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Illinois' Medicaid Program is Expensive, but Spending Will Be Tough to Cut

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EXECUTIVE SUMMARY

In recent years, more than one out of every four dollars spent by the state of Illinois went to Medicaid and more than one out of five state residents got their healthcare through the program. Given Illinois' budgetary challenges, there has been demand to reduce Illinois' growing Medicaid costs. In light of these issues, we provide an analysis of Illinois' Medicaid finances and a comparative analysis of Illinois' experience relative to nearby states.

From 1997 to 2017, Illinois Medicaid spending rose from $7.2 billion to $17.5 billion. This growth rate was low relative to other states; Illinois spent 2.43 times as much in 2017 as it did in 1997, compared to the U.S. average of 3.83. This increased spending was financed by growth in own source spending, provider taxes, and federal matching revenues. Federal matching funds have been the largest source, followed by own-source funding,[1] and finally provider taxes.[2] Federal matching funds increased at a compound annual rate of 6.2% between 1998 and 2017.

Illinois' Federal Medical Assistance Percentage (FMAP) (the default federal match rate) has generally been near, or at, the minimum of 50%. In recent years Illinois' match rate rose substantially above 50%, primarily due to the additional Affordable Care Act (ACA) enrollees with corresponding higher match rates. Illinois' spending growth was driven by large growth in enrollment. While Illinois had a relatively low annual enrollment of 12% of the population in 1999, by 2017[3] the relatively typical average monthly enrollment increased to 22.5% due to large increases in the proportion of poor and near poor people that were enrolled. Spending per enrollee changed relatively little. In 1999, Illinois spent $5,069 per enrollee; by 2017, the state spent $6,088. Nationwide, Medicaid spending grew from $4,913 to $8,933 per enrollee during this time. Accounting for healthcare inflation, spending per enrollee declined significantly, to a level far less than the U.S average or the average of other nearby states.

Similar to other states, Illinois shifted heavily toward managed care in the 2010s. Managed care spending rose from $290 million in 2010 to $9.31 billion in 2016. However, the share of spending on managed

care was still relatively low in 2017 (38% compared to a U.S. average of 45%). Managed care enrollment grew from 7.5% in 2003 to 67.1% in 2016, and spending per managed care enrollee increased from $1,446 in 1999 to $3,536 in 2017. "These are both relatively low compared to nearby states. It is unclear whether further shifts towards managed care will reduce costs. Administrative spending relative to medical assistance payments (medical reimbursements) declined significantly during this period—from 11% in 1999 to 6% in 2017.

Based upon this analysis, we are pessimistic about the existence of opportunities to substantially reduce Medicaid spending while maintaining care for vulnerable populations. Because of Illinois' comparative frugality and the federal match rate system that funds most of the program, large reductions in enrollment would be necessary to significantly reduce the state's budgetary challenges. Given Medicaid's numerous benefits, such cuts would likely be socially harmful, and we advise that reforms outside of Medicaid be pursued to address Illinois' financial difficulties.

INTRODUCTION

In recent years, more than one out of every four dollars spent by the state of Illinois went to Medicaid,[4] and more than one out of five state residents got their healthcare through the program. The amount spent on the program and the number of people served have grown dramatically over the last several decades. A program of this size and breadth deserves tremendous attention and scrutiny, both because healthcare is a linchpin for people's well-being and because the Medicaid program is tremendously important to Illinois' economy and fiscal situation. In this paper, we focus on one facet of Medicaid—its financing and interaction with Illinois' fiscal situation. We provide some comparative analyses that indicate the extent to which Illinois' experience is typical of, or substantially different from, other states.

Medicaid has been a contentious fiscal issue for lawmakers as the program has typically been one of Illinois' largest spending categories over the years, accounting for 27% of total expenditures in 2020.[5] Efforts to constrain or cut Medicaid spending have been commonplace in previous administrations, such as Gov. Pat Quinn's $1.6 billion in cuts in 2012[6] and Gov. Bruce Rauner's proposed $1.5 billion in cuts in 2015.[7] The Illinois Policy Institute contends that Illinois' Medicaid program is "bloated," as the state spends more on a per capita basis than its neighboring states when considering

both state and federal sources of payment.[8] On the other hand, the Better Government Association, asserts that spending cuts are not justified as Illinois already spends less state money per Medicaid patient than the national average.[9] Our study provides an overview of Illinois' trend in Medicaid spending relative to other states and potential policy implications for lawmakers involved in the budgetary process.

Adjusting Illinois' Medicaid spending should not be done hastily given the numerous benefits of the program shown in the literature. A systematic review found that quality of care was improved with Medicaid expansion in over half of the studies assessed, while the rest showed no decline in quality of care.[10] A recent paper found that states with Medicaid expansions experienced large declines in mortality driven by disease-related deaths.[11] Studies frequently find increases in screenings and diagnoses across a variety of diseases,[12] improving detection of disease. Results from a seminal experimental study in Oregon (titled "the Oregon Health Insurance Experiment") show that Medicaid increases access to healthcare and lowers rates of depression among enrollees.[13]

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While Medicaid is often known as a program designed to improve health access, it can also be viewed as a program designed to reduce or shift the financial burdens existing within the healthcare market. Medicaid provides better financial outcomes for enrollees by offering risk protection via less debt and lower out-of-pocket medical expenses.[14, 15] Providers also benefit significantly from Medicaid because they receive a monetary transfer in place of having to provide uncompensated care for the uninsured.[16] Medicaid helps the uninsured gain access to healthcare without having to rely on emergency room visits, which are a significant source of uncompensated costs for providers. For instance, in Illinois, Medicaid expansion under ACA has been associated with lower uncompensated emergency room visits.[17] Rural areas and small towns in Illinois have also experienced significant drops in uninsured rates among vulnerable populations through Medicaid.[18]

