ILLINOIS GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

SPECIAL COMMITTEE ON MEDICAID REFORM
December 13 and 14, 2010

RECIPIENT ELIGIBILITY REFORMS, MORATORIUMS AND COVERAGE REFORMS, TASK FORCES AND REPORTS, AND OTHER

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Supported by Illinois Maternal and Child Health Coalition
and Health and Disability Advocates

Thank you, chairwomen and members of the committee, for this opportunity to submit testimony on the issues scheduled for two hearings of the Special Committee on December 13 and 14, 2010. For the most part, this testimony will address the list of issues the committee has distributed under the headings "Recipient Eligibility Reforms, Moratoriums and Coverage Reforms, Task Forces and Reports, and Other", but I will first address additional ideas. Please also note that the Shriver Center joined in the testimony of Health and Disability Advocates regarding the managed care issues the committee heard on December 8. We believe that most of the significant short term savings that the committee can identify will be within that set of issues rather than the issues covered here. The Shriver Center is a non-profit law office that uses policy development, communications and advocacy to increase opportunity and justice for low income people. We have been active in health care issues for many years, including Medicaid, All Kids, FamilyCare, private insurance and many coverage, access, and quality issues. (Specific recommendations in the text below are marked with the symbol ">>" and printed in bold type.)

A. Ideas not in the committee materials

1. Federal information technology funds

The committee is considering several ideas to tighten enrollment determinations and ongoing eligibility redeterminations (more on those issues below). The reality of the situation, though, is that these measures require staff and cost money in other ways, and it is not at all clear that implementing them will accomplish savings through more accurate administration. The best way to accomplish this, while also preparing the state for the unified and simplified enrollment system required for implementation of national health reform is through a major improvement in information technology that allows most of the eligibility verification to be based on data exchanges. The state needs a great deal of upgrading in both the interoperability of data bases and the "real time" currency of the information in data bases. Fortunately, there are major streams of federal funds available right now for those purposes: 90% match.

>> The state should draw down significant sums of federal funding for information technology upgrades and system design. The committee should designate some portion of the savings it identifies and designate it for the state share of this expense. For example, if the committee identifies $200 million in savings through

ongoing managed care initiatives, it could designate $10 million of that to invest in information technology, which would amount to a $100 million fund for this purpose (with the $90 million federal match). Or a $20 million investment would create a $200 million fund, etc. This will add very significant federal funds to the state budget for tasks that the state must complete in any event. And, upon completion, those investments will produce a more efficient and accurate administration of health insurance.

2. Early implementation of Medicaid eligibility expansion for certain populations.

This runs counter to some of the themes in the committee's materials, but there are small populations that, if covered by insurance that is federally matched, would reduce the state's spending. One example was brought to the committee's attention in the testimony on December 8 of the representatives from TASC, an organization that deals with drug and alcohol treatment. The data shows a clear savings when there is treatment of both the addiction issues and the surrounding medical issues. The savings are in reduced emergency room visits and hospital stays, social services, criminal justice system involvement, and more. The federal government, which requires "federal cost neutrality" to grant a waiver, would consider granting these waivers because in 2014 it assumes 100% of the cost of covering these populations, and by covering them early at the regular 50% matching rate for the intervening years the costs to be incurred in 2014 will have been substantially reduced through treatment and ongoing primary care.

>> The committee should not restrict the ability of DHFS to identify and pursue waivers for early implementation of Medicaid eligibility expansion when an expansion can save overall state spending. The General Assembly can retain a case by case approval authority without imposing a blanket up front bar or moratorium.

3. All Kids audit process.

215 ILCS 170/63 provides for an annual audit of the All Kids expansion program, to focus on "[P]ayments for health services covered by the Program and contracts entered into by the Department in relation to the Program." It is not a good use of limited DHFS staff time and resources to undergo an audit annually. The Auditor General released the first annual audit last Spring, and then was already in motion on the next annual audit. The agency is expected to implement federal reform, cope with a state budget in crisis, provide brainpower and data for this committee and to other General Assembly committees and task forces, and immediately and successfully execute whatever changes result from this committee's process. The agency's staffing levels are low already. The audits cost money and commandeer staff and resources that are better used elsewhere. The Auditor General's staff can be better deployed as well. The annual audit requirement was an artifact of the tense relations between the executive and legislative branches during the Blagojevich era (hence the statutory focus for the audit on "payments and contracts"). It is no longer necessary. The regular program audit cycle should be adequate.

