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Congressionally Mandated Evaluation of the State Children's Health Insurance Program

Site Visit Report: The State of Illinois Kid Care Program

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I. PROGRAM OVERVIEW

Illinois is one of 19 states that chose to use SCHIP funds to implement a combination program, expanding Medicaid coverage while also creating a separate program to cover children with higher incomes. The Medicaid component of Illinois' SCHIP program, KidCare, covers children under age 19 living in families with incomes up to 133 percent of the federal poverty level and pregnant women and their infants up to 200 percent of poverty. KidCare's separate program, which utilizes Medicaid's infrastructure, covers all children under age 19 living in families with incomes above 133 and at or below 185 percent of poverty. The KidCare program also includes a state-only-funded premium assistance program which subsidizes all or part of the premium eligible families pay for employer-sponsored or private insurance. The Medicaid expansion was implemented in January 1998 and the separate programs were implemented in August of the same year (see Tables 1 and 2).

Administered by the Illinois Department of Public Aid, KidCare integrates the Medicaid (KidCare Assist), separate (KidCare Share and KidCare Premium), and state-only (KidCare Rebate) components into one cohesive program using a single, 2-page application, a consistent benefit package, and a common service delivery system. Although considered a true Medicaid "look-alike" program with respect to benefits and service delivery, the separate components of KidCare reflect a strong desire by many Republican policymakers for SCHIP to model private insurance. Thus KidCare Share (the program for children in families earning between 133-150 percent of the federal poverty level (FPL)) requires modest copayments and KidCare Premium (the program for children in families earning between 150-185 percent FPL) requires both copayments and monthly premiums.

Enrollment was initially slow after the Medicaid and separate program expansions. Enrollment rates increased, however, after strong administrative and political support for outreach and enrollment efforts began in the spring of 1999. Notable outreach and enrollment efforts included training application assistants from community-based organizations, termed KidCare Application Agents or KCAAs, and paying them $50 for each complete application that results in a newly enrolled family. In

December 2001, KidCare enrollment reached 153,811 children, 81 percent of its target level.[1] Although enrollment rates have improved, the state has faced challenges with regard to improving access to specialists and dental providers, particularly in rural areas.

This case study is based on information gathered during a visit to Illinois conducted in November 2001 as part of the Congressionally-Mandated Evaluation of the State Children's Health Insurance Program. During the 5-day visit, we conducted 20 interviews with a range of key informants at state and local levels including state program administrators, the Governor's staff, state legislative staff, state and local Departments of Human Services offices, local health care providers, child advocates, provider association representatives, and staff of community-based organizations involved in outreach and enrollment. In addition to interviews at the state capitol, we visited 3 local areas including rural Macon County, a suburban area of DuPage County, and the urban area of Cook County. Macon County, located in rural south central Illinois, has a high poverty rate—23 percent of its children lived below the poverty line in 1997, compared to 17 percent across the state. DuPage County is a relatively wealthy suburban area west of Chicago. While only 5.6 percent of DuPage County children lived below the poverty line in 1997, there is a growing immigrant population and in 1999 an estimated 12 percent of children were uninsured. Cook County, which includes the city of Chicago, is a densely populated area, containing 42.3 percent of Illinois' children, roughly one fifth of whom live below the poverty line. Chicago is a diverse city with large minority and immigrant populations. (Illinois Kids Count 2001)

[1]In total, 174,778 children and pregnant women were enrolled in KidCare as of December 2001. This total enrollment number includes those children in the Assist program (Medicaid) as a result of Medicaid eligibility expansions and KidCare outreach, the Moms and Babies Program, and the Share, Premium, and Rebate programs. Of this total enrollment, 20,967 were infants and pregnant women in KidCare Moms and Babies, a Title XIX program. Thus, the percent of target is the ratio of 174,778 minus the 20,967 infants and pregnant women to 190,783 (the revised target listed in Illinois' March 2000 SCHIP evaluation).

II. BACKGROUND AND HISTORY OF SCHIP POLICY AND POLICY DEVELOPMENT

In early 1997, before Federal SCHIP legislation was passed, Illinois, along with the rest of the country, was enjoying the general economic prosperity of the late 1990s. These flush economic conditions spurred advocates and some legislators to push for a Medicaid expansion. The idea was eventually rejected due to a lack of confidence that such a plan would be financially feasible in the long-run; Illinois was still haunted by Medicaid's financial instability in the early 1990s when the program experienced funding shortfalls. SCHIP legislation provided the added incentive to address the issue of children's health coverage in the fall of 1997. At that time, governor Jim Edgar was nearing the end of his term and feared a protracted battle over how to spend the new funds. Thus, in order to avoid legislative debates, Governor Edgar used the flexibility allowed in the Illinois Medicaid administrative code to expand Medicaid coverage to 133 percent of poverty for all children and extended eligibility to pregnant mothers and their infants to 200 percent of poverty without legislative approval. The new program was not seen as a "placeholder" to secure federal funds, rather as a significant expansion especially for older children who were previously eligible only if their family's income was at or below AFDC levels (about 46 percent FPL). Yet, after this first phase of Illinois' expansion little effort was made to aggressively market the program and encourage enrollment.

The governor's action was unexpected to legislators, but there was general approval of the policy of eliminating the age-based differences in Medicaid eligibility for children. In order to decide how to spend the remaining SCHIP funds the governor organized a task force consisting of legislators and selected outside representatives. The task force's debates centered around the extent to which the program should model private insurance or Medicaid.

According to interview respondents, most of the Republican task force members were firmly in favor of creating a separate program disassociated from the negative perceptions some families reportedly had toward the Medicaid program and modeled after private insurance, including contracting with private plans and imposing cost

sharing. They felt that cost sharing was essential to foster personal responsibility for healthcare coverage and were against expanding Medicaid, in part, because of the bad reputation the program received in the early 1990s when the state delayed provider payments to address Medicaid budget shortfalls. The delayed billing cycles, which reached 100 days, adversely affected provider participation and consequently access to health care and services. Medicaid was perceived by many as a poorly managed "big government" program. Another element that shaped the debate was Republicans' concern over the federal requirement that children be uninsured as a condition of SCHIP eligibility. They believed that extending coverage only to the uninsured would punish those with similar incomes whose parents had chosen to purchase private insurance. Consequently, some Republicans proposed that they subsidize insurance premiums with state-funds for insured children who meet the income requirements.

Many Democratic legislators and child advocates were in favor of a Medicaid expansion that would extend coverage to families with incomes up to 200 percent of poverty. They argued that expanding Medicaid would provide children with the best benefit package and that using Medicaid provider networks and administrative structures would make the program easier to operate. They favored developing a program with no cost sharing, fearing that extra costs would adversely affect enrollment and utilization. They were also concerned that the Republican's premium assistance program would be too costly.

Ultimately, the task force members compromised and recommended that Illinois create a separate, Medicaid look-alike program. The legislation extended coverage to all children in families with income at or below 185 percent of poverty under a separate program but using the same Medicaid provider network. The compromise to 185 percent of poverty satisfied those who feared that extending eligibility to 200 percent of poverty might financially strain the state. As noted above, the separate program includes two components—KidCare Share for children in families earning between 133 and 150 percent of the FPL, and KidCare Premium for children in families earning between 150 and 185 percent of the FPL. The Share program requires families to pay small copayments, while the Premium program requires families to pay monthly premiums in addition to copayments. The final plan also created KidCare Rebate, a state-only funded

premium assistance program, which provides subsidies for children in families with private coverage earning between 133 and 185 percent of poverty (see Table 2 for KidCare program descriptions). The final bill passed with strong support, receiving only 7 nays among 175 legislators.

III. OUTREACH

POLICY DEVELOPMENT

While there was overwhelming support for the design of the KidCare program, this support did not initially translate into a strong outreach campaign. According to key respondents, some policymakers still feared that the program was not financially sound and were hesitant to advertise a program that had an uncertain future. Others were wary that some legislators would manipulate KidCare outreach for their own personal political campaigns. The federal rule imposing a 10 percent administrative cap on SCHIP funds also discouraged state leaders from devoting resources to outreach. With little outreach being conducted, enrollment in KidCare remained low. In early 1999, a few months after enrollment began for both expansions, the state started to receive criticism from the media for its failure to take active steps to enroll more children.

In April 1999, supported by the new governor, George Ryan, the Illinois Department of Public Aid instituted additional simplified enrollment procedures and started a new wave of outreach efforts. The state sponsored media campaigns in various markets around the state using television, radio, and billboards to spread the word about KidCare. At the same the time the state began to foster community-based-outreach efforts by partnering with chambers of commerce, schools, farm bureaus and community resource centers. In order to bridge local outreach efforts with enrollment, state program officials organized events to train and enroll KidCare Application Agents (KCAAs) who are eligible to receive a $50 “technical assistance payment” for each application that results in a newly enrolled family. Later that year, the governor’s office also awarded $1.6 million in outreach grants to 29 community agencies to conduct outreach in immigrant, rural, minority, and other communities needing special attention. In March, 2000, the state awarded $500,000 more in grants for targeted outreach. The state continued to support community-based outreach as well as state-wide media campaigns through 2001. However, according to state officials, future state funding of outreach remains uncertain.

STATEWIDE OUTREACH EFFORTS

The state's initial KidCare message was "Keeping Your Kids Healthy, Something to Grow on." Later, the phrase "Health Insurance for Illinois Children" was added to advertising materials as state officials learned that many people confused the program with day care. The individual components of the state's outreach campaign are summarized below.

- ***Radio and television advertisements:*** The state-sponsored statewide radio campaigns in 1999 and 2000 and television advertisements in Chicago. Media blitzes including TV, radio and print ads were held in Central Illinois for a "Back-to-School" campaign in fall 2000, and a flu season campaign in Winter 2001. Radio advertisements are targeted to working families and provide the state's toll-free hotline number.

