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A Race to the Top: Illinois's All Kids Initiative

Prepared by
Teresa A. Coughlin and Mindy Cohen
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Executive Summary

In the summer of 2006, Illinois joined several other states in advancing health care reform by launching the nation's first universal coverage program for children. Called "All Kids," the initiative builds on the state's Medicaid and State Children's Health Insurance Program (SCHIP) programs but is funded exclusively with state funds. The program offers coverage to all uninsured children, regardless of income, health status or citizenship. On a sliding income basis, families can purchase coverage under All Kids, and as of April 2007, nearly 50,000 children were enrolled in the program. The entire Medicaid, SCHIP and state only programs cover 1.3 million children under the umbrella of All Kids.

This brief reports on a case study of the All Kids initiative that was conducted in spring 2007. It provides some general background information on Illinois's public health programs, describes key features of All Kids, and discusses why the state designed the program the way it did. The report also highlights early program experiences.

With particularly strong leadership of Governor Rod Blagojevich (the principal architect of the initiative), along with widespread support from state advocacy groups, health care stakeholders and the legislature, All Kids was implemented in July 2006. In terms of enrollment, the program has met with great success and has surpassed state targets. Interviewees attribute some of that success to the state's considerable outreach effort that involved several innovative strategies including an application agent initiative in which community organizations, medical providers and insurance agents help individuals complete the All Kids application. Illinois's consumer friendly application is also noted as a being a major reason for the program's early enrollment success. Another important ingredient cited is the universality of All Kids—that is, the program is simply available to *all* children in the state, which makes it easy to market and easy for families to understand.

In putting the program together, Illinois officials had to deal with several programmatic matters. For example, because the program is available to children at all income levels, the state wanted to deter both employers from dropping dependent coverage and families from dropping private coverage to enroll their children in All Kids. So they opted to impose a 12-month uninsurance waiting period for children in families with income over 200 percent of the federal poverty line, though there are several exceptions to the rule such as children who lost coverage because a parent lost a job for any reason. Another challenge was how to set cost sharing to emphasize preventive care and to make it affordable for low-income families. At the same time, for higher-income families, who typically have other insurance options, officials wanted premiums to be sufficiently high to prevent All Kids from "crowding out" private coverage. Under All Kids, no cost sharing is imposed for preventive care (medical and dental) regardless of income, and cost-sharing is designed so that the program is "very affordable" for low-income families. For higher-income families, All Kids premiums are set to be comparable to those in the commercial market.

Financing for the All Kids expansion largely comes from projected savings from two new managed care initiatives—a primary care case management (PCCM) program and a disease management (DM) program. Combined, the PCCM and DM are estimated to save \$57 million each year, which would cover the first-year costs of the All Kids program, estimated at \$25 million. The bulk of Illinois’s Medicaid and SCHIP populations (along with All Kids expansion children) will be required to enroll in the PCCM when it is fully implemented, and about 200,000 high-cost Medicaid beneficiaries are targeted for the DM program. Unlike many other states, Illinois has limited managed care for its publicly insured populations and is using these financing strategies employed by other states in the 1990s to fund the All Kids coverage expansion.

Illinois has successfully implemented the All Kids expansion and 50,000 previously ineligible children now have coverage. In addition, the marketing and outreach for the program has led to increased enrollment in Medicaid and SCHIP of children who were previously eligible for these programs, but not enrolled. Approaching its one-year anniversary, the real test of All Kids will be whether the program can sustain this momentum. Like any new initiative, the program faces several challenges in moving forward. Key among them is the success of the PCCM and DM programs, which are currently being rolled out but have experienced implementation problems. Given that savings generated by PCCM and DM initiatives are the primary financing vehicle for the All Kids expansion, it is critical for the program’s long-term viability that these new managed care initiatives be successfully implemented. Another important issue is whether the program offers meaningful universal coverage to children. Given premiums for higher income families were purposefully set high, a question is whether All Kids offers true coverage to all children, particularly those with higher family incomes.

Apart from these and other program issues, Illinois policymakers are debating a new health reform initiative that would build on All Kids and calls for offering affordable health insurance to adults in the state. More broadly, given Illinois’s reliance on federal flexibility in using SCHIP funds in its public insurance programs, the current SCHIP reauthorization debate in Congress will also have important implications for the All Kids program.

A RACE TO THE TOP: ILLINOIS'S ALL KIDS INITIATIVE

While health reform remains stalled at the federal level, states have stepped in and are leading the effort to find workable solutions to cover the nation's nearly 45 million uninsured. In 2006, at least half of the states passed significant health care legislation or seriously contemplated major health reforms. The initiatives are wide-ranging, from expanding existing coverage programs to pursuing individual and employer mandates to developing insurance pools or "connectors" to help individuals and small businesses buy insurance.

Illinois is among the leaders of the recent state health care reform efforts. Proposed by Governor Rod Blagojevich (D), the Illinois General Assembly in 2005 passed legislation to establish All Kids, the nation's first universal coverage program for children. All Kids allows parents to obtain health insurance for their children with premiums scaled to family income. All Kids is available to all uninsured children without regard to income, health status or citizenship.

