Project Abstract

Current Status of Access to Health Insurance in Illinois

Illinois is the sixth largest state with a population of 12,295,000 based on 1998 U.S. Census Bureau data. Of that total, the report categorized approximately 15 percent as uninsured in 1998, while an average of 12.9 percent were estimated to be uninsured during the three year period from 1996 through 1998. Data indicates the uninsured tend to be young and living in low-income households. The majority of Illinois residents with health insurance obtain their coverage through employer sponsored plans, Medicaid or Medicare. Other sources of health insurance covering smaller percentages of the Illinois population include the Illinois Comprehensive Health Insurance Plan (ICHIP) and the State Children's Health Insurance Plan (KidCare) as well as the Department of Defense CHAMPUS and CHAMPVA programs.

Illinois is a center for medical and health care leadership in the country, with nine medical schools and a school of public health. Unfortunately many persons, especially in rural and inner city urban areas are underserved by health care professionals and often cannot afford health insurance. Diseases and conditions that could be prevented present the most critical issues resulting from restricted access to care. Throughout Illinois local health departments form the backbone of the state system for providing public health services at the community level, but wide variations based on jurisdictional demographics and community resources account for variations in the range, level and intensity of services available through local health departments.

Earlier Efforts to Expand Access to Health Coverage in Illinois

There have been a variety of earlier attempts to reduce the uninsured population in Illinois. We concentrated on reducing the number of persons medically uninsurable due to preexisting conditions through the creation of the Illinois Comprehensive Health Insurance Plan (ICHIP) which serves as the state health insurance pool. The deficit of premiums over claims for ICHIP's original pool is funded by the state's general revenue fund and the state has paid more than $200 million for this purpose. In 1997, Illinois implemented a major new ICHIP pool, funded by the entire Illinois health insurance industry, to act as an alternative mechanism for guarantying access to individual coverage as allowed by HIPAA.

The creation of the SCHIP KidCare Program both expanded existing Medicaid and created a new program for the children of working families who earn too much money to qualify for Medicaid, but do not earn enough to easily afford health care coverage for their children. As a result of intensified outreach efforts, approximately 70,000 additional children have enrolled since Governor Ryan took office.

Illinois has implemented a number of other proposals to help persons access the insurance market in Illinois including: the ability to form purchasing groups, major managed care reform, HIPAA portability requirements, and rating restrictions on small group health insurance plans. Illinois has also considered but not enacted various other rating and universal health care laws.

Project Goals and Project Description

Illinois is proposing a multi-tiered plan to study the demographics and the needs of the uninsured population and to bring together stakeholders in all segments of Illinois society to develop strategies to reduce the number of uninsured in Illinois. In order to devise programs to assure access to insurance coverage for all citizens, we need to understand what constitutes the barriers to individuals in accessing insurance. We also need to learn how those problems vary by region, ethnicity, income and other characteristics.

To accomplish this goal, Illinois will create a Steering Committee that will work in partnership with other stakeholders to identify the characteristics of the uninsured population and develop a plan to provide access to health insurance coverage. We will contract with two state universities to obtain data using research methods including a population-based survey of the uninsured, an expansion of the Illinois Behavioral Risk Factor Surveillance System, analysis of existing data sets, thirty-five focus group

discussions with key stakeholders located throughout the state, twenty personal interviews with strategic informants throughout the state and analysis of literature concerning projects to reduce the number of uninsured.

Department of Insurance staff will craft potential solutions and programs for reducing uninsurance in Illinois. The Steering Committee will meet on a regular basis to monitor the data gathering process and to examine these proposed options and evaluate program designs. Final strategies to provide coverage for all citizens will be developed in consultation with representatives from organizations from all sectors of society that have specific stakes in the uninsured population. In addition, the Steering Committee will use an adaptation of the American Assembly model to reach a consensus among stakeholders regarding strategies in a structured mediated environment to reach the goal of 100 percent access.

Lead Agency and Partners

A Steering Committee has been formed to prepare this application and organize the planning project. The lead agency of the Steering Committee is the Illinois Department of Insurance. Assistant Director of Insurance Madelynne Brown will be the main contact person throughout this planning project. Other members of the Steering Committee include staff of Governor George Ryan's Office, the Departments of Public Health, Public Aid, Commerce and Community Affairs, and Human Services, the Illinois Comprehensive Health Insurance Plan and faculty members from Southern Illinois University at Carbondale and the University of Illinois at Chicago. Throughout the planning process the Steering Committee will work with numerous stakeholders including local government agencies, public health and social service agencies, faith groups, insurance companies and agents, employers, health care providers, health issues interest groups, community groups, members of Public Health Futures Illinois (a partnership to promote a broad public health system with prevention as the key component) and other groups as is warranted. For a full list of the partners that cooperated in preparing this application and will be cooperating on the Planning Grant, please see Appendix.

Projected Results

The projected results of this plan will incorporate strategies for attacking the uninsured problem in Illinois through various methods. Illinois will build on existing programs and incorporate new ideas and new projects with the ultimate goal of reducing the uninsured population to zero. By using ICHIP, KidCare, the local health networks throughout Illinois and the resources which are abundant in Illinois as a base to build upon, we will create new strategies to reduce the number of uninsured in Illinois through whatever public and private means present themselves.

Current Status of Health Care Insurance

Description of access to health insurance coverage in the state and rates of uninsurance, or description of specific knowledge gaps about uninsurance in the state.

Illinois - the 6th largest state with a population of 12,295,000 based on a 1998 U.S. Census Bureau estimate released in 1999 - is a demographically diverse state. From the extremely urban environment of Chicago in the north to the rural, sparsely populated counties in the southern third of the state, Illinois represents a microcosm of the various issues involved in assuring affordable, accessible health care for all citizens of this country. According to the Census Bureau fifteen percent of the Illinois population was estimated to be without health insurance coverage in 1998, and during the period of 1996 through 1998 an average of 12.9 percent were estimated to be uninsured.

Access to Health Insurance Coverage in the State

The majority of Illinois residents with health insurance obtain their coverage through employer-sponsored plans, Medicaid, or Medicare. Other sources of health insurance covering smaller percentages of the Illinois population include the Illinois Comprehensive Health Insurance Plan (ICHIP), designed to cover persons unable to obtain private health insurance because of medical conditions; the State Children's Health Insurance Program (KidCare), providing coverage to children of qualifying low-income families; and the Department of Defense programs, CHAMPUS and CHAMPVA, providing coverage to active duty and retired members of the armed forces and their families. Individual health insurance coverage is available from approximately 200 insurers and health maintenance organizations licensed to sell health insurance in Illinois.

A 1998 Urban Institute analysis of the Census Bureau's 1994-1995 Current Population Survey (CPS) data examined insurance coverage of the non-elderly. Approximately 72 percent of the non-elderly Illinois population were covered by employment-related health benefits plans. Almost 12 percent of the non-elderly were covered by Medicaid at that time, around 5 percent were covered through other sources, and over 11 percent were uninsured.[1] [1]

Hospital billing records also yield important information about health insurance coverage. Data from billing forms collected by the Illinois Health Care Cost Containment Council for 1998 show that nearly 92 percent of hospitalizations for adults 18 years of age and older were billed to third party payers, including Medicare, Medicaid, commercial insurance, a health maintenance organization (HMO) or a self-administered plan; only about eight percent of 1998 charges for hospitalizations were self-pay or other (Black Lung, CHAMPUS, CHAMPVA, Hill Burton Free Care, charity care, or other miscellaneous). For children six to 18 years of age, the same data source indicates slightly less than 88 percent of charges for hospitalizations were covered through Medicare, Medicaid, commercial insurance, HMOs or self-administered plans, while a little more than 12 percent were self-pay or other.

Mortality among children hospitalized by payer type in 1998 was more than twice as high for those children in the self-pay or other categories than for those covered by Medicaid, commercial insurance, or HMOs. For adults between the ages of 18 and 65 in the self-pay and other categories, the mortality rate was nearly 30 percent greater than for those covered by Medicaid, commercial insurance or HMOs. These data seem to support the notion that the uninsured are more likely to delay seeking care until their condition is more critical and less amenable to successful treatment.

Rates of Uninsurance

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11 [1][1] D.W. Liska, N. J. Brennan, & B. K. Bruen, *State-Level Databook on Health Care Access and Financing*, 3rd ed., Urban Institute Press, Washington, DC, 1998.

CPS data estimates that 15 percent of the entire Illinois population was without health insurance coverage during 1998, while an average of 12.9 percent was uninsured during the three year period of 1996-1998.[2] [2] It should be noted that rates of uninsurance for at least one month tend to be higher than the annual rates reported. Rates of noncoverage vary in duration, and interruptions in coverage for at least one month tend to be much higher.

Details provided by the Urban Institute analysis of 1994-1995 CPS data reveal that a lack of health insurance in Illinois is characteristic of particular age ranges, family incomes, and occupations. For example, nearly half of the non-elderly uninsured in Illinois were between 19 and 34 years of age, and almost 30 percent of adults in families with incomes less than the 200 percent of the federal poverty level were uninsured. Nearly one-third of the uninsured private-sector workers in Illinois were employed in service occupations.

Results provided by the Illinois Behavioral Risk Factor Surveillance System survey (BRFSS) relating to the uninsured are consistent with the Urban Institute's CPS findings. BRFSS estimates based on 1999 data characterize the uninsured as predominantly young and living in low-income households. Interestingly, while most elderly residents of Illinois are eligible for Medicare, Medicaid, or both, 1999 BRFSS data indicated that nearly 3 percent of Illinois residents 65 years of age or older do not have a health benefit plan.

Specific Knowledge Gaps About Uninsurance in the State

To effectively address the problem of uninsurance in Illinois, program design and evaluation will require a more detailed, routinely-available data source yielding information about characteristics of both the uninsured and the health insurance marketplace. A consistent source of data is needed to determine identifying characteristics of the uninsured such as gender, race, ethnicity, income level, employment status, and occupation. Additionally, such information should be collected with a frequency and in a manner that would allow monitoring and surveillance of trends over time. A useful understanding of health insurance coverage in Illinois would be strengthened by detailed knowledge about health benefits plans sponsored by employers, and by research to explore consumer motivations in the purchase of health insurance. Data is also needed to understand the care currently obtained by the uninsured. We need to understand why there is limited provider participation in publicly funded programs and what cultural influences or other patient related factors restrict utilization of health care or health insurance.

Description of key health issues in the state related to access and uninsurance.