>> The All Kids audit process should not be annual. It should be backed off to a normal cycle, both to save money and to deploy scarce resources on more immediate priorities.

B. Recipient Eligibility Reforms

1. In general.

Generally, many of the changes suggested in the committee materials deal with the enrollment and redetermination practices of DHFS with respect to the All Kids program. These procedures are part of a national trend of best practices designed to facilitate enrollment and rapid connection to primary and

preventive care, and then to refrain from interrupting that care. This is a key not only to better health outcomes but to bringing down the overall costs in the health care system (not just public programs). Appendix A to this testimony is entitled "Benefits of Insured Children", and it provides data and citations to support this trend in Illinois and the nation. Among other things, the policies targeted for change by some of the committee's suggestions have been the basis of multi-million dollar federal performance bonuses to Illinois.

The following testimony takes the suggestions in the committee materials in order.

2. Non-citizens. The committee materials contain a proposal to eliminate non-emergency coverage to all non-citizens (SB 2152 -Lauzen). SB 2152 would deny coverage to legally present non-citizen adults even after they have been in the country for five years, a group that is federally matchable and is currently covered in Illinois. Similarly, it would deny coverage to legally present children, even though they are federally matchable (CHIPRA re-authorization eliminated the five-year bar for children in January 2009).

>> **Illinois should not eliminate federally matchable non-emergency coverage to non-citizens.** All are legally present – including the adults for over five years. All are within income levels for federal match. All the reasons that support coverage of citizens apply to them. Illinois should continue to cover them.

The rest of this issue involves non-citizen children whose coverage is not federally matchable. Illinois has adopted the policy, which is a leadership position in the country, that all children in the state should have access to affordable coverage. The All Kids program implements that policy, and the last expansion to complete that policy was the Covering All Children Health Insurance Act. It received significant Republican support in the House. It was launched at the same time as the Primary Care Case Management and Disease Management programs, with the savings generated by those programs as the funding source identified for the coverage. From the very first year, that funding source has more than covered the expansion, as promised. So the program has always been paid for by promised spending reductions and has not driven an increase in general revenue spending.

There are two small categories of children covered under All Kids for whom Illinois does not receive federal funds. All Kids covers undocumented non-citizen children. And All Kids covers children who are in families with income between 200-400% of the federal poverty level who are long-term uninsured and who pay significant sliding scale premiums and co-payments. There may be some non-citizen children in the latter group as well. This higher income group is addressed below in the section on "Moratoriums and Coverage Reforms".

The coverage for undocumented children implicates an emotional issue in American life that has yet to be resolved. Illinois, to its lasting credit, decided not to include children's health care in that impasse. This is a strong statement of values and commitment to the care for children in our midst, who are blameless in the larger struggle over immigration. But it is also smart policy and fiscally responsible. The extremely small cost (about $1,000 per year per child) of covering a few thousand children is offset in large part by the costs it avoids. Coverage brings preventive and primary care, which avoids emergency care, hospital stays, public health gaps in immunizations and control of contagious diseases, and medically-driven social problems.

>> **Illinois should not eliminate coverage for all non-citizen children in All Kids.** The "savings" associated with cutting off the coverage of undocumented non-citizen children are meaninglessly small in the context of this committee's charge to find immediate large savings. The change would reverse an important bi-partisan policy decision, which has made Illinois a national leader. A policy decision of that importance should not be reversed as part of a hasty emergency budget process.

3. Presumptive Eligibility

The committee materials overstate the use of presumptive eligibility in Illinois, and then propose that, other than for pregnant women, the policy be revoked. Presumptive eligibility is only in use for children under 200% of the federal poverty level and pregnant women. (We assume the committee materials do not reference the disability program. There is a small group of adults who have serious medical problems and are applying for federal Supplemental Security Income and Medicaid eligibility on the basis of disability. Based on a disciplined evaluation of their medical conditions the department can find them "probably eligible" for the federal programs and provide them with medical coverage. The coverage helps them document their medical conditions, and most of them are then found eligible for SSI and Medicaid, at which point the state is able to go back and claim federal match for the coverage.)