The program went live July 2006 and, as of April 2007, over 50,000 children had enrolled.¹ All Kids has served as a model for other states, such as Pennsylvania, Tennessee, and Washington, which followed Illinois's approach by implementing programs to cover uninsured children using an insurance buy-in approach. In addition, other states are considering similar expansion proposals.²

¹ The 50,000 figure includes only children in the 2005 All Kids expansion population. All Kids is actually a collection of programs and includes the state's Medicaid and SCHIP programs, which cover eligible children in families with incomes up to 200 percent of the federal poverty line.

² Bordt A, Burton A, Cohn D et al. 2007. *State of the States*, AcademyHealth, State Coverage Initiatives, Washington, D. C.

All Kids is being carefully watched by policymakers across the nation, both as way to offer insurance to children and as a possible strategy to expand coverage to adults. Indeed, in January 2007 Governor Blagojevich proposed Illinois Covered, which builds on All Kids and calls for offering affordable health insurance to all adults in Illinois.

In this brief, we report on a case study of the All Kids initiative. Conducted in spring 2007, the case study focused on why Illinois designed the program as it did, and the state's early experiences under the initiative. To carry out the study, we interviewed a range of key stakeholders, including Medicaid and SCHIP officials, health policy staff from the governor's office, representatives from provider groups and consumer advocates. We supplemented interview data with background information obtained from All Kids program documents, as well as from press reports.

We begin with a brief summary of Illinois's publicly-sponsored health insurance programs, which provided the foundation for All Kids. Next, we describe the design of All Kids and highlight initial program implementation experiences. We conclude with a discussion of how All Kids fits into Governor Blagojevich's 2007 health care proposal.

Summary Overview of Selected Illinois Public Health Insurance Programs

Illinois historically has not been a state to boldly pursue health reform initiatives or coverage expansions. For example, as recently as 2002 Illinois covered parents only up to approximately 39 percent of FPL, ranking 39th among states in coverage of this population.³ While Illinois covered children from 134 percent up to 185 percent of poverty in what was then KidCare (the state's SCHIP program), because of limited

³ Long S, Yemane A and A Lutzky. 2005. Model Waiver Evaluations: The Health Insurance Flexibility and Accountability Initiatives, Case Study Report for Illinois, Submitted to Centers for Medicare and Medicaid Services, Contract No. HHS-500-00-045, T.O. #1, June.

marketing and outreach, enrollment in the program was low. In 1999, fewer than 30,000 children were enrolled in KidCare, according to study interviewees.⁴ Reflecting its lower than average coverage under Medicaid and limited enrollment in SCHIP, Illinois's uninsured rate among non-elderly individuals with income below 100 percent of the FPL was higher than the national average in 2002.⁵

Laying the Foundation for All Kids. Beginning in late 2001, however, Illinois initiated a series of coverage expansions that continue today. Under the leadership of former Governor George Ryan (R), Illinois secured and implemented a Medicaid/SCHIP Section 1115 Health Insurance and Flexibility and Accountability (HIFA) waiver in 2002, which, among other things, allowed the state to expand insurance eligibility to parents and other caretaker relatives with incomes up to 185 percent of the FPL. The HIFA waiver also enabled Illinois to obtain federal Medicaid and SCHIP match for children enrolled in its state-funded premium assistance program—KidCare Rebate, which subsidizes the purchase of individual or employer-sponsored coverage.⁶

Governor Blagojevich (D), who was elected in November 2002, continued to support the HIFA waiver by making funding available for the phased-in coverage expansion for parents. In January 2006, the coverage expansion of parents with incomes up to 185 percent of poverty was completed. Also during the this time, Illinois broadened coverage to children by raising eligibility levels from 185 to 200 percent of the

⁴ Bouman J. 2006. "The Path to Universal Health Coverage for Children in Illinois." Clearinghouse REVIEW Journal of Poverty Law and Policy, Sargent Shriver National Center on Poverty Law, Chicago, Illinois, March-April.

⁵ Long S, Yemane A and A Lutzky. 2005.

⁶ Children in households with a family income of less than 200 percent of the FPL can qualify for KidCare Rebate if their private (individual or employer-sponsored) insurance covers doctor and inpatient hospital care. Under Rebate, Illinois offers up to \$75 per child per month towards the premium.

FPL for both KidCare SCHIP under the state plan and KidCare Rebate under its HIFA waiver in 2004.

Thus in a few short years Illinois significantly expanded its public insurance programs. The expansions were spearheaded by the executive branch (both Governors Ryan and Blagojevich) with strong support from state advocacy groups.⁷ Support for the HIFA waiver and the SCHIP and Rebate expansions was also strong among state legislators, Democrats and Republicans alike.

