The Path to Universal Health Coverage for Children in Illinois

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The All Kids Health Insurance Act, which creates the All Kids program to provide health insurance to every child in Illinois regardless of income or status, was signed into law on November 15, 2005, by Illinois Gov. Rod R. Blagojevich.[1] The All Kids program is aimed at the 253,000 children in Illinois without coverage.[2] With the passage of this program, and its implementation on July 1, 2006, Illinois became the first state in the country to offer health insurance to literally every child.[3]

Like virtually everywhere else in America, Illinois had been suffering through a record fiscal crisis for the previous several years, and the crisis continued during 2005 even as All Kids was proposed and passed. Governor Blagojevich is a Democrat. In the Republicans' attempt to regain the political power they long held and only recently lost in Illinois, they have been vigorously challenging the Governor's stewardship of state finances.[4] Yet the All Kids bill, creating new spending on health care, garnered Republican support in both chambers.[5]

As other states and Congress consider covering all children, the path to All Kids in Illinois may be a useful case study.

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

In the first half of the decade, Illinois had experienced a strong performance in expanding public health insurance programs for low income children and adults.[6] As of August 2004, Illinois covered more than one million children and almost 400,000 parents under the Medicaid, State Children's Health Insurance Program (known in Illinois as "KidCare"), and FamilyCare programs.[7]

In a state faced with a large population of uninsured, especially the employed uninsured,[8] and plagued by an ongoing, years-long, and historically large fiscal crisis, Illinois' standout performance on publicly funded insurance was evidence of an increasing political consensus on health coverage. This consensus was the work of many different sectors and consistent pressure to maintain and increase health care coverage.

A. Influential Players Outside State Government

Many players outside of state government shaped the consensus on health coverage expansion in Illinois. Their contributions to creating a policy atmosphere conducive to the All Kids announcement were made in various contexts over a period of years: specific coverage expansion initiatives, advocacy to avoid budget cuts, community organizing, antipoverty issue organizing, and the annual assertion during the legislative process by health-oriented professions, businesses, and interest groups of their own agendas promoting their self-interest (e.g., reimbursement rates, targeted eligibility, specific disease initiatives, and private insurance mandates).

Some of the influential players:

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- **The FamilyCare Coalition**: An ad hoc coalition that successfully promoted a health coverage expansion to the parents of children covered by Medicaid and KidCare.[9]
- **The Medicaid Leadership Group**: Led by Health and Disability Advocates, an advocacy organization, the group brought together key elements of the health care provider, consumer, and advocacy communities to find common health-related causes in the state budget and on the federal front.[10]
- **The Emergency Coalition for a Fair Budget**: An ad hoc group of advocacy and provider groups in the areas of health and human services, with the shared agenda that the budget should not be balanced by cutting programs for vulnerable populations and that everyone would be better off if revenue increased.[11]
- **Health care provider organizations**: Their self-interest promotes health care expansions, they have good professional advocacy capacity (e.g., research and lobbying) and strong ties to political fund-raising, and they are often locally prominent employers and social institutions (e.g., hospitals, pharmacies, and clinics).
- **Organized labor**: The Illinois American Federation of Labor—Congress of Industrial Organizations (AFL-CIO) and especially the unions that represent or seek to organize lower-income workers, such as the Service Employees International Union (SEIU); the American Federation of State, County and Municipal Employees (AFSCME); and United Food and Commercial Workers (UFCW).
- **Organized employers**: Several chambers of commerce, such as the Chicagoland Chamber, supported the KidCare and FamilyCare health coverage expansions, and none of the organized business groups publicly opposed them (although many sat out of the debates). Those that supported the initiatives not only understood generally that health insurance improves employee productivity but also particularly appreciated the way that premium assistance options have the potential to keep lower paid but, on average, healthier employees participating in employer insurance programs. This improves their plans' actuarial performance, which controls premium increases and thus helps all employees.
- **Local government**: It is on the hook for much of the uninsureds' safety-net free care, which it provides directly as a cost of local government. The local government also deals with the impact of the uninsured in the community as a public health and quality-of-life issue.
- **Health care consumer organizations**: One leading group, the Illinois Maternal and Child Health Coalition, was the coordinator of the statewide Covering Kids and Families Illinois enrollment campaign and became a leading grassroots supporter of all the health coverage initiatives.[12] Another leading group, the Campaign for Better Health Care, waged a very active universal coverage campaign that had a strong impact on the policy atmosphere throughout the time period described here.[13] Other consumer organizations advocate on behalf of the disabled and elderly on health care issues, and still others are disease-specific or condition-specific organizations (e.g., American Cancer Society, March of Dimes, and AIDS Foundation). Any expansion of health insurance helps their causes dramatically because the insurance means increased preventive care, better maintenance care, and earlier diagnosis and remedial care.
- **Multi-issue antipoverty advocacy organizations**: Health insurance is a key issue for almost any low-income issue group or constituency (early childhood, K–12 education, abuse and neglect, public safety, welfare to work, and so forth). These organizations have key relationships and influence, and they can be persuaded to include health care in their list of objectives from year to year even if their main focus is elsewhere. Many of these organizations have developed both policy and grassroots capacity organized around their core issues or constituencies.[14]

- **Multi-issue grassroots or community organizations**: Health insurance often tops the charts when community-based organizations discern issues affecting their constituent members and citizen leaders. This adds tremendous ground-level power and "real people" capacity to advocacy on the state budget.[15]
- **Religious organizations**: Health care is a powerful moral issue for faith-driven people concerned with social justice and with the state budget as a statement of values. Some religious denominations maintain legislative advocacy capacity in the state capital to look after the interests of their professional social service organizations and other issues they care about (e.g., the Catholic Conference and Catholic Charities, Lutheran Social Services, and Jewish Federation). These organizations provide not only professional help in the capital but active grassroots support in the districts.
- **Media opinion leaders**: News organizations are interested in many of the health coverage–related budget stories, both as news and as editorial content, because of the size and ongoing growth of the health care crisis and the health care budget lines, the news value of stories of people without adequate access to health care, and the potential for political controversy.