Children's presumptive eligibility is part of the policy to connect children to primary and preventive care as quickly as possible and then maintain it. Bear in mind that in the All Kids environment, the determination of eligibility is not about coverage – all kids are covered – but is a determination of appropriate premium and co-payment levels. If the child will be covered in any event, it makes no sense to delay the establishment of a medical home and the commencement of the salutary benefits of primary and preventive care. The coverage of these children is extremely low cost, and there is little or no evidence that elimination of presumptive eligibility would avoid any costs, while there is solid evidence that primary and preventive care does save money in both the short and long term.

>> **The state should not change its presumptive eligibility policies.** There are no savings to be had by taking this step, and it would reverse a smart policy.

4. Income Verification

The committee materials support a requirement of pay verifications for 30 days' worth of income as part of the eligibility determination process for medical assistance. In testimony, HFS has indicated that it intends to move in this direction. While this thus seems settled, the committee should be aware that this is not best practice nationally, nor does it align with the direction of a unified and simplified health care coverage system that fosters rapid engagement with a medical home and emphasizes prevention.

Historically, procedures requiring the exchange of papers and the handling of those papers by state workers have resulted primarily in the erection of barriers and delays for access to programs by eligible people, not ineligible ones. These "churning" schemes are wasteful. While it may or may not have been appropriate for traditional cash assistance type social programs, it is not appropriate for a modern health care system, especially one for children, that intends to focus on rapid engagement with preventive care as a key component of overall cost control and wellness.

The direction to go on this issue is the upgrading of the state's information technology capacity exchange. While the Auditor General identified some mistakes in the current system for All Kids, the answer is not to ratchet up paperwork, red tape and personnel needs, which will cost more than they are worth and will erect barriers to care for eligible people.

>> **The state should not erect new paperwork barriers for access to medical assistance programs and increase demands on agency personnel to administer them.**

5. Asset tests.

The committee materials cite SB 2991 as a possible policy direction. It would impose an asset test on the All Kids program of $5,000. The reason it cites is that the state has an asset test for medical assistance for seniors and people with disabilities, so why not everyone?

The federal government requires the asset test for Medicaid for seniors and the disabled (although there are a number of "exempt" assets and a way to channel assets towards work activity). Those policies may or may not be wise, but they deal with a much different situation than coverage for children and parents. Seniors and people with disabilities use much more health care; there are institutionalization and end of life considerations, and so forth. Children and parents are low cost (about $1,000 per person per year), and there are different policy considerations, such as work and savings incentives and the imperative of engaging them in preventive care and wellness activities. The national trend and the weight of evidence on these issues is away from asset tests.

Most importantly for this committee's purposes, there is no evidence that imposing an asset test saves any money. There are few current beneficiaries that would be rendered ineligible. And they would thereby be deterred from engaging in preventive care, instead waiting for an emergency, spending savings on it, and coming on to the state's program with unnecessary high medical bills. While there are scant demonstrable short term savings in imposing an asset limit, there are clear costs associated with it. Forms, procedures and, above all, personnel costs would be required to administer an asset test. Short term costs would almost certainly outpace any short term savings.

>> **The state should not impose an asset test on medical assistance for children and parents.**

6. Redetermination of Eligibility.

The committee materials suggest moving from 12-month to 6-month redeterminations of eligibility. This would be a doubling of the administrative burden on DHFS. In the short term, which is the purview of this committee, it would significantly increase costs. And it would not produce long-term savings – quite the opposite. Twelve-month redeterminations are a part of the national policy direction to refrain from interrupting children's care. Especially in an environment where all kids are eligible, and the redetermination involves only financial issues about premium and co-pay levels, which can be adjusted retroactively and prospectively, this is simply not an area for serious short-term savings. Moreover, moving from 12-month to 6-month redeterminations will almost certainly disrupt the care of eligible children simply through administrative hassle, mistakes, delays and staffing shortages. Most of the illusory "savings" would be in the form of interruption of care to eligible children.