Development of All Kids. Once the commitment to expanding children’s coverage was made, the state explored different mechanisms for implementing the expansion. While the state considered the idea of expanding coverage in the late 1990s using a private insurance model, estimates demonstrated that it would be more cost-effective to use the Medicaid program as the base, which is the strategy Illinois pursued.⁸ All Kids expands directly on the public insurance programs that Illinois implemented in the early 2000s. Akin to these earlier efforts, the All Kids expansion was developed almost exclusively by the governor’s staff with little input from the state health care community. Given that All Kids was building on existing programs state officials felt there was not a need to consult stakeholders prior to introducing the legislation. The governor was a champion of All Kids, an essential ingredient to the success of the initiative according to several study informants. Materials released by the governor’s office when the proposal was unveiled state that All Kids was designed to provide access to “good, affordable,” and “comprehensive” coverage to the state’s more than 250,000

⁷ Long S, Yemane A and A Lutzky. 2005; Bouman 2006.

⁸ Hadley J and M Craven. 2005. “The Cost of Using Private Insurance to Cover Uninsured Children in Illinois.” Report prepared under contract with the Illinois Department of Central Management Services, October.

uninsured children. Key reasoning behind the initiative was that offering health insurance to children was cost-effective, and kids with health insurance do better in school.⁹

Even though health care stakeholders were not involved in the design of All Kids, there was not a lot of outcry about the initiative when it was proposed, according to study respondents. As one respondent put it, “no one was going to come out against insurance for kids.” Although some charged that All Kids was an election year proposal (for the governor, who was running for a second term in 2006), there was near universal support for the program. Indeed, the legislature voted unanimously in favor of All Kids.

While there was widespread support for All Kids, interviewees noted that there were some misgivings and concerns about the initiative. For example, there was concern about the program’s financial sustainability, especially given the “ebb and flow” of the state’s budget. Others felt that the state should work on fixing existing programs before starting a new one. Also, during the debate in the legislature some policymakers were concerned that since All Kids would cover all children, including undocumented children, the state may become a magnet for this population. The Illinois Department of Healthcare and Family Services, the agency responsible for managing the state’s Medicaid program, will address this issue in a statutorily mandated study on All Kids of which a preliminary report is due to the governor and General Assembly in 2008.

⁹ State of Illinois. 2005. “Governor’s Blagojevich’s ALL KIDS program: Giving Every Child in Illinois Access to Good, Affordable Health Insurance,” October 5.

Key Design Features of All Kids

In terms of enrollment, All Kids has been a great success: Implemented July 2006, the initiative had a goal of expanding coverage to 50,000 children in the first year. Within nine months of implementation (April 2007), it had already reached that enrollment target. In this section we describe the major programmatic features of All Kids (Table 1) and provide some discussion on why Illinois designed the program the way it did.

Table 1
Key Programmatic Features of Illinois's All Kids Expansion Program

Enrollment (April 2007)	50,000
Eligibility	Universal coverage for all uninsured children, regardless of income, health or citizenship status
Waiting Period	Uninsured for 12 months prior; some exceptions
Cost Sharing	
Premiums	Yes, sliding scale based on income; none below 150% FPL
Co-payments	Yes, varies by income and service; no copays below 133% FPL; no copays for well-child and immunization for all income groups.
Delivery System	Same as Medicaid/SCHIP
Financing	State funded only; financing: savings from Medicaid managed care and enrollee cost sharing

Eligibility. All Kids is open to all uninsured children through age 18, regardless of income, health status, or citizenship status. According to state officials, Governor Blagojevich was keen on offering coverage to all children for several reasons. Having a universal program for children—a Medicare-like program for children--made it easy for the public to understand: The program is simply available to *every* child in Illinois. In addition, as one state respondent noted, putting an income limit on the program probably

would not save much money because only a few children in the upper income brackets were predicted to enroll since this population generally has other insurance options. Further, a program with an income cut-off is no longer universal, tarnishing its appeal. Moreover, with an income cap, some moderate-income families may not enroll because they do not think they are eligible. A program with an income cap may also be viewed by some as welfare, which could affect enrollment and appeal.

Allowing non-citizen children to enroll in All Kids was, according to interviewees, particularly important to Governor Blagojevich. The son of immigrants, the governor argued that these children attend school and thus should be immunized and healthy. Plus, many will go on to become citizens so giving them health care in their early years will provide future rewards, both to the individual and to the community.

While all children are eligible for All Kids, the state does impose some eligibility requirements. Perhaps most important, children in families with income over 200 percent of FPL must be uninsured for 12 months before they can enroll in All Kids. This was done to avert insurance crowd out--that is, to prevent families from dropping private coverage to enroll their children in All Kids. There are some exceptions to the one-year waiting period including, among others, children who lost insurance because a parent lost his or her job and children whose insurance covers only limited services. When All Kids was implemented in July 2006, the state imposed only a six-month waiting period rather than the current twelve-month waiting period. Program officials said that a shorter waiting period was used initially because they wanted to ramp up enrollment and did not want to make people wait a year to enroll. At the same time, they felt they needed some waiting period to deter employers and families from dropping coverage.

