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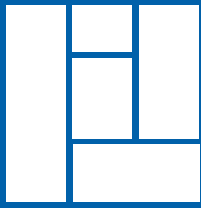

NEW FEDERALISM
HIGHLIGHTS OF STATE POLICIES

Health Policy for Low-Income People in Illinois

Jack A. Meyer and Stephanie E. Anthony

Illinois, described as a microcosm of America, has a mix of metropolitan areas—including the third-largest city in the country—small towns, and vast farmland. A crossroads between east and west, Illinois is a major transportation hub and has a strong industrial base, particularly in the Chicago area.

Traditionally, many industries in the state have offered generous employee benefits, and, as a result, Illinois boasts a high employer-sponsored health insurance rate and a low uninsurance rate. Managed care penetration in Illinois is significantly lower than the national averages for both the private and public sectors. In general, the sweeping changes taking place in health care markets across the country have not created the level of disruption in Illinois as elsewhere.

The low-income population in Illinois has also benefited from widespread employer-sponsored insurance. Medicaid is an equally important source of coverage for the low-income population, despite the state's historically strict eligibility rules. Under the Children's Health Insurance Program (CHIP), Medicaid eligibility will be expanded, covering thousands more children in the state.

> ***Movement toward managed care in the Illinois health care market has occurred much less rapidly than in the nation as a whole.***

State Characteristics

Sociodemographic Profile

In 1994–95, Illinois's population was 11.8 million, which has remained relatively steady in recent years. The age distribution of the state's population closely reflects that of the nation. Children under age 18 comprise 27.3 percent of Illinois's population, compared with 26.8 percent of the total U. S. population. The corresponding figures for the elderly population are 11.7 percent and 12.1 percent, respectively.

Virtually the same proportion of people in Illinois are non-Hispanic whites as in the nation (72.5 percent and 72.6 percent, respectively). Among the remaining one-fourth or so of the population, there are proportionately more non-Hispanic blacks in Illinois than in the United States (15.7 percent versus 12.5 percent) and slightly smaller proportions of Hispanics and other groups (such as Asian-Americans) (table 1).

Although the southern part of the state is largely rural, Illinois is more urbanized than the country as a whole. About 85 percent of the state's population live in urban areas, in contrast to about 78 percent nationally.

A product of "Assessing the New Federalism," an Urban Institute Program to Assess Changing Social Policies