Some studies find that Medicaid has an effect on various measures of health. For instance, the Oregon Health Insurance Experiment found no significant effects on health outcomes such as lowering blood pressure. However, many papers that fail to find such effects arguably do so because of aspects of the research design, such as studying a short period (e.g the Oregon Health Insurance Experiment only lasted two years), looking at a small sample, or using

large geographic data where exposure is limited. While not all null findings are because of flaws with the research design (i.e Medicaid probably fails to improve some measures of health), the overall evidence in the literature suggests that Medicaid produces health benefits and improves access to care.[19]

The beneficiaries of Medicaid include not only Medicaid enrollees who get additional healtcare that they might have done without, but also healthcare providers who are compensated for care that otherwise might have been delivered for free. Empirical estimates suggest that the value of benefits to providers of uncompensated care actually exceeds the value of benefits to Medicaid enrollees.[20] Consequently, Medicaid should be understood as providing a large transfer toward uncompensated care providers, as well as providing insurance to vulnerable groups. Overall, the literature's findings suggest that significant cutbacks in Medicaid spending and/or enrollment could be especially adverse for the vulnerable and needy population in the state and the organizations that serve them.

To foreshadow our main conclusions: When we began our research we knew that Illinois' Medicaid program was large, growing, and expensive, and we were intrigued by the possibility that carefully thought through efficiencies might help Illinois move toward a structurally balanced budget. After carefully considering the data, we find that Illinois' experience with Medicaid is quite typical of other states. Although the federal government shares a large and growing part of the responsibility to pay for Medicaid, a substantial state fiscal responsibility remains. Because Illinois has controlled costs about as well, or even better than, other states, we are pessimistic about the possibility of substantial reductions in state fiscal commitments for Medicaid in the near future.

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HOW MUCH DOES ILLINOIS SPEND ON MEDICAID AND HOW IS IT FUNDED?

We first provide some perspective on the level and growth of spending in Illinois' Medicaid program and the sources of funds to pay for that spending. Understanding the sources of Medicaid funding can clarify how much money Illinois might save by cutting spending. Our data come from the University of Illinois' Fiscal Futures database, which has been assembled with the cooperation of the Illinois Comptroller over more than two decades. This dataset allows consistent, over time comparisons of Medicaid spending and sources of revenue as shown in Figure 1 for state fiscal years 1999 to 2017. We display the raw data in Appendix Table A1. Figure 1 displays total spending over time and the three revenue streams that are used to pay for Illinois' Medicaid program. These figures are in "nominal" dollars and have not been adjusted for the rising cost of Medicaid services.

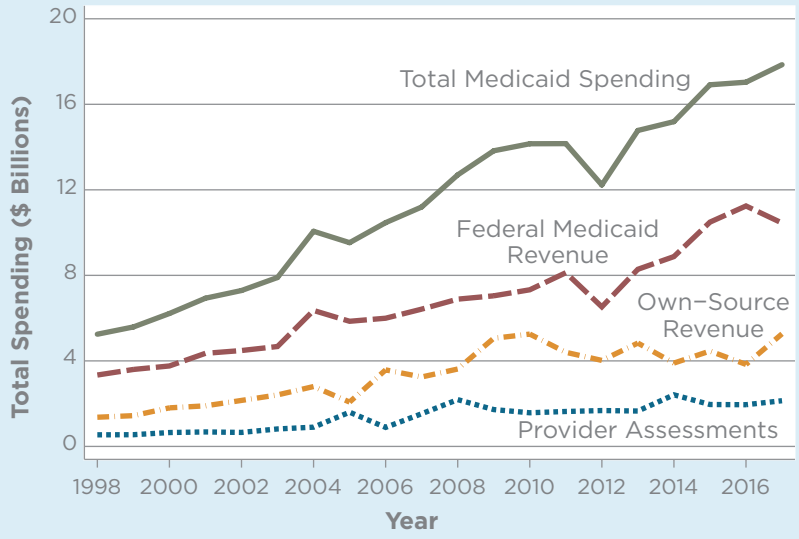
Total spending on Medicaid, the top (green) line, has increased significantly over time. The average yearly change in spending was 6.7%. The largest growth in total spending occurred in 2004 when spending jumped more than 27% over its 2003 value. This was not due to a sudden surge in the use of Medicaid services but rather resulted from state fiscal choices. Illinois has routinely deferred

some Medicaid liabilities from one fiscal year to future years as allowed by state legislation.[21] In 2004, federal reimbursements for all states' Medicaid expenditures were temporarily increased by 2.95% by federal legislation designed to provide fiscal relief for recession-induced revenue losses and expenditure increases. Illinois capitalized on this higher match rate by borrowing $850 million in June 2004 and using the proceeds to reduce accumulated Medicaid liabilities. This resulted in higher spending during state fiscal year 2004.[22]

Illinois uses three revenue sources to pay for Medicaid: federal matching funds, discussed above, provider tax revenue, discussed in more detail below, and own-source revenue that may come from taxes or fees paid for by the general population or businesses. As shown in Figure 1, federal matching funds have been the largest source, followed by own-source funding and finally provider taxes. While this ranking has remained consistent over time, the share paid by each revenue source has varied.

