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Kidcare and the Uninsured Child: Options for an Illinois Health Insurance Plan

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Comment

Kidcare and the Uninsured Child: Options for an Illinois Health Insurance Plan

I. INTRODUCTION

"The health of a nation depends on the health of its people . . . . Human potential is being wasted needlessly as an increasing number of citizens find even routine preventive and primary care beyond their reach."[1]

Child advocates estimate that ten million children in America currently have no health insurance and that the majority of these children have parents who work.[2] These working parents earn too much to be eligible for Medicaid benefits, do not have employer-sponsored health coverage, and cannot afford to purchase private coverage for their children.[3] Although safety-net programs have been developed to meet some of the basic medical needs of America's poorest children,[4] little had been done to ensure medical care for the nation's "near poor" children until August of 1997.[5]

In a move paralleled only by the passage of the Medicaid Act in 1965,[6] President Clinton and congressional leaders made a significant

1. NATIONAL GOVERNORS' ASS'N, A HEALTHY AMERICA: THE CHALLENGE FOR STATES 4 (1991).

2. *See* CHILDREN'S DEFENSE FUND, 14 THINGS YOU SHOULD KNOW ABOUT THE NEW CHILD HEALTH PROGRAM 1 (Aug. 20, 1997). Between 1989 and 1995, health coverage for children decreased from approximately 73% to 66%. *See* Health, Educ. & Human Services Div., Gen. Accounting Office, No. 97-122, Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures 4 (1997). A recent study found that 89% of the children who lacked health insurance for one or more months in 1995 and 1996 lived in families where the head of the household worked all or part of the time during those two years. *See* FAMILIES USA FOUND., ONE OUT OF THREE: KIDS WITHOUT HEALTH INSURANCE 1995-1996 (Mar. 1997).

3. *See* CHILDREN'S DEFENSE FUND, *supra* note 2, at 1.

4. *See infra* notes 57-197 and accompanying text for a discussion on Medicaid. *See also infra* notes 198-212 and accompanying text for a discussion on other state-funded medical programs in Illinois.

5. *See id.*

6. *See* Edward M. Kennedy & Orrin Hatch, *Health Insurance for Every Child*, WASH. POST, August 20, 1997, at A25. "The recently signed Balanced Budget Act of 1997 contains the most significant health reform since the enactment of Medicare and Medicaid in 1965, representing one of the most far-reaching steps the country has ever taken to help the nation's children." *Id.*

social investment in the provision of health care services to children in the United States by signing the Balanced Budget Reconciliation Act of 1997 ("BBA") on August 5, 1997.[7] Under the BBA, forty-eight billion dollars from the federal government is guaranteed for the State Children's Health Insurance Program ("SCHIP").[8] This money will be distributed to the states over the next ten years to assist in subsidizing health care coverage for uninsured children of the working poor.[9] The result of bi-partisan efforts in Congress, this program seeks "to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children."[10]

The BBA serves as an opportunity to significantly reduce the number of uninsured poor and "near poor" children by permitting states to design and implement cost-effective health delivery systems to meet the essential health care needs of low-income children.[11] Under the BBA, states will have the options of expanding their existing Medicaid program, creating an entirely new and separate system of health care for uninsured children of low-income families, or providing health insurance through a combination of the two approaches.[12] Parents, health care providers, and child advocates must work with policy makers to ensure that each state meets the needs of its children.[13]

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7. Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, 111 Stat. 251 (to be codified at 42 U.S.C.A. § 1397).

8. *See* Balanced Budget Act of 1997, State Children's Health Insurance Program, Pub. L. No. 105-33, Title IV, § 4901 111 Stat. 251 (to be codified at 42 U.S.C.A. § 1397).

9. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 558 (to be codified at 42 U.S.C.A. § 1397dd(a)), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997).

10. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397aa(a)). Specifically, Senators Chafee (R-RI), Rockefeller (D-WV), Kennedy (D-MA) and Hatch (R-UT) were key players in the bi-partisan effort to advance this child health legislation through the Senate. *See* Abigail English, *Expanding Health Insurance for Children and Adolescents: Medicaid or Block Grants?*, YOUTH L. NEWS, Mar.-Apr. 1997, at 1.

11. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397aa).

12. *See id.*

13. *See* Marian Wright Edelman, *A Healthy Start for Millions More Children*, 18 CDF REP. (Children's Defense Fund, D.C.), Sept. 1997, at 3. In a letter thanking child advocates for their efforts in assisting with the passage of the State Children's Health Insurance Program of the BBA, Edelman rallied parents and advocates to remain involved in order to ensure accountability on the part of the states. *See id.*

This Comment will begin by briefly examining the status of poor children in America, describing the relationship between poor health and poor child development.[14] The Comment will then explore how the publicly funded health care delivery system currently operates at both the federal and state levels, paying particular attention to the current status of the Medicaid program in Illinois.[15] The Comment will then review various state-funded programs designed to meet the health care needs of children.[16] Next, the Comment will parse through the major provisions of the BBA relating to the new SCHIP and Medicaid expansions.[17] The Comment briefly will discuss Illinois' Governor Edgar's initial administrative response to the passage of the Balanced Budget Act.[18] After discussing the child health insurance provisions in the BBA, the Comment will explore the shortcomings in services provided by the current Illinois system of health care for children.[19] The Comment will examine the advantages and disadvantages of reforming child health care in Illinois through the implementation of a new plan as opposed to an expansion of Medicaid.[20] Finally, the Comment proposes that Illinois expand Medicaid to cover the state's uninsured children as an interim measure, recognizing the potential negative impact the changes could have upon the health of Illinois' poor children.[21]

II. BACKGROUND

A. The Current Health Status of Indigent and "Near Poor" Children

1. Nationally

Despite attempts by the federal government to provide children with health care coverage, studies estimate that ten million children, or one in seven, are currently without any type of health insurance.[22] The vast majority of these children are members of families where the working parent lacks employer-sponsored coverage, does not earn

14. *See infra* Part II.A.1-2.
15. *See infra* Part II.B-C.1.
16. *See infra* Part II.C.2.
17. *See infra* Part III.A.
18. *See infra* Part III.B.
19. *See infra* Part IV.A.
20. *See infra* Part IV.B.
21. *See infra* Part V.
22. *See* Stand for Children, *Our Children's Health* (visited June 3, 1997) <http://www.stand.org/vs97/docs/health.html>.

enough to purchase private health insurance, and yet earns too much to qualify for publicly funded medical assistance.[23] Seventy-seven percent of these children are Caucasian and sixty-one percent of them live in two-parent families.[24] Although Medicaid provides a system of care for truly indigent children, no health care system exists for those who are "near-poor."[25] In effect, these children have been squeezed out of systems of health care coverage because their parents cannot afford the associated costs.[26] Moreover, because of inefficiencies within the Medicaid system, particularly related to burdensome enrollment procedures, nearly twenty percent of income-eligible children are not enrolled in the Medicaid system and thus do not have access to adequate health care.[27]

Studies indicate that uninsured children are less likely than insured children to receive preventive health care, routine medical and dental care, immunizations, or treatment for injuries and chronic illnesses.[28] In fact, approximately two-fifths of children who were uninsured for more than one year did not see a doctor at all during 1996.[29] Furthermore, twenty percent of children who lack health coverage for a year or longer are missing all of their current immunizations.[30] In comparison, only twelve percent of insured children lack all of their current immunizations.[31] Lack of preventative and routine care can

23. *See id.*

24. *See id.*

25. *See* Michael D. Kogan et al., *The Effect of Gaps in Health Insurance on Continuity of a Regular Source of Care Among Preschool-aged Children in the United States*, 274 JAMA 1429, 1433 (1995). "The children of the working poor ($10,000 to $19,999 per year) were most likely to experience gaps [in insurance coverage] suggesting that there continues to be a group of vulnerable children that falls outside of the safety net provided by Medicaid." *Id.*

26. *See* HEALTH, EDUC. & HUMAN SERVICES DIV., U.S. GEN. ACCOUNTING OFFICE, NO. 96-129, HEALTH INSURANCE FOR CHILDREN—PRIVATE INSURANCE COVERAGE CONTINUES TO DETERIORATE 3 (1996). Since 1987, the percentage of children with private coverage has decreased at a steady rate. *See id.* at 8. In 1994, the percentage of children with private coverage reached its lowest level in nearly a decade with only 65.6% of children covered under a private insurance plan. *See id.* at 2.

27. *See* LAURA SUMMER ET AL., CTR. ON BUDGET AND POLICY PRIORITIES, MILLIONS OF UNINSURED AND UNDERINSURED CHILDREN ARE ELIGIBLE FOR MEDICAID 2 (1997).

28. *See* Ami Nagle & Gina DiRenzo Coffey, *New Federal Funds Available to Cover Uninsured Children: Options for Illinois*, Special Rep. (Voices for Illinois Children, Chicago, Ill.), Sept. 1997, at 7.

29. *See* RON POLLACK, ET AL., FAMILIES USA FOUND., UNMET NEEDS: THE LARGE DIFFERENCES IN HEALTH CARE BETWEEN UNINSURED AND INSURED CHILDREN 1 (1997). When long-term uninsured children do visit the doctor, they are twice as likely as insured children to make their visit in an emergency room. *See id.*

30. *See id.* at 4.

31. *See id.*

lead to subsequent severe health impairments.[32] Treating children who experience medical crises because they lacked the coverage necessary to treat an illness in its early stage is an expensive undertaking.[33] For each dollar that is spent on immunizations, up to sixteen dollars is saved in health care and other related costs.[34]

Furthermore, because good health is closely associated with the proper growth and development of a child,[35] children with untreated health problems are likely to be less productive learners in school.[36] Thus, a lack of continuous and adequate health care translates into less productivity in the classroom and greater absence from school.[37] Because children develop at an accelerated rate, the success of their cognitive, emotional, and physical growth and development in great part depends on their health status early in the developmental process.[38] Consequently, a child's quality of life can suffer if that child is not able to participate in developmentally appropriate physical, psychological, and social activities because of poor health.[39]

However, access to health care coverage alone does not assure appropriate child health care services.[40] New insurance benefits have little significance if providers do not participate in the provision of appropriate child health care or if children cannot readily access the services.[41] Having a source of payment is a significant factor in the

32. *See* Kogan et al., *supra* note 25, at 1429.

33. *See id.* at 1434. In fact, children with a regular source of health care had 25% lower medical costs than children who have no regular source of health care. *See id.* at 1430.

34. *See* Stand for Children, *supra* note 22.

35. *See* David A. Hamburg, *Children's Security and the Nation's Future, in* SECURITY FOR AMERICA'S CHILDREN 13, 13 (Paul N. Van de Water & Lisbeth B. Schorr eds., 1992).

36. *See* Stand for Children, *supra* note 22. For example, children with uncorrected vision impairments, who do not have glasses, may have trouble reading or seeing the blackboard. *See id.* Also, children experiencing pain or discomfort may have trouble concentrating in school. *See id.*

37. *See* CHILDREN'S DEFENSE FUND, *supra* note 2, at 2.

38. *See* Christopher B. Forrest et al., *Child Health Services Research: Challenges and Opportunities*, 277 JAMA 1787, 1788 (1997).

39. *See id.* Studies show that poor health does indeed have a disproportionate impact on a child's ability to participate in appropriate childhood activities. *See* Paul W. Newacheck et al., *The Effect on Children of Curtailing Medicaid Spending*, 274 JAMA 1468, 1469 (1995). Children from lower-income families are almost twice as likely as those from higher-income homes to be limited in school or recreational activities by chronic health problems. *See id.*

40. *See* Sarah S. Brown, *Health Care Reform: What's in It for Mothers and Children?, in* SECURITY FOR AMERICA'S CHILDREN 129, 132 (Paul N. Van de Water & Lisbeth B. Schorr eds., 1992).

41. *See* Lawrence D. Brown, *The Medically Uninsured: Problems, Policies, and Politics*, 15 J. HEALTH POL. POL'Y & L. 413, 418 (1990).

receipt of continuous care.[42] However, actually providing health insurance benefits that reflect the health care needs of children, including preventive and primary care, is the only way to assure the health of the nation's children.[43]

2. In Illinois

In Illinois, more than 300,000 children are not covered by any form of health insurance.[44] Two-thirds of these children come from families with income levels above the federal poverty line.[45] Experts predict that the numbers will grow as soon as the state begins complying with the welfare to work requirements of the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA").[46]

As of June 3, 1997, only four states had more uninsured children, in real numbers, than Illinois.[47] Illinois also has more uninsured

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42. *See* Brown, *supra* note 40, at 132.

43. *See id.* at 133.

44. *See* AMI NAGLE & SARAH ADKINS, VOICES FOR ILLINOIS CHILDREN, FALLING THROUGH THE GAP: UNINSURED CHILDREN IN ILLINOIS 1 (1997). The insurance status of Illinois children is as follows: 68% receive some sort of private coverage; 22% receive Medicaid benefits; and 10% are wholly without insurance. *See id.* Additionally, one in every three Illinois children (30%) lacked health insurance coverage for at least one month in both 1995 and 1996. *See One in Three Children in Illinois Lacks Health Insurance*, CAMPAIGN FOR BETTER HEALTH CARE (Campaign for Better Health Care, Chicago, Ill.), Summer 1997, at 10.

45. *See* Nagle & Coffey, *supra* note 28, at 1. In fact, nearly 20% of Illinois children whose parents earn income between 100-185% of the poverty level are uninsured. *See* NAGLE & ADKINS, *supra* note 44, at 1. Fifty-nine percent of uninsured children in Illinois live in two-parent households; 43% of them are Caucasian, and 56% of them live in suburban or rural areas. *See id.* at 1-2. Black children in Illinois account for 28% of uninsured children, while Latino children account for 26% of uninsured children in the state. *See id.* at 2.

46. *See* Terry H. Burns, *Uninsured Children Called Health Crisis for Illinois: Advocacy Groups Says Welfare-To-Work Push by State May Make Problem Worse*, PEORIA J. STAR, Apr. 16, 1997, at A8, *available in* 1997 WL 7659917. Although children who continue to meet income eligibility standards for medical assistance are entitled to receive medical assistance under the PRWORA, child advocates and public benefits specialists fear that removing families from the cash-assistance welfare rolls will result in the termination of medical benefits. *See* SUMMER ET AL., *supra* note 27, at 3 (explaining that children in families dropped from the cash-assistance program are less likely to enroll in Medicaid). The United States Census Bureau confirmed this fear by releasing data showing that some states, already dropping families from welfare, appear to be removing low-income children from Medicaid, even though some of them may still be eligible. *See* Ctr. on Budget and Policy Priorities, *Poverty Rate Fails to Decline as Income Growth in 1996 Favors the Affluent: Child Health Coverage Erodes As Medicaid for Children Contracts*, NEWS RELEASE (Ctr. on Budget and Policy Priorities, D.C.), Oct. 1997, at 3-5 (reporting on the Census Bureau data).

47. *See* Children's Defense Fund, *Child Health Coverage: Ten Best States, Ten Worst States* (last modified Jan. 21, 1998) <http://www.childrensdefense.org/insurememo3.html>. Although Illinois has the fifth highest number of actual uninsured children,

children than any of its Midwestern neighbors.[48] In addition, Illinois is one of only three states that has failed to create a health insurance program to help meet the needs of the "near-poor" uninsured children.[49] Historically, despite attempts to meet the health care needs of both children and adolescents, the reality is that the state provides only sub-standard preventive care.[50]

B. Medicaid and the Coverage of Children Prior to the Balanced Budget Reconciliation Act of 1997

In discussing the Federal Medicaid Statute, this comment details the eligibility standards,[51] the benefits provided,[52] enrollment processes,[53] cost-sharing provisions,[54] the manner in which services are provided,[55] and the costs to the government in administering the program.[56]

1. Federal Requirements of Medicaid

Medicaid, an individual entitlement program,[57] provides health care

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other states may have a higher percentage of uninsured children. *See id.* The ten states with the highest percentages of uninsured children are: New Mexico, Texas, Oklahoma, Arizona, Louisiana, Arkansas, Nevada, California, Mississippi, and Florida. *See id.* These percentages range from almost 25% in New Mexico to 17% in Florida, and just over 10% in Illinois. *See id.*

48. *See id.* Four Midwestern states made the top ten list of states with the lowest percentages of uninsured children. *See id.* Under 7% of children in Minnesota and Wisconsin are uninsured. *See id.* Michigan has just over 8% uninsured children, whereas Ohio has just over 9%. *See id.*

49. *See* Nagle & Coffey, *supra* note 28, at 1. Illinois, Alaska, and Wyoming are the only states that have not created a health insurance program designed to meet the needs of "near-poor" children. *See id.*

50. *See* JAMES KROHE, JR., FIXING KIDS: ILLINOIS' PROGRAMS FOR CHILDREN 9 (Illinois Tax Foundation 1993).

> Illinois . . . has . . . a[n] individualistic "political culture in which children's services are funded to the extent that their proponents can prevail over competing interests . . . . [C]ountered by a strong reformist streak, . . .[t]hese social philosophies have been in tension for decades, with political interventionists of the latter camp devoting themselves to getting programs approved and political minimalists of the former devoting themselves with equal vigor to keeping them from working . . . . This muddled sense of priority has been characteristic of Illinois children's programs for a century."

Id.

51. *See infra* Part II.B.1.a.

52. *See infra* Part II.B.1.b.

53. *See infra* Part II.B.1.c.

54. *See infra* Part II.B.1.d.

55. *See infra* Part II.B.1.e.

56. *See infra* Part II.B.1.f.

57. An entitlement program is one in which benefits are guaranteed for those who

coverage to low income families, including children and pregnant women, and certain categories of aged and disabled persons.[58] Modeled on the traditional fee-for-service delivery system,[59] the Medicaid program was created to provide poor Americans with access to a range of mainstream medical services.[60] Enacted in 1965, the program is jointly funded by the federal and state governments and is administered by a "single state agency."[61] The state agency is

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meet the eligibility requirements. *See* Kerry Martin & Sunny Kim Dubois, *An Overview of Medicaid, in* MEDICAID MANAGED CARE: AN ADVOCATE'S GUIDE FOR PROTECTING CHILDREN 1-11, n.26 (1996). Thus, there is no risk of funds being used up before all those who are eligible get the services they need. *See id.*

58. *See* 42 U.S.C. § 1396 (1994); 42 C.F.R. §§ 430-456 (1996). The Medicaid program is neither a cash-assistance program nor a direct provider of health-care services to eligible beneficiaries. *See* 42 C.F.R. § 430.0. Instead, Medicaid is a vendor payment system that reimburses health-care providers who choose to participate in the program. *See id.*

59. Under a fee-for-services delivery model, a health care provider charges and receives a fee for each service rendered. *See* Lewis D. Solomon & Tricia Asaro, *Community-Based Health Care: A Legal and Policy Analysis*, 24 FORDHAM URB. L.J. 235, 240 (1997). In comparison to a risk-based managed care delivery system, fee-for-services delivery systems do not assume financial risks for the cost of services delivered. *See id.* This model results in a lack of incentives to deliver services in a cost-effective manner. *See id.*

60. *See* Colleen A. Foley, *The Doctor Will See You Now: Medicaid Managed Care and Indigent Children*, 21 SETON HALL LEGIS. J. 93-4 (1997). Prior to the enactment of the Medicaid statute, the poor had little choice but to rely on a loosely constructed safety net of charity care, public hospitals, and clinic services. *See* Martin & Dubois, *supra* note 57, at 1-1.

The Medicaid Act sets forth its intent:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children . . . whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capacity for independence or self-care . . . .

Grants to States For Medical Assistance Programs, 42 U.S.C. § 1396.