Table 1
State Characteristics

Sociodemographic	Illinois	United States
Population (1994–95) (in thousands)	11,766	260,202
Percent under 18 (1994–95)[a]	27.3%	26.8%
Percent 65+ (1994–95)[a]	11.7%	12.1%
Percent Hispanic (1994–95)[a]	8.9%	10.7%
Percent Non-Hispanic Black (1994–95)[a]	15.7%	12.5%
Percent Non-Hispanic White (1994–95)[a]	72.5%	72.6%
Percent Non-Hispanic Other (1994–95)[a]	2.8%	4.2%
Percent Noncitizen Immigrant (1996)[b]	5.9%	6.4%
Percent Nonmetropolitan (1994–95)[a]	15.1%	21.8%
Population Growth (1995–96)[c]	0.5%	0.9%
Economic		
Per Capita Income (1996)[d]	$26,848	$24,426
Percent Change in Per Capita Personal Income (1995–96)[d]	4.9%	4.6%
Percent Change in Personal Income (1995–96)[d]	5.4%	5.6%
Employment Rate (1997)[e, f]	65.3%	63.8%
Unemployment Rate (1997)[e]	4.7%	4.9%
Percent below Poverty (1994)[g]	12.8%	14.3%
Percent Children below Poverty (1994)[g]	20.8%	21.7%
Health		
Vaccination Coverage of Children Ages 19–35 Months (1996)[h, i]	75.0%	77.0%
Low Birth-Weight Births (<2,500 g) (1995)[j]	7.9%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1996)[k]	8.1	7.2
Premature Death Rate (Years Lost per 1,000) (1995)[l]	49.3	46.7
Violent Crimes per 100,000 (1996)[m]	886.2	634.1
AIDS Cases Reported per 100,000 (1996)[n]	18.6	25.2
Political		
Governor's Affiliation (1998)[o]	R	
Party Control of Senate (Upper) (1997)[p]	28D-31R	
Party Control of House (Lower) (1997)[p]	60D-58R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. Three-year average of the CPS (March 1995–March 1997, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship.
c. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1997* (117th edition). Washington, DC, 1997. 1995 population as of April 1. 1996 population as of July 1.
d. Bureau of Economic Analysis, U.S. Department of Commerce, January 1998.
e. U.S. Department of Labor. *State and Regional Unemployment, 1997 Annual Averages.* USDL 98-78. Washington, DC, February 27, 1998.
f. Employment rate is calculated using the civilian noninstitutionalized population 16 years of age and over.
g. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.
h. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. "National Immunization Survey, 1996." *Morbidity and Mortality Weekly Report* 46 (29). Hyattsville, MD, July 25, 1997.
i. 4:3:1:3 series: four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of any MCV, and three or more doses of *Haemophilus influenzae* type b vaccine.
j. S.J. Ventura, J.A. Martin, S.C. Curtin, and T.J. Mathews. "Advance Report of Final Natality Statistics, 1995." *Monthly Vital Statistics Report* 45 (11), supp. Hyattsville, MD: National Center for Health Statistics, 1997.
k. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for June 1996." *Monthly Vital Statistics Report* 45 (12). Hyattsville, MD: Public Health Service, 1997.
l. Rate was calculated using years of potential life lost from age 65 (National Center for Health Statistics. Multiple Cause of Death Mortality Tapes, 1995) as the numerator and population estimates (U.S. Bureau of the Census. ST-96-1. Estimates of the Population of States: Annual Time Series, July 1, 1990, to July 1, 1996) as the denominator.
m. U.S. Department of Justice, FBI. *Crime in the United States, 1996*. September 28, 1997.
n. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 8 (2), 1996.
o. National Governors' Association. *The Governors, Political Affiliations, and Terms of Office, 1998.* January 15, 1997.
p. National Conference of State Legislatures. *1997 Partisan Composition, May 7 Update*. D indicates Democrat and R indicates Republican.

Economic Indicators

Illinois residents, as a whole, have above-average income compared with the nation. Per capita income in Illinois was $26,848 in 1996, about 10 percent greater than the national average of $24,426. In addition, the employment rate in Illinois is higher than the national average (65.3 percent versus 63.8 percent), while the unemployment rate is slightly lower than the national average (4.7 percent versus 4.9 percent). In 1994, 12.8 percent of Illinois's population lived below the federal poverty level (FPL), versus 14.3 percent for the U.S. population overall. This gap is narrower for children living in poverty, as 20.8 percent of children in Illinois lived below the FPL, compared with the national average of 21.7 percent (table 1).

The economy of Illinois is primarily dependent on manufacturing, mining, and transportation, with support from agriculture, tourism, and energy. The manufacturing sector accounted for a 9 percent greater share of total earnings in Illinois than for the nation as a whole. The state is the largest employer, with 82,000 jobs; the largest private employers are Jewel/Osco, Caterpillar, and Motorola. The Forbes 500 lists 57 Illinois firms.[1]

Illinois manufactures mostly industrial machinery (especially farm and construction equipment), fabricated metal products (e.g., steel), electronic goods, and chemicals. There are 29 active coal mines in the state, placing Illinois fifth in coal production among the states. Illinois's transportation sector is built around railroads and airline travel, and includes the nation's busiest airport, O'Hare. The state is also second in the nation in miles of railroad networks and third in miles of interstate highways.

Health Indicators

Illinois has slightly less favorable incidence rates for certain health problems than the nation as a whole. For example, the incidence of low birth-weight babies in Illinois—at 7.9 percent—is higher than in the United States as a whole, at 7.3 percent (table 1). The infant mortality rate also is higher in Illinois than the national average (8.1 deaths per 1,000 live births versus 7.2 deaths per 1,000). In addition, the vaccination rate among toddlers (19 to 35 months in age) is slightly lower in Illinois than nationwide (75.0 percent versus 77.0 percent).