With all of these players emphasizing public investments in health coverage, an atmosphere conducive to All Kids emerged. An aggressive improvement in health coverage for children could be considered not only politically "safe" but also politically advantageous. However, an expansion such as All Kids is far from an inevitable outgrowth of this kind of atmosphere. A bold expansion such as All Kids is never an ordinary step, and the conventional wisdom regarded it as politically risky during a fiscal crisis. The atmosphere offered an interesting opportunity for a governor willing to assert leadership on the issue, but, without that leadership, any bold expansion was probably out of the question.

B. The Illinois Budget Context

Illinois historically is a comparatively low-tax, low-spend state. As of 2002 (the 2003 state fiscal year), Illinois ranked forty-ninth in generating state and local tax revenue (including property tax) as a percentage of total personal income in the state. It was forty-seventh in collecting general revenue taxes when measured against personal income and thirty-eighth when measured as tax receipts per person. This is because Illinois has a low and flat income tax rate of three percent (on all income levels), imposes sales tax on only 17 of 164 categories of services (only six states tax fewer services), and is one of only three states to completely exempt all public and private pensions from taxation, regardless of income level. That Illinois ranked forty-third in general funds spending as a percentage of personal income was consistent with this revenue picture.[16]

Like most states, and worse than many, starting late in the 2001 calendar year, Illinois has been undergoing a historic state budget crisis. The Illinois crisis is predominantly a revenue problem because spending (of state-source funds) has been flat in recent years.[17] The revenue crisis was caused not just by the recession early in the decade but also, more fundamentally, by an antiquated and inadequate revenue system that produces a structural deficit. Because Illinois revenues do not produce enough money to fund current obligations and policy choices, the state is in a more or less perpetual bind: find new revenues or cut programs.[18] This bind is even worse in a recession, and it makes recovery from recessions slower.

Most politicians hesitate to support increases in general taxes—income and sales taxes—the two primary workhorses of the Illinois revenue system.[19] Thus in a deep budget crisis, the

annual budget puzzle could be solved only by finding new types of revenue enhancements or making deep cuts in current spending. When deep cuts are needed in current general revenue spending, the focus historically has turned inevitably to Medicaid, not because it is disfavored or an unimportant program, but because it is one of the few places to find enough general revenue spending to cut to make a significant dent in a large budget deficit.

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

The budget process in Illinois, by law and custom, gives tremendous power to the governor.[20] The General Assembly does not have a budget bureaucracy of its own and does not produce a competing budget, nor do any of its component caucuses, parties, or committees. The spring General Assembly session conducts hearings on the Governor's budget and can resist parts of it or demand changes. After negotiations with the Governor, the General Assembly then passes the budget before the scheduled Memorial Day adjournment.

If the Governor proposes a health care expansion, then opponents of the expansion will have difficulty eliminating it from the final budget. The Governor's leadership on the budget is usually determinative of the spending priorities that end up in each year's budget.

C. Coverage Expansions Before the Fiscal Crisis

Health coverage has broad appeal across party lines.[21] During the boom years of the late 1990s and early 2000s, under moderate Republican governors and a more conservative Republican state senate, Illinois expanded health care coverage many times. Each expansion was an occasion for public advocacy activity on health coverage by some configuration of the aforementioned players—activity that prepared the groundwork for the public opinion and policy environment later conducive to the All Kids proposal. There were three such expansions:

- Illinois adopted KidCare in 1998. After a very slow start, which resulted in only 28,241 enrolled as of January 1999, the new administration of Republican Governor George Ryan launched an all-out enrollment effort that brought enrollment to 176,602 by March 2002.[22]
- The number of elderly and disabled persons eligible for Medicaid coverage substantially increased. In 2001, flush with revenues from the economic boom, the state committed to a three-year plan to increase eligibility for Medicaid for these groups from 41 percent of the federal poverty level to 100%. The last year of this increase was threatened by the emerging fiscal crisis, but, to keep its promises on a crucial health coverage issue, the Ryan administration fit the initiative into the troubled 2003 state budget.[23]
- Illinois has a pharmaceutical assistance program that helps seniors pay for prescription drugs needed to treat certain conditions (e.g., heart disease). In an expansion funded by tobacco settlement proceeds, the program increased from serving 50,182 in 1999 to serving more than 150,000 by mid-2001.[24]

In February 2002, the Ryan administration also sought federal financial participation under the State Children's Health Insurance Program and Medicaid for the new FamilyCare program to cover the parents of children covered by Medicaid or KidCare. With federal approval, the FamilyCare program was launched on October 1, 2002. It was only a modest start-up. Full implementation would require several years of increasing state funds needed to draw down the matching federal funds to cover potentially 400,000 working parents.

