

# The Path to Universal Health Coverage for Children in Illinois



By John Bouman



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**T**he All Kids Health Insurance Act, which creates the All Kids program to provide health insurance to every child in Illinois regardless of income or status, was signed into law on November 15, 2005, by Illinois Gov. Rod R. Blagojevich.<sup>1</sup> The All Kids program is aimed at the 253,000 children in Illinois without coverage.<sup>2</sup> With the passage of this program, Illinois became the first state in the country to offer health insurance to literally every child.<sup>3</sup>

Like virtually everywhere else in America, Illinois has been suffering under a record fiscal crisis for the past several years, and the crisis continued during 2005 even as All Kids was proposed and passed. Governor Blagojevich is a Democrat, and Democrats control both houses of the General Assembly. In the Republicans' attempt to regain the political power they long held and only recently lost in Illinois, they have been vigorously challenging the governor's stewardship of state finances.<sup>4</sup> Yet the All Kids bill, creating new spending on health care, garnered Republican support in both chambers.<sup>5</sup>

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<sup>1</sup>All Kids Health Insurance Act, Pub. Act No. 094-0693 (2005), available at [www.ilga.gov/legislation/publicacts/fulltext.asp?name=094-0693&GA=94&SessionId=50&DocType=HB&DocNum=806&GAID=8&Session=](http://www.ilga.gov/legislation/publicacts/fulltext.asp?name=094-0693&GA=94&SessionId=50&DocType=HB&DocNum=806&GAID=8&Session=). The bill authorizes the All Kids program and provides basic eligibility rules but leaves most of the details to administrative implementation decisions leading up to the July 1, 2006, effective date. The bill requires Illinois residency but has no other eligibility criteria related to status or traditional categorical eligibility rules. The "all" in All Kids thus far really means "all."

<sup>2</sup>Press Release, Illinois Government News Network, Governor Blagojevich Signs Landmark Legislation to Provide Comprehensive Health Coverage for Every Uninsured Child in Illinois (Nov. 15, 2005), available at [www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=37&RecNum=4463](http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=37&RecNum=4463).

<sup>3</sup>*Id.*

<sup>4</sup>Illinois Gov. Rod R. Blagojevich is the first Democrat in that office since the mid-1970s.

<sup>5</sup>One Republican voted "yes" and two "present" in the highly partisan state Senate, where the bill passed 32-23-2 (with 30 needed to pass). Twelve Republicans voted "yes" and nine "present," in the House, where the bill passed 79-23-9 (with 60 needed to pass). See Illinois General Assembly, Bill Status of HB0806, [www.ilga.gov/legislation/billstatus.asp?DocNum=806&GAID=8&GA=94&DocTypeID=HB&LegID=15394&SessionID=50](http://www.ilga.gov/legislation/billstatus.asp?DocNum=806&GAID=8&GA=94&DocTypeID=HB&LegID=15394&SessionID=50) (last visited Feb. 16, 2006) (note that because a preexisting bill that was originally about another topic was amended to include the All Kids legislation, the bill synopsis available at this link does not look like the All Kids legislation; the final version of the bill is the All Kids legislation, and the votes were on the bill "as amended"). The Democrats had enough votes to pass the bill by themselves. The significance of the Republican support and "present" votes is that health care is a potent issue that matters to many legislators of both parties either politically or on a policy basis, and they do not want to cast a recorded vote against it.

As other states and Congress consider, in the midst of persistent state and national fiscal troubles, whether to pursue the All Kids strategy to provide health coverage to all children, the path to All Kids in Illinois may be a useful case study.<sup>6</sup> Leading up to the All Kids proposal in Illinois, a sustained effort to promote health coverage across many different sectors created a politically receptive policy environment. Then the governor decisively asserted political leadership to take advantage of this environment. Both were indispensable. However, the development of the policy environment and the assertion of political leadership on health coverage are not artifacts of unique circumstances prevalent only in Illinois but are possible in other states and on the national level.

### I. Health Coverage Policy Environment in Illinois Before the All Kids Initiative

In July 2004 the Kaiser Commission on Medicaid and the Uninsured reported that in 2003 Illinois had increased the number of working parents insured by the state's FamilyCare program—an ini-

tiative to expand health insurance to cover children's uninsured working parents—by an astonishing 227 percent.<sup>7</sup> Illinois was by far the national leader and was fourth in the nation in increasing the number of children covered by KidCare (the state's name for the State Children's Health Insurance Program).<sup>8</sup> As of August 2004 Illinois covered more than one million children and almost 400,000 parents under the Medicaid, KidCare, and FamilyCare programs.<sup>9</sup>

In a state faced with a large population of uninsured, especially the employed uninsured, this growth in public insurance eligibility and enrollment was both crucial and timely.<sup>10</sup> In a state plagued by an ongoing, years-long, and historically large fiscal crisis, Illinois's standout performance on publicly funded insurance documented in the Kaiser Commission report is an example that may be useful to proponents of health coverage in other states.<sup>11</sup> That performance evidences the increasing political consensus on health coverage that made the decision to launch All Kids possible. This consensus was the work of many different sectors and consistent pressure to maintain and increase health care coverage.

<sup>6</sup>U.S. Sen. Richard Durbin (D-Ill.), in a joint initiative with U.S. Rep. Rahm Emanuel (D-Ill.), filed on December 16, 2005, S. 2137, the All Kids Health Insurance Coverage Act of 2005. See GovTrack.us, S. 2137: All Kids Health Insurance Coverage Act of 2005, [www.govtrack.us/congress/bill.xpd?bill=s109-2137](http://www.govtrack.us/congress/bill.xpd?bill=s109-2137) (last visited Jan. 31, 2006). The bill would give states enhanced federal resources to help and prompt them to cover all children using strategies similar to the Illinois program, including outreach and enrollment into existing coverage under the Medicaid and State Children's Health Insurance programs and new coverage to reach all income levels. For a description of the federal bill, see Press Release, Office of Rep. Rahm Emanuel, Durbin and Emanuel Introduce Legislation to Help States Provide Access to Health Insurance for All Children (Dec. 13, 2005), available at [www.house.gov/apps/list/press/il05\\_emanuel/ALLKIDS\\_DEC132005.html](http://www.house.gov/apps/list/press/il05_emanuel/ALLKIDS_DEC132005.html).

<sup>7</sup>Vernon K. Smith et al., Kaiser Commission on Medicaid and the Uninsured, SCHIP [State Children's Health Insurance Program] Program Enrollment: December 2003 Update 9 (2004), available at <http://kff.org/medicaid/7134.cfm>.

<sup>8</sup>*Id.* at 4.

<sup>9</sup>Press Release, Illinois Government News Network, Blagojevich Administration Delivers on Health Care Pledge (Aug. 5, 2004), available at [www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=3258](http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=3258) (response to the Kaiser Commission report, *supra* note 7). A flavor of the enrollment activity is found in a press release associated with the Illinois governor's budget speech on February 16, 2005: the state Medicaid agency stated that in the foregoing year, "[t]hrough aggressive outreach efforts to ensure that eligible uninsured working families have access to the program, the Blagojevich Administration has enrolled an additional 136,500 children in KidCare and an additional 138,500 parents in FamilyCare." Press Release, Illinois Department of Healthcare and Family Services, Governor Blagojevich Delivers Healthcare and Family Services Budget that Maintains Access to Health Care While Managing Costs (Feb. 16, 2005), available at <http://www.hfs.illinois.gov/newsroom/021605.html>.

<sup>10</sup>Illinois has about 1.8 million uninsured, or 14.4 percent of the state's population (10 percent of children). See Illinois Hospital Association, Illinois Uninsured, [www.ihatoday.org/about/facts/illuninsured.html](http://www.ihatoday.org/about/facts/illuninsured.html) (last visited Feb. 4, 2006) (summary of U.S. Census Bureau data on the uninsured).

<sup>11</sup>See Smith et al., *supra* note 7.