61. *See* 42 U.S.C.A. § 1396a(a)(5) (West 1992 & West Supp. 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4454, 4700-02, 4711-12, 4714-15, 4724, 4731-33, 4741, 4751-53, 4911-13, 111 Stat. 368, 431, 493, 495, 506-10, 516-17, 519-20, 522-25, 571, 573; 42 C.F.R. § 431.10(a), (b)(1). At the federal level, the Medicaid program is administered by the Health Care Financing Administration (HCFA), an agency of the United States Department of Health and Human Services (HHS). *See* JANE PERKINS, ET AL., NAT'L HEALTH LAW PROGRAM, AN ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM, 2.1 (1993). The HCFA promulgates regulations that interpret the Medicaid Act and govern the administration of the program at the state level. *See id.* The HCFA also publishes the *State Medicaid Manual* which sets forth guidelines for the states to follow in implementing the regulations and the act. *See id.* In Illinois, the state agency that administers the medical assistance program is the Department of Public Aid. *See* 305 ILL. COMP. STAT. ANN. 5/5-5 (West 1993 & West Supp. 1997), *amended by* Act of June 10, 1997, P.A. No. 90-7, § 45, 1997 Ill. Legis.

responsible for the administration of the state plan that specifies the persons eligible for coverage, the benefits offered, and payment methodologies.[62] State plans must comply with federal standards as set forth in section 1902(a) of the Social Security Act.[63]

Although the Medicaid program has been somewhat successful in achieving its goal of providing health care services to the poor, the concept of "cooperative federalism"[64] has created administrative and financial burdens at each level of government.[65] The Medicaid program, although designed, implemented, and administered by the states, must comply with federal standards.[66] Because of the varied success of the several state Medicaid programs, this state-federal arrangement begs the question of which level of government is better equipped to administer the program.[67]

The federal government sets minimum standards[68] related to eligibility,[69] benefits,[70] procedural safeguards,[71] provider participation,

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Serv. 173-80 (West).

62. *See* LARRY S. GAGE & WILLIAM H.E. VON OEHSEN, MANAGED CARE MANUAL: MEDICAID, MEDICARE AND STATE HEALTH REFORM, 2.1 (1996-97 ed.).

63. *See* 42 U.S.C.A. § 1396a(a).

64. *See* Foley, *supra* note 60, at 97-98. The term "cooperative federalism" describes programs that are "designed, implemented and administered by individual states using federal funds and following federal guidelines." *Id.* For a discussion of the concept of cooperative federalism, see Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855 (1990); Fernando R. Laguarda, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 GEO. L.J. 159, (1993); and Thomas R. Oliver & Pamela Paul-Shaheen, *Translating Ideas into Actions: Entrepreneurial Leadership in State Health Care Reforms*, 22 J. HEALTH POL. POL'Y & L. 721, 722-25 (1997).

65. *See* Herweg v. Ray, 455 U.S. 265, 279 (1982) (Burger, C.J., dissenting) (referring to the Medicaid Act as "a morass of bureaucratic complexity"). *See also* Feld v. Berger, 424 F. Supp. 1356, 1357 (S.D.N.Y. 1976) (describing the Medicaid case before the court as "involv[ing] three governmental agencies—federal, state and city—and centers about regulations so drawn that they have created a Serbonian bog from which the agencies seemingly are unable to extricate themselves . . . 'a confusing state of flux'. . . . It is a mess.").

66. *See* Foley, *supra* note 60, at 98. For examples of federal standards that states must meet see *infra* notes 70-75 and accompanying text.

67. *See* Kinney, *supra* note 64, at 857-58.

68. *See* 42 U.S.C.A. § 1396a(a) (describing the requirements that a state must meet to receive federal approval of the state's medical assistance plan).

69. *See infra* notes 79-94 and accompanying text.

70. *See infra* notes 95-112 and accompanying text.

71. *See* 42 U.S.C.A. § 1396a(a)(3) (requiring that states must "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness"); *see also id.* §1396a(a)(7) (requiring states to "provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan").

and provider reimbursement.[72] The Medicaid Act also suggests optional provisions that states can choose to adopt when implementing their respective Medicaid programs.[73] Therefore, similar to other welfare programs, states have the option to expand their programs beyond the minimum required federal standards.[74] The federal government provides the states with a substantial matching rate, the federal matching assistance percentage ("FMAP"),[75] for medical assistance program expenditures made by the states.[76] The FMAP rate ranges from 50% to 83% reimbursement, and is determined annually[77] through a formula based primarily on state per capita income.[78]

2. Eligibility Standards

Medicaid's original design was to provide medical assistance to poor families receiving cash assistance through programs such as Aid to Families with Dependent Children ("AFDC") and Supplemental Security Income ("SSI").[79] Beginning in the 1980s, however, Congress enacted a series of laws that had the effect of "de-linking"

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72. *See id.* § 1396a(a)(30)(A) (requiring states to implement procedures that foster participation).

73. For example, when determining eligibility for Medicaid benefits, states may choose to provide Medicaid coverage to individuals who are referred to as the "optional categorically needy," *see id.* § 1396a(a)(10)(A)(ii); 42 C.F.R. § 435.200-435.236, or to those referred to as the "medically needy," *see* 42 U.S.C.A. § 1396a(a)(10)(C); 42 C.F.R. § 435.300-435.350.

74. *See* Martin & Dubois, *supra* note 57, at 1-5.

75. FMAP is the percentage of federal dollars contributed to the states' total amount of Medicaid expenditures. *See* Martin & Dubois, *supra* note 57, at 1-4.

76. *See* 42 U.S.C.A. § 1396b(a) (West 1992 & West Supp. 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4701-03, 4705, 4707-08, 4712, 4722, 4724, 4742, 4753, 4802, 4912, 111 Stat. 493-95, 498, 500-01, 505-06, 509, 514-16, 523, 525, 573, *and* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997); *id.* § 1396d(b) (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4702, 4711-12, 4714, 4725, 4732, 4802, 4911, 111 Stat. 494, 508-10, 518, 520, 538, 570, *and* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997).

77. *See id.* § 1301(a)(8)(B) (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 570.

78. *See id.* § 1301(a)(8). Thus, poorer states have a higher matching percentage rate than states with a higher per capita income level. *See id.* §§ 1396b(a), 1396d(b)(1994); Martin & Dubois, *supra* note 57, at 1-5.

79. *See* PERKINS ET AL., *supra* note 61, at 1.1. AFDC (now Temporary Assistance for Needy Families, *see infra* note 153) is the cash-assistance public benefits program most commonly associated with "welfare" and is generally available to single women with children. *See id.* at 3.1. SSI is the cash-assistance program for poor, disabled, or elderly persons. *See id.* at 3.3.

Medicaid eligibility from eligibility for cash-assistance programs, and thus expanding Medicaid's role as a health-care safety net.[80] Based on federal poverty guidelines, rather than on receipt of cash assistance, these acts provide eligibility standards for particular categories of pregnant women and children.[81] While some congressional actions mandated new eligibility requirements,[82] others merely permitted states to expand coverage to include new categories of eligible persons.[83]

Beginning in 1984, Congress effectively severed children's Medicaid eligibility from AFDC eligibility.[84] As a result, states are required to extend Medicaid coverage to pregnant women and children

80. *See* Martin & Dubois, *supra* note 57, at 1-10 to 1-11, 1-13. For the names and citations of some of these acts, see *infra* notes 82-83.

81. *See* Martin & Dubois, *supra* note 57, at 1-13 For the names and citations of some of these acts, see *infra* notes 82-83.

82. *See generally* DEBORAH CHANG & JOHN HOLAHAN, URBAN INST. REPORT NO. 90-2, MEDICAID SPENDING IN THE 1980's: THE ACCESS-COST CONTAINMENT TRADE-OFF REVISITED, 22, 24 (1990). *See also* Martin & Dubois, *supra* note 57, at 1-14. The Deficit Reduction Act of 1984, 42 U.S.C.A. § 1396a(a)(10)(A) (amended 1997), required states to cover women who were pregnant for the first time, two-parent families where the principal wage earner is unemployed, and all children up to age five born after September 30, 1983. The Omnibus Budget Reconciliation Act of 1986, 42 U.S.C.A. § 1396a(a)(10)(A)(ii)(IX) (amended 1997), required states to expand Medicaid income eligibility thresholds above AFDC levels up to the federal poverty level for pregnant women and infants. The Medicare Catastrophic Coverage Act of 1988, 42 U.S.C.A. § 1396a(a)(1), (a)(10) (amended 1997), mandated minimum coverage of pregnant women and infants at the federal poverty level. The Omnibus Budget Reconciliation Act of 1989, 42 U.S.C.A. § 1396a(a)(10)(A) (amended 1997), superseded Medicare Catastrophic Coverage Act's mandate by requiring states to cover pregnant women and children up to age six at 133% of the federal poverty level. The Omnibus Budget Reconciliation Act of 1990, 42 U.S.C.A. § 1396a(a)(10)(A), (e) (amended 1997), required states to begin to phase in coverage of children born after September 30, 1983, until all children living below the federal poverty level up to age nineteen are covered.

83. *See generally* CHANG & HOLAHAN, *supra* note 82, at 24; *see also* Martin & Dubois, *supra* note 57, at 1-14 to 1-15. The Omnibus Budget Reconciliation Act of 1986, gave the states the option of phasing in coverage for poor children up to age five up to the federal poverty level. The Omnibus Budget Reconciliation Act of 1987, 42 U.S.C.A. § 1396r (amended 1997), allowed states to raise Medicaid income thresholds for pregnant women and infants as high as 185% of the federal poverty level and added § 1902r(2) (codified at 29 U.S.C.A. § 49b (West 1992 & West Supp. 1997)) to the Social Security Act, allowing states to use more liberal criteria for Medicaid than is used for the AFDC program to determine Medicaid financial eligibility. States can now disregard specific amounts of income and other resources and allow certain categories of eligible populations to qualify for Medicaid. *See id.* The Omnibus Budget Reconciliation Act of 1989 § 6401, 42 U.S.C.A. §§ 1396r-7 (amended 1997), 1396a(a)(10)(A)(i)(V), (VI), (*l*)(1)(A)-(C), (2)(A)(B) (amended 1997)), allowed states to elect to expand eligibility above the required 133% of the federal poverty level to 185% of the federal poverty level for pregnant women and children under age six.

84. *See* Sara Rosenbaum, *Children in Heavy Traffic: Health Status, Health Policy, and Prospects for Reform*, 4 HEALTH MATRIX 129, 145-46 (1994); *see also supra* note 79 discussing the AFDC program.

under the age of six as long as their family income does not exceed 133% of the federal poverty level.[85] States can elect to expand coverage to pregnant women and infants whose family incomes are as high as 185% of the federal poverty level.[86] Poor children between the ages of six and eighteen, living below the poverty level are gradually being phased into Medicaid coverage so that all poor children under the age of nineteen will be covered by Medicaid by the year 2002.[87] The states' use of the optional expansions for pregnant women and children has varied considerably, but most states expand coverage above the mandated 133% of the federal poverty line.[88]

Notwithstanding new income eligibility standards, individuals are not automatically eligible for Medicaid solely based on their low-income status.[89] Rather, eligibility is determined by an individual's status as part of a defined group, which is generally limited to pregnant women, children and their relative caretakers, the aged, the blind, and the disabled.[90] As described above, eligibility for medical assistance occurs if an individual falls within one or more of the following three distinct and federally defined categories:[91] (1) the mandatory categorically needy;[92] (2) the optional categorically needy;[93] and (3) the

85. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2106, 2258) (codified as amended at 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VI); 1396a(*l*)(1)(A)-(C), (2)(B) (West 1992 & West Supp. 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4454, 4700-02, 4711-12, 4714-15, 4724, 4731-33, 4741, 4751-53, 4911-13, 111 Stat. 368, 431, 493, 495, 506-10, 516-17, 519-20, 522-25, 571, 573). For determining eligibility, a pregnant woman is treated as a family of two persons. *See* 42 C.F.R. § 435.116(a)(3).

86. *See* 42 U.S.C.A. § 1396a(a)(10)(A)(ii)(IX), (*l*)(1)(A)-(B), (2)(A)(i).

87. *See id.* § 1396a(*l*)(1)(D), (2)(C).

88. *See* Div. of Health Policy Research, Am. Academy of Pediatrics, State Children's Health Insurance Program (SCHIP): Current Medicaid Eligibility and Maximum State Children's Health Insurance (SCHIP) Eligibility By State and Age 1-4 (1997) (on file with American Academy of Pediatrics, Elk Grove Village, Ill). Illinois, one of only 16 states, has not expanded coverage for pregnant women and infants above the mandated 133% of the federal poverty level. *See id.*

89. *See* Martin & Dubois, *supra* note 57, at 1-11. In other words, not all poor people are covered by Medicaid, and not all persons who receive Medicaid benefits are poor (living below the poverty line). *See id.*

90. *See id.*

91. *See id* at 1.11-1.13. These categories include those for whom states are required to provide health insurance and those whom the states have the option to cover. *See id.*

92. *See* 42 U.S.C.A. § 1396a(a)(10)(A)(i); 42 C.F.R. § 435.100-.170. States are required by federal law to provide medical assistance to the mandatory categorically needy. *See id.* This category of Medicaid-eligible persons includes, generally: families and children, the aged, blind and disabled. *See id.*

93. *See* 42 U.S.C.A. § 1396a(a)(10)(A)(ii); 42 C.F.R. § 435.200-.236. States' coverage of the optional categorically needy is elective. *See* 42 U.S.C.A. §

optional medically needy.[94]

3. Medical Benefits

Federal law requires a state to subsidize a number of services for the mandatory categorically needy and the optional categorically needy if the state elects to extend benefits to the latter.[95] These two categories, one mandatory and one optional, include both children under the age of six, living at or below 133% of the federal poverty line, and infants[96] living at 185% of the poverty line or below.[97] Services most significantly affecting children that must be provided to Medicaid beneficiaries include the following:[98] inpatient hospital services;[99] outpatient hospital services;[100] rural and federally qualified health center services;[101] lab and X-ray services;[102] early and periodic screening, diagnostic and treatments services ("EPSDT") for children

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1396a(a)(10)(A)(ii); 42 C.F.R. § 435.200-.236. If a state elects to provide Medicaid to an optional group, that state must then provide Medicaid to all eligible individuals in that group. *See* 42 U.S.C.A. § 1396a(a)(10)(B)(i); 42 C.F.R. § 435.201(a)(6)(b). In general, these individuals include people who meet AFDC or SSI financial requirements but fail to satisfy other eligibility requirements. *See* PERKINS ET AL., *supra* note 61, at 3.5-3.7.

94. *See* 42 U.S.C.A. § 1396a(a)(10)(C); 42 C.F.R. § 435.300-.350. States have the option of covering the medically needy groups. *See* 42 U.S.C.A. § 1396a(a)(10)(C); 42 C.F.R. § 435.300-.350. The medically needy category includes persons who fit into federal benefit program categories, (e.g., single women with children) whose income and resources exceed the established categorically needy levels, but are insufficient to meet medical costs. *See* PERKINS ET AL., *supra* note 61, at 3.7-3.9.

95. *See* 42 U.S.C.A. § 1396d(a)(1)-(5) (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4702, 4711-12, 4714, 4725, 4732, 4802, 4911, 111 Stat. 494, 508-10-518, 520, 538, 570, *and* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997). Although the state is not required to provide medical benefits to the optional categorically needy, if it elects to do so, that group is entitled to the same benefits that the mandatory categorically needy are required to receive. *See id.*

96. Infants are children under one year of age. *See* 42 U.S.C.A. § 1396a(*l*)(1)(B).

97. *See* 42 U.S.C.A. § 1396a(a)(10)(A)(i). *See also supra* notes 85-86 and accompanying text.

98. *See* 42 U.S.C.A. § 1396d(a). Other services include: nursing facility services for individuals over the age of 21, *see* 42 U.S.C.A. § 1396d(a)(4)(A); 42 C.F.R. § 440.40; family planning services and supplies, *see* 42 U.S.C.A. § 1396d(a)(4)(C); 42 C.F.R. § 441.20; nurse-midwife services, *see* 42 U.S.C.A. § 1396d(a)(17); 42 C.F.R. § 440.165, .210, 441.21; home health services, *see* 42 U.S.C.A. § 1396a(a)(7); 42 C.F.R. § 440.70, 441.15; and pediatric nurse practitioner or certified family nurse practitioner services, *see* 42 U.S.C.A. § 1396d(a)(21).

99. *See* 42 U.S.C.A. § 1396d(a)(1); 42 C.F.R. § 440.10(a).

100. *See* 42 U.S.C.A. § 1396d(a)(2)(A); 42 C.F.R. § 440.20(a).

101. *See* 42 U.S.C.A. § 1396d(a)(2)(B), (C), (*l*); 42 C.F.R. § 440.20(b), (c).

102. *See* 42 U.S.C.A. § 1396d(a)(3); 42 C.F.R. § 440.30.

under twenty-one years of age;[103] and physician services.[104] In addition to these mandatory services, states have a good deal of flexibility in determining whether to provide additional optional services.[105] Of these optional benefits, the following are most useful to children: clinic services;[106] dental services;[107] prescription drugs and eyeglasses;[108] case management;[109] and other diagnostic, screening, and preventive services.[110] If a state program elects to provide assistance to the medically needy, at a minimum, the state must provide prenatal care and delivery services for pregnant women[111] and ambulatory services for children under the age of nineteen.[112]

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103. *See* 42 U.S.C.A. § 1396d(a)(4)(B); 42 C.F.R. § 440.130. EPSDT services act almost as a "program within a program" and are important for children because these services were specifically designed to promote child health by ensuring access to coordinated well-child and sick-child health care. *See* Martin & Dubois, *supra* note 57, at 1-8. EPSDT provides initial and periodic medical, vision, hearing, and dental screenings to children up to age 21 who are enrolled in the Medicaid program. *See* 42 U.S.C.A. § 1396d(a)(4)(B). Case management services are available to assist the beneficiaries with scheduling appointments and arranging transportation. *See* Martin & Dubois, *supra* note 57, at 1-9. Also, other mandatory EPSDT services include all medically necessary services needed to treat conditions identified during a screening, interperiodic screenings when a child is suspected to have a health problem, follow-up vision and hearing care, and restorative and emergency dental care. *See* 42 U.S.C.A. §1396d(r). Despite the fact that EPSDT services are federally mandated for Medicaid recipients through the age of twenty, EPSDT expenditures for fiscal year 1995 represented less than one percent of total Medicaid expenditures. *See* Health Care Fin. Admin., *Medicaid Vendor Payments by Type of Service* tbl. 5 (last modified Jan. 21, 1998) <http://www.hcfa.gov/medicaid/2082-5.htm>.

104. *See* 42 U.S.C.A. § 1396d(a)(5)(A); 42 C.F.R. § 440.50.

105. *See* 42 U.S.C.A. § 1396d(a)(6)-(24). 42 C.F.R. § 440.225.

106. *See* 42 U.S.C.A. § 1396d(a)(9); 42 C.F.R. § 440.90.

107. *See* 42 U.S.C.A. § 1396d(a)(10); 42 C.F.R. § 440.100.

108. *See* 42 U.S.C.A. §§ 1396d(a)(12), 1396r-8(g); 42 C.F.R. § 440.120.

109. *See* 42 U.S.C.A. § 1396d(a)(19). Case management services under this section differ from mandatory case management services under EPSDT. *See id.* § 1396d(a)(4)(B). Here case management services are those "services which will assist individuals eligible under the plan in gaining access to needed medical, social, education and other services." *Id.* § 1396n(g)(2) (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4743, 111 Stat. 368, 524.

110. *See id.* § 1396d(a)(13); 42 C.F.R. § 440.130.

111. *See* 42 U.S.C.A. § 1396a(a)(10)(C)(iii)(II) (West 1992 & West Supp. 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4454, 4700-02, 4711-12, 4714-15, 4724, 4731-33, 4741, 4751-53, 4911-13, 111 Stat. 368, 431, 493, 495, 506-10, 516-17, 519, 520, 522-25, 571, 573; 42 C.F.R. § 440.220(a)(1).

112. *See* 42 U.S.C.A. § 1396a(a)(10)(C)(iii)(I); 42 C.F.R. § 440.220(a)(2)(i). According to a House-Senate conference report, Congress intended ambulatory services to include physician services, clinic services, nurse practitioner services, dental

4. Enrollment in Medicaid

Medical assistance applicants are to be afforded due process,[113] with the Medicaid Act requiring that eligibility for participation be determined with "reasonable promptness."[114] Although most applicants generally apply for Medicaid benefits at the local state welfare agency, the federal government requires that states allow pregnant women and children to use short-form applications that are processed at federally designated locations.[115] States are often criticized for the level of difficulty and inconvenience involved in the Medicaid application process.[116] The substantial burden of the application process and the lack of parents' knowledge concerning their potential eligibility serve as the primary reasons for underenrollment of children in the Medicaid program.[117]

5. Cost-Sharing Requirements

States may impose cost-sharing arrangements on Medicaid beneficiaries in the form of co-payments.[118] Children under eighteen

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services and preventive services. *See* H.R. REP. NO. 97-208, *reprinted in* 1981 U.S.C.C.A.N. 1010, 1333.