But late in 2001 (the first half of the 2002 state fiscal year) Illinois' fiscal crisis began to emerge in full force. Not only did the crisis slow down the implementation of the FamilyCare initiative, but it also turned the administration's attention to the possibility of using the historic expedient of cutting Medicaid as a means to help address the larger state budget problem. However, the intense advocacy around the health care expansions that was adopted in the preceding years (KidCare enrollment, Medicaid eligibility for seniors and disabled, and pharmaceutical assistance) and the expansion that was still pending (FamilyCare) had created an atmosphere in which cutting Medicaid was not as politically expedient as it had been in the past. Coalitions had been built. Strong public arguments had been successfully maintained. Politicians had been impressed by the positive public appeal of health care, and many of them in both parties had invested significant political capital in expanding health care, including Governor Ryan.

As a result, the Medicaid cuts that Governor Ryan proposed to help solve the fiscal crisis in late 2001 did not involve a reduction in eligibility or covered services. Instead the Ryan administration cut provider rates by 6%.[25] And his state fiscal year 2003 budget included the modest start-up of the FamilyCare program.

The arrival of the fiscal crisis caused key elements of the health care and human services community to form the Emergency Campaign for a Fair Budget.[26] The campaign vigorously explained to policymakers and the general public the deep human costs of cuts in health coverage (among other programs) and marketed to policymakers a long list of revenue ideas and alternative appropriation cuts that could be adopted instead of cutting needed benefits and services. As a result of the efforts of the Emergency Campaign and others, the cuts were ameliorated by the adoption of an increase in the cigarette tax and a number of other revenue measures.[27] This was a victory for a significant principle that helped create the environment for All Kids to be proposed during a fiscal crisis: in both a political and a public policy sense, health coverage justifies increased revenues. Increasingly, for a politician to oppose health coverage might be more politically "dangerous" than to support at least some types of revenue enhancement needed to support health coverage.

D. Health Coverage During the Fiscal Crisis

The Illinois governorship was at stake in the November 2002 election. Republican Governor Ryan was not running for reelection. Because health coverage was already a high profile issue, both candidates adopted it as a strong priority and promised to implement FamilyCare fully and otherwise address health care needs.[28] When Democrat Rod Blagojevich won, many of the aforementioned players participated in transition committees and explained to the new administration the dimensions and significance of the health coverage issues, the necessity of adequate funding, and ways to maximize federal financial participation consistent with both state and federal program goals. The challenge facing the new governor was immense. The transition team estimated the eighteen-month budget deficit (from mid-2003 state fiscal year through the 2004 state fiscal year) to be about $5 billion (in a general funds budget of about $25 billion per year).[29]

The new Governor quickly made two central promises: he would not cut "essential services," which he defined as health care, education, and public safety; and he would not increase income or sales taxes.[30] He also announced that he was going to keep campaign promises to increase eligibility for KidCare from 185% to 200% of the federal poverty level (20,000 more children) and to implement FamilyCare fully over three years (300,000 parents).[31]

In his proposed budget, the Governor posited no cuts in provider rates, eligibility, and covered services in Medicaid. KidCare and FamilyCare would be expanded as promised. He promised to implement FamilyCare in three annual installments and allocated funds for the first year.[32]

The good picture on health care spending existed within a very austere total budget proposal, and most of the budget balancing would take place on the revenue side. Overall spending was to be reduced. The state workforce was to be reduced severely; all state grants other than in the areas of health care, education, and public safety were to be reduced; several small agencies were to be eliminated; and various additional cuts were to be made.[33] Many of the revenue and spending proposals had been on the "alternatives to cuts" list of the Emergency Campaign for a Fair Budget in the fight against the cuts the year before (and all of which had been given to the transition team).[34]

The new Governor had absorbed the preceding years' lessons, which taught that health coverage was politically "safe" even when paid for with at least some types of revenue enhancement. In his first budget he had decided not only to test, but also to bank on, this proposition.

During the legislative session after the budget announcement, the FamilyCare coalition, the Emergency Campaign for a Fair Budget, the health care provider associations, and many others lined up to support the Governor's positions on health care in the budget and the revenue enhancements that made them possible. Opposition came in the form of general resistance to expanding spending in such a tight budget, but nobody was willing to take on FamilyCare or other health issues on a policy or ideological basis or as distinct cost items. The Governor's leadership and the inherent power of the health coverage issues proved too much to challenge or overcome. Nobody wanted to be the champion of the cause of fighting health coverage expansion.

The following two years saw increasing controversies around the state budget but continued success for health care expansion issues, including the completion of the FamilyCare implementation ramp-up, and avoidance of any deep Medicaid cuts.[35]

II. The Illinois All Kids Program

The All Kids initiative, which Governor Blagojevich announced on October 6, 2005, provides health insurance to every child in Illinois regardless of income or status.[36] Enabling legislation, cosponsored by the speaker of the house and the senate president, was filed in the Illinois General Assembly's Fall 2006 "veto session" later the same month. As noted above, with this kind of powerful support, the bill not only passed handily but also acquired Republican support.