FIGURE 1

Illinois Medicaid Revenue and Spending 1997–2017



Data Source: IGPA Fiscal Futures Database
Year reflects the state fiscal year (July to June of each year).

Federal Medicaid revenue increased significantly over time. Federal government matching funds increased at a compound annual rate of 6.2% between 1998 and 2017. The largest yearly increase in federal Medicaid revenue was in 2004 under the temporarily higher federal match rate. The largest decreases in total spending and federal Medicaid revenue occurred in 2012. The cuts in spending and revenue coincide with the expiration of federal stimulus from the American Recovery and Reinvestment Act (ARRA) in June 2011 after which many states adopted cost-cutting or containment strategies. While Illinois did not cut provider rates, the state appropriated $1.4 billion less for Medicaid in 2012 than it had in FY2011.[23] Following the ACA expansion between 2014 and 2017, Illinois' total Medicaid expenditures grew at a compound annual rate of 5.5%.

Illinois uses provider taxes (also called provider assessments) to partially finance the state share of Medicaid spending. Provider taxes are state-imposed taxes for which at least 85% of the tax burden falls on a medical provider, such as hospitals or managed care plans.[24] States can claim federal matching funds for provider taxes and in turn reimburse medical providers so long as: 1) the provider tax is broad-based across 19 specific classes of providers and 2) states do not guarantee that providers will be held harmless (or receive more money back than they paid in taxes). To limit states'

use of provider taxes, federal law stipulates that the taxes can be used to pay a maximum of 25% of the state share of Medicaid expenditures.[25] Our data suggest that Illinois' use of provider taxes has generally approached this maximum limit.[26]

As displayed in Figure 1, Illinois provider taxes account for a smaller share of Medicaid expenditures than own-source revenues. Provider taxes have also fluctuated from year to year, with an average yearly increase of 7.5%. Illinois currently imposes provider taxes on hospitals, intermediate care facilities for individuals with intellectual disabilities, and nursing facilities. Critics claim provider taxes incentivize states not only to shift costs to the federal government but also to increase overall expenditures. For example, a 2014 report of the U.S. Government Accountability Office found that Illinois levied a new provider tax on nursing facilities in 2012 and increased Medicaid payments to the facilities.[27] Federal matching revenue increased by $110 million without any increase in state general funds.

FEDERAL MEDICAID MATCH RATES

The federal government reimburses many state Medicaid expenditures at the FMAP, determined by a formula that depends on a comparison of each state's average per capita income and the national average per capita income. The FMAP minimum is 50% and Illinois' FMAP has generally been near the minimum. The federal government reimburses some state Medicaid expenditures at different rates as specified by federal legislation. As mentioned above, all states' FMAPs have been substantially enhanced during recent recessions. Also, most state expenditures for newly eligible individuals under the Medicaid expansion authorized by the ACA are reimbursed at a higher rate. There are other legislative and regulatory exceptions, and some states have applied for and received federal waivers that allow flexibility in compliance with standard Medicaid regulations. These waivers may also alter federal reimbursement rates.

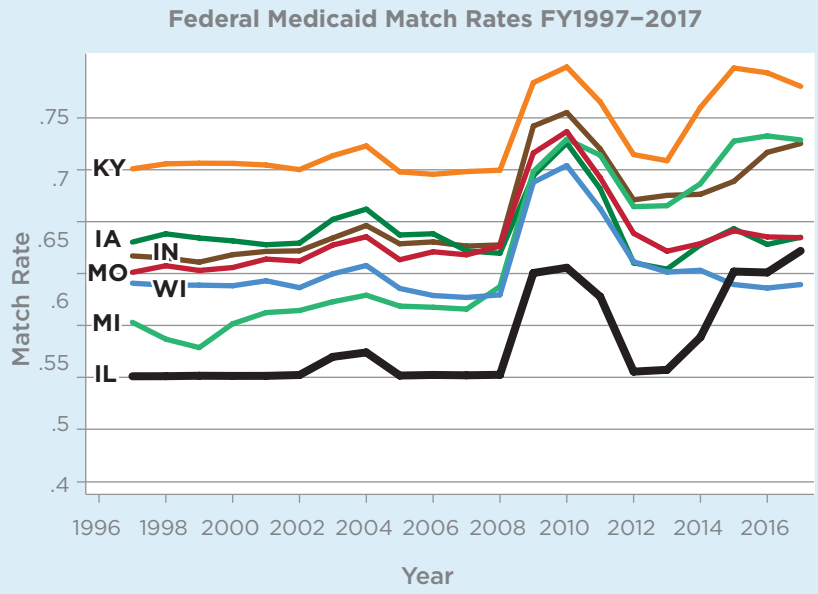
The Centers for Medicare and Medicaid Services (CMS) collects state Medicaid expenditure data through CMS-64 forms on which states report Medicaid spending for several hundred categories of healthcare and administration services. Federal officials record the federal matching amount for each state expenditure and release annual data to the public on the Medicaid.gov website. We use this data to compute observed match rates, which equal federal reimbursements divided by total spending, for each of the subcategories in the data and for total spending. Match rates indicate the share of each state's Medicaid costs that are paid for by the federal government.