As demonstrated in "Benefits of Insured Children" (Appendix A), the national trend and the best potential for long term savings is in smooth and mostly electronic annual redeterminations.

>> **Illinois should not adopt 6-month All Kids redeterminations or otherwise increase the procedural difficulty of redeterminations.**

7. Federal Eligibility Requirements

The committee materials indicate that there is a problem with Illinois being more lenient than the federal government on enforcing eligibility requirements for coverage, and the suggestion is to adhere to federal requirements. Other than "probable eligibility" for some applicants for federal disability determinations and certain non-federally-matched coverages in All Kids, which are dealt with elsewhere in this testimony, it is not

clear to us where this problem might exist, or where there are any significant savings to be had by closer adherence to federal eligibility rules.

8. Use of the Outstanding Warrant Data Base and Immediate Suspension of Benefits

The committee materials reference HB 6139 (Rose) and suggest the cross-matching of medical assistance databases with the outstanding arrest warrants database, and then the immediate suspension of health coverage if there is an outstanding warrant for a beneficiary. This is an unwise idea for several reasons. Benefit suspensions without prior notice and an opportunity for a hearing are not consistent with accepted principles of due process of law contained not only in the state and federal constitutions but in the governing statutes and regulations for the programs. This would also amount to a new eligibility requirement – "having no outstanding warrants" – which would violate the governing federal statutes and threaten federal matching funds. The state police records on warrants are not uniformly reliable. Local jurisdictions do not consistently tell the State Police when warrants are quashed, for example. This factor highlights the need for due process and the danger of totally unjustified terminations. It is also not the case that people who have warrants out for their arrest are aware of it or have even done anything arrest-worthy, nevermind conviction-worthy. Finally, Illinois law already gives law enforcement access to information on public benefits recipients, so there is no apparent law enforcement need for this measure.

>> **Illinois should not adopt immediate suspension of benefits for outstanding warrants.**

9. Urine test for public assistance applicants.

The committee references SB 3477 (Jones). This would be an immense short term cost, in terms of staffing and technology and chain-of-custody and more. It would produce no predictable short-term savings other than chasing away eligible people not willing to go through the process. And it implies the adoption of new eligibility rules that would transgress governing federal statutes and threaten matching funds.

>> **Illinois should not adopt urine testing for public assistance applicants.**

10. Privatization of determination process.

The committee materials reference a suggestion from the Lucas Group that the determination of eligibility for benefits be privatized, which Lucas Group asserts would achieve cost savings estimated at $120 million. That cost saving estimate did not have a convincing evidentiary basis and is incredible. There is no evidence that DHFS is making $120 million worth of mistakes or inefficiencies, no evidence that a private company might remedy any costs or inefficiencies, and no evidence that any such remedies only can be done by a private company and not by DHFS or that a private company can do it for less money.

Benefit eligibility determinations should never be privatized. This is a core government function, which should be performed with dedication to the proper determination for or against eligibility, and not with a profit motive attached to one of the outcomes. Illinois is accountable to the federal government, and DHFS is accountable to the General Assembly, for proper eligibility determinations that accurately implement policy for public expenditures. That accountability is not avoided through privatization. Privatization only adds a layer of loss of control and of risk. The idea has been tried elsewhere and has been a costly failure. Milwaukee tried it with the TANF program, and Indiana with its medical programs. In any event, even if Lucas Group's estimate had some validity, there are certainly no short term savings in this idea.

>> **Illinois should not privatize eligibility determinations.**

C. Task Forces and Reports

We have no position on most of this. It is sensible to examine these sources of information and then evaluate the ideas. We note that the idea of a "forensic audit" of the Medicaid program has recently been costed out and found to be well beyond what the state can afford right now. The case has not been made that such an expenditure is justified even in the best of times, but in any event it is not the kind of short term savings idea that falls within the committee's charge.

>> Illinois should not undertake a forensic audit of Medicaid at this time.