The All Kids program provides the same coverage as the State Children's Health Insurance Program (basically Medicaid coverage) to all children residing in Illinois (with no citizenship restrictions), as long as the family pays the premiums.[37] A twelve-month waiting period (when fully phased in) applies to those previously covered by other insurance.[38] Co-payments for

services other than well-child care are required.[39] The state agency implementing the new program is granted wide authority to flesh out the full program in rules.[40]

Because of the need in the current fiscal crisis to show how new programs will be paid for, the Governor has rhetorically linked funding for the All Kids program to an initiative to change the Illinois Medicaid program to a primary care case management model.[41] Generally this model would require all Medicaid beneficiaries to select a physician or clinic to be the primary care coordinator. The coordinator would provide all primary care and be the conduit for specialty care, hospitalizations, and all other medial care.[42] Based on the experience of several other states, notably North Carolina, this model is expected to achieve the twin goals of better patient outcomes and better efficiency for the health care dollar.[43] The first year savings of primary care case management are expected to be higher than the expected first year costs of the All Kids coverage expansion. Linking All Kids to primary care case management means that implementing the All Kids program does not result in a net budget increase, at least in its first year.[44] It is, in effect, "paid for" by the savings resulting from primary care case management.

III. Application to Other States and the National Level

Universal health coverage for children is a reality in Illinois because of the confluence of a favorable political and policy environment and the timely leadership by the chief executive in taking advantage of this environment. The story shows that such success need not be unique to Illinois.

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

- Covering all children is a much bigger idea, and a much more powerful political concept, than it is a public expense. Covering children is relatively inexpensive and should be affordable in most state budgets.
- Creating a policy atmosphere conducive to achieving universal coverage for children in Illinois was a multiyear endeavor, and this may seem daunting to advocates who are just beginning to create in their state a policy atmosphere conducive to universal coverage. Advocates should keep in mind that much of the state's policy atmosphere comes from national public opinion and policy trends, the larger economy, and research that applies nationally. At least this much of the favorable environment is already in place to be used in any state.[45] And the environment in any particular state is the product of many different state initiatives large and small involving health issues. Relationships, information, public education, and successful tactics from one initiative should be regarded as ongoing resources for future initiatives. Advocates should frame issues and specific arguments more broadly than for just their immediate purposes.[46]
- Although the chief executive's leadership is crucial, recognizing the potential contributions of the many and varied players interested in improving health care coverage and gaining their cooperation are critical as well. Coalition building is essential, as are avoiding traditional rivalries and taking advantage of individual interest groups' strengths.
- Allying with provider associations on health coverage issues is a must for consumer groups.[47] Generating mass appeal on the issues is easier for consumer groups, but the provider groups have more professional and financial resources. Bringing these different resources together behind particular initiatives can be a forceful combination. While providers may prefer the funding of their

rates over the expansion of eligibility, and consumers vice versa, both groups can promote both positions and refuse to be pitted against each other. This cooperation is made much easier when the two interest groups agree to promote either increased revenues or alternative budget cuts that free up funds.

- Health care is a big issue for organized labor. It is a core issue to those unions that organize lower paid workers unlikely to work for employers who offer health insurance.[48] (And increasingly workers somewhat higher up the income scale are losing or are never offered affordable coverage.) The direct influence of these labor organizations on the policymakers' health policy decisions cannot be overstated. A governor may from time to time, among other concerns, feel the need to make decisions with which organized labor may disagree. Because of that need, the governor may have to be able to point to a strong record on health care when the time comes for the next election.
- Grassroots allies contribute mightily not just to specific initiative campaigns but also to the creation of the favorable policy atmosphere. Among other activities, they can fill up a space for a hearing or a rally, apply district-level pressure on legislators and candidates for higher office, and produce a good supply of powerful personal stories to illustrate issues and generate public sympathy. These activities create the impression, and usually the reality, of wide public support for issues. And that impression outlasts specific campaigns.[49]
- The wider community of education, health, and human service interests that rely on the general revenue fund for the support of the programs significant to them can form a strong coalition in favor of revenue enhancements over cuts in such programs.[50] While all of these interests compete over their slice of the budget pie, all of them should be able to agree that they all would be helped if the pie were larger and that budgets should not be balanced by cutting any program for vulnerable people. Also, these interest groups serve clientele for whom health coverage is essential, and the groups will support health coverage expansion even if other issues are their priorities. Many of these groups have organized statewide grassroots capacity that can be very useful in health coverage campaigns.
- Expanding health coverage appeals to business interests for a variety of reasons, and some business associations will actively support an expansion. One reason is that health insurance is a growing cost issue for all businesses. A premium assistance option (such as the one in the Illinois FamilyCare program) can be very helpful in attracting business support.
- Health coverage is an issue that resonates strongly with religious interest groups and constituencies and is a common ground for groups divided on other issues because of religious beliefs. Much of the grassroots advocacy on health issues in Illinois has been anchored by religious institutions, including many local congregations. Many denominations have advocacy capacity in the state capital, and this professional strength is helpful to the coalition. But there is real power in ground-level activity aimed at policymakers in home district offices by people they know who are likely to vote. Legislators believe that "people from the pews" not only vote but also talk to their friends about the reasons for their vote.
- Working to gain favorable news coverage is part of the creation of the favorable policy atmosphere. News coverage highlights an issue for policymakers, who see that large numbers of people are active (in the news story itself), and, perhaps more important, who perceive that thousands of readers, viewers, or listeners will be concerned about the items in the news coverage. Local media coverage is also useful; even relatively few letters to the editors of small papers can create a

favorable atmosphere signaling that voters care about this issue. News coverage should be incorporated into advocacy materials (e.g., copies of articles or quotes from editorials).