### A. Influential Players Outside State Government

While legislators influence public policy initiatives, the most significant leader in Illinois, as in most other states, on public spending initiatives is the governor. Many outside state government contributed primarily by making the governor feel politically comfortable enough to exert leadership on particular issues. They also contributed by shaping the consensus on health coverage expansion in Illinois. Their contributions to creating a policy atmosphere conducive to the All Kids announcement were made in various contexts over a period of years: specific expansion initiatives, advocacy to avoid budget cuts, community organizing, antipoverty issue organizing, and the annual assertion during the legislative process by health-oriented professions, businesses, and interest groups of their own agendas promoting their self-interest (e.g., reimbursement rates, targeted eligibility, specific disease initiatives, and private insurance mandates).

Some of the influential players:

- The FamilyCare Coalition—an ad hoc coalition that successfully promoted a health coverage expansion to the parents of children covered by Medicaid and the State Children’s Health Insurance Program (the aforementioned KidCare), the coalition consisted of representatives of most of the players listed here.<sup>12</sup>
- The Medicaid Leadership Group—led by Health and Disability Advocates, an advocacy organization, the group brought together key elements of the health care provider, consumer, and advocacy communities. The group overcame entrenched rivalries and identified common health-related causes in the state budget and on the federal front.<sup>13</sup>
- The Emergency Coalition for a Fair Budget—an ad hoc group of advocacy and provider groups, it serves low-income people in the areas of health and human services. Again, rivalries were put aside to focus on two common themes agreeable to everyone: the budget should not be balanced by cutting programs for vulnerable populations, and everyone would be better off if revenue increased.<sup>14</sup>
- Health care provider organizations—although they do not have persuasive grassroots power, such organizations have good professional advocacy capacity (e.g., research and lobbying) and strong ties to political fund-raising, and they are often locally prominent employers and social institutions (e.g., hospitals, pharmacies, and clinics).
- Organized labor—the Illinois American Federation of Labor—Congress of Industrial Organizations (AFL-CIO) and especially the unions that represent or seek to organize lower-income workers, such as the Service Employees International Union (SEIU); the American Federation of State, County and Municipal Employees (AFSCME); and United Food and Commercial Workers (UFCW)—to the extent that small businesses benefit from certain health insurance expansions (e.g., those with premium assistance options), the unions with which they work (e.g., electricians and others) also support those expansions.
- Organized employers—several chambers of commerce, such as the Chicagoland Chamber, supported the KidCare and FamilyCare health coverage expansions described here, and none of the organized employers publicly opposed them (although many sat out the debates). Those that supported the initiatives not

<sup>12</sup>The Sargent Shriver National Center on Poverty Law led the FamilyCare coalition and advocacy campaign. Materials from the campaign are available on the Shriver Center’s website, [www.povertylaw.org/advocacy/familycare\\_materials.cfm](http://www.povertylaw.org/advocacy/familycare_materials.cfm).

<sup>13</sup>For information on the Medicaid Leadership Group and its activities during the time described in this article, see Health and Disability Advocates, Medicaid Leadership Group, [www.hdadvocates.org/accesstohealth/Medicaid/index.htm](http://www.hdadvocates.org/accesstohealth/Medicaid/index.htm) (last updated Jan. 30, 2006). See also *infra* note 61.

<sup>14</sup>This ad hoc coalition does not have an organizational home or a website. It was hosted during its first years by the Women Employed Institute and now is hosted by the Center for Tax and Budget Accountability (see <http://ctba.inspired.com>). Different groups took leadership on features of the advocacy and authored advocacy materials for use by the coalition. See also *infra* note 32 and accompanying text.

only understood generally that health insurance improves employee productivity but also particularly appreciated the way that premium assistance options have the potential to keep lower-paid but on average healthier employees participating in employer insurance programs. This improves their plans' actuarial performance, which controls premium increases and thus helps all employees.

- Local government—it is on the hook for much of the uninsured's safety-net free care, which it provides directly as a cost of local government. The local government also deals with the impact of the uninsured in the community as a public health and quality-of-life issue.
- Health care consumer organizations—one leading group, the Illinois Maternal and Child Health Coalition, was the coordinator of the statewide Covering Kids and Families Illinois enrollment campaign and became a leading grassroots supporter of all the health coverage initiatives.<sup>15</sup> Another leading group, the Campaign for Better Health Care, waged throughout the time period described here a very active universal coverage campaign that had a strong impact on the policy atmosphere.<sup>16</sup> Most universal health care advocates also supported all of the incremental gains that have occurred in recent years. Many consumer organizations
- advocate on behalf of the disabled and elderly on health care issues, and many are disease- or condition-specific organizations (e.g., American Cancer Society, March of Dimes, and AIDS Foundation). Any expansion of health insurance helps their causes dramatically because the insurance means increased preventive care, better maintenance care, and earlier diagnosis and remedial care.
- Multiissue antipoverty advocacy organizations—health insurance is a key issue for almost any low-income issue group or constituency (early childhood, K–12 education, abuse and neglect, public safety, welfare to work, and so forth). These organizations have key relationships and influence, and they can be persuaded to include health care on their list of objectives from year to year even if their main focus is elsewhere. Many of these organizations have developed both policy and grassroots capacity organized around their core issues or constituencies.<sup>17</sup>
- Multiissue grassroots or community organizations—health insurance often tops the charts when community-based organizations discern issues affecting their constituent members and citizen leaders. This adds tremendous ground-level power and “real people” capacity to advocacy on the state budget.<sup>18</sup>

<sup>15</sup>Covering Kids and Families Illinois is one of the many state-level health coverage enrollment initiatives funded by the Robert Wood Johnson Foundation. See Covering Kids and Families Illinois, [www.ilmaternal.org/CoveringKidsIL.index.htm](http://www.ilmaternal.org/CoveringKidsIL.index.htm) (last updated, Jan. 11, 2006).

<sup>16</sup>The signature achievement of this coalition is the passage of the Health Care Justice Act in 2004. Health Care Justice Act, Ill. Pub. Act No. 93-0973 (effective Aug. 20, 2004), available at [www.ilga.gov/legislation/publicacts/fulltext.asp?Name=093-0973&GA=093](http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=093-0973&GA=093). That law established the Adequate Health Care Task Force, which, at this writing, is conducting a series of public hearings and substantive studies of universal health care options. *Id.* § 20. The task force will produce a plan for universal coverage by the end of 2006 and present it to the Illinois General Assembly for consideration in 2007. *Id.* § 35. The Department of Public Health, which has created a website on the Health Care Justice Act (see [www.idph.state.il.us/hcja/index.htm](http://www.idph.state.il.us/hcja/index.htm)), is supervising the task force's efforts.

<sup>17</sup>Leading examples of these kinds of groups include Action for Children, Illinois's main organization for child care providers and child care policy advocacy, and Voices for Illinois Children, the leading multiissue children's issues advocacy group. See Action for Children, 2005 Legislative Session Ends with Victories for Early Care and Education, available at [www.actforchildren.org/\\_uploads/documents/live/2005\\_Legislative\\_Wrap\\_Up.pdf](http://www.actforchildren.org/_uploads/documents/live/2005_Legislative_Wrap_Up.pdf) (last visited Feb. 19, 2006) (describing the FamilyCare expansion); BUDGET AND TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, ILLINOIS' FISCAL YEAR 2006 BUDGET: SIGNIFICANT EDUCATION AND HEALTH CARE INCREASES, LONG TERM FISCAL CONCERNS (2005), available at [www.voices4kids.org/B&T\\_publications.htm](http://www.voices4kids.org/B&T_publications.htm) (describing the FamilyCare expansion).

<sup>18</sup>E.g., one of the most powerful supporters of Illinois's FamilyCare campaign was the Industrial Areas Foundation—organized United Power for Action and Justice, a metropolitanwide organization in Chicago and Cook County consisting of more than 300 religious congregations and other institutions. Through a variety of actions involving thousands of citizen leaders, United Power for Action and Justice had a profound impact on the political atmosphere for health coverage issues. In downstate Champaign, Illinois, Champaign County Health Care Consumers had a similar impact. For an article describing the community organizing aspects of the FamilyCare campaign, see John Bouman, *The Power of Working with Community Organizations: The Illinois FamilyCare Campaign—Effective Results Through Collaboration*, 38 CLEARINGHOUSE REVIEW 583 (Jan.–Feb. 2005).