113. *See* Atkins v. Parker, 472 U.S. 115, 128 n.31 (1985) (holding that Medicaid benefits are a protected property interest requiring due process protections). Thus, improper denials of benefits by new applicants, co-payment requirements, and reduction in services are violations of due process. *See* Martin & Dubois, *supra* note 57, at 1-15 to 1-6.

114. *See* 42 U.S.C.A. §1396a(a)(8); *see also* Smith v. Miller, 665 F. 2d 172, 178 (7th Cir. 1981) (finding that the district court did not abuse its discretion in granting automatic approval of benefits after determining that the Illinois Department of Aid failed to act promptly). Reasonable promptness has been interpreted to mean that applications for medical assistance must be processed within 90 days for disability determinations, and within 45 days for all other cases. *See* 42 C.F.R. § 435.911(a)(1), (2).

115. *See* 42 U.S.C.A. §1396a(a)(55). The processing of Medicaid applications off-site is known as "outstationing." *See* PERKINS ET AL., *supra* note 61, at 2.2. Designated "outstations" include disproportionate share hospitals, and federally qualified health centers. *See* 42 U.S.C.A. § 1396a(a)(55)(A). In House Report No. 101-881, the committee expressed concern that, "unless poor women and children are able to apply for Medicaid in locations other than welfare offices, many of them will be deterred from obtaining the health care coverage they need in order to receive preventive health services." H.R. REP. NO. 101-881, at 104 (1990), *reprinted in* 1990 U.S.C.C.A.N. 772, 2116.

116. *See* HEALTH, EDUC. & HUMAN SERVICES DIV., U.S. GEN. ACCOUNTING OFFICE, NO. 95-175, HEALTH INSURANCE FOR CHILDREN—MANY REMAIN UNINSURED DESPITE MEDICAID EXPANSIONS 4 (1995), *available in* WESTLAW, File No. 516305.

117. *See id.*

118. *See* 42 U.S.C.A. § 1396*o*(a), (b) (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4743, 111 Stat. 368, 524; 42 C.F.R. § 447.51(b). Co-payments, along with deductibles, premiums, and

years of age are excluded from the co-payment requirements.[119] These co-payments are permitted only if nominal in amount,[120] and a Medicaid-participating health care provider cannot deny care to a Medicaid beneficiary unable to pay the fee upon receipt of services.[121]

6. Service Delivery

Medicaid beneficiaries generally may choose from any of the participating providers.[122] However, states may seek waivers from the Department of Health and Human Services ("HHS") to create alternative health care delivery systems that have the primary effect of limiting freedom of choice on the part of Medicaid beneficiaries.[123] States can relax various federal Medicaid requirements or become exempt from them by applying for section 1915(b) or section 1115 waivers.[124] Such waivers, granted by HHS, allow states to implement

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coinsurance, are charges that require a beneficiary to share in the cost of services provided to them. *See* 42 C.F.R. § 447.50(a).

119. *See* 42 U.S.C.A. § 1396*o*(a)(2)(A); 42 C.F.R. § 447.53(b)(1).

120. *See* 42 U.S.C.A. § 1396*o*(a)(3), (b)(3). The maximum amount of charges are set forth in 42 C.F.R. § 447.54. For outpatient care: any deductible imposed cannot exceed $2 per month per family, *see* 42 C.F.R. § 447.54(a)(1); any coinsurance rate cannot exceed 5% of the payment made by the state, *see* 42 C.F.R. § 447.54(a)(2); and co-payments cannot exceed $3, *see* 42 C.F.R. § 447.54(a)(3). States can seek a waiver requesting that cost-sharing amounts not be nominal if non-emergency room services are furnished in the emergency room. *See* 42 C.F.R. §447.54(b). For inpatient services, a beneficiary will not be required to pay more than 50% of the amount paid by the state for the first day of care. *See* 42 C.F.R. § 447.54(c).

121. *See* 42 U.S.C.A. § 1396*o*(e); 42 C.F.R. § 447.15. If a beneficiary cannot pay upon receipt of services, they can be billed for services. *See* PERKINS ET AL., *supra* note 61, at 4.3.

122. *See* 42 U.S.C.A. § 1396a(a)(23) (West 1992 & West Supp. 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4454, 4700-02, 4711-12, 4714-15, 4724, 4731-33, 4741, 4751-53, 4911-13, 111 Stat. 368, 431, 493, 495, 506-10, 516-17, 519, 520, 522-25, 571, 573. For example, a Medicaid beneficiary could access any provider who participates in the Medicaid program, and is not required to get approval for such care. *See* Solomon & Asaro, *supra* note 59, at 250. Provider participation in the Medicaid program is voluntary, however, a state agency must make payments "sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." 42 C.F.R. § 447.204.

123. *See* 42 U.S.C.A. § 1396n(b) (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4743, 111 Stat. 368, 524; 42 C.F.R. § 431.54-431.57. Examples of allowable alternative delivery systems that the state may implement include: (1) case management systems that require recipients to choose one primary care provider from a selected list; (2) a locality acting like a central broker; and (3) a prudent buyer system that limits freedom of choice for particular medical services to specified hospitals or other providers with whom contracts have been negotiated. *See* 42 U.S.C.A. § 1396n(b)(1)-(2), 1396n(b)(4).

124. *See* 42 U.S.C.A. § 1315(a) (West 1992 & West Supp. 1997), *amended by*

experimental projects free from federal Medicaid mandates.[125]

The section 1915(b) "freedom of choice" waivers give states increased flexibility in restricting Medicaid recipients' access to certain providers by allowing states to implement health care delivery systems as an alternative to the traditional delivery system.[126] The section 1115 waivers permit states to implement "experimental," "pilot," or "demonstration" managed care delivery systems that are likely to promote the objective of the Medicaid program.[127] As such, states may contract with managed care organizations ("MCO's") to deliver services to Medicaid beneficiaries.[128] An MCO is a health care delivery system that has a single point of entry for consumers and provides its enrollees with specific and limited benefits in exchange for a "capitation rate" or a prepaid price per enrollee.[129] Absent a section 1915(b) or section 1115 waiver, enrollment in a managed care organization is the voluntary choice of the Medicaid beneficiary.[130]

7. Medicaid Costs

Medicaid expenditures escalated dramatically in the early 1990s.[131] Such rising costs occurred because of a greater amount of payments

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Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4757, 111 Stat. 527; *id.* § 1396n(b); 42 C.F.R. § 431.55(b). The process of applying for and receiving approval for a section 1115 or section 1915(b) waiver is rigorous. *See* Judith M. Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545, 547 (1995). States must submit detailed project proposals detailing the statutory and regulatory mandates sought to be waived. *See id.* at 547-48.

125. *See* Rosenberg & Zaring, *supra* note 124, at 545.

126. *See* Martin & Dubois, *supra* note 57, at 1-22.

127. *See id.* at 1-23.

128. *See* 42 U.S.C.A. § 1396b(m) (West 1992 & West 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4701-03, 4705, 4707, 4708, 4712, 4722, 4724, 4742, 4753, 4802, 4912, 111 Stat. 493-95, 498, 500-01, 505-096, 509, 514-16, 523, 525, 573, *and* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997).

129. *See* Kerry Martin, *Managed Care and Medicaid in* MEDICAID MANAGED CARE: AN ADVOCATE'S GUIDE TO PROTECTING CHILDREN 2-1, 2-2 (1996).

130. *See* National Health Law Program, *Medicaid Waiver Repeal: Implications for Post-Waiver Advocacy*, HEALTH ADVOCATE (Nat'l Health Law Program, L.A.), summer 1997, at 1.

131. *See* HEALTH, EDUC. & HUMAN SERVICES DIV., U.S. GEN. ACCOUNTING OFFICE, NO. 97-128, MEDICAID - SUSTAINABILITY OF LOW 1996 SPENDING GROWTH IS UNCERTAIN 2 (1997) [hereinafter MEDICAID SUSTAINABILITY UNCERTAIN]. Over the ten-year period between 1984 and 1993, combined state and federal Medicaid spending more than tripled from $35.4 billion to $125.2 billion. *See* Martin & Dubois, *supra* note 57, at 1-18. From 1993 to 1995, Medicaid expenditures increased again to $156.5 billion. *See id.*

being made to disproportionate share hospitals ("DSH"),[132] an increase in the cost of providing health care services, and larger numbers of Medicaid beneficiaries.[133] The growth in the number of enrollees can be partially attributed to the federal mandates expanding eligibility to pregnant women and children who otherwise would not have met Medicaid eligibility requirements.[134] For these reasons, states are exercising their option to relax or waive Medicaid requirements and are increasingly moving toward adopting managed care delivery systems for providing health care.[135] In 1994, Medicaid enrolled approximately eight million beneficiaries in managed care health delivery systems.[136]

In 1996, Medicaid covered more than thirty-seven million Americans at an annual cost of approximately $160 billion in combined state and federal funds.[137] Of these current Medicaid enrollees, approximately twenty million are children.[138] Although children made up half of all Medicaid beneficiaries in 1995, less than one-fifth of Medicaid expenditures were spent on children.[139]

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132. Disproportionate share hospitals are those hospitals that service a large proportion of low-income persons and Medicaid beneficiaries. *See* MEDICAID SUSTAINABILITY UNCERTAIN, *supra* note 131, at 2.

133. *See id.* at 2-3.

134. *See id.* at 7.

135. *See id.* at 2. For example, in 1994, expenditures grew from nearly $60 billion annually in 1989 to $157 billion in 1995. *See id.* The Congressional Budget Office has asserted that savings realized in the long run from enrolling Medicaid beneficiaries into managed care delivery systems are not likely to be significant enough to offset the currently high Medicaid expenditures. *See id.* at 12.

136. *See* Martin, *supra* note 129, at 2-1.

137. *See* MEDICAID SUSTAINABILITY UNCERTAIN, *supra* note 131, at 2-3. This amount accounts for nearly six percent of total federal expenditures and twenty percent of total state expenditures. *See id.*

138. *See* ANDY SCHNEIDER, CTR. ON BUDGET AND POLICY PRIORITIES, OVERVIEW OF MEDICAID PROVISIONS IN THE BALANCED BUDGET ACT OF 1997, P.L. 105-33, at 1 (Sept. 1997).

139. *See* THE KAISER COMM'N ON THE FUTURE OF MEDICAID, THE HENRY J. KAISER FAMILY FOUND., MEDICAID FACTS: THE MEDICAID PROGRAM AT A GLANCE 1 fig. 1 (1997). The elderly make up 11.1%, the blind and disabled account for 16.5 %, adults make up 23.1% and children account 49.3% of all Medicaid beneficiaries nationally. *See id.* However, the majority of Medicaid spending went to the blind and disabled (32.9% of Medicaid dollars) and the elderly (25.9% of Medicaid dollars). *See id.* Adults accounted for 11.2% of the Medicaid dollars, while children accounted for only 17.4% of the total Medicaid dollars in 1995. *See id.* The rest (12.6%) went to hospitals who care for a disproportionate share of uninsured patients. *See id.* These statistics indicate that it is relatively inexpensive to provide coverage for children compared to others covered by Medicaid. *See* Jacob S. Hacker & Theda Skocpol, *The New Politics of U.S. Health Policy*, 22 J. HEALTH POL. POL'Y & L. 315, 332 (1997).

C. Publicly Funded Child Health Care in Illinois

This Section of the Comment details the Illinois Medical Assistance Program[140] and also briefly describes other sources of publicly funded health care coverage for children in Illinois.[141] In discussing Illinois' Medicaid program, this Comment outlines eligibility requirements,[142] enrollment procedures,[143] benefits covered,[144] and special projects aimed at women and children.[145]

1. Illinois' Medical Assistance Program[146] Prior to the Passage of the Balanced Budget Act of 1997

Of the 11.8 million people living in Illinois, approximately 1.9 million currently receive health insurance coverage through the Medicaid program.[147] Children make up more than half of these Medicaid recipients.[148] However, these children accounted for just over one-fifth of the total Medicaid expenditures for the state.[149] In

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140. *See infra* Part II.C.1.

141. *See infra* Part II.C.2.

142. *See infra* Part II.C.1.a.

143. *See infra* Part II.C.1.b.

144. *See infra* Part II.C.1.c.

145. *See infra* Part II.C.1.d.

146. *See* 305 ILL. COMP. STAT. ANN. 5/5-1 to 5/5-19 (West 1993 & West Supp. 1997) (amended 1997); ILL. ADMIN. CODE tit. 89, §140 (1994). This program references the Illinois state Medicaid plan. The purpose of the Illinois Medical Assistance Act is to:

> provide a program of essential medical care and rehabilitative services for persons receiving basic maintenance grants under this Code and for other persons who are unable, because of inadequate resources, to meet their essential medical needs.
>
> Preservation of health, alleviation of sickness, and correction of handicapping conditions for persons requiring maintenance support are essential if they are to have an opportunity to become self supporting or to attain a greater capacity for self-care. For persons who are medically indigent but otherwise able to provide themselves with a livelihood, it is of special importance to maintain their incentives for continued independence and preserve their limited resources for ordinary maintenance needs to prevent their total or substantial dependency.

305 ILL. COMP. STAT. ANN. 5/5-1 (West 1996).

147. *See* ILL. DEP'T OF PUB. AID, ANNUAL REPORT, MEDICAL ASSISTANCE PROGRAM 1993-1995, at 1.

148. *See* Kaiser Family Foundation, *State Medicaid Info: Illinois 1994*, (visited Jan. 25, 1998) <http://www.kff.org/state_health/states/il.html>. Fifty-two and one fifth percent of all Illinois Medicaid recipients were children. *See id.* Although federal law permits states to cover children up to age 21, Illinois sets the age limit at under 19, except for ESPDT services. *See* 42 C.F.R. §§ 435.222(a), 436.222(a); *see also infra* notes 160-64 and 192-96 and accompanying text (discussing the various income level limits for children of various ages in Illinois).

149. *See* Kaiser Family Foundation, *supra* note 148. Medicaid expenditures on

hard figures, the State of Illinois spent: only $1,364 per child in 1994, as compared to $1,879 spent on each adult between the ages of twenty-one and sixty-four in the Medicaid program; $9,055 per blind or disabled beneficiary; and $8,762 per elderly beneficiary.[150] From 1983 through 1994, Illinois Medicaid expenditures grew at an average rate of eleven percent per year.[151] Following a national trend, Illinois saw a moderate decrease in Medicaid expenditures in 1996.[152]

a. Eligibility Requirements

Illinois, like other states, is required to provide Medicaid to families receiving cash assistance under Temporary Assistance for Needy Families ("TANF")[153] or to individuals receiving SSI benefits.[154] In Illinois, Medicaid offers a medically needy program ("MANG") for families that meet categorical requirements but have income levels that

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children in Illinois in 1994 equaled 20.6% of the total Medicaid spending for the state. *See id.*

150. *See id.*

151. *See* LAWRENCE B. JOSEPH & HENRY S. WEBBER, MEDICAID MYTHS AND REALITIES: AN ANALYSIS OF THE ILLINOIS MEDICAID PROGRAM 1983-1994 16-17 (1995). In 1992, Illinois experienced astronomical increases in Medicaid expenditures after the district court found Illinois' Medicaid provider reimbursement plan to be arbitrary and inadequate. *See* Illinois Heath Care Ass'n v. Bradley, 776 F. Supp. 411, 423 (N.D. Ill. 1991), *aff'd*, 983 F.2d 1460 (7th Cir. 1993). As a result, provider reimbursement rates increased significantly in Illinois after this ruling, increasing Medicaid expenditures by 48% in fiscal year 1992. *See* JOSEPH & WEBBER, *supra*, at 16-17.

152. *See* MEDICAID SUSTAINABILITY UNCERTAIN, *supra* note 131, at 10-12. Some experts attribute the low Medicaid expenditures in 1996 to a healthier economy. *See id.* at 12-13. Others point to 1996 census data showing that one million children were dropped from Medicaid coverage in response to welfare reform mandates. *See* CTR. ON BUDGET AND POLICY PRIORITIES, *supra* note 46.

153. *See* Act of June 19, 1997, P.A. No. 90-17, 1997 Ill. Legis. Serv. 1503 (West) (amending 305 ILL. COMP. STAT. ANN. 5/4) (West 1993 & West Supp. 1997)) (changing Aid to Families with Dependent Children (AFDC) to TANF). These amendments reflect the federal mandates set forth in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (codified at 42 U.S.C. § 601 (1994). These welfare reforms are significant because they limit cash assistance under TANF to five years. *See* Act of June 19, 1997, P.A. No. 90-17, § 10, 1997 Ill. Legis. Serv. 1507 (to be codified at 305 ILL. COMP. STAT. ANN. 5/4-1.12). Nevertheless, Illinois must continue to apply the Medicaid eligibility rules that were in effect on July 16, 1996. *See* SSI Coalition for a Responsible Safety Net, *Welfare "Reform": Implications for Medicaid*, CLEARINGHOUSE REV. (forthcoming 1998). Therefore, public aid case managers who move clients into work and off welfare, must ensure that children who still meet the income eligibility standards continue to receive Medicaid coverage. *See id.* Additionally, data indicates that children in families that do not receive cash assistance are much less likely to enroll in Medicaid. *See* SUMMER ET AL., *supra* note 27, at 7.

154. *See* 305 ILL. COMP. STAT. ANN. 5/5-2(1) (West Supp. 1997); *see also supra* note 79 discussing the SSI program.

exceed the Medicaid eligibility standards.[155] MANG requires assessment of its recipients on a monthly basis.[156] If their medical expenses in any given month cause them to spend down[157] to the medically needy income level ("MNIL") or 133% of the TANF payment level for the same size family, they then will be eligible for Medicaid benefits for that particular month.[158]

Under federally mandated Medicaid expansions, Illinois began offering Medicaid to an even greater number of low income families ('MANG-P').[159] MANG-P expands the coverage of Medicaid to include children under the age of six, infants, and pregnant women in families whose incomes are at or below 133% of the federal poverty level.[160] Children over the age of six but under the age of thirteen[161] must have family income levels at or below 100% of the poverty level to receive MANG-P in Illinois.[162] Currently, in Illinois, children between the ages of fourteen and eighteen who would have been eligible for TANF but fail to qualify as a dependent are eligible for Medicaid if their household income is below the MANG standard.[163] Essentially, children in this age group in Illinois must live in extremely poor households with incomes well below 50% of the federal poverty level in order to qualify for Medicaid.[164]

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155. *See* 305 ILL. COMP. STAT. ANN. 5/5-2(2). The acronym "MANG" stands for "Medical Assistance—No Grant." *See* JOSEPH & WEBBER, *supra* note 151, at 6. This category was a response to federal mandates that severed eligibility for Medicaid from eligibility for cash assistance. *See id.* at 7. "No grant" refers to families that do not receive cash assistance under TANF or SSI, but meet the income eligibility standards set forth by the federal government because they incur large amounts of medical expenses in any given month. *See id.* at 6-7.

156. *See id.* at 6.

157. The "spend down" concept can be likened to a deductible. A family is said to have spent down to a medically needy level if, although its income exceeds the Medicaid eligibility standards, it incurs medical expenses in any given month that are so high that if the individual or family actually spent the money on these medical costs, it would meet the financial eligibility standards of Medicaid. *See* THE PUBLIC WELFARE COALITION, HANDBOOK OF ILLINOIS PUBLIC AID AND POLICY E-10 (2d ed. 1986).

158. *See* JOSEPH & WEBBER, *supra* note 151, at 7.

159. *See* 305 ILL. COMP. STAT. ANN. 5/5-2 (4). MANG-P refers to pregnant women and children who are eligible for medical assistance but not for other federally funded cash assistance (TANF). *See* ILL. DEPT. OF PUB. AID, POLICY MANUAL 1997, § 06-09-00.