In Illinois, diseases and conditions that could be prevented present the most critical issues resulting from restricted access to care and the lack of health insurance. Adequate health insurance coverage can provide access to preventive services, including screening, immunizations, and counseling. Delivered within a continuum of care, these services can: prevent diseases from occurring; detect diseases at earlier, more treatable stages; and treat chronic conditions effectively to avoid disabilities. Aspects of lost opportunities to prevent health problems and avoid related health care costs fall into the general categories of *individual health*, *population health*, *health system performance*, and *sentinel health events* that warn of underlying access barriers.

Individual Health

In the lives of individual Illinois residents, impeded access to care is most seriously manifested in the lack of a "medical home," or a regular delivery system entry point where individuals can seek and obtain a continuum of health care services across their lifespan. Services actually received by individuals without a "medical home," are typically discontinuous, episodic, and most likely delayed until an urgent situation or health-related emergency has developed.

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33 [2] Author, *Health Insurance Coverage 1998: Consumer Income*, U.S. Census Bureau, Washington, DC, 1999, pp. 60-208.

Population Health
Impediments to health care access, such as the lack of adequate health insurance, are manifested differently at the individual and the population levels of consideration. At the population level, the aggregate health effects of impeded access are reflected in disparities between the health status of groups that have health insurance coverage and those that do not. Subpopulations without access to health insurance coverage and adequate prenatal care, for example, are more likely to experience lower birth weights and higher rates of infant mortality.

Health System Performance
The Illinois health care delivery system includes an essential "safety net" subsystem comprised of local health departments, public clinics, and charity/uncompensated care delivered by hospitals and other providers. Providing care to uninsured persons presents an immediate challenge to this "safety net," as well as an economic burden transferred to the rest of the health care delivery system and to public agencies. Functioning as a contingency for the uninsured, even the best safety net health care is likely to be discontinuous due to delayed and episodic care-seeking by the uninsured and gaps in available services, such as dental and mental health services.

Sentinel Health Events
Underlying access barriers, especially the lack of adequate health insurance coverage, are exposed by sentinel health events - conditions or diseases that would not have occurred, or would have been dramatically less severe, if appropriate health care services had been accessed. Health events that could be viewed as "sentinel" and indicative of impeded access to care include uncontrolled hypertension; uncontrolled diabetes; rheumatic fever; vaccine-preventable communicable diseases; elevated blood lead levels in children; hospitalizations due to asthma or infant dehydration; and the late-stage diagnosis of breast and cervical cancers that could have been detected at earlier, more treatable stages of the disease's progression.

Description of the state's current health care delivery system and its adequacy.
The adequacy of the current health care delivery system in Illinois can be described in terms of various characteristics related to the supply of and demand for health care services.

Supply Aspects
Illinois is a center for medical and health care leadership in the country, with nine medical schools and a school of public health. The state is a net exporter of physicians and can be characterized as having excess, but inadequately allocated, capacity in its health care delivery system. Nearly 32,000 physicians practice in Illinois (American Medical Association: 1996 data reported in 1997/98), including nearly 3,400 engaged in family practice, nearly 1,800 obstetrician/gynecologists, and more than 2,400 pediatricians. Many rural and inner-city urban areas, however, are underserved by health care professionals. Illinois ranks fourth among the states in total population residing in federally designated Health Professional Shortage Areas, reflecting the serious and long-term problem of uneven distribution of primary care health professionals. There are no obstetricians practicing in 48 rural counties and no hospital obstetrical units in 40 rural counties. In 1996, 205 community hospitals with a total of 40,686 beds existed in Illinois, including 95 hospitals with 25,784 beds in Chicago (American Hospital Association, 1998).

Throughout Illinois, local health departments, federally qualified health centers, and rural health clinics, operated by units of local government through local boards of health, form the backbone of the state's system for providing public health services at the community level, focusing on community and individual prevention. Currently, more than ninety-nine percent of the Illinois population is served by a local health department, but wide variations based on jurisdictional demographics and community resources account for variations in the range, level, and intensity of services available through local health departments. In Illinois, the local health department certification process requires jurisdictions to complete an organizational capacity assessment, health priority selection, and planning process known as the Illinois Plan for the Local Assessment of Needs (IPLAN). Although priorities related to health status have been

the focus of the IPLAN process, an increased number of local health jurisdictions selected access to health care services as a priority concern during the most recent certification cycle.

While HMO participation has increased significantly in recent years across the nation, Illinois HMO enrollment has lagged behind that of other states with smaller rural populations or more rapidly instituted Medicaid managed care programs. Nearly 18 percent of all Illinoisans are enrolled in health maintenance organizations (HMOs) (Illinois Department of Insurance, 1999). In addition, fee-for-service coverage is increasingly subject to preferred provider, prior approval and utilization review mechanisms that parallel managed care efforts to control utilization and costs.

Demand Aspects

The health care delivery system of Illinois serves a large and diverse population. Illinois is the sixth most populous state, with an estimated 12.3 million residents. More than 80 percent of the state's population is white, with African Americans representing nearly 15 percent and Asian Americans another three percent. Approximately eight percent of the state's residents are of Hispanic origin. Nearly 85 percent of Illinois' population resides in metropolitan areas. Chicago is home to nearly one quarter of the state's residents; 65 percent of the state's population lives in the nine-county Chicago metropolitan area. Eighty-four of Illinois' 102 counties are rural.

More than one quarter of the Illinois population live in households with income at or less than 200 percent of the federal poverty level, and with 12.9 percent of the population uninsured (CPS 3-year average, 1996-98), the health effects of low income and impeded access to the health care system are significant. These effects are seen in poor health status and in utilization of the health care system that results in an immense cumulative financial burden on hospitals, clinics, local health departments and other "safety net" providers. A statewide health needs assessment in 1993 found a wide variety of health status problems, but reducing the unacceptable health disparities between white and minority populations emerged as an overarching priority. The multidimensional nature of current public health problems continuously challenges statewide and community efforts to improve health.

Earlier Efforts to Reduce the Number of Uninsured Residents

Over the past fifteen years Illinois has proposed and in many cases implemented a variety of concepts designed to reduce our uninsured population. Two of the most successful are the Illinois Comprehensive Health Insurance Plan (ICHIP) and our state children's health insurance program, KidCare. These programs, as well as some of the others described below, have the potential of being expanded to provide coverage for other uninsured. Last fall, the Governor's Office and the Department of Insurance initiated dialogue between several state agencies, business groups and the insurance industry to review concepts on how to make incremental improvements in the uninsured rate in Illinois. This ongoing collaboration, which is focusing on methods to increase employer based coverage, will be vital to this project.

ICHIP On February 9, 1987, Governor James R. Thompson signed into law Public Act 84-1478, creating ICHIP, the state's health benefits risk pool. Illinois thus became the first state to pledge the use of state revenues to cover the deficits which were anticipated to result from establishing this state health insurance pool for its medically uninsurable citizens. Since it became operational on May 1, 1989, more than 20,000 Illinois residents from every county in the state have enrolled for some period of time in ICHIP. ICHIP has paid more than $400 million in benefits on behalf of participants and the state has provided more than $200 million in funding. ICHIP has definitely worked well to serve those who have found it necessary to access to enroll. Applications for ICHIP are currently coming in at a record rate of approximately 500 per month, which is up more than 30 percent over those received in the previous fiscal year.

Illinois implemented a major new ICHIP program on July 1, 1997, in response to the enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). That law gave states the choice of requiring insurance companies in the individual market to guarantee issue policies or of selecting an alternative mechanism, such as HIPAA-ICHIP.[3] [3] Since then more than 6,400 persons have applied for HIPAA-ICHIP coverage and more than 4,750 federally eligible individuals in Illinois have obtained coverage without a preexisting condition exclusion. HIPAA-ICHIP claims totaled $31.5 million as of the end of April 2000.

The use of ICHIP to comply with the individual requirements of HIPAA clearly has been the right decision for Illinois. HIPAA-ICHIP's deficit is funded by an assessment which spreads the cost of insurance for these high-risk individuals across the entire health insurance industry in Illinois. Thus, the total of $19.5 million in assessments for the first three years of HIPAA-ICHIP has been spread across a premium base totaling more than $10 billion annually. As a result the Illinois individual health insurance market which amounts to approximately $800 million in annual premiums has not been forced to fully absorb and subsidize these costs.

This has allowed the individual health insurance market in Illinois to remain stable and not experience the significant increases in premiums that have occurred in many of the states that implemented the guarantee issue requirements in HIPAA. With few exceptions, the same insurers continue to offer individual health insurance policies in Illinois without significant increases in the premiums. This in turn contributes to lower ICHIP rates. The ICHIP Act places a ceiling on premium rates for ICHIP enrollees. ICHIP premiums must be set between 125 to 150 percent of the premiums in the individual health insurance market. ICHIP premiums currently are 135 percent of the average rate charged by the largest carriers for comparable coverage.

3[3] Other states using high risk pools are *Alabama, Alaska, Arkansas, Connecticut, Indiana, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, Texas, Utah, Wisconsin* and *Wyoming*. *Mississippi, Nebraska, Oklahoma, South Carolina, Texas*, and *Wisconsin* – like Illinois – use the high-risk pool exclusively. Other states use it in combination with other mechanisms.

The ICHIP program was established to address problems with availability, not affordability, of health insurance. Nevertheless, it clearly has also impacted affordability, both for its participants and for the persons who are insured under private insurance policies. This is important since the clear majority of current ICHIP participants report income of less than $60,000 per year, and a high percentage report income of less than $40,000 per year.[4] [4] Based on other states' experiences, HIPAA-ICHIP enrollees are being provided comprehensive major medical coverage at a cost that, in all likelihood, is lower than it would be if the individual health insurance market were being accessed directly.

Illinois has received national recognition for the ICHIP program. For example, in June 1999 ICHIP's Executive Director was invited to testify before a special hearing of the Subcommittee on Health and Environment of the U.S. House of Representatives' Committee on Commerce on "Access to Affordable Health Coverage for the Uninsured." His testimony focused on how Illinois has used the ICHIP program to comply with the individual requirements of HIPAA.

In a May, 1999 report to the Chairman of the Committee on Health, Education, Labor and Pensions of the United States Senate, entitled *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards*,[5] [5] the General Accounting Office (GAO) also made favorable comments about Illinois' ICHIP program. The report examined premiums in states with high risk pools and guaranteed issue and concluded that HIPAA eligible persons in guarantee issue states pay much more than they would pay in states that use risk pools as an alternative mechanism. A recent report by the Urban Institute reached similar conclusions about premiums. Another report on state-chartered Health Insurance Plans (HIPS) issued in August of 1999 by The Heartland Institute, a Chicago-based think tank, outlined five key "Steps for Creating a Successful HIP," and referred to Illinois ICHIP as "one of the most successful and efficiently run HIPS in the nation."