Illinois officials also view the state's premium assistance program - Rebate - as an "anti-crowd out" strategy: Rebate provides subsidies to families with income between 134 and 200 percent of FPL for children and 134 and 185 percent FPL for parents to help purchase or maintain private coverage which should help deter families from dropping private coverage to enroll in All Kids. Officials also stated that All Kids premiums and cost-sharing structure were designed in part to prevent crowd-out. Specifically, at higher income levels the state set premiums to be comparable to those in the commercial market. In addition, all All Kids enrollees use the same provider network, which may not include a family's current providers. One official speculated that the few higher income enrollees currently in the program are likely children who cannot get insurance elsewhere because of a pre-existing health condition.

Benefits. All Kids benefits are nearly identical, regardless of the child's family income. State officials noted that in an effort to make All Kids universal and to keep the program as simple as possible, the benefit package is the same across covered groups. In addition, a single benefit package makes it easier to market the program and easier for people to understand. Officials also commented that it did not make sense to tailor benefits. They argued that tailoring benefits only saves money if services enrollees use are eliminated. Further, customizing coverage just makes the program more complicated and confusing to enrollees.

Cost-sharing. An important feature in the design of the program is the cost sharing. According to program materials, a principal goal of All Kids is to provide comprehensive coverage that, while not free, is affordable. Table 2 shows program premiums and co-payment maximums by income level as a percent of the 2006 FPL. As

can be seen, premiums are scaled to income, with no premiums charged for children in families with incomes at or below 150 percent of the FPL but \$300 per child with no maximum for families with incomes above 800 percent of the FPL (\$160,000 for a family of four in 2006). Up to 500 percent of the FPL, there is a family premium limit; above that, there is no limit.¹⁰ Premiums levels used in the SCHIP programs helped guide the development of the premiums, and every effort was made to keep them close to three to five percent of family income, according to officials.

**Table 2
All Kids Premium and Cost Sharing by Family Income as a Percent of the
Federal Poverty Level (FPL)**

	0-133% FPL	133-150% FPL	150-200% FPL	200-300% FPL	300-400% FPL	400-500% FPL	500-800% FPL	800% FPL and above
Monthly Premium Per Child	None	None	1 child: \$ 15 2 children: \$25 Each additional child: \$5	\$40/child	\$70/child	\$100/child	\$150-250 per child	\$300 per child
Maximum Monthly Premium	N/A	N/A	\$40 for 5 or more children	\$80 for 2 or more children	\$140 for 2 or more children	\$200 for 2 or more children	NO CAP	NO CAP
Maximum Per Child Per Year Copayments	No co-payments	\$100 per family for all services	\$100 per family for all services	\$500 per child for hospital services	\$750 per child for hospital services	\$1000 per child for hospital services	\$5000 per child for hospital services	NO MAX

Source: Illinois Department of Healthcare and Family Services

How much families pay in co-payments also varies by income and type of service (Table 3). For example, office visit co-payments range from \$2 per visit for children in families with income between 133 and 150 percent of the FPL to \$25 per visit for children in families with income above 800 percent of the FPL. An important exception to income related co-payments is that there is no cost sharing for immunizations or regular medical and dental check-ups regardless of income.

¹⁰ For families with incomes less than 200 percent of the FPL, the All Kids premiums and co-payment schedule was not changed with the All Kids expansion. .

Table 3
All Kids Copayments by Type of Service and Family Income as a Percent of the Federal Poverty Level (FPL)

Service	0-133% FPL	133-150% FPL	150-200% FPL	200-300% FPL	300-400% FPL	400-500% FPL	500-800% FPL	800% FPL and above
Preventative Care Visits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Office Visit	N/A	\$2	\$5	\$10	\$15	\$20	\$25	\$25
Encounter	N/A	N/A	N/A	\$10	\$15	\$20	\$25	\$25
Dental	N/A	\$2	\$5	\$10	\$15	\$20	\$25	\$25
Emergency Room Visit	N/A	\$2	\$25	\$30	\$50	\$75	\$100	\$100
Prescription Drugs including insulin and diabetic supplies	N/A	\$2 for brand or generic	Brand \$5 Generic \$3	Brand \$7 Generic \$3	Brand \$14 Generic \$6	Brand \$21 Generic \$9	Brand \$28 Generic \$12	Brand \$28 Generic \$12
Hospital Admission	N/A	\$5 per admission	\$100 per admission	\$100 per admission	\$150 per admission	\$200 per admission	10% of IL Medicaid rate per admission	25% of IL Medicaid rate per admission
Percentage of IL Medicaid rate for each paid outpatient service	N/A	N/A	N/A	5%	10%	15%	20%	25%
Maximum co-pay per year	N/A	\$100 per family for all services	\$100 per family for all services	\$500 per child for hospital services	\$750 per child for hospital services	\$1,000 per child for hospital services	\$5,000 per child for hospital services	No Max

Source: Illinois Department of Healthcare and Family Services

Out-of-pocket limits also vary by income. Families with incomes up to 133 percent of the FPL pay no co-payments whereas those between 133 and 200 percent of the FPL pay up to \$100 in co-payments per year. Above 200 percent of the FPL, the co-payment maximum shifts to a per child basis and applies only to hospital services. There is no co-payment maximum for families with income above 800 percent of the FPL.

