AN EVALUATION OF PROPOSALS TO REDUCE THE NUMBER OF ILLINOIS' UNINSURED

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AN EVALUATION OF PROPOSALS TO REDUCE THE NUMBER OF ILLINOIS' UNINSURED

A Thesis

by

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Abstract

of

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Statement of Problem

Illinois' health insurance system is fragmented. As noted by the Governor and various interest groups, more than 16.2% of Illinois' residents do not have access to health insurance. Yet the Governor's plan to insure Illinoisans failed to pass through the legislature this year (2007). The failure of the Governor's plan s provides the opportunity to reconsider the best policy option for expanding coverage to the uninsured and meeting other policy objectives.

Sources of Data and Method of Analysis

I drew upon research and literature about the underinsured and how the underinsured access health care. My sources included, among others, the Gilead Center, Ethnic Health Disparities Action Council, California Health Care Foundation, Congressional Budget Office, Center for Budget and Tax Accountability, Kaiser Family Foundation. These sources considered the current system of care, best practices in improving participation rates, and challenges and barriers to health care delivery to the underinsured.

To assess the data, I developed a modified criteria-assessment matrix (CAM). Based upon the literature, I identified criteria for assessing publicly led health care programs. These criteria included: increasing insurance coverage, cost containment and sustainability, and communications and outreach. The criteria each prompted questions that help to evaluate the success of health care insurance plans. I used the criteria to evaluate the current system of extending healthcare, the Governor's program "Illinois Covered" and the Massachusetts Plan, which is seen as a successful program. Finally, I assessed the various policy options for political and administrative feasibility.

Conclusions Reached

Based on my CAM analysis, I determined that the status quo has some desirable features. However, the Massachusetts plan best meets the practice standards set forth in the literature.

_____, Committee Chair _____
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Chapter 1

INTRODUCTION

The state of Illinois' legislature spent the summer of 2007 debating the value of a statewide healthcare plan. The price of healthcare has increased, and this has led to the overwhelming desire for change in the healthcare system from individuals, unions and businesses (Chorneau, 2007). With increasing prices, model state health plans, the upcoming presidential elections and, a movie on the subject, the Democratic Governor and State Legislature are coming under increased pressure to institute some level of universal coverage.

In 2007, the governor proposed a single payer system, funded by a 3% payroll tax on business or an alternative 2% gross receipts tax. Both these funding solutions failed in the state legislature and the session ended without a compromise plan. This leaves Illinois policy makers and residents alike with the question 'what next'?

This failure to pass a comprehensive healthcare reform provides the opportunity to revisit potential policy solutions and evaluate them against different measures of success that are determined from academic and practitioner literature.

This thesis begins with an overview of Federal and State healthcare policy, a discussion of the methodology and a review of the literature. I will assess the health care policies against the criteria found in the literature to determine if the plan moves Illinois closer to meeting these criteria. Finally, I will discuss the feasibility of passing any of the programs in Illinois.

Chapter 2

AN OVERVIEW OF HEALTH CARE IN THE U.S.

The U.S. system spends more on healthcare than any other country in the industrialized world, this is fifteen percent of national income (Gerard F. Anderson, 2005). However, fewer health care resources are available to citizens than in other industrialized countries. The Organization for Economic Cooperation and Development (OECD) reports that the U.S. has one third fewer physicians per capita than the OECD average (Gil, 2002). However, this merely reports numbers and perhaps raises the question of efficiency and whether there is a need for more physicians. For example there has been growth in the telemedicine field that reduces the need for additional physicians but increases the quality of medical care, especially in rural communities that historically may have had difficulty sustaining a physician (Carolyn Clancy, 2005; U.S.Medicine, 2005). Whatever the causes, there is increasing consensus better health care should be available to more individuals.

There are a number of public health programs in the U.S. The largest of these, Medicare and Medicaid were established as part of a Social Security Act extension in 1965. Other programs were established later as either separate programs or as extensions of current programs (for example the State Children's Health Insurance Program or Medicare Part D, prescription drug benefit). These programs are financed by the Federal government with a smaller state match. The law mandates that these programs serve certain groups, for example the elderly, low income or children, but states may add additional state funding in order to use the same program and serve a larger group.

Table 2.1: Outline of National Healthcare Programs

	Funding		Who Does It serve?									
Program	Federal	State	TANF Recipient	Pregnant	Children	Disabled	Elderly	Permanent Resident	SSI <75%	Medically needy	Approx. Program Cost in millions	Recipient Cost Sharing? Yes/No
Medicare	X	X					X (incl. Rx)				$342,048	Y
Medicaid	X	X	X	X	X	X	X (No Rx)	X	X	X	$310,992	Y on Sliding Scale (some groups exempt)
SCHIP	X	X			X						7,992	N

Source: (CMS, January 2007)

The level of spending on Medicaid programs can vary by state. Each state must commit to a basic, mandated level of spending and then may choose to extend these programs by appropriating a state match to provide healthcare coverage to a larger group.

Table 2.2: Medicaid Coverage

Mandatory Coverage (States must cover these groups)	Optional groups (States can choose to cover these groups)
Poor families that meet the financial requirements of Temporary Assistance to Needy Families (TANF) (previously known as Aid to Families with Dependent Children—AFDC) programs. Pregnant women and children <6 years with income <133% Federal Poverty Level (FPL)	Pregnant women and infants with income 133% FPL <>185% FPL. Individuals with disabilities or elderly whose income is 75%FPL<>100%FPL Individuals that require institutional care whose income exceeds SSI 75% FPL<300%FPL

Children age 6<>19 with family income <100% FPL Disabled that qualify for cash assistance under Supplemental Security Income (SSI) Elderly that qualify for cash assistance under SSI Legal permanent residents with more than 40 quarters of creditable coverage; refugees for the first 7 years; immigrants who have been honorably discharged from the US military.	"Medically needy" who can qualify with income <133.3%FPL after a 'spend down', which is income less medical coverage costs. Legal immigrants after their first 5 years in the country.

Levels of coverage vary by state, because of state funding commitments. Services will also differ across states to allow states to cater to the needs of their citizenship. Federal rules indicate that: care must be sufficient in duration, amount and scope to achieve its purpose; services must be equal between all eligible groups (comparability rule) and the amount, duration and scope of benefits must be the same statewide (statewideness rule). The recipient, with some limitations, must be free to choose their healthcare provider.

Table 2.3: Options for Care in Medicaid Coverage

Examples of Mandatory Benefits	Examples of Optional Benefits
Early and Periodic Screening, Diagnostic and Treatment (EPSDT). In patient hospital services (excluding mental services) Laboratory and x-ray services Physician services Pregnancy-related services up to 60 days post partum Home healthcare for those entitled.	Prescribed drugs (offered by all states) Dental care Physician-directed clinic services In patient psychiatric care for the elderly and those under 21 Physical therapy, prosthetics

Source: (Herz, 2005)

The amount spent on healthcare in the U.S. is growing faster than the consumer price index (CBO, 2007). This is a combination of the increased value of healthcare and the increased number of residents that use public health programs (Cutler, 2004; Sundquist, 2006). The Centers for Medicare and Medicaid Services (CMS) have recently targeted this growth by rationing (healthcare) or cutting (pharmaceuticals) benefits to the states and passing 'clawback' provisions as part of the Deficit Reduction Act, 2005 (Levinson, 2007; Sundquist, 2006). A clawback provision is where the federal government moves all duel eligibility (Medicare and Medicaid) individuals in to the Medicare system and then charges the states for some of the benefits that they receive, rather than allowing the states to use these individuals to gain economies of scale when purchasing healthcare services. Just as in the private market the insurer must develop contracts with providers that generate incentives for efficiency and delivery; the states must do the same. This cost shifting reduces the amount spent by the federal government because they can now assume these economies of scale, whereas the state governments may suffer from the bargaining loss as they only purchase prescription drugs for Medicaid and other state public assistance programs.

Although there is a general trend that health insurance costs and prescription drug costs are increasing at the private level, an important additional input that affects the cost of public programs at the state level is that there may be an increased number of eligible citizens if there is an economic downturn or increased unemployment. The structure of the public program limits the flexibility of administrators because the FMAP determines federal matches. Some of the unforeseen increases in public health spending can be

attributed to the federal system of using the Federal Medical Assistance Percentage (FMAP) to forecast a budget that meets the public need. FMAP is a measure of the economy including unemployment, however it has a three-year time-lag and therefore what was a robust 2004 economy may not give administrators an accurate depiction of their 2007 spending needs (Herz, 2005). When unemployment increases, there is an increase in the number of citizens that apply for public health assistance programs and this is because they lose access to employer based programs. This is a possible area for reform because updated projections will result in more accurate budget estimates.