It is critical that any program designed to reduce the number of uninsured be adequately publicized and that the public be educated as to its availability. ICHIP has been lauded for making a genuine and effective effort to let those who might be eligible know of its availability. In the GAO study referenced above, Illinois was the only state specifically identified that uses its high-risk pool as an alternative mechanism *and* has "undertaken educational efforts to inform the public about the availability of coverage through the pool."[6] [6] In June 2000 the ICHIP Executive Director was invited to make a presentation on effective outreach programs at a forum sponsored by the Health Care Financing Administration.

KidCare The State Children's Health Insurance Program legislation, enacted in 1997, allotted federal dollars to the states to create their own programs to provide health insurance to children of low income families. In August of 1998, Governor Jim Edgar signed Public Act 90-736 creating the Illinois' KidCare Program. This act both expanded existing Medicaid and created a new program for the children of

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[4] [4] Based on a preliminary analysis of a survey of HIPAA enrollees who terminated their coverage with ICHIP, which was conducted in May, 2000. The survey results suggest that 77 percent of those who responded reported annual household income of less than $60,000, and that 58 percent reported annual household income of less than $40,000. Less than 10 percent reported incomes of $80,000 or higher. This corroborates previous surveys of the ICHIP population. This is significant in light of a recent study by Brandeis University, sponsored by the United Power for Action and Justice, which suggests that the fastest growing group of uninsureds report incomes of from between $25,000 and $50,000. See "Uninsured on the Ropes," Arlington Heights *Daily Herald*, April 2, 2000.

[5] [5] GAO/HEHS-99-100, U.S. General Accounting Office.

[6] [6] GAO/HEHS, op. cit., p. 20.

working families that earned too much money to qualify for Medicaid, but did not earn enough to easily afford health care coverage for their children.

KidCare consists of five insurance plans: KidCare Assist; KidCare Share; KidCare Premium; KidCare Mom's and Babies and KidCare Rebate. A family of four can have income of up to $31,548 annually and qualify for KidCare. Pregnant women and their babies can be covered up to an annual income of $34,104.

KidCare Assist reaches all children under the age of 19 and below 133 percent of the federal poverty level (FPL). This program is available at no charge and with no co-payment to the recipient. It provides comprehensive covered benefits including: physician, surgical and clinic services; inpatient and outpatient hospital services; prescription and over-the-counter drugs; prenatal and maternity care; skilled pediatric nursing facilities; dental and optometric services; laboratory and radiological services; medical transportation; family planning services; podiatric and chiropractic services; early intervention services, including case management; hospice, nursing care, and home health care services; physical therapy, occupational therapy, speech and audiology services; durable medical equipment and devices, and disposable medical supplies; services of intermediate care facilities for the mentally retarded; inpatient and outpatient mental health and substance abuse treatment services.

KidCare Share is available for children between 133 percent and 150 percent of FPL. It includes all the benefits listed above. There is no premium, but modest co-payments (usually $2) apply.

KidCare Premium is available for children between 150 percent and 185 percent of FPL. It includes all the benefits listed above. There is a monthly premium ($15 for one child, $25 for two, $30 for three or more) and larger co-payments.

KidCare Moms and Babies covers pregnant women and children below age one whose income is below 200 percent of FPL. The benefit package is identical to KidCare Assist.

KidCare Rebate is for families up to 185 percent of FPL who have employer sponsored or private insurance. For those families whose children are currently covered by comprehensive health insurance through their employer or a private company, the Department of Public Aid will offer a rebate amount, subject to a $75 per child cap, determined by the current monthly premium paid. The rebate amount is per child and is sent directly to the policyholder on a monthly basis.

In April 1999, Governor George Ryan directed the KidCare program to embark on a comprehensive outreach effort to dramatically increase the state's enrollment and outreach activities. At that time there were only 31,820 children and pregnant women enrolled in the program. Six months after this initiative began, KidCare enrollment nearly doubled. A year afterward, three times as many children and pregnant women had enrolled in KidCare. The program continues to grow toward its goal of providing health coverage for every eligible Illinoisan, estimated to be approximately 200,000 citizens.

As part of this outreach effort Governor Ryan announced the creation of a state partnership with hospitals, clinics, community service agencies, businesses, labor unions, chambers of commerce, schools and congregations to promote KidCare, boost enrollments and distribute application forms. In August 1999, the Governor signed into law two bills (Public Acts 91-470 and 91-471) which formalized these partnerships by requiring state government to work with these local groups throughout the state to expand KidCare.

Today, the KidCare program is working with hundreds of hospitals, clinics, and neighborhood and community-based organizations that are closest to prospective KidCare enrollees. Efforts underway include collaborative efforts with the school districts, community-based organizations, employer groups, faith-based organizations, hospitals, clinics, local communities, and many other state agencies. Last fall, the Governor announced $1.6 million in grants to 29 community organizations for outreach activities to

hard-to-reach children, families and pregnant women. In order to increase awareness and enrollment, Illinois has contracted with health providers, related provider sites and licensed insurance agents to act as KidCare Application Agents and help families complete applications. The KidCare program has undertaken a number of other strategies to reach families of varying ethnic and language backgrounds.

The KidCare program has also undertaken an extensive, targeted public media campaign, designed to increase enrollment in concert with all their other efforts. The campaign has included radio advertisement in the Chicago market and downstate, as well as brochures and posters on buses, in public libraries, in public buildings, and elsewhere. Nearly 1,000,000 brochures and over 120,000 applications have been distributed throughout the state.

Both KidCare and ICHIP have the potential for growth through attracting more uninsured who are currently eligible as well as expanding eligibility.

The "Gilead Project" received state funding this spring to conduct an outreach and referral program to sign people up for the health insurance for which they are eligible.

Medicaid Eligibility Legislation passed this spring that over the next three years will raise the eligibility threshold for the elderly and disabled to the poverty level thereby increasing coverage.

Managed Care Reform After years of intense debate and discussion by the legislature and interest groups, Governor Ryan helped negotiate a compromise on the issue of managed care reform in 1999. The Managed Care Reform and Patient Rights Act establishes myriad consumer friendly initiatives, including the creation of the Office of Consumer Health Insurance within the Department of Insurance to assist consumers with questions and difficulties.

Rating of Health Insurance Products In 1999, the state enacted a system of rating bands for the small group market similar to a rating system in place in the state prior to HIPAA. The purpose of these rating bands is to contain the amount of rate increases, thereby encouraging small employers to continue to offer or begin to offer health insurance to their employees. Although historically not successful, legislation has been introduced to promote the regulation of all health insurance rates in Illinois. These proposals typically hold health insurance premium rate increases to the consumer price index and provide for rate filing and approval authority by the Department of Insurance. It should be noted that Illinois is not a rate regulating state. The philosophy behind this policy is to encourage insurers to compete for the consumer's dollars, which should in theory provide more choice and affordability in the health care market.

HIPAA In 1997, the State of Illinois enacted state specific provisions of the federal Health Insurance Portability and Accountability Act. Significant reforms, in addition to the establishment of the HIPAA-ICHIP risk pool, was the institution of guaranteed issue in the small group market and guaranteed renewability for all groups. These changes, along with limits on preexisting conditions and new standards on portability and discrimination, have in part stabilized the group health insurance market and increased the availability of coverage.

Public Health Futures Illinois Partnership In 1997, Illinois through the Department of Public Health, established the Public Health Futures Illinois (PHFI) partnership to promote a broad public health system with prevention as a key component. PHFI is funded by the state and a grant from the Robert Wood Johnson Foundation. One of the strategic priorities of the partnership is to ensure that all Illinois citizens have adequate access to health care, including health insurance coverage through the funding of an "Access to Care Consortium."

Health Care Purchasing Groups (HPG) In 1997 the Illinois General Assembly authorized two or more employers, each with no more than 500 employees, to voluntarily pool employees for the purpose of purchasing health insurance. The goal of HPGs is to allow smaller employers to create a larger pool of

insured individuals with the anticipation of reducing health care rates and spreading risk. As of the date of this application no HPG has been formed.

"Barebones" Small Employer Group Health Insurance Law was enacted in 1990. It was intended to reduce the number of uninsured by allowing small employers to obtain more affordable health insurance due to limited mandated benefits. The "barebones" policy was repealed due to its unpopularity as well as HIPAA conflicts. In spite of the lower cost, in seven years fewer than 20 employers purchased policies. Reduced benefit policies were unattractive.

Pharmaceutical Assistance The Pharmaceutical Assistance program was enacted in 1985 to provide low-income senior and disabled residents access to essential medication. Governor Ryan recently approved legislation to expand the program by increasing the qualifying income levels and expanding the covered medical conditions.

Favorable Tax Policies Medical Care Savings Accounts (MSA) allow employers to provide affordable, high deductible catastrophic coverage and deposit the premium savings into a nontaxable MSA to pay for routine medical care of employees. An employee can deduct money withdrawn for eligible medical expenses from Illinois income tax. The Illinois Income Tax Act also contains a provision whereby self-employed individuals may be eligible to receive a deduction for premiums paid for health insurance or long-term care insurance. This deduction is only offered to individuals that are not eligible to participate in any health insurance plan offered by an employer. Further, the amount permitted to be deducted for Illinois purposes cannot have been deducted for federal tax purposes. The state has considered other proposed legislation to provide favorable tax incentives for those who purchase health insurance.

Other Proposals While universal health care has not been implemented in Illinois, a number of proposals have been introduced. Legislation has also been introduced to implement a grant program to allow Illinois communities to develop demonstration projects for providing access to health care coverage for low income uninsured residents of the state who are not eligible for other types of medical coverage.

Request for Preference

Illinois requests the preference in evaluating applications given to states with either lower rates of uninsured or the potential for a significant decrease in their uninsured population. We meet both of these standards. Illinois' uninsured rate is both lower than the national average and that of most other states of comparable size. Illinois also has established programs which have successfully provided coverage, or set goals to improve access, for uninsured individuals. Even if the planning process does not result in additional strategies for decreasing the uninsured population, these programs have the potential to serve a significant number of uninsured.

Illinois has lower rates of uninsurance compared to other states of similar size and urban-rural composition. Census data estimates that in 1998, 15 percent of the Illinois population was uninsured and the three year average for 1996 to 1998 was 12.9 percent. Both figures are less than the national averages for those periods and our three year average ranks in the lower third of all states. Of states with populations greater than 12 million, Illinois had the lowest percent of uninsured and the lowest percent of uninsured employed individuals.