The decision behind only counting hospital co-payments toward the yearly maximum (except at the lowest income levels) was driven in large part by an artifact of the state's information system. Specifically, different service claims are processed by different systems, which do not "communicate," making it administratively impossible to track co-payments across services. At the same time, officials observed that given the relatively low copayment amounts for most services, most children would only hit the

maximum if they had a hospital admission because inpatient care is so much more costly than other services. So, to avoid people having to keep a “shoe box” of medical receipts, the state opted to base the co-payment maximum on hospital services only (which the state tracks) for most income groups.¹¹

In setting cost sharing for All Kids, state officials said they wanted to emphasize preventive care—therefore no co-pays for such care are charged, irrespective of income. Another objective was also to make cost sharing “very affordable” at the low end of the income scale and comparable to the prevailing cost of private insurance at the top end. Cost sharing for the middle-income tiers was based on a sliding scale between the low and top end. Given the commercial level premiums for the upper income groups, Illinois officials assumed that not many children in these groups would enroll in All Kids, an assumption that has been borne out. Advocates expressed concern about the steep cost sharing at the higher income levels, which they claim is higher than the average cost of providing health care for a child and poses an enrollment barrier.

Delivery System. As discussed below, in early 2007 Illinois began implementation of a mandatory primary care case management (PCCM) program, called Illinois Health Connect. All Kids participants (Medicaid, SCHIP and expansion enrollees) are required to enroll in Illinois Health Connect, as well as much of the rest of the state’s Medicaid and adult SCHIP population, including parents, the disabled and the elderly.

Financing. The All Kids expansion is at present financed exclusively with state funds. Illinois estimated that providing coverage to newly entitled children in All Kids

¹¹ The state continues to use the shoe-box method to track out-of-pocket costs across services for enrollees with incomes less than 200 percent of the FPL.

would cost \$31 million in the first year.¹² In making this estimate, the state assumed that 10 percent of children covered by private insurance would switch to All Kids.¹³ In addition to collecting premiums and co-payments from enrollees, Illinois implemented two new cost-saving measures—a PCCM program and a disease management (DM) program for high cost Medicaid enrollees--to fund the All Kids coverage expansion. Unlike most states, until 2007 Medicaid managed care in Illinois was very limited; in 2005 less than 10 percent of Illinois Medicaid enrollees were in managed care compared to the national rate of 63 percent.¹⁴ Illinois was thus able to budget savings to be generated from switching from Medicaid fee-for-service to a managed care arrangement to help pay for the All Kids initiative, a strategy many other states used in the 1990s.¹⁵ With the bulk of the projected savings coming from the disease management program, the state estimated that combined the two care management initiatives would save \$57 million annually, more than what was needed to finance the All Kids expansion.

The state has considered trying to secure federal Medicaid or SCHIP match to help fund the All Kids expansion. Indeed, Illinois's HIFA waiver is up for renewal in 2007 and officials plan to try to get matching funds for children with household income over 200 percent of FPL. The state's ability to secure additional federal funds for these children will likely depend on the outcome of the federal debate over reauthorization of the SCHIP program.

¹² A one-time cost to decrease the payment cycle for some physician and dental services, estimated at \$40 million, matched at 50 percent, is sometimes also included in the cost of the All Kids coverage.

¹³ General Information Q and A, October 5, 2005.

¹⁴ The Kaiser Family Foundation, State Health Facts, "Medicaid Managed Care Enrollment as a Percent of Total Enrollment, June 2005," <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Managed+Care&topic=MC+Enrollment+as+a+%25+of+Medicaid+Enrollment>

¹⁵ See for example, CJ Conover and HH Davies. 2000. "Role of TennCare in Health Policy for Low-Income People in Tennessee," <http://www.urban.org/publications/309341.html>

Early Program Experience

While stakeholders by and large did not play a role in the design of All Kids, they have been involved in implementing the program. Below we discuss implementation and early experiences surrounding outreach, enrollment and eligibility re-determination, cost sharing, as well as the two managed care initiatives—the PCCM and the DM program. Program expenditures are not addressed since no information is available at this initial stage of the initiative.

Outreach. As described by all interviewees, the state had an “aggressive” outreach campaign that started about six months before All Kids was implemented in July 2006. The state was intent on having the program “work,” according to interviewees. There was no set outreach budget, but state officials acknowledged that funding to market All Kids was considerable. The state contracted with an outside marketing firm to help with the All Kids campaign. Specific outreach activities included media advertising, participating in back-to-school events and health fairs, and conducting bus tours across the state. Many of these events were planned and/or conducted in conjunction with patient advocacy groups.

In addition to these efforts, the state expanded its application agent program. When Illinois implemented its SCHIP program, the Department of Healthcare and Family Services (formerly called the Department of Public Aid) began an initiative in which community-based organizations (for example, day-care centers, local governments and school districts) and individuals (medical providers and licensed insurance agents) could serve as application agents to assist individuals with completing and submitting an

application form. For each application that resulted in new coverage, the agent could receive a Technical Assistance Payment of \$50.