Improvements in U.S. Healthcare come from Quality Improvements

The quality of healthcare in the U.S. has vastly improved throughout the 20th century and this is reflected in both mortality measurements and society's increase in "quality of life" benefits such as blood pressure medication, hip and knee replacements, nutritional programs or smoking-cessation programs that enrich the quality of life and perhaps increase the length of life.

Life expectancy has increased in the U.S. due to advancement in medical technologies, public health and nutritional improvements (Cutler, 2004). The nature of mortality risks also changed from infectious diseases such as the flu before 1940 to cardiovascular disease and cancers today. The cost of treating today's illnesses is significantly higher than vaccinating against infectious diseases of prior decades. The value of these vaccines, especially related to childhood diseases, has had a clear impact on childhood mortality from these diseases. One benefit of this expansion in demand for the vaccines is that prices have fallen due to the significant economies of scale for

vaccine manufacturers. The resulting expansion in service has positive externalities that result from society realizing the benefit of the productivity of saved lives.

Medical advances have also correlated with improved quality of life. As the population ages, there are a greater number of citizens with painful degenerative joint diseases, dementia, Alzheimer's disease that gain relief and quality of life from technologies such as hip replacements, and cognitive drugs. It is clear that society values these technological advances as they lobby their health insurance plans to pay for them.

Due to the increases and improvements in medical technology, and expansion in research and development activities, the cost of healthcare has also increased since 1950. In 1950 an adult would, on average, spend $500 in today's dollars on medical treatments per year. In 2004, that adult would, on average, spend $5000 in today's dollars on healthcare each year (Cutler, 2004). The additional $4500 is reflected in the benefits gained from the additional medical care and technologies.

The increases in service have been funded principally through increases in funding from both private employers and the government. However, though many funders discuss cost control as a mechanism to continue funding and expand services, this has taken a backseat to searching for new funding through increased rates (Barer, 1994). There is a great deal of opposition to increasing the cost of health insurance to funders, including insurance companies, prescription benefits managers and elected officials. This cost must be met by employers and may affect both the price of goods or salaries as the cost is passed on to the consumer of goods and services or employees. If cost increases for government programs, the additional funding may be found through an increase in

taxes or a decrease in another public program. Both of these options may create opposition to any new program.

In considering any level of health coverage or health plan expansion, it is important to look at some of the endemic 'health policy' tensions. These are tensions among the efficiency considerations in extending health insurance, equity considerations in coverage, and institutional considerations that may be required in order to create an acceptable health care solution. When assessing a program, it is useful to be aware of these tensions as they may provide valuable insights in to what changes could be made to build coalitions, who should be present in any coalition and the motives of each group when they support or oppose a policy.

There are clear tensions between different groups that provide input to the public policy debate (Munger, 2000). The tensions between markets and politics fall in to equity and efficiency areas. The American experience shows that healthcare services are more accessible to those with financial means, which shows the value of the market structure. This market system does have a number of externalities, for example those without means have less access to health programs and visits to the doctor or clinics for preventative care may be cost prohibitive even with the low cost of Medicaid co-pays. In contrast, some of the equity considerations are to improve access to healthcare for all and to do this by controlling externalities, such as the price of hospital stays and pharmaceuticals. The final tension comes from institutional reform policies. Institutions reduce financial uncertainty by reducing the number of choices available for decision makers.

This assessment of current U.S. policy gives some insight in to the strengths, weaknesses and policy inputs that affect the development of policy. Some states have determined that they can benefit their residents by developing state health programs that extend the provision of healthcare to a larger group. This has been done through a combination of tools, including Medicaid waivers that allow the state to expand the Medicaid entitlement in their state, an increase of state funding to current health care plans and individual mandates.

State Policy Models

After the defeat of a number of federal initiatives to expand healthcare coverage, most notably the Clinton Plan (1994), some states have taken the initiative to provide their constituents with increased coverage (Table 2.4). There is no clear distinction between the role of government and the role of the private sector in the provision of healthcare. Although it has historically been considered a private good, the government is not prohibited from providing programs and resources to augment the private selection of programs. The private sector has excelled at creating new plans that better fit the needs of consumers and protect individuals from catastrophic bills. But states, are increasingly stepping to address inequities in health care coverage.

States have addressed the problem of universal medical coverage through a series of plans. The effect of these plans has varied from the Massachusetts plan that mandates coverage to the Maryland plan that merely affects one employer. The recent Massachusetts Plan (2006) was passed under the threat of a popular healthcare ballot initiative. The plan expanded Medicaid eligibility and benefits and mandated individual

insurance plans. This was supplemented in 2007 by the addition of additional approved health plans to the program.

The Vermont Plan (2006) echoes the Massachusetts plan by expanding Medicaid eligibility and benefits, but also subsidizes private insurance for low-income families and launches cost containment initiatives. Californians are also ready for a change to their healthcare system, although the question remains what form this change will take as they are currently considering three different approaches in the state legislature. In 2007 comprehensive healthcare plans were introduced in the Illinois and Minnesota legislature. Washington and Oklahoma supplemented their children's health plan to cover thousands more uninsured children.

Table 2.4: State Healthcare Reforms

State	Act and Year	What the existing law provides	What changes may be made to the existing law
Massachusetts	Healthcare Reform 2006 (2007 Legislature adds to list of acceptable private plans)	Expands Medicaid eligibility and benefits. Mandates individuals to buy insurance. Financed by reallocation, increased revenue and employer assessments.	Healthcare cost controls Define 'affordability' better to allow increased plans.
Vermont	Healthcare Affordability Act 2006	Expands Medicaid Subsidizes low income individuals Restructures treatment pools for chronic illnesses Creates cost containment programs.	Further expansion of services if governor changes to Democrat.
Maryland	Fair Share Healthcare Act 2006	Mandates employers with over 10,000 employees to spend 8% payroll on healthcare or pay 8% payroll tax.	Passed by state legislature over governor veto. Has been ruled arbitrary by the courts because it only affected one employer in the state (Wal-Mart).
California	Current discussion of 3 plans in legislature	Mandates affordable healthcare for working adults, expands Medicaid provisions to working poor.	Unknown
Washington	2007	Expands Children's health insurance to a greater number of uninsured children	This is a reform to supplement S-CHIP and other state programs.
Oklahoma	2007	Expands Children's health insurance to a greater number of uninsured children	This is a reform to supplement S-CHIP and other state programs.

Chapter 3

AN OVERVIEW OF HEALTH CARE IN ILLINOIS

I have chosen to consider the current system of Illinois health coverage as a second option within the assessment. This is because it is possible that incremental changes could be made to the program to improve its efficacy. In order to properly assess the current program, it is necessary to understand its strengths and challenges.

The State of Illinois has made overtures to providing healthcare coverage to all residents of the state. In 2007 the Governor championed a plan to expand the 'AllKids' program, which serves all children that have been uninsured for more than one year regardless of income, to also cover adults. This was met with opposition due to the proposed financing of the program. However, the Governor has vowed to return with a new plan in 2008.

The current system of healthcare in Illinois is a combination of public programs, administered by the department of health, and employer sponsored healthcare plans, administered by MCOs. There is no current mandate to guarantee employer-funded healthcare to workers.

Public programs are available to different groups at different co-pays ranging from an out-of-pocket maximum of $2,222 annually to $22,000 annually, dependent on age, sex, and location of the payer.

Table 3.1: Current Healthcare Programs

Program	Target Population	Cost of Co-Pay
Employer Sponsored Plan	Employees of companies that offer health insurance	Variable
Privately Purchased PPO Plan	Individuals and families that are not offered health insurance through their employers	Variable
Medicaid	Adults that have income up to 100% FPL and parents or primary care givers with income up to185% FPL	Up to $2,222 annually
AllKids	Children up to 300% FPL	$0
CHIP Plan 2 (Medicaid)	Illinois residents unable to obtain private health insurance coverage that are enrolled in Medicare part A and B due to disability, renal disease.	From $600 per month to $2000 per month.
CHIP Plan 3 (PPO)	PPO plan available to traditional CHIP recipients that are not eligible for Medicare.	From $356 per month to $1159 per month.
CHIP Plan 5 (PPO)	Federally eligible individuals who qualify for Section 15 HIPPA-CHIP. (No pre-existing condition limitation)	From $304 per month to $1390 per month.
Plan T	TAA Certified individuals (No pre-existing condition limitation)	Tax credit up to 65% PPO premium.
Plan P	Pension Benefit Guaranty Corporation recipients (No pre-existing condition limitation)	Tax credit up to 65% of PPO Premium.