- Religious organizations—health care is a powerful moral issue for faith-driven people concerned with social justice and with the state budget as a statement of values. Some religious denominations maintain legislative advocacy capacity in the state capital to look after the interests of their professional social service organizations and other issues they care about (e.g., the Catholic Conference and Catholic Charities, Lutheran Social Services, and Jewish Federation). These organizations provide not only professional help in the capital but active grassroots support in the districts.
- Media opinion leaders—news organizations are interested in many of the health coverage-related budget stories, both as news and as editorial content, because of the size and ongoing growth of the health care crisis and the health care budget lines, the news value of stories of people without adequate access to health care, and the potential for political controversy.

With all of these players emphasizing over many years public investments in health coverage, an atmosphere conducive to All Kids emerged. Considering an aggressive improvement in health coverage for children was not only politically “safe” but also politically advantageous. However, an expansion such as All Kids is far from an inevitable outgrowth of this kind of atmosphere. In a fiscal crisis, a bold expansion such as All Kids is never an ordinary step, and the conventional wisdom regarded it as politically risky. The atmosphere offered an interesting opportunity for a governor willing to assert leadership on the issue. But,

without that leadership, any bold expansion was probably out of the question.

## B. The Illinois Budget Context

Illinois historically is a comparatively low-tax, low-spend state. As of 2002 (the 2003 state fiscal year), Illinois ranked forty-ninth in generating state and local tax revenue (including property tax) as a percentage of total personal income in the state. It was forty-seventh in collecting general revenue taxes when measured against personal income and thirty-eighth when measured as tax receipts per person. This is because Illinois has a low and flat income tax rate of 3 percent (on all income levels), imposes sales tax on only 17 of 164 categories of services (only six states tax fewer services), and is one of only three states to exempt completely all public and private pensions from taxation regardless of income level. That Illinois ranked forty-third in general funds spending, as a percentage of personal income, was consistent with this revenue picture.<sup>19</sup>

Like most states, and worse than many, starting late in the 2001 calendar year Illinois has been undergoing a historic state budget crisis. The Illinois crisis is predominantly a revenue problem since spending (of state-source funds) has been flat in recent years.<sup>20</sup> The revenue crisis was caused not just by the recession early in the decade but also, more fundamentally, by an antiquated and inadequate revenue system that produces a structural deficit. Because Illinois revenues do not produce enough money to fund current obligations and policy choices, the state is in a more or less perpetual bind: find new revenues or cut programs.<sup>21</sup> This bind is even worse in a

<sup>19</sup>See BUDGET AND TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, ILLINOIS SPENDING IN PERSPECTIVE: THE CHALLENGE OF MEETING NEEDS IN A LOW-TAX STATE 8 (2002), available at [www.voices4kids.org/btspecialreport0502.pdf](http://www.voices4kids.org/btspecialreport0502.pdf). This special report, an excellent summary of the Illinois revenue and spending track record, was drawn from official sources and written at the critical moment when Illinois was making the transition from the boom years into the current fiscal crisis.

<sup>20</sup>Illinois general funds spending, adjusted for inflation, increased 4.21 percent from the 1999 state fiscal year to the 2003 state fiscal year. *Id.* at 10.

<sup>21</sup>See generally Ralph Martire, Center for Tax and Budget Accountability, Fiscal System Basics (2005), available at [http://ctba.inspidered.com/files/fiscal\\_basics.pdf](http://ctba.inspidered.com/files/fiscal_basics.pdf). See also A+ Illinois, Facts About Illinois’ Education Crisis, [www.aplusillinois.org/issues/facts.asp](http://www.aplusillinois.org/issues/facts.asp) (last visited Feb. 4, 2006) (materials gathered by the A+ Illinois coalition, which is actively seeking reform of the Illinois revenue system to accomplish education funding reform, among other things). For specifics and technical information about the Illinois budget, I mostly cite materials from the Center for Tax and Budget Accountability and the Voices for Illinois Children Budget and Tax Policy Initiative, both highly respected expert sources, because their materials are organized directly around the issues addressed in this article. For broader information about Illinois budgets and revenues, see generally [Illinois] Commission on Government Forecasting and Accountability, at [www.ilga.gov/commission/cgfa/cgfa\\_home.html](http://www.ilga.gov/commission/cgfa/cgfa_home.html) (last visited Feb. 4, 2006). Formerly known as the Economic and Fiscal Commission, the commission is a bipartisan arm of the Illinois General Assembly.

recession, and it makes recovery from recessions slower.

Most politicians hesitate to support increases in general taxes—income and sales taxes—the two prime workhorses of the Illinois revenue system.<sup>22</sup> Thus in a deep budget crisis the annual budget puzzle could be solved only by finding new types of revenue enhancements or making deep cuts in current spending. When deep cuts are needed in current general revenue spending, the focus historically has inevitably turned to Medicaid, not because it is disfavored or an unimportant program but because it is one of the few places to find enough general revenue spending to cut to make a significant dent in a large budget deficit.

The official reflex in a budget crisis has been to unmoor the budget from state policies and make cuts that not only hurt vulnerable people but also undo or set back carefully debated and voted-on policy directions and to claim that there was “no choice.” But in a total budget of about \$50 billion in Illinois (about half of which is general funds), there are many choices for addressing a budget crisis on both the revenue and spending sides other than cutting Medicaid. The habit of defaulting to large cuts in Medicaid to help resolve budget crises has not been because there was “no choice” but because there has been insufficient leadership to develop or champion alternatives.

The budget process in Illinois, by law and custom, gives tremendous power to the governor.<sup>23</sup> Annually the governor and the governor’s agencies and budget office produce a budget proposal that is announced in late February. The General Assembly does not have a budget bureaucracy of its own and does not produce a competing budget, nor does any of its component caucuses, parties, or committees. The spring General Assembly session conducts

hearings on the governor’s budget and can resist parts of it or demand changes. At the end of the session the governor and the four leaders of the legislative caucuses (speaker and minority leader of the House, president and minority leader of the Senate) negotiate a final budget that consists mostly of the governor’s original proposal as changed by the negotiated items (which, even in contentious years, never involve more than a tiny percentage of the total line items in the proposed budget). The General Assembly then passes the negotiated budget before the scheduled Memorial Day adjournment. If an impasse develops and lasts beyond June 1, passage of the budget requires a 60 percent supermajority, so that the minority parties in the two chambers gain power that they did not have before passage of the deadline.<sup>24</sup>

If the governor, in proposing the budget, says that there is “no choice” but to cut Medicaid, this means that the governor has made exactly that choice. Opponents must find other cuts or revenues and develop support in the legislative chambers to avoid the Medicaid cuts in the proposed budget.

However, if the governor does not propose Medicaid cuts, then proponents of cuts will have great difficulty forcing such cuts into the final budget. And if the governor proposes a health care expansion, then opponents of the expansion will have great difficulty eliminating it from the final budget. The governor’s leadership on the budget is usually determinative of the spending priorities that end up in each year’s budget.

### C. Coverage Expansions Before the Fiscal Crisis

Because health coverage affects all citizens across the political spectrum, health care programs in Illinois were expanded under moderate Republican regimes

<sup>22</sup>See Martire, *supra* note 21. The most sensible revenue reform that cures the structural deficit (among others) involves an increase in the income tax, an expansion of the sales tax base to cover more services, and a substantial reduction in the property tax, in addition to other features. *Id.* at 6–7.

<sup>23</sup>For a good summary of the Illinois budget process, see [ILLINOIS] COMMISSION ON GOVERNMENT FORECASTING AND ACCOUNTABILITY, FISCAL YEAR 2006 BUDGET SUMMARY 1–2 (2005), available at [www.ilga.gov/commission/cgfa/cgfa\\_home.html](http://www.ilga.gov/commission/cgfa/cgfa_home.html) (find the report in the column on the left and click on it).