Figure 2 displays the observed match rates for Medicaid health services excluding administrative spending across Illinois and six nearby states (Michigan, Kentucky, Wisconsin, Missouri, Indiana and Iowa) from federal fiscal year (FY) 1999 to the latest year available, 2017.[28] For most of the period, Illinois has had the lowest average match rate while Kentucky has the highest. Note that in recent years Illinois' match rate substantially exceeds its FMAP of approximately 50%. This is due to several factors, but the most important factor is

probably that an increasing share of Illinois' Medicaid expenditures were reimbursed at the higher rates that apply to those eligible for Medicaid due to the ACA expansion.

The curves in Figure 2 exhibit noticeable bumps beginning in FY2003 and FY2009. This pattern is the result of temporarily enhanced FMAPs that belatedly provided federal fiscal relief to states after the 2001 and 2007-2009 recessions. From April 2003 through June 2004, the federal match rate was temporarily increased by 2.95 percentage points across all states to provide federal fiscal relief after the 2001 recession. After the Great Recession, the federal match rate was temporarily increased by 6.2 percentage points from October 2008 through December 2010. From January to March 2011, the match rate was increased by 3.2 percentage points, and from April to June 2011, it was increased by 1.2 percentage points. FMAPs were also held harmless and increased using a formula based upon unemployment rate changes.

FIGURE 2



Data Source: U.S. Centers for Medicare & Medicaid Services form CMS–46 and authors' calculations
Notes: Lines show health services spending only. Administrative categories not included.

All the states in the group except Missouri and Wisconsin show an upward trend in match rates after 2014 as the result of ACA expansions. From FY2014 to FY2016, an FMAP of 100% was applied to adults who were newly eligible under the ACA expansion. In FY2017, this match rate fell to 95%. Missouri and Wisconsin did not expand Medicaid to include this group in the period and experienced a decrease in match rates from FY2015 to FY2016.

BROAD CHANGES IN MEDICAID SPENDING AND ENROLLMENT

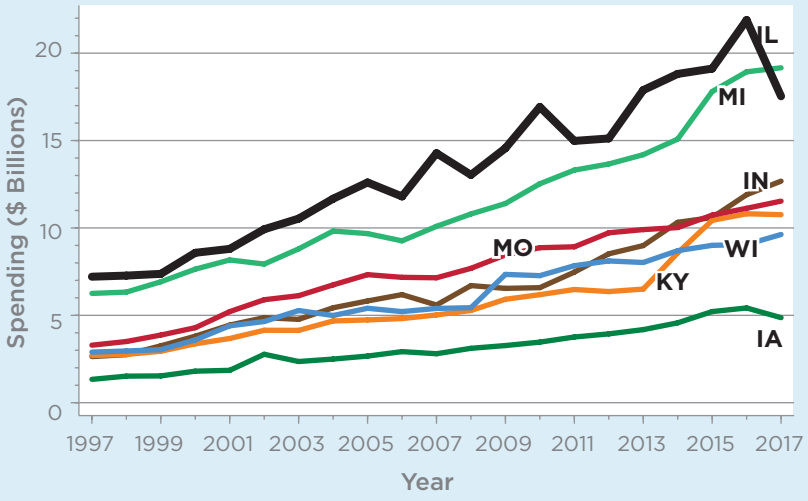
Changes in Spending[30]

From 1997 to 2016, Illinois spent more on Medicaid than other nearby states. In 1997, Illinois' nominal Medicaid spending was $7.21 billion based on CMS data. By 2016, this had increased by more than 200% to $21.9 billion. In 2017, Illinois significantly reduced its spending to $17.5 billion, resulting in Michigan becoming the highest spender among nearby states—as can be seen in Figure 3 on page 7. However, it is possible this drop might be due to Illinois failing to make timely payments rather than reducing the provision of Medicaid services.[31]

Compared to other states, Illinois' spending growth has been relatively small. Figure 4 shows how spending over time in each state compares to its 1997 level of spending. Although Illinois spent 2.43 times as much in 2017 as it did in 1997, this rate of increase was less than the U.S. average of 3.83 times and was also less than the increase in other nearby states. For example, Indiana's Medicaid spending in 2017 was 4.80 times larger than it had been in 1997. Illinois has been comparably effective at slowing down spending during this period.

FIGURE 3

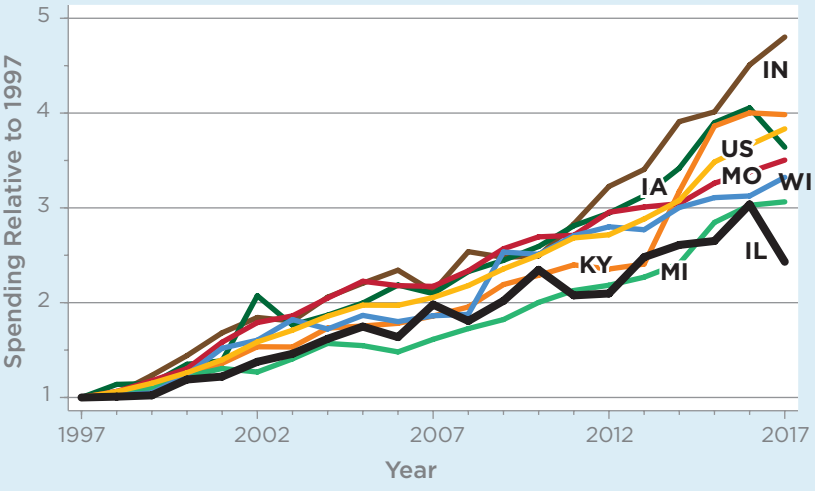
Medicaid Spending By State FY1997–2017



Data Source: U.S. Centers for Medicare & Medicaid Services form CMS–64 and authors' calculations. *Note:* Lines show total spending on Medicaid by state over time.