Source: (CHIP, 2007b)

Table 3.2: Funding the current Illinois public health system

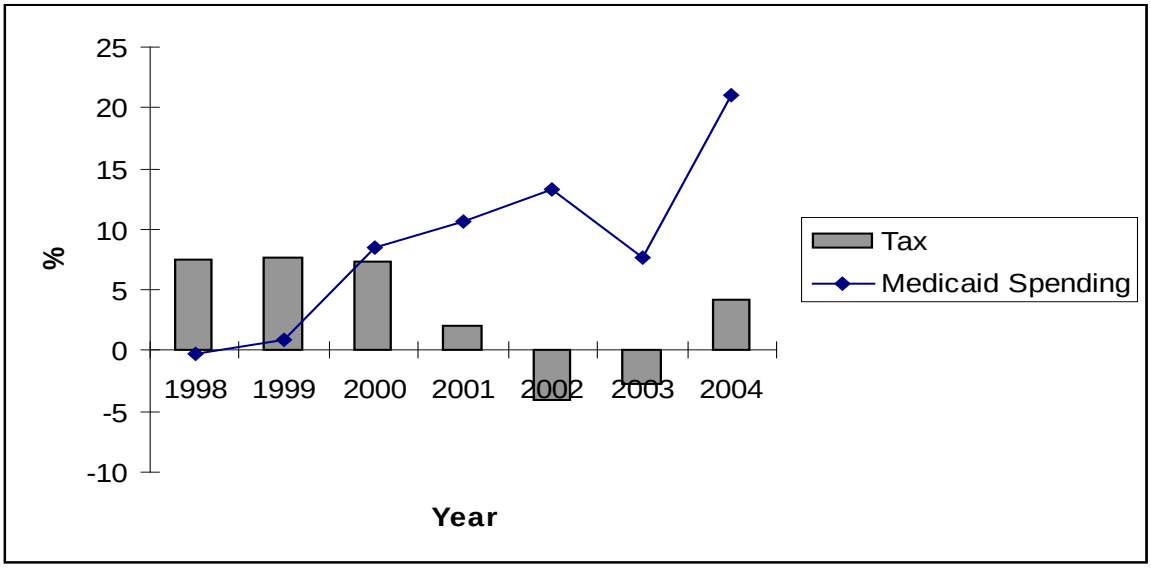
	Funding			Who Does It serve?								
Program	Private	Federal	State	TANF Recipient	Pregnant	Children	Disabled	Elderly	Permanent Resident	SSI <75%	Medically needy	Recipient Cost Sharing? Yes/No
Employer sponsored plan	X											Y Likely Co-Pay
Privately purchased PPO plan	X											Y
Medicaid		X	X	X	X	X	X	X (No Rx)	X	X	X	Y Some groups on sliding scale
S-CHIP (Part of AllKids, different funding)		X	X			X						N
AllKids			X			X						Y Sliding scale
CHIP plan 2 (Medicaid , No Rx)		X	X				X				X Renal disease	Y
CHIP Plan 3 (PPO)		X	X		X (minor)	X					X Eligible institution	Y
CHIP Plan 5 (PPO)		X	X									Y
Plan T	X	X Federal grant	X									Y Monthly premium
Plan P	X	X Federal grant	X									Y Monthly premium

Source: (CHIP, 2007b)

There are a number of gaps in the current system. In some of the programs the numbers of participants are limited because of cost concerns, for example plan T is limited to around 6,000 participants and other eligible residents may apply to the Plan T waiting list until a current member leaves the plan. Additional gaps are present in the participation levels of these programs and this can be seen in the level of uninsured children, since all children are eligible for public coverage in Illinois. On the private-side, not all employers provide health care coverage for their employees and this is also a challenge of the current system.

The cost of Illinois programs is high, and the growth in state tax revenues to pay for the programs has not historically kept pace with healthcare inflation. Figure 3.1 shows the growth in Illinois state tax revenue compared to Medicaid spending growth (CBTA, 2007).

Figure 3.1: Comparison of Illinois Tax Income and Medicaid Spending



The effect of this deficit is that any program expansion must be paid from outside the current state budget, through enterprise funds or tax increases. This will affect the political feasibility of the project.

Approximately 16.2% of Illinois residents remain uninsured; this is both a product of the funding for care and the system of care. The funding for care is provided through employer, individual, government or charitable plans. Krieg (Krieg, 1991) indicates that Illinois Medicaid covers only 79% of Medicaid costs. This results in healthcare rationing as the state creates waiting lists to join its comprehensive health insurance plans (CHIP, 2007a). However, this rationing should not be surprising since the system of care was created to ration healthcare. In the case of Pegram v. Herdrich, Justice David Souter suggested that the HMO could not be held liable for rationing healthcare when it is their mission to deliver profit for their shareholders, and it is the job of the consumer to be informed when they purchase or use a health plan (Souter, 2000). This certainly extends to state healthcare programs, though it cannot extend to the federal Medicaid and Medicare programs because of how the statutes are written. This is because the federal match for state funding is determined by the amount of funding that the state budgets for a program and the FMAP. The federal funding cannot be refused if it is to match to eligible state funding and participants.

When managed care organizations were set up, they were at the forefront of improving healthcare because they changed the system from a fee-for-service system to a more holistic approach of preventative medicine (Cutler, 2004). These systems have gone through a number of changes, in particular during the 1990s when cost savings

began to drive managed care by controlling spending. Today, managed care programs are the targets of a great deal of negative rhetoric from the media and medical professionals alike (Levine, 1997) as they aim to reduce costs to meet consumer (employer) demand through cost-cutting measures.

Illinois has made some incremental policy changes intended to make healthcare more affordable. For example, high-risk groups often increase the cost of insurance for more than merely the individual because healthcare is negotiated on a group basis. Illinois, as well as 33 other states, has created a 'high risk' pool, that is a public program to provide insurance for high risk individuals that would otherwise push up the price of private health coverage or may not be considered to be a good candidate for private insurance. Federal grant dollars are also associated with this program and these have helped to reduce individual premiums.

There is increased pressure on politicians and healthcare providers to expand service as a poor economy has created healthcare challenges for working families across the country, including within the state of Illinois Since 2001, the number of employer-sponsored health plans and pension plans has decreased (Dianne Rucinski, 2006). This correlated with an increase in the number of uninsured in Illinois to almost two million (Gilead_Center, 2004). The majority of the uninsured within the state are located within the Chicago metro area (Rucinski, 2006).

Illinois' systems of insurance also falls short of the Governor's stated goal of universal coverage: Illinois' falls in the middle of the states when assessed for coverage

and has the 25th largest population of uninsured in the nation at 16.2% in Illinois, slightly higher than the national average of 15.9%.

Employment has a positive effect on insurance status, since the majority of Illinoisans are covered under an employer provided plan. However, those covered under employer provided plans has declined to 20% (Gilead, 2004). In 2006 only 55% of employers offered coverage for employees ("State Health Facts," 2007). The size of the company is also correlated with insurance coverage, as smaller companies are less likely to offer coverage. In fact, 99% of large employers offer health insurance plans, compared with 42% of small employers (AHIP, 2006). Nearly 1 in 4 adults (23.6%) in the Chicago Metro Area that work for businesses with less than 100 employees is uninsured (Gilead, 2004).

Demographic factors also influences whether Illinoisans are insured. In Illinois ethnicity, gender, income and age correlate with insurance status. Ethnicity has a strong influence on whether an individual is insured. Latinos have the largest percentage of uninsured (30.4%) (Kaiser 2004), of which 54.7% are non-citizens (Gilead, 2004). A large number of African Americans are uninsured (25%); this is more than one and one-half the number of whites (11.4%) (Gilead, 2004) This is surprising because 80% of African Americans are in working families (Kaiser, 2004). However, this may reflect the type of work that African Americans participate in, or the employers that they choose to work for that may not offer insurance. For example if they work in lower paid positions or perhaps becoming, or working for, sole-proprietors or small businesses that find it difficult to offer benefits because a small benefits pool increases the cost of insurance.

