharge them to sub-acute rehab and so they would be stuck with the patient in their acute rehab unit so they would not accept the**

Healthcare System Issue	Representative Quote:
	patients at all. And so basically we would have to do provider-to-provider consults with the acute rehab facilities where the hospital would agree that, **if the patient doesn't recover enough to be discharged home, they can be discharged back to the hospital, and we'll take care of it. It was a mess essentially by them not covering the same services that Medicaid covers**. It creates this giant mess and confusion that's confusing for providers. It's confusing for the patients, confusing with families.
Language errors, language barriers and lack of cultural competency cause healthcare treatment issues and poorer health outcomes	"Another Spanish workshop that we did in diabetes in the little village neighborhood. **A participant said that she was like, 'Oh, I don't take my diabetes medication anymore, because it makes me sick. It makes me want to throw up. I am dizzy. I can't take it. So I stopped taking it.'** She comes, and **she brings the bottle, and the bottle is in English.** And it just says, **'Take one pill orally,' and because she doesn't speak English, she thought it meant hourly so she was literally taking her diabetes medication every hour that she was awake.** Basically, she said, **'Oh, I would only take like 2 or 3, and then I would be so sick that I wouldn't take them anymore.** And for that day, and then the next day I would like wake up, and I would take it and then I would get sick.'"
Billing issues and systems navigation issues causes significant distress to enrollees in addition to already stressful health situation	"As far as the interviewee knows, his services have all been covered, **except for an ambulance bill they received. He was taken to the hospital via ambulance by himself and did not have his medical card with him, so they are now receiving a $3,000 bill.** She [the granddaughter] will contact the biller to find out if they simply did not receive his medical card information, or if HBIS has refused to cover the expense. **It has been stressful for her to receive this bill on top of the stressful situation with her father."**
Lack of awareness of HBIS and HBIA hurting enrollment	"...I think that's why when people are aware of it, It's pretty accessible like the application process, it could be done over the phone, in person like a welcoming- center, and at a benefits office. Or it can be done online. Yeah, that once people are aware of, and that process is available in multiple languages, **I feel like once people are aware of it. Then it's easy. But it's getting people aware of it.**