This program was expanded under the All Kids initiative with a major focus of state outreach being training more application agents. In Chicago alone there are now nearly 400 All Kids application agents. State officials noted that most applications generated through the application agent program come in through local public health agencies and Federally Qualified Health Centers. Officials added that these organizations have been particularly helpful in enrolling immigrant families in All Kids as they are trusted by the population.

State officials viewed most of these outreach strategies as successful, particularly the media advertising and expanding the application agent program. The bulk of outreach expenditures went to media advertising, mostly television commercials and billboards. The state marketed All Kids to thirty-something year old, middle-income parents (described as the “J. Jill” market by one official) in an effort to remove the stigma often attached to government sponsored insurance coverage. Respondents commented that the commercials were particularly effective due to their repeated showings. Training tours used to recruit more application agents were also considered helpful, particularly in areas outside of the Chicago metropolitan area.

One strategy that officials identified as not being successful was school-based outreach. According to state officials, few children were newly enrolled into the program through this mechanism.

Enrollment. Illinois has a single application that is used by all parents and children at any income level. After reviewing application information, the state

determines which program or programs a child qualifies for. Illinois began the single application approach when it implemented SCHIP. While officials acknowledge that completely integrating the operation of all coverage is complex to administer, it makes it easier for the applicant as he or she does not have to determine in advance which programs their child might be eligible for.

A fairly new online application modified to accommodate All Kids has become increasingly common; online applications now account for roughly half of the applications received by the central All Kids Unit. The online application requires a signature page that must be mailed in and a recent paycheck stub for working parents that they must mail to the state, which does deter some from completing the process, but otherwise the online application tool has been successful. In some cases, the state does allow applicants to self declare income. This was done in response to advocates concerns that some immigrant workers are paid on a cash-only basis making it impossible for them to produce a pay check stub.

For children in families with income up to 200 percent of the FPL, there is presumptive eligibility that begins on the date of application. Once approved, enrollees receive a monthly notice stating their enrollment status, which is their insurance “card.” (Medicaid enrollees are also sent a monthly letter documenting eligibility.) Advocates and provider groups would very much like the state to switch to using “hard” insurance cards that also note the enrollee’s cost-sharing requirements. Advocates believe the hard card will help remove any stigma associated with the program, and providers want the cost-sharing level noted on the card to help with collection of co-payments.

As of April 2007, about 50,000 children have enrolled in the expansion part of the All Kids initiative. About half are in households with income less than 200 percent of the FPL. Many of these are immigrant children who do not yet qualify for Medicaid and SCHIP because of program citizenship and immigration requirements. Most of the remaining new enrollment has occurred in the low-to moderate-income groups but some children in the higher income groups have also enrolled. About 100 children with \$100,000 or greater family income have enrolled. Prior to the All Kids expansion, the state estimated that there were about 250,000 uninsured children across all income groups in Illinois.¹⁶

Enrollment of poor, immigrant children into the program has created a challenge for the state. While the state is pleased with strong enrollment among a traditionally difficult population to reach, some in the state do not support coverage for this group. Also, All Kids has not enrolled as many middle income children as they had originally projected.

Mentioned earlier, the state has observed an increase in enrollment in other groups--for example, parents as well as lower income children. State officials speculated that some of that increase could be attributed to the All Kids initiative. The state, however, has not examined the spillover effect of the All Kids expansion but enrollment in state health programs totaled more than 1.8 million in January 2007, up from 1.6 million in April 2006, or a 13 percent enrollment increase in nine months.

Eligibility Re-determination. Once qualified, All Kids enrollees can stay in the program for up to a year before eligibility re-determination. The first round of re-determination will thus begin July 2007. For children in Medicaid and SCHIP with

¹⁶ <http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=37&RecNum=4406>

income below 200 percent of the FPL, Illinois uses a passive renewal process, which has worked well and improved retention rates, according to state officials.

At the time of our site visit in March 2007, the state was struggling with several issues in operationalizing the All Kids re-determination process. One important matter, among others, was that the All Kids statute requires that during re-determination the state assess whether enrollees who entered under an exception to not being uninsured have “affordable and accessible” insurance options. At initial application to All Kids, the state simply assesses whether the child has had insurance in the last twelve months or meets an exception. Should, for example, affordability be based on premiums only (which has been the strategy in the past) or premiums and co-payments? Or, what does affordable mean in terms of income? Given that middle and higher income children are enrolled in All Kids, there is a good chance these families’ insurance options have changed during the year. And, what should be the minimum acceptable level of coverage to be considered a true insurance option?

In a recent program rule, state officials defined the terms affordable and accessible for the purposes of All Kids. Specifically, for children in families with incomes between 200 and 400 percent of poverty, the cost of the monthly premium of all children should not exceed three percent of the family’s monthly countable income. For children in families between 400 and 500 percent of poverty, this amount should not exceed four percent, and for those in families above 500 percent, it should not exceed five percent.

Advocates are concerned about how re-determination for immigrants will be handled. Specifically, given the recent federal requirement that applicants for Medicaid

document citizenship, advocates are worried that immigrant All Kids enrollees may erroneously think that they will have to produce these documents to renew their eligibility in the program.