- All of the public teaching, organizing, and relationship building on health care is advantageous over the long term as well as the short term. Broad-based advocacy for health care expansion and favorable budget treatment in good years creates an ongoing policy atmosphere around health care that is very helpful in a fiscal crisis. Advocacy to prevent health coverage cuts can be the basis for a campaign for expansion when the fiscal conditions improve, or even before then. Governors do not want all of their initiatives and accomplishments to involve traumatic program cuts even in a deep budget crisis where budget cuts and revenue enhancements are inevitable. Health care is an ideal issue to be positioned as one area of expansion in austere times, when most other programs are being cut or held to the same level of funding as the previous year. If a governor has to find billions of dollars to plug a budget hole, finding incrementally more to fund a significant positive step on health care in the same budget is not difficult.
- Campaigns for a significant but incremental expansion in health coverage are productive even though they are short of the full solution. First, they win health coverage for many people sooner than if everyone waited for the comprehensive solution. Second, they contribute strongly to the policy atmosphere, and, in the ways described here, they can be structured to support the next campaign. And, third, they need not conflict with a simultaneous campaign to win full coverage of all uninsured. Achieving an incremental step serves to increase public knowledge of the issues and demands a solution for the lack of coverage for those left behind after the incremental step is taken.
- One of the most profitable tactics deployed in Illinois was the development of and marketing to policymakers and the public revenue ideas and alternative budget cuts that do not hurt low-income people. When fighting budget cuts, advocates for low-income people and programs are often confronted with the responses: “Well, we just don’t have the money” or “You tell me whom to cut if you don’t think that you should be cut.” By having revenue ideas and alternative budget cuts, advocates have ready answers to these standard ploys.
- When engaging in advocacy to prevent harmful budget cuts and promote expansion, having access to budget and tax expertise is critical.[51] Revenue issues are very difficult, but in Illinois they became more attractive than cutting health care or stopping a proposed health coverage expansion. With appropriate expertise, state-level groups can develop a long list of revenue alternatives ranging from income tax or sales tax increases to more targeted fees, tax-loophole closures, and so forth. The Center on Budget and Policy Priorities in Washington, D.C., is a leading national expert on state budget and tax alternatives, and it has extensive contacts in many states. The center is a good place to start if advocates do not know any experts of this type in their state.[52]
- Health coverage is legitimately a bipartisan issue, and advocates should approach both parties for leadership and support. When health coverage is the featured issue in an advocacy campaign or the governor’s proposed budget, many Republicans support it. And even those who oppose it on principle face a difficult political challenge if they do so in the public debate. When the chief executive proposes an expansion such as All Kids and suggests a way to pay for it, the opposition is outflanked. If the opposition cannot attack the financing (“good idea, but we can't afford it”), then the opposition has to attack the

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

- Advocates should inject the issue of health coverage expansion into election campaigns, educate the candidates, and try to obtain candidates' promises to implement specific programs such as All Kids. Health coverage expansion is an attractive promise to make, and it is a difficult promise to refrain from making when an opponent has made it already.[53]
- Advocates should remind policymakers and the general public that health care, which generates good jobs and economic activity far in excess of the public funds spent on it, is a key part of the larger economy and cannot be separated from it.[54] Health care industry jobs are a growing component of urban economies, and they pay better than other entry-level jobs and have better career paths.[55]
- On the state level, in all the various ways indicated by the Illinois experience, using the political power of the health coverage issue is timely. A sensible set of revenue ideas and budget-cutting alternatives that do not hurt vulnerable people can defuse the "we can't afford it" response and deprive politicians from being able to say that they have no choice but to cut programs or refuse to expand them. They always have a choice and to refuse to expand health coverage is an exercise of that choice, a decision for which politicians need to be held accountable. Health coverage is popular, and, if coverage is framed as a policy choice that politicians are free to make, many politicians will shy away from opposing it or at least from being the visible leader of the opposition.

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

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[1]All Kids Health Insurance Act, Ill. Pub. Act No. 094-0693 (2005), *available at* http://www.ilga.gov/legislation/publicacts/fulltext.asp?name=094-0693&GA=94&SessionId=50&DocTypeId=HB&DocNum=806&GAID=8&Session=. The bill authorized the All Kids program and provided basic eligibility rules but left most of the details to administrative implementation decisions leading up to the July 1, 2006, effective date. The bill requires Illinois residency but has no other eligibility criteria related to immigration status or traditional categorical eligibility rules.
[2]Press Release, Illinois Government News Network, Governor Blagojevich Signs Landmark Legislation to Provide Comprehensive Health Coverage for Every Uninsured Child in Illinois (Nov. 15, 2005), http://www.illinois.gov//PressReleases/ShowPressRelease.cfm?SubjectID=37&RecNum=4463.
[3]*Id.*
[4]Illinois Gov. Rod R. Blagojevich is the first Democrat in that office since the mid-1970s.

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

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

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

[8]Illinois has about 1.8 million uninsured, or 14.4 percent of the state's population (10 percent of children). See Illinois Hospital Association, Hospital and Health Care Financial Statistics, *available at* http://www.ihatoday.org/about/facts/uninsured.pdf (summary of U.S. Census Bureau data on the uninsured).