The number of uninsured Asians/ Pacific Islanders or Native Americans more closely follows the trend of White Americans, with 15.3% uninsured (Kaiser, 2004). The number is significantly less than the national average of 21% (Kaiser, 2004). This may be explained by a number of factors. For example the Indian Health Service provides a low level of health care to tribes on reservations. The Federal Government has supplemented this with urban Indian health centers in cities. However, because of the many forms and the evidence required to gain access to services urban Native Americans that are located far from their native population may find it difficult and time consuming to prove their heritage and access these services. In contrast, more than 50% of Chinese and Japanese have traditional employer-based insurance (Kaiser, 2004).

Gender correlates with insurance status, as a higher number of men than women are uninsured. Indeed 16% of Illinois men are uninsured compared with women (14%) (Kaiser, 2007b). This is surprising because men are more likely than women to have their own employment-based health insurance, and are more likely to be able to afford and access medical services and supplies because of higher income (Paral, 2007).

Income is shown to have a positive effect on insurance. Of those earning over $75,000 16.2% are uninsured, between $50,000 and $75,000 16.0% are uninsured, of those between $50,000 and $25,000, 27.6% are uninsured, compared with 40.2% of those earning under $25,000 (IHA, 2006). This may indicate that those on lower incomes are not offered insurance through their work, or perhaps they choose to forgo the insurance coverage that his offered to them in favor of using their income on other items (Austin, 2007).

Age has a positive effect on insurance status. In 2006 the State of Illinois expanded the children's healthcare program to cover children in households with less than $75,000 household income. Before this expansion, 19.5% of Illinois children were uninsured. To date, there has not been an assessment of the success of the new program. Of those ages 19-29, 32% are uninsured, compared with 14% of those 50-64 years old (IHA, 2006). This may be a product of income, as older people are likely to have more established careers, and be more qualified or may fear illness due to their more advanced age. Whereas, younger adults may work in positions that do not offer health insurance, or may move positions more regularly and for these reasons they may not have access to affordable health insurance.

It is clear from the overview of current Illinois health coverage that there are a number of population groups in the community, and this should be considered when discussing possible policy solutions.

Chapter 4

METHODOLOGY

I have chosen to structure this project as a modified Criteria Alternatives-Matrix (CAM) analysis. This is because CAM analysis allows the comparison of at least two policies by discussing their strengths and weaknesses within the context of the set criterion (Munger, 2000). I will identify the group of policies to discuss and then assess them against a framework created from the literature to assess policy solutions to the problem of the uninsured.

The assessment criteria are based upon findings in both academic and practitioner literature. In a review of the literature three main criteria were identified, these were: program expansion, communications and outreach, and cost control. In short, communications is integral to the success of any program and therefore deserves closer consideration. These are broad criteria that are established in the literature, however other factors were present such as the importance of 'quality' of care (Cutler, 2004; PriceWaterhouseCoopers, 2007), but were not prevalent enough to become a key factor in the creation of a plan. Another reason that I chose not to include quality as a factor is that quality care is an arbitrary measure that is dependent upon value judgments as to the course of treatment prescribed by the doctor. The qualifications of a doctor, the number of visits to a physician or the number of prescription drugs are not indications of a quality level of care. There are a number of groups that regulate a basic standard for all physicians such as the Office of Professional Regulation or the Board, however peer-

review of treatments is not a factor in registering a physician and therefore this does not guarantee the 'quality' of one service over another.

The criteria offer some frameworks for analysis, and the plans will be discussed and measured against these frameworks. Each discussion will include an overview of the policy, a discussion of whether the policy moves Illinois closer to the practices that are outlined in the criteria.

I will score each policy's ability to improve Illinois' health care system. If the policy will have a negative effect on the state's ability to meet the best practice then it will receive a negative "-" mark. If the policy has no effect on the state's ability to meet the criteria then it will receive a check "x" mark and finally, if the policy positively effects the ability of the state to meet the criteria then it will receive a plus "+" mark. The policy with the greatest number of plus marks will be suggested as the most beneficial policy to the state.

I identified the policies for consideration based upon a review of programs discussed within the state and a review of successful policies around the country. The value of assessing programs that have been discussed within the state is that they have some support from different groups. When states have successful policies, this provides a potential model for other states to adopt.

I will also consider political and administrative feasibility as potential allies or roadblocks to passing a policy through the legislature to the Governor. This is important because though a policy may meet each criterion, if there is little public support and political will then a policy may not gain enough support in the legislature to pass.

Administrative feasibility is also important because the administration of a program has associated costs. The opposition of a department that will bear the burden of additional staffing and resource costs may result in an unsuccessful program. Organizational factors may also affect the assessment of administrative feasibility such as whether the law can be implemented within the current organizational structure or whether the relationships between and structure of departments would preclude the effective implementation of a policy. Other issues that may affect organizational effectiveness may be technological, such as the need for a new piece of software that requires time to development, or they may also be legal such as security systems put in place to protect residents under the Health Information Portability and Accountability Act that requires patient confidentiality.

The discussion of the feasibility of these programs will provide some insight in to which program may be most successful.

Chapter 5

LITERATURE AND ASSESSMENT CRITERIA

In considering policy solutions, the literature suggests that expanded programs, cost control and sustainability, and communication are key components that would contribute to a successful solution to the uninsured in Illinois.

It is difficult to separate the federal from state programs when considering health coverage in Illinois. This is because although the majority of the programs are administered by the state, they are funded from federal monies. This includes the administration of VA hospitals, S-CHIP provisions and Medicaid treatment and drug benefits. States provide their public health plans to CMS for approval or to request exceptions to CMS rules, and this gives state administrators a great deal of flexibility in co-mingling State and Federal funds and administering public health programs. Thus, discussions below, while focused on improving the state situation, may include expanding the availability of federal programs.

Expanded Coverage

Under the American tradition of employer provided health coverage (Terris, 1998), it is those that work that are provided with healthcare coverage. This may be restricted to the employee or provided to their family unit (Long, 1987). The literature (Long, 1987; Kaiser, 2007) suggests that mandating health insurance for the employed would significantly expand the number of insured in a particular state.

Expanding public health plans, however, would reach a different population. SCHIP and Medicaid programs insure individuals under 200% Federal Poverty Line

(FPL) ($41,304 for a family of 4). The FPL is instrumental on the state level because eligibility for all Federal healthcare programs is set at the federal level and administered by the states. Lewit (2003) suggests that by expanding this income barrier to 300% FPL, more than 87% of children would fall under one of these two programs. Research shows that public health programs, such as S-CHIP and Medicaid increase the interaction between the primary care physician and the uninsured (Draper, 2007). The literature suggests that the cost associated with these visits discourages visits for preventative care (Kaiser, 2007b). However the State of Illinois recognized this pattern and has waived any co-pay for preventative care visits (AAP, 2007).

The expansion of coverage criteria is intended to measure whether the program increases the number of insured in Illinois. This criterion is not intended to measure whether the programs are accessible to the intended groups of participants, but whether programs exist to serve these groups.

Communications and Outreach

Participation rates are important to the success of a healthcare program (Lewit, 2003; Terris, 1998). It is not enough for the government to pass a law and administer funds for a program if it does not reach the desired population. The success of simplified enrollment, outreach and communication plans can be seen in the 1997 S-CHIP program.

The S-CHIP program is politically popular because the target population is children (Lewit, 2003). The program had a large outreach budget that extended registration in to schools, community centers and in some states the child could be enrolled at the point of need. Some states encouraged their uninsured population to use

the program; other states put in place a series of forms to ensure 'program integrity', which discouraged use. (Lewit, 2003). In short, when states do not integrate their forms or start to mandate face-to-face interviews, making participation easy, they reduce the participation rates.

Programs that employ staff that reflect the users cultural and linguistic needs tend to have higher participation rates. This suggests how central language is to ensuring high quality healthcare (Culhane-Pera, 2007; Ethnic_Health_Dispartities_Action_Council, 2004; Jones, 2006; Lewit, 2003). This is because barriers to use are removed, to some extent, and trust built when the nursing staff or physician can communicate easily with the patient (Culhane-Pera, 2007; Jones, 2006).

Although 'participation rates' can be traced back to the administration of a program, it would be incumbent upon the architects of any new program to consider the barriers to use and act to reduce them.