The Illinois Comprehensive Health Insurance Plan (ICHIP) was established by the Illinois General Assembly in 1987 to provide a source of health insurance coverage for medically uninsurable individuals. This high risk pool enrolled its first insured in 1989 and has served more than 20,000 citizens since then. In 1997 the program was expanded to provide a second pool which serves as the state's alternative mechanism for persons who are federally eligible for individual portability as defined by HIPAA. Total ICHIP enrollment has nearly doubled during the three years since the formation of the second pool. The potential exists in ICHIP for the existing pools to be expanded and for new pools to be formed with varying eligibility requirements.

Most individuals in Illinois obtain health insurance coverage through employer sponsored plans. There is the potential to develop strategies that can enhance the business community's ability to sponsor health insurance. In the fall of 1999, the Governor's office and staff of the Insurance Department and other state agencies met with representatives of employers and the insurance industry to discuss potential expansion of ICHIP to include small groups. A carve out or reinsurance mechanism was proposed to be used for employees who would medically qualify for ICHIP which could ease affordability for small employer groups with high cost members. This plan has potential and is still under consideration.

Our State Children's Health Insurance Program, KidCare, also has the potential for significant expansion. For instance, the number of children enrolled can be increased by intensified outreach efforts and increasing the income eligibility levels. In addition, the program could be expanded to cover adult members of families with covered children or single adults. A committee of legislators has been exploring these possibilities.

Finally, the Public Health Futures Illinois Partnership of public, private and voluntary institutions, which has worked since 1997 to strategically plan the future of prevention-focused public health practice, has set as one of its strategic priorities access to care which includes providing access to health insurance coverage. The Partnership is currently working to implement its strategies.

For all these reasons Illinois qualifies as a state that is entitled to the preference in evaluating applications for states with lower rates of uninsured or the potential for significant decrease in their uninsured population.

Project Goals

The overarching goal for this project is to assure 100 percent access to health insurance benefits for all citizens. To accomplish this and to facilitate the creation of insurance products for the uninsured population our objective is to address the following inter-related questions:

Who are the uninsured in Illinois? We want to define and understand who is uninsured in Illinois by using a variety of research techniques to provide detailed, usable and accurate information. We will collect and analyze demographic data, and study the duration of noncoverage; health status; source of health services; use of prevention services; employment status; insurance availability through employer or employer of other household member; premium cost of employment-based plan; reason(s) for declining employment based-coverage if available; awareness of alternative sources of health insurance (privately and publicly-sponsored) and attempts to secure such coverage. Recognizing that insurance coverage is a dynamic status, we must examine short as well as long term periods of uninsurance.

What types of programs will best address the barriers to insurance found in an analysis of the uninsured? To what extent do products currently available through private and public sector providers address those barriers? What gaps between the uninsured and providers must be bridged? To maximize the potential for success, it is likely that Illinois' plans will build upon our current successes. Therefore fundamental to the planning process is a detailed study of the uninsured population and the employer community, since most Illinois residents have employment based coverage. Promoting expansion of employment based coverage where viable militates against crowd-out and promotes efficiencies through competition. A thorough analysis of barriers to coverage as perceived by the uninsured and barriers to offering coverage as perceived by employers will contribute to design of feasible plans. Programs in other states, proposed programs and cost effective funding must be examined as well as the impact of regulation. Price elasticity questions about health insurance must be addressed by both individuals and employers in this project. It will be necessary to examine how best to reach out to uninsured individuals and make them aware of the availability of affordable coverage. As such we must also develop a communication plan.

What programs are currently available in Illinois and what possibilities are there for expansion? What new programs can be developed? What are the strengths and weaknesses, in terms of reducing the number of uninsured, of the currently available programs? We will examine expansion of public (KidCare), employer–based, and high risk pool (ICHIP) coverage as well as developing specific models that could be tested in Illinois.

What is the best partnering structure to achieve this goal? A system should be created where all of the key stakeholders can meet in a structured, mediated environment to reach as much consensus as possible, first on the basic facts/data of the uninsured, and then on ways to move the number of uninsured as close as possible to zero. Employers, labor unions, social service advocates, commercial insurers, insurance agents, and medical practitioners, may share more common ground on this issue than they might believe, but they rarely have a chance to work cooperatively toward addressing this issue. Creating an organized, interactive system where all of these entities work and meet together to provide access for affordable health care for everyone will have benefits beyond the specific work product that they create.

Project Description

A. DETAILED PROJECT NARRATIVE

OVERVIEW

Illinois is a state rich in resources, opportunities, imagination, and potential. Among the state's resources are premier health care and graduate medical education institutions, highly skilled practitioners, and sophisticated systems of health care delivery. Yet, paradoxically, Illinois is also a home to tens of thousands of residents who cannot obtain the care they need because they lack health insurance coverage. Some uninsured Illinoisans suffer needlessly from conditions that could have been prevented, and some will die from afflictions that could have been treated, if adequate care had been made available through insurance coverage. Variations in insurance coverage and in access to quality lie beneath the disparities in health status that are manifested in disease and death for the young, the minority, the impoverished, and other vulnerable segments of our population. In requesting this planning grant, the goal of the State of Illinois is identical to that of the Health Resources and Services Administration: to promote access to quality health care services that nurture the health of Illinois residents by assuring access to health insurance coverage for all citizens.

The State of Illinois proposes to accomplish this goal through a partnership of the Governor's Office, the Departments of Insurance, Public Health, Public Aid, Commerce and Community Affairs, Human Services, ICHIP, along with faculty members from Southern Illinois University Carbondale (SIUC) and the University of Illinois Chicago (UIC). These entities have already formed a Steering Committee to develop this application and will continue to work together to address these issues. The Steering Committee will continue to involve representatives of stakeholders who contributed to the application process as well as other interested entities.

We propose to use five research methods to gather data about the uninsured, current health insurance programs and other program possibilities: (1) a population-based survey of uninsured in Illinois; (2) expansion of the state's Behavioral Risk Factor Surveillance System (BRFSS); (3) analysis of existing data sets to augment and contextualize primary data collection efforts; (4) focus group discussions with key stakeholders; and (5) personal interviews with strategic informants throughout the state.

In our effort to develop strategies to assure 100 percent access, the Steering Committee will meet on a regular basis to examine coverage options and evaluate program designs. Data will be of major importance in the planning and evaluation processes. Also of importance will be consultation and negotiation with stakeholders. Strategies to provide coverage for all citizens will be developed in consultation with representatives from: insurance companies; employers; health issues interest groups; community groups; government agencies; public and social health agencies; the faith community and members of Public Health Futures Illinois. Programs will be analyzed in terms of cost and nature of benefits. One component of formulating strategies will be a forum to reach consensus with the stakeholders on the steps to achieve our goals. In addition, we will conduct a comprehensive literature review to identify potential strategies to address the problem of uninsured.

The final phase of the project, the preparation and submission of the final report, will be coordinated by staff from the Illinois Department of Insurance. The report will be formally submitted to the Secretary of Health and Human Services by Governor George Ryan.

PHASE I - DATA COLLECTION

Who are the uninsured in Illinois?

Through a population-based survey of the uninsured, and an analysis of data from an expansion of BRFSS and a thorough analysis of existing data sets, we will provide a profile of the uninsured in Illinois. We will also conduct a series of focus groups with stakeholders throughout Illinois, to provide a qualitative picture of the uninsured as well as barriers to insurance.

The objectives of this research on the uninsured are three-fold. First, to develop reliable and accurate estimates of the number of uninsured persons in the State of Illinois and for each of five sub-state regions. Second, to define the demographic, economic, and health related characteristics of the uninsured in Illinois. Third, to collect sufficient information to facilitate the design of an effective communication plan to inform the insured of the availability of any programs emerging from this planning grant, and to encourage them to find out more about the plans. These research efforts will build on existing data streams and utilize proven research methods to establish a solid base of evidence pertaining to the uninsured. This evidence base will be capable of supporting data-driven policy development and program design, and subsequent program evaluation and performance monitoring. This evidence should allow us to answer the following general questions about our uninsured population:

1. 1. What are the demographic characteristics (race, gender, age, ethnicity, education, employment status, type of employment, size of employer, income level, marital status, immigrant status, etc.) of the uninsured?
2. 2. How does the level of uninsurance vary by region?
3. 3. What is their general health status? Do they have chronic health conditions?
4. 4. Are these individuals unable to obtain or afford health insurance due to “preexisting conditions”?
5. 5. Have these individuals ever had health insurance? If so, what type?

--Employer-provided commercial insurance
--Personally purchased coverage
--Medicare
--Medicaid

6. 6. How long have these individuals been intermittently or continuously uninsured?
7. 7. What factors have caused them to be currently uninsured?

--Loss of job
--Lack of employer-provided insurance/wages too low to purchase individually
--Welfare-to-work-transition
--School-to-work transition
--Preexisting conditions
--Amount of employee share of employer’s coverage

8. 8. What are the main barriers to obtaining health insurance coverage?
9. 9. What percentage of uninsureds would be willing to pay for some of their health coverage? What methods can be used to get the uninsured to contribute to the costs of their health coverage? What amount of take home pay would they be willing to pay?
10. 10. How are these individuals getting their medical needs met (if they are) without insurance?

--Emergency departments
--Public Health clinics
--Free Clinic
--Self-diagnosis/Self-treatment

11. 11. How many people are eligible for health insurance programs and do not access them? Why?
12. 12. What are the awareness and information levels of KidCare, Medicaid, ICHIP and other insurance coverage among the uninsured? What do they think about those programs? How does this impact enrollment decisions?
13. 13. What channels or mechanisms might be used to reach uninsured groups with targeted messages to inform them of the existence of programs and plans? What are the points of contact through interpersonal, organizational, and mass media channels to facilitate information dissemination?

What insurance coverage options are currently available in Illinois, and how are they being expanded? What are the strengths and weaknesses of the currently available programs? How can coverage be increased?

Department of Insurance personnel will develop a profile of insurance programs (public and private) currently available to Illinois residents. The department will identify: the types of programs currently being implemented; the services provided by these programs; who is covered by these programs

(demographic profile); and the costs of the programs. In this process the Department will examine health insurer trends in premium rates and trends in employee premiums and co-pays.

We will also examine planned and proposed expansions of existing programs, including public programs (KidCare), employer-based, and high risk pool (ICHIP) coverage. Questions related to increasing employer-based coverage in job settings and types of employer-based incentives that could be used to increase coverage will be addressed.