The premature death rate for all age groups is somewhat worse in Illinois than in the United States (49.3 years of potential life lost before age 65 per 1,000 population versus 46.7). Notably, the violent crime rate in Illinois is much higher than in the country as a whole. There were 886 violent crimes per 100,000 people in Illinois in 1996, about 40 percent higher than the national average. Finally, Illinois compares favorably to the United States overall in its incidence of AIDS: 18.6 cases per 100,000 reported in 1996, compared with a national average of 25.2 cases per 100,000.

Politics and Budgetary Policy

Illinois is known as a "swing state" in national elections, and the voters tend to elect moderate political leaders. Moderate Republican governors (James R. Thompson and Jim Edgar) have led the executive branch for more than two decades. Currently, both chambers in the state legislature are almost evenly divided between Republicans and Democrats: Republicans have a slight majority in the Senate, while Democrats have a thin margin in the House. Democrats generally enjoy large majorities of Chicago votes, while Republicans typically garner substantial votes in most other parts of the state.

State revenues totaled roughly $32 billion in fiscal year 1997, $7.7 billion of which were federal funds. Medicaid represented 19.2 percent of state general fund spending in 1995, a sharp increase from 11.8 percent in 1990. When outlays outside the general fund (including other state funds and federal aid) are accounted for, Medicaid outlays in Illinois reached 28.1 percent of the state's total budget for 1995, greater than the proportion allocated to elementary and secondary education (20.0 percent) or to higher education (10.4 percent) for that year. Total state Medicaid outlays in Illinois grew at an average annual rate of 23.2 percent over the 1990–95 period.[2] Spending increases in Medicaid have slowed considerably over the past two years, however, as education has become the top budget priority in Illinois. For fiscal year 1999, education funding will increase by $614 million while Medicaid funding is expected to increase by only $251 million.[3]

The Health Care Market

Movement toward managed care in the Illinois health care market has occurred much less rapidly than in the nation as a whole. An estimated 17.4 percent of the state's residents were enrolled in health maintenance organizations (HMOs) in 1996, slightly less than three-fourths of the U.S. average (24.0 percent). The gap is even more pronounced among publicly insured residents. Only 7.0 percent of Medicare beneficiaries had joined risk-based HMOs in 1997, compared with 12.5 percent nationwide. Moreover, only 13.7 percent of Medicaid enrollees were in an HMO or primary care case management (PCCM) program in 1997, versus 47 percent in the country as a whole.[4]

HMO penetration is greater in Chicago than in the smaller cities and rural areas of Illinois. But the managed care market in Chicago is characterized by rather broad provider networks and prevalent point-of-service options. As a result, most consumers have open access to providers across the community. Fully integrated health care systems are not as common in Chicago—or in other parts of Illinois—as in many other areas of the country. Indemnity insurers, such as Aetna and Blue Cross, are still prevalent in Chicago's health care market. In September 1998, Blue Cross and Blue Shield of Illinois merged with Blue Cross and Blue Shield of Texas, although the deal is being challenged in Texas.[5]

Chicago has experienced some important restructuring in the hospital sector since the 1980s. Several hospitals closed as hospital utilization and length of stay began to decline, reducing the substantial excess bed capacity in the area, and others merged in an effort to expand their market share. For example, the Evangelical system merged with Lutheran General to form the Advocate system. As of October 1998, an Arizona-based health care management firm and a group of Chicago physicians had entered into negotiations with

Columbia/HCA to purchase two of its hospitals—Michael Reese, a large teaching hospital, and Grant. Further, Columbia/HCA has agreed to sell three other facilities in the Chicago area, potentially leaving the organization with only one hospital in the area.[6]

Academic health centers (such as University of Chicago and Northwestern) are doing better financially than many of their counterparts in other large American cities. The success of these academic health centers and other teaching hospitals in Chicago has been attributed to their ability to maintain financial flexibility through periods of fluctuation and change in the health care market. This flexibility is based on charging high prices, which have yielded significant profits, stable reserves of cash and investments, and employee productivity.[7] The slow growth in managed care has likely helped preserve the financial viability of these hospitals as well.