<sup>24</sup>See *id.*

when revenues permitted.<sup>25</sup> During the boom years of the late 1990s and early 2000s, under moderate Republican governors and a more conservative Republican state senate, Illinois expanded health care coverage many times. Each expansion was an occasion for public advocacy activity on health coverage by some configuration of the aforementioned players—activity that prepared the groundwork for the public opinion and policy environment later conducive to the All Kids proposal. Three such expansions:

- Illinois adopted KidCare, the State Children’s Health Insurance Program, in 1998. After a very slow start, which resulted in only 28,241 enrolled as of January 1999, the new administration of Republican Gov. George Ryan launched an all-out enrollment effort that brought enrollment to 176,602 as of March 2002.<sup>26</sup>
- The number of elderly and disabled persons eligible for Medicaid coverage substantially increased. In 2001, flush with revenues from the economic boom, the state committed to a three-year plan to increase eligibility for Medicaid for these groups from 41 percent of the federal poverty level to 100 percent. The last year of this increase was threatened by the emerging fiscal crisis, but, to keep its promises on a crucial health coverage issue, the Ryan administration fit the initiative into the troubled 2003 state fiscal year budget by delaying the effective date of the eligibility expansion from July 1, 2002, to April 1, 2003.<sup>27</sup>
- Illinois has a pharmaceutical assistance program operated as part of the proper-

ty tax relief program for low-income seniors (together, both programs are known as the “circuit breaker” program). The pharmaceutical assistance program helps seniors pay for prescription drugs needed to treat certain conditions (e.g., heart disease). In an expansion funded by tobacco settlement proceeds, the program increased from serving 50,182 in 1999 to serving more than 150,000 by mid-2001.<sup>28</sup> This is not duplicative of prescription coverage available under Medicaid.

The Ryan administration also initiated activity on two key waivers to access federal funds for expanding health coverage. In February 2002 the Ryan administration filed the FamilyCare waiver by which they sought federal financial participation under the State Children’s Health Insurance Program and Medicaid for an expansion to cover the parents of children covered by Medicaid or KidCare. If approved, the waiver would allow a modest start-up of the program during the 2003 state fiscal year with newly accessed federal matching funds (and no new state dollars). Governor Ryan included in his budget announcement the program’s modest corresponding appropriation to spend the newly accessed federal dollars and proposed the necessary amendments to substantive state law to establish the FamilyCare program contingent on the waiver’s approval. The federal authorities approved the waiver in September 2002, and the FamilyCare program was launched effective October 1, 2002. This expansion increased eligibility from 39 percent of the federal poverty level (the level applicable to the preexisting Medicaid category for parents) to 49 percent, resulting in the eligibility of about

<sup>25</sup>Among the materials from the FamilyCare campaign is a summary of a 2001 public opinion poll finding that 79 percent of likely voters favored the establishment of that program, and 70 percent favored it when the public costs were included in the question. Memorandum from Stephanie Gadlin, Director of Communications and Media, National Center on Poverty Law, to Members of the Illinois General Assembly (May 16, 2001) (regarding “New Poll Shows 79% of Illinois Voters Support Family Care”), available at [www.povertylaw.org/advocacy/surveyresults.doc](http://www.povertylaw.org/advocacy/surveyresults.doc).

<sup>26</sup>See Press Release, Illinois Government News Network, Ryan Announces Dramatic Increase in KidCare Enrollment (Jan. 24, 2000), available at [www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=378](http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=378); *id.*, Governor Ryan Proposes Balanced \$52.8 Billion 2003 Budget (Feb. 20, 2002), available at [www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=1684](http://www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=1684).

<sup>27</sup>See Press Release (Feb. 20, 2002), *supra* note 26.

<sup>28</sup>Press Release, Illinois Government News Network, Governor Signs Bill Assisting Seniors in Circuit Breaker Program (July 23, 2001), available at [www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=946](http://www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=946).

30,000 parents.<sup>29</sup> However, any further expansion of the program would require significant state funds to draw down further federal funds.

At the same time (2001–2002) the Ryan administration launched an effort to secure the SeniorCare waiver. That initiative was designed to increase access to prescription drugs among seniors not eligible for Medicaid and beyond the access under Illinois's pharmaceutical assistance program. Like the FamilyCare waiver, the SeniorCare waiver accessed federal matching funds for the previously state-funded pharmaceutical assistance program. The Centers for Medicare and Medicaid Services granted the SeniorCare waiver in January 2002, and the SeniorCare program began in June 2002.<sup>30</sup>

But late in 2001 (the first half of the 2002 state fiscal year) Illinois's fiscal crisis began to emerge in full force. Not only did the crisis slow down the implementation of the FamilyCare initiative, but also it turned the administration's attention to the possibility of using the historic expedient of cutting Medicaid as a means to help address the larger state budget problem. However, the intense advocacy around the health care expansions adopted in the preceding years (KidCare enrollment, Medicaid eligibility for seniors and disabled, and pharmaceutical

assistance) and the expansions still pending (FamilyCare and SeniorCare) had created an atmosphere in which cutting Medicaid was not as politically expedient as it had been in the past. Coalitions had been built. Strong public arguments had been successfully maintained. Politicians had been impressed by the positive public appeal of health care, and many of them in both parties had invested significant political capital in expanding health care, including Governor Ryan.

As a result, the Medicaid cuts that Governor Ryan proposed to help solve the in-year fiscal crisis in late 2001 did not involve a reduction in eligibility or covered services. Instead the Ryan administration cut provider rates. Later Governor Ryan's proposed 2003 state fiscal year budget (announced in February 2002) imposed another rate cut (a total of 6 percent for the two cuts). And modest recipient copays were instituted on prescription drugs. Overall Medicaid spending decreased \$600 million below the spending required for a maintenance budget, which would have funded only existing obligations adjusted for inflation and population growth in the 2003 state fiscal year.<sup>31</sup> Because Illinois already paid lower rates to providers than other states, these cuts made participation in Medicaid less attractive for providers and thus were a blow to Medicaid beneficiaries' access to health

<sup>29</sup>*Id.*, Governor Ryan, HHS [Health and Human Services] Secretary Thompson Announce FamilyCare Federal Approval (Sept. 12, 2002), available at [www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=1906](http://www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=1906). The establishment in state law and start-up of FamilyCare culminated a multiyear advocacy campaign. The FamilyCare campaign involved a broad-based coalition that brought attention to the large numbers of people without health insurance in Illinois, the impact of being uninsured on being able to work, the relationship between the health of parents and the health of children, and the "use it or lose it" nature of federal funding for the State Children's Health Insurance Program (each state is allotted, for the State Children's Health Insurance Program, federal funds that, if the state does not draw them down from year to year, are redistributed to other states). All the major newspapers and leading business periodicals endorsed FamilyCare at least once. In addition to addressing FamilyCare, this campaign brought a tremendous amount of attention to the general issue of health care in Illinois and to the political attractiveness of the issue (and political risks associated with opposition to it). Materials from this campaign, as well as the document containing the terms and conditions of the demonstration waiver, are available on the Shriver Center's website, [www.povertylaw.org/advocacy/familycare\\_materials.cfm](http://www.povertylaw.org/advocacy/familycare_materials.cfm). For an article describing the community organizing aspects of the FamilyCare campaign, see Bouman, *supra* note 18.

<sup>30</sup>For waiver papers for SeniorCare, see Centers for Medicare and Medicaid Services, Medicaid Waivers and Demonstrations List: Details for Prescription Drug Benefit for Illinois' Low Income Seniors 1115 (last modified Sept. 28, 2005), available at <http://new.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS028652>.

<sup>31</sup>See BUDGET AND TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, THE ILLINOIS BUDGET IN HUMAN TERMS: THE IMPACT OF BUDGET CUTS ON THE PEOPLE OF ILLINOIS 6 (2002), available at [www.voices4kids.org/humancosts2.pdf](http://www.voices4kids.org/humancosts2.pdf). Thus this budget included both the \$600 million reduction from the maintenance budget and the modest initial steps of the expansion under FamilyCare and SeniorCare. This apparent contradiction demonstrates two competing themes: the reflex to cut Medicaid in a budget crisis and the growing political appeal of expanding health care coverage. So the cuts were principally in provider rates (not eligibility groups or the range of covered services), and the expansion stayed in the budget (although FamilyCare was substantially scaled back for the 2003 state fiscal year). A big reason that SeniorCare stayed in the budget was that it initially generated federal matching funds for the pharmaceutical assistance program—a net revenue gain for Illinois in the first year.

care. However, as noted, eligibility and covered services were not cut due to Governor Ryan's leadership, and the 2003 state fiscal year budget included the modest start-up of the FamilyCare program.