D. Moratoriums and Coverage Reforms

1. Non-federally matched beneficiaries

The committee materials suggest eliminating eligibility for non-federally matched beneficiaries, "especially General Assistance". The only coverage in the General Assistance program of any size is the "probably eligible for SSI" coverage described above. As noted, this helps destitute individuals who have significant medical issues both to obtain health care and to document their medical issues to help them prove federal eligibility. For all of the successful ones, which is most of them, Illinois can obtain retroactive federal match. And as to all of them, the coverage allows access to treatment, maintenance medication, primary care and prevention, all of which prevent acute care episodes and other high costs and, in some cases, help to put the person on a path to employability. All of this population will be covered by the Medicaid expansion in 2014.

The last non-federally matched population of any appreciable size not mentioned yet in this testimony is the higher income children in All Kids, those from 200-400% of the federal poverty level who pay premiums and co-payments on a sliding scale. There is a very significant waiting period of one year for this coverage. So the children who are beneficiaries of this coverage are those whose lower middle class working parents have not been able to insure privately. Nevertheless, it does not appear to be a high cost group --- the need seems to be mostly for preventive and maintenance care.

There may be opportunities to transition the chronically ill children in this group onto the new state high risk program, or into private insurance (with the recent elimination of the pre-existing condition bar). And in the next few years this whole population will be served by private plans in the exchange. All of these avenues should be pursued, but in the meantime it will not save significant money to abruptly interrupt this coverage and the care that the children are receiving under it. There are only a few thousand, and their parents are paying significant premiums and co-pays on a sliding scale.

>> Illinois should not terminate "probably eligible for SSI" coverage nor abruptly terminate All Kids coverage for 200-400% FPL children, although it should transition these children into affordable high risk or private coverage as soon as practicable.

2. Increased Cost-Sharing.

The committee materials suggest an increase in co-payments, especially for non-emergency hospital visits. This is a commendable narrowing of the issue of co-payments, so that it does not include primary care or increases with respect to needed specialty or emergency care.

Co-payments have often resulted in a cost-shift to providers, because many beneficiaries are simply unable to pay at the point of service, or providers are not willing or able to set up the administration of co-pays within their practices. However, the matter of co-pays for non-emergent use of emergency rooms is worthy of study because it is an important way to foster overall cost control in the health care system (not just public programs). It should be combined with close attention to the ability of the hospital personnel to refer people they are turning away from the Emergency Room to a consistent source of primary and non-emergency care.

In any event, this does not appear to be a source of significant short-term savings.

>> Illinois should study the use of higher co-pays for non-emergent Emergency Room care, in conjunction with establishing all beneficiaries in medical homes for consistent primary and non-emergent care.

3. New and Expanded Program Moratorium

The committee materials suggest a moratorium on new or expanded programs for 2010 and 2011. The materials substantially overstate the cost of recent program expansions ("billions") to All Kids and FamilyCare, which extended coverage to low cost populations and were implemented along with successful care management reforms. Nevertheless, the general point is a good one, as 2010 and 2011 should be spent getting a handle on the current state budget and preparing for implementation of national health care reform. We described in section A.2., above, the possibility of targeted federal waivers for expansion of Medicaid eligibility to certain populations that could save the state money. With that exception, we support this idea.

>> **With the exception of small program expansions that can save the state money, we support a moratorium on new or expanded programs for 2010 and 2011 and thereafter until federal reforms are implemented.**

4. Remove state co-payment for generic drugs

If the state co-payment encourages the use of generic drugs over brand name drugs, it is well worth the money. In any event, this does not appear to offer significant short-term cost savings.

E. Other

1. Improve Birth Outcomes

Improved care coordination for pregnant women, especially those at risk of adverse experiences, is an excellent idea and offers good potential for short and long term savings.

>> Illinois should improve and invest in care coordination programs for pregnant women.

2. Pursue federal "global waivers".

This strategy is both immensely complex and an unnecessary financial gamble. Currently Illinois receives federal matching funds for whatever approved Medicaid expenditures it makes. Under a "global waiver" Illinois would have to agree in advance to an overall cap on federal funds for the state, in return for marginal flexibility in programming. A cap on federal funds would place the entire burden of increases in spending on the state – not just increases due to new coverages or services but increases due to the cost of care, the aging of the population, disasters, economic downturns, and the like. This kind of gamble is unwise and not worth it.