The Chicago Business Group on Health, a subsidiary of the Midwest Business Group on Health (MBGH), organized large, self-insured corporations in the Chicago area to contract selectively with hospitals through an organization called CCN, Inc. (formerly called Community Care Network), in an effort to negotiate lower hospital charges and establish quality standards. The effectiveness of the group is questionable since most hospitals are in the CCN network and the group represents less than 5 percent of the market. An attempt to organize the city's smaller employers into a purchasing cooperative in 1996 failed when the employers backed out as the group purchasing activity was about to begin.[8]

More recently, MBGH helped organize another subsidiary group of eight large Chicago employers, including Ford, the state of Illinois, First Chicago NBD, and the University of Chicago, to negotiate with, and purchase health services from, area HMOs.[9] This group, called the Healthcare Purchasing Group, represents 97,000 individuals in the Chicago area.

Health Insurance Coverage

Illinois has proportionately fewer people without health insurance than the national average. Some 11.3 percent of the nonelderly residents of the state lack coverage, more than one-fourth below the national average of 15.5 percent in 1994–95 (table 2). Moreover, proportionately fewer children are without health insurance in Illinois than the national average (6.6 percent compared with 10.4 percent). These gaps reflect the more widespread presence of employer-based coverage in Illinois. The proportion of nonelderly people with employer-sponsored coverage in Illinois was 71.9 percent, nearly six percentage points above the U.S. average of 66.1 percent in 1994–95. The higher rates of employer-sponsored health insurance may result, in part, from the industrial mix of the state's economy. As noted above, a larger-than-average proportion of the state's economy is in the manufacturing and mining sectors, where collective bargaining agreements and employer practices have made health coverage relatively more prevalent than in the service sector.

Among the poor and the near-poor (people in households with incomes less than 200 percent of the FPL), proportionately fewer were uninsured in Illinois than in the United States overall (17.9 percent versus 25.3 percent). One reason is that the rate of employer-based coverage among low-income children and working-age adults is greater in Illinois than in the country as a whole (38.5 percent versus 33.9 percent). Lower-income households in Illinois also get a boost from the somewhat higher penetration of Medicaid in the state's low-income population (38.6 percent versus 34.1 percent).

Medicaid

Eligibility and Enrollment

State Medicaid programs are required to cover certain categories of persons who receive cash assistance, as well as other federally mandated groups. The latter include pregnant women and children under 6 years old living in households with income less than 133 percent of the FPL, and children ages 6 to 15 with family income under 100 percent of the FPL. As of October 1, 1999, this group will be expanded to include age 16 and will then increase by one year annually until all poor children under age 19 are covered. Prior to 1998, Illinois met, but did not go beyond, these minimum federal standards, with one exception: Older teenagers not yet included in the federal mandate were covered if their household income was below 50 percent of the FPL. Eligibility rules have expanded under CHIP, as described below.

Illinois has opted to support a medically needy program to assist low- to moderate-income families that "spend down" into Medicaid eligibility because of costly medical expenses that reduce their incomes. The income and asset limits for qualification are substantially below the national averages, however.

Despite its somewhat stringent criteria, Illinois's Medicaid program covers a relatively large share of the state's low-income population (table 2). Nearly 2 million people were enrolled in Medicaid in 1996. Of these, 126,000 (7 percent) were elderly, 297,000 (16 percent) were blind and disabled, 419,000 (22 percent) were adults, and 1,048,000 (55 percent) were children. About the same proportion of Medicaid enrollees in Illinois are cash assistance recipients as in the United States as a whole—53.4 percent versus 54.3 percent, respectively.

The number of Medicaid beneficiaries has dropped since the mid-1990s. This change largely reflects a decline in the number of people receiving cash assistance (one route to receiving Medicaid); the decline is generally attributed to a strong economy and welfare reform. In Illinois, the number of persons receiving cash assistance through Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF) fell by 18.5 percent over the 1994–97 period. This drop, although significant, is lower than the corresponding decline of 23.2 percent in the United States over this period.