Cost-sharing. The state collects premiums for All Kids using a system it has in place for its other health programs. In an effort to make payment as easy as possible, there are various ways enrollees can pay their monthly All Kids premium—by mail, by phone, online, or by debit or credit card. A family is allowed to a grace period of two months, which effectively assures three months of coverage. After that time, the family is dropped from the program and then must wait three months before they can re-enroll, at which time they have to pay their account balance in full plus a month in advance. The state estimates that they lose about three percent of their premium cases each month because of premium non-payment.

Providers are responsible for collecting co-payments. The state acknowledged that this could become an issue with the All Kids expansion population because cost sharing can be significant for higher-income enrollees. While Illinois has used co-payments in other health care programs, state officials said that they had heard anecdotally that providers did not bother collecting them because the amounts were small.

Provider groups were also concerned about the co-payments but for a different reason: The monthly eligibility notice used to document program enrollment does not indicate the enrollees' cost sharing level. Instead, providers must determine what co-payment they need to collect, which, given the variation in co-payments, could become an “administrative nightmare” according to provider groups.¹⁷

¹⁷ Since the time of our visit, the state has added the co-payment information to the notice.

Cost-Containment Strategies. Illinois estimated that the All Kids coverage expansion would cost \$31 million in the first year. Apart from enrollee cost sharing, projected savings from the two new managed care initiatives—the PCCM and DM programs—are the other two funding mechanisms in this state-only funded initiative. The PCCM and the DM programs are statewide initiatives and affect almost all enrollees in Illinois’s means-tested healthcare programs. Combined, the state projects that PCCM and the DM programs will generate first-year savings of at least \$57 million. Both programs are fairly standard DM and PCCM initiatives but for Illinois they break new ground in that managed care has historically been limited in the state.

Disease Management. The bulk of the savings is expected to come from the disease management project, called Your Healthcare Plus. Participation in the program is voluntary for both patients and doctors. It focuses on high-risk enrollees, including frequent users of emergency rooms or enrollees with chronic diseases such as diabetes, coronary artery disease and persistent asthma. Launched in July 2006, the goal of the program is to help enrollees better manage their health while reducing the cost of care.

Illinois hired McKesson Health Solutions (MHS) to administer the DM program negotiating an arrangement that puts the contractor at risk for generating the \$40 million in savings the state projected the initiative would realize. Using claims data, MHS has identified 225,000 individuals that fit the target population for the DM program. Depending upon the enrollee’s determined risk level, MHS uses different patient contact methods, which range from mail contact for low-risk patients to in-person appointments for a needs assessment for the highest-risk patients. In addition to helping beneficiaries, MHS offers support to physicians such as providing educational information and care

coordination and management. Unlike the PCCM program, physicians do not receive additional payment for treating beneficiaries in the DM program.

While the DM program was implemented in July 2006, interviewees all agreed that it was too early to judge how the program is faring and whether MHS will be able to realize the expected cost savings. According to physician representatives, doctors have not seen much member response to the program yet and are taking a “wait and see” approach. Industry representatives added that a DM program can be a positive undertaking if it helps the patient, but they were concerned that it could become a burden on the physician or could interfere with how doctors practice. Advocates noted that MHS has done little community outreach to publicize the program and worry that the program is not reaching beneficiaries.

Primary Care Case Management. Illinois also expects to generate program savings through its new PCCM program—Illinois Health Connect. Most individuals enrolled in one of the state’s means-tested programs will eventually be required to enroll in the program. The PCCM was implemented July 2006 with voluntary enrollment allowed. In February 2007, mandatory enrollment began phasing in, starting in Cook County (the county Chicago is located in) and surrounding areas. Mandatory enrollment in 24 counties in the northwest region of the state began in May 2007. Physicians receive a monthly management fee for each beneficiary (\$2 for children, \$3 for adults and \$4 for disabled and elderly) in their practice. Unlike the DM program, the contractor selected to administer the program, Automated Health Systems (AHS), is not at risk for producing cost savings.

While both advocates and provider groups alike agree with the overall objective of the PCCM program - to create a medical home for the beneficiary - they have some concerns. Chief among them is that the PCCM may not be able to adequately serve enrollees in all parts of the state because of the geographic distribution of physicians participating in the new PCCM. While acknowledging that the number of doctors in the PCCM may be sufficient to serve enrollees overall, where they are located may be a problem. State officials, however, noted that their analyses, which were conducted before implementation, showed the geographic distribution of primary care doctors in the PCCM was more than sufficient in mandatory areas.

Apart from the geographic distribution of providers, advocates also noted another problem: Physicians have to actively sign up for the PCCM, even if they participated in Illinois's Medicaid fee-for-service program. Given the difficulty in getting doctors to participate in public programs, having them sign up a second time may be that much harder.