- ***Print media and materials:*** The state has developed a wide range of outreach materials including brochures, posters, billboards, and signs for buses. They all include the KidCare logo and the 1-800 number for the Hotline. The state began print advertising for KidCare in 2000 and continued this approach through 2001.

- ***Toll-free hotline:*** The Department of Public Aid in Springfield administers a toll-free hotline staffed with over 30 operators. The hotline fields calls from interested families, KCAAs who have questions about the program, enrolled families with questions about providers, and physicians with questions about participating in the program.

COMMUNITY-BASED EFFORTS

State outreach staff, in conjunction with community-based organizations, have also worked at the community level to educate people about KidCare and encourage families to apply. The state's outreach efforts and outreach grants have placed a high value on local contacts and relied heavily on the strategy of spreading the word from within communities. This strategy is believed to be especially important for reaching Illinois' large rural and immigrant populations, as well as working families without previous experience with public aid programs. Community-based strategies have also allowed outreach to address families' concerns such as the welfare-based stigma often associated with Medicaid and fears of public charge among immigrant populations.

State outreach staff have developed direct ties with community organizations to fuel outreach across the state, particularly in rural areas. They have formed partnerships with chambers of commerce, farm bureaus, and local resource centers to ensure that agency staff are aware of the program and either have KidCare outreach materials available or can act as a KidCare resources within the community. State staff also attend state and county fairs to conduct outreach in rural areas. Program officials have placed a high priority on reaching working families and have devised many employer-based outreach strategies, including efforts to build relationships with large corporations, trade organizations, and unions in order to inform employers and employees alike about KidCare. Special efforts were made in response to recent lay-offs at large corporations to inform affected workers about the program. State staff have also made efforts to partner with Illinois school districts in order to gain access to school lunch lists for KidCare outreach.

Illinois has received outreach money through a Covering Kids grant from the Robert Wood Johnson Foundation, administered by the Illinois Maternal and Child Health Coalition (MCHC). MCHC has targeted these resources to three locations: Macon County, DuPage County, and the metropolitan Chicago area. MCHC has facilitated outreach in each area by providing materials and guidance for outreach efforts. They have developed "tool kits" for churches and other organizations to enable community groups to conduct their own outreach and education activities. For example, MCHC provided local churches with KidCare descriptions to include in Church bulletins and paper fans with KidCare slogans to use during warm summer services. They have also led broad outreach campaigns like their most recent Back-to-School Campaign in central Illinois, which included television advertisements and outreach events.

A key element of Illinois' community-based outreach strategy is the network of KCAAs trained by the state to help families complete the KidCare application. KCAAs lead local outreach efforts and serve as a community contact to answer questions about KidCare and help families through the application process. KCAAs are generally located in federally qualified health centers (FQHCs), County Departments of Health, General Assistance offices, Chambers of Commerce, hospitals and clinics, and community organizations.

Illinois' community-based outreach efforts are numerous and vary among communities and target populations. Some specific approaches we learned about include:

- ***Broad community-wide education:*** State and community organizations have held presentations about KidCare, printed newspaper advertisements, set up booths at health fairs, county fairs, school events, park services and recreation programs.

- ***Partnerships with other organizations:*** Many outreach contractors have affiliated themselves with providers at health departments, FQHCs and individual KCAAs in order to link their outreach efforts with enrollment assistance, or KCAAs.

Some examples of community-based outreach projects in Cook (Chicago), Macon, and Dupage Counties are detailed below.

- ***Chicago Public Schools:*** The school district has developed a school-lunch application which allows families to check a box indicating that the school may release their information to a local KCAA. In 2001, approximately 70,000 school-lunch applications included "checked boxes." The school district then matches these names with KidCare enrollment files to get a list of unenrolled potentially eligible children and their contact information. Five hundred out of the 600 schools in the Chicago School District have partnered with KCAAs in local community organizations or clinics to follow up with these families and help them enroll their children in KidCare. The schools also conduct community outreach, giving presentations to local organizations and holding outreach events during report card pick-up days and back-to-school nights—although key respondents noted that school-based outreach events were often unsuccessful because parents had other priorities when visiting their child's school.

- ***Campaign for Better Healthcare's Macon County and Decatur Project:*** The Campaign for Better Healthcare is a grassroots health care coalition that receives Covering Kids money to conduct outreach in the region. The organization conducts community outreach by attending local events, making connections with large employers and chambers of commerce, forming rural outreach groups, and funding local media coverage. The Campaign for Better Healthcare has begun a joint effort with the local school districts to use school-lunch applications to target eligible children. Families can mark the school-lunch application if they are interested in KidCare and the Campaign provides the list of families to KCAAs for follow-up. They also support outreach efforts of local KCAAs and link them to local outreach events. The

Campaign was involved in the Covering Kids Back-to-School outreach event where Covering Kids funded a media campaign at the beginning of the school year. KCAAs participated in the events by setting up information booths for parents at schools and handing out applications around the community.

- ***Illinois Primary Care Association:*** The Illinois Primary Care Association is a trade association representing all FQHCs in Illinois. IPCA has facilitated individual FQHC's support of KCAAs and outreach activities by keeping them abreast of new KidCare policy information and offering support and ideas for outreach events. The IPCA also runs the Building Healthy Families Program which builds coalitions between FQHCs and community colleges. Each college has a student trainer who trains other students to give presentations about KidCare. Nearly 500 presentations have been given with around 9,000 community members in attendance.

- ***DuPage County Health Department:*** The DuPage County Health department provides immunizations, well-child care, WIC services and other preventive health care services to DuPage residents. The department also receives money from the Illinois' Covering Kids grant to conduct community outreach. There are 40 staff at the health department who can assist families in filling out the KidCare application and all families who use services are screened for health insurance status. KidCare representatives from the department have done community outreach at health fairs, grocery stores, retail stores, food banks, and churches. The Health Department also works with local school districts to obtain lists of families receiving school lunch who are interested in KidCare and KCAAs from the department contact these families.

LESSONS LEARNED

Despite the slow start of outreach efforts in Illinois, the multi-faceted outreach program that has emerged through state and local initiatives is credited with steadily improving KidCare enrollment. Statewide mass-media strategies have contributed to greater name recognition—although, despite the change in slogan, there is reportedly still some confusion among families about whether KidCare is a healthcare or daycare initiative. A wide variety of targeted outreach strategies have evolved around the state to address Illinois' diverse population ranging from rural communities in southern Illinois to urban neighborhoods in Chicago. School outreach efforts are being implemented across the state with variable success. The network of community-based organizations conducting outreach and application assistance has provided the local voice often times necessary to motivate many families to apply.

Targeted outreach appears to have been effective with children who receive other public services from various agencies. FQHCs, health departments, and WIC sites have had success screening the children they already serve for health insurance and have KCAAs on staff to help parents fill out an application. WIC sites and FQHCs receive strong support for their efforts from their parent organizations, the Office of Family Health and the Illinois Primary Care Association respectively. The Office of Family Health has made KidCare enrollment a performance measure for WIC sites encouraging more vigilant outreach efforts in the offices. In September 2000, 46,795 WIC children were not enrolled in KidCare and by October 2001 this number dropped to 20,000—reportedly due to using KidCare enrollment as a measure of each WIC site's performance. The IPCA provides support for outreach work and assistance to KCAAs at the member FQHCs. These models of provider outreach have proved to be efficient and effective outreach strategies in Illinois.

FQHCs, health departments, and some community clinics in Illinois have illustrated how providers can play an important role in outreach and enrollment efforts. Some respondents noted that parents are more receptive to discussing KidCare when they visit a healthcare provider than in other settings. While there has been strong involvement by safety net clinics, hospital participation in KidCare outreach has been much more variable. One hospital representative in Chicago felt that outreach and enrollment activities were very resource and staff intensive and "not worth" the effort. In Macon County, key informants were disappointed that neither of the area's two local hospitals were involved in KidCare outreach. However, one hospital we met with in Chicago found that conducting outreach and enrollment through its system of community clinics attracted and maintained a new patient base.

School-based outreach efforts have had varying success across the state. Efforts were made by the IDPA, Chicago Public Schools, and local outreach organizations to use the school as a center for KidCare outreach and to use school lunch lists to target eligible children. Informants felt that schools aren't the ideal setting for outreach because while "schools are where the children are," they aren't "where the parents are" and parents are the ones who fill out the application. KCAAs reported that outreach events they held at schools, typically during report card pick-up days and back-to-school events, were often

ignored because parents had other priorities when they were visiting their child's school. Despite sometimes disappointing results from school-based outreach events, efforts to use school lunch lists to link eligible children with application assistance is reportedly effective. Chicago public schools created an effective system to target only eligible children who aren't already enrolled in KidCare. But the school system has run into some difficulties with this approach due to the transient nature of its population—school officials noted that as many as 25,000 children move within the school year. KCAAs report being unable to contact many families because their telephone and mailing information are outdated by the time they received it. To rectify this problem, the district now updates families' contact information provided to KCAAs on a monthly, rather than yearly, basis. According to key informants, the success of school-based outreach efforts also seems to relate to whether schools are a trusted and frequently-used resource in a given community.

Media campaigns across the state have reportedly been effective in increasing name recognition and motivating parents to apply or request more information, but many informants felt that some people still do not understand that KidCare is a health insurance program. The extensive media coverage surrounding KidCare in the spring of 1999 sparked increased call volume at the state Hotline and calls steadily increased throughout the year as the state began renewed outreach efforts. The Back-to-School media campaign and associated community outreach increased call volume at the Hotline by 3,500 over a monthly average of 9,000 calls. KCAAs reported that the Back-to School campaign also led to increases in application volume. Media campaigns have been effective where and when they've been implemented, but some informants complain that media efforts have been sporadic and targeted to urban and other select markets to the detriment of other areas.