The arrival of the fiscal crisis caused key elements of the health care and human services community to form the Emergency Campaign for a Fair Budget.<sup>32</sup> The campaign vigorously explained to policymakers and the general public the deep human costs of cuts in health coverage (among other programs) and marketed to policymakers a long list of revenue ideas and alternative appropriation cuts that could be adopted instead of cutting needed benefits and services. As a result of the efforts of the Emergency Campaign and others, the cuts were ameliorated by the adoption of a \$0.40-per-pack increase in the cigarette tax and a number of other revenue measures.<sup>33</sup> This was a victory for a significant principle that helped create the environment for All Kids to be proposed during a fiscal crisis: in both a political and a public policy sense, health coverage justifies increased revenues. Increasingly, for a politician to oppose health coverage might be more politically "dangerous" than to support at least some types of revenue enhancement needed to support health coverage.

#### D. Health Coverage During the Fiscal Crisis

The Illinois governorship was at stake in the November 2002 election. Republican

Governor Ryan was not running for reelection. Because health coverage was already a high-profile issue, both candidates adopted it as a strong priority and promised to implement FamilyCare fully and otherwise address health care needs.<sup>34</sup> When Democrat Rod Blagojevich won, many of the aforementioned players participated in transition committees and explained to the new administration the dimensions and significance of the health coverage issues, the necessity of adequate funding, and ways to maximize federal financial participation consistent with both state and federal program goals. The challenge facing the new governor was immense. The transition team estimated the eighteen-month budget deficit (from mid-2003 state fiscal year through the 2004 state fiscal year) to be about \$5 billion (in a general funds budget of about \$25 billion per year).<sup>35</sup>

The new governor quickly made two central promises: he would not cut "essential services," which he defined as health care, education, and public safety; and he would not increase income or sales taxes.<sup>36</sup> In his State of the State address in March 2003 Governor Blagojevich revealed that he not only was committed to resisting health care cuts but also was going to expand health coverage aggressively. He would keep campaign promises to increase eligibility for KidCare from 185 percent to 200 percent of the federal poverty level (20,000 more children) and to implement FamilyCare fully over three years (300,000 parents).<sup>37</sup>

<sup>32</sup>The Women Employed Institute in Chicago hosted this ad hoc coalition, and the coalition received from the Center for Tax and Budget Accountability tax and budget expertise, particularly with respect to a list of alternative budget cuts and revenue generators that gave the coalition ample proposals to show policymakers how to avoid making damaging cuts. The Center for Tax and Budget Accountability plans to make these materials available in the archive section of [www.ctbaonline.org](http://www.ctbaonline.org); they are also available from [cmancini@ctbaonline.org](mailto:cmancini@ctbaonline.org). The Budget and Tax Policy Initiative of Voices for Illinois Children produced the report cited in *supra* note 31 as a strategy for the Emergency Campaign for a Fair Budget.

<sup>33</sup>Center for Tax and Budget Accountability, FY 2003 Budget Wrap-Up (2002) (to be available in the archive section of [www.ctbaonline.org](http://www.ctbaonline.org) and also available from [cmancini@ctbaonline.org](mailto:cmancini@ctbaonline.org)).

<sup>34</sup>The grassroots members of the FamilyCare coalition were particularly effective in keeping the health coverage issue at the center of the campaign. United Power for Action and Justice, a Chicago metropolitanwide citizens' organization, produced enthusiastic crowds for events at which FamilyCare and other health care issues were central to the interactions with the candidates. See Bouman, *supra* note 18, at 594.

<sup>35</sup>Press Release, Illinois Government News Network, State Budget Director Outlines \$4.8 Billion Deficit Facing Illinois (Feb. 17, 2003), available at [www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=2026](http://www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=2026).

<sup>36</sup>*Id.*

<sup>37</sup>Rod R. Blagojevich, [Ill.] Governor, State of the State Speech Transcript (March 12, 2003), available at [www.illinois.gov/gov/sospeech.cfm](http://www.illinois.gov/gov/sospeech.cfm). In making this promise, the governor specifically cited that Illinois had lapsed \$150 million of its federal allotment for the State Children's Health Insurance Program over the years and stated that he was not going to allow this to continue. *Id.*

Weeks later, the budget address demonstrated the real substance of the governor's promises. He proposed a \$570 million increase in general funds appropriations for health care. Provider rates, eligibility, and covered services would not be cut. The delay in paying health care providers' bills for health care services (the "payment cycle") would be reduced from (at least) 90–120 days to 40 days. (This reduction addressed a major issue that tends to keep providers from participating in Medicaid.) SeniorCare drug coverage would expand from 200 percent of the federal poverty level to 250 percent.<sup>38</sup> KidCare and FamilyCare would be expanded as promised in the State of the State message. The first increment of the promised three-year implementation of FamilyCare would see that program's eligibility level increased from 49 percent to 90 percent of the federal poverty level. Budget savings were projected in prescription drugs through more vigorous negotiation of drug prices and emphasis on promoting the use of generic drugs over more expensive brand-name drugs. However, the proposal did not restore any of the cuts in provider rates made the prior year.<sup>39</sup>

The good picture on health care spending existed within a very austere total budget proposal, and most of the budget balancing would take place on the revenue side. Overall spending was to be reduced. The state workforce was to be reduced severely;

all state grants other than in the areas of health care, education, and public safety were to be reduced; several small agencies were to be eliminated; and various additional cuts were to be made. On the revenue side, the governor proposed a wide array of additions totaling a 13 percent increase over revenues expected in the 2003 state fiscal year.<sup>40</sup> Many of these proposals had been on the "alternatives to cuts" list of the Emergency Campaign for a Fair Budget in the fight against the cuts the year before (and all had been given to the transition team).<sup>41</sup>

The new governor no doubt cared deeply about health coverage. But he also had absorbed the preceding years' lessons, which taught that health coverage was politically "safe" even when paid for with at least some types of revenue enhancement. In his first budget he had decided not only to test, but also to bank on, this proposition.

During the legislative session after the budget announcement, the FamilyCare coalition, the Emergency Campaign for a Fair Budget, the health care provider associations, and many others lined up to support the governor's positions on health care in the budget and the revenue enhancements that made them possible. Opposition came in the form of general resistance to expanding spending in such a tight budget, but nobody was willing to take on FamilyCare or other health issues on

<sup>38</sup>*Id.* The SeniorCare expansion required an amendment to the SeniorCare waiver. Illinois state officials have requested the amendment, but, as of this writing, federal authorities have not ruled on it.

<sup>39</sup>See Press Release, Illinois Government News Network, Public Aid Budget Fulfills Governor's Commitment to Protecting Health Care for Illinois' Families and Seniors (April 9, 2003), available at <http://wwwc.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=2083>; see also Rod R. Blagojevich, [Ill.] Governor, 2003 Budget Address (April 9, 2003), available at <http://wwwc.illinois.gov/gov/budget2003.cfm> (transcript). See generally BUDGET & TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, THE GOVERNOR'S FY 2004 BUDGET PROPOSAL: INVESTING IN CHILDREN IN TOUGH TIMES (2003), available at [www.voices4kids.org/archives.htm](http://www.voices4kids.org/archives.htm) (summarizing budget proposals affecting children and families).

<sup>40</sup>See Press Release, Illinois Government News Network, Governor's Budget Delivers on Promise to Boost Education, Health Care and Public Safety Spending; Solves \$5 Billion Fiscal Crisis (April 9, 2003), available at <http://wwwc.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=2082>.

<sup>41</sup>*Id.*; see also BUDGET AND TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, ILLINOIS' FISCAL YEAR 2004 BUDGET: HOW DO CHILDREN AND FAMILIES FARE? 5 (2003), available at [www.voices4kids.org/archives.htm](http://www.voices4kids.org/archives.htm). See generally Center for Tax and Budget Accountability, Fiscal Year 2004 Budget Wrap-Up (undated) (to be available in the archive section of [www.ctbaonline.org](http://www.ctbaonline.org) and also available from [cmancini@ctbaonline.org](mailto:cmancini@ctbaonline.org)) (summarizing revenue and appropriations for the year). Note that in the 2004 state fiscal year Illinois also had the advantage of increased federal matching funds amounting to more than \$200 million under the "fiscal relief" enacted by Congress. Late in the 2004 state fiscal year the state enacted another bonding scheme of about \$800 million that it used to pay down the Medicaid backlog of bills before this enhanced federal matching rate expired. The gain in matching percentage and avoidance of late payment fees more than offset the interest on the bonds. See Press Release, Illinois Government News Network, Governor Blagojevich Announces Illinois Taps \$25 Million in Additional Federal Medicaid Funds (June 29, 2004), available at [www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=3182](http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=3182).

a policy or ideological basis or as distinct cost items. The governor's leadership and the inherent power of the health coverage issues proved too much to challenge or overcome—nobody wanted to be the champion of the cause of fighting health coverage expansion.