160. *See* ILL. ADMIN. CODE tit. 89, § 120.31(a) (1994).

161. This age limitation for children born after September 30, 1983, will be expanded by the year 2002 to include all children under age 19 who live below the federal poverty line. *See* The Omnibus Budget Reconciliation Act of 1990, *supra* note 82.

162. *See* ILL. ADMIN. CODE tit. 89, § 120.31(a).

163. *See* 305 ILL. COMP. STAT. ANN. 5/5-2(6); ILL. ADMIN. CODE tit. 89, § 140.7(a)(1), (2).

164. *See* ILL. ADMIN. CODE tit. 89, § 120.391(a)(2) indicating that MANG (AFDC) standards apply to this group. MANG income levels for a family of four is $558 per

In response to federal authority permitting states to cut off federally means-tested programs from certain categories of noncitizens, Illinois recently amended its Public Aid Code to reflect the eligibility restrictions now imposed on noncitizens.[165] Other than prohibiting undocumented persons from receiving anything more than emergency medical care, Illinois previously had no citizenship restrictions on the receipt of medical assistance.[166] After the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, however, Illinois elected to make noncitizen, legal permanent residents who entered the country after August 22, 1996, ineligible for medical assistance for the first five years after their date of entry.[167] Although law suits challenging the constitutionality of this new law on equal protection grounds are currently pending,[168] it is likely that this provision will withstand the deferential scrutiny applied to congressional action in matters of immigration.[169] As a result, low-income children who are eligible for medical assistance but for their citizenship status will not be eligible to apply for medical assistance until after the first five years of their entry into Illinois.[170] Because children grow and develop rapidly,[171] a five-year wait for access to

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month. *See id.* § 120.30. This is the equivalent of $6,696 annual income which is 43% of the federal income poverty guideline ($16,050). *See* Annual Update of HHS Poverty Guidelines, 62 Fed. Reg. 10,856, 10,857 (1997).

165. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1612 (1994). The categories of ineligible citizens include: legal permanent resident aliens who have worked 40 qualifying quarters of coverage, veterans and their spouses and children; and for five years, refugees and aliens whose deportation has been withheld. *See id.*

A federally means tested public benefit is defined as a federal benefit subject to an income or resource screen, and the mandatory, rather than discretionary, spending programs of the federal budget process. *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996; Interpretation of "Federal Means-Tested Public Benefit," 62 Fed. Reg. 45,256 (1997).

166. *See* ILL. ADMIN. CODE tit. 89, § 140.2(a)(7).

167. *See* Act of June 19, 1997, P.A. No. 90-17, § 10, 1997 Ill. Legis. Serv. 1504-05 (West) (to be codified at 305 ILL. COMP. STAT. ANN. 5/1-11 in the Public Aid Code).

168. *See* City of Chicago v. Shalala, No. 97 Civ. 4884, (N.D. Ill. July 10, 1997) (complaint); Sinelnikov v. Callahan, No. 97 Civ. 4884 (N.D. Ill. Sept. 8, 1997) (complaint in intervention).

169. *See* Abreu v. Callahan, 971 F. Supp. 799, 817-818, (S.D.N.Y. 1997) (holding that Congress did not violate the equal protection clause because the distinction in the Act between citizens and permanent resident aliens, on one hand, and all other resident aliens, on the other, was rationally related to legitimate federal interests in promoting naturalization, reducing the strain on the federal budget, and encouraging self-sufficiency).

170. *See* Act of June 19, 1997, P.A. No. 90-17, § 10, 1997 Ill. Legis. Serv. 1504-05 (West) (to be codified at 305 ILL. COMP. STAT. ANN. 5/1-11 in the Public Aid Code).

171. *See generally* Forrest et al., *supra* note 38, at 1788.

essential and preventive medical care, regardless of their citizenship status, may be more detrimental to children than to adults.[172]

b. Special Enrollment Procedures

Illinois also has a Medicaid presumptive eligibility program known as the Healthy Start program.[173] Designed to ensure early and continuous prenatal care, the Healthy Start program provides coverage to low-income pregnant women who, after an initial determination procedure, are presumed eligible for Medical Assistance based on income requirements.[174] The provider of prenatal care arranges an eligibility interview and can begin providing ambulatory services before the pregnant woman actually has applied for Medical Assistance.[175] In 1995, the Healthy Start program provided prenatal services to nearly 28,000 pregnant women.[176]

An additional program, the Maternal Child Health Application Process Program, allows the Department of Public Aid to accept Medical Assistance applications at sites other than the local Public Aid offices.[177] Staff at these "outstation" sites assist pregnant women and children in completing the applications at more convenient locations and then forward the applications to the local Public Aid office for processing.[178] The applications are shorter, and the process is simplified in order to expedite the eligibility determination process for pregnant women and children.[179] In 1995, more than 100 hospitals and health centers statewide functioned as "outstation" application sites.[180]

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172. J. GOLDSTEIN ET AL., BEYOND THE BEST INTERESTS OF THE CHILD 31-52 (1979) (discussing children's sense of time in the context of children's innate need for continuity). "A child will experience a given time period not according to its actual duration, measured objectively by a calendar and clock, but according to his purely subjective feelings . . . ." *Id.* at 41.

173. *See* ILL. ADMIN. CODE tit. 89, § 120.12 (1994). "The purpose of the Healthy Start-Medicaid Presumptive Eligibility (MPE) Program is to encourage early and continuous prenatal care to low income pregnant women who otherwise may postpone or do without such care." *Id.*

174. *See id.* "Presumptively eligible pregnant women shall receive ambulatory prenatal care before completing an application for medical assistance under the State plan at the local Public Aid Office." *Id.*

175. *See* ILL. DEP'T OF PUB. AID, *supra* note 147, at 6.

176. *See id.*

177. *See id.*

178. *See id.*

179. *See id.*

180. *See id.*

c. Medical Benefits

Illinois offers all of the mandatory health services required by federal law[181] and most of the optional federally permitted Medicaid services.[182] The optional services offered by Illinois' Medical Assistance program that are most important for children include: clinic services; prescribed drugs; prosthetic devices; physical therapy; occupational therapy; speech, hearing and language therapy; diagnostic services; preventive services; rehabilitative services; emergency hospital services; skilled nursing facility services for individuals under age twenty-one; care for individuals under age twenty-one in psychiatric hospitals; extended services to pregnant women; case management services; and home and community based services.[183]

d. Specific Medicaid Programs

In compliance with federal mandates and in an effort to control costs, Illinois created other Medicaid-funded programs aimed at better serving women and children.[184] For example, Healthy Moms/Healthy Kids ("HM/HK"), a primary care case management initiative,[185]

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181. *See* 305 ILL. COMP. STAT. ANN. 5/5-5 (West 1993 & West Supp. 1997), *amended by* Act of June 10, 1997, P.A. No. 90-7 § 45, 1997 Ill. Legis. Serv. 173-80 (West).

182. *See* ILL. DEP'T OF PUB. AID, *supra* note 147, at tbl. VI.

183. *See* 305 ILL. COMP. STAT. ANN. 5/5-5; ILL. ADMIN. CODE tit. 89, §§ 140.3, 140.5, 140.452-140.454, 140.460(f), 140.462(a)(4)(B)(i)(1994); ILL. DEP'T OF PUB. AID, *supra* note 147, at tbl.VI. Illinois also covers the following optional services: optometry services; podiatry services; chiropractors' services; dentures; private duty nursing; institutional services in intermediate care facilities; hospice care services; care for persons over 65 in mental health institutions; and services provided through managed care organizations. *See* ILL. ADMIN. CODE tit. 89, § 140.3; ILL. DEP'T OF PUB. AID, *supra* note 147, at tbl.VI.

Medical services that are not specifically covered under the Illinois Medicaid program include: services available without charge; services prohibited by state or federal law; experimental procedures; research oriented procedures; medical examinations required for entrance into educational or vocational programs; autopsies; preventive services (except those provided by the Healthy Kids program); artificial insemination; abortion; cosmetic surgery; medical or surgical transsexual treatment; infertility and sterility treatments; acupuncture; medical services provided by mail or telephone; unkept appointments; follow-up treatments for sexually transmitted diseases when such treatment is available through public health clinics; non-medically necessary items and services; preparation of records, forms and reports; and visits with people other than the recipient. *See* ILL. ADMIN. CODE tit. 89, §140.6 (a)-(t).

184. *See infra* notes 185-97 and accompanying text.

185. A primary care case management model combines managed care with the more traditional fee-for-services delivery system. *See* HUMAN RESOURCES DIV., U.S. GEN. ACCT. OFF., NO. 93-121, MEDICAID MANAGED CARE: HEALTHY MOMS, HEALTHY KIDS—A NEW PROGRAM FOR CHICAGO 5 (1993) [hereinafter A NEW PROGRAM FOR CHICAGO]. The primary care provider, who acts as a gatekeeper to the provision of services, continues to be paid on a fee-for-service basis, but also receives an additional payment to

sought to improve the health of women and children enrolled in Medicaid in Illinois.[186] The Department of Public Aid developed the program in response to several factors, including: (1) escalating Medicaid costs; (2) the state's high infant mortality rate; (3) clients' inability to obtain needed primary medical care; (4) the need to meet federal requirements for participation in the EPSDT program;[187] and (5) the need to ensure access to care for pregnant women and children.[188] In 1995, the HM/HK program served 18,902 pregnant women and 209,890 children statewide.[189] The program was designed to operate only for two years, at which time the MediPlan Plus managed care project would replace it.[190] MediPlan Plus is a Medicaid managed care program proposed by Governor Edgar in 1994.[191] After much concern over Illinois' difficulty with

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coordinate the patient's care. *See* ILLINOIS MATERNAL & CHILD HEALTH COALITION, MEDICAID MANAGED CARE FOR PREGNANT WOMEN AND CHILDREN: A USER PERSPECTIVE 8 (1996). Although the managed care component was in place in downstate Illinois, primary care case management services were offered to women and children in Chicago. *See* ILL. DEP'T OF PUB. AID, REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY ON THE HEALTHY MOMS/HEALTHY KIDS PROGRAM FISCAL YEAR 1995 1 (1996).

186. *See* 305 ILL COMP. STAT. ANN. 5/5-22 (West Supp. 1997). Specifically, the goals of the program were to: "improve the health care delivery system for Medicaid-enrolled pregnant women and children; expand access to primary care and preventive services; reduce infant mortality; improve participation in preventive services and health outcomes of pregnant women and children; control escalating Medicaid costs; and ensure that federal Medicaid mandates are met." ILL. DEP'T OF PUB. AID, *supra* note 185, at 1. The HM/HK program was granted authority to operate by the Health Care Financing Administration (HCFA) under a federal 1915(b) waiver, setting aside statewide uniformity, freedom of choice and comparability of services requirements. *See id.*

187. *See* 42 U.S.C.A. § 1396d(a)(4)(B) (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4702, 4711-12, 4714, 4725, 4732, 4802, 4911, 111 Stat. 494, 508-10, 518, 520, 538, 570, *and* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997); *see also supra* note 109 and accompanying text (describing the EPSDT program).

188. *See* A NEW PROGRAM FOR CHICAGO, supra note 185, at 1.

189. *See* ILL. DEP'T OF PUB. AID, *supra* note 147, at 5.

190. The HM/HK program was to begin in 1993, and terminate on June 30, 1995. *See* ILL. DEP'T OF PUB. AID, *supra* note 185, at 1.

191. *See* 305 ILL. COMP. STAT. ANN. 5/5-16.3 (West Supp. 1997), *amended by* First 1997 General Revisory Act, P.A. No. 90-14, Art. 2, § 2-190, 1997 Ill. Legis. Serv. 1301-09 *and* Act of Jul. 29, 1997, P.A. No. 90-254, § 5, 1997 Ill. Legis. Serv. 2975-92; ILL. ADMIN. CODE tit. 89, §142 (1994). "MediPlan Plus is intended to encourage the integration of health care services and the management of the health care of Enrollees while preserving reasonable choice within a competitive and cost-efficient health care environment." ILL. ADMIN. CODE tit. 89, §142.100 (1994). Once in place, MediPlan Plus will require Medicaid recipients to enroll in a "managed care entity," with the Department of Public Aid assigning enrollees to managed care entities if such enrollees fail to choose one after notification. *See id.* § 142.340 (1994). "If an Eligible Enrollee does not submit an adequately completed selection form . . . the Department may assign

administering the HM/HK program, MediPlan Plus finally received approval from the Health Care Financing Administration ("HCFA") in July 1996, although it is yet to be implemented.[192]

The Healthy Kids Program is Illinois' version of the Early and Periodic Screening, Diagnosis, and Treatment services ("EPSDT") required by federal law.[193] Healthy Kids aims to improve the health status of Illinois children by providing preventive medical care and early intervention in the diagnosis and the treatment of poor health conditions.[194] Under the Healthy Kids program, which has comprehensive services ranging from prevention to treatment allowing the program to define Medicaid benefits for eligible children in Illinois, any child under the age of twenty-one enrolled in Illinois' Medicaid program is eligible for: health, vision, hearing and dental screening services; school physical examination; immunizations; tests; and, referral for dental care.[195] As a by-product of providing preventive services, Healthy Kids also aims to reduce the long-term medical costs of children who otherwise would go untreated.[196] In 1994, of the 1,021,707 children enrolled in Medical Assistance, 514,869 received

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the Eligible Enrollee to [a Managed Care Entity]." *Id.* 89, § 142.340(a) (1994).

192. *See Federal Budget Goes to Conference Committee*, PUBLIC HEALTH ISSUES (Chicago Department of Health, Chicago, Ill.) July 14, 1997, at 4. "Continuing problems with Healthy Moms/Healthy Kids is one factor that has federal regulators concerned about approving Gov. Jim Edgar's ambitious plan to shift the poor into his MediPlan Plus managed-care program." Rick Pearson, *State Trims Its Postnatal, Early Child Care Program*, CHI. TRIB., June 20, 1995, § 2, at 7. "Illinois' failures with Healthy Moms/Healthy Kids cast doubts on the state's ability to pull off a more ambitious welfare program called MediPlan Plus." Hanke Gratteau & Rick Pearson, *Its Health Plan in Ruins, State Fires Firm*, CHI. TRIB., May 7, 1995, § 2 (Metro DuPage), at 1. Despite delayed approval, and a late implementation date, it now appears that the Department of Public Aid will completely abandon the controversial plan. *See generally* Judith Graham & Rick Pearson, *Illinois May Drop Plan for Big Medicaid Shift*, CHI. TRIB., Oct. 1, 1997, § 1, at 1 (reporting that the Illinois Department of Public Aid is "seriously considering scrapping a controversial plan that has been in the works three years and that would shift virtually all of the state's . . . Medicaid recipients into managed care").

193. *See* 305 ILL. COMP. STAT. 5/5-19 (West 1996). Despite the similar name, this program is not the HM/HK program, but is what remains of the diagnostic services provided through HM/HK. *See id.* Nevertheless children enrolled in HM/HK, as well as any Medicaid-enrolled child under the age of 21 are eligible for Healthy Kids screening services. *See id.* The purpose of the program is to "improve the health status of Medicaid-eligible children ages birth through 20 years through the provision of preventive medical care and early diagnosis and treatment of conditions threatening the child's health; and . . . reduce the long term costs of medical care to eligible children." ILL. ADMIN. CODE tit. 89, § 140.485(a)(1)(A)-(B).

194. *See id.* § 140.485(a)(1)(A).

195. *See* 305 ILL. COMP. STAT. 5/5-19.

196. *See* ILL. ADMIN. CODE tit. 89, § 140.485(a)(1)(B).

Healthy Kids screenings at an estimated cost of $51.2 million.[197]

2. Other Child Health Safety Net Programs in Illinois

Each program discussed above falls within the auspices of the Illinois' Medical Assistance Act, and as such, utilizes federal pass-through funds, and thus each program must comply with federal Medicaid mandates.[198] In addition to these programs, the Illinois General Assembly attempted to alleviate other pressing health concerns by enacting a series of laws that appropriate state funds to cover vulnerable populations.[199] For instance, the State's General Assistance (GA) program provides limited cash and medical assistance to eligible needy families or individuals who fail to meet eligibility requirements for federally funded welfare programs.[200] However, the GA medical program has a less extensive benefits package for adults and a more restrictive income eligibility level than Medicaid.[201]

The Illinois GA consists of two distinct programs: (1) the State Transitional Assistance program for adults without children; and (2) the State Family and Children Assistance program for pregnant women and families with children.[202] The State Family and Children Assistance program provides medical coverage without limitation on the number of months an eligible pregnant woman or child may receive the benefits.[203] Under the State Family and Children Assistance program, a family that is poor enough to be financially eligible for TANF but has a principle wage earner who fails to meet the state's work history or hours worked requirement still may be eligible for GA, and therefore is eligible for medical coverage.[204] Under the State

197. *See* ILL. DEP'T OF PUB. AID, *supra* note 147, at 5.

198. *See supra* notes 147-97 and accompanying text.

199. *See infra* notes 200-212 and accompanying text.

200. *See* 305 ILL. COMP. STAT. ANN. 5/6-1 to 5/6-11 (West 1993 & West Supp. 1997) (amended 1997); ILL. ADMIN. CODE tit. 89, § 114.1. The federally-funded programs listed are Aid to the Aged, Blind, or Disabled (AABD), Aid to Families with Dependent Children (AFDC, now TANF), Supplemental Security Income (SSI), and Medicaid. *See* ILL. ADMIN. CODE tit. 89, § 101.30(b)(7).

201. *See id.* § 114.2(b)(4). Gross income cannot exceed $2,000 in the past year, and the eligible individual must not have earned $200 in three of the previous twenty-four months. *See id.*

202. *See* 305 ILL. COMP. STAT. ANN. 5/6-11(b) (West 1993 & West Supp. 1997).

203. *See* ILL. ADMIN. CODE tit. 89, § 114.1(b). Individual adults under the Transitional Assistance program can only receive medical assistance for nine months. *See id.* § 114.1(c)(1).

204. TANF cash assistance may be available to dependent children and their families based on the death, absence, incapacity or unemployment of a parent. *See id.* § 112.1(b), (c). In order to be considered "unemployed" for purposes of TANF eligibility, the principle wage earner must meet certain work history and hours worked requirements.

Family and Children Assistance program, families and pregnant women receive services comparable to those received by Medicaid beneficiaries.[205] Although eligibility standards are restrictive, the state-funded GA program provides resources to needy families that do not qualify for federal assistance.[206]

Additionally, the Illinois General Assembly statutorily created the Illinois Division of Specialized Care for Children ("DSCC"), an official agency for the specialized treatment and rehabilitation of children with certain chronic physical disabilities and health impairments.[207] To be eligible under this program, a child must be under eighteen years of age, must meet specified financial and state residency requirements, and must have a diagnosed chronic medical condition falling into a category of listed medical impairments.[208] The

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See id. § 112.64(e), (f). If a family is unable to meet these requirements, but still has a low enough income to be eligible for GA, this family's children could also receive medical coverage. *See id.* § 140.5. *See also supra* note 153 discussing the TANF program.

205. *See id.* § 140.5. Those services include: encounter rate clinic visits; physician services; vital pharmacy services; vital medical supplies and equipment; group care services; family planning services; laboratory and x-ray services; transportation; prostheses and orthoses; home health agency visits; hospice visits; adult emergency dental services; inpatient hospital visits; hospital outpatient and clinic services for surgical procedures; and emergency room visits. *See id.*

206. *See* 305 ILL. COMP. STAT. ANN. 5/6-1.3 (West 1993 & West Supp. 1997), *amended by* Act of June 19, 1997, P.A. No. 90-17, § 10, 1997 Ill. Legis. Serv. 1516-17 (West).

207. *See* 110 ILL. COMP. STAT. 345/0.01 to 345/3 (1994); ILL. ADMIN. CODE tit. 89, § 1200. This program is administered by the University of Illinois at Chicago and serves children statewide. *See* ILL. ADMIN. CODE tit. 89, § 1200.10(a). The stated purpose of the program is to:

> provide diagnostic and treatment services for children who are disabled as a result of congenital and/or acquired states or have a condition which may lead to disability. The objective is to provide a program of comprehensive evaluation, medical care and related habilitative services appropriate to their various needs and to financially support such care . . . .