Broad media campaigns were praised by many respondents for alleviating some of the welfare-stigma sometimes associated with public health coverage. TV and radio advertisements, as well as the brightly colored KidCare logo on posters in buses and trains, help to legitimize the program and are received positively. However, many respondents also emphasized the importance of having the outreach message come from within the community. Community organizations, supported by grants from the state and

other organizations, bring the KidCare message into communities and link families with KCAAs for application assistance. Key informants felt that community organizations were able to address cultural, language, and other barriers to enrollment better than state-wide campaigns. KCAAs were credited with playing a key role in addressing barriers to enrollment—for example, respondents explained how KCAAs are able to address concerns families have about public charge on a more personal level than is possible in general outreach efforts.

Respondents noted the importance of financial support through state grants as well as the technical assistance payments in supporting community outreach. Some organizations we visited used technical assistance payments to employ KCAAs and pay for outreach materials, while other organizations gave portions of the payments as bonuses to their KCAAs which provided an effective incentive to increase the volume and accuracy of the applications they complete. Respondents reported that the $50 payment often motivates KCAAs to get more involved in outreach initiatives and even spearhead their own outreach activities. Respondents also noted the importance of targeted outreach grants from the states in supporting outreach by community organizations, especially ethnic organizations that offer translation services and a cultural understanding that can rarely be provided by other KidCare resources. Some respondents feared that community organizations might be forced to scale back their outreach efforts if they aren't able to retain financial support.

IV. ENROLLMENT AND RETENTION

POLICY DEVELOPMENT

When the separate KidCare programs (Share and Premium) were enacted in August 1998, the enrollment processes were simplified for all programs. The state introduced a shortened, 4-page mail-in application designed to screen children for Medicaid as well as the SCHIP and state-only components of KidCare. The application was printed in English and Spanish, state officials eliminated the assets test as well as the previous requirement for a face-to-face interview. Although the state instituted 12 months of continuous eligibility for Share and Premium programs, children in Assist (Medicaid) were still required to update local DHS offices if their financial and/or family circumstances changed. Under the reformed process, applications are mailed to local DHS offices who determine eligibility and manage the cases. A central hotline is also available for helping families with questions.

Despite these reforms, six months after enrollment began for the new program, enrollment levels remained low and the state began to receive public criticism from media and advocates for implementing a program without effective administrative support and coordination. The state responded in the spring of 1999 by revising the application process and instituting numerous additional simplification strategies. The state shortened the KidCare application to 2 pages and made it available on the internet (only for downloading, not for on-line submission). The state reorganized the enrollment process by expanding the role of the central processing unit in Springfield to receive and process all mail-in applications (completed by families and application agents), and manage all KidCare Share, Premium, and Rebate cases. They also began to train and pay KidCare Application Agents (KCAAs) to help families complete the application accurately. The state previously relied on local DHS offices and outstationed eligibility workers located in disproportionate share hospitals and FQHCs to help families enroll. The new system of KCAAs was designed to have a much broader reach and the state encouraged all hospitals, WIC sites, community organizations, faith-based organizations, physician groups, and insurance agents to have their staff trained to be KCAAs.

Moreover, the state began providing KCAAs with the $50 technical assistance payment for every application resulting in a newly enrolled family.

The system of KCAAs greatly increased the availability of community-level help in completing KidCare applications. In late 1998, there were 333 sites where families could receive assistance and by December 2000, this number increased to 1,408 sites. Currently, 67 percent of all applications sent to the Central Processing Unit are completed with the help of KCAAs. The IDPA provided ongoing support to KCAAs in the form of periodic training and by providing tools to assist them in evaluating their work.

More recently the state has taken further steps to make enrollment and redetermination easier. In March 2000, the state initiated 12-month continuous eligibility for KidCare Assist (the Medicaid program for children), creating consistent enrollment policies across all KidCare programs. (For more information on KidCare eligibility policies, see Table 4). IDPA also redesigned the eligibility redetermination form for the Share and Premium programs. The form is now pre-printed with information that was collected at the time of initial application. (For more information about the KidCare application form, see Table 5.) Families only need to answer a few questions and submit new income verification. In addition, the toll-free hotline is beginning to accept phone applications on a limited basis and the central processing unit has started calling families who fail to respond to the redetermination notices. These and other strategies to simplify enrollment are discussed in more detail below.

ENROLLMENT PROCESS

The simplified 2-page mail-in application and the creation of a central processing unit for KidCare applications were highlighted by program officials and other interview respondents as the most significant improvements in Illinois' enrollment process. While many families interested in health insurance apply for KidCare using the mail-in application, families are still able to apply for KidCare at local DHS offices and the central processing unit also takes applications by phone on a limited basis. The following subsections describe the two primary means of applying to KidCare, the mail-in

application process and the process of applying through local DHS offices, in addition to the less commonly used approach of applying over the phone.

1. Mail-in Application

Families can obtain a mail-in application for KidCare by calling the state's KidCare Hotline or by downloading the application from the internet. Applications are also available at community centers such as libraries, township offices, public health departments and other community organizations. Families may also find applications at community events or through a healthcare provider. Families can fill out and mail in applications on their own, or receive the assistance through the hotline. In addition, they can receive assistance from a KCAA in their community. Some KCAAs are available for walk-ins and others will make appointments to speak with families either during business hours or at a time that is convenient for the parent. The KCAA will help parents complete each step of the application. If the parent provides income, child-care, social security number, and immigration documentation, the KCAA can send the application to the Central Processing Unit. Otherwise the parent can follow up with the KCAA at a later date to provide documentation. KCAAs often follow up with parents to ensure that applications are complete; the state creates an incentive for KCAAs to follow through with completing applications in a timely manner by only awarding the TAP payment if the application is completed and submitted within 30 days of the time it was initiated. KCAAs noted that it is fairly common for families to initiate an application without having the necessary documentation on-hand to complete it.

Once the application is completed, the KCAA sends the application to the central processing unit where staff determine whether the child is eligible for KidCare Assist, Share, Premium or Rebate. If the child is eligible for KidCare Assist, the Central Processing Unit (CPU) transfers the case to the family's local DHS office. The State sends a letter to the family notifying them that the child is enrolled in KidCare Assist and provides them with a white MediPlan card. If the child is eligible for KidCare Share or Premium staff at the CPU notify the family by mail and send a Yellow KidCare card.

2. Applying via DHS

A parent can either walk in to their local DHS office or call to inquire about KidCare. Typically, DHS offices are open for walk-in appointments in the morning and case-workers are available to schedule appointments at most times during regular business hours, usually 8:00 a.m. to 4:30 p.m. Parents can also come into the office during business hours and fill out an application without an interview. Although there is no face-to-face interview required for KidCare eligibility determination, in practice, caseworkers typically try to schedule an in-person interview with the applicant so that they can be screened for multiple public programs for which they may be eligible. At some offices, caseworkers will assist families with the KidCare application over the phone and attempt to screen them for other programs as well.

The application typically used at DHS is not the 2-page KidCare mail-in application. Rather, DHS workers generally follow the traditional application procedures to screen for a range of other services (i.e., TANF, Food Stamps, etc.), even if a parent only requests KidCare. If a parent does not have the necessary income and other documentation at the interview, they have 10 days to mail or bring in documentation before their case is closed. However, extensions are usually granted if a parent contacts the caseworker. If a parent has the necessary documentation at the interview and the child is determined to be eligible for KidCare Moms and Babies or KidCare Assist, their caseworker can process their application at the local office and give them a temporary medical card that day if necessary. If the child is eligible for KidCare Assist, a caseworker will be assigned from the local office and a white MediPlan card will be mailed to the family. If the child is eligible for KidCare Share or Premium their case will be transferred to the CPU, which will send the family a yellow KidCare card. Like KidCare Share and Premium, KidCare Rebate cases are all maintained by the CPU.

3. Applying by phone

Occasionally, families contacting the KidCare hotline are interested in applying for the program over the phone. Hot-line staff members will help families complete the application over the phone and then send the application to the parent or guardian to be signed and returned to IDPA with the documentation. State program officials reported

that this is not a common KidCare enrollment process, but that some families appreciate the immediate application assistance they receive from hotline staff.

REDETERMINATION PROCESS

All KidCare enrollees must have their eligibility redetermined every 12 months, but the process is different for KidCare cases managed by the CPU and those managed by local DHS offices.

KidCare Share and Premium cases are managed by the CPU, and during the tenth month of a child's enrollment period parents are sent a renewal form preprinted with information from their original application. Parents need only fill in income and disregard information, attach the required income verification, and sign the form to renew their child's enrollment. If premiums are required, parents must also pay the monthly premium. If parents do not respond to the initial mailing, the CPU sends an additional reminder notice by mail. If they do not hear from parents after the mailing, they follow-up with them by phone.

The redetermination process for KidCare Assist enrollees is less standardized due to differing practices in local DHS offices across the state. If a family is enrolled in other income-dependent programs, such as Food Stamps, redeterminations for these programs will count as a redetermination for KidCare. If not, caseworkers will send out a re-enrollment form requesting income information and documentation in the eleventh month of enrollment. The redetermination form may be mailed to the local office because caseworkers do not generally try to use the redetermination process as a screening mechanism for other programs, as they do during the initial application process. Most offices have a policy that the form must be completed and returned in 10 days, but this deadline is often flexible if families notify the caseworker that they need additional time. Some caseworkers mail additional reminders to families if they do not respond and some will call the family, but this is not usually the case. Families can still submit re-enrollment information immediately after their case is closed and the case worker will reinstate benefits without the family reapplying.