Table 2
Health Insurance Coverage

Health Insurance, 1994–1995	Illinois	United States
Nonelderly Population		
Percent Uninsured [a]	11.3%	15.5%
Percent Medicaid [a]	11.9	12.2
Percent Employer-Sponsored [a]	71.9	66.1
Percent Other Health Insurance [a, b]	5.0	6.2
19–64 Population		
Percent Uninsured [a]	13.5	17.9
Percent Medicaid [a]	6.5	7.1
Percent Employer-Sponsored [a]	74.1	67.8
Percent Other Health Insurance [a, b]	5.9	7.2
0–18 Population		
Percent Uninsured [a]	6.6	10.4
Percent Medicaid [a]	23.2	23.1
Percent Employer-Sponsored [a]	67.3	62.5
Percent Other Health Insurance [a, b]	2.9	4.0
<200 Percent of the Federal Poverty Level, Nonelderly Population		
Percent Uninsured [a]	17.9	25.3
Percent Medicaid [a]	38.6	34.1
Percent Employer-Sponsored [a]	38.5	33.9
Percent Other Health Insurance [a, b]	5.0	6.7

a. Two-year concatenated March CPS files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

Expenditures

Medicaid outlays in Illinois totaled $6.5 billion in 1996 (table 3). This figure includes expenditures for benefits, administrative costs, and disproportionate share hospital (DSH) payments, which are allocated to hospitals based on the amount of care they provide to uninsured and Medicaid patients. With a federal matching rate of 50 percent, the cost of Illinois's Medicaid program was split evenly between the state and the federal government. Expenditures for benefits alone were nearly $6.0 billion in 1996, with 34 percent spent on long-term care services and 66 percent spent on acute care services.

Children, who make up 55 percent of those on Medicaid, accounted for only 19 percent of the state's Medicaid outlays in 1996. In contrast, the elderly and those who are blind and disabled, combined, represented just 23 percent of enrollees but accounted for 63 percent of 1996 outlays. On a per enrollee basis, the average expenditure per child was $1,171 in 1996, compared with almost $9,000 per elderly enrollee and almost $10,000 per blind and disabled enrollee (table 4). Expenditures per elderly enrollee are lower in Illinois than the national average, whereas expenditures per disabled enrollee are higher.

Throughout the 1990s, Illinois's Medicaid spending on both acute and long-term care services has generally increased more rapidly than the national average. However, growth rates in both Illinois and the country overall have decelerated significantly in recent years, following double-digit growth in the first half of the decade. The average annual growth rate in Illinois's program was 30.6 percent from 1990 to 1992, falling to 11.9 percent from 1992 to 1995, and 3.6 percent from 1995 to 1996. The corresponding U.S. growth rates were 27.1 percent, 9.7 percent, and 2.3 percent (table 3). Expenditure increases in Illinois's program can be attributed more to growth in spending per enrollee than to growth in number of enrollees. In fact, from 1995 to 1996, enrollment fell in absolute terms for all categories of beneficiaries, while expenditures per enrollee, especially for the blind and disabled, continued to rise (table 4).

DSH payments totaled roughly $15 billion in the United States in 1996, down from almost $19 billion in 1995, and are scheduled to be trimmed back further over a period of five years under the provisions of the Balanced Budget Act of 1997. Illinois spent $244 million in DSH payments in 1996, representing a much smaller proportion of total Medicaid outlays (3.8 percent) than in the country as a whole (9.4 percent).

Medicaid Managed Care

As noted earlier, Illinois has a much smaller proportion of its Medicaid population in HMO or PCCM models of managed care than do many other states (about 14 percent versus 47 percent nationwide in 1997). In fact, the proportion of the Medicaid caseload enrolled in managed care has not been growing in Illinois, while in many other states it has at least doubled in recent years. This situation results in part from the wholly voluntary nature of managed care enrollment among the Medicaid population in Illinois—many other states have made such enrollment mandatory for at least younger adults and children. Another factor is the relatively lower HMO penetration in the state.