FIGURE 4

Medicaid Spending by State Over Time Relative to 1997



Sources: U.S. Centers for Medicare & Medicaid Services form CMS–64 and authors' calculations. *Notes:* Lines show states' total spending over time on Medicaid as a proportion of 1997 spending. For example, a value of 2 indicates a state is spending twice as much as it did in 1997.

Changes in Enrollment

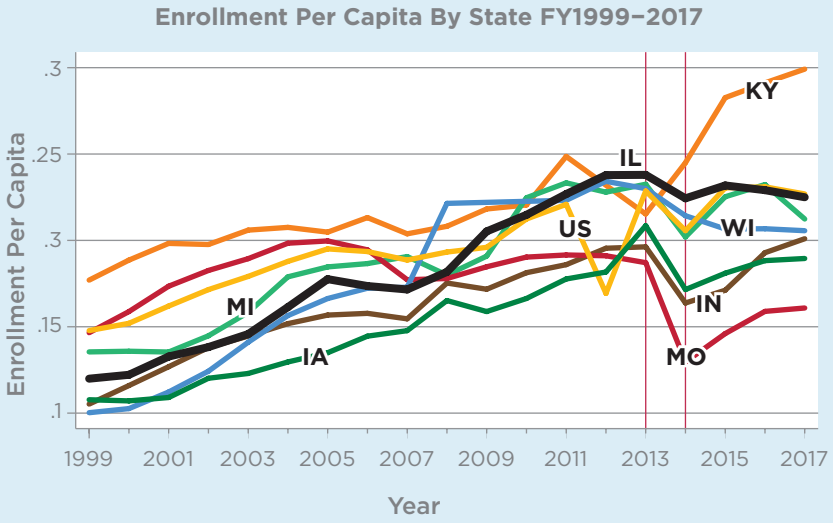
Measuring the number of people who potentially get their healthcare through Medicaid can be complex. Many people who could qualify for Medicaid simply have not signed up or "enrolled." Often these individuals are enrolled only when the need for healthcare is imminent. Others may not need, and may not be eligible for, Medicaid under ordinary circumstances. During an economic downturn, many individuals may lose their usual sources of income and health insurance and may switch to Medicaid. The share of people who are enrolled in Medicaid can be quite different from the number of people who are using Medicaid services and the relationship between these two amounts can vary over time. As a result, it can be complex to calculate the cost per Medicaid client.[32] Despite our recognition of these complexities, we use the best available data to track Medicaid enrollees and the cost per enrollee over time.

Enrollment data are shown in Figure 5 on page 9, but we caution readers that the apparent decline in enrollments between 2013 and 2014 (in all lines except Kentucky) is probably an artifact of changes in the way the data were collected and should be treated with skepticism. The enrollment

measure switches from "ever enrolled during the year" to "average monthly enrollment" between 2013 and 2014. This likely accounts for the observed decline in enrollment. Consistently calculated Illinois Department of Healthcare and Family Services (HFS) data show that Illinois' Medicaid enrollment increased by more than 300,000 people between 2013 to 2014.[33]

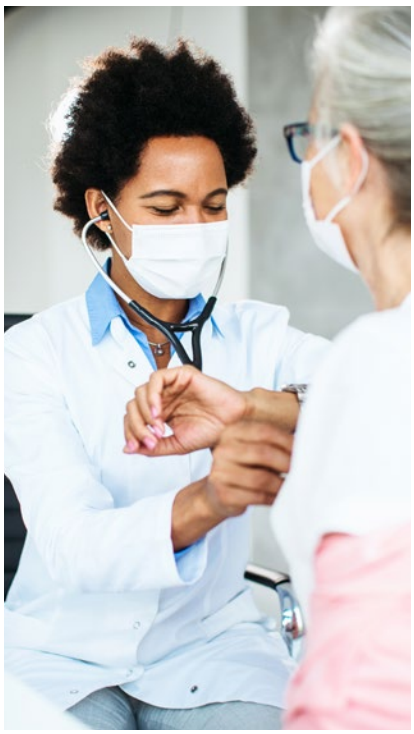
As shown in Figure 5, from 1999 to 2013 Illinois' Medicaid enrollment grew significantly. Twelve percent of the population was enrolled in Medicaid in 1999, but almost 24% was enrolled at some point during 2013. Around 2015, enrollment in Illinois Medicaid started to decline, with average monthly enrollment as a share of the population declining from 23.2% in 2015 to 22.5% in 2017.

FIGURE 5



Enrollment data comes from multiple sources: U.S. Centers for Medicare & Medicaid Services's (CMS) Medicaid Statistical Information Statistics (MSIS) Beneficiary Tables for 1999–2013, Kaiser Family Foundation (KFF) for 2013, CMS's Medicaid Budget and Expenditure Systems (MBES) for 2014–2017. Enrollment is measured as total annual enrollment for 1999–2013 and is average monthly enrollment for 2014–2017. Due to data quality concerns, 2 year rolling averages are used for Wisconsin's enrollment measures. Population data comes from the University of Kentucky Center for Poverty Research's National Welfare Data set. Vertical lines at 2013 and 2014 indicate changes in data sets.