Another problem cited by advocates is how quickly the PCCM was implemented. While understanding the state's desire to move on the initiative, advocates felt this has contributed to what they perceive as network problems. In addition, the short implementation schedule has also not allowed for beneficiary education about how to use a PCCM. According to advocates, the state has not provided necessary information to beneficiaries about the new program and instead has relied on social service agencies to do this work. They caution that for the PCCM to succeed, a behavior change on the part of beneficiaries is required (for example, enrollees need to understand they can no longer go to the emergency room for ambulatory care), and this has not been effectively

communicated by the state. State officials, however, noted that to help ease beneficiary enrollment, the state delayed implementation of the PCCM in Cook County. Officials also noted that the state contracted or collaborated with various social service agencies to provide client education.

Expanding on All Kids: The Illinois Covered Proposal

In March 2007, Governor Blagojevich announced Illinois Covered, which called for providing access to health care services to all Illinoisans, making it among the most comprehensive health care reform proposals in the nation. While not a call for an individual mandate as in other states (for example, Massachusetts), Illinois Covered envisioned creating several insurance choices that parallel many of those offered under All Kids--providing publicly-subsidized coverage up to 400 percent of the FPL for parents with no access to employer coverage, giving rebates to help middle-income families pay for health insurance premiums (again up to 400 percent of the FPL), and developing affordable insurance plans for individuals and small businesses to buy into. It also would allow parents to keep adult children up to age 29 on their health insurance policies.

Distinct from other states (such as Maine and Massachusetts), which partially finance their reforms by shifting existing health care funds around, Illinois Covered would have been financed largely with revenues from a new gross receipt tax on businesses. On March 30, 2007 legislation for both the proposal and the new tax were

introduced in the Illinois General Assembly. It proved to be a controversial proposal, with several prominent state political and businesses leaders opposing the measure.¹⁸

In May 2007, the Illinois House resoundingly voted (by a vote of 170 to 0) down the governor's tax plan, which included funding for Illinois Covered.¹⁹ Failing to enact a budget by the May 31 deadline, as of this writing in July 2007, the fate of the health plan is unclear. A scaled-down version of the plan has reportedly been developed.²⁰ Key ingredients include providing coverage to those living below poverty and reliance on a payroll tax on companies that are not spending at least 4 percent of their payroll costs on health insurance rather than being funded with revenues from a new tax on business's gross receipts.

Discussion

Illinois is one of a few states to have recently enacted a major health care initiative designed to reduce the number of uninsured within its borders. Within a few months of implementing All Kids, the country's first universal coverage program for children, about 50,000 previously ineligible children now have coverage. The initiative appears to enjoy wide support, from the governor to legislators to consumer advocates to providers. While broad support appears to be important, strong leadership from the governor was cited as being especially critical to the program's enactment and implementation.

¹⁸ Chase, J. 2007. "Blagojevich Readies Supporters for Fight." Chicago Tribune, March 5. Finke, D. 2007. "Dems Shy Away from the Governor's Tax Plan." The Lincoln Courier, March 22. Saulny S. 2007. "Tax to Pay for Health Plan in Illinois Faces Resistance." New York Times, May 5.

¹⁹ McKinney D and Woodward W. 2007. "107-0: Illinois House Crushes Gov's Tax Plan." Chicago Sun-Times, May 11.

²⁰ Meitrodt, J. 2007. "Health Care Plan Revived, Blagojevich Scales Back First Proposal." Chicago Tribune, July 21.

By all accounts and by enrollment numbers, program outreach for All Kids has been a success. In large part, this success was attributed to the considerable campaign the state undertook to market All Kids, one that used a range of innovative strategies. The state's streamlined application and follow-up processing, which includes a new online option, also likely contributed to the program's enrollment success. Another likely important factor is the state's decision to incorporate the expansion directly into its Medicaid and SCHIP programs and then market all under the single umbrella name of All Kids. In short, the outreach, the application process and the integrated program, make All Kids customer friendly and easy to understand.

Approaching its one-year anniversary, the real test of All Kids will be whether the program can sustain this momentum. Like any new initiative, there are several challenges that the program faces as it moves forward. Key among them is launching the PCCM and DM programs. Given that projected savings generated by these programs are the primary financing vehicles for the All Kids expansion, it is critical for the program's stability that they be successfully implemented. In addition, making these programs work will also help maintain the support and good will of providers and consumer advocates.

Another issue is whether the program truly offers meaningful universal coverage to children. As discussed, the premiums for higher income enrollees were purposefully set high to prevent insurance crowd out, which raises the question whether the program is affordable to children at all income levels. Related to this, it will be important to track how the PCCM network develops. If the state has problems recruiting physicians in all regions of the state, including more moderate-income areas, then the universality of the initiative could also be compromised. How the recently developed tests of affordability

and accessibility of other insurance options work as part of the eligibility re-determination will also be important to monitor. These too have implications for universal nature of the program.

As All Kids matures, other matters will also need to be monitored. For example, is the one-year waiting period the right amount of time to prevent insurance crowd out? Are the premium levels, co-payments, and out-of-pocket limits affordable? Also, what happens with the governor's health care proposal being debated by state policymakers has implications for All Kids. More broadly, given Illinois's reliance on federal flexibility in using SCHIP funds, what happens with the SCHIP reauthorization debate currently taking place in Congress could also have significant consequences for All Kids. The outcome of these debates will go a long way in shaping the future direction of the program.

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