The following year, the governor's February budget message laying out his plan for the 2005 state fiscal year gave the bad news that the fiscal crisis was ongoing and assessed the budget deficit for the coming year at about \$1.7 billion.<sup>42</sup> Nevertheless, the governor maintained his strategy of assigning health care issues a high priority and constructing a budget (including new revenue) that could pay for them. On Medicaid he proposed no cuts in provider rates, eligibility, or covered services. He included in his proposal the funds necessary for the second year of the promised three-year FamilyCare implementation scheme, which would move eligibility from 90 percent to 133 percent of the federal poverty level.<sup>43</sup> To fund his overall budget, the governor proposed a long list of revenue enhancements, many of which would have ended business tax credits or deductions. Many of these ideas had been on the "alternatives to cuts" list of the Emergency Coalition for a Fair Budget. Business interests opposed to these tax and fee measures started to line up against the proposed budget.

The pressure of the fiscal crisis, combined with his pledge not to increase income or sales taxes, began to create for the governor

trouble concerning some of his revenue ideas, but none of this trouble involved a specific threat to his health care priorities. The General Assembly failed to pass a final budget by the June 1 deadline. An interim stopgap budget was passed, and the session went into overtime, with a 60 percent majority in each house then required to pass a final budget. While some legislators wanted to pass a "hold even" budget at the 2004 state fiscal year levels for all programs, that idea did not progress. The governor held firm on his health care priorities, and no real opposition specific to those issues ever emerged. The fight was over revenues, other spending cuts, and political positioning.<sup>44</sup>

After a contentious summer, the General Assembly, with the necessary additional votes for the supermajority from Republicans, passed a final budget at the end of July 2004. In general, deep spending cuts were adopted—the cuts replacing many of the revenue initiatives that had been in the governor's announced budget. But the governor and his allies remained firm on health care. All of the governor's major health care initiatives remained, including no cuts in Medicaid provider rates, covered services, or eligibility groups. The FamilyCare expansion remained in the budget, with the expansion to be effective September 1, 2004. The political importance of health coverage initiatives, when supported by steadfast leadership, had been proven again.<sup>45</sup>

<sup>42</sup>See Press Release, Illinois Government News Network, Blagojevich Balances \$1.7 Billion Deficit Without Increasing Income and Sales Taxes; Boosts Funding for Education, Health Care and Public Safety (Feb. 18, 2004), available at [www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=2767](http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=2767).

<sup>43</sup>*Id.* See generally BUDGET AND TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, ILLINOIS' FISCAL YEAR 2005 BUDGET PROPOSAL: SUPPORT FOR CHILDREN AND FAMILIES IN A TIME OF CONTINUING DEFICITS (2004), available at [www.voices4kids.org/B&T\\_publications.htm](http://www.voices4kids.org/B&T_publications.htm) (summarizing budget proposals affecting children and families).

<sup>44</sup>See John Bouman, *State Budget Remains in Limbo: Fight for Crucial Antipoverty Programs Continues in New Fiscal Year*, ILLINOIS WELFARE NEWS (Sargent Shriver National Center on Poverty Law, Chicago, Ill.), July 2004, available at [www.poverty-law.org/advocacy/iwn/index.cfm?action=show\\_article&id=1121](http://www.poverty-law.org/advocacy/iwn/index.cfm?action=show_article&id=1121).

<sup>45</sup>See generally BUDGET AND TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, ILLINOIS' FISCAL YEAR 2005 BUDGET: LACK OF REVENUES FORCES TOUGH CHOICES (2004), available at [www.voices4kids.org/B&T\\_publications.htm](http://www.voices4kids.org/B&T_publications.htm) (summarizing budget outcomes for programs affecting children and families). One new revenue source is a hospital assessment plan, under which Illinois hospitals would pay a special monetary amount to the state, which would use the money to attract Medicaid matching funds from the federal government, and all of which would be used to enhance access to health care and reinforce the rates paid to hospitals on behalf of Medicaid patients. Overall the plan would produce about \$1 billion, but it requires a federal waiver. Late in 2004 the federal government approved the waiver, but the negotiations produced only half of the expected revenue. Illinois netted \$490 million. See Press Release, Illinois Hospital Association, Hospital Community Applauds Final Legislative Approval of Illinois Hospital Assessment Program (May 30, 2005), available at [www.ihatoday.org/issues/payment/assessment/pressrel.html](http://www.ihatoday.org/issues/payment/assessment/pressrel.html) (referring to the assessment plan and describing activity to renew it for 2005–2006).

In February 2005 the now-established script was followed again when Governor Blagojevich announced his 2006 state fiscal year budget proposal.<sup>46</sup> The state still faced a \$1.1 billion deficit. He proposed the final year of the FamilyCare implementation, establishing eligibility to 185 percent of the federal poverty level effective January 1, 2006. He also proposed no reductions in Medicaid eligibility groups or in base provider rates or most covered services. However, the years of pressure forced him to propose certain minor cuts around the edges of the optional services covered by Medicaid (e.g., stopping coverage for over-the-counter medications). Again the governor proposed a wide array of budget cuts in other areas of state government and various revenue enhancements. The most controversial and largest one of these ideas involved aspects of the state pension system.<sup>47</sup>

Many of the revenue ideas that would have increased financial burdens on business ran into strong opposition, and the legislature largely rejected them. However, once again the pressure-packed public debate did not produce focused resistance to the governor's health care and coverage proposals, and they were never in danger. In the end, coalescing around the political needs of the coming election year, the three top Democrats (speaker, senate president, and governor) worked out a two-year

compromise on the budget (through the 2007 state fiscal year and thus through the spring 2006 General Assembly session as well as the November 2006 election). The FamilyCare expansion was complete, and Medicaid emerged from years of fiscal pressure substantially intact.<sup>48</sup>

## II. The Illinois All Kids Program

The All Kids initiative, which Governor Blagojevich announced on October 6, 2005, provides health insurance to every child in Illinois regardless of income or status.<sup>49</sup> Enabling legislation, cosponsored by the speaker of the house and the senate president, was filed in the Illinois General Assembly's fall "veto session" later the same month. As noted above, with this kind of powerful support, the bill not only passed handily but also acquired Republican support.

The All Kids program provides the same coverage as the State Children's Health Insurance Program (basically Medicaid coverage) to literally all children residing in Illinois (with no citizenship restrictions), as long as the family pays the premiums.<sup>50</sup> A twelve-month waiting period (when fully phased in) applies to those previously covered by other insurance.<sup>51</sup> Copayments for services other than well-child care are required.<sup>52</sup> The state agency implementing the new program is granted wide authority to flesh out the full program in rules.<sup>53</sup>

<sup>46</sup>See Press Release, Illinois Government News Network, Gov. Blagojevich Proposes Major Reforms to Ensure Fiscal Solvency in Fiscal Year 2006 and Beyond (Feb. 16, 2005), available at [www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=3699](http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=3699) (summarizing the major challenges and initiatives).

<sup>47</sup>See *id.*

<sup>48</sup>See generally BUDGET AND TAX POLICY INITIATIVE, *supra* note 17 (describing budget outcomes for programs affecting children and families). The budget deal was predicated on several pension system reforms that will produce substantial savings in future years when new state employees retire. The state will realize those savings in part by substantially reducing current scheduled payments to the pension funds in the 2006 and 2007 state fiscal years. Those payments created the basis for the budget deal for those two years. *Id.* at 1.

<sup>49</sup>Press Release, Illinois Government News Network, Governor Blagojevich Unveils Landmark Proposal to Provide Comprehensive Health Coverage for Every Child in Illinois (Oct. 6, 2005), available at [www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=4381](http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=4381).