An interesting manifestation of the state's gradual approach to Medicaid managed care involves its Section 1115 waiver proposal, entitled Illinois MediPlan Plus Demonstration. In July 1996, after almost two years of debate among state and federal policymakers, the Health Care Financing Administration (HCFA) approved the proposal for a five-year period. The goals of the program, which will be implemented on a statewide basis, are to increase access to providers and services, improve quality of care, and hold down cost increases through mandatory enrollment of state Medicaid recipients in managed care. Unlike many other states that have used Section 1115 research and demonstration waivers to expand coverage to working families otherwise ineligible for Medicaid, Illinois's waiver involves no eligibility expansion.

Table 3
Medicaid Expenditures
by Eligibility Group and Type of Service,
Illinois and United States
(Expenditures in Millions)

	Illinois				United States			
	Expenditures	Average Annual Growth			Expenditures	Average Annual Growth		
	1996	1990–92	1992–95	1995–96	1996	1990–92	1992–95	1995–96
Total	**$6,494.3**	**30.6%**	**11.9%**	**3.6%**	**$160,968.6**	**27.1%**	**9.7%**	**2.3%**
Benefits								
Benefits by Service	5,970.1	28.3	11.9	7.1	140,290.1	18.8	10.9	5.4
Acute Care	3,939.7	30.6	17.0	8.2	84,666.5	22.3	12.8	6.6
Long-Term Care	2,030.3	25.3	4.4	5.1	55,623.6	14.6	8.2	3.5
Benefits by Group	5,970.1	28.3	11.9	7.1	140,290.1	18.8	10.9	5.4
Elderly	1,130.3	28.9	8.1	–0.2	42,418.5	16.7	8.4	3.7
Acute Care	342.6	28.1	17.5	4.1	11,229.3	18.9	12.7	8.6
Long-Term Care	787.7	29.1	5.0	–2.0	31,189.2	16.0	7.1	2.1
Blind and Disabled	2,940.2	27.0	11.9	11.0	56,601.3	17.6	13.3	8.6
Acute Care	1,745.4	31.8	19.6	11.8	33,880.1	22.9	15.8	10.7
Long-Term Care	1,194.7	22.9	3.6	9.9	22,721.2	11.9	10.1	5.7
Adults	673.1	31.1	10.9	2.1	16,956.6	21.4	9.1	0.7
Children	1,226.5	29.1	17.3	8.2	24,313.8	23.8	11.4	4.4
Disproportionate Share Hospital	243.7	122.6	9.6	–41.0	15,102.6	263.4	2.0	–19.6
Administration	280.5	14.0	14.5	0.5	5,575.9	9.8	12.8	2.3

Source: The Urban Institute, 1998. Based on HCFA 2082 and HCFA 64 data.

Under the Section 1115 demonstration program, Illinois will contract with HMOs, managed care community networks (MCCNs), and enrolled managed care providers (EMCPs). MCCNs are provider-based organizations that will typically be developed by either an academic health center or county health providers to provide or coordinate health services exclusively for enrollees in Illinois's MediPlan Plus program. Community providers who want to form MCCNs are permitted to participate initially as prepaid health plans until they gain experience in operating managed care delivery systems, and then they are classified as MCCNs. EMCPs include federally qualified health centers, rural health clinics, and physicians who agree to provide PCCM services to enrollees.

While the MCCNs and HMOs will provide a full range of health services on a capitated basis, the EMCPs will provide only a gatekeeping function. Individuals participating in MediPlan Plus are given the opportunity to enroll in one of the three health systems; if they do not, they are automatically assigned to either an HMO or an MCCN.

As of October 1998, plans to implement MediPlan Plus had been put on hold. No implementation date has been set, as the program is still in the planning and design stages.

Current State Health Policy Issues

Children's Health Insurance Program

In December 1997, Illinois submitted its Children's Health Insurance Program plan to HCFA to expand Medicaid coverage for near-poor children on a limited, phased-in basis. Although the first phase of Illinois's program, called KidCare, began in January 1998, the program was not officially approved by HCFA until April 1998.

Under the first phase of the program, the state expanded Medicaid coverage for infants and pregnant women up to 200 percent of the FPL (formerly infants and pregnant women were eligible for Medicaid only up to 133 percent of the FPL) and for children ages 6 through 18 up to 133 percent of the FPL (formerly only children ages 1 through 6 with family incomes up to 133 percent of the FPL, children ages 7 through 14 up to 100 percent of the FPL, and youth ages 15 through 18 up to 50 percent of the FPL were eligible for Medicaid). This expansion will cover an estimated 40,400 children. One benefit of the first phase of Illinois's CHIP plan is greater equalization of coverage within families. Previously, a family might have had a younger child eligible for Medicaid and an older child ineligible for assistance.