[9]The Sargent Shriver National Center on Poverty Law led the FamilyCare coalition and advocacy campaign. Materials from the campaign are available on the Shriver Center's website, http://www.povertylaw.org/advocacy/familycare.

[10]For information on the Medicaid Leadership Group and its activities during the time described in this article, see Health and Disability Advocates, Medicaid Leadership Group, http://www.hdadvocates.org/accesstohealth/Medicaid/index.htm.

[11]This ad hoc coalition does not have an organizational home or a website. It was hosted during its first years by the Women Employed Institute and now is hosted by the Center for Tax and Budget Accountability, *see* http://ctba.inspidered.com. Different groups took leadership on features of the advocacy and authored advocacy materials for use by the coalition.

[12]Covering Kids and Families Illinois is one of the many state-level health coverage enrollment initiatives funded by the Robert Wood Johnson Foundation. *See* Covering Kids and Families Illinois, http://www.ilmaternal.org/CoveringKidsIL.index.htm (last visited, Apr. 17, 2007).

[13]The signature achievement of this coalition is the passage of the Health Care Justice Act in 2004. *See* Health Care Justice Act, Ill. Pub. Act No. 93-0973 (effective Aug. 20, 2004), *available at* www.ilga.gov/legislation/publicacts/fulltext.asp?Name=093-0973&GA=093. That law established the Adequate Health Care Task Force, which conducted a series of public hearings and substantive studies of universal health care options. *Id.* at § 20. The task force produced a plan for universal coverage for Illinois in January 2007. *See* Illinois Department of Public Health – Health Care Justice Act, http://www.idph.state.il.us/hcja/index.htm. Drawing heavily from the task force report, Governor Blagojevich has proposed a universal health care program for Illinois that is pending in the Illinois General Assembly's Spring 2007 session as this article goes to press. *See* S.B. 0005, 95th Ill. Gen. Assembly (Ill. 2007), *available at* http://www.ilga.gov/legislation/billstatus.asp?DocNum=5&GAID=9&GA=95&DocTypeID=SB&LegID=27215&SessionID=51.

[14]Leading examples of these kinds of groups include Action for Children, Illinois' main organization for child care providers and child care policy advocacy, and Voices for Illinois Children, the leading multi-issue children's issues advocacy group. *See, e.g.,* Action for Children, 2005 Legislative Session Ends with Victories for Early Care and Education, http://www.actforchildren.org/_uploads/documents/live/2005_Legislative_Wrap_Up.pdf (describing the FamilyCare expansion); MANEESHA DATE, VOICES FOR ILLINOIS CHILDREN BUDGET & TAX POLICY INITIATIVE, ILLINOIS' FISCAL YEAR 2006 BUDGET: SIGNIFICANT EDUCATION AND HEALTH CARE INCREASES, LONG TERM FISCAL CONCERNS (2005), http://www.voices4kids.org/FY06_Final_Budget.pdf (also describing the FamilyCare expansion).

[15]One of the most powerful supporters of Illinois' FamilyCare campaign was the Industrial Areas Foundation–organized United Power for Action and Justice, a metropolitan-wide organization in Chicago and Cook County consisting of more than 300 religious congregations and other institutions. Through actions involving thousands of citizen leaders, United Power for Action and Justice had a profound impact on the political atmosphere for health coverage issues. In downstate Champaign, the Champaign County Health Care Consumers had a similar impact. *See, e.g,* John Bouman, *The Power of Working with Community Organizations: The Illinois FamilyCare Campaign—Effective Results Through Collaboration*, 38 CLEARINGHOUSE REV. 583 (Jan.–Feb. 2005) (describing the community organizing aspects of the FamilyCare campaign), *available at* http://www.povertylaw.org/clearinghouse-review/issues/2005/20050115/501048.

[16]*See* ANDREA INGRAM, VOICES FOR ILLINOIS CHILDREN BUDGET & TAX POLICY INITIATIVE, ILLINOIS SPENDING IN PERSPECTIVE: THE CHALLENGE OF MEETING NEEDS IN A LOW-TAX STATE (2002), http://www.voices4kids.org/btspecialreport0502.pdf (summarizing Illinois revenue and spending track record, drawn from official sources and written at the critical moment when Illinois was making the transition from the turn-of-the-millennium boom years into the fiscal crisis).

[17]Illinois general funds spending, adjusted for inflation, increased 4.21% from state fiscal years 1999 to 2003. *Id.* at 10.

[18]*See generally* RALPH MARTIRE, CTR. FOR TAX & BUDGET ACCOUNTABILITY, FISCAL SYSTEM BASICS (2005), http://www.ctbaonline.org/All%20Links%20to%20Press%20and%20Reports/Home%20Page/Fiscal%20System%20Basics.pdf. *See also* A+ Illinois, Facts About Illinois' Education Crisis, http://www.aplusillinois.org/issues/facts.asp (last visited Apr. 17, 2007) (materials gathered by the A+ Illinois coalition, which is actively seeking reform of the Illinois revenue system to accomplish education funding reform, among other things). For broader information about Illinois budgets and revenues, see generally Commission on Government Forecasting and Accountability, http://www.ilga.gov/commission/cgfa2006/home.aspx (last visited Apr. 17, 2007) (formerly known as the Economic and Fiscal Commission, the commission is a bipartisan arm of the Illinois General Assembly).