<sup>50</sup>Ill. Pub. Law No. 094-0693 §§ 20 (eligibility) & 35 (coverage) (2005), available at [www.ilga.gov/legislation/publicacts/fulltext.asp?name=094-0693&GA=94&SessionId=50&DocTypeId=HB&DocNum=806&GAID=8&Session=](http://www.ilga.gov/legislation/publicacts/fulltext.asp?name=094-0693&GA=94&SessionId=50&DocTypeId=HB&DocNum=806&GAID=8&Session=).

<sup>51</sup>*Id.* § 20(a)(3).

<sup>52</sup>*Id.* § 40.

<sup>53</sup>*Id. passim.*

Because of the need in the current fiscal crisis to show how new programs will be paid for, the governor has rhetorically linked funding for the All Kids program to an initiative to change the Illinois Medicaid program to a primary care case management model.<sup>54</sup> Generally this model would require all Medicaid beneficiaries to select a physician or clinic to be the primary care coordinator. The coordinator would provide all primary care and be the conduit for specialty care, hospitalizations, and all other medical care. Based on the experience of several other states, notably North Carolina, this model is expected to achieve the twin goals of better patient outcomes and better efficiency for the health care dollar.<sup>55</sup> The first year savings of primary care case management are expected to be higher than the expected first-year costs of the All Kids coverage expansion. Linking All Kids to primary care case management means that implementing the All Kids program does not result in a net budget increase, at least in its first year.<sup>56</sup> It is, in effect, “paid for” by the savings resulting from primary care case management.

Although the All Kids enabling legislation passed in the 2005 fall veto session, the program is not effective until July 2006, and its funding is part of the governor’s 2007 state fiscal year budget proposal announced in February 2006.<sup>57</sup> As explained above, the budget is expected to pass because it is the second year of a two-year agreement designed to avoid acrimony in an election year. The All Kids program likely will be funded and go into effect on July 1, 2006.<sup>58</sup>

### III. Application to Other States and the National Level

Universal health coverage for children is on its way to reality in Illinois because of the confluence of a favorable political and policy environment and the timely leadership by the chief executive in taking advantage of this environment. The story shows that such success need not be unique to Illinois. The conditions needed for the opportune political and policy environment are either present or within reach in many states. Then the governor needs to take advantage of this environment.

Some lessons from the Illinois experience may be helpful in creating the opportune environment in other states:

- Creating a policy atmosphere conducive to achieving universal coverage for children in Illinois was a multiyear endeavor, and this may seem daunting to advocates who are just beginning to create in their state a policy atmosphere conducive to universal coverage. Advocates should keep in mind that much of the state’s policy atmosphere comes from national public opinion and policy trends, the larger economy, and research that applies nationally. At least this much of the favorable environment is already in place to be used in any state.<sup>59</sup> And the environment in any particular state is the product of many different state initiatives large and small involving health issues. Relationships, information, public education, and successful tactics from one initiative should be regarded as ongoing resources for future initiatives. Advocates should frame issues and specific argu-

<sup>54</sup>Press Release, *supra* note 49. The linkage is rhetorical and political and not technical. If primary care case management does not produce the expected savings, there would be no automatic threat to All Kids.

<sup>55</sup>See Press Release, Illinois Government News Network, Governor Blagojevich Poised to Make Illinois Only State in the Nation to Offer Comprehensive Health Coverage to Every Child (Oct. 27, 2005), available at [www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=4416](http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=4416).

<sup>56</sup>See *id.*; see also Sargent Shriver National Center on Poverty Law, Support the “All Kids” Program and the Related Primary Care Case Management Reform (2005), available at [www.povertylaw.org/advocacy/documents/All%20Kids.pdf](http://www.povertylaw.org/advocacy/documents/All%20Kids.pdf) (fact sheet).

<sup>57</sup>See Press Release, Illinois Government News Network, Governor Blagojevich Proposes Preschool for All in Fiscal Year 2007 Budget (Feb. 15, 2006), available at [www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=4663](http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=4663).

<sup>58</sup>The Illinois Department of Healthcare and Family Services (the state Medicaid agency) will develop the operational details of both the All Kids insurance program and the primary care case management initiative during the months leading up to July 2006.

<sup>59</sup>Excellent materials describing national trends for this purpose are available from Families USA at [www.familiesusa.org](http://www.familiesusa.org).

ments more broadly than for just their immediate purposes.<sup>60</sup>

- Although the chief executive's leadership is crucial, recognizing the potential contributions of the many and varied players interested in improving health care coverage and gaining their cooperation are critical as well. Coalition building is essential, as are avoiding traditional rivalries and taking advantage of individual interest groups' strengths.
- Allying with provider associations on health coverage issues is a must for consumer groups.<sup>61</sup> Generating mass appeal on the issues is easier for consumer groups, but the provider groups have more professional and financial resources. Bringing these different resources together behind particular initiatives can be a forceful combination. While providers may prefer the funding of their rates over the expansion of eligibility, and consumers vice versa, both groups can promote both positions and refuse to be pitted against each other. This cooperation is made much easier when the two interest groups agree to promote either increased revenues or alternative budget cuts that free up funds.
- Health care is a big issue for organized labor. It is a core issue to those unions that organize lower-paid workers unlikely to work for employers who offer health insurance.<sup>62</sup> (And increasingly workers somewhat higher up the income scale are losing or are never offered affordable coverage.) The direct influence of these labor organizations on the policymakers' health policy decisions cannot be overstated. A governor may from time to time, among other concerns, feel the need to make decisions with which organized labor may disagree. Because of that need, the governor may have to be able to point to a strong record on health care when the time comes for the next election.
- Grassroots allies contribute mightily not just to specific initiative campaigns but also to the creation of the favorable policy atmosphere. Among other activities, they can fill up a space for a hearing or a rally, apply district-level pressure on legislators and candidates for higher office, and produce a good supply of powerful personal stories to illustrate issues and generate public sympathy. These activities create the impression, and usually the reality, of wide public support for issues. And that impression outlasts specific campaigns.<sup>63</sup>
- The wider community of education, health, and human service interests that rely on the general revenue fund for the support of the programs significant to them can form a strong coalition in favor of revenue enhancements over cuts in such programs.<sup>64</sup> While all of these interests compete over their slice of the budget pie, all of them should be able to agree that they all would be helped if the pie were larger and that budgets should not be balanced by cutting any program for vulnerable people. Also, these interest groups serve clientele for whom health coverage is essential, and the groups will support health coverage expansion even if other issues are their priorities. Many of these groups have organized statewide grassroots capacity that can be very useful in health coverage campaigns.
- Expanding health coverage appeals to business interests for a variety of reasons, and some business associations

<sup>60</sup>E.g., the FamilyCare expansion was always addressed to "the uninsured" and as "health care for working families" in addition to the low-income families that it actually would cover.

<sup>61</sup>In Illinois a successful collaboration of this sort is the Medicaid Leadership Group, which has cooperated for three years on the state budget, federal issues, and the hospital assessment initiative. Health and Disability Advocates in Chicago coordinates the Medicaid Leadership Group. For more information, see Health and Disability Advocates, Medicaid Leadership Group, [www.hdadvocates.org/accesstohealth/Medicaid/index.htm](http://www.hdadvocates.org/accesstohealth/Medicaid/index.htm) (last visited Feb. 16, 2006).

<sup>62</sup>In Illinois many of these unions not only contribute to political campaigns but also get involved on the ground in political work.

<sup>63</sup>For a full description of the powerful grassroots portion of the FamilyCare campaign, see Bouman, *supra* note 18, at 589–94.

<sup>64</sup>In Illinois, since 2001, this kind of ad hoc coalition has been active under the name Emergency Coalition for a Fair Budget (which recently dropped the term "Emergency" from its name and became a standing coalition).

will actively support an expansion. One reason is that health insurance is a growing cost issue for all businesses. A premium assistance option (such as the one in the Illinois FamilyCare program) can be very helpful in attracting business support.