Illinois formed a task force, comprised of members of the governor's office, state agencies, and the General Assembly, to develop the subsequent phases of CHIP, which are expected to cover an additional 157,000 children. Phase II of Illinois's KidCare program, which has two components, was recently developed by the task force and

Table 4
Medicaid Enrollment and Expenditures per Enrollee: Contributions to Total Expenditure Growth

	Illinois				United States			
		Average Annual Growth				Average Annual Growth		
	1996	1990–92	1992–95	1995–96	1996	1990–92	1992–95	1995–96
Elderly								
Total expenditures on benefits (millions)	$1,130.3	28.9%	8.1%	–0.2%	$42,418.5	16.7%	8.4%	3.7%
Enrollment (thousands)	126.2	5.9	3.9	–1.4	4,103.2	5.1	2.9	0.0
Expenditures per enrollee	$8,958	21.6	4.1	1.2	$10,338	11.0	5.4	3.7
Blind and Disabled								
Total expenditures on benefits (millions)	$2,940.2	27.0	11.9	11.0	$56,601.3	17.6	13.3	8.6
Enrollment (thousands)	297.4	11.9	8.3	–0.8	6,698.2	9.8	9.3	5.2
Expenditures per enrollee	$9,886	13.5	3.4	11.9	$8,450	7.1	3.7	3.2
Adults								
Total expenditures on benefits (millions)	$673.1	31.1	10.9	2.1	$16,956.6	21.4	9.1	0.7
Enrollment (thousands)	419.2	8.3	4.7	–3.2	9,225.0	11.4	5.0	–4.1
Expenditures per enrollee	$1,606	21.0	5.9	5.4	$1,838	8.9	4.0	5.0
Children								
Total expenditures on benefits (millions)	$1,226.5	29.1	17.3	8.2	$24,313.8	23.8	11.4	4.4
Enrollment (thousands)	1,047.5	7.8	5.3	–1.4	21,270.5	13.1	4.8	–1.6
Expenditures per enrollee	$1,171	19.8	11.3	9.8	$1,143	9.5	6.3	6.3

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

signed into law by Governor Edgar in August 1998. Children in families with incomes from 133 to 185 percent of the FPL who do not have employer-sponsored insurance available to them will be enrolled in KidCare Phase II, a Medicaid "look-alike" program that uses the same provider networks, reimbursement rates, and benefit package as the Medicaid program. However, this component of the program will use a different identification card and will require cost-sharing. Also under Phase II, children from families with incomes from 133 percent to 185 percent of the FPL who have employer-sponsored insurance available to them (they may or may not be currently enrolled in the employer plan) will be eligible for coverage through a credit voucher program that will subsidize the cost of employer coverage. Phase II had not yet received approval from HCFA as of October 1998.

Phase III of Illinois's CHIP program is still to be developed and will be based on a study, authorized by Phase II, of uninsured and low-income children in Illinois. This stage may expand coverage to children in families up to 200 percent of the FPL.

Under the federal Balanced Budget Act of 1997, which established CHIP, Illinois is eligible for $620 million in federal funds over the 1998–2002 period. The coverage expansions called for in the first phase of Illinois's CHIP program will cost $45 million for FY 1999, of which the state's share is $19 million. To draw down the full allotment of federal funds for the first year ($122 million), the state would have had to spend $51 million of its own money. However, states have two additional fiscal years to spend the unused portion of the first-year allotment of federal money.

An estimated 300,000 children are without health insurance in Illinois. Of these, 100,000 are eligible for the regular Medicaid program (prior to the CHIP expansion) but not yet enrolled. The state is trying to augment its outreach efforts to find and enroll these children. It plans to sign them up at schools, clinics, and community health centers. The state will also employ door-to-door canvassing; distribution of handbills; public service announcements and advertising on radio and television; and coordination with other organizations such as Special Supplemental Food Program for Women, Infants, and Children (WIC), schools, social service agencies, and day care centers. Other steps include simplification of the Medicaid application process and off-site enrollment.