LESSONS LEARNED

Interview respondents believe that Illinois has taken significant steps to restructure and refine the KidCare enrollment process since the initial implementation of the program. These actions, they believe, have directly contributed to steady increases in enrollment which reached 81 percent of the target enrollment at the time of our visit in December 2001. In particular, respondents credited the improved enrollment rates to the joint and streamlined application process between Medicaid and the separate program portion of the KidCare program, the ability to submit the application by mail, and KCAAs.

The initial KidCare plan proposed in 1998 included a single application for all KidCare programs including the state-funded Rebate program, allowing even children with private coverage to apply through the same process. This streamlined application process has eliminated the logistic difficulties inherent in multiple applications faced by many states. The 2-page from, which requires the submission of only income verification, social security number, and immigration status, was praised by many informants as one of the keys to successful enrollment. Some advocates and providers noted that providing income documentation was still a barrier to enrollment for some families, and they feel that allowing self-declaration of income would further improve enrollment rates. State staff, however, feel that requiring income documentation is necessary to ensure that enrollees are truly eligible.

KCAAs and the community organizations, clinics, and health departments that support them were described as crucial for providing the on-going assistance often necessary to help families enroll. Key informants told us about KCAAs helping self-employed families provide acceptable alternative forms of income documentation, providing translation assistance, and giving encouragement to families who were hesitant to apply. According to state administrators at the CPU, KCAAs have improved the quality of applications being returned; application approval rates increased from 30 to 85 percent after KCAAs began assisting families complete applications. Many informants noted that the $50 payment provided to KCAAs for approved applications has created an effective incentive to submit accurate and complete applications. Key informants

generally felt the payment is adequate to cover the costs of application assistance and noted that some KCAAs find that the payment allows them to get involved in outreach activities as well. Some informants report, however, that the payment is insufficient for the amount of follow-up necessary to assist some families in completing the application; immigrant families were noted as one group that required extra time.

The shift to a mail-in application process has reportedly contributed to a decline in the negative perceptions some families associate with public programs. Many informants noted that the transition from enrollment being centered at local DHS offices to the CPU helped enforce the idea that KidCare was a different program from Medicaid and wasn't associated with welfare. For this reason, some advocates and KCAAs interviewed for this study believed that KidCare Assist cases should not be managed by local DHS offices because some families negatively perceive these offices as associated with welfare. They cited applicants' frustration and disappointment when they found that their KidCare Assist services were handled by their local DHS office. A major point of contention for many of the advocates, KCAAs, and providers interviewed was the fact that KidCare Assist enrollees receive a white MediPlan card, the same card used by all Medicaid recipients, rather than a KidCare card. Reportedly, applicants felt "cheated" because they were led to believe that KidCare was different from Medicaid, only to find out that their case is maintained at DHS and that their enrollment card is the same as used by traditional Medicaid. Advocates and KCAAs told us that applicants believed they would not be treated well by caseworkers at DHS, and generally did not want to be involved with DHS. These respondents felt that all KidCare cases should be managed by the CPU, noting that some applicants actually refused coverage when they found they were eligible for Assist and referred to a local DHS office. Conversely, informants from local DHS offices argued in favor of managing Assist cases, maintaining the importance of educating families about other social services that are available to them through DHS. Nearly all informants agreed that a plastic KidCare medical card, similar to private insurance cards, would serve to alleviate some of the problems associated with handling Assist cases at DHS offices. State program officials are currently considering such a change.

While enrollment is increasing, the state is now looking more closely at retaining eligible children in KidCare. Although the state has streamlined the redetermination process for Share and Premium cases, they are just starting to look more closely at the redetermination process for Assist. Efforts are underway to track renewals more closely at the local DHS offices. Recent data on renewals for the KidCare Share, Premium and Rebate programs reveal that 58 percent of children who were due for renewal between November 2000 and October 2001 retained their coverage. Of the remaining 42 percent, 45 percent returned their redetermination forms but were not eligible and 55 percent either did not respond to renewal notices or submitted incomplete redetermination forms.

V. CROWD OUT

POLICY DEVELOPMENT

In contrast to the experiences of many other states, the potential that SCHIP would lead to crowd out (the displacement of private coverage by public coverage), was not a significant issue during the development of the Illinois KidCare program. Indeed, policymakers, primarily Republicans, were more concerned about the federal requirement that children be uninsured to qualify for SCHIP, believing that this created an inequity for those families that met SCHIP's income eligibility, but had "done the right thing" by previously purchasing available coverage for their children. Consequently, lawmakers proposed the KidCare Rebate program, a state-only funded premium assistance program for children with incomes above 133 percent and at or below185 percent FPL (which is discussed further in Section IX of this report).

The Rebate program, in addition to addressing equity concerns, served to diminish apprehension about crowd out, as policymakers believed that subsidizing employer-sponsored insurance would help families maintain private coverage and reduce the potential that they might drop it to enroll in Medicaid or SCHIP. Beyond this, there was also general agreement that Illinois should institute a waiting period as an additional deterrent to crowd out. Unlike other states, however, there was little concern that a waiting period would create an enrollment barrier because the Rebate program would provide subsidies to families who already had private coverage.

POLICIES AND PROGRAM CHARACTERISTICS

Illinois officials primarily view the Rebate program as the state's best strategy for deterring crowd out, however, other policies include a plan to monitor crowd out and a 3-month waiting period, during which time children must be uninsured prior to enrolling in the program. To determine insurance status at the time of enrollment, the KidCare application asks: "Is this child or pregnant woman covered by health or hospital insurance (including Medicare) now or in the last 3 months?" The waiting period has exceptions for those who lose coverage through no fault of their own. In addition to the

waiting period, Illinois is planning to monitor crowd out by conducting surveys to collect information about whether families are dropping private insurance to enroll in KidCare.

EXPERIENCES AND LESSONS LEARNED

At the time of this writing, Illinois does not have any estimates on the number of children that are denied eligibility because they possessed other insurance within three months of their application, or any survey data on whether families are dropping private coverage to enroll in KidCare. Nevertheless, state officials are not concerned about crowd out, primarily due to the existence of the Rebate program. If anything, the state has received criticism for not allowing children with family incomes under 133 percent FPL into the Rebate program (if an applicant with private insurance qualifies for Medicaid, then they must enroll in Medicaid and are not eligible for Rebate). Reportedly, a number of families with private insurance would prefer to receive subsidies to maintain that insurance rather than enroll in Medicaid.

At the local level, KidCare Application Agents (KCAAs) noted that some families ask whether they should drop their private coverage to enroll in the KidCare Assist, Share or Premium program. KCAAs said that they were generally able to convince families to maintain their coverage and apply for the Rebate program.

Respondents were also not worried about employer-based crowd out—the incidence of employers reducing or eliminating dependent coverage due to the existence of SCHIP—because state insurance law prohibits employers from dropping coverage for only some of its employees. Consequently, only firms with all low-income employees would be able to drop or reduce coverage with the intention of taking advantage of KidCare and, at this time, there is no anecdotal or quantitative evidence that this is happening.

VI. BENEFITS COVERAGE

POLICY DEVELOPMENT

As the Governor's task force debated whether to expand Medicaid coverage or create a separate children's health insurance program under SCHIP, it became clear that those advocating for a Medicaid expansion felt strongly about providing children with the richest benefit package possible. Some Republicans were against expanding the Medicaid program due to its entitlement nature and the negative perceptions of some families regarding the program, but were willing to compromise on the design of the benefit package as long as the program was modeled after private health insurance in terms of cost-sharing requirements. Using the Medicaid benefit package was also appealing because it would be relatively simple to operationalize, using the same claims processing system as used by traditional Medicaid.

POLICIES AND PROGRAM CHARACTERISTICS

Thus, the task force recommended the creation of a separate program that offered participants the full Medicaid benefit package, with two exceptions. Children in the KidCare Share and Premium programs receive the same benefits as those children in KidCare Assist, except for Home and Community Based Waiver Services (i.e., respite care, housekeeping, personal care services) and abortions. Aside from these two types of services, all children in KidCare receive the same rich benefit package and enjoy very few benefit limits.

EXPERIENCES AND LESSONS LEARNED

The KidCare benefit package was uniformly viewed by key informants as very generous and one of the key strengths of the program. In addition to participants benefiting from a comprehensive array of services, the providers interviewed for this study believed that the richness of the benefit package encouraged physicians to participate in the program. Providers view the KidCare benefit package as ideal,

especially compared to private insurance coverage, because its comprehensiveness allows them to practice medicine "in the way they see best" for the patient.

While the benefit package was consistently viewed as a key strength of the KidCare program, a few respondents were skeptical of whether the case management benefit was sufficient, particularly for children with special heath care needs. Case management is limited to children diagnosed with mental illness and children under age three who are receiving early intervention services. Additional case management is offered to children with special health care needs by the Division of Specialized Care for Children (DSCC), a department within the University of Illinois that administers the MCH, Title V Block Grant. One advocate noted that it is still unclear how well DSCC is able to wrap-around KidCare benefits. Reportedly, there are KidCare participants with asthma and diabetes that do not qualify for DSCC wrap-around services that would benefit from additional case management.

VII. SERVICE DELIVERY AND PAYMENT ARRANGEMENTS

POLICY DEVELOPMENT

With the decision to offer the Medicaid benefit package to all children in KidCare, Task Force members believed it made sense to keep the service delivery system and provider payment arrangements consistent as well. Consequently the KidCare Share and Premium programs are predominantly fee-for-service, as is the traditional Medicaid program in Illinois. According to respondents involved with the Task Force, Task Force members did not seriously consider instituting more widespread managed care for SCHIP due to a general aversion to managed care penetration in Illinois and past MCO marketing abuses when the state began voluntary Medicaid managed care in the early 1990s. Moreover, a few Task Force members felt that it was important for KidCare participants to have "freedom of choice" when selecting providers.