Id. § 1200.30(a).

208. *See id.* § 1200.30(b)(c). Medically eligible conditions include: orthopedic impairments; nervous system impairments; cardiovascular impairments; external body impairments; hearing impairments; speech impairments; cystic fibrosis; hemophilia; metabolic disorders; eye impairments; and urinary impairments. *See id.* § 1200.40(b). For the child to receive financial assistance and treatment services, the child must be a United States citizen, and the adult legally responsible for the child ("LRA") must be a resident of Illinois, and must be lawfully admitted to the United States or have been admitted under color of law. *See id.* § 1200.30(c)(2)(A), (B). An LRA is expected to use any existing insurance or other third party benefits to pay for treatment before seeking payment from the DSCC. *See id.* § 1200.50(a). Once it has been determined that a child is eligible for treatment, financial eligibility is based upon a sliding scale as determined by the financial standing of the LRA requesting financial assistance. *See id.* § 1200.50(c)(1),(2).

DSCC provides care, coordination, and payment for a range of diagnostic and treatment services.[209]

Finally, the Illinois Comprehensive Health Insurance Plan is a state-administered health insurance package for qualified Illinois residents who cannot procure health insurance because of a preexisting mental or physical condition.[210] Significantly, this plan provides family coverage under the program if at least one family member meets the eligibility standards.[211] The maximum lifetime benefit the program will pay is $500,000.[212]

III. DISCUSSION

A. *The Balanced Budget Act of 1997*

Provisions of the Balanced Budget Act ("BBA"), enacted on August 5, 1997, mark the most significant federal funding increase for the benefit of children's health since the Medicaid Act's enactment in 1965.[213] Through its passage, a bipartisan Congress and President Clinton recognized the importance of making a social investment in the health of America's children.[214] The new law represents an effort to

209. *See id.* §§ 1200.80, 1200.90. Other than early identification and diagnostic evaluation, the DSCC provides the following medical services: consultative services; outpatient services; hospitalization and inpatient services; convalescent care; home-based care; assistive appliances; speech and hearing therapy, physical and occupational therapy; nutrition services; specialized dental care; home follow-up services; prescriptive drugs; genetic testing; psychiatric services and referrals. *See id.* § 1200.80(d), (e).

210. *See* 215 ILL. COMP. STAT. ANN. 105/1 to 105/14 (West 1993 & West Supp. 1997) (amended 1997). It is important to note that this plan is not an entitlement program, meaning that all Illinois residents eligible for this program will not be guaranteed a right to be issued the policy. Therefore, the number of persons who will receive coverage is limited by the amount of funds the program has available. *See* 215 ILL. COMP. STAT. ANN. 105/1.1(b) (1996).

211. *See* 215 ILL. COMP. STAT. ANN. 105/7(c) (West 1993 & West Supp. 1997), *amended by* Act of June 26, 1997, P.A. No. 90-30, § 92, 1997 Ill. Legis. Serv. 1902-03 (West). For a discussion of both medical and financial eligibility standards under DSCC, *see supra* note 208.

212. *See* 215 ILL. COMP. STAT. ANN. 105/7(e)(5).

213. *See* CHILDREN'S DEFENSE FUND, *supra* note 2, at 1.

214. *See generally*, 143 CONG. REC. S8386-02 (daily ed. July 31, 1997) (statement of Sen. Jeffords).

> [T]here is no resource more precious than the children who are right now playing in the school yards from Vermont to California. I worked closely with my colleagues Senator HATCH, Senator KENNEDY, Senator CHAFEE and Senator ROCKEFELLER to develop legislation that would provide health care coverage for our Nation's uninsured children . . . . The establishment of this coverage is not the end but only the beginning to ensure that every child born in this country will have a healthy start in order for them to fulfill their own

provide and coordinate health insurance coverage to some of America's ten million uninsured children in an effective and efficient manner.[215] Under the Act, states can elect to: (1) expand Medicaid benefits to previously ineligible children; (2) create a new State Child Insurance Health Plan ("SCHIP") to provide such medical assistance to low-income children; or (3) provide health insurance to low-income children through a combination of the two approaches.[216]

The states will be given significant latitude to create a comprehensive children's health insurance program, including the authority to determine eligibility criteria,[217] benefit packages,[218] and cost-sharing requirements.[219] In addition, states can set aside up to ten percent of the federal funds received for administration, outreach, and direct purchase of coverage.[220] States can amend their programs from time to time.[221] Significantly, the BBA contains a provision allowing states to implement mandatory managed care initiatives without having

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personal American dream . . . .

Id. at S8402.

215. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. 1397aa).

216. *See id.*

217. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397bb(b)).

218. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc).

219. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 564 (to be codified at 42 U.S.C.A. § 1397cc(e)).

220. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 560 (to be codified at 42 U.S.C.A. § 1397ee(c)(2)(A)), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997). Outreach should be intended to provide potentially eligible families with information about the availability of health insurance coverage. *See* Abigail English, Nat'l Ctr for Youth Law, Expanding Health Insurance for Children and Adolescents: A Preliminary Analysis of the Balanced Budget Act of 1997 10 (Sept. 1997) (on file with the National Center for Youth Law, Chapel Hill, N.C.); Health Care Financing Association, *Balanced Budget Act of 1997* (last modified Sept. 17, 1997) <http://www.hcfa.gov/init/kidssum.htm>. Direct purchases of services references the states' authority under the Balanced Budget Act to contract with providers to furnish specified health care services directly to children. *See* English, *supra*, at 24.

Expenditures for outreach activities and other reasonable administration costs must not exceed ten percent of the sum of federal funds received by the state. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 560 (to be codified at 42 U.S.C.A. § 1397ee(c)(2)(A)). These funds may also be spent on parent education classes, case management services to ensure coordination of a child's health care, drug, alcohol, and injury prevention workshops, centralized rehabilitation services, DSH payments, and contracts with providers to serve marginalized communities. *See* Nagle & Coffey, *supra* note 28, at 4.

221. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 563 (to be codified at 42 U.S.C.A. § 1397ff(b)(1)).

a waiver approved by the Department of Health and Human Services ("HHS").[222] The major provisions of the Balanced Budget Act of 1997's State Children's Health Insurance Program are set forth below.[223]

1. Federal Funding[224]

In total, states will be allotted approximately $4 billion per year to expand health coverage for children through the year 2007.[225] Through the year 2007, each state with an approved Child Health Plan will receive its allotment of federal funds based on a formula that computes the product of the state's combined number of low-income children and uninsured low-income children multiplied by a geographic cost factor.[226] Current estimates indicate that Illinois is

222. *See id.* State entitlement to experimental program planning is built into the language of the act. *See id.* Under the Act, states may require beneficiaries to enroll in managed care organizations without initially receiving an approval to limit freedom of choice of provider or waive statewideness criteria. *See* National Health Law Program, *supra* note 130, at n. 1. This is significant because the waiver process allows for consumers and advocates to participate in the development of the managed care program, and has forced states to be more accountable to their constituents than they will in the absence of HHS and consumer scrutiny. *See id.*

223. *See infra* notes 224-97 and accompanying text; *see supra* note 220 for other summaries of the major provisions of the Balanced Budget Act of 1997 §§ 4901-4913. *See generally* Children's Defense Fund, *Summary of Child Health Provisions in the 1997 Budget Reconciliation Act*, (Aug. 8, 1997) <http://www.childrensdefense.org/hatchken_newsum.html> (providing a general summary of the BBA); English, *supra* note 220, at 1-29 (concluding that the provisions of the BBA present states with the opportunity to reduce the number of low-income children without health insurance).

224. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 558 (to be codified at 42 U.S.C.A. § 1397dd), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997). The program at the federal level will be funded in part by the increase in taxes on tobacco products that will begin to take effect in the year 2000. *See* Children's Defense Fund, *supra* note 223, at 2.

225. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 558 (to be codified at 42 U.S.C.A. § 1397dd(a)).

226. *See id.* (to be codified at 42 U.S.C.A. § 1397dd(b)(2)-(3)). The geographic cost factor consists of a complicated equation that compares the state's health care costs to the costs incurred by other states. *See id.* (to be codified at § 1397dd(b)(3)). Specifically, the statute reads:

> (A) [The] "State cost factor" for a State for a fiscal year equal to the sum of:
>
> (i) 0.15, and
>
> (ii) 0.85 multiplied by the ratio of -
>
> (I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to
>
> (II) the annual average wages per employee for the 50 States and the District of Columbia.
>
> (B) [F]or purposes of subparagraph (A), the "annual average wages per employee" for a State, or for all the States, for a fiscal year is equal to the

slated to receive close to $1.22 million the first year.[227]

2. Payment to States

Although the BBA explicitly states that the State Children's Health Insurance Program does not entitle children to available funds,[228] the BBA provides that states are entitled to the federal funds as early as October 1, 1997.[229] The Secretary of Health and Human Services will make payments to states with approved child health plans for targeted low-income children who meet section 1397cc coverage requirements.[230] Particular Medicaid expenditures will be counted against the amount of funds a state receives under the BBA.[231]

3. Use and Restriction of Funds

As already mentioned, the states may use the federal funds to expand Medicaid coverage to otherwise ineligible children, to create a new insurance plan, or to provide coverage by combining both of these approaches.[232] If a state decides to use the funds to expand Medicaid coverage to uninsured children, it must not only comply with the requirements contained in the BBA but also satisfy the requirements of the state's Medicaid plan under Title XIX.[233] States

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> average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry . . . , as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

Id.

227. *See* Health Care Fin. Admin., State Children's Health Insurance Program; Revised Allotments to States for Fiscal Year 1998; Enhanced Federal Medical Assistance Programs, 62 Fed. Reg. 48,098, 48,101 (1997).

228. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397bb(b)(4)). "Nothing in this subchapter shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan." *Id.*

229. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397aa(c), (d)). "This subchapter constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 1397dd of this title." *Id.* (referring to 42 U.S.C.A. § 1397dd(a)).

230. *See infra* notes 266-84 and accompanying text.

231. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 558 (to be codified at 42 U.S.C.A. § 1397dd(d)). For example, the federal government will deduct from a state allotment the amount of funds equal to those funds spent by the state in administering medical assistance to a child during a presumptive eligibility period. *See id.* § 1397dd(d)(1). In essence, this provision works like a penalty against those states that recognize presumptive eligibility in their new plan. *See id.*

232. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 552 (to be codified at § 1397aa(a)).

233. *See id.*

will receive enhanced matching rates ("Federal Medical Assistance Percentage or FMAP") under any of the three approaches available to the states in creating their plans.[234] For Illinois, the fifty percent matching rate under the Medicaid program will become a sixty-five percent matching rate under the new state plan.[235]

Although states have a great deal of discretion in determining how to spend the funds, the BBA has placed some limits on payments for particular expenditures.[236] For example, funds provided to the states under this program may not be used to cover expenses incurred for abortion procedures unless such action is necessary to save the life of the mother or if the pregnancy is the result of rape or incest.[237] Upon meeting the funding criteria, states are then granted a significant amount of flexibility in designing the particulars of their program.[238]

4. Creating a Plan

Because states have a great deal of flexibility in choosing how to provide health care coverage for children, this Comment will detail what eligibility standards states can impose,[239] what benefits states can choose to cover,[240] and to extent to which states can impose cost-

234. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 560 (to be codified at § 1397ee(b)), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997). Enhanced FMAP is equal to the current matching rate for each state determined by a per capita income formula plus a number of percentage points up to 30% of that percentage, so long as the FMAP is less than 100% and does not exceed 85%. *See id.*

235. *See* Nagle & Coffey, *supra* note 28, at 3. In other words, the federal government will increase its reimbursement rate by $.15 for every dollar that Illinois spends on insuring children under the Act. *See id.* Illinois will now receive a $.65 match for every dollar spend, rather than the $.50 it currently receives. *See id.*

236. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 560 (to be codified at 42 U.S.C.A. § 1397ee(c)).

237. *See id.* (to be codified at 42 U.S.C.A. § 1397ee(c)(1)). However, the BBA also states, "Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion." *Id.* (to be codified at 42 U.S.C.A. § 1397ee(c)(7)(C)). Some other limitations on payments for certain expenditures under the BBA include a prohibition on expenditures for a targeted child to the extent that a private insurer is obligated to provide such assistance, and a limit on expenditures not used for Medicaid or health insurance assistance, but for the 10% set-aside funds. *See id.* (to be codified at § 1397ee(c)(6)(A), (c)(2)(A)).

238. *See States May Move Quickly to Decide How to Use Funds: New Children's Health Insurance Program*, 13 ASAP! UPDATE (Families USA Foundation, D.C.), Aug., 1997, at 1.

239. *See infra* Parts III.A.4.a, III.A.4.b.

240. *See infra* Part III.A.4.c.

sharing requirements on beneficiaries.[241]

a. Eligibility Standards

Under the State Children's Health Insurance Program ("SCHIP"), states are given great discretion in determining the eligibility criteria of program beneficiaries.[242] The states may include standards relating to geographic areas served by the plan, age, income, resources, residency, disability status, access to coverage under other health coverage, and duration of eligibility.[243] However, the standards must not discriminate on the basis of diagnosis.[244] Few eligibility requirements are imposed on the states by the BBA other than that the program created by the state be available to "targeted low-income children."[245] The definition of "targeted low-income child[ren]" demarcates the outer limits of the category of children that the state chooses to cover.[246] The word "children" refers to individuals under nineteen years of age,[247] and "low-income children" refers to children whose family income is at or below 200% of the federal poverty level for the given number of family members.[248] In states that already have raised their Medicaid eligibility levels above 150% of the federal poverty line, the income eligibility ceiling may exceed 200% of the federal poverty line.[249]

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241. *See infra* Part III.A.4.d.

242. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397bb(b)(1)(A)).

243. *See id.*

244. *See id.* In other words, in creating eligibility standards, a state would not be permitted to exclude from coverage those children who suffer from a particular diagnosis because it is expensive to treat. Nor would a state be permitted to exclude from coverage a child who has a particular pre-existing condition. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397aa(b)(1)(B)(ii)).

245. *See id.* (to be codified at 42 U.S.C.A. § 1397aa(a)).

246. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 567 (to be codified at 42 U.S.C.A. § 1397jj(b)(1)), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997).

247. *See id.* (to be codified at 42 U.S.C.A. § 1397jj(c)(1)).

248. *See id.* (to be codified at 42 U.S.C.A. § 1397jj(c)(4)). States can determine this percentage above the poverty line so long as it exceeds the Medicaid applicable income level, but does not exceed 50 percentage points above this Medicaid applicable income level. *See id.* (to be codified at 42 U.S.C.A. § 1397jj(b)(1)(B)(ii)).

249. *See id.* In the few rare instances where the state's medicaid applicable income level exceeds 150%, children may benefit from funding under the bill if their family income is less than 50 percentage points above the Medicaid applicable level. *See id.* So, for example, if a state currently has an applicable income level of 185%, then that state could opt to cover children living in families with incomes as high as 235%.

Within the targeted low-income group, preference is given to children with lower family incomes.[250] In addition, the program may not deny participation to any child merely based upon that child's pre-existing medical condition.[251]

b. Methodology

Each state must develop an eligibility screening procedure to ensure: that only targeted low-income children enroll in the program;[252] that children eligible for Medicaid are covered under the old Title XIX Medicaid program, rather than the new Title XXI program;[253] and that coverage provided through the new SCHIP does not replace existing coverage under employer-sponsored packages.[254] Under a Medicaid expansion option, states may cover the same categories of children that they would be permitted to cover under a new insurance program.[255]

"Medicaid applicable income level" is defined in the Act as "the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under subchapter XIX . . . (including under a waiver authorized by the Secretary or under section 1396a(r)(2) of this title), as of June 1, 1997, for the child to be eligible for medical assistance under section 1396a(l)(2) of this title for the age of such child." *Id.* (to be codified at 42 U.S.C.A.§ 1397jj(b)(4)).

250. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at § 1397bb(b)(1)(B)(i)). This provision states, "Such eligibility standards shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income . . . ." *Id.*

251. *See id.* (to be codified at 42 U.S.C.A. § 1397bb(b)(1)(B)(ii)). Note that children of public employees who are eligible for state coverage, as well as children in penal institutions, are excluded from coverage under an SCHIP plan. *See id.* (to be codified at 42 U.S.C.A. § 1397bb(b)(2); Balanced Budget Act of 1997, § 4901, 111 Stat. 567 (to be codified at 42 U.S.C.A. 1397jj(b)(2)).

252. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397bb(b)(3)(A)).

253. *See id.* (to be codified at 42 U.S.C.A. § 1397bb(b)(3)(B)). If a child is found to be eligible for Medicaid, that child must be enrolled in Medicaid rather than enrolled in the new plan. *See id.*

254. *See id.* (to be codified at 42 U.S.C.A. 1397bb(b)(3)(C)). This phenomena is known as "crowding out" of private insurance under group health plans. *See* Lisa C. Dubay & Genevieve M. Kenney, *The Effects of Medicaid Expansions on Insurance Coverage for Children*, 6 THE FUTURE OF CHILDREN 152, 155 (Spring 1996). If the result of this new plan is to substitute public coverage for private coverage, the desired health reform may be unsuccessful. *See id.* at 153. What is problematic about "crowding out" is that this new law aims to insure those children who lack health coverage, not to create larger numbers of persons on public welfare rolls. So if a child has private health insurance through their parent's employer, their parent will not be permitted to disenroll for the purpose of taking advantage of the new health insurance program at the cost of public dollars. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397bb(b)(3)(A), (C)).

255. *See* 42 U.S.C.A. § 1396d(u) (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4702, 4711-12, 4714,

Because Medicaid is an entitlement program,[256] children who are determined eligible will remain eligible, even when the state exhausts its allotment.[257] Once the state exhausts its allotment of funds, the federal government no longer will provide the enhanced matching rate;[258] however, it will continue to provide funding under the current FMAP under the old Medicaid Title XIX program.[259] Under a Medicaid expansion plan, once children are made eligible, they may become entitled to the entire range of services provided under Medicaid.[260] The federal government will permit states to take advantage of the enhanced matching rate if they agree to cover all children under the age of nineteen who are living below 100% of the poverty level at an accelerated rate.[261]

4725, 4732, 4802, 4911, 111 Stat. 494, 508-10, 518, 520, 538, 570, *and* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997).

256. See Goldberg v. Kelly, 397 US. 254, 262 (1970) (holding that "such [welfare] benefits are a matter of statutory entitlement for persons qualified to receive them"). In other words, if a child meets the eligibility requirements set forth by the state in compliance with federal requirements, the state agency must recognize the claim. *See* CINDY MANN, CTR. ON BUDGET AND POLICY PRIORITIES, WHY NOT MEDICAID?: USING CHILD HEALTH FUNDS TO EXPAND COVERAGE THROUGH THE MEDICAID PROGRAM 5-6 (1997). Although this statutory entitlement provides an assurance of coverage for children, such entitlement may force states to spend funds they had not originally appropriated for Medicaid spending. *See id.*

257. *See* ANDY SCHNEIDER, CTR. ON BUDGET AND POLICY PRIORITIES, REDUCING THE NUMBER OF UNINSURED CHILDREN: BUILDING UPON MEDICAID COVERAGE IS A BETTER APPROACH THAN CREATING A NEW BLOCK GRANT TO THE STATES 3 (1997). "If a state uses its block grant funds to expand Medicaid, the newly eligible children will be entitled to coverage for needed basic health care services, just as children currently eligible for Medicaid are. If a state uses block grant funds to establish or expand a separate state program, no individual child will be entitled to coverage." SCHNEIDER, *supra* note 138, at 4.

258. *See* Nagle & Coffey, *supra* note 28, at 3. The FMAP in Illinois under the BBA is 65%. *See id.*

259. *See* Div. of State Gov't and Chapter Affairs, Am. Academy of Pediatrics, Comparison of Major State Options for State Children's Health Insurance Program 1 (1997) (on file with the American Academy of Pediatrics, Elk Grove Village, Ill.).