Through a series of personal interviews with key strategic informants throughout the state including leaders from the insurance industry, as well as general business and industry in the State of Illinois and legislative leaders, we will gather specific opinions regarding the problems and solutions related to uninsurance.

Research Methods

Population-Based Survey of the Uninsured

To meet the objectives of a population-based survey of the uninsured, the study design must allow estimates of the number and distribution of households with at least one person uninsured at the time of the interview. Thus, the study should be composed of two instruments: a screening instrument and a main instrument. A screening instrument must be conducted with all contacted households to determine if an eligible person lives in the household. If an eligible person were found in a household, the main instrument would be conducted. The screening and main instruments would address the issues listed below:

Estimated distribution (numbers and percentages) of uninsured persons by region.

- Estimated distribution (numbers and percentages) of uninsured persons residing in households at 0-100 percent FPL; 101-133 percent FPL; 134-150 percent FPL; 151-185 percent FPL; 186-200 percent FPL; 201-250 percent FPL; 251-300 percent FPL; 301-350 percent; 351-400 percent FPL, and; above 400 percent FPL.

- Characteristics of households with at least one member without health insurance including:

  Age of children
  Location of household (zip code)
  Family size
  Family composition
  Race
  Ethnic background
  Citizen status
  Nation of origin
  Number of adults in family working
  Employment status of adults
  Number of jobs held by working adults
  Employment sector of working adults
  Occupation of working adults
  Nature of employer -- self-employed or working for employer
  Size of organization employing working adults
  Reasons for unemployment if applicable

- Income from adults' employment, child support received, SSI, social security, Veterans benefits, alimony, and help from friends and family.

- Child support paid for children not residing in sampled household.

- Day care or child care paid for each child.
- Availability of insurance coverage through employment or other group-based plan.
- Reasons for lack of coverage if employer or union-based coverage is or has been available to but not used by an employee or by family members of an insured employee.
- Amount it would cost to cover additional family members.
- Continuity of insurance coverage over the last 12 months for at least two members of household.
- Was COBRA offered, accepted?
- Was private individual insurance applied for? Results?
- Medicaid application, where application was taken, and outcome of application.
- Reasons for not applying for Medicaid, if applicable.
- Reasons for not using Medicaid if children are eligible.
- Awareness of KidCare, Medicaid and ICHIP.
- Perceptions and attitudes toward KidCare, Medicaid and ICHIP.
- Medicare enrollment.
- Medical service usage of youngest child including well-child check-up in the last 12 months, number of times child has visited a doctor, nurse practitioner, or physician assistant, and number of times child has used a hospital emergency room in the last 12 months.
- Presence of chronic and preexisting conditions.
- Among those with preexisting conditions, efforts to secure coverage and the costs of such coverage.
- Participation in institutions, organizations, and programs which might facilitate information dissemination.
- Media use patterns of uninsured to target information.

The population-based survey would be conducted by Health Research and Policy Centers (HRPC) at the University of Illinois Chicago in collaboration with the Survey Research Laboratory (SRL) at the University of Illinois Chicago. The HRPC would take responsibility for the study design, questionnaire development, data analysis and report writing, and the SRL would take responsibility for data collection. HRPC and SRL will consult with the survey research staff of the Illinois Center for Health Statistics (ICHS). The study would be directed by Drs. Dianne Rucinski and Richard Warnecke of the University of Illinois Chicago in coordination with the Steering Committee.

In order to accomplish the survey design, data collection and analysis, and report writing within the time-frame of the Planning Grant at a reasonable cost, an RDD (random digit dial) telephone survey is proposed. A sample size of 300 households per region, or 1500 total, is advised to permit analyses of important population sub-groups. Having recently guided a similar survey of low-income families in

Illinois to successful completion, Drs. Rucinski and Warnecke are capable of ensuring the successful completion of the proposed data collection efforts.

Data will be analyzed by statisticians at the Health Research and Policy Centers in consultation with the team of state agency and academic professionals participating in the project. Dr. Rucinski will take primary responsibility for ensuring the analyses address questions raised by the project team and that a written report is presented to the project team by June 30, 2001. All appropriate descriptive, bivariate and multivariate analyses will be conducted in accordance with specified, policy-driven questions.

BRFSS Expansion

In Illinois, an important source of data pertaining to insurance coverage and insurance access is the Behavioral Risk Factor Surveillance System (BRFSS), a state-based survey of the non-institutionalized population 18 years of age or older. Since 1991, the BRFSS has asked respondents if they have a health plan, and about past (up to 5 years) coverage by a health plan. Details regarding the type of health plan (private pay, Medicaid, Medicare, employer-sponsored, etc.) have been regularly collected by the BRFSS in Illinois since 1993. Answers to the BRFSS questions regarding coverage can be viewed in conjunction with a respondent's answers to other survey questions in a manner that would portray households with and without health insurance on a number of dimensions (age, gender, race/ethnic origin, marital status, education, employment status, income and respondent's "medical home") which would facilitate an understanding of the dynamics of insurance coverage in the state across time, alerting the state to important trends as they are emerging, thereby providing Illinois with an important monitoring tool. The Illinois BRFSS program is currently engaged in an unprecedented effort to survey each county in Illinois. These surveys were conducted over a four-year period, and can provide a detailed source of previously non-existent county-level health-related data, including data on insurance coverage. These data will support community-level research, assessment, planning, and policy-making throughout Illinois.

Despite the utility of the BRFSS for ongoing monitoring on a broad range of topics, certain enhancements to the survey are necessary. Specifically, the addition of routine questions concerning insurance availability; reason(s) for declining employment based-coverage if available; awareness of alternative sources of health insurance (privately and publicly-sponsored); and attempts to secure such coverage would maximize the usefulness of the BRFSS in informing the design of policies to address the needs of the uninsured in Illinois. The expansion of the BRFSS proposed here would provide a solid baseline against which trends in insurance status and access to affordable insurance in Illinois can be monitored and will be used in conjunction with other monitoring tools, such as the March Supplement of the Census Bureau's Current Population Survey.

The Illinois Center for Health Statistics (ICHS), which resides in the Illinois Department of Public Health, will be responsible for ongoing survey enhancements and expanded data analysis utilizing the BRFSS; analysis of hospital discharge data obtained from the Illinois Health Care Cost Containment Council pertaining to payers and uncompensated hospital care; and analysis of data pertaining to the uninsured in Illinois collected each year in the March Supplement of the Census Bureau's Current Population Survey.

The BRFSS, in particular, can provide needed data on trends in health insurance coverage of Illinois adults. For a six-month period, the size of the BRFSS will be expanded to a monthly sample size of 350, yielding a total of 2,100 interviews. The baseline data will be analyzed for purposes of the Planning Grant, but we recognize that the total number of uninsured individuals captured in a general population survey is apt to be too small for multivariate or sub-group analysis of the uninsured. (If we expect 15 percent of the Illinois population to be uninsured during the past twelve months, 315 respondents will be available for sub-group analysis. If 29 percent of the Illinois population is uninsured for at least one month over the last twelve, 609 cases will be available for sub-group analysis.) The ongoing value of the expanded BRFSS to the state will be its utility in monitoring trends which may result from policies implemented to reduce the number of uninsured or from economic and market factors which might occur

in the absence of programs implemented by the state and stakeholders. An expanded BRFSS will provide insights into questions, such as:

1. Has the percentage and composition of the insured and uninsured in Illinois changed over time? What demographic characteristics (i.e., race, gender, age, ethnicity, education level, employment status, income level and marital status) are associated with those trends?
2. How does the percentage of uninsured and insured vary in different areas of the state over time?
3. What is the general health status of Illinoisans with and without health care coverage?
4. Are the reasons for noncoverage stable or variable over time? What are the trends in reasons persons are without health care coverage?
5. About how long has it been since the respondents had health care coverage?
6. What types of health care coverage do the respondents use to pay for most of their medical care?
7. During the past 12 months, was there any time that the respondents did not have any health insurance or coverage?
8. What was the main reason they were without health care coverage during the past 12 months?

In addition to the questions listed above, additional questions could be implemented into the BRFSS within three to four weeks to guide planning to reduce the number of people that do not have health insurance.

Benefits to utilizing the BRFSS as an information tool include the following:

- responses to these questions can be examined to observe long-term trends relating to health insurance dating back to 1990;

- the data are comparable to other states since all states participate in the BRFSS and use the same procedures and questions used by Illinois and the same sampling procedures are used in each state;

- the BRFSS is an ongoing system, so asking questions in subsequent years will permit evaluation of any plan resulting from this grant;

- the Illinois BRFSS collects data on telephone transience, considered a reasonable proxy indicator of people who are intermittently or newly poor, and correlations of telephone transience and those without health insurance could be quite useful; and

- correlations between those without health insurance and other health related behaviors or conditions are possible.

Analysis of Existing Data Sets

We plan to focus our analysis on three data sets: (1) the Current Population Survey (CPS), (2) a University of Illinois Chicago data set developed for the Illinois Department of Public Aid, and (3) the BRFSS. We will consult with the entire Steering Committee throughout the process to ensure that the analysis will yield data useful to state program administrators. Drs. Richard Warnecke and Dianne Rucinski of the University of Illinois Chicago, in coordination with Dr. Merwyn Nelson of ICHS, will take the lead in the analysis of these data sets.

One of the most relied upon sources of current information regarding health insurance in the United States comes from the March Supplement of the CPS conducted by the Census Bureau for the Bureau of Labor Statistics. While no other publicly available source of information can compete with the CPS in timeliness and authority, its utility in providing stable state level estimates is limited. Furthermore, detailed information about the availability and costs of employment-based coverage, reasons for not using employment-based coverage when available, participation in publicly sponsored programs such as Medicaid and KidCare, and reasons for declining to participate in publicly sponsored programs are

unavailable in the CPS. Thus data at the state level, sensitive to regional variations based on rural/urban differences, are needed.

Another existing source in Illinois comes from a study conducted by Drs. Dianne Rucinski and Richard Warnecke of the Health Research and Policy Centers at the University of Illinois Chicago (HRPC-UIC) for the Illinois Department of Public Aid during the winter of 1998-1999. Apart from being somewhat dated and including only households with children, the dual-frame, mixed mode survey collected highly detailed health status, health insurance, employment, income and family composition data from over 1000 low-income families. Families with coverage available through employers or income eligible for Medicaid were asked detailed questions about why they chose not to participate in health insurance. This survey will permit estimates at the regional level of the number of uninsured families with access to insurance through employment and through Medicaid or KidCare. Because the HRPC-UIC study included only households with children, supplemental data collection is necessary to provide information on households without children. It has been proposed that we use the Population Survey of the Uninsured and the Behavioral Risk Factor Surveillance System.