There was some concern that access problems within the Medicaid program would continue and also plague SCHIP KidCare participants. During state budget shortfalls in the early 1990s, the state delayed payments to providers and billing cycles averaged 100 days or more. Providers also felt that Medicaid reimbursement was too low. Between the "slow and low" payments, provider participation in the program dropped, which adversely affected access. With changes to improve the timeliness of provider payments in 1996 and an increase in reimbursement rates in 1998, the number of participating providers has improved. As discussed further below, the timeliness of payments and competitive reimbursement rates have actually become a draw for many providers hesitant about participating in KidCare.

SERVICE DELIVERY SYSTEM

In contrast to many other states, Illinois' Medicaid and SCHIP programs primarily rely on a fee-for-service delivery system. In 1999, there were over 44,700 enrolled providers, including more than 260 hospitals, nearly 29,000 physicians, and over 2,500 pharmacies.

KidCare participants do not receive a list of participating providers with their enrollment packet, but they may call the state KidCare hotline to get the names of local providers that typically accept KidCare. The state tries to keep an updated list of participating providers, but independent physicians will often agree to take only a limited number of KidCare patients at a time and it is difficult to keep the list current. The state is currently working on a phone service for physicians to call in on a regular basis to notify the state as to whether or not they are accepting new KidCare enrollees.

A small number of children in KidCare voluntarily participate in managed care. There are five managed care organizations (MCOs) in three counties (Cook County, St. Claire County, and Madison County) that participate in KidCare. The five MCOs serve about 145,500 adults and children in the KidCare Assist and Moms and Babies programs**.** Three of the five MCOs also serve a very small number of children (145) in the KidCare Share and Premium Programs. Managed care plans have access to KidCare enrollees through IDPA mail vendors—plans may submit materials to the mail vendors to be sent to enrollees, but no enrollee information (i.e., names, addresses, phone numbers, etc.) are shared with MCOs. In order to attract members, plans sometimes target health fairs, neighborhood grocery stores, and other venues that are likely to draw KidCare or adult Medicaid participants. Plans may even ask shoppers if they are enrolled in KidCare or Medicaid, and if so, whether they would be interested in enrolling in managed care. Nonetheless, MCOs feel it is difficult to achieve any kind of volume of managed care participants. The state has strict guidelines regarding the marketing of managed care to Medicaid enrollees because of previous abuses, including aggressively soliciting participants by going door-to-door in lower income neighborhoods and signing up Medicaid enrollees without fully explaining the implications of transitioning from fee-for-service providers to a managed care plan.

Dental care for both fee-for-service and managed care KidCare enrollees is administered by Doral Dental USA, the largest dental administrator for Medicaid programs in the nation.[2] Doral began administering Illinois' Medicaid dental program in March 1999. Previously, dental services were administered by Delta Dental. The state then decided to contract with Doral because of the company's reputation for reducing

[2] Doral currently administers Medicaid dental programs in 20 states, including Illinois.

administrative costs and enlarging provider networks. Currently, Doral's network in Illinois includes 1,933 dentists that participate in both KidCare and the adult Medicaid program.

PAYMENT ARRANGEMENTS

In Illinois, the fee-for-service payment rates are the same for Medicaid and SCHIP. In 2001, the state paid between $34 and $44.30 per visit. For managed care organizations, the capitated rates paid by the state are slightly higher for Medicaid and SCHIP children; plans typically receive higher capitation rates for KidCare beneficiaries who do not receive TANF due to higher utilization rates of that population. Managed care capitation rates reflect that the following services are carved out and provided fee-for-service to managed care enrollees:

- Dental services, except for prescribed drugs ordered by a dentist and dental hospitalization in case of trauma;
- Vision refractions, eyeglasses, and other devices to correct vision;
- Nursing facility services beginning on the 91st day;
- Intermediate Care Facilities for the Mentally Retarded;
- Early Intervention services, including case management;
- Services provided through local education agencies and school-based clinics;
- Services provided under Section 1915 (c) home and community-based waivers; and
- Audiology services, physical therapy, occupational therapy and speech therapy provided to beneficiaries under 21 years of age.

Illinois' rates have improved over the years and at the time of our site visit, respondents reported that the fee-for-service provider payments were competitive with many commercial payers. Though rate payment is also considered timely, respondents stated that Medicaid still has a bad reputation among many providers in part because of the "slow and low" payments of the early 1990s. State officials and representatives from the Illinois Chapter of the American Academy of Pediatrics have been working to improve the image of KidCare among providers by hosting seminars that explain the

program and its positive features, highlighting the improved rates and payment cycles. Providers interviewed for this study especially appreciated the expediency of the payments, which now average 30 days, and noted that it was better than many commercial payers, which often take 90 to 100 days. However, in February 2002, after our site visit, well-child rates were reduced from between $34 and $44.30 to $33 and $43 due to state fiscal problems. It remains to be seen how the reduction will impact provider participation.

Dental visit payments in 2002 were $17.25 for a periodic oral exam. Key dental informants were pleased to note that the dental rates have increased steadily over the past several years, increasing by 31 percent in FY 1999, from $6 per visit in 1998. In FY 2000 rates increased 13.6 percent, 4.7 percent in FY 2001, and 4.6 percent in FY 2002. However rates decreased by 3 percent in FY 2003.

IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

For the most part, study participants believed that access to care was generally acceptable under both SCHIP and Medicaid for children, and had improved with the program's rate increases, expedited payment processes, and more concerted efforts to recruit providers. In both the rural and urban areas we visited, primary and preventive care was described as accessible, although the lack of a provider directory often resulted in parents calling KCAAs and County DHS workers to inquire about participating physicians.

To assist with locating providers, KCAAs and DHS workers reported that typically, they first suggest families check with their primary care doctor to see if they participate. If the physician doesn't participate, or if the family does not already have a doctor, then KCAAs and DHS caseworkers resorted to several different strategies to locate a doctor, including: calling, or suggesting that families call, the state's hotline to get a list of local providers that usually accept KidCare (this was the most common approach reported); directing families to the yellow pages; and targeting their inquiries to physicians with new practices because they seemed more likely to accept KidCare as they build up their patient base. Overall, interviewees seemed to think that most KidCare

enrollees could find a participating doctor, but that sometimes it required the persistent efforts of families, DHS caseworkers, and KCAAs.

While access to preventive and primary care was considered generally acceptable, interviewees reported that access to specialty care and dental services needed improvement. Although respondents reported difficulties accessing specialists and dentists in both the urban and rural areas we visited, KidCare enrollees in Cook County and the "collar counties" (suburban areas surrounding Chicago) reportedly have greater access to these types of providers than enrollees in central and southern Illinois.

Regarding access barriers to specialty care, no one type of specialty was singled out by study participants—rather, they seemed to think that access was consistently poor across all specialties and a greater problem in rural areas. Limited access to specialists was largely related to capacity—greater numbers of specialists in Cook County and the collar counties translated into better access in these areas, while shortages of specialists in rural areas caused access problems. The Chicago area particularly benefits from the presence of Cook County Hospital, a safety-net public hospital that provides a full spectrum of specialty and sub-specialty services. In fact, Cook County Hospital reported that about 5 percent of all patients come from other counties—primarily the collar counties, but also more distant counties—for specialty care. However, demand within Cook County, coupled with demand for specialty care from other counties, often results in long waiting lists for services. Interviewees noted that it was not unusual for patients to wait 8-9 months for an appointment with a specialist at Cook County Hospital.

In addition to some areas being affected by a short supply of specialists, respondents felt that some specialists were not interested in participating in KidCare because of Medicaid's reputation for being a "slow and low" payer. Respondents also believed that some physicians weren't interested in serving the KidCare population because of a perceived "welfare stigma" associated with low-income families. One FQHC noted that referrals to specialists were sometimes declined because specialists said they did not want to serve "these people." Reluctance to serve KidCare participants seemed to be greater in the rural and suburban areas than in the urban areas, reportedly due to the suburban and rural providers having less familiarity with low-income patients.

In order to improve access to KidCare services, state program officials and the American Academy of Pediatrics (AAP) have been holding seminars to educate physicians about the benefits of participating in KidCare. AAP has 20 physician volunteers that work individually or jointly with state officials to meet with providers and emphasize KidCare's increased rates, timely payments, and to address providers' reluctance to serve low-income families. Thus far about one-fifth of the offices targeted by these efforts have gotten involved with KidCare. Currently, AAP volunteers are expanding their approach to target office administrative staff as well as physicians because they are finding that most physicians have little understanding and little interest in their payer-mix.

Although access to KidCare services was viewed as generally acceptable, several respondents believed that access could deteriorate in the coming year because of the state's budget outlook. Respondents warned that if the state resorted to delaying provider payments as a means of coping with budget shortfalls, as it did in the early 1990s, the number of participating providers would decline and negatively affect access to health care services. Since our site visit, the state has in fact, reduced well-child provider payments due to the state's fiscal conditions. It remains to be seen how this might impact provider willingness to participate in the program.

Almost universally, study participants noted that the most significant problem related to KidCare's service delivery was a lack of access to dental care services, particularly in the state's rural areas. Poor dental access was attributed to limited participation by dentists, a limited and diminishing supply of dentists in the state, and a variety of barriers facing children and their families that range from ignorance about the importance of oral health care to transportation problems. Limited participation among dentists in KidCare was primarily attributed to dentists' need for "reliable payers"—dentists are concerned that the high "no-show" or missed appointment rate among KidCare patients will adversely affect their revenue. In addition, there is a diminishing supply of dentists in the state, which also limits access. Due to two dental school closures in the state and the downsizing of a third, the number of Illinois' yearly dental graduates has decreased from 460 in 1980 to about 110 in 2002 (Byck, Cooksey, and Walton, 2001). Rural areas are particularly affected by the low supply of dentists. While

there are 1,643 persons per dentist in Illinois urban areas, there are 3,162 persons per dentist in the state's rural areas (Byck, Cooksey, and Walton, 2001). Indeed, about half of the dentists in Doral's dental network are located in Cook County, with the remainder spread across the state.