Cost Control

Cost control is an important component of any health plan; this is both for employer provided healthcare or public health programs (Posey, 1997; Terris, 1998). Terris (1998) notes that considering cost control when devising a healthcare plan helps the program to be both sustainable and politically feasible. Since the majority of public health spending comes from the federal level (up to 2:1), there is a great deal of concern about the sustainability of programs (NASMD, 2007). In particular experts agree that sustainability depends on significant changes in financing long-term care services in this country (Sundquist, 2006).

Indeed one negative aspect of the health plan developed by former President Bill Clinton (1994) was that it would have capped payroll expenditure on healthcare at 7.4%, which was higher than the 6% that was then spent on healthcare benefits (Terris, 1998). It is irrational to assume that a private employer will choose to spend healthcare funds on a public program when they can invest that funding in improving healthcare for their own employees (McGuire_Woods, 2007). Researchers argue (CBO, 2007; Terris, 1998) that adequate funding for the program is more important than political feasibility or the number of recipients that the service will cover. They might agree on this but political feasibility seems important if they want it implemented.

Terris (1998) suggests that a successful way to control costs is the use of Managed Care Organizations (MCO) where the insurer employs the physicians. An example of this is Kaiser Healthcare. This system has proven successful because they offer a fixed premium per member and a capitation method of payment. For an equal or sometimes better quality of care, the plan experiences a 40% lower hospitalization cost and 25% lower overall cost. By offering the consumer a salaried physician, there is no incentive for the physician to offer superfluous care and an incentive to avoid repeat doctors' visits. Yet the majority of consumers still opt for a 'fee for service' system, offered primarily by traditional Point of Service (POS), Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) health plans. Cost control also ensures that other benefits continue to increase. Cutler (2004) suggests that when there is a large increase in expenditure on benefits, this correlates with slower growth in salaries. In order to maintain healthcare as a benefit that is expected by employees, rather than a

benefit used to attract high-powered executives in boom periods, cost must be controlled for employers (Cutler, 2004).

Sustainability is an important component when considering a healthcare plan. Society will not realize the benefits of a healthier population until minor illnesses can be caught before they become expensive and catastrophic (Cutler, 2004). Therefore the sustainability of coverage is integral to any plan. This is certainly a difficult consideration unless the state opts for a publicly option, because much of the non-working population depends on public health funding that originates with the federal government. As the economy improves, fewer individuals enroll for public benefits and this makes the program less expensive for the state (Lewit et al, 2003). But when the economy has a downturn, this correlates with an increase in benefit seekers. For this reason, Lewit suggests that a successful and sustainable plan will institute counter cyclical financing, whereby states pay for downturns in the economy in the economic upswing (Lewit, 2003).

Political Feasibility

From a political perspective, a successful plan would maximize the support of both the legislature and the Governor. The legislature failed to pass the Governor's plan in 2007 after a great deal of public opposition to the method of funding the plan. The Governor suggested funding the plan with a Gross Receipts Tax (GRT) which would have increased tax on retail business to pay for the healthcare of a broad cross-section of the community. Therefore a plan that spreads the responsibility of coverage across more groups may be more successful in the legislature.

The Governor plays an important role in policy making because he prepares a budget for the legislature, has the power of veto and can command the attention of the press. The governor has indicated that although he would accept some incremental change, such as the recent expansion through executive authority of the breast cancer screening program, he will only support universal, though not single payer, healthcare for all Illinoisans as his starting position.

Illinois is no exception to a number of states that would require revenue to be found for any new or expanded program because the state has, and is expected to continue to have, a budget deficit. This may provide political opposition to any program. The main opposition that was present in 2007 was from conservatives and the business lobby. This is because the plan called for tax increases on business that would pay for the state's share of the plan. If additional business taxes are proposed to pay for the 2008 plan, opposition may be seen from business groups that may be taxed or Illinois' downstate republicans that see the benefit of any healthcare program as focused largely in the northern Illinois/ Chicago metro area (Paral, 2007) while they bear the costs.

Where there may be an area of consensus between legislators and the governor is the need for healthcare for all Illinoisans. A number of conservative legislators have a number of uninsured in their districts (Paral, 2007) and so this is a concern for all legislators. Both republicans and democratic legislators supported the notion of individual responsibility in health care purchasing, and that was present in the plan. Therefore, individual mandates may be a starting point for negotiations as to what is feasible.

Administrative Feasibility

The administrative feasibility of any program is important because it can affect the success of a program. The public must be able to solve problems by speaking with administrators, and compliance to the program is central to its success particularly if the program includes a number of mandates on private business.

Administrative costs should be considered when evaluating a program, and these are above the program costs. The cost of compliance is dependent on where the program is housed. If the program is situated within an existing department then it may have lower costs than if a new body is created to administer the program. This is because a simple expansion of staffing is less expensive than creating office space, policies and procedures and staffing the body. Politicians might also pass an unfunded mandate that made the compliance program part of a government department without adding further funding to that departmental budget, though this may create a less effective compliance team if resources are spread among a number of competing priorities.

In considering administrative feasibility it is important to consider the structure of the departments that will administer the program. This is because the form of the department should represent the job that the department does in order to optimize the efficacy of the department. The mission of the department is important, since this will also effect whether staff are qualified or enthusiastic about making a plan successful. For example, if the role of the government body is to provide health coverage to a large group then a health-focused team would perform this task best.

Other inputs to administrative feasibility may relate to the ability of the government departments to perform their tasks with the tools and technology that is available to them. For example, if the department is called on to perform compliance but there is no interoperable method to collect data from insurers and employers then this creates a burden for the department.

The ability of a department to perform its tasks can lead to the success of a program, and therefore it is important to consider these factors when making the recommendation.

Chapter 6

ASSESSING THE POLICY OPTIONS

There have been a number of suggested healthcare coverage plans in Illinois. Indeed the Governor's plan, which failed this year, has several supporters in the state and the Governor has pledged to adjust it and send it to the legislature next year. The Massachusetts plan has been suggested as the other comprehensive health reform plan, that its supporters say may be implemented in Illinois ("Medical News Today," 2007). I will assess the status quo, the Governor's plan and the Massachusetts plan within the criteria established in the literature review and then assess the political and administrative feasibility.

I have chosen to discuss the status quo and this will be considered as the default policy solution. This is because, despite its limitations, the current system provides a set level of care for Illinoisans. It is also an established budget item in the Illinois state budget. Should reform fail again in 2008, an assessment of the current plan may give some indication of incremental changes that could be made to improve the program.

I will also assess the Governor's Plan ("Illinois Covered"). This is because it is a pet project of the Governor and a number of influential non-governmental groups, such as the SEIU Union, Action for Kids and the Pastors Network of Illinois, that support the efforts to expand health insurance. The plan is also well known by the public, because of the governor's efforts to gain public support, and therefore an assessment of this program may provide valuable information on potential incremental adjustments in program provisions or funding mechanisms.

The Massachusetts Plan is an example of comprehensive health policy reform that a state has already instituted. The plan combines both private insurance mandates with the expansion of public programs. For this reason, I will assess the Massachusetts program as an alternative policy within the framework because it has already been established, there is some information on the success of the program, and modifications have already been made to improve the program.

Applying the Criteria

In applying the criteria to the suggested Illinois healthcare plans, I will consider the effect that the plan will have on expanding coverage to the uncovered groups. It is not my intention in this paper to evaluate how 'just' a system is, but rather whether Illinois citizens have access to an adequate package of healthcare. Though it is difficult to define 'adequate' (Kalb, 1992), in this case it is enough healthcare to allow individuals to function and avail themselves of a 'normal' range of lifetime opportunities (Buchanan, 1984) . Healthcare provision has been piecemeal in the U.S. and Illinois. There are a number of programs that aim to provide service to vulnerable groups including children, women, low income and elderly populations.

In discussing the reach of the health plan, it is important not only to assess how it will serve Illinois in terms of the factors stated by the literature, but also that it reaches the uninsured populations.

These populations are:

Table 6.1: The Uninsured in Illinois

Ethnicity	White	Latino	African American	Non Citizens
Income	>$50,000	<$250,000	<200% FPL	Non-citizens are not currently provided coverage by the state.
Work Status	Firm size <100 employees	Firm size 100-1000 employees	Full Time working adults	
Age	Children < 17 years	Adults 18-29 years	Adults 55-64 years	

The Current Illinois Health Care Plan

The current system of healthcare in Illinois illustrates a number of strengths, including provision of healthcare to all children and the exemption of co-pays for children that require preventative care. However, the shortcoming of that same system is the number of uninsured that exists within the state.