- Health coverage is an issue that resonates strongly with religious-based interest groups and constituencies and is a common ground for groups divided on other issues because of religious beliefs. Much of the grassroots advocacy on health issues in Illinois has been anchored by religious institutions, including many local congregations. Many denominations have advocacy capacity in the state capital, and this professional strength is helpful to the coalition. But there is also real power in ground-level activity aimed at policymakers in home district offices by people they know who are likely to vote. Legislators believe that “people from the pews” not only vote but also talk to their friends about the reasons for their vote.
- Working to gain favorable news coverage is part of the creation of the favorable policy atmosphere. News coverage highlights an issue for policymakers, who see that large numbers of people are active (in the news story itself), and, perhaps more important, who perceive that thousands of readers, viewers, or listeners will be concerned about the items in the news coverage. Local media coverage is also useful; even relatively few letters to the editors of small papers can create a favorable atmosphere signaling that voters care about this issue. News coverage should be incorporated into advocacy materials (e.g., copies of articles or quotes from editorials).
- All of the public teaching and organizing and relationship building on health care is advantageous over the long term as well as the short term. Broad-based advocacy for health care expansion and favorable budget treatment in good years creates an ongoing policy atmosphere around health care that is very helpful in a fiscal crisis. Advocacy to prevent health coverage cuts can be the basis for a campaign for expansion when the fiscal conditions improve or even before then. Governors do not want all of their initiatives and accomplishments to involve traumatic program cuts even in a deep budget crisis where budget cuts and revenue enhancements are inevitable. Health care is an ideal issue to be positioned as one area of expansion in austere times, when most other programs are being cut or held to the same level of funding as the previous year. If the governor has to find billions of dollars to plug a budget hole, finding incrementally more to fund a significant positive step on health care in the same budget is not hard.
- Campaigns for a significant but incremental expansion in health coverage are productive even though they are short of the full solution. First, they win health coverage for many people sooner than if everyone waited for the comprehensive solution. Second, they contribute strongly to the policy atmosphere, and, in the ways described here, they can be structured to support the next campaign. And, third, they need not conflict with a simultaneous campaign to win full coverage of all uninsured. Achieving an incremental step serves to increase public knowledge of the issues and demands a solution for the lack of coverage for those left behind after the incremental step is taken.
- One of the most profitable tactics deployed in Illinois was the development of and marketing to policymakers and the public revenue ideas and alternative budget cuts that do not hurt low-income people. When fighting budget cuts, advocates for low-income people and programs are often confronted with the responses: “Well, we just don’t have the money” or “You tell me whom to cut if you don’t think that you should be cut.” By having revenue ideas and alternative budget cuts, advocates have ready answers to these standard ploys.
- When engaging in advocacy to prevent harmful budget cuts and promote

expansion, having access to budget and tax expertise is critical.<sup>65</sup> Revenue issues are very difficult, but in Illinois they became more attractive than cutting health care or stopping a proposed health coverage expansion. With appropriate expertise, state-level groups can develop a long list of revenue alternatives ranging from income tax or sales tax increases to more targeted fees, tax-loophole closures, and so forth. The Center on Budget and Policy Priorities in Washington, D.C., is a leading national expert on state budget and tax alternatives, and it has extensive contacts in many states. The center is a good place to start if advocates do not know any experts of this type in their state.<sup>66</sup>

- Health coverage is legitimately a bipartisan issue, and advocates should approach both parties for leadership and support. When health coverage is the featured issue in an advocacy campaign or the governor's proposed budget, many Republicans support it. And even those who oppose it on principle face a difficult political time if they do so in the public debate. When the chief executive proposes an expansion such as All Kids and suggests a way to pay for it, the opposition is outflanked. If the opposition cannot attack the financing ("good idea, but we can't afford it"), then the opposition has to attack the expansion on the merits.

When faced with having to consider a head-on opposition to a health coverage expansion on no other basis than that the legislator opposes more people having publicly supported health coverage, few will decide to take that position publicly.

- Advocates should inject the issue of health coverage expansion into election campaigns, educate the candidates, and try to obtain candidates' promises to implement specific programs such as All Kids. Health coverage expansion is an attractive promise to make, and it is a difficult promise to refrain from making when an opponent has made it already.<sup>67</sup>
- Advocates should remind policymakers and the general public that health care—which generates good jobs and economic activity far in excess of the public funds spent on it—is a key part of the larger economy and cannot be separated from it.<sup>68</sup> Health care industry jobs are a growing component of urban economies, and they pay better than other entry-level jobs and have better career paths.<sup>69</sup>
- On the state level, in all the various ways indicated by the Illinois experience, using the political power of the health coverage issue is timely. A sensible set of revenue ideas and budget-cutting alternatives that do not hurt vulnerable people can defuse the "we can't afford

<sup>65</sup>Illinois is fortunate to have two expert organizations that provide this kind of specialized help: the Center for Tax and Budget Accountability and the Voices for Illinois Children Budget and Tax Policy Initiative. They are highly collaborative and complementary, and there is plenty of work for both.

<sup>66</sup>See Center on Budget and Policy Priorities, [www.cbpp.org](http://www.cbpp.org) (last visited Feb. 18, 2006).

<sup>67</sup>In Illinois the governor's advisers were familiar with the publicity about and popularity of the health care expansion of the late 1990s and the FamilyCare campaign in the early 2000s. The publicity about and popularity of the issue of health care during the governor's campaign influenced his campaign promises. He knew that there had been supporting newspaper editorials, broad-based public support, and highly favorable public messages and images about the expansion of health care coverage in the past. The new governor's campaign promises in support of health care coverage were made with knowledge of the fiscal crisis, and his commitment to support health care coverage involved not just preserving Medicaid from cuts but also following through on the FamilyCare expansion.

<sup>68</sup>See generally FAMILIES USA, PUB. NO. 04-102, MEDICAID: GOOD MEDICINE FOR STATE ECONOMIES—2004 UPDATE (2004), available at [www.familiesusa.org/assets/pdfs/Good\\_Medicine\\_2004\\_update93b7.pdf](http://www.familiesusa.org/assets/pdfs/Good_Medicine_2004_update93b7.pdf) (finding, e.g., that every \$1 of Medicaid spending generates \$3 of business activity, every \$1 million in Medicaid spending generates almost thirty-four jobs, and every \$1 million in Medicaid spending generates about \$1.3 million in wages).

<sup>69</sup>DANIEL GITTERMAN ET AL., THE OTHER SIDE OF THE LEDGER: FEDERAL HEALTH SPENDING IN METROPOLITAN ECONOMIES exec. summary (2004), available at [www.brookings.edu/metro/pubs/20040917\\_gitterman.htm](http://www.brookings.edu/metro/pubs/20040917_gitterman.htm). E.g., All Kids is estimated to produce about \$87 million in business activity in Illinois and \$30 million in wages. See FAMILIES USA, PUB. NO. 05-106, GOOD FOR KIDS, GOOD FOR THE ECONOMY: HEALTH COVERAGE FOR ALL KIDS IN ILLINOIS 2, 4 (2005), available at [www.familiesusa.org/resources/publications/by-date/publications-by-date-2005.html](http://www.familiesusa.org/resources/publications/by-date/publications-by-date-2005.html) (describing research that shows the likely positive economic effects in Illinois as a result of implementation of universal health insurance for children).

it” response and deprive politicians from being able to say that they have no choice but to cut programs or refuse to expand them. They always have a choice, and to refuse to expand health coverage is an exercise of that choice, a decision for which politicians need to be held accountable. Health coverage is popular, and, if coverage is framed as a policy choice that politicians are free to make, many politicians will shy away from opposing it, or at least from being the visible leader of the opposition.

Many of these lessons translate to the federal level and can be relevant for promoting S. 2137, the federal All Kids Program bill.<sup>70</sup> The bill should be explained to the policy committees of both parties’ candidates for the House and Senate. And, remembering the lesson from Illinois that the chief executive is crucial, it should be explained to the policy committees of all the candidates in the next round of presidential primaries. If the next president supports All Kids, the bill has a strong chance of success. If Congress passes it even without presidential leadership, the power of the issue is such that it would be very hard to veto.



Communities and states all over the country are concerned about the loss of health coverage, the cost of health coverage, the plight of the uninsured, and the cost to everyone of having so many uninsured. Perhaps the leading lesson to be gleaned from the story of the path to universal coverage for children in Illinois is the growing strength of the public will that is driving policymakers to take significant action on health coverage. Policymakers have a tremendous corresponding opportunity to assert effective leadership on this issue. With timely advocacy, the move to All Kids in Illinois can spark a trend in many other states and nationally.

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<sup>70</sup>See *supra* note 6. As of mid-February 2006, the Senate had taken no action on this bill.