Illustrative of the barriers to dental care, we found that in Decatur, there is a two-month waiting list to receive care from the one participating dentist in the area. Although children in Decatur could travel to Springfield or Champaign where there are more participating dentists, the approximate hour-long drive to these more urban areas was described as prohibitive to many low-income families who don't have transportation or the flexibility of leaving their jobs for an extended period of time during the day.

Doral Dental was credited by several interviewees as making notable headway in expanding the dental network. According to Doral's records, they have increased the network of participating dentists by 200 percent since their contract began in 1999. Doral has built up KidCare and the adult Medicaid dental network by making the program administratively appealing through accurate and timely claims processing (within about 10 business days), streamlining the application form for dentists interested in participating, and offering medical guidance and technical assistance through a 1-800 number staffed by dentists. Doral thinks that its billing efficiency is one of the key selling points in getting dentists to participate. It is also addressing dentists' concerns that they will be "over-run" with KidCare/Medicaid patients by establishing a directory of participating providers that is updated frequently and allows dentists to indicate exactly how many KidCare/Medicaid patients they are willing to see. Dentists can even call in and let Doral know if they are having a slow month and can take on additional enrollees. Doral's dental directory is accessed by KidCare/Medicaid enrollees via a 1-800 "Geo-Access" referral number, which helps enrollees locate participating dentists in their area.

In addition to the above-mentioned strategies to improve participation, Doral is collaborating with the Illinois State Dental Society's "Take Two" program which encourages dentists to take at least two Medicaid patients into their practices. Doral views the Take Two program as a great opportunity to "show off" KidCare and the adult Medicaid dental program and leads to dentists eventually taking on additional Medicaid/Kidcare patients.

Also credited with improving Illinois' Medicaid/KidCare dental program is the Dental Program Policy Committee (DPPC). DPPC reviews policies and procedures for the provision of dental services to adults and children in the Medicaid/KidCare programs and is responsible for advising the Department of Public Aid of any recommendations for policy changes. The committee consists of 15 voting members, which include dentists participating in Medicaid/KidCare, dental consultants, and representatives from Doral, the Department of Public Health, and the state dental societies. Doral believed that the committee was very effective in addressing provider concerns about the program, particularly with respect to benefit limitations.

VIII. COST SHARING

POLICY DEVELOPMENT

Whether or not to include cost sharing, and to what extent, was a controversial issue during the development of KidCare. According to interview respondents, the Republicans on the Governor's Task Force generally advocated for the creation of a separate program that modeled private insurance as closely as possible. While these task force members were willing to concede to the Democrats and advocates' desire for a comprehensive benefit package, they were adamant in their belief that the program should reflect private insurance in its cost-sharing policies. They believed that requiring participants to pay premiums and copayments would encourage them to value the program and help them "transition to private health insurance coverage." Although the Democrats and advocates could accept the proposal for copayments, they were against the imposition of premiums because they believed that premiums would hinder enrollment and retention. In the end, a compromise was reached which allowed for modest copayments for children in families earning over 133 percent FPL and premiums for children in families earning over 150 percent FPL.

POLICIES AND PROGRAM CHARACTERISTICS

As detailed in Table 7, Illinois requires cost sharing of KidCare Share and Premium enrollee, while participants in Assist do not have any cost-sharing requirements. Children in families earning between 150 and 185 percent of FPL in the Premium program pay a $15 monthly premium for one child, $25 for two, and $30 for three or more. Copayments are required of children in both the Share and Premium programs, but are tiered based on income level. Children in the Share program pay a $2 copayment for all services other than well-child visits, which are free. Children in the Premium program pay a $5 copayment for brand-name prescription drugs and for all services other than well-child visits, $3 for generic prescription drugs, and $25 for inappropriate use of the emergency room. In Illinois, the annual copayment maximum per family is $100. With or without premiums, state officials note this amount will not come close to the SCHIP cost-sharing limit of 5 percent of a family's income for even the families with the lowest

incomes. For example, if a family with an annual income as low as $12,372 per year has monthly premiums of $15 and monthly copayments of $100, this would equal 2.2 percent of annual income (Illinois State Evaluation, March 30, 2000). The KidCare program has no deductibles.

Once eligibility has been determined for the Premium program, families are required to submit payment on a monthly basis either by mailing it to the KidCare central processing unit within IDPA or by paying the premium over the phone using a credit card. Families are given a 60-day grace period in which to pay premiums. If the premium is still not paid after this period, the case is cancelled and the family must wait three months and pay unpaid premiums before coverage can begin again.

Collection of copayments is the responsibility of participating providers. Because the copayment amount is in addition to the fee paid to the provider, it acts as an additional bonus to the provider if he/she chooses to collect it. Based on our interviews, it seems that most clinics and independent physicians participating in the program do not collect the copayments because the additional administrative effort is not worth the monetary return and because they feel that the family could make better use of the money. The few managed care organizations participating in KidCare do not collect copayments as a marketing strategy, as they advertise this policy when encouraging families to sign up.

In the state-only funded Rebate program, families pay the copayment levels established in their employer-sponsored plan. The program provides subsidies for all or part of the premiums families pay for employer-sponsored insurance, up to a maximum of $75 a month per child. The amount of a families' premium contribution is determined by dividing the premium amount for dependent coverage by the number of family members covered to arrive at a per person premium amount. This per person premium amount is multiplied by the number of eligible children in the family up to a maximum of $75 per eligible child.

EXPERIENCES AND LESSONS LEARNED

The majority of KidCare enrollees fall into the Assist program and, consequently, do not have any premium or copayment requirements. In December 2001, 131,750

children were enrolled in Assist, compared to 7,420 children in Share and 8,887 children in Premium. The state-only funded Rebate program consisted of 5,754 in December 2001 (Illinois Department of Public Aid, December 2001).

The key informants we spoke with almost uniformly maintained that KidCare's cost-sharing levels did not cause barriers to enrollment and/or utilization of services. With very few providers even collecting the small copayments, interviewees universally agreed that copayments were not deterring families from seeking health care and that very few families even reached the SCHIP out-of-pocket maximum. State officials report that over the past year, only 6 families have met the annual $100 copayment limit. While most interviewees also believed that premiums were not an issue, one legislative staff member felt that premiums might be a problem for families with three or more children.

State officials report that approximately 200 families are disenrolled each month for non-payment of premiums, which is about 4 percent of the families enrolled in KidCare Premium at any one point in time. However, officials were unclear as to whether these families stopped paying premiums because they could not afford the payment, forgot to submit the application, or deliberately as a means of disenrollment—perhaps because they obtained private health insurance coverage. KidCare officials did not have data on how many of those disenrolled for failure to pay premiums re-enrolled after the three-month "black-out" period of ineligibility. However, they noted that there was controversy over the black-out period because some believed children were "unfairly punished" by being disenrolled from KidCare for their parents' failure to make payments. Nevertheless, there is little discussion to alter this policy because lawmakers and state officials generally believe that it is an important means of holding families accountable for premium payments and instilling a sense of responsibility.

IX. FAMILY COVERAGE AND PREMIUM ASSISTANCE PROGRAMS

As mentioned earlier, during the initial policy formation of KidCare, some members of the task force were concerned about the federal requirement that children must be uninsured to qualify for SCHIP. They believed that this requirement created an equity disparity for those families that met SCHIP's income eligibility, but were ineligible for coverage because they had "done the right thing" and purchased available coverage. Consequently, some task force members pushed for the establishment of the KidCare Rebate program, a program that subsidizes premiums for children with employer-sponsored insurance in families with incomes between 133 and 185 percent FPL. Although Illinois had the option of creating this premium assistance program as part of its SCHIP expansion, policymakers in Illinois viewed the federal regulations for such programs as administratively burdensome. Specifically, policymakers were averse to federal regulations that required children to be uninsured, and have access to employer-sponsored insurance that met specific benefit, cost-sharing, and employer contribution criteria. The Rebate program, in addition to addressing policymakers' equity concerns, also served to diminish apprehension about crowd out, as policymakers believed that subsidizing employer-sponsored insurance would help families maintain private coverage rather than dropping it to enroll in Medicaid or SCHIP.

The Illinois Rebate program provides subsidies for all or part of the premiums families pay for employer-sponsored insurance, up to a maximum of $75 a month per child. The KidCare application instructs families that already have health insurance, or access to insurance, to complete a separate one-page form for the Rebate program, which is included as the last page of the KidCare application. The instructions also note that "KidCare Rebate is not available to families with very low income, for example, under approximately $23,000 a year for a family of four" because those families are eligible for KidCare Assist (Medicaid). There is no minimum employer contribution requirement and no benefit benchmark. Key informants did not express concern about the lack of a benefit benchmark. However, the employer coverage must provide hospital and physician care. Premium assistance is provided directly to the family (rather than the employer). The state considered providing the subsidy to the employer, but decided that it would be too administratively burdensome for the employer and it would require the

state to monitor employers to make sure they disbursed the subsidy. In addition, it would be more "meaningful" for the family to receive the subsidy.