Illinois has plenty of flexibility under Medicaid, and it can ask for more without sacrificing its financial rights. Global waivers have not had much success either in health outcomes or state finances. This is no time for Illinois to engage in risky experiments. And whatever savings might accrue from a global waiver scheme would require a lengthy period of planning and design and federal approval processing; they would not be realized in the short term.

>> **Illinois should not experiment with global waiver schemes.**

3. Section 25 Medicaid liability

The committee materials describe a change in the current laws that allow the delay of the Medicaid payment cycle at the end of a fiscal year, paying one year's bills with the following year's appropriation. We have no position on this, but we note that it does not offer any short term savings and thus perhaps is not for this committee to determine.

4. Move Inspector General

We have no position. It is not clear what problem this change would be aimed at. In any event, it does not offer any short term savings.

5. Public data warehouse and Medicaid Recipients Information

The committee materials suggest that the Medicaid data warehouse be made available to the public and the legislature. HB 5241 (Bellock) would also make Medicaid information available on the HFS website. If done consistent with privacy laws, these are good ideas, although they do not offer short terms savings.

6. Pictures and names on LINK cards.

The committee materials reference HB 5544 (Cavaletto), which would require that the card contain the holder's photo and name. This is a costly idea that does not seem to be aimed at solving any documented problem or worth the expense.

>> **Illinois should not adopt photos on LINK cards.**

7. HFS reimbursed by fathers for costs of childbirth.

The committee materials reference HB 6882 (Mitchell), which would require the state to be reimbursed for child birth costs, by the father where possible. There would be very little actual reimbursement, and there would be an accumulation of debt that would add to the barriers these fathers face in trying to begin productive lives. There would also be a disincentive for pregnant women to seek health care during pregnancy. HFS would incur the expense of setting up a whole new operation to assess and collect these debts, as would the Attorney General. And there would be no short term savings whatsoever.

>> **Illinois should not establish a duty to reimburse for child birth costs.**

8. Generic drug competitive bidding.

The committee materials reference SB 3846 (Milner). We have no position.

9: Buy in.

This idea would create a way for people not eligible for Medicaid to buy into it as their chosen means of health insurance. This could be phased in so that it is available in the near future to on-average healthy populations, so that it would make money for the system.

>> **We support creation of a buy-in option for Medicaid.**

10. Episode of Care Payments and Medical Global Payment System demonstrations.

These are ideas that are in the national health reform law and present good ideas for cost containment and better quality care.

>> **We support demonstrations of these ideas.**

Appendix A.

Benefits of Insured Children:

1. Illinois was the first state in the nation to offer comprehensive health insurance coverage to all uninsured children. Through its All Kids health insurance program, children receive coverage that includes doctor visits, hospital stays, prescription drugs, vision care, dental care and medical services like eyeglasses and asthma inhalers at little or no cost to the parents. After the inception of All Kids, the rate of uninsured children in Illinois dropped from 10.4% to 8.1%, which was more than three percentage points below the national rate.

2. Illinois recently received an additional $9.1 million from the federal government for enrolling more children in health insurance through Medicaid and improving its process for enrolling children in health insurance.[1] By streamlining enrollment, Illinois encourages families to enroll when they are healthy despite not needing immediate care. This reduces costs in the long-run by encouraging preventive care and preventing costly emergency room use.[2] Illinois recognizes that everyone benefits when children are healthy. Insured children have access to well-child care so they can avoid absences from school and develop healthy habits early on in life.

3. Illinois' Medicaid program stimulates the local economy. Medicaid funding has an economic "multiplier effect" because money comes into the state economy through federal matching funds. Under ARRA, state and federal Medicaid funding resulted in $46 billion in increased business activity in 2009 and $15.8 billion in wages. This means that state and federal Medicaid funding supported 385,742 jobs.[3] The federal matching funds are vital to the state economy, and serve as one of the most important sources of funding for the state of Illinois.[4]