Focus Groups

Focus groups sessions will be conducted throughout Illinois. The focus groups will be conducted by Professor Paul Sarvela and his staff from Southern Illinois University Carbondale. The focus groups will be implemented to create a qualitative picture of the problems related to uninsured in Illinois, along with potential solutions.

The focus groups will be conducted and organized around the five regions identified in the population-based survey study described above. Focus groups will be conducted in each region for the following stakeholder groups:

- Employers and labor unions
- Medical, dental, optical, rehab, mental health groups
- Local government agencies
- Public health and social service agencies
- Insurance agents
- Uninsured people

All regions will have at least one focus group per stakeholder group. The region including Chicago will be over sampled with additional focus groups for each stakeholder group.

Focus group participants will be identified for each region by the research team. Local organizations including business groups and public health and social service staff members will be asked to identify potential participants for each of the focus groups. The potential focus group participants will be sent an introductory letter explaining the project along with human subjects informed consent materials, followed up by a phone call from research team members. A reminder letter and reminder phone call will be made to ensure their attendance at the focus group meeting.

Incentives for participation will be extremely important for the uninsured group. Each participant in the "uninsured group" will be given a $25 gift certificate for use at a local store or restaurant. At each focus group, appropriate refreshments or lunch will be provided.

Separate sessions will be conducted with each of the principal sets of stakeholders. Each focus group will be conducted with a small group of participants (seven to ten) in a relaxed, comfortable atmosphere so that the participants can share their ideas and perceptions. Two project staff members will be in attendance at each focus group; one staff member will lead the group while the other will take notes.

Focus group questions will be designed to address the goals of the project. Questions will vary by focus groups, but will emphasize areas of concern such as:

- What factors are related to people being currently uninsured?
- What is preventing people from obtaining health insurance coverage?

- What percentage of uninsured would be willing to pay some of the costs of their health coverage?
- What incentives can be used to get small companies and businesses to help cover their employees?
- How are these individuals getting their medical needs met (if they are) without insurance?
- What are the awareness and information levels of KidCare, Medicaid, ICHIP and other insurance coverage among the uninsured? What do they know about and think about those programs?
- How can we best inform the uninsured people about KidCare, Medicaid, ICHIP, etc.?

Participant comments will be recorded and analyzed for trends and themes by stakeholder group (e.g., common trends among uninsured people), geography (e.g., comparison between rural and urban), and total group (e.g., common themes coming forth from all of the focus groups), for the final report. It is expected that the focus group sessions will allow more detailed discussions concerning the various study questions. This information will be combined with the quantitative information to provide the Steering Committee and other partners with a comprehensive picture of the problems and potential solutions related to the uninsured in Illinois.

Personal Interviews

Personal interviews will be conducted with CEOs and leaders from the insurance industry as well as general business and industry in the State of Illinois and legislative leaders. The purpose of the personal interviews will be to gather more specific opinions regarding the problems and solutions related to the uninsured population in a way that will not be threatening to the interview subjects. For example, a CEO from a large insurance company may be reluctant to voice her or his opinions publicly, even in a focus group setting. However, in the setting of a personal interview with anonymity guaranteed, a more free flowing discussion may be possible. The personal interviews will be conducted by Professor Paul Sarvela of SIUC. These individual interviews will be conducted in a variety of settings throughout Illinois, at the convenience of the individual being interviewed.

The personal interview subjects will be identified by the project team, with special consultation from agencies and organizations. For example, Illinois Department of Insurance staff will identify key insurance industry executives, while we will ask Illinois Chamber of Commerce staff for input concerning ideal business and industry executives to be interviewed. We expect to interview 15 to 20 high profile individuals throughout the state.

The potential interview participants will be sent an introductory letter explaining the project along with human subjects informed consent materials, followed up by a phone call from research team members to schedule an appointment. All subjects will be sent a copy of the interview questions two weeks prior to the interview, to serve as an “advanced organizer.”

Interview questions will focus on issues such as:

- Perceptions related to why people are currently uninsured.
- Perceptions related to why employer-based coverage is decreasing.
- Identification of incentives that can be used to get small companies and businesses to help cover their employees.
- Methods the insurance industry, along with state government and employers, can use to increase coverage.
- Characteristics of the ideal insurance program.
- Statewide cost estimates of providing the ideal program to those currently uninsured.
- Ideas concerning the best partnering structure to achieve the goals of statewide coverage.

Protection of Human Subjects

SIUC and UIC require all projects implemented by faculty and staff to undergo a rigorous review by a Human Subjects Committee. Professors Sarvela and Warnecke are familiar with the process and have submitted many different projects covering a wide variety of topics to their Human Subjects Committees.

A document describing each of the research projects implemented as a part of the study will be submitted to the Human Subjects Committee. This document will include information concerning time required to participate in various aspects of the study, approximate dates when research will take place, description of the research methods used (research design, instrumentation, sampling techniques, data analysis procedures), exact procedures used to collect data from subjects (i.e., data collection protocol), and copies of informed consent forms. This document is then reviewed by the Committee, which will accept the proposal or make recommended changes before final approval is granted.

Literature Review

In the process to craft solutions we will need information on existing ideas. Reducing uninsurance is a topic that has been of interest to a variety of researchers. Other states have implemented a variety of ideas. One graduate student from UIC and one graduate student from SIUC will be charged with conducting a comprehensive literature review and making contact with other states who have identified proposals and implemented programs to reduce the number of uninsured. They will prepare a report on the subject of proposals for reducing uninsurance in order to provide ideas on potential programs for Illinois. The report will identify "best practices" among policy options to be considered for addressing the goal of providing access to affordable health insurance in Illinois.

PHASE II - DEVELOPMENT OF COVERAGE OPTIONS AND PROGRAM DESIGN

How can we assure access to affordable health insurance coverage in Illinois for all citizens?

In Phase II of the study, we will develop a series of recommendations to help address the lack of adequate health insurance in the State of Illinois. Illinois' strategy will undoubtedly include a variety of solutions designed to meet the needs of the various types of uninsured. These solutions may include expansions of existing programs as well as implementation of new programs. We must develop programs to move from making health insurance available to everyone, which already is the case, to making health insurance affordable for everyone. The long-range goal is to propose a means to expand the provision of affordable health insurance benefits similar to the care provided in state employee coverage, the Federal Health Benefit Plan, Medicaid or similar quality benchmark plans to everyone in the state. At the same time we must be aware of the need to maintain existing coverage.

Our policy recommendations will be based on analysis of the data obtained during Phase I of the study, reviews of efforts by other states, reviews of other proposals and negotiations with stakeholders. Our process will include consideration of the applicability of specific solutions for expanding access to health care coverage proposed by the leading professional, consumer, business, provider, labor, and insurance organizations represented at the Robert Wood Johnson Foundation's January 2000 conference, Health Coverage 2000--Meeting the Challenge of the Uninsured. Using all this information we will identify and evaluate a selection of programs that might be appropriate for Illinois. The Steering Committee will develop proposals for Illinois which will be presented to the various stakeholders for reaction. Stakeholder comment will be sought prior to and during the Illinois Assembly process.

To further the process of identifying programs for Illinois, a set of criteria or questions will be developed that will be used to evaluate the different approaches for achieving universal coverage. For example, one approach may cover all the insured, but cost more than another or provide fewer benefits. This evaluation process will help to set a framework for discussion, guide the researchers and indicate which factors will be important in determining which approach is best for Illinois.

Among the questions to be considered for this process are:

- Will it achieve the goal of 100 percent coverage and on what timeline?
- What is the total cost to taxpayers, businesses and individuals?
- Is it affordable for individuals and families or does it present financial barriers to health care such as high cost-sharing requirements?
- Do the benefits meet the benchmark?
- Does it include parity for mental health and other services?

- Does it address the needs of people with special health care needs and underserved populations in rural and urban areas?
- Does it promote quality and better health outcomes?
- Is it adequately funded to guarantee access to providers and will it foster a strong network of health care facilities, including safety net providers?
- Will it ensure continuity of coverage and continuity of care?
- Does it maximize consumer choice of providers?
- Is it easy for patients and providers to use? Are paperwork burdens limited?

Illinois Assembly on Uninsured

We will use a modified version of the American Assembly Model for engaging in dialogue and establishing consensus, first pioneered by Dwight Eisenhower when he was President of Columbia University. We will follow closely the work of deHaven-Smith and Wodraska (1996) in the implementation of this process.[7] [7] This Illinois Assembly on Uninsured will allow the key stakeholders to meet in a structured, mediated environment to reach as much consensus as possible, first on the basic facts and data related to the problem of uninsurance, and then on ways to move the number of uninsured as close as possible to zero. Employers, labor unions, social service advocates, commercial insurers, insurance agents, medical practitioners and others may share more common ground on this issue than they might believe, but they rarely have a chance to work cooperatively towards addressing this issue. Creating an organized, interactive system where all of these entities work and meet together to provide access for affordable health care for everyone will have benefits beyond the specific work product that they create. The Assembly will convene next summer but potential participants will be introduced to the concept early in the planning process.

A meeting of potential participants in the Illinois Assembly on Uninsured will be convened in late 2000 or early 2001 to review the progress of the project to date, explain the Assembly process and to encourage them to fully participate. The Illinois Assembly on Uninsured will be convened for a three day meeting at a central location in Illinois in June or July 2001. Former Senator Paul Simon, now a professor at SIUC and director of the Public Policy Institute and Mike Lawrence, Public Policy Institute Associate Director, will lead the Assembly activity.

Our procedure will be as follows:

1. 1. The research team will select topics for discussion and develop briefs, based on data collection activities and proposals for reducing the number of uninsured. At the assembly, people will be divided into groups to discuss the issues.
2. 2. Two research team members will be assigned to each group as facilitators and recorders.
3. 3. The research team will synthesize the small groups' work into a final report.
4. 4. A final open forum will be held to discuss the synthesis of results (end of day three).
5. 5. The report will be distributed throughout the state for discussion by the groups represented by the stakeholders.
6. 6. Adaptations to the document will be made on the basis of this input.
7. 7. A final plenary session will be held in late summer, with participants agreeing on the final report of the Illinois Assembly on Uninsured.

What is the best partnering structure to achieve our goal?