The Rebate program was implemented in October 1998 in conjunction with the KidCare Share and Premium programs. As of December 2001, there were 5,754 children enrolled in Rebate. Although enrollment in Rebate is modest compared to total KidCare enrollment (approximately 4 percent of KidCare enrollment, excluding pregnant women and infants), it is relatively sizeable compared to enrollment in the SCHIP-funded components of KidCare—with Share having about 7,420 children and Premium consisting of about 8,887 children. In addition, Rebate's enrollment is noteworthy compared to other states' premium assistance programs that are SCHIP funded and therefore required to have stricter eligibility criteria. For example, as of Fall 2001, Massachusetts had about 700 SCHIP-funded children in their premium assistance program and Wisconsin had only 47 families (Lutzky and Hill, forthcoming). Study participants spoke highly of the Rebate program and several felt that children in families below 133 percent of poverty should be allowed to enroll as well. As mentioned earlier, KCAAs noted that it was not uncommon for very low-income families to want subsidies for their private coverage, and were disappointed to find out that they were not eligible for Rebate but could enroll in KidCare Assist (Medicaid).

A unique feature of the Rebate program compared to premium assistance programs in other states, is that Illinois provides subsidies only for children's coverage and not for parents coverage. While some states subsidize the family premium and thereby incidentally cover parents, Illinois prorates the subsidy so that it is only directed to the children's portion of the family premium. The amount of a families' premium contribution is determined by dividing the premium amount for dependent coverage by the number of family members covered to arrive at a per person premium amount. This per person premium amount is multiplied by the number of eligible children in the family up to a maximum of $75 per eligible child.

Although there didn't seem to be any interest in extending the Rebate program to parents, there is a proposal to provide parental coverage through the Medicaid and SCHIP-funded KidCare programs. Currently, parents in Illinois are only covered at the Medically Needy Level (roughly 40 percent FPL). House Bill 23 was initiated with bi-

partisan support in March 2001 and proposed expanding KidCare eligibility to 200 percent FPL and extending coverage to the parents of children eligible for the Assist, Share, and Premium programs. It is expected that FamilyCare would provide health care services to about 80,000 low-income parents in Illinois who do not currently have coverage (Illinois Department of Public Aid, November 6, 2001). While the state submitted a waiver application for Family Care to CMS, the proposal is unlikely to prove successful in the general assembly due to the state's current budget shortfalls.

X. FINANCING

In fiscal year 1998, Illinois spent only 5 percent of its federal allotment because of slow building enrollment and the fact that the separate program expansion only began enrollment in August 1998. Although expenditures have increased with enrollment, the state still only spent 23 percent of its allotted funding for year 2000 (Kenney, et al, 2000). Details of Illinois' KidCare spending are provided in Table 8.

State officials expect that, with enrollment continuing to increase, a greater percentage of federal funding will be used. However, they were still not anticipating utilizing all of their federal allotment and believed that there was enough federal funding to expand the program to 200 percent of poverty and provide coverage to parents. Several of the legislative staff interviewed for this study believed that the Illinois' ability to generate state matching funds was questionable given the softening economy. The state's revenues were down by $416 million in the first quarter of FY 2002 and economic conditions are not expected to improve in the near future (Illinois Bureau of the Budget, Fiscal Year 2002, First Quarter).

KidCare received high praise from all interview respondents and is clearly a very politically popular program. Despite the state's uncertain economic outlook, interviewees did not believe there would be any "retrenchment" in KidCare, but speculated that the state might resort to delays in provider payments as a means to balance the budget, which could adversely affect access to health care services, as it did in the early 1990s. Following our site visit, the state responded to its fiscal problems by reducing well-child care provider payments from between $34 and $44.40 to between $33 and $43. At the time of this writing it is unclear whether, and to what extent, this payment reduction will affect provider participation.

XI. OVERARCHING LESSONS LEARNED

During its first year of implementation, KidCare came under a fair amount of criticism due to its limited enrollment of eligible children. Prompted by negative press, child advocacy groups, and a new governor who was interested in promoting the program, Illinois began to devote more resources to outreach and enacted a number of strategies to streamline the program's enrollment processes. While KidCare enrollment, as a result of program expansions and outreach initiatives, totaled 75,127 in December 1999, it more than doubled just two years later when enrollment reached over 174,000 children, infants, and pregnant mothers**.** Interview respondents were hopeful that if the state implements the new FamilyCare proposal, the enrollment rate of eligible children would increase even more dramatically.

Key informants interviewed for this study identified a number of overarching lessons that they had learned regarding designing and implementing a children's health insurance expansion. These lessons are summarized below.

- ***Compromise led to a "best of both worlds" situation with the creation of a Medicaid "look-alike" program***. Interview respondents were generally pleased with the final design of KidCare, believing that it combined the best aspects of both a Medicaid expansion and a new separate program. State and local officials and providers were particularly pleased with the decision to provide children in the Share and Premium programs with the Medicaid benefit package. Key informants also believed that using the same provider networks, claims processing systems, and rates as Medicaid, made the separate programs easier to administer. Alternatively, some of the Share and Premium characteristics that are divergent from Medicaid and more similar to private coverage have also been viewed as a positive change. Simplified enrollment processes, a more user-friendly and shortened application, and the ability to apply for KidCare through the mail are credited with helping to improve enrollment rates. Although cost sharing was initially feared to negatively impact enrollment and utilization, thus far, the Share and Premium programs do not seem to be adversely affected by copayment and premium requirements.

- ***Mass-media efforts have increased KidCare's name recognition and reduced the welfare stigma sometimes associated with public programs, but they need to be combined with community-based outreach efforts to increase enrollment.*** Illinois' broad-based media campaigns, which use radio, television, and print-media campaigns to raise the public's awareness of KidCare, were credited with improving the name recognition of the program, in addition to legitimizing the program and reducing the welfare stigma often associated with medical assistance programs. However, many study participants stressed the importance of community-based

outreach initiatives as a means of ensuring that interested families actually enroll their children. Local organizations were described as having the ability to tailor outreach activities to target venues with potentially eligible families, such as schools, churches, WIC sites, and grocery stores. In particular, key informants noted the effectiveness of outreach conducted at locations where low-income families typically receive their health care services such as FQHCs and local health department clinics. In areas with large immigrant communities, who may be distrustful of government programs, key informants believed that it is especially important for the outreach message to come from trusted sources within the community.

- ***Providing application assistance and payments for accepted applications has decreased the number of incomplete applications and improved enrollment.*** KidCare Application Agents, state-trained community-based individuals that provide families with assistance in completing the application, are credited as being very helpful in encouraging families to enroll in the program and accurately complete the application. With the establishment of a network of over 1,400 KCAA sites, the application approval rate increased from roughly 30 percent to 85 percent. The $50 technical assistance payment awarded to KCAAs for successful applications has provided a strong incentive for local outreach and more complete and accurate applications.

- ***School-based outreach and enrollment efforts, while considered effective in some areas of the state, have not been the silver bullet advocates initially anticipated.*** While the Chicago public school system finds it effective to release the contact information of potentially eligible students (identified through the school lunch application and cross-matched with KidCare enrollment files) to local KCAAs for follow-up, other types of school-based initiatives they have conducted have been disappointing. One respondent noted that "schools are where the children are, but they aren't where the parents are." Even at school events that targeted parents, families were not expecting to discuss their child's health coverage and not prepared to fill out a KidCare application. Efforts to involve administrators, teachers, and school nurses in KidCare outreach yielded disappointing results because the individuals already felt over-burdened with their day-to-day responsibilities. Moreover, several key informants noted that in some communities, schools are not a trusted resource and outreach is much more effective through other community-based organizations such as churches and health centers.

- ***Despite efforts to promote KidCare as a new and improved health care program, some families still associate KidCare Assist (Medicaid) with welfare and perceive the Share, Premium and Rebate programs as more desirable***. Although SCHIP has fostered many improvements that have permeated all the KidCare programs (both Medicaid and separate programs)—such as increased outreach efforts, the streamlined application and enrollment process, and improved provider payments—some families are "disappointed" to learn that they qualify for Assist rather than the other KidCare programs. Key informants believe that the perception of Assist as less desirable or welfare related is because the Assist cases are managed at local DHS offices while the

other programs' cases are managed at the Central Processing Unit. Some families who would not apply for other types of social services at their local DHS office apply for KidCare because they feel it is "different" and not welfare related. These families apparently feel "tricked" when their KidCare acceptance letter notifies them that their case is being managed at DHS. Some key informants felt that all medical assistance cases should be managed by the central processing unit in keeping with the idea that KidCare is a healthcare program and not welfare. However, others argued that it is important to maintain Assist's ties to local offices to increase the likelihood that they will be screened for other social services for which they may be eligible. In addition, Share and Premium participants receive a yellow KidCare enrollment card, while Assist participants receive a white card. Although the cards contain similar information, they do vary in color and logo—contributing to a sense among enrollees that the programs are different.

Despite the differences between the SCHIP and Medicaid-funded components of KidCare and the perception that Medicaid is less desirable, it is important to note that the majority of KidCare enrollees are in the Assist program (as of December 2001, 131,750 children were in Assist as a result of Medicaid expansions and KidCare outreach initiatives, compared to 7,420 in Share, 8,887 in Premium, and 5,754 in Rebate.) Interviewed KCAAs and DHS workers reported that despite applicants' disappointment regarding eligibility for Assist rather than Share, Premium, or Rebate, they were generally able to convince applicants that it was worth enrolling in Assist.

- ***The decision to extend the Medicaid benefit package to children enrolled in the separate KidCare Share and Premium programs was universally acknowledged as one of KidCare's key strengths.*** Providing virtually all the Medicaid benefits package to all KidCare enrollees is viewed uniformly as one of the most positive features of KidCare. The comprehensiveness of the benefit package helps to ensure that children receive an adequate array of services, but also serves as a draw for providers frustrated with the benefit limitations of private coverage. None of the key informants were concerned about the comprehensive benefit package being too costly.