4. Illinois' Primary Care Case Management (PCCM) – Disease Management (DM) program saves Illinois money without sacrificing care. The PCCM model is a patient-centered, medical home model that ties patients to physicians. All Kids enrollees are linked with a medical home of their choosing through Illinois Health Connect, which saved Illinois an estimated $100 million during the 2008 fiscal year. Having a usual source of care (medical home), such as a pediatrician or family practice doctor, has been associated with earlier diagnosis, fewer hospitalizations, lower costs, and increased patient satisfaction. The DM program helps patients with chronic conditions coordinate their care and manage their conditions, preventing flare-ups and providing patients access to health care professionals who can answer their questions.[5] This DM program is expected to save the state more money in the long-term because of the savings that come from a healthier population and prevention of costly emergency care. In 2008, the DM program saved the state $104 million.[6] And it saved the state $320 million in fiscal year 2009—the first full year of its operation.[7] Illinois ranks 42nd in spending per Medicaid beneficiary.[8]

5. Employer-sponsored coverage is significantly decreasing and public insurance "catches" these families until they get back on their financial feet. In 2008, the number of workers without insurance rose by 932,000 and the number of people without insurance at all grew by 682,000. However, because of programs like All Kids, the number of uninsured children actually dropped by 801,000. All Kids health insurance program is needed more than ever to "catch" children whose parents are losing their jobs and thus their employer sponsored coverage. Illinois' unemployment rate is hovering at 11.7%, and one study showed that each percentage point increase in the nation's unemployment rate leads to an increase in Medicaid and children's health insurance enrollment by 1.0 million and the number uninsured grows by 1.1 million.

6. Studies show that lack of health coverage for children leads to poorer health in childhood, greater rates of avoidable hospitalizations, higher childhood mortality, delay in care and prescriptions that go unfilled.[9] Compared to insured children, uninsured children are more likely to have gone without needed medical, dental or other health care (22.1% versus 6.1%) and are less likely to have seen a physician during the previous year than children with health insurance (67.4% versus 83.8%).[10]

7. There is a connection between children's health insurance status and outcomes in adult life. The long term labor force impact of being uninsured as a child may be significant: Better health in childhood has been linked in adulthood to higher incomes, higher wealth, more weeks worked, and a higher growth rate in income.[11] Siblings who were healthy as children earn as much as 24% more in adulthood than their unhealthy siblings.[12]

8. Research indicates that only 35.3% of uninsured children in the United States were in compliance with the American Academy of Pediatrics recommended guidelines for well-child visits.

9. One study estimates the present value at birth of lifetime health capital lost due to lack of children's health insurance is $15,572 for each male and $11,646 for each female. The present value of health value lost for an uninsured male age 18 years old is $19,136. Health capital was valued based on both the quality and length of life for insured and uninsured children. A separate study suggests that the cost of providing health insurance to each uninsured child through age 18 is $7,451 in current dollars. Thus, the costs of covering children with health insurance could be offset by the value of future health capital gained.[13]

10. Past studies showed that providing health insurance to low-income children and pregnant women increased spending on other consumer goods by the equivalent of approximately $800 per family per year in 2009 dollars. Boosting consumer expenditures for these families by such a sizable amount in the midst of the current economic recession and decrease in spending would contribute significantly to a broad-based economic recovery.[14]

11. Children's health insurance status can have significant public health consequences for all children. One study found that medical care is delayed for 15.9% of children who had been uninsured for a year compared with 1.5% of privately insured children. Prescriptions for 10% of children without insurance for a year went unfilled compared with 1.0% of privately insured children. A Rand Corporation study of the impact of costs on the demand for medical care found that children eligible for free care were more likely to receive preventive services (immunizations, vision tests, general medical examinations).

They were also more likely to receive care for illnesses such as acute bronchitis, acute respiratory infections, common childhood injuries, and ear infections.[15]

12. There are serious consequences on the health of children due to their uninsured status. A study published in the journal *Pediatrics* compared the health status of uninsured children to privately insured children in families with similar incomes. The uninsured children were almost one-and-a-half times as likely to report being in fair or poor health relative to privately insured children in families with similar incomes.[16]