[19]See MARTIRE, *supra* note 18. The most sensible revenue reform that cures the structural deficit (among others) involves an increase in the income tax, an expansion of the sales tax base to cover more services, and a substantial reduction in the property tax, in addition to other features. *Id.* at 7–8.

[20]For a good summary of the Illinois budget process, see COMM'N ON GOV'T FORECASTING AND ACCOUNTABILITY, FISCAL YEAR 2006 BUDGET SUMMARY 1–2 (2005), http://www.ilga.gov/commission/cgfa2006/Upload/FY2006budgetsummary.pdf.

[21]*See, e.g.,* Memorandum from Stephanie Gadlin, Director of Communications and Media, National Ctr. on Poverty Law to Members of the Ill. Gen. Assembly (May 16, 2001) (summarizing a 2001 public opinion poll finding that 79% of likely voters favored the establishment of that program, and 70% favored it when the public costs were included in the question), *available at* http://www.povertylaw.org/advocacy/publications/surveyresults.pdf.

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

[23]*See* Press Release, Illinois Government News Network (Feb. 20, 2002), *supra* note 22.

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

[25]*See* EMILY MONDSCHEIN, VOICES FOR ILLINOIS CHILDREN BUDGET & TAX POLICY INITIATIVE, THE ILLINOIS BUDGET IN HUMAN TERMS: THE IMPACT OF BUDGET CUTS ON THE PEOPLE OF ILLINOIS 6 (2002), http://www.voices4kids.org/humancosts2.pdf. This budget included both a $600 million reduction in Medicaid spending and the modest initial steps of the expansion under FamilyCare and SeniorCare. This apparent contradiction demonstrates two competing themes: the reflex to cut Medicaid in a budget crisis and the growing political appeal of expanding health care coverage.

[26]The Women Employed Institute in Chicago hosted this ad hoc coalition and the coalition received tax and budget expertise from the Center for Tax and Budget Accountability, particularly with respect to a list of alternative budget cuts and revenue generators that gave the coalition ample proposals to show policymakers how to avoid making damaging cuts. The Center for Tax and Budget Accountability plans to make these materials available in the archive section of http://www.ctbaonline.org; they are also available from cmancini@ctbaonline.org. The Budget and Tax Policy Initiative of Voices for Illinois Children produced the report cited in note 25 as a strategy for the Emergency Campaign for a Fair Budget.

[27]CENTER FOR TAX AND BUDGET ACCOUNTABILITY, FY 2003 BUDGET WRAP-UP (2002) (to be available in the archive section of http://www.ctbaonline.org and also available from cmancini@ctbaonline.org).

[28]The grassroots members of the FamilyCare coalition were particularly effective in keeping the health coverage issue at the center of the campaign. United Power for Action and Justice, a Chicago metropolitan-wide citizens' organization, produced enthusiastic crowds for events at which FamilyCare and other health care issues were central to the interactions with the candidates. *See* Bouman, *supra* note 15, at 594.

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

[30]*Id.*

[31]Rod Blagojevich, Ill. Governor, State of the State Address (March 12, 2003) (transcript available at http://www.illinois.gov/gov/sosspeech2003.cfm). In making this promise, the governor specifically cited that Illinois had lapsed $150 million of its federal allotment for the State Children's Health Insurance Program over the years and stated that he was not going to allow this to continue. *Id.*

[32]*See* Press Release, Illinois Government News Network, Public Aid Budget Fulfills Governor's Commitment to Protecting Health Care for Illinois' Families and Seniors (April 9, 2003), http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=2083; Rod Blagojevich, Ill. Governor, Governor Blagojevich's Budget Address – FY 2004 (April 9, 2003) (transcript available at http://wwwc.illinois.gov/gov/budgetTranscript2003cfm); *see generally* BUDGET & TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, THE GOVERNOR'S FY 2004 BUDGET PROPOSAL: INVESTING IN CHILDREN IN TOUGH TIMES (2003), http://www.voices4kids.org/btspecialreport0403.pdf (summarizing budget proposals affecting children and families).

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

[34]*Id.*; *see also* BUDGET AND TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, ILLINOIS' FISCAL YEAR 2004 BUDGET: HOW DO CHILDREN AND FAMILIES FARE? 5 (2003), http://www.voices4kids.org/finalbudget04.pdf; *see generally* CENTER FOR TAX AND BUDGET ACCOUNTABILITY, FISCAL YEAR 2004 BUDGET WRAP-UP (undated) (to be available in the archive section of http://www.ctbaonline.org and also available from cmancini@ctbaonline.org) (summarizing revenue and appropriations for the year). Note that in the 2004 state fiscal year Illinois also had the advantage of increased federal matching funds amounting to more than $200 million under the "fiscal relief" enacted by Congress. Late in the 2004 state fiscal year, the state enacted another bonding scheme of about $800 million that it used to pay down the Medicaid backlog of bills before this enhanced federal matching rate expired. The gain in matching percentage and avoidance of late payment fees more than offset the interest on the bonds. *See* Press Release, Illinois Government News Network, Governor Blagojevich Announces Illinois Taps $25 Million in Additional Federal Medicaid Funds (June 29, 2004), http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=3182.