- ***Illinois has found that access to KidCare services may be related to the amount and timeliness of provider payments.*** The improvement in access to services in recent years both before and after SCHIP implementation was attributed to the state's increase in provider payments and improved payment timeliness. At the time of our site visit, rates were seen as generally comparable with some private plans and the state's 30-day billing cycles were actually a draw for providers frustrated with delayed payments from commercial insurers. Similarly, Illinois has seen an increase in the size of its Medicaid/KidCare dental network reportedly due in part to accurate and timely claims processing. Doral Dental USA, the state's dental administrator for the adult Medicaid and KidCare programs, highlights its billing efficiency as a "selling point" to get dentists to participate in the program.

- ***Although a state-only funded program, premium assistance is believed to be an important component of KidCare.*** Illinois' premium assistance program, Rebate, received strong support from Republican policymakers during the initial debates regarding the design of KidCare. Concerned about the federal requirement that children need to be uninsured to qualify for SCHIP, policymakers felt that it was important to offer premium assistance to families that had "done the right thing" and purchased available coverage for their children. Although states may design premium assistance programs under Title XXI and receive federal matching funds, Illinois chose to develop a state-only funded program to avoid what it viewed as extremely burdensome federal requirements that children be uninsured to qualify and meet specific benefit, cost-sharing, and cost-effectiveness criteria. Many key informants believed that Rebate is an important component of KidCare because it provided much-needed assistance to families with private coverage or access to private coverage. In addition, they believed that Rebate was an important part of the state's strategy for deterring crowd out, as it offers families an appealing alternative to dropping or not taking advantage of available private coverage.

- ***Despite the state's uncertain economic outlook, interviewees did not believe there would be any "retrenchment" in KidCare.*** Key informants believed that given the popularity of KidCare, it was unlikely that the program would experience eligibility curtailment. However, in light of the state's uncertain economic outlook, a number of interviewees speculated that the state might resort to delays in provider payments as a means to balance the budget. Following our site visit, the state decided to reduce well-child provider payments due to fiscal problems. At the time of this writing it is unclear whether, and to what extent, this payment reduction will impact provider participation.

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APPENDIX A—KEY INFORMANTS

State SCHIP administrators

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Humana Health Plan
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Brett Bostrack
Dr. Fred Tye
Doral Dental
Mequon, Wisconsin

TABLE 1
SCHIP STATE PLAN AND AMENDMENTS

	Dates			
Document	Submitted	Approved	Effective	Description
Original Submission	12/31/97	4/1/98	1/1/98 (Medicaid expansion)	Expansion of insurance coverage for children through: 1) Expanding the Title XIX program with Title XXI funds to all children under age 19 in families with incomes less than or equal to 133% FPL. *At the same time, Illinois expanded the Title XIX program to pregnant women and their babies in families with incomes less than or equal to 200% FPL
Amendment 1	11/10/98	3/30/00	8/12/98	Expansion of insurance coverage for children through: 1) Expanding coverage through a separate program to children in families with incomes between 133% and 185% FPL.

SOURCE: Centers for Medicare & Medicaid Services (CMS), *Illinois Title XXI Program Fact Sheet.* CMS web site http://www.hcfa.gov/init/chpfsil.htm;

NOTES: SCHIP=State Children's Health Insurance Program. FPL=federal poverty level.

TABLE 2
SCHIP AND MEDICAID PROGRAMS

Program Name	Funding	Eligibility	Cost-Sharing	Cases Administered by
KidCare Assist Base	Title XIX	1997 Medicaid Eligibility	No	DHS
KidCare Moms and Babies	Title XIX	<200%FPL	No	DHS
KidCare Assist	Title XXI	1997 Medicaid – 133%FPL	No	DHS
KidCare Share	Title XXI	133-150% FPL	Yes	KidCare Unit
KidCare Premium	Title XXI	150-185% FPL	Yes	KidCare Unit
KidCare Rebate	State-only	133-185% FPL	ESI levels	KidCare Unit

SOURCE: Illinois Title XXI Program and Amendment Fact Sheet, CMS, updated November 2001. Available on the web at http://www.hcfa.gov/init/chpfsil.htm

NOTE: 1997 Medicaid eligibility is described in Table 3. SCHIP=State Children's Health Insurance Program (Title XXI); DHS = Illinois Department of Human Services; ESI = Employer-Sponsored Insurance

TABLE 3
MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS [a], EXPRESSED AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL

	Age (in Years)			
	Up to 1	1-5	6-14	15-18
Medicaid standards in effect 12/1/97	133%	Up to 133%	Up to 100%	Up to 46%[c]
SCHIP Medicaid expansion	200%[b]	NA	100-133%	46-133%
SCHIP separate child health program	NA	133-185%	133-185%	133-185%

SOURCES: Centers for Medicare & Medicaid Services (CMS), Illinois Title XXI Program Fact Sheet. CMS web site http://www.hcfa.gov/init/chpfsil.htm; Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000;

NOTES: SCHIP= State Children's Health Insurance Program (Title XXI). NA=Not applicable.
[a] Income standards are gross
[b] This expansion is not part of Illinois' Title XXI program
[c] An estimate of Illinois' medically needy standard

TABLE 4
SCHIP AND MEDICAID ELIGIBILITY POLICIES

Policy	SCHIP	Medicaid
Retroactive eligibility	Yes, services delivered within two weeks prior to the time the application was completed are covered.	Yes. Services received up to three months prior to the time the application was completed are covered.
Presumptive eligibility	No	No
Continuous eligibility	Yes, 12 months	Yes, 12 months
Asset test	No	No
U.S. citizenship requirement	Yes (or qualified alien)	Yes (or qualified alien)

SOURCE: Centers for Medicare & Medicaid Services (CMS), Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: Illinois November 2001 website: http://www.hcfa.gov/init/ileval98.pdf

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

TABLE 5
APPLICATION AND REDETERMINATION FORMS, REQUIREMENTS AND PROCEDURES

Characteristic	SCHIP	Medicaid
APPLICATION		
Form		
Joint form	Yes	Yes
Length	2 pages	2 pages
Languages	2 languages	2 languages
Verification Requirements		
Income	Yes	Yes
Deductions	Yes	Yes
Assets	No	No
State residency	No	No
Immigration status (residency papers or birth certificate)	Yes	Yes
Social security number	Yes	Yes
Enrollment Procedures		
Mail-in application	Yes	Yes
Phone application	Yes	Yes
Internet application	No (application is available on the internet)	No (application is available on the internet)
Hotline	Yes	Yes
Outstationing	No	No
Enrollment assistance	Yes	Yes
REDETERMINATION		
Same form as application	No	No
Pre-printed form	Yes	Yes
Mail-in redetermination	Yes	Yes
Income verification required	Yes	Yes
Other verification required	No	No

SOURCE: Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000; Centers for Medicare & Medicaid Services (CMS), *Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999:Illinois*. March 2000 website: http://www .hcfa.gov/init/ileval98.pdf

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI). NA=Not applicable.

TABLE 6
ENROLLMENT TRENDS

Enrollment Measure	1998	1999	2000	2001
Number ever enrolled in federal fiscal year (FFY)	27,780	42,699	62,507	83,510
Number enrolled at year end (point in time)	24,982	47,020	61,123	64,817[a]
Percent change in point-in-time enrollment		88%	30%	6%

SOURCES: Vernon K. Smith CHIP Program Enrollment: June 2000. Kaiser Commission on Medicaid and the Uninsured, January 2001. Available on the web at: Vernon K. Smith, *CHIP Program Enrollment: December 2000.* Kaiser Commission on Medicaid and the Uninsured, September 2001. Available on the web at: http://www.kff.org/content/2001/4005/4005.pdf
Centers for Medicare & Medicaid Services (CMS), *The State Children's Health Insurance Program Annual Enrollment Report for Federal Fiscal Year 2001* website*:* http://www.hcfa.gov/init/schip01.pdf

NOTES:
[a]*Framework for State Evaluation of Children's Health Insurance Plans, December 28, 2001* available on the web at: http://www.hcfa.gov/init/charil01.pdf

TABLE 7
COST-SHARING POLICIES

Policy	SCHIP
Enrollment fee	No
Premiums by Program	
KidCare Assist and Share	No
KidCare Premium	$15 monthly for one child, $25 for two, $30 for three or more
Consequences for non-payment of premiums	Yes
Disenrollment	Yes, after a 60-day grace period
Black-out period	Yes, for three months
Copayments by Program	
KidCare Assist	No
Kid Care Share	$2 co-payment for services other than well-child visits
Kid Care Premium	$5 for services other than well-child visits and brand-name drugs, $3 generic drugs and $25 fee for inappropriate use of emergency room
Deductibles	No

SOURCE: *Illinois Title XXI Program and Amendment Fact Sheet* available on the web at: http://www.hcfa.gov/init/chpfsil.htm

TABLE 8
SCHIP ALLOTMENTS AND EXPENDITURES, IN THOUSANDS, 1998-2001

FFY	Federal Allotment	Expenditures	Expenditures as Percentage of Allotment for the Year	Percentage of Year's Allotment Spent Within 3 Years	Redistributed Amount
1998	$122,529	$6,082	5%	44%	
1999	$121,950	$14,731	12.1%	72%	
2000	$137,481	$32,659	23.8%		
2001	$159,839	$40,760[a]	25.5%		0

SOURCE: Federal Register Notice, State Children's Health Insurance Program; Final Allotments to States for Fiscal Years 1998 and 1999. Volume 65 No 101. Federal Register Notice, State Children's Health Insurance Program; Final Allotments to States for Fiscal Year 2000. Volume 65 No 101. Federal Register Notice, State Children's Health Insurance Program; Final Allotment to States, Fiscal Year 2001. Volume 66, No 14. Kaiser Commission on Medicaid and the Uninsured, Trends in CHIP Expenditures: State-by State Data, October 1, 2001 available on the web at: http://www.kff.org/content/2001/4011/trendsinSCHIP.pdf

NOTES: [a]Based on projections for final two quarters
SCHIP=State Children's Health Insurance Program (Title XXI); FFY=federal fiscal year.