13. In another study published in *Pediatrics*, researchers compared the experience of children with asthma who were *newly* enrolled in a public health insurance program versus another sample of asthmatic children in the public insurance program 13 months later. Children were found to have far fewer asthma-related attacks (3.8) in the year after enrollment, versus the 12 months prior to enrollment in the public health insurance program (9.5). The percentage of children hospitalized for asthma in the previous year also declined dramatically (from 11.1% to 3.4%). The percentage of children visiting the emergency department in the previous year for asthma treatment declined after enrollment in the public health insurance program (from 35.2% to 15.6%). This before-versus-after comparison provides a striking picture of the benefits of children's health insurance for just one particular chronic ailment.[17]

    a. Asthma affects approximately 6.2 million children nationally and is one of the leading causes of school absenteeism, accounting for more than 14 million missed school days annually. Children with asthma miss an average of twice as many school days as other children. Among adults, asthma is the leading work-related lung disease. Employed adults 18 years of age and over missed 11.8 million work days due to asthma. Illinois has a higher rate of mortality from asthma than the U.S. population.[18]

14. The absence of health insurance has been associated with increased childhood mortality. Researchers studying data during states' expansion of their Medicaid programs found that the 15.1% rise in Medicaid eligibility that occurred between 1984 and 1992 decreased child mortality by 5.1%. The researchers further found that the Medicaid expansions reduced internal causes of death (e.g., diseases) by 8% but had no significant impact on external causes (e.g., accidents, homicides, suicides).[19]

15. Research indicates that enrolling children in Medicaid before they get sick reduces the need for hospitalizations. One study found that a 15% increase in Medicaid enrollment could lead to a 2.7% decline in hospitalizations due to better preventive care resulting from insurance coverage. This study used California Medicaid data and found that the total estimated savings amounted to $8 million annually for California.[20]

[1] U.S. Department of Health and Human Services press release, "States Get Bonuses for Boosting Enrollment in Children's Health Coverage," 17 December 2009, http://www.hhs.gov/news/press/2009pres/12/20091217a.html

[2] Testimony of John Bouman to Senate Committee on Deficit Reduction, 10 March 2009.

[3] Heather O'Donnell, "Medicaid Plays a Critical Role in Illinois' Economy," Center for Tax and Budget Accountability, December 2009.

[4] Memo from health advocacy organizations to Illinois Taxpayer Action Board Re: The TAB Medicaid Subcommittee's opportunities for changes to Illinois' Medicaid program, 8 May 2009.

[5] Dean Olsen, "Hot Line is Healthy for State Budget," Springfield State Journal Register, 17 May 2009, http://www.sj-r.com/homepage/x1194178152/Health-care-hotline-saves-patients-time-states-money

[6] Id.

[7] Illinois Academy of Family Physicians, Memo to Senate and House Medicaid Committees, December 1, 2010.

[8] StateHealthFacts.org, Kaiser Family Foundation, http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4

[9] "The Economic Impact of Uninsured Children on America," Baker Institute Policy Report, James A. Baker III Institute for Public Policy of Rice University, No. 40, (June 2009).

[10] Id.

[11] Id.

[12] Id.

[13] Id. In other words, a newborn male child who goes through life without health insurance will experience a loss in prolonged life span and health status that is valued at $15,572. The present value of health value lost for an uninsured male age 18 years old is $19,136.

[14] Id.

[15] Id.

[16] Id.

[17] Id.

[18] Illinois Department of Public Health 2009-2014 Asthma State Plan, Addressing Asthma in Illinois, (3rd ed.) available at: http://www.idph.state.il.us/pdf/Asthma_State_Plan_3rd_Edit.pdf

In 2007, it was estimated that 12.8 percent of the adults in Illinois (an estimated 1,226,335 people) have suffered or currently suffer from asthma. Of these persons who self-report doctor-diagnosed asthma, 64.9 percent currently have asthma. These latter data show that 8.2 percent of adults (an estimated 783,581 people) currently have asthma. The occurrence of adverse asthma mortality and hospitalization in the state has been increasing. In 2007, asthma accounted for approximately 111,618 hospitalizations either as a primary or secondary diagnosis. A snapshot of Illinois asthma data: In 2007, an estimated

• 1,226,335 people had been diagnosed with asthma during their lifetime

• 783,581 people currently were diagnosed with asthma

• 18,504 hospitalizations were due to asthma or 14.4 percent per 10,000 people

• $280,423,044 were direct charges for asthma hospitalizations

[19] "The Economic Impact of Uninsured Children on America," Baker Institute Policy Report, James A. Baker III Institute for Public Policy of Rice University, No. 40, (June 2009).

[20] Id.