The partnering structure will consist of two parts: the Illinois Assembly and Public Health Futures Illinois (PHFI). Illinois policy formulation related to the State Planning Grant will be strengthened by the momentum of the PHFI strategic planning partnership, formed in 1997. The PHFI effort has been led by the Illinois Department of Public Health and driven by the collaborative energies of a broadly inclusive group representing public, private, and voluntary institutions. The PHFI process has been funded by the State of Illinois and a grant from the Robert Wood Johnson foundation's initiative, *Turning Point:*

7[7] L. DeHaven-Smith & J.R. Wodraska, *Consensus-Building for Integrated Resources Planning*, Public Administration Review, 1996, 56(4), pp. 367-371

Collaboration for a New Century in Public Health. Participants have included representatives from health care providers, business, academic, state and local government, charitable and social service, and faith communities. Access to care is a priority concern identified within the PHFI strategic plan, the *Illinois Plan for Public Health Systems Change*, which calls for the establishment of an Access to Care Consortium in the state to utilize data to assess need and design access initiatives, with a goal of assuring that all Illinoisans have adequate access to care, including health insurance coverage. PHFI can be used as a collaborative platform for a multi-disciplinary, participatory approach to the development of feasible implementation models under the State Planning Grant.

PHASE III - PREPARATION OF REPORT TO THE SECRETARY

The preparation of the final report to the Secretary will be coordinated by staff from the Department of Insurance working with members of the Steering Committee. We will use the same cooperative technique for preparation of the final report that we used to prepare this application. In this process we will rely on guidance from HRSA and follow the reporting format developed by the Federal program staff. All partners in the planning process will be asked to comment on the report before it is submitted. The Steering Committee will be planning to prepare the final report throughout the course of the State Planning Grant year. Research and other reports will be drafted so that they are easily adapted for inclusion. Information and consensus included in the final report of Illinois Assembly on Uninsured will be an integral part of the final report to the Secretary.

B. PROJECT MANAGEMENT MATRIX

The matrix below lists the major tasks and action steps of the project by project and then by month of projected completion. The description of the action steps implies the desired results. The results will be monitored by the Department of Insurance staff and by the management oversight process of the Steering Committee. The following abbreviations are used in the matrix to represent the organizations responsible for completing the tasks and action steps:

University of Illinois Chicago	UIC
Southern Illinois University Carbondale	SIUC
Department of Public Health	DPH
Department of Insurance	DOI

Population-Based Survey Responsible Agency: UIC

Prepare and submit Human Subjects protocol to UIC	October
Design questionnaire, mail advance letter	October
Review survey instrument with ICHS and Steering Committee	October
Conduct pretest	November
Conduct main data collection	February
Data cleaning, coding and preparation	March
Analysis of population-based survey data	May
Write report of population-based survey results	June

Existing Data Analysis Responsible Agencies: UIC and DPH

Submit initial Human Subjects document to UIC	October
Secure most recent data sets	October
Conduct initial data management tasks	November
Identify criteria, standards, and caveats for research variables	November
Analyze basic trends in data set	December
Using bivariate or multivariate procedures, analyze trends	January
Continue using bivariate or multivariate procedures	February
Continue using bivariate or multivariate procedures	March

Develop figures and tables for final report for analysis	April
Plot descriptive and multivariate data using GIS procedures	April
Develop figures and tables for final report	May
Plot descriptive and multivariate data using GIS procedures	May
Final report of existing data analysis	June

Focus Group Process Responsible Agency: SIUC

Submit initial Human Subjects document to SIUC	October
Develop preliminary questions	October
Identify sample	October
Steering Committee reviews preliminary questions	November
Preliminary questions revised	November
Finalize research protocol	November
Conduct focus groups	December
Continue to conduct focus groups	January
Continue to conduct focus groups	February
Analyze results	March
Review results with research team, Steering Committee	March
Begin developing draft report	March
Develop draft focus group report	April
Final focus group research team meeting for comments	May
Write final focus group report	June

Personal Interview Process Responsible Agency: SIUC

Submit initial Human Subjects document to SIUC	October
Develop sample questions	October
Sample questions reviewed by Steering Committee	October
Identify sample	October
Steering Committee reviews preliminary questions	November
Sample revised	November
Finalize research protocol	November
Conduct personal interviews	December
Continue to conduct personal interviews	January
Review results with research team, Steering Committee	February
Begin developing draft report	February
Develop draft personal interview report	April
Final research team meeting for comments	May
Write final personal interview report	June

BRFSS Expansion Process Responsible Agency: DPH

Develop additional questions	October
Initiate six-month enhanced BRFSS	November
Develop trend data	January
Develop 1999 population estimates needed to support analysis	March
Conclude enhanced data collection	April
Edit and clean enhanced data	April
Analysis of BRFSS data	May
Write report of enhanced BRFSS analysis	June

Literature Review Responsible Agencies: UIC and SIUC

Select graduate students	November
Identify relevant literature	December
Review literature	January
Contact states	February

Continue to contact states — March
Identify best practices — April
Prepare report — April

Consider Solutions Responsible Agency: DOI

Prepare profile of existing programs — November
Continue to prepare profile of existing programs — December
Consider expansion of existing state programs — January
Continue to consider expansion — February
Prepare several alternative solutions for evaluation — March
Continue to prepare solutions — April
Continue to prepare solutions — May

Illinois Assembly Process Responsible Agencies: SIUC and DOI

Identify potential participants — November
Select initial meeting date — November
Arrange meeting logistics — November
Send invitations — November
Confirm agenda — December
Conduct introductory assembly process meeting — January
Conduct process evaluation survey of participants — January
Select topics for discussion at Assembly and develop briefs — June
Conduct Illinois Assembly on Uninsured — July
Present research results — July
Distribute report to stakeholder groups for discussion and feedback — July
Conduct process evaluation survey of Assembly participants — July
Stakeholder discussion and feedback — August
Revise Assembly Document — August
Final meeting — September
Conduct process evaluation survey of Assembly participants — September

Report to the Secretary Responsible Agency: DOI

Begin drafting — August
Finish drafting — September
Submit report — September

Matrix Organized by Completion Month:

October 2000

For Population-based survey: Prepare and submit Human Subjects protocol to UIC
- Design questionnaire, mail advance letter
- Review survey instrument with ICHS and Steering Committee

For Existing Data Analysis: Submit initial Human Subjects document to UIC
- Secure most recent data sets

For Focus Group Process: Submit initial Human Subjects document to SIUC
- Develop preliminary questions
- Identify sample

For Personal Interview Process: Submit initial Human Subjects document to SIUC Committee
- Develop sample questions
- Sample questions review by Steering Committee
- Identify sample

Develop additional questions for BRFSS Expansion Process

November 2000
For Population-based survey: Conduct pretest
Initiate six-month enhanced BRFSS
For Existing Data Analysis: Conduct initial data management tasks
Identify criteria, standards, and caveats for research variables
For Focus Group Process: Steering Committee reviews preliminary questions
Preliminary questions revised
Finalize research protocol
For Personal Interview Process: Steering Committee reviews preliminary questions
Sample revised
Finalize research protocol
For Illinois Assembly Process: Develop preliminary agenda
Identify potential participants
Select initial meeting date
Arrange meeting logistics
Send invitations

December 2000
Analyze basic trends in data set for existing data analysis
Conduct focus groups
Conduct personal interviews

January 2001
For Illinois Assembly: Conduct introductory assembly process meeting
Conduct process evaluation survey of participants
Using bivariate or multivariate procedures, analyze trends for existing data analysis
Continue to conduct focus groups
Continue to conduct personal interviews
Develop trend data for BRFSS Expansion

February 2001
Conduct main data collection for population-based survey
Continue using bivariate or multivariate procedures for existing data analysis
Continue to conduct focus groups
For Personal Interviews: review with research team, Steering Committee develop draft report

March 2001
Data cleaning, coding and preparation for population-based survey
Develop 1999 population estimates needed to support analysis for enhanced BRFSS
Continue using bivariate or multivariate procedures, analyze trends for existing data analysis
For Focus groups: analyze results
review with research team, Steering Committee
begin developing draft report

April 2001
For Enhanced BRFSS: Conclude enhanced data collection
Edit and clean enhanced data
For Existing Data Analysis: Develop figures and tables for final report for analysis
Plot descriptive and multivariate data using GIS procedures
Develop draft focus group report
Develop draft personal interview report

May 2001
Analysis of population-based survey data

Analysis of BRFSS data
For Existing Data Analysis: Develop figures and tables for final report
Plot descriptive and multivariate data using GIS procedures
Final focus group research team meeting for comments
Final personal interview research team meeting for comments

June 2001
Write report of population-based survey results
Write report of enhanced BRFSS analysis
Final report of existing data analysis
Write final focus group report
Write final personal interview report
Select topics for discussion at the Illinois Assembly and develop briefs

July 2001
For Illinois Assembly: Conduct Illinois Assembly on Uninsured
Present research results
Distribute report to stakeholder groups for discussion and feedback
Conduct process evaluation survey of Assembly participants

August 2001
For Illinois Assembly: Stakeholder discussion and feedback
Revise Assembly document
Begin drafting report to the Secretary

September 2001
For Illinois Assembly: Final meeting
Conduct process evaluation survey of Assembly participants
For Report to the Secretary: Finish drafting
Submit report

C. GOVERNANCE

Structure

This project will be governed by a Steering Committee composed of representatives of the Governor's office, state agencies and state universities. The Illinois Department of Insurance will serve as the lead agency and coordinate the project. Initially, the Steering Committee will meet every other week and when appropriate, on a weekly or monthly basis to monitor the management plan. An executive committee or core management group of the Steering Committee will be established to handle interim decisions. Staff of the Department of Insurance will communicate regularly with all participants to assure that action steps are being undertaken and that time lines are being met. The Department of Insurance will also serve a fiscal role, authorizing and monitoring expenditure of grant funds. The Department will prepare and maintain all necessary accounting records and submit all required accounting reports.

Organizations and Project Personnel

The Steering Committee will be composed of the following organizations and personnel:

Governor George H. Ryan's Office

Eric Brenner, Senior Advisor for Regulatory Affairs, has worked for three Governors in two states and also served as Deputy Insurance Commissioner in Pennsylvania, where he helped draft and implement their Children's Health Insurance Program, which preceded the federal SCHIP law.

Department of Insurance is charged with protecting the rights of Illinois citizens in their insurance transactions and monitoring the financial solvency of all regulated entities through effective administration and enforcement of the Illinois Insurance Code.

Madelynne Brown, Assistant Director, appointed in 1992, focuses on health insurance regulation and other consumer market issues and represents the Director as Chair of the Illinois Comprehensive Health Insurance Plan. Prior to joining the Department, Ms. Brown, an attorney with a Master's degree in International Management, was in private practice.