260. *See id.*

261. *See* 42 U.S.C.A. § 1396d(u)(2)(C). Under the Medicaid Act, states are currently required to phase in eligibility for children up to age nineteen by the year 2002 if such children live at or below 100% of the federal poverty level. *See id.* § 1396a(*l*)(1)(D), (2)(D) (West 1992 & West Supp. 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4454, 4700-02, 4711-12, 4714-15, 4724, 4731-33, 4741, 4751-53, 4911-13, 111 Stat. 368, 431, 493, 495, 506-10, 516-17, 519-20, 522-25, 571, 573. This provision of the BBA allows states to receive an enhanced FMAP for accelerating this phase in order to cover all such children immediately. *See id.* § 1396d(u)(2)(C).

Additionally, the BBA includes an option for states to implement twelve-month continuous eligibility for children under Medicaid programs, including those children who, prior to the enactment of the BBA, were eligible for Medicaid benefits.[262] Continuous eligibility would prevent children from experiencing sporadic health insurance coverage on a month-by-month basis, which results in the inability of the child to form a relationship with a primary care provider.[263] States will have the option of presuming that children are eligible for Medicaid benefits during the processing of their applications.[264] Again, this process would apply to children already enrolled in the state's Medicaid program, as well as those children covered by an expansion in Medicaid.[265]

c. Coverage Requirements

Under a Medicaid expansion, states would be required to provide the entire range of services and benefits already required by the Medicaid Act to the targeted low-income children.[266] Under a new SCHIP plan, states would have more discretion in determining which benefits would be offered under the plan, as long as the state provides a few required minimum benefits.[267] Even with this discretion, however, the coverage under a new state child health insurance program would have to qualify as one of the four specified types of coverage available.[268]

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262. *See id.* § 1396a(e).

263. *See* Stephen Berman, *Uninsured Children: An Unintended Consequence of Health Care System Reform Efforts*, 274 JAMA 1472, 1472 (1995).

264. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4912, 111 Stat. 572 (to be codified at 42 U.S.C.A. § 1396r-1a(a)).

265. *See id.*

266. *See* English, *supra* note 220, at 7. *See also supra* notes 95-112 and accompanying text (discussing the services and benefits provided under the Medicaid Act).

267. *See generally* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc) (discussing the types of child health assistance provided to a targeted low-income child). The categories of services that must be provided under a new state health insurance plan include the following: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including immunizations. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(c)(1)(A)-(D)). Additional services include, but are not limited to, coverage of prescription drugs, mental health services, vision services, and hearing services. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(c)(2)(A)-(D), (3)).

268. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(a)). The four types specified are benchmark coverage, benchmark equivalent coverage, existing state program coverage, and secretary-approved coverage. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(a)(1)-(4)). *See infra* notes 269-283 and accompanying text (discussing these four types of

First, coverage may be "benchmark."[269] The legislation specifies three distinct benchmark coverage packages.[270] The first benchmark coverage package is the equivalent of the Blue Cross/Blue Shield preferred provider option service benefit plan, as described in the Federal Employee Health Benefit Plan.[271] The second benchmark coverage package is equivalent to the plan that is already offered and generally available to state employees by the particular state proposing the plan.[272] Finally, the third benchmark coverage package is the plan offered by the health maintenance organization with the largest insured commercial, non-Medicaid enrollment in the involved state.[273]

Second, states can offer "benchmark equivalent coverage."[274] To qualify as "benchmark equivalent," such coverage must provide basic services[275] and have an "aggregate actuarial value that is at least

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coverage).

269. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc(a)(1)).

270. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(b)(1)-(3)).

271. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(b)(1)). The standard Blue Cross/Blue Shield preferred provider option service benefit plan offers benefits for which "payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services," or for which payment is made directly to the beneficiary for hospital benefits, surgical benefits, in-hospital medical benefits, ambulatory patient benefits, supplemental benefits and obstetrical benefits. 5 U.S.C. §§ 8903(1), 8904(1)(A)-(F) (1994). This is one of the coverage options that is offered to federal employees. *See id.* § 8903.

272. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc(b)(2)). In Illinois, state employees can choose from a variety of health insurance packages. *See* Chicago Health Policy Research Council: Fact Sheet, #3: SCHIP Benefit Package Comparison 1 (Oct. 1997) (on file with the Chicago Health Policy Research Council, Chicago, Ill.). Generally, all of these packages provide the following minimum benefits: inpatient services; outpatient services; clinic services; ambulatory care services; prescription drugs; laboratory and radiological services; dental services; and case management services. *See id.* at 2.

273. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc(b)(3)(A)-(B)). In Illinois, the Department of Insurance reports that HMO Illinois has the largest market share of enrolled commercial, non-Medicaid covered lives offered by an HMO. *See* Chicago Health Policy Research Council, *supra* note 272, at 1. Fully covered benefits under this plan include: inpatient services; outpatient services; physician services; surgical services; clinic services; ambulatory care services; laboratory and radiological services; abortion under certain circumstances; and case management services. *See id.* at 2.

274. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc(a)(2)).

275. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(a)(2)(A)). Categories of basic services include: inpatient and outpatient hospital services; physicians surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunizations. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(c)(1)(A)-(D)).

actuarially equivalent" to one of the named benchmark coverage packages.[276] If the state plan proposes to provide for any additional services, it must have an actuarial value that is equal to at least seventy-five percent of the actuarial value of the coverage of the category of services in the benchmark package.[277] The BBA explicitly provides that if the package chosen by a state covers any prohibited services named in the BBA, the state will not be required to cover those services.[278]

Third, states may provide coverage as defined under the existing comprehensive programs offered in New York,[279] Florida,[280] or

276. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(a)(2)(B)). "The actuarial value of coverage of benchmark benefit packages and coverage of any categories of additional services . . . offered by such a plan [must] be set forth in an actuarial [report] prepared by . . . a member of the American Academy of Actuaries; using generally accepted actuarial principles and methodologies; using a standardized set of utilization and price factors; [and] using a standardized population[.]" *Id.* (to be codified at 42 U.S.C.A. § 1397cc(c)(4)(A)-(D)). The value must not consider the differences in coverage based on method of delivery, but must take into account the ability of a state to reduce benefits. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(c)(4)(F)-(G)).

277. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(a)(2)(C)). Categories of additional services include the following: coverage of prescription drugs; mental health services; vision services; and hearing services. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(c)(2)(A)-(D)).

278. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(c)(5)). Specifically, the statute reads, "Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this subchapter, notwithstanding that any benchmark benefits package includes coverage for such an item or service." *See id.*

279. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(a)(3), (d)(1)(C)). New York's Child Health Plus Program is available to all children under age nineteen whose parents have incomes below 185% of the federal poverty level, unless covered by another plan. *See* N.Y. PUBLIC HEALTH LAW §§ 2510(4), 2511(2)(a)-(c) (McKinney 1993 & Supp. 1997). Child Health Plus benefits include well-child preventative care, immunizations, emergency care, ambulatory surgery, laboratory tests, chemotherapy and prescriptions. *See id.* § 2510(7)(a). Families at the lowest income levels have no cost-sharing obligations, while families with higher annual incomes will be charged fees on a sliding scale. *See id.* § 2510(9)(a), (b)(i)-(iii). Households with up to 100% of the federal poverty level pay nothing. *See id.* § 2510(9)(b)(i). Families with between 100-132% pay $9 per child per month, but such payment is not to exceed $36 for any family each month. *See id.* § 2510(9)(b)(ii). Families with incomes between 133-185% of the federal poverty level will pay $13 per child per month, but not to exceed $52 per family per month. *See id.* § 2510(9)(b)(iii).

280. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc(a)(3), (d)(1)). Florida's section 1115 waiver project, Florida Healthy Kids Corporation, is designed to coordinate health care delivery systems with local school districts. *See* Oliver & Paul-Shaheen, *supra* note 64, at 732. The Florida Legislature found that,

> increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in this state . . . . It is the intent of the Legislature that a nonprofit

Pennsylvania.[281] The statutory language of the BBA effectively pre-approves these states' programs by specifying that their benefit packages are among the four accepted types that other states may choose to adopt when developing their respective plans .[282]

Fourth, the state may offer health coverage that the Secretary of HHS approves as sufficient to provide coverage for the targeted low-income children.[283] Thus, each state may submit for approval a benefit package that does not fall into one of the above-defined categories.[284]

d. Premiums and Cost-Sharing

A state child health program permits the states to impose premiums, deductibles, coinsurance and other cost-sharing provisions based on the family income of the targeted group, only if such provisions do not favor children from higher income families over children from lower income families.[285] Under the new SCHIP program, states will be required to offset the amount of their expenditures by the amount of any premiums and other cost-sharing receipts received by the State.[286]

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corporation be organized to facilitate a program to bring preventive health care services to children, if necessary through the use of school facilities . . . and to provide comprehensive health insurance coverage to such children.

FLA. STAT. ANN. § 624.91(2) (West 1996 & West 1998).

281. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc(a)(3), (d)(1)(C)). In Pennsylvania, all children under the age of eighteen shall have health insurance coverage if their family income is at or below the federal poverty line. See 62 PA. CONS. STAT. ANN. § 5001.701(d)(5) (West 1996). If a child is under six years of age and his or her family income does not exceed 185% of the federal poverty level, health care coverage is provided at no cost to the family. *See id.* § 5001.701(d). For children under age six whose family income does not exceed 235% of the federal poverty level, that child's health coverage costs will be subsidized at a rate not to exceed 50% of costs incurred. *See id.* § 5001.701(e)(1). Because this program is not an entitlement program, when funds are no longer available, the family may purchase this coverage for the child at cost. *See id.* § 5001.701(e)(3).

282. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc(d)(1)(A)-(D)). This section specifies that these programs must include coverage of a range of benefits, must be administered and overseen by the State and receive funds from the State, must be located in one of the three named states, and must have been offered to children at the date of the enactment of the new law. *See id.*

283. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(a)(4)).

284. *See id.*

285. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(e)(1)(B)).

286. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 560 (to be codified at 42 U.S.C.A. § 1397ee(c)(5)), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997). This is significant because the federal matching payments are calculated by the amount of expenditures made by each state. *See id.* (to be codified at 42 U.S.C.A. § 1397ee(a)). The money collected from enrollees will be deducted from the state expenditures when the federal government calculates their matching rate. *See id.*

Cost-sharing provisions may not be imposed on benefits for preventive services[287] including well-baby care, well-child care, and age-appropriate immunizations.[288] In addition, the new SCHIP program accords special protection to children whose family income is at or below 150% of the poverty line.[289] For this group, the new plan may not impose enrollment fees, premiums, deductibles,[290] or other similar charges that would exceed the existing Medicaid provisions that provide for and limit cost-sharing fees.[291] For children whose family income exceeds 150% of the poverty line but is below 200% of the poverty line, any premiums, deductibles, cost sharing or other similar charges may be imposed on a sliding scale based on income.[292] For this group, the total expenditures for all the targeted children in the family cannot exceed 5% of the family's income for the year involved.[293]

Under a Medicaid expansion program, the BBA provides that the existing provisions and limitations of the Medicaid statute regarding cost sharing obligations would continue to apply.[294] As discussed previously, although the Medicaid statute allows for some cost sharing obligations, it also contains protections for recipients of medical assistance with respect to such obligations.[295] For example, one such protection is that the Medicaid statute requires that cost-sharing payments be nominal in amount.[296] Therefore, under a Medicaid expansion, these near poor children and their families would be

287. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc(e)(2)).

288. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(e)(2), (c)(1)(D)).

289. *See id.* (to be codified at 42 U.S.C.A.§ 1397cc(e)(3)(A)(i)-(ii)).

290. *See id.*

291. *See id. See also supra* notes 124-27 and accompanying text.

292. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 (to be codified at 42 U.S.C.A. § 1397cc(e)(3)(B)).

293. *See id.*

294. *See id.* (to be codified at 42 U.S.C.A. § 1397cc(e)(4)). *See also supra* note 120-21 and accompanying text.

295. *See* 42 U.S.C.A. § 1396a(a)(14) (West 1992 & West Supp. 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4454, 4700-02, 4711-12, 4714-15, 4724, 4731-33, 4741, 4751, 4752, 4753, 4911-13, 111 Stat. 368, 431, 493, 495, 506-10, 516-17, 519-20, 522-25, 571, 573; 42 U.S.C.A. § 1396*o* (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4743, 111 Stat. 368, 524; Health Care Fin. Admin. 42 C.F.R. §§447.50 (1997).

296. *See* 42 U.S.C.A. § 1396*o*(a)(3), (b)(3) (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4743, 111 Stat. 368, 524.

protected by these statutory limitations on cost-sharing contributions.[297]

B. *Medicaid in Illinois After the Passage of the Balanced Budget Act of 1997*

In response to the Balanced Budget Act of 1997 and the SCHIP initiative, on December 9, 1997, Governor Edgar announced that the state administration intends to expand health care coverage to some of Illinois' uninsured children through the state Medicaid program.[298] Beginning on January 5, 1998, Illinois administratively extended Medicaid coverage to all infants up to age one with a family income up to 200% of the federal poverty level, as compared to the previous 133% percent limit.[299] In early 1998, Illinois also extended Medicaid coverage to all children up to age nineteen with family incomes up to 133% of the poverty level.[300] The State Administration estimates that this Medicaid expansion will result in the coverage of more than 40,000 uninsured children.[301] Edgar also announced the creation of a task force consisting of legislators and advocates to develop and implement an initiative to cover more uninsured children in Illinois with the help of SCHIP funds made possible through the Balanced Budget Act of 1997.[302]

IV. ANALYSIS

A. *Current Gaps in Illinois' Efforts to Provide Health Care to Children*

Given the myriad of health insurance programs in Illinois, there lacks a comprehensive set of health care services designed to

297. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 554 ((to be codified at 42 U.S.C.A. § 1397cc(e)(4)).

298. *See* State of Illinois, *Governor Announces Initiative To Expand Health coverage to 43,300 Uninsured Children and Pregnant Women By Jan. 5; Forms Task Force To Study Expanding Coverage Further*, (visited Jan. 30, 1998) <http://www.state.il.us/gov/press/97/Dec/kidcare.htm>.

299. *See* Dep't of Pub. Aid, Notice of Emergency Amendments, 22 Ill. Reg. 1,576 (amending ILL. ADMIN. CODE tit. 89 §§ 120.11, 120.31, 120.64, 120.380). Pregnant women with household incomes up to 200% of the poverty level are now also covered under Medicaid. *See* State of Illinois, *supra* note 298. An estimated 2,900 women will benefit from this expansion. *See id.* Governor Edgar said, "'[W]e can help more pregnant women stay healthy and give birth to stronger babies.'" *Id.*

300. *See* Dep't of Pub. Aid, Notice of Emergency Amendments, 22 Ill. Reg. 1,576 (amending ILL. ADMIN. CODE tit. 89 §§ 120.11, 120.31, 120.64).

301. *See* State of Illinois, *supra*, note 298.

302. *See id.*

adequately meet the health care needs of children.[303] The system of publicly funded health coverage in Illinois is a "bewildering hodge-podge of different programs and laws: each with different eligibility criteria; different scopes of coverage; and different problems."[304] Generally, a child has to be very poor, very ill, or disabled to receive a continuum of care in Illinois.[305] As a result, "near poor" children who are not severely or chronically ill and who are not covered by a family plan must rely on the inadequate protections of free immunizations, minimal health screenings, and scant reproductive care provided by schools, community health centers, and private health centers, none of which are sufficient to ensure the overall wellness of a child.[306] Thus, more than 300,000 children in Illinois, or one of every ten, are not receiving adequate health care due to the lack of sufficient health care coverage.[307]

Even for the very poor children, it is estimated that nationally, nearly 3,000,000 Medicaid-eligible children remain uninsured.[308] In Illinois, studies estimate that between 117,700 and 227,300 Medicaid-eligible children are not enrolled in the state's medical assistance program.[309] This fact alone points to severe problems within the loosely constructed system of publicly-funded medical coverage and

303. *See* KROHE, JR., *supra* note 50, at 35-46.

304. Thomas Yates, Legal Assistance Found. of Chicago, An Advocate's Guide to Medical Assistance and Indigent Health Care in the City of Chicago (Aug. 1991) (on file with the Legal Assistance Foundation of Chicago, Chicago, Ill.).

305. *See supra* notes 147-211 and accompanying text.

306. *See* KROHE, JR., *supra* note 50, at 37-46. Because the publicly funded system of health insurance has failed Illinois children, several other groups have attempted to fill in some of the gaps. For example, the Chicago Department of Health developed a comprehensive school health program that encourages linkages between local public schools and city public health clinics to provide comprehensive care and screening services to school children. *See* Chicago Department of Public Health, *Comprehensive School Health Program* (visited Jan. 26, 1998) http://www.ci.chi.us/WorksMart/Health/html/SchoolHealth.htm>. Currently, however, only sixteen schools statewide operate on-site health clinics. *See* Telephone interview with Judy Redick, Illinois Department of Public Health, Springfield, Ill. (October 9, 1997).

The Illinois Department of Public Health also has a Vaccines for Children Plus program to provide free vaccines to children enrolled in Medicaid, those without health insurance, and those without adequate health insurance coverage for immunizations. *See* Illinois Department of Public Health, *Gov. Announces Dramatic Improvement in Illinois Immunization Rates for 2-Year-Olds* (last modified Feb. 28, 1997) <http://www.idph.state.il.us/public/press97/immunize.htm>.

307. *See* Nagle & Coffey, *supra* note 28, at 1.

308. Health Insurance for Children: Declines in Employment-Based Coverage Leave Millions Uninsured; State and Private Programs Offer New Approaches, GAO No. 97-105, 105th Cong. 2 (1997) (testimony of William J. Scanlon, Director Health Financing and Systems Issues Health, Education, and Human Services Division).

309. *See* SUMMER ET AL., *supra* note 27, at 13tbl. 1.

care in the state of Illinois.[310]

1. Illinois' Failure to Expand Coverage of Medicaid

Prior to the creation of the State Children's Health Insurance Program ("SCHIP") initiative, Illinois responded by implementing Medicaid expansions to increase health coverage to low-income children and pregnant women.[311] Despite ranking tenth in the amount of per capita income in the nation, Illinois ranks thirty-sixth in state spending on maternal and child health programs.[312] Prior to January 5, 1998, the state only had met the minimum federally mandated requirements, capping the income eligibility income standard at 133% of the federal poverty line for children under age six and extending benefits for children living at 100% of the poverty level only to children under the age of thirteen.[313] Other states, prior to the creation of SCHIP, had taken advantage of the federal matching rates, by expanding their income-eligibility standards to the highest level, 185% of the federal poverty line for infants,[314] and by insuring children up to the age of eighteen.[315] Still other states previously have gone beyond the federal requirements and have extended Medicaid coverage to include even more uninsured children.[316]

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310. *See* NAGLE & ADKINS, *supra* note 44, at 5.

311. *See* Div. of Health Policy Research, Am. Academy of Pediatrics, *supra* note 88, at 1.

312. *See* Ctr. for Health Admin. Studies at Univ. of Chicago, Medicaid Enrollees in HMOs: A Comparative Analysis of Perinatal Outcomes for Mothers and Newborns in a Large Chicago HMO 9 (Feb. 1989) (on file with the Center for Health Administration Studies University of Chicago).

313. *See supra* notes 160-62 and accompanying text. *But see supra* notes 298-302 and accompanying text for Medicaid expansions in Illinois after passage of the Balanced Budget Act of 1997.