In 1999, 14.7% of the U.S. population was enrolled in Medicaid, while Illinois enrolled only 12% of its residents. Compared to nearby states, Illinois' enrollment was about average. Over time, and increasingly so between 2007 and 2013, Illinois' Medicaid enrollment increased relative to both the U.S. and nearby states. By 2013, Illinois had the highest enrollment rate among the nearby states as shown in Figure 5. However, after 2014, Illinois' enrollment declined and was surpassed by Kentucky. As of 2017 (the latest available data), Illinois enrollment per capita was similar to the national average, with 22.5% enrolled each month, compared to a U.S. average of 22.7%.



Illinois' enrollment has grown greatly during this period. To better understand these changes in enrollment, we examine how enrollment per person in poverty has changed over time in Illinois, compared to other nearby states (see Figure 6 on page 10).[34] Changes in Medicaid enrollment per person in poverty are not influenced by the *number* of people in poverty but reflect changes in enrollment *rates* among eligible groups. Because many individuals with resources above the poverty level are enrolled in Medicaid, the ratio of Medicaid enrollment to people in poverty exceeds one.

Medicaid enrollment per person in poverty in Illinois increased from 1.2 in 1999 to 2.1 by 2017. In 1999, Illinois had relatively low enrollment per person in poverty compared to other nearby states. During the 2000s, enrollment increased compared to other nearby states. During the 2010s, Illinois and several other states in the

region (Kentucky, Iowa, and Wisconsin) had relatively high levels of enrollment per person in poverty. Among states in the region, only Illinois and Wisconsin had large growth in this ratio during this period. From 1997 to 2017, Medicaid enrollment in Illinois increased by about 75%. per person in poverty. Based upon this, Illinois spending growth is likely driven greatly by increasing enrollment. More and more Illinoisans are on Medicaid.

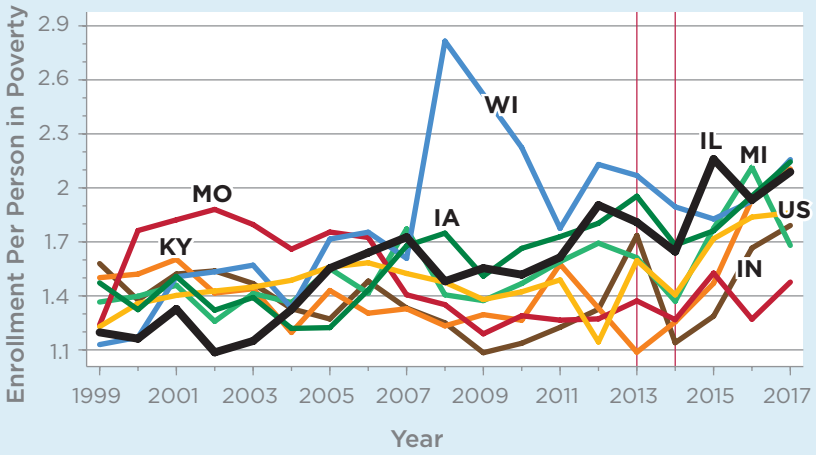
Changes in Spending Per Enrollee

While enrollment increased greatly during this period, spending per enrollee changed relatively little. In 1999, Illinois spent about $5,069 per Medicaid enrollee. By 2012, spending per enrollee remained essentially unchanged, at approximately $4,938 per enrollee. From 2012 to 2014, spending per enrollee increased. Because the way enrollment data are reported changed over that period, our measure of the spending increase is imprecise. The authors' best estimates using CMS and HFS data are that spending per enrollee increased between $520 and $569 during this period. From 2014 to 2017, spending per enrollee declined from $6,509 to $6,087, with a brief spike to $7,466 in 2016. Thus, while Illinois spending per enrollee has varied year-to-year, the overall picture is that spending per enrollee has been remarkably stable.

Moreover, Illinois' per-enrollee spending increased much slower than surrounding states and the nation. In 1999, Illinois spent $5,069 per enrollee, which was about the same as the amount spent on average across the U.S. ($4,913) and by other states in the region (see Figure 7). By

FIGURE 6

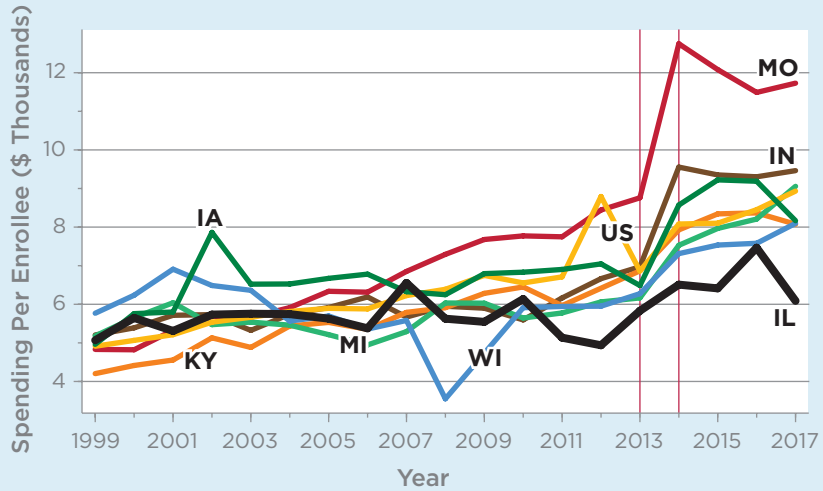
Enrollees Per Person in Poverty By State FY1999–2017



Enrollment data comes from multiple sources: U.S. Centers for Medicare & Medicaid Services's (CMS) Medicaid Statistical Information Statistics (MSIS) Beneficiary Tables for 1999–2013, Kaiser Family Foundation (KFF) for 2013, CMS's Medicaid Budget and Expenditure Systems (MBES) for 2014–2017. Enrollment is measured as total annual enrollment for 1999–2013 and is average monthly enrollment for 2014–2017. Poverty data comes from the University of Kentucky Center for Poverty Research's National Welfare Data set. Vertical lines at 2013 and 2014 indicate changes in data sets. Lines show total enrollment divided by number of people in poverty by state and year.