[35]For the 2004 session (FY2005 budget), *see generally* BUDGET AND TAX POLICY INITIATIVE, VOICES FOR ILLINOIS CHILDREN, ILLINOIS' FISCAL YEAR 2005 BUDGET: LACK OF REVENUES FORCES TOUGH CHOICES (2004), http://www.voices4kids.org/B&T_publications.htm (summarizing budget outcomes for programs affecting children and families). For the 2005 session (FY2006 budget), *see generally* BUDGET AND TAX POLICY INITIATIVE, *supra* note 14 (describing budget outcomes for programs affecting children and families).
[36]Press Release, Illinois Government News Network, Governor Blagojevich Unveils Landmark Proposal to Provide Comprehensive Health Coverage for Every Child in Illinois (Oct. 6, 2005), http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=4381.
[37]Ill. Pub. Act No. 094-0693 §§ 20, 35 (2005), *available at* http://www.ilga.gov/legislation/publicacts/fulltext.asp?name=094-0693&GA=94&SessionId=50&DocTypeId=HB&DocNum=806&GAID=8&Session=.
[38]*Id.* § 20(a)(3).
[39]*Id.* § 40.
[40]*Id. passim*. An excellent presentation of the All Kids program rules and procedures can be found at the official website, http://www.allkidscovered.com.
[41]Press Release, *supra* note 36. The linkage is rhetorical and political and not technical. If primary care case management does not produce the expected savings, there would be no automatic threat to All Kids.
[42] This program is called Illinois Health Connect, and it is being implemented in stages beginning in late 2006 and continuing in early 2007. The program rules and procedures are summarized at http://www.illinoishealthconnect.com.
[43] Press Release, Illinois Government News Network, Governor Blagojevich Poised to Make Illinois Only State in the Nation to Offer Comprehensive Health Coverage to Every Child (Oct. 27, 2005), http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=4416.
[44]*Id.*; *see also* Sargent Shriver National Center on Poverty Law, Support the "All Kids" Program and the Related Primary Care Case Management Reform (2005), *available at* http://www.povertylaw.org/advocacy/documents/All%20Kids.pdf.
[45]Excellent materials describing national trends for this purpose are available from Families USA at http://www.familiesusa.org.
[46]For example, the FamilyCare expansion was always addressed to "the uninsured" and described as "health care for working families" in addition to the low-income families that it actually would cover. *See* Press Release, *supra* note 7.
[47]In Illinois, a successful collaboration of this sort is the Medicaid Leadership Group, which has cooperated for three years on the state budget, federal issues, and the hospital assessment initiative. Health and Disability Advocates in Chicago coordinates the Medicaid Leadership Group. For more information, see Health and Disability Advocates, Medicaid Leadership Group, http://www.hdadvocates.org/accesstohealth/Medicaid/index.htm.
[48]In Illinois, many of these unions not only contribute to political campaigns but also get involved on the ground in political work.
[49]For a full description of the powerful grassroots portion of the FamilyCare campaign, see Bouman, *supra* note 15, at 589–94.
[50]In Illinois, since 2001, this kind of ad hoc coalition has been active under the name "Emergency Campaign for a Fair Budget" (which recently dropped the term "Emergency" from its name and became a standing coalition).
[51]Illinois is fortunate to have two expert organizations that provide this kind of specialized help: the Center for Tax and Budget Accountability and the Voices for Illinois Children Budget and Tax Policy Initiative. They are highly collaborative and complementary, and there is plenty of work for both.
[52]*See* Center on Budget and Policy Priorities, http://www.cbpp.org.
[53]In Illinois, the Governor's advisers were familiar with the publicity about, and popularity of, the health care expansion of the late 1990s and the FamilyCare campaign in the early 2000s. The publicity about, and popularity of, the issue of health care during the Governor's campaign influenced his campaign promises. He knew that there had been supporting newspaper editorials, broad-based public support, and highly favorable public messages and images about the expansion of health care coverage in the past. The new Governor's campaign promises in support of health care coverage were made with knowledge

of the fiscal crisis, and his commitment to support health care coverage involved not just preserving Medicaid from cuts but also following through on the FamilyCare expansion.

[54]*See generally*, FAMILIES USA, PUB. NO. 04-102, MEDICAID: GOOD MEDICINE FOR STATE ECONOMIES – 2004 UPDATE (2004), *available at* http://www.familiesusa.org/assets/pdfs/Good_Medicine_2004_update93b7.pdf. (finding, for example, that every $1 of Medicaid spending generates $3 of business activity, almost thirty-four jobs, and about $1.3 million in wages).

[55]DANIEL GITTERMAN ET AL., THE OTHER SIDE OF THE LEDGER: FEDERAL HEALTH SPENDING IN METROPOLITAN ECONOMIES exec. summary (2004), *available at* http://www.brookings.edu/metro/pubs/20040917_gitterman.htm. For example, All Kids is estimated to produce about $87 million in business activity in Illinois and $30 million in wages. *See* FAMILIES USA, PUB. 05-106, GOOD FOR KIDS, GOOD FOR THE ECONOMY: HEALTH COVERAGE FOR ALL KIDS IN ILLINOIS 2, 4 (2005), *available at* http://www.familiesusa.org/resources/publications/by-date/publications-by-date-2005.html (describing research that shows the likely positive economic effects in Illinois as a result of implementation of universal health insurance for children).