314. *See* Div. of Health Policy Research, Am. Academy of Pediatrics, *supra* note 88, at 1-4. These states include the following: Connecticut, Colorado, Washington D.C., Florida, Georgia, Hawaii, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota (up to 275%), Mississippi, Missouri, New Hampshire, New Mexico, New York, North Carolina, Pennsylvania, Rhode Island (up to 250%), South Carolina, Tennessee, Texas, Vermont (up to 225%), Washington, and Wisconsin. *See id.*

315. *See id.* The states that extended Medicaid coverage to children up to the age of eighteen are: California, Colorado, Georgia, Hawaii, Kentucky, Missouri, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, South Dakota, Virginia, Washington, and West Virginia. *See id.*

316. *See* SCHNEIDER, *supra* note 257, at 4. As of May, 1997, the following twenty-eight states have expanded Medicaid coverage beyond the federal requirements: Arkansas, Connecticut, Delaware, Georgia, Hawaii, Indiana, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Mexico, North Carolina, North Dakota, Oregon, Rhode Island, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, and Wisconsin. *See id.* Seven of these states have extended Medicaid coverage to all children under the age of eighteen

2. Lack of Continuous Care

Not only are some children in Illinois without any kind of insurance, but also even those who do have coverage under Medicaid lack continuous care.[317] For Medical Assistance No Grant ("MANG") recipients and MANG-P (a version of MANG for pregnant women and their children) recipients in Illinois, income eligibility is determined on a monthly basis.[318] During the months when the family income exceeds the predetermined state income standards or when the medically needy family does not spend down to the predetermined medically needy income level, the child will go completely without coverage.[319] This kind of gap in health coverage creates a variety of problems for children.[320] For example, interruptions in eligibility interfere with a child's ability to establish an ongoing relationship with a primary care provider.[321] More importantly, providers may erroneously fail to provide care to an enrollee when medical services are necessary because the patient's enrollment status is not clear at the time.[322]

3. Failure of Managed Care Initiatives

The public expressly disapproves of Illinois' Medicaid initiatives that incorporate managed care components.[323] Moreover, evaluative studies conducted on the Healthy Moms/Healthy Kids ("HM/HK") program indicate that the program experienced a number of unexpected outcomes.[324] For example, in 1995, the HM/HK program registered

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in families with incomes at or below 200% of the federal poverty line. *See id.*

317. *See* Berman, *supra* note 263, at 1472.

318. *See* JOSEPH & WEBBER, *supra* note 151, at 6-7. *See also supra* notes 155-64 and accompanying text (discussing MANG and MANG-P programs).

319. *See* JOSEPH & WEBBER, *supra* note 151, at 7.

320. *See* Berman, *supra* note 263, at 1472.

321. *See* Jane Perkins, *Enrollment, Education, and Plan Use in Medicaid Managed Care Programs in* MEDICAID MANAGED CARE: AN ADVOCATE'S GUIDE TO PROTECTING CHILDREN 3-4, (1996).

322. *See id.*

323. *See* Gratteau & Pearson, *supra*, note 192, at 1. "Illinois' failures with Healthy Moms/Healthy Kids casts doubts on the state's ability to pull off a more ambitious welfare program called MediPlan Plus." *Id.* "The decision to eliminate children ages one through five from the Healthy Moms/Healthy Kids program and limit new participants to pregnant women is but the latest chapter in an experiment that has failed to meet expectations." Pearson, *supra* note 192, § 2, at 7. "[The Department of Public Aid overpaid] by $5.48 million the company that oversees the agency's Healthy Moms-Healthy Kids program in Chicago." Dave McKinney, *State Audit Blasts Public Aid Deal*, CHI. SUN TIMES, April 5, 1996, at 12.

324. *See* ILL. DEP'T OF PUBLIC AID, *supra* note 185, at 2. "[T]he Healthy Moms/Healthy Kids Program was hampered by a short timeline, had less enrollment in

nearly 210,000 Medicaid-enrolled children. However, 191,000 Medicaid-enrolled children did not participate in the HM/HK program.[325] Thus, the program failed to provide the necessary services to half of the targeted population of children.[326] Likewise, the number of Medicaid-enrolled pregnant women in the HM/HK program was approximately 19,000, yet the number of HM/HK-eligible pregnant women not enrolled in the program equaled nearly 10,000.[327] Although providing services to two-thirds of the targeted population of pregnant women is significant, this figure is particularly misleading owing to the release of eligible post-natal women from the HM/HK program at the end of 1994, because of escalating costs.[328]

Not only does HM/HK fail to cover the targeted number of eligible women and children, but also the program fails to satisfy the individuals it covers.[329] A significant number of women with infants and children reported using a provider outside of the HM/HK program, indicating disapproval of primary care providers under the program.[330] Only slightly more than half of these women indicated that it was "extremely or very easy" for them to obtain basic pre-natal or well-child care under the HM/HK program.[331] For those women receiving case management services, one-third reported that they were never even contacted by a case management agency.[332] In addition, one-third of the women contacted did not receive services from their case manager beyond their first contact.[333] The inadequacies of the case management services are due in part to the excessive numbers of

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the managed care component than anticipated, received negative press, and experienced implementation problems . . . ." *Id.* *See also* Ctr. for Health Admin. Studies at the Univ. of Chicago, Evaluation of the Healthy Moms/Healthy Kids Program (1995) (on file with the Ill. Dept. of Pub. Aid, Contract No. 94500215); ILLINOIS MATERNAL AND CHILD HEALTH COALITION, *supra* note 185, at 17-21.

325. *See* ILL. DEP'T OF PUBLIC AID, *supra* note 185, at 7-8 (noting that 400,726 eligible children could have registered, yet only 209,890 eligible children did register).

326. *See id.*

327. *See id.* (noting that 28,393 eligible pregnant women could have registered, but only 18,902 registered in the program).

328. *See* Ctr. for Health Admin. Studies at the Univ. of Chicago, *supra* note 324, at 53-59.

329. For a discussion of the shortcomings of the HM/HK program, see text accompanying *supra* notes 323-328 and *infra* notes 330-334.

330. *See* ILLINOIS MATERNAL AND CHILD HEALTH COALITION, *supra* note 185, at 44. Nearly one-fifth of the women interviewed for the report had been to a provider outside the HM/HK program. *See id.* at 43.

331. *See id.* at 51.

332. *See id.* at 55.

333. *See id.*

enrollees per case.[334]

In general, Medicaid enrollees who have elected to enroll in a managed care plan have also encountered difficulties.[335] Studies indicate that the following barriers exist in the provision of adequate health care coverage in Chicago's Medicaid managed care programs: (1) high-pressure sales tactics and false marketing; (2) difficult processes for changing providers; (3) poor quality of care; (4) lack of informed consent; and (5) inadequate specialty referrals.[336] Despite a federal mandate to monitor the quality of care of new managed care initiatives, both the Illinois Department of Public Aid and the Department of Public Health have failed to do so.[337] The General Accounting Office found that both Medicaid HMOs and the Illinois Department of Public Health lacked adequate quality assurance programs to evaluate the care provided, failed to gather and analyze utilization data to detect underserving, and performed scant follow-up to correct quality of care problems.[338]

Because Illinois has a low Medicaid provider reimbursement rate,[339] half of the state's physicians refuse to accept Medicaid patients.[340] Further, because health care providers cannot afford to provide services for which they will not be reimbursed, Illinois' low capitation rates are both inadequate to provide basic care to Medicaid beneficiaries and insufficient to reimburse, and thus retain, providers.[341]

Although Illinois' system of child welfare agencies is extensive, the agencies are structurally uncoordinated and fragmented.[342] Illinois

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334. *See* Ctr. for Health Admin. Studies at the Univ. of Chicago, *supra* note 324, at 113: Case loads often exceeded the guidelines of 155 cases per case manager, with reported case loads of up to 300 enrollees. *See id.* One case manager was reported to say, "'[Y]our best efforts are undermined by the sheer volume of what you have to do.'" *See id.* at 114.

335. *See* Ctr. for Health Admin. Studies Univ. of Chicago, *supra* note 312, at 11.

336. *See id.*

337. *See id.*

338. *See*, A NEW PROGRAM FOR CHICAGO, *supra* note 185, at 2.

339. *See* Ctr. for Health Admin. Studies Univ. of Chicago, *supra* note 312, at 9. Despite the fact that Illinois ranks 10th nationally in per capita income, it ranks 51st (including the District of Columbia) in the percentage of charges and costs reimbursed to hospitals by Medicaid. *See id.*

340. *See* KROHE, JR., *supra* note 50, at 34.

341. *See* Ctr. for Health Admin. Studies Univ. of Chicago, *supra* note 312, at 9. For example, one community health clinic that was previously reimbursed $105 for each treatment offered to a Medicaid patient under the fee-for-service delivery system, now receives only $14 per month capitation fee for each Medicaid patient. *See* Carol Jouzaitis, *Clinics' Main Ailment: Funding*, CHI. TRIB., Nov. 25, 1996, § 1, at 14.

342. *See* KROHE, JR., *supra* note 50, at 36. This phenomenon is not specific to

needlessly spends billions of dollars each year providing care to children who are not seen until they have become too sick to be treated in a less expensive manner.[343] Generally speaking, children in Illinois receive only episodic and crisis-related care, leaving preventive, chronic, dental, and mental health needs unmet.[344]

Despite its many problems, however, Medical Assistance in Illinois continues to provide an important safety net for children whose families could not otherwise afford the most basic health care services.[345] Furthermore, Medicaid continues to play a vital role in off-setting the decline in employer-sponsored coverage of dependents.[346] For the foregoing and the following reasons, a Medicaid expansion that is closely monitored by the Department of Public Aid is the most effective and efficient way to insure health care for a growing number of near poor children.[347]

B. Implications of the Balanced Budget Act of 1997 in Illinois: Medicaid Expansion versus a New Plan

The Medicaid program plays an integral part in ensuring a child's access to health care by significantly increasing the opportunities for the lowest income children to receive basic and essential care services.[348] As such, many child advocates argue that the Medicaid program is the better vehicle for reducing the number of uninsured

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Illinois. Experts note that publicly funded health care services for children make up a "system that is fragmented across service sectors, patched together with a fragile mix of financing arrangements, and vulnerable . . . cost-containment policies . . . that limit access to health care services." Forrest et al., *supra* note 38, at 1789. For example, nutritional advice and education is provided through the Medicaid program to the poor, but the actual food is provided by the Department of Public Health through a separate program called Women, Infants and Children ("WIC"). *See* KROHE, JR., *supra* note 50, at 37.

In addition, turfism among the various state agencies is a significant problem in Illinois that may be exacerbated by the creation of a new agency, the Department of Human Services. *See* Ctr. for Health Admin. Studies at the Univ. of Chicago, *supra* note 324, at 89. "There's a tremendous amount of political manipulation . . . and territorial wars." *Id.* (quoting member of the HM/HK advisory board). This new state agency will be responsible for administering most of the public assistance programs in the state. *See* 20 ILL. COMP. STAT. ANN. 1305/80-10(d) (West Supp. 1997). The Medical Assistance program, however, will remain within the Department of Public Aid, resulting in a further fragmentation of publicly funded assistance programs. *See id.*

343. *See* KROHE, JR., *supra* note 50, at 44.

344. *See* NAGLE & ADKINS, *supra* note 44, at 3.

345. *See* Martin & Dubois, *supra* note 57, at 1-24.

346. *See id.* at 1-25.

347. *See generally* SCHNEIDER, *supra* note 257 (analyzing how Medicaid expansion is a better approach than block grants to reducing the number of uninsured children).

348. *See* English, *supra* note 10, at 15.

children.[349] However, deciding which program to pursue must be based on an informed decision,[350] considering the advantages and disadvantages of a Medicaid expansion as opposed to the advantages and disadvantages of a new health insurance plan.[351]

1. Administrative Ease

Arguably, the best reason for expanding Medicaid instead of creating a new block grant program is the fact that administratively, the Medicaid system and structures are already in place.[352] Expanding and modifying an existing program would be much less difficult than creating an entirely new system and structure.[353] Under Medicaid, enrollment procedures, provider reimbursement rates, and systems for monitoring and regulating the quality of care are already established.[354] Thus, the construction and implementation of an entirely new program would be more expensive, and less efficient, than expanding Medicaid.[355] Currently, administrative costs in the Medicaid program average less than five percent of total expenditures.[356]

Because implementation costs of an entirely new and separate program would be substantially higher than the less-than-five-percent costs generally spent on average to administer Medicaid programs across the country, it is likely that such a new program would use the entire ten percent set-aside[357] to subsidize start-up costs and education costs.[358] Consequently, little if any funds would remain to subsidize enrollment initiatives and service coordination with other public or private heath insurance programs.[359] Further, implementation of a

349. *See id.*

350. *See* Nagle & Coffey, *supra* note 28, at 4-6. "The challenge is to determine the best form of health coverage, and the amount of state funds necessary to ensure that as many children as possible are covered." *Id.* at 4.

351. *See id.*

352. *See* CHILDREN'S DEFENSE FUND, *supra* note 2, at 4.

353. *See id.*

354. *See* John Holahan, Expanding Insurance Coverage for Children 10 (May 1997) (on file with the Urban Institute, D.C.). In a preliminary report, the Congressional Budget Office found that because a system already exists, the Medicaid approach would provide coverage to a greater number of children than under a separate health insurance program created through a block grant. *See* English, *supra* note 10, at 3.

355. *See* SCHNEIDER, *supra* note 257, at 5-6.

356. *See id.*

357. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 560 (to be codified at 42 U.S.C.A. § 1397ee(c)(2)(A)), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997).

358. *See* SCHNEIDER, *supra* note 257, at 5.

359. *See id.*

new program likely will require a new state agency or private contractor bureaucracy.[360] In an already fragmented and territorial system of child welfare, development of a new child health insurance program would result in a complicated two-tier system of publicly subsidized health coverage, separating poor children from near-poor children.[361] For example, if a new block grant program is implemented, a family in Illinois whose income is at 120% of the federal poverty line will be able to enroll their seven-year-old child in Medicaid, while their fifteen year old child would have to be enrolled in the separate SCHIP program.[362] Under a block grant program, eligibility standards, enrollment procedures, and benefits could differ considerably from those under the state's Medicaid program, creating confusion among families.[363]

2. Individual Entitlement

The most significant problem with the creation of a new and separate health insurance program for children is the lack of an entitlement for the children.[364] The annual federal funds available to each state under a block grant would be capped in advance at a particular amount.[365] After exhausting the allotted funds, the child would have no guarantee of basic health care coverage.[366] Depending upon the number of children eligible in each state, children may have to receive a reduction in benefits or be forced onto a long waiting

360. *See id.* If a new program is administered by a private contractor instead of the state agency, such two-tiered system of publicly-funded health care for children will only further the fragmentation of services available to children in the state. *See id.*

361. *See id.* Arguably, such a two-tiered system could potentially stigmatize poor children because they are separated out from other "near poor" children. *See id.*

362. *See id.* The BBA explicitly states that if a child is Medicaid-eligible, that child must be enrolled in Medicaid and not in a new program. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397bb(b)(3)(B)). "Children found through the [eligibility] screening to be eligible for medical assistance under the State medicaid plan under [title] XIX are [to be] enrolled for assistance under such plan." *Id.* In the above example, the family could not choose to enroll both children in the new block grant program merely for reasons of convenience. *See id.*

363. *See* SCHNEIDER, *supra* note 257, at 6.

364. *See* Balanced Budget Act of 1997, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397bb(b)(4)). "Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan." *Id.*

365. *See* SCHNEIDER, *supra* note 257, at 5-6. Any amount spent in excess of the amount allotted would necessarily have to be paid for with state funds; or, because it is not an entitlement, not be subsidized at all. *See id.*

366. *See id.*

list.[367] Because Medicaid-eligible children are entitled to basic health care services, under a Medicaid expansion, the federal government will continue to match state expenditures, regardless of whether the number of children eligible for Medicaid increases.[368]

3. Enrollment Procedures

Opponents to a Medicaid expansion program argue that Medicaid expansions merely expand eligibility and that enrollment remains voluntary.[369] Because the Medicaid enrollment process is quite burdensome, a significant number of Medicaid-eligible children still lack Medicaid coverage.[370] However, some of the problems associated with Medicaid enrollment have been alleviated by the federal Medicaid requirement that pregnant women and children have access to short forms, outstations, and presumptive eligibility.[371] In addition, the BBA has earmarked up to ten percent of the federal dollars to be used in non-provision activities, including outreach and other innovative enrollment strategies.[372] Conversely, enrollment in a separate state health insurance program will depend on the friendliness of the process, which is not guaranteed.[373]

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367. *See id.* This result occurred in Massachusetts where over 5,000 uninsured children were wait-listed after the Child Medical Security Program closed enrollment due to financial concerns. *See id.*

368. *See id.*

369. *See* Holahan, *supra* note 354, at 10. As discussed, not all Medicaid-eligible children enroll in Medicaid often because the procedure for enrolling is burdensome, parents are unaware of their child's eligibility, and because of the stigma attached to Medicaid coverage due to its relation to cash-assistance programs. *See supra* text accompanying notes 113-17.

370. *See* Kenneth E. Thorpe, *Incremental Strategies for Providing Health Insurance for the Uninsured: Projected Federal Costs and Number of Newly Insured*, 278 JAMA 329, *passim* (1997).

371. *See supra* notes 115-17, 172-79 and accompanying text.

372. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 560 (to be codified at 42 U.S.C.A. § 1397ee(a)(2), 1397ee(c)(2)(A)), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997). This set aside money can be used to provide other child health assistance to targeted low-income children; fund health services initiatives to improve the health of targeted low-income children; create innovative outreach activities; and to fund reasonable administrative costs. *See id.* (to be codified at 42 U.S.C.A. § 1397ee(a)(2)).

373. *See* Nagle & Coffey, *supra* note 28, at 5. In this special report, Voices for Illinois Children sets forth several steps that Illinois must take to best use the new federal funds. *See id.* at 7. One of these steps is to "[d]evelop an aggressive outreach plan to ensure that uninsured children benefit from this new initiative." *Id.* Hence, whether under a Medicaid expansion, or an entirely new block grant program, Illinois must reach out to ensure that children are enrolled in this health initiative. *See id.*

4. Benefits and "Crowding Out" of Private Insurance

In terms of children's needs, Medicaid offers one of the best currently available preventive and primary care packages, and it represents a tested approach to addressing children's health needs.[374] An argument against expanding Medicaid is that a majority of benefits covered under Medicaid are not covered under employee-sponsored plans, thus resulting in unequal coverage of children under Medicaid.[375] Not only do Medicaid enrollees generally receive a richer array of benefits, but they also cannot be excluded for preexisting conditions or be forced to wait for long periods of time before coverage for preexisting conditions is made available.[376] Under a "crowding out of private insurance" theory, families that meet the new eligibility will elect to remove their children from such coverage and enroll them in Medicaid in order to receive the more extensive benefits.[377]

This argument fails for three reasons. First, anticipating the "crowding out" problem, the BBA prohibits families and employers from disenrolling beneficiaries for precisely this reason.[378] Second, given the current research linking the lack of adequate health care to poor achievement among children, it would be logical to offer the widest array of medical services to as many children as possible.[379] Third, studies have found, and previous Medicaid expansions indicate, that the subsidization of health insurance coverage for children in low-income families will result in very little substitution of employer

374. *See* CHILDREN'S DEFENSE FUND, *supra* note 2, at 4.

375. *See* Jeffrey A. Buck & Mark S. Kamlet, *Problems with Expanding Medicaid for the Uninsured*, 18 J. HEALTH POL. POL'Y & L. 1, 13-14 (1993). Such services generally include dental care, vision care, rehabilitative services, nursing care, and home care. *See id.* State legislators are often reluctant to expand Medicaid because they have to purchase dependent insurance, and their own children do not receive the rich array of services comparable to those offered by Medicaid. *See* Interview with Tom Yates, Attorney for the SSI Coalition For A Responsible Safety Net, Chicago, Ill. (October 6, 1997).

376. *See* Buck & Kamlet, *supra* note 375, at 14. *See also* Martin & Dubois, *supra* note 57, at 1-15 to 1-16 for due process requirements during Medicaid enrollment procedures.

377. *See* Buck & Kamlet, *supra* note 375, at 14. For a short discussion on why "crowding out" is problematic, see *supra* note 254.

378. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397bb(b)(2)(C)) (explaining "that the insurance provided under the State child health plan does not substitute for coverage under group health plans").