Table 6.2: Illinois' Status Quo

Program	Target Population	Proposed Changes
Employer Sponsored Plan	Employees of companies that offer health insurance	Unknown
Privately Purchased PPO Plan	Individuals and families that are not offered health insurance through their employers	Unknown
Medicaid	Adults that have income up to 100% Federal Poverty Line (FPL) and parents/ primary care givers with income up to185% FPL	
AllKids	Children up to 300% FPL	
CHIP Plan 2 (Medicaid)	Illinois residents unable to obtain private health insurance coverage that are enrolled in Medicare part A and B due to disability, renal disease.	
CHIP Plan 3 (PPO)	PPO plan available to traditional CHIP recipients that are not eligible for Medicare.	
CHIP Plan 5 (PPO)	Federally eligible individuals who qualify for Section 15 HIPPA-CHIP. (No pre-existing condition limitation)	
Plan T	TAA Certified individuals (No pre-existing condition limitation)	
Plan P	Pension Benefit Guaranty Corporation recipients (No pre-existing condition limitation)	

Assessing the Status Quo

Expanded Coverage

Staying within the same healthcare plan would not expand coverage to a larger number of Illinoisans than are currently offered coverage because unless there are changes it is possible to assume that there would be little increase in program size or participation rates. Under some of the alternative policy proposals there is a limit to the number of residents that may be covered, and there is a waiting list to become part of that healthcare plan. However, there is some opportunity to expand coverage within the established programs for children and families if there is an increase in outreach to sign up eligible groups.

The current program, though it does not move Illinois closer to the higher participation rates that were identified in the plan, does not hurt the state's ability to continue to work towards this goal. Illinois has used tools such as the Medicaid waiver to increase coverage to children and families, and therefore there is some indication that the state may use other tools such as increased funding to expand coverage within the current model. There is the possibility that incremental changes to the program could increase coverage, for example increases in funding and eligibility may increase participation. Therefore, the value of retaining the current program is that the program would be easily expanded to a wider population.

Communications and Outreach

Communications and outreach are limited within the current system. The state uses the Internet and community health centers to spread information about public health

plans. This means that those that need care are touched by the system; however it does not reach in to communities and allow ready access to preventative care. Jones (2006) suggests that reaching out to cultural groups using members of those groups may improve participation rates, and the literature agrees that by removing these cultural barriers a public program can be better utilized and reach out to the intended recipients of the program (Culhane-Pera, 2007; Lewit, 2003; "Medical News Today," 2007). The current program goes some way towards achieving this by placing information on the internet in different languages, and by placing information in community and health centers within communities around the state; this may remove further barriers to entry because information is easily accessible.

One challenge to the current system is that printed information is time consuming to change and distribute. It would therefore be both quicker to communicate changes on the CHIP program internet site. However, a number of public health recipients are low income and therefore there is a problem of the 'digital divide'. The digital divide exists when lower income families do not have access to computers and the internet and therefore do not receive the benefit of the information. This problem may make communicating changes and updates more difficult for administrators.

The current communications plan does not move Illinois closer to the best practices set forth in the literature. However, it does observe some of these best practices, such as the printing of information in a number of languages and the dissemination of information in sites that are community based. Incremental changes

such as creating community based positions that assist individuals to register for programs or navigate forms and rules, may bring this program closer to the best practices.

Cost control

The status quo has built-in cost control measures because it is funded by a combination of state and federal tax dollars under a well-established group of programs. However, tax revenue is not growing at the same rate as the cost of health entitlement programs (figure 3.1), and this indicates that the program is not currently sustainable without further commitments of tax dollars from state government. This may be agreeable to employers since it restricts the growth in private healthcare funding to its current responsibility, which can be expected to be below 6% of total payroll.

The current program does not improve or negatively affect Illinois cost control efforts. The current plan provides entitlement care to groups such as Medicaid and S-CHIP recipients, and a proportion of that funding is an appropriation from federal government. The program also has some built-in cost measures such as limiting the number of participants in the program. This benefits the ability of the state to control costs and program expansion. The current program also has some measures that may take the program away from sustainability, which is discussed in the literature. In particular this is the structure of the program's eligibility requirements, some of which are set by the federal government statute, and also in areas such as prescription drugs and doctor care. The entitlement plans cannot refuse to cover eligible participants that meet the requirements of the plan, such as income or health. This means that the current program is subject to increases in cost as the economy changes. One solution to this may

be to change the financing of the program to a counter-cyclical plan. This would mean that in a better economy the program receives more funding that it can carry over in to years when the economy has a down-turn.

Incentives are also not present in the current plan for participating service providers such as physicians and pharmacists to control costs. In private plans, physicians share the benefit of cost-control when a patient participates in more cost-effective therapies. Pharmacists also receive a financial incentive to advise private plans on closed formularies, step therapies and to divert patients to generic substitutions. Public administrators cannot use some tools, such as closed formulary lists, because they federal statutes prevent them from doing so. However, these may help to control costs should they be adopted in to the plans that are not federally funded.

Table 6.3: Assessing the current healthcare program

Criteria	Score	Explanation
Expands Coverage	X	Plan does not expand coverage
Cost Control	X/-	The program is established within the state budget. Costs may be controlled in the short term, however increases in health spending exceed increases in tax income. Improvements in structure and incentives may move this plan closer to the best practice.
Communications and outreach	X	There are efforts to bring information to communities, however there is no door-to-door or grassroots effort to increase participation.

Under these criteria, the status quo does not move Illinois closer to best practice, as identified in the literature, but does leave open the door to incremental changes that may improve the ability of the plan to assist residents and provide comprehensive health care services.

The Governor's Plan

The Governor's health insurance plan is a hybrid of expanding public health program coverage and expanding private health insurance plans.

Table 6.4: Governor's Plan

Program	Target Population	Proposed changes
Medicaid expansion	Parents and care givers of AllKids recipients with have income less than 400% FPL ($82,600 for family of 4).	Parents and care givers are currently covered when they have income of less than 185% FPL ($38,202 for family of 4)
Medicaid expansion	Adults with incomes below 100% FPL ($10,210)	Adults are not currently eligible for any assistance unless they are over age 65 years or permanently disabled.
Medicaid Expansion	Residents that would be eligible for Medicaid outside the 5-year ban.	Residents that are currently banned do not normally have access to any state programs.
Medicaid expansion Purchase insurance on a sliding scale.	Working people with disability if their income is less than 350% FPL	No coverage is offered if the employer does not offer coverage.
Illinois Covered Choice	Working people that are not offered insurance by their employer.	The state mandates that this program be offered by all MCOs that operate in Illinois.
Illinois Covered Choice	Small business with up to 25 employees that wish to extend health insurance.	The state mandates that all MCOs that operate in Illinois offer this program.
Rebate	Working people with income less than 400% FPL that pay for employer sponsored health care.	A rebate will be awarded by the state for the difference between the employer plan and the state plan.
Private Plan Expansion	Young people, under age 30, with no dependents may remain on their parents' plan.	Private plans offer dependent coverage on a per-plan basis.

Source: Table created from 'Illinois Covered' publicity material and legislation. (FamiliesUSA, 2007; Illinois_Covered, 2007a, 2007b; Secretary_of_State, 2007; Segal, 2006)

Assessing the Illinois Covered Plan

Expanding coverage

This expansion in public and private coverage is a comprehensive plan that would address the different groups of uninsured in Illinois. It does so by a combination of public plan expansions. It is notable that 400% FPL is likely to cover a large number of families in Illinois (Lewit, 2003).

The public plan expansion provides primary care health care to a wider group of Illinoisans. The effect of this expansion is that acute health care problems may be treated before they become chronic problems that require higher levels of care. The private mandates seem to act as a supplement to the public programs. Long (1987) suggests that by mandating employers to cover their employees, this will lead to a dramatic expansion of health care coverage.

Illinois Covered moves Illinois forward towards expanded coverage that gives access to services to a larger number of residents. There may be some benefits to the state from expanded coverage as managed care organizations (MCOs), prescription benefits managers (PBM) and public benefits administrators are better able to provide a range of services to patients that better fit their needs. For example, a patient may access primary care and prescription drugs before presenting at the emergency room, which may not be the best treatment and is costly.

Communications and outreach

When discussing the importance of communications and outreach, it is impossible to suggest that these are a proxy for participation rates, since there will be other inputs to

behavior such as mandates on individuals and employers under the Illinois covered plan. That said, communications and outreach are not discussed as part of the Illinois Covered publicity material or their draft bill. However, the current system would be expected to change structure so that the printed materials and websites reflected the new plan. For this reason, we could expect some baseline for the communications strategy for the program. There is no individual line-item in the plan for outreach however, and so this could challenge the success of the program if participation does not increase (Lewit, 2003).