Insurance Market Reform

Illinois has taken a number of steps to assure initial access to, and continuity of, private health insurance coverage. These reforms are aimed at ensuring that people judged to be high risks in the insurance community because of known medical conditions are able to obtain insurance at affordable rates and continue their coverage when their job status, marital status, or other circumstances change.

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to (1) guarantee issue of all small group insurance products to any group with 2 to 50 workers, regardless of past claims experience or group health status; (2)

guarantee renewal of insurance policies to individuals and groups of all sizes regardless of claims experience; (3) limit the exclusion period for preexisting illnesses to 12 months for any condition that was diagnosed or treated up to 6 months before the policy was issued; (4) eliminate pregnancy as a preexisting condition that may be excluded from coverage; and (5) convert a group enrollee's coverage to a nongroup (or individual) policy if the person meets HIPAA eligibility requirements.

Prior to HIPAA, many states had taken some legislative steps in the direction of the federal legislation. Illinois, under a 1993 act, had required the following:

- Exclusion of coverage is permitted for not more than 12 months for conditions treated or diagnosed up to 12 months prior to enrollment;
- Exclusion periods elapsed under a previous policy must be credited under new policies (credit must be given if the gap between new and previous coverage is less than 30 days);
- Policies must be renewed except in the cases of fraud, nonpayment, and so on; and
- Rate bands must be used to limit variations in rates for claims experience, health status, and duration of coverage (35 percent above and below the mean).

In addition, 15 years ago Illinois enacted a legislative requirement to allow people to convert from group to nongroup coverage.

In 1997, Illinois enacted a law to implement HIPAA. Provisions include the following:

- Exclusion of coverage is permitted for not more than 12 months for conditions treated or diagnosed up to 6 *(instead of 12)* months prior to enrollment;
- Credit must be given if the gap between new and previous coverage is less than 63 *(instead of 30)* days;
- All products must be issued if applied for; and
- A high-risk pool is used to cover HIPAA-eligible individuals who convert from group to nongroup coverage.

Illinois did not enact a provision to guarantee renewability in the individual market. Thus, HCFA is responsible for enforcing this provision.

Conclusion

The state of Illinois is economically sound and has a strong industrial base, contributing to a high rate of employer-sponsored insurance. The low-income population in Illinois, like the state population as a whole, is more likely to have employer-sponsored insurance than is the case nationwide. Perhaps as a result, Illinois has not been a major innovator in extending publicly financed insurance to the low-income population. This level of stability and maintenance of the status quo extends to Illinois's health care market; both insurer and provider markets have undergone little upheaval compared with many other markets in the country. Managed care penetration has been modest, and, where it exists, provider networks appear relatively unrestricted. Within the Medicaid program in particular, managed care participation is much lower than the national average. Although the state has been slow to adopt managed care for its Medicaid program, it plans to begin statewide enrollment in capitated plans of many beneficiaries in the near future. Other changes underway that will affect the low-income population are the decline in welfare participation, with associated declines in Medicaid enrollment, and new health insurance coverage under CHIP. Illinois's insurance rates have mirrored the national trend of rising uninsurance over the past few years; it remains to be seen to what extent welfare declines and CHIP expansions will alter this trend.

Notes

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About the Authors

Jack A. Meyer is the founder and president of the Economic and Social Research Institute. Dr. Meyer has conducted policy analysis and directed research on frontline issues in health care reform and social policy for 20 years. He is the author of numerous books, monographs, and articles on topics including health care, labor market and demographic trends, and policies to reduce poverty. Dr. Meyer is also the founder and president of New Directions for Policy, a health care consulting firm.

Stephanie E. Anthony is a senior research associate at the Economic and Social Research Institute. Ms. Anthony has conducted policy research and analysis on federal and state programs that improve the health of women, children, and families. Her writing has focused on health issues concerning uninsured children, Medicaid managed care for persons with disabilities, public hospital conversions, and youth violence.

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