379. *See* Forrest et al., *supra* note 38, at 1790. "[Y]oung children['s] . . . rapid growth and development demand careful monitoring over time." *Id.*

sponsored coverage,[380] primarily because the majority of these families do not currently enjoy a variety of other insurance coverage options.[381]

5. Costs

In terms of cost control, many state legislators are concerned that the entitlement nature of Medicaid would place a heavy burden on state budgets.[382] Given the increase in Medicaid spending since the mid-1980s and the anti-welfare mood placing pressure on state governments to cut back the "welfare rolls," opponents to Medicaid expansion argue that expanding a costly and ineffective system only would result in greater fiscal stress on the state.[383]

However, enhanced federal matching rates made available to states electing to expand their Medicaid programs help to alleviate the cost control problem.[384] Estimates show that in comparison to a new program, Medicaid expansion would not have a significant effect on the annual state expenditures needed to cover children under age eighteen, with family incomes up to 200% of the federal poverty line.[385]

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380. *See* Lessons from the Medicaid Expansions for Children and Pregnant Women: Implications for Current Policy: Hearings on Children's Access to Health Coverage Before the Subcomm. on Health of the House Comm. on Ways and Means, 105th Cong. 5-6 (1997) (statement of Lisa Dubay and Genevieve Kenney, Senior Research Associates, The Urban Institute) (on file with the Urban Institute, D.C.). Although the two authors in this report suggest that very little substitution of private coverage will result from an expansion in Medicaid, they also suggest that as the income eligibility standard is increased, the chance of crowding out increases. *See id.* at 6. They attribute this finding to the prevalence of employer-sponsored coverage in families with higher incomes. *See id.*

381. *See id.*

382. *See id.* at 3.

383. *See* Buck & Kamlet, *supra* note 375, at 12 (discussing the financial stress of Medicaid expansions on the States' budgets).

384. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 560 (to be codified at 42 U.S.C.A. §1397ee(b)), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997).

385. *See* Nagle & Coffey, *supra* note 28, at 5. This report estimates that the state would need to contribute $46.1 million dollars to an expanded Medicaid program covering all children under age 18 with family incomes up to 200% of the federal poverty level. *See id.* Under a new state health insurance program, the state would be responsible for contributing an estimated $35.7 million annually for the same population. *See id.* The $10 million dollar difference in the calculated cost of the two options is attributable to a higher estimated amount of annual family contributions to the provision of medical services to their children. *See id.* This report estimates that under an entirely new program, families would on average pay $1330 per year on health care for their children. *See id.* This is an unreasonable amount to expect poor parents to pay in light of the fact that combined state and federal expenditures per Medicaid-enrolled child per year is $1,158. *See* SCHNEIDER, *supra* note 257, at 4.

6. Continuity of Care

The Medicaid system already has proven that lack of continuous care creates a variety of problems for children enrolled in the Medicaid system.[386] Because the new state program, like the existing Medicaid program, would base its eligibility standards on income, a family might find its children only sporadically eligible for coverage.[387] In fact, a new state program might even exacerbate the situation by bouncing children between providers available under the Medicaid program and providers available under the new program, as children's families' incomes fluctuate between 133% to 200% of the federal poverty level.[388] As a result, as a child's family income rises, the child may lose benefits when he or she is transferred into a new program providing fewer services.[389] The only way to effectively alleviate the problem of sporadic coverage would be for the state to take advantage of the twelve-month continuous eligibility option made available to states in the BBA.[390]

7. Provider Reimbursement

Illinois' Medical Assistance program inadequately reimburses physicians, hospitals, and other providers.[391] Poor reimbursement rates create a concern about whether the services provided to uninsured children under separate coverage also would be available to the same extent for Medicaid beneficiaries.[392] The concern is that a provider may be more inclined to adequately treat a patient for whom they are

386. *See* Perkins, *supra* note 321, at 3-4. *See also supra* text accompanying notes 317-22.

387. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 552 (to be codified at 42 U.S.C.A. § 1397bb(b)(1)(A)).

388. *See* CHILDREN'S DEFENSE FUND, *supra* note 2, at 4.

389. *See id.*

390. *See* 42 U.S.C.A. § 1396a(e) (West 1992 & West Supp. 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4454, 4700-02, 4711-12, 4714-15, 4724, 4731-33, 4741, 4751, 4752, 4753, 4911-13, 111 Stat. 368, 431, 493, 495, 506-10, 516-17, 519-20, 522-25, 571, 573; *id.* § 1396*o* (West 1992 & West Supp. 1997), *amended by* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4743, 111 Stat. 368, 524.

391. *See* Ctr. for Health Admin. Univ. of Chicago, *supra* note 312, at 9. Illinois hospitals are reimbursed for less than 70 percent of the costs they incur to treat Medicaid clients, and the cost of care provided without compensation has doubled for Illinois hospitals since 1980. *See id.*

392. *See* Buck & Kamlet, *supra* note 375, at 19. If a provider is receiving a low fee for the services provided, such provider lacks the incentive to provide alternative treatment that may be more effective but also more costly. *See* Martin, *supra* note 129, at 2-12, 2-15 to 2-16.

confident they will be reimbursed for their services or for whom they receive a pre-paid fee to treat. However, because the BBA provides that both program options are similarly subsidized by the same state and federal matching funds, provider reimbursement rates under either program would need to be adequate.[393] Additionally, federal dollars would have greater purchasing power through the Medicaid program, particularly in the managed care market.[394] States would have more leverage to obtain lower prices and higher quality care if the new funds are combined with the Medicaid program, given that the largest volume purchasers commonly get the better deals.[395] An insurance purchasing program that is a fraction of the size of Medicaid is much less likely to be successful in negotiating for low rates and high quality services with physicians, hospitals or managed care plans.[396]

8. Immigrant Children[397]

Because either of the health insurance plans developed under the BBA would be supported by federal dollars and because eligibility would be subject to an income screening, it appears that the new SCHIP health coverage is a federal means-tested public benefit.[398] Therefore, the benefit would be subject to the five-year barring of noncitizens.[399] Under a Medicaid expansion, it is possible that any state funds used to cover uninsured children would be subject to the same noncitizen rules applicable to other expenditures under state Medicaid plans.[400] Thus, if Illinois were to expand Medicaid, the state would be prohibited from using these new federal dollars on noncitizen children[401] and only could provide coverage to immigrant

393. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4901, 111 Stat. 558 (to be codified at 42 U.S.C.A. § 1397dd(b)(2)-(3)), *amended by* District of Columbia Appropriations Act of 1998, Pub. L. No. 105-100, § 162, 111 Stat. 2160 (West, WESTLAW through 1997). *See also supra* notes 224-35 and accompanying text.

394. *See* CHILDREN'S DEFENSE FUND, *supra* note 2, at 4.

395. *See id.*

396. *See* SCHNEIDER, *supra* note 257, at 5.

397. This is a cursory discussion of the eligibility of immigrant children for SCHIP funds which may be mooted by federal guidance. For more in depth discussion of immigrant children's eligibility for SCHIP benefits, see DAVID A. SUPER, CTR. ON BUDGET AND POLICY PRIORITIES, CAN STATES USE THEIR MATCHING FUNDS UNDER THE CHILD HEALTH BLOCK GRANT TO INSURE IMMIGRANT CHILDREN? 1 (1997).

398. *See supra* note 165 (defining means-tested public benefit).

399. *See* SUPER, *supra* note 397, at 1.

400. *See* Nat'l Immigration Law Ctr., Analysis of Immigrant Eligibility Under the State Children's Health Insurance Program (SCHIP) 1 (Sept. 15, 1997) (on file with the National Immigration Law Center, Los Angeles, Cal.).

401. *See id.*

children through a state-funded program.[402] Unfortunately, the federal administration has not yet definitively stated whether any of the ten percent set-aside funds can be used for immigrant health care.[403]

Because the new State Children's Health Insurance Plan statute does not explicitly restrict immigrant eligibility,[404] the question remains whether Illinois could use its own state matching funds under a new plan to insure immigrant children.[405] Nothing in the SCHIP statute indicates whether coverage for any particular child must be paid for with federal funds, state matching funds, or a combination of the two.[406] Arguably, Illinois could structure its assistance funds in a manner that would effectively insure sixty-five children with federal funds for every thirty-five children that the state covers, rather than saying that each child gets $.35 state money and $.65 federal money for each dollar spent.[407] If this conceptualization of funding streams is determined to be legitimate, creating a new and separate child health plan would be the better tool for insuring all low-income children in the state.[408]

Despite some of the inherent and perhaps unavoidable problems with the current status of Medicaid, the scales tip in favor of opting for a Medicaid expansion to ensure the health care coverage of some 300,000 Illinois children.[409] Medicaid is the nation's largest single health insurer for low-income children, and most states have already used it to extend health insurance coverage to all low-income children.[410] Although states would have less flexibility expanding Medicaid than they would if they implemented a block grant program, enough flexibility exists in Medicaid to allow states to enroll beneficiaries in managed care programs.[411]

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402. *See id.* at 1-2.

403. *See* Chicago Health Policy Research Council: Fact Sheet, #4: Who Is Eligible for Coverage Under SCHIP Funds? 1 (Oct. 1997) (on file with the Chicago Health Policy Research Council at the University of Chicago). Because the ten percent set-aside can be spent without direct reliance on the assets of the family, it is unclear whether this money is considered "means-tested." *Id.*

404. *See id.*

405. *See* SUPER, *supra* note 397, at 1.

406. *See id.* at 2.

407. *See id.*

408. *See* Nat'l Immigration Law Ctr., *supra* note 400, at 2.

409. *See supra* notes 352-96 and accompanying text.

410. *See* SCHNEIDER, *supra* note 257, at 4.

411. *See id.* at 2-8.

V. PROPOSAL

Currently, neither the national system of health care nor Illinois' system is adequate to meet the health care needs of a vast number of near poor children.[412] Somewhat surprisingly, federal legislators and the current administration not only listened to but also responded to the call for action in the area of uninsured children.[413] The issue of uninsured children is now in the hands of state policy makers who must develop and implement a strategic health insurance model designed to insure the future of Illinois' children without generating unacceptable side effects.[414] Governor Edgar took a sensible first step when he announced a limited Medicaid expansion to cover some of Illinois' uninsured children.[415] However, a plan to cover more uninsured children with the new federal matching funds needs to be developed and implemented quickly.

A. The Healthy Start Insurance Plan

In response to the recent findings regarding the number of uninsured children in Illinois, Democratic State Representative Barbara Flynn Currie introduced a bill at the ninetieth session for the Illinois General Assembly concerning health insurance for children.[416] Entitled the Healthy Start Insurance Plan, the bill proposed to promote children's access to specific health care services.[417] More liberal than the options subsequently set forth in the BBA, this bill proposed to extend eligibility to children under the age of nineteen whose family income does not exceed 250% of the federal poverty level.[418]

412. *See supra* notes 302-347 and accompanying text.

413. *See supra* Part III.

414. *See* Brown, *supra* note 41, at 425.

415. *See supra* notes 298-302 and accompanying text.

416. *See* H.B. 1302, 90th Leg. Sess. (Ill. 1997). Section 5 reads in part:

> About 310,000, or nearly 10% of more than 3,000,000 children in Illinois, have no health insurance coverage, either through a parent's employment, through the State's Medicaid program, or any other health plan . . . . Parents moving from welfare to work will lose Medicaid coverage for their children and are unlikely to be offered health care coverage in low-skill and service sector jobs . . . . Numerous states have implemented health insurance programs for insured children in recognizing that access to immunizations, ongoing check-ups, and other health services helps children avoid serious health problems that can lead to life-long physical and mental disabilities. Preventive care is cost effective and can reduce expensive hospitalization.

Id. § 5.

417. *See id.* § 15(a).

418. *See id.* § 20(a)(1). Children with family incomes exceeding 250% would have the opportunity to buy into the insurance plan. *See id.* § 25(c).

Although the bill was silent as to whether the coverage is continuous for a twelve-month period, language in the bill supports a finding of such an intent.[419] The cost sharing provisions of the bill propose premium payments on a sliding scale fee based on family income, ranging from $15 per child per year to $375 per child per year.[420] The benefits that the bill proposes to cover are similar to Medicaid benefits.[421] Although the status of this bill is currently inactive, its language serves as an important precursor to what should be proposed over the next few months.

B. Proposal for an Expansion of Medicaid

Building upon the language from the Healthy Start bill, this Comment proposes an amendment to Article V of the Illinois Public Aid Code, expanding Medicaid for uninsured children.[422] This proposal seeks to provide necessary and comprehensive health insurance benefits to low-income children who are otherwise ineligible for Medicaid.[423] In order for a defined population to access care, several factors must be present.[424] First, low-income targeted children must have financial access to care by means of insurance.[425] Second, be an adequate number of providers must be willing to provide the care.[426] Third, patients must be educated so that they understand how to utilize that care.[427] Finally, institutional, social, cultural, and logistical barriers must be eliminated so that patients can effectively use care made available to them.[428] Each provision in this proposal is designed to meet the essential medical needs of the targeted population

419. *See id.* § 20(a)(2). "The child's family pays an annual premium . . . ." *See id.* "The period of a child's eligibility for the Healthy Start Plan shall terminate on the last day of the month in which the child's birthday occurs at the age he or she is no longer an eligible child . . . ." *See id.* § 20(c).

420. *See id.* § 25(a). The bill also provides that total premium costs are not to exceed five percent of the family's net income. *See id.* § 25.

421. *See id.* § 15(a). These services include: well-child care, including immunizations, outpatient care, emergency room care, prescription drugs, hearing and vision services, dental care, home health care, allied health services, mental health services, and substance abuse treatment. *See id.*

422. *See infra* notes 424-49 and accompanying text.

423. *See infra* notes 424-49 and accompanying text.

424. *See* Ctr. for Health Admin. Studies at the Univ. of Chicago, *supra* note 324, at 28.

425. *See id.*

426. *See id.*

427. *See id.*

428. *See id.*

while being sensitive to cost-containment issues and the trend towards managed care health delivery systems.

1. Enrollment and Eligibility

It is imperative that a new expansion in Medicaid cover eligible low-income children up to age eighteen.[429] Additionally, Illinois must extend coverage to children who live at or below 200% of the federal poverty level.[430] It is currently estimated that extending coverage to all children up to age eighteen, with countable family income below 200% of the federal poverty level, would cover only about half of the 300,000 uninsured Illinois children.[431] Capping family income at a lower level would result in too few children receiving coverage, thus defeating the goal of providing health care coverage for low-income children of the "working poor."[432] Thus, it is important for the state to extend presumptive eligibility to these children and to provide for twelve-month continuous coverage.[433] Also, because presumptive eligibility is believed to encourage and simplify enrollment for children and women, it is imperative that a Medicaid expansion provide for such eligibility.[434]

2. Benefits and Service Delivery

Although it will be a difficult battle to convince the Illinois General Assembly that the targeted children should receive a benefits package equivalent to that already set forth in the Public Aid Code,[435] it is

429. *See supra* notes 239-51 and accompanying text (explaining and describing eligibility requirements for low income children in the Balanced Budget Act of 1997).

430. *See supra* notes 181-197 and accompanying text (explaining the medical benefits provided to children under the Medicaid program in Illinois).

431. *See* Nagle & Coffey, *supra* note 28, at 5. This report estimates that under a broad Medicaid expansion, the program would cover more than 113,000 children. *See id.*

432. *See* Interview with Tom Yates, *supra* note 375.

433. *See supra* notes 386-90 and accompanying text.

434. *See supra* notes 173-80 and accompanying text. The purpose of presumptive eligibility as it was enacted is "to avoid delays in access of low-income women to needed prenatal care while their formal applications for Medicaid eligibility are being considered." 42 U.S.C.A. § 1396a(a)(55) (West 1992 & West Supp. 1997), *amended by* Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, § 9, 111 Stat. 26, *and* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, §§ 4106, 4454, 4700-02, 4711-12, 4714-15, 4724, 4731-33, 4741, 4751-53, 4911-13, 111 Stat. 368, 431, 493, 495, 506-10, 516, 517, 519-20, 522-25, 571, 573.

435. *See* Interview with Tom Yates, *supra* note 375. Many state legislators repeatedly express disdain about the fact that their own children don't receive as rich a benefit package as Medicaid enrollees do. *See id.* Despite the number of medical services covered under Medicaid, however, the low per capita spending on children in Illinois indicates that children do not use all the services available to them. *See supra*

imperative that the health insurance program cover preventive as well as primary care.[436] Furthermore, the new expansion must retain its entitlement status so that children will continue to be covered, despite concern over the amount of state expenditures.

Because there is a national trend toward utilizing managed care delivery systems, and because managed care plans have the potential for containing costs if effectively administered,[437] Illinois may choose to develop and implement a managed care delivery system. However, such systems can operate with the goal of cost-containment only if the manner of operation does not diminish in any way the provision of essential medical services to eligible children nor restrict access to care for eligible children.[438]

3. Cost Sharing Provisions

Although studies have found that coinsurance payments can have negative effects on utilization rates and on the health status of poor children, this Act proposes nominal co-payments and premiums.[439] For children with a family income below 150% of the poverty level, no premiums shall be imposed, and only nominal co-payment charges consistent with current Medicaid levels shall be issued.[440] Premiums and co-payments may be imposed on a sliding scale fee related to income level for children whose family income exceeds 150% of the federal poverty level, so long as such charges do not exceed 5% of the family income for the year involved.[441] Programs in other states report that state subsidies must be large for lower-income people to be encouraged to participate.[442]

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notes 147-50 and accompanying text. Nonetheless, it is important to have a comprehensive package available. *See* Comm. on Child Health Fin., Am. Academy of Pediatrics, *Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents and Young Adults Through Age 21 Years*, 91 PEDIATRICS 508, 508 (1993).

436. *See* Comm. on Child Health Fin., Am. Academy of Pediatrics, *supra* note 435, at 508.

437. *See* Martin, *supra* note 129, at 2-1.

438. *See supra* notes 323-33 and accompanying text for a discussion of the HM/HK program that jeopardized services to children and resulted in a decline in access. Because of Illinois' poor track record with implementing effective managed care initiatives, it will be important for policy makers and advocates to insert procedural safeguards into the accompanying regulations.

439. *See* Buck & Kamlet, *supra* note 375, at 14.

440. *See supra* notes 284-97 and accompanying text (discussing the BBA's limits on cost-sharing requirements).

441. *See supra* notes 291-92 and accompanying text.

442. *See* Amy Goldstein, *New York Children's Health Plan Offers Laboratory For New Federal Aid*, WASH. POST, September 28, 1997 at A10. "The premiums for each child will increase from $25 a year to $9 a month for a family of three earning up to

4. Ten Percent Set Aside

Use of the federal ten percent set aside funds shall be used to conduct outreach and education activities throughout the state to encourage participation.[443] The high numbers of Illinois Medicaid-eligible children not enrolled in Medicaid indicate that either the enrollment process is too cumbersome or that families are not informed about their eligibility status.[444] Illinois must conduct a better outreach campaign so that the greatest number of children can receive services as quickly and efficiently as possible.[445] Moreover, the new act should provide that some of this set aside money shall be used to educate and recruit physicians to participate as providers of care in the new program.[446] Already, provider participation in Illinois' Medicaid program is insufficient to adequately meet the medical needs of children enrolled in the program.[447] This federal funding source will assist in enrolling both children and physicians into the program.

This proposal addresses a number, but not all, of the important provisions that Illinois should be urged to adopt.[448] It is time for Illinois to act so that in early 1998, Illinois' uninsured children will have access to adequate health care services. The state must move quickly in implementing a program, first because children need access to care as soon as possible, and second, because the longer the state waits to get a plan approved by HHS, the fewer federal funds the state will have to meet the needs of uninsured children.[449]

VI. CONCLUSION

States are now at the helm of the most comprehensive health care reform since the passage of the Medicaid Act in 1965. Illinois must act quickly in order both to take advantage of the funds and to select a plan that offers the broadest range of services and that pursues aggressive outreach activities to assure that uninsured children take advantage of

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$21,000 . . . . Although the program remains far less expensive than private insurance, HMO's and children advocates already have heard some families say they will drop out." *Id.*

443. *See supra* note 220 and accompanying text.

444. *See supra* notes 113-17 and accompanying text.

445. *See* Nagle & Coffey, *supra* note 28, at 1.

446. *See supra* note 220 and accompanying text. This outreach could be determined to be a reasonable administrative cost under the 10% set-aside.

447. *See supra* notes 339-41.

448. At a minimum, the provisions proposed thus far need to be enacted. Details about some of the more minor options may be decided upon by the legislature after hearings involving advocates and parents.

449. *See* Nagle & Coffey, *supra* note 28, at 7.

the benefits. Thus, the best option for Illinois is a Medicaid expansion to extend benefits to the state's 300,000 uninsured children.

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