FIGURE 7

Spending Per Enrollee By State FY1999–2017



Enrollment data comes from multiple sources: U.S. Centers for Medicare & Medicaid Services's (CMS) Medicaid Statistical Information Statistics (MSIS) Beneficiary Tables for 1999–2013, Kaiser Family Foundation (KFF) for 2013, CMS's Medicaid Budget and Expenditure Systems (MBES) for 2014–2017. Enrollment is measured as total annual enrollment for 1999–2013 and is average monthly enrollment for 2014–2017. Spending data comes from CMS's form CMS–64 and authors' calculations. Vertical lines at 2013 and 2014 indicate changes in data sets.

2017, Illinois was spending $6,088 per enrollee, which was noticeably less than other nearby states, as well as the U.S. average of $8,933.

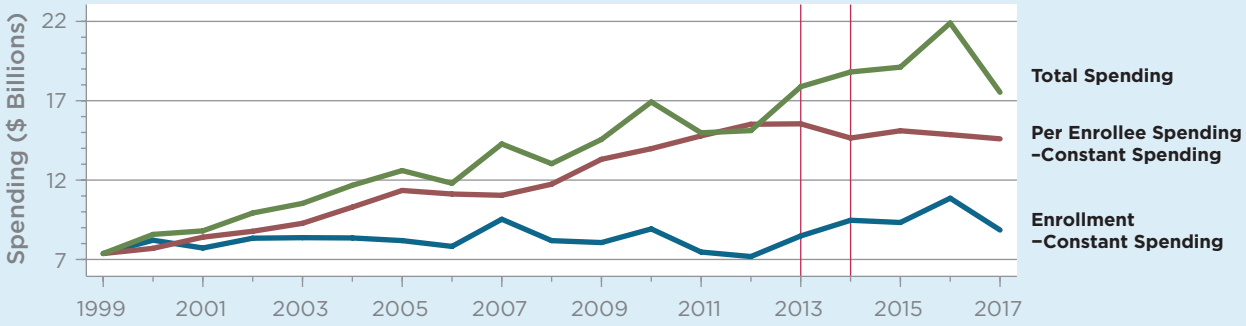
We caution that these figures do not take into account increases in the price of healthcare, which has been rising significantly in recent history. While the standard Consumer Price Index (CPI) shows that overall prices increased by 48% from 1999 to 2017, the CPI for Medical Care indicates that prices increased 90% during this period; the price of hospitals increased by 191%, prescription drugs increased by 90%, and physician prices increased by 61%.[35] Given these various price changes, and knowing nominal spending per enrollee increased by at most 20% (which is an overestimate given data changes, with our best guess being closer to 10%), spending per enrollee *adjusted for healthcare inflation* clearly declined significantly from 1999 to 2017.

Decomposition of Spending Growth into Growth in Enrollment and Growth in Spending Per Enrollee

Illinois' Medicaid spending has increased significantly over the last two decades. Figure 8 illustrates a decomposition of the change in the state's total Medicaid spending into the part contributed by increases in spending per enrollee and the part contributed by increases in the number of people enrolled. The Per Enrollee Spending-Constant Spending line shows how much Illinois would be spending each year if spending per enrollee had remained at its

FIGURE 8

Illinois Medicaid Spending Growth: Decomposition of Growth by Enrollment and Spending Per Enrollee FY1999–2017



The Enrollment–Constant Spending line shows how much Illinois would be spending if they had 1999 levels of enrollment but current levels of spending per enrollee. The Per Enrollee Spending–Constant Spending line shows how much Illinois would be spending if they had 1999 spending per enrollee levels and current levels of enrollment. Enrollment data comes from multiple sources: U.S. Centers for Medicare & Medicaid Services's (CMS) Medicaid Statistical Information Statistics (MSIS) Beneficiary Tables for 1999–2013, Kaiser Family Foundation (KFF) for 2013, CMS's Medicaid Budget and Expenditure Systems (MBES) for 2014–2017. Enrollment is measured as total annual enrollment for 1999–2013 and is average monthly enrollment for 2014–2017. Spending data comes from CMS's form CMS–64 and authors' calculations. Population data comes from the University of Kentucky Center for Poverty Research's NationalWelfare Data set. Vertical lines at 2013 and 2014 indicate changes in data sets.