The continuation of the current communications plan used by CHIP to Illinois Covered does not move Illinois forward towards best communications methods. The new plan, with new needs and requirements, increases the need for multi-lingual and community based communications methods.

This plan may benefit from earned media, which may result from the adoption of a comprehensive health insurance plan. The program would also be able to take advantage of public service announcements to increase participation and inquiries about the program, though any press coverage would be less detailed than necessary to inform potential participants of any particulars of the plan.

Cost control

Affordability for the individual could act as a barrier to entry to the new healthcare market in Illinois, and the legislation empowers the state department of Healthcare and Family Services to set rules for coverage and income. However, the

Governor's office did offer suggested guidelines for healthcare premium assistance. These are

Table 6.5: Illinois Premium Assistance

% FPL	Premium Assistance
< 100% FPL	Premiums fully covered by the State
>100% FPL < 250% FPL	Individual premium <1.5% income Family premium <3% income
> 250% FPL < 400% FPL	Individual premium <2.5% income Family premium < 5% income
> 400% FPL	No premium assistance (estimated to be $10,020 premium for family of 4).

Source: Governor's office

The Governor's plan would pay for the expansions in service through a series of fees and tax increases. On average, the plan would cost $7.2 billion each year, and would continue to assist those already receiving benefits, whilst extending those benefits to assist 1.4 million currently uninsured individuals (Olsen, 2007).

Paying for the program is achieved through a combination of 'fair share' payments and taxes. If an employer has more than 10 employees, they would be required to pay a 3% 'privilege tax' that is a 3% payroll tax, capped at $7500 per employee. However, if the employer pays more than 4% of payroll to healthcare for their employees, they will receive a full credit of this tax. If the total healthcare expenditure of the employer is between 2.5% and 4% then the employer will receive a prorated credit of the 3% tax and if the employer pays less than 2.5% of payroll to healthcare then they will be required to pay the entire tax. This seems to be an incentive for the employer either to drop medical coverage in favor of paying a 3% tax or to pay more than 4% of the tax in order to control the company's healthcare expenditures.

The cost control features of Illinois Covered are limited and moves Illinois further away from the best practices. The increase in state spending on the plan may draw a number of opponents from both the business sector and conservative politicians. The statutes do not protect the state general fund portion of the funding, and therefore could be diverted away from the program if there was a deficit in the state budget. The plan may also influence the salaries of Illinoisans, and this is because private companies would be required to provide health care as a benefit of employment. It is possible that costs will eventually level to some extent as residents better maintain their health and therefore do not require as much care for chronic illnesses.

Table 6.6: Assessing the Governor's healthcare plan

Criteria	Score	Explanation
Expands Coverage	+	Plan uses a combination of state programs and mandates to expand coverage to all residents of Illinois.
Cost Control	-	The program will likely increase the amount of state funding spent on both healthcare, but also administration of health programs. By placing the program in an already established department, this will reduce some set-up costs.
Communications and outreach	X	There is no additional funding for outreach listed in this plan, however there are current state programs in place that can be used to provide outreach. Private companies may be expected to reach-out to private employers to offer approved plans.

The Massachusetts Plan

The Massachusetts plan will be considered as an alternative to the Governor's plan and the status quo because it has been heralded as one of the most comprehensive and successful health reform programs instituted by any one of the states (Saulny, 2007). The effect of the Massachusetts plan was to insure more than 100,000 previously uninsured residents. The plan expands state programs and mandates individual and employer accountability. The cost to the state of Massachusetts to extend this plan is $1.578 billion in 2007 and is projected to grow to $1.725 billion in 2008. This expenditure is financed through a combination of sources. These sources include fair share assessments, assessments for uncompensated care/ pool/ safety net, federal funds and the state general fund (Raymond, 2007).

Table 6.7: Massachusetts Plan Features

Program	Target Population	Nature of the program change
Individual Mandate (Penalty is 50% health insurance premium imposed via income tax filing.	All adults	Previously there was no mandate
Employer Mandate: Employer must pay $295 per employee and must offer a Section 125 HAS	Employers with more than 11 employees	No previous employer mandate
Insurance Connector: Offers health insurance for sale to individuals and businesses from plans approved by the Connector Board.	Individuals and employers	No previous connector. Previously individuals and businesses could purchase insurance through the 7 insurers that operated in Massachusetts.
Government Subsidized Programs	Individuals with incomes up to 300% FPL received subsidized premiums on a sliding scale. Individuals with incomes up to 150% FPL are not required to pay any premiums.	No previous mandate. However, Medicare and Medicaid programs had assisted low income residents of the state.
MassHealth	Children up to 300% FPL Increased adult caps	Increased caps at both child and adult level.
Health Safety Net Trust Fund	Health service providers	Previously the uncompensated care pool paid for uncompensated care through Medicaid funds.

Source: Kaiser Commission, 2007

The plans approved by the Board must all meet a minimum standard of preventative and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services and prescription drug coverage (Kaiser, 2007a). They must also have a deductible less than $2000 for individuals and $4000 for families.

There seems little incentive to change health plans in order to comply with the law, but to cut the present level of coverage since there is no tax rebate for spending an increased or lesser amount on insurance.

Assessing the Massachusetts plan for use in Illinois

Expanding coverage

The Massachusetts plan meets the criteria of expanding coverage to all Illinoisans through a combination of state and private programs. The mandates set forth in the Massachusetts plan meet the criteria to expand coverage (Long, 1987) and suggests that a larger group of the uninsured will be brought in to programs due to state mandates and penalties. The program also makes all children with less than 300% FPL family income eligible for the MassHealth program, and Lewit (2003) suggests that this may ensure that more than 87% of children are covered by health insurance. This expanded coverage can be expected to reduce state spending on catastrophic care as more illnesses are discovered as part of a preventative care program (Kaiser Commission, 2005).

A limitation of this plan is that it does not offer medical care on the terms of the individual, but the legislature must approve plans that are offered to the public. This presents a problem for individuals that might other be able to get similar medical care, though for a lesser price, from an out of state provider. It also removes the right of the individual to choose the services that they will need as part of a medical plan. For example, should a patient know that they are healthy but have a family history of cancer they may choose a plan with a high deductable but no limits. In turn, if a patient is more prone to acute sickness they should choose a plan with a lower deductable.

Massachusetts mandates a certain level of coverage and this may prevent effective participation in the plan.

The Massachusetts plan would move Illinois closer to the increased coverage best practices. It is clear that the increase in private mandates is effective in increasing the number of uninsured without a high subsidy from the state. The public plan benefits from a Medicaid waiver that increases the number of participants in the plan. This expansion is paid by a combination of sources, federal, state and private, and therefore shares the burden of insuring the uninsured. It also means that should one funding source become restricted, it may be possible to still offer some level of coverage based upon the other two funding sources.

Communications and outreach

The Massachusetts plan benefited from being the first in the nation to mandate universal healthcare. This allowed the program a great deal of free publicity from the press and helped to raise awareness in the state. Should Illinois offer this same plan, it is impossible to determine whether it would get similar unpaid media attention and therefore the responsibility may fall on the Board. The Massachusetts Health Insurance Connector is housed within the department of administration and finance and was created for the purpose of providing assistance and publicity for the program and for ensuring compliance to the program (Massachusetts, 2006). This outreach mechanism provided a two-way communications tool for the state as employers may use the tool to find affordable, compliant insurance plans, but also the state could receive feedback on the

plans from the employer. In 2007 the number of plans was expanded after the plan was criticized for not offering enough healthcare options to employers and individuals.

The Massachusetts plan has been reviewed by the legislature, which oversees the board, and this allowed the Board to make some changes to offerings and services to the public. If the communication between the legislature and board continues, this will keep this issue in the public domain and help the state to raise awareness that the program is mandatory for all residents.

The Massachusetts Plan creates communications mechanisms that would move Illinois closer to increased participation and access. The plan has some challenges that seem to result from the limited number of plans that are approved by the board, and therefore do not account for individual preferences. However, by offering a 'communications center' that can talk to different groups about the programs and by publicizing this service, the Board benefits from two-way communications. The plan also uses state workers, based in the community, to assist residents and this may help residents to be aware of what public services they are eligible.