Southern Illinois University at Carbondale (SIUC) is a comprehensive university with nationally and internationally recognized instructional, research, and outreach programs. It is a single state system with campuses in Carbondale and Edwardsville, a medical school in Springfield, and a dental school in Alton. SIUC offers undergraduate and graduate programs through eight colleges, a law school, a medical school, and a school of social work.

Illinois' former senior *Senator Paul Simon* teaches political science and journalism at SIUC, where he also heads a public policy institute founded by him. He has enjoyed a long and illustrious political career. Elected to both the state's house and senate, he also served a term as lieutenant governor. He spent 10 years in the U.S. House before his 1984 Senate election. His wide-ranging policy interests span topics such as the budget, labor, education, disability policy, foreign affairs, and television violence. His many honors include over 50 honorary degrees.

Mike Lawrence is the Associate Director of the SIUC Public Policy Institute and a Professor of Journalism at SIUC. From 1991 to 1997, he was the Press Secretary to Illinois Governor Jim Edgar. In that capacity, Mr. Lawrence oversaw, managed and coordinated all media relations, news releases and other publications for the Governor and for dozens of state agencies under his control. He directly managed the Governor's press office, which included three deputies and eight support personnel. As a newspaper journalist, he has worked for the Chicago Sun Times, Lee Enterprises, Inc., and the Quad City Times.

Paul Sarvela is a Professor of Health Care Management and Chairman of the Department of Health Care Professions and a Clinical Professor of Family & Community Medicine. From 1993 to 2000, he was the Director of the SIUC Center for Rural Health and Social Service Development. He has consulted with a variety of private, state and federal agencies concerning evaluation and strategic planning problems. His teaching interests include evaluation and measurement, strategic planning, and community health and epidemiology.

University of Illinois Chicago (UIC) is the largest institution of higher learning in the Chicago area and one of the top seventy research universities in the United States. UIC offers more graduate study in dentistry, medicine, nursing, pharmacy, and public health than any other health education institution in the nation. UIC's 25,000 students (approximately 65 percent undergraduate, 34 percent graduate and professional degree students) can earn bachelor's degrees in ninety-seven fields, master's degrees in eight-six fields, and doctorates in fifty-eight academic specializations. Academic employees number 4,000 and are supported by 5,800 nonacademic staff.

The Health Research and Policy Centers (HRPCs) were formed on the campus of the University of Illinois at Chicago in September 1997 to conduct and foster the development of research on health behaviors, health promotion, disease prevention, health services/outcomes and health policy and to promote the interaction of investigators and projects in these areas. The work of the Centers incorporates basic science (including methods and theory development), health behavior research, intervention development, clinical and efficacy trials, effectiveness trials, health services research, demonstration projects, dissemination research and research-to-practice and practice-to-policy translation.

Dr. Dianne Rucinski is Research Scientist in the Health Policy Centers and the Centers for Health Services Research. She has over fifteen years of experience conducting surveys and has focussed exclusively on health services and policy studies in the past five years. In 1998, Dr. Rucinski designed and provided oversight to the population survey of low-income families the Illinois Department of Public Aid used to estimate KidCare enrollment goals. She provides evaluation consultation to Healthy Start Southside, a federally-funded program intended to improve maternal and infant health in high-risk communities. Her research interests concern health access for underserved populations, communication strategies and tactics in health promotion, and survey research methodology in health and special populations contexts.

Dr. Richard Warnecke is Director of the Health Policy Center and Center for Health Services Research at the HRPCs. He is Professor of Sociology, Urban Planning and Public Affairs and Epidemiology/Biostatistics. Dr. Warnecke is widely recognized for his research in cancer prevention and control, as well as for his innovation and leadership in health research methodology. Dr. Warnecke has provided consultation and support to numerous local, state and federal agencies in the design and implementation of health monitoring systems, prevention and early detection, and reaching hard-to-serve populations.

Department of Public Health promotes the health of the people of Illinois, primarily through the prevention and control of disease and injury. IDPH endeavors to assess health status and the determinants of health, develop policy options to address health priorities, and assure that Illinois residents have access to the health services that they need. IDPH efforts, intended to benefit the entire population of Illinois residents, are conducted through nearly 200 programs that focus on specific health issues; through local health departments that provide services in Illinois counties and municipalities; and through collaborations with a broader system of partners with interests and concerns related to the health of the state's population.

Michael C. Jones, M.A., Senior Health Economist and Acting Administrator of the Policy Section of the Division of Health Policy, has extensive experience in the analysis of public policy and economic implications related to issues of health, health care, and public health. Monitoring access to care issues in Illinois, such as the lack of health insurance, have been among his primary responsibilities since joining the Department in 1989.

Department of Public Aid is the single state Medicaid agency. It administers the $7 billion Medicaid program that provides health care to the indigent population of Illinois.

David Citron, Assistant Director, has over fifteen years experience with an HMO in managed health care and the financing of health care delivery systems. He holds an M.B.A. from the University of Chicago.

Department of Commerce and Community Affairs (DCCA) is the lead economic development agency for the State of Illinois. As a part of DCCA, the FirstStop Business Information Center focuses on providing information and advocacy to Illinois' small business community. A top issue arising from the Governor's Small Business 2000 Summit conducted by DCCA in January was affordable and accessible health care for small business owners and their employees.

Mark Grant, Manager of the First Stop Business Information Center has been with DCCA since 1985, serving in various managerial and administrative capacities within the small business office.

Department of Human Services assists Illinois residents to achieve self-sufficiency, independence, and health to the maximum extent possible by providing integrated family-oriented services, promoting prevention, and establishing measurable outcomes, in partnership with communities.

Stephen E. Saunders, M.D., M.P.H., is the Associate Director for Family Health of the Illinois Department of Human Services. In this capacity, he is responsible for planning and directing the State of Illinois' Maternal and Child Health Program authorized by Title V of the Social Security Act. Dr. Saunders is a Board certified pediatrician and is a Fellow of the American Academy of Pediatrics.

Comprehensive Health Insurance Plan is the state's high risk pool for uninsurable or federally eligible individuals.

Richard Carlson, Executive Director since 1989, previously served as Assistant Director of the Illinois Department of Insurance, as Superintendent of Illinois State Lottery, and as staff consultant in the Illinois General Assembly. He has an M.B.A. and Master's degree in Political Science from the University of Illinois at Urbana-Champaign.

Partners

During the preparation of this Planning Grant Application, the Steering Committee consulted with a variety of stakeholders, both individuals and organizations, that are interested in reducing the uninsured population in Illinois (see Appendix). These organizations include elected officials, representatives of community groups, employers, rural groups. hospitals, physicians and the insurance industry. The Steering Committee will continue to consult with these stakeholders during the course of the planning year. The stakeholders all strongly support this application and are excited about the opportunity to participate in the Planning Grant process.

Evaluation

In order to successfully meet the objectives of the Planning Grant, many tasks need to be accomplished simultaneously or in quick succession by individuals working in different organizations. The consensus process we have proposed to use to set the discourse tone and procedural rules is designed to permit broad participation by all stakeholders. We are mindful of the fact that the consensus process can often take longer than a hierarchical management and decision-making system. Yet, the need to ensure that all tasks and activities occur on a timely basis within the consensus-building process requires a close monitoring of all tasks and activities associated with the Planning Grant, and an ongoing assessment of the degree to which objectives are being met and goals are being reached.

There are several indicators of a successful Planning Grant process. Reporting to the Secretary of the Department of Health and Human Services (DHHS) a data-driven plan for reducing the number of uninsured in the State of Illinois is one successful outcome. Developing plans that are sensitive to regional variations and are politically and economically feasible are other successful outcomes. The extent to which participants in the planning process believe the outcomes fairly reflect the consensus of the planning group and that plans developed take into account and fully consider minority perspectives are other successful outcomes. The first three outcomes can be fully assessed upon completion of the project, yet milestones on the way to those outcomes can and should be assessed throughout the year. They can be assessed on an ongoing basis through the Assembly Model.

The evaluation of the Illinois Project will consider what can be learned from the Project and subsequently communicated in a manner that will allow implementation of programs to expand health insurance coverage in Illinois, as well as replication of the Project's strategies in other states.

A formative evaluation will be funded by a sum reserved from the Grant proceeds for this purpose. The Project will enter into contracts for consultations with outside expertise, drawn from academic policy centers and private health policy professionals. The outside expertise will assess the processes and intermediate outcomes of the Project on an on-going basis for the purpose of providing a regular flow of information about the Project's efforts. This continuing feedback will focus on progress towards attainment of the goals of collecting, assembling, and analyzing data; and of formulating policy and program options to expand health insurance coverage to uninsured residents of Illinois.

To assess the extent to which participants in the Assembly on the uninsured believe the outcomes fairly reflect the consensus of the planning group and that minority perspectives are fairly considered, all Assembly participants will be asked to complete an evaluation survey three times during the Grant period. The first survey will be distributed in January after the introductory meeting. The second will be distributed after the second Assembly meeting and the final evaluation survey will be distributed after the late August Assembly meeting. The surveys will be designed, collected and analyzed by faculty and graduate students from the Department of Communication Studies at the Northwestern University or an institution of similar stature. Results will be reported to the Steering Committee as collected and assimilated into the Assembly process.

Internal mechanisms for self-evaluation established within the Project will allow for continuous review, and modification if appropriate, of the Project's strategies for data collection and policy option formulation. The self-evaluative mechanisms will draw upon internal expertise, particularly expertise related to data collection and analysis methodologies and substantive public policy development, to systematically review the activities of the Project, for the purposes of assuring progress towards attaining the Project's goals.

To ensure that the Grant's activities and tasks are completed on schedule, within the first fifteen days of the Grant being activated, the Steering Committee will appoint a core management group and confirm a management work plan. In addition to a detailed work structure by tasks, the management work plan will include a schedule of brief bi-weekly management conferences. Meetings will be established to review

progress of the Grant activities and tasks. During these sessions task leaders will report on activities performed during the reporting periods, activities to be accomplished during the following reporting period, potential problems or circumstances which might delay activities, and follow-up plans associated with potential delays. This management process will facilitate compliance with the objectives set by the Planning Grant. Thus, the expected outcomes associated with providing the final reports to DHHS can be tracked through an ongoing work management system.

Since the Steering Committee is made up of key agencies including the Governor's Office it will have sufficient authority to implement this structured management process. Illinois will fully participate in the process to prepare the report to the Secretary and is willing to do what is necessary to prepare a framework. The Department of Insurance and the Steering Committee will work with Federal program staff and other grantees, will comply with the format for the report prepared by the Federal program staff and will cooperate as needed with requests by the Secretary for available data.