Cost control

The Massachusetts program now has a track-record with an established budget for each year. This shows the expansion of cost that the state has assumed under the Massachusetts plan (Raymond, 2007). However, what is unclear in such a young program is the amount that the state and business will save from trade-offs such as reduced emergency room care and reduced catastrophic illnesses. Raymond (2007) shows that cost control has not been the hallmark of the state plan, however the plan does

pass this cost on to uninsured adults as part of their state taxes and employers that prefer not to offer health plans. This shared responsibility for the cost of the plan ensures some level of sustainability because a downtrend economy and falling federal health spending would not guarantee the end of the program.

The plan aims to control costs by creating a managed care environment for residents of the state and this would advance Illinois efforts to control costs. This is because managed care environments that control costs, such as Kaiser Permanente, have lower costs than other managed care organizations. One possible reform that the state could offer to encourage cost control is to remove any incentives to provide additional or expensive care where it is not necessary. The state will still be limited by federal rules, but by mandating the use of a formulary list in drug choices or reimbursing physicians less for follow up meetings, the state provides incentives to cut costs. By sharing cost, the state is also able to control the state share of any increased costs that result from participation. There are definite areas where the Massachusetts plan could control costs better, however the plan would move Illinois forward towards a sustainable program.

Table 6.8: Assessing the Massachusetts Plan for use in Illinois

Criteria	Score	Explanation
Expands Coverage	+	Combines individual mandates and expansion of state programs to establish universal healthcare.
Cost Control	+	Requires expansion in state funding, but also the individual mandates share responsibility with the private sector. Federal and individual funds help to ensure program sustainability.
Communications and outreach	+	Creates outreach/ information program to connect individuals and businesses to providers. Also, to collect feedback on program short-comings.

Comparing the Plans

Each of these programs has different advantages to offer the residents of Illinois, and a compromise plan may be necessary in light of the political-will to pass a program to expand health services and revise the current program to reflect any need for a new departmental home and budgetary need for a program that insures a greater number of Illinoisans.

Table 6.9: Comparison of Health Care Plans

	Status Quo	Governor's Plan	Massachusetts Plan
Expand Coverage	X	+	+
Communications and Outreach	X/-	-	+
Cost control	X	x	+

It is clear that from a high-level evaluation of each program, the Massachusetts plan offers a solution to each of the best practices identified in the literature.

The Governor's plan and Massachusetts plan expand coverage to a larger number of residents using both private and public plans to a greater or lesser extent. The Governor's plan places more emphasis on public funding and taxes (an expansion of $7.2 billion in state funding, compared with an increase of $1.572 billion in Massachusetts), which increases the role of government within healthcare provision. An increase in the state's responsibility for public health may be unpopular politically with a number of groups that believe in a smaller government.

Although it is possible to determine that the Massachusetts Plan best fits the best practices that are identified in the literature, it is not possible to determine whether this plan is administratively or politically feasible without further analysis.

Political feasibility

The status quo is politically feasible because it requires no further political action. Medicaid and other state entitlement programs are established line-items within the department's budget. Though there is some question as to whether this would continue to be politically feasible if there were a necessity to cut funding across the state budget, any cuts would likely come from the state programs with no federal match such as AllKids. Lewit (2003) argues that children are the most sympathetic recipients of public health funding and so this may protect current programs from political cuts.

The Governor has made strong statements regarding expanding healthcare to all Illinois residents under the Illinois Covered plan. This would be a more difficult plan to pass than merely making small, incremental changes such as increased funding to the status quo. The political position of the governor will be important in negotiating the passage and implementation of his plan. The governor is now entering the second year of his second term, in a non election year, and for this reason may have less power to influence legislators. However, 2008 is expected to see a capital spending bill pushed by down-state legislators and so this may provide an opportunity to trade-off investment in the South of the state with an expansion of state programs and mandates on private employers.

The Massachusetts plan balances the desire of the Governor to expand healthcare through a number of state programs and expanding taxes or fees to pay for this and the desire of the more conservative legislature to encourage personal responsibility. This plan may be feasible in Illinois because all that are able to afford health insurance will be expected to do so, however those that cannot will be funded through re-deployed state funds. This removes some barriers to entry for low-income residents, and ensures continued Federal support of the Medicaid program by using additional state funds and the already-established Medicaid waiver, rather than using federal funds for other groups, which may ensure support for the program at both state and federal levels.

It seems that the status quo remains the most politically feasible program because small changes could be made to improve the program. Opponents of the Governor's plan may choose to push for incremental changes in order to show the public some movement towards expanded programs without larger, more expensive reform. However, the Governor's position is to expand healthcare programs and therefore he may oppose any incremental changes in favor of pushing for larger reforms. For that reason, the political feasibility will be reviewed for each program despite the fact that the Massachusetts plan has the highest score.

Administrative feasibility

The status quo has an established home within the CHIP department and it is therefore administratively feasible to stay within the same system.

The current plan for Illinois Covered is to sit the program within the responsibilities of the board that administers the Illinois Comprehensive Health Insurance

Plan. This board would likely be a natural fit since it currently administers all public health programs for the state and regulates health insurers. This would reduce the fiscal note for any plan because the board would likely need to increase staff, but may use the same systems and programs that are already established.

The Massachusetts plan places the program within the Division of Taxation and Administration, but creates a board to oversee the program. This is because it depends heavily on tax returns to ensure compliance. Should the program be mirrored in Illinois, it is likely that compliance at least should be passed to the taxation department since enforcement for unpaid health insurance also falls to this department. This would create the need for clear systems of communication between the already established CHIP board and the department of taxation, but does not preclude either department from administering this program since it calls on their core competencies (healthcare administration and tax compliance respectively) to administer the program.

The most administratively feasible program is the status quo; however the Massachusetts plan, because of its structure that uses the core competencies of different departments seems to be similarly feasible.

When reviewing the feasibility of each program, it is necessary to review whether the plan meets the criteria for a successful program with the extent to which the program is administratively and politically feasible.

The analysis indicates that the Massachusetts plan best achieves the ‘best practices’ that are identified in the literature on healthcare programs. However, it is clear from the discussion that the status quo has the highest level of feasibility.

Chapter 7

CONCLUSION

This study provides policymakers and their staff some insight in to the strenghts and weaknesses of health care reform proposals in Illinois. Illinois policymakers are under pressure to address the problem of the growing number of uninsured in the state. The 2007 bill failed because of its fiscal feasibility and there was insufficient political will to pass a large tax reform and spending bill. However, there are a large number of uninsured in the state and health is a useful tool to ensure the continued effectiveness of a group of people. For that reason, the recommendation of this analysis is that although it may create more of a political challenge for proponents than the status quo, the Massachusetts plan is superior to both the status quo and the suggested Illinois Covered plan.

In conducting this analysis I was surprised that the current plan met a number of the best practices found in the literature. Although the current plan falls short of offering everyone insurance, the plan is structured to meet the needs of the public and therefore may be expanded or contracted. I was also surprised that the Governor's plan did not offer more incremental changes to health care, but chose to provide massive reforms. In the first year after an election, it may have been possible to garner some additional support and make progress on an incremental level; however, the failure of the bill shows that the fiscal problems could not be overlooked. It may also suggest the Governor will not have the political capital to make major changes.

It is clear from the failure of the Governor's plan in 2007 that the Governor must work more closely with legislators to pass any plan that he wishes to champion. Political feasibility and compromise will therefore prove important if the leadership wishes to pass a plan in 2008. The incremental changes made in 2007 may indicate the level of political willingness to move away from the status quo.

There are a number of limitations to this study including access to data and proprietary information. I wrote this thesis during an extended legislative session and for that reason it has been difficult to get information and feedback from legislative staff and the Governor's policy staff. The Illinois legislature is currently debating transportation infrastructure and taxation and therefore healthcare is not currently a priority issue. Proprietary information on the cost of services to different groups is unavailable because the health plans protect that data so that they can better negotiate further contracts with clients. This information would give a great deal of insight to the amount that different groups are paying for programs and would help to inform a better analysis on areas that could be targeted for cost control.

This project provides criteria against which a policy maker's staff may evaluate a program that intends to solve, to some extent, the issue of the uninsured in Illinois. Other states are likely to consider alternative plans to improve health services to their residents. Because the decision criteria I have identified are taken from a variety of non-state-specific sources, they may be applicable to jurisdictions other than Illinois. My hope is that policy makers outside Illinois could use these criteria to assist in evaluating proposals.

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