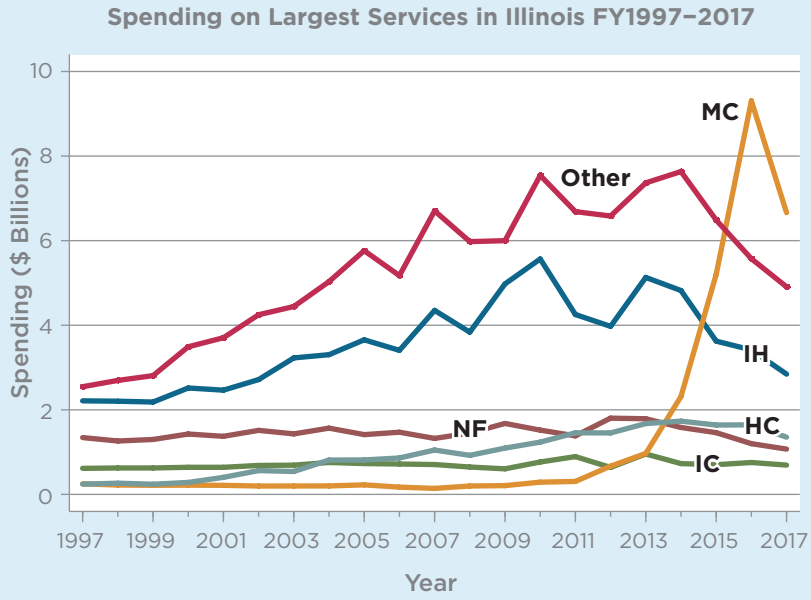
1999 level, while enrollment increased at the observed rate. In other words, how much would Illinois be spending if it was spending the same amount on each current enrollee as it had in 1999? As shown in Figure 8, through 2012, increases in enrollment explain *all* of the growth in Illinois' Medicaid spending. This is truly remarkable because our calculations are based on *nominal* spending and do not account for the very rapid increases in the cost of healthcare. After 2012, total spending does exceed per enrollee constant spending but even at the end of the period (2017) most of the increase in Illinois' Medicaid spending is explained by increases in enrollment rather than increases in spending per enrollee.

ANALYZING MAJOR CHANGES IN SPENDING

Change in Top 5 Services Plus "Other"

While spending has grown over time, it has not grown uniformly across medical service categories. From 1997 to about 2012, Illinois' Medicaid spending was distributed across medical service categories in a relatively stable manner. The five main services were (1) home and community-based services (HC), (2) inpatient hospital services (IH), (3) nursing facilities (NF), (4) intermediate care facilities (IC), which provide care to those who need less intensive interventions than those provided in nursing facilities, and (5) managed care (MC). As shown in Figure 9, except for inpatient hospital services (IH), which were volatile and growing, absolute spending was relatively stable from 1999 until about 2012. Spending on managed care rose very rapidly after 2012. Spending on all other services (the top red line in Figure 9) rose substantially between 1999 and 2005 and was volatile and somewhat increasing after that.

FIGURE 9



Data Source: U.S. Centers for Medicare & Medicaid Services form CMS–64 and authors' calculations. Graph shows Medicaid spending over time on five high spending services and the sum of all other services. If a service was in the top three for 1997 or 2017, it was included.
Abbreviations: HC = Home and Community Based Services, IC = Intermediate Care Facility, IH = Inpatient Hospital Services, MC = Managed Care, NF = Nursing Facility Services, Other indicates total spending on all other services.

During the 2010s, a major shift in Illinois' Medicaid occurred. Managed care spending rose from $290 million in 2010 to $9.31 billion in 2016. During this period, we observe large declines in spending across many other services as Illinois' Medicaid program increasingly shifted from fee-for-service to managed care. However, 2017 data (the most recently available from this source) show managed care spending declined by $2.64 billion, without evidence of increases in spending on other services.

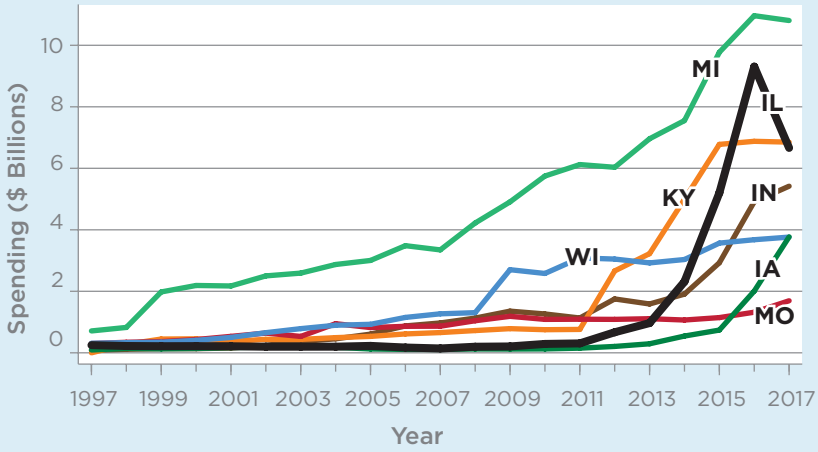
Managed Care Over Time

Managed care is typically argued for as a way to cut costs without worsening quality of care. In the fee-for-service system, health providers receive money for each of their services; thus they may tend to provide excessive services because they are paid to do so. Managed care organizations (MCOs), on the other hand, do not receive more revenue when they provide more services. While MCOs still need to provide quality care to attract enrollees, they do not directly benefit from spending money on services. Moreover, because healthy patients spend less on healthcare, it is argued that MCOs will focus more on keeping patients healthy rather than on providing costly services. Thus, managed care is seen as a more affordable healthcare system. When we compare Illinois' managed care spending to other nearby states (Figure 10), we see that all except Missouri had very rapid growth in managed care spending during much of the 2010s. Many Medicaid programs transitioned away from fee-for-service and toward managed care during this period. Among nearby states, only Michigan spent more on managed care in 2016 than Illinois.

Illinois' relatively large level of spending on managed care is not surprising because it has a very large Medicaid population. The 38% share of Illinois' Medicaid spending that goes to managed care is actually below the national average of 45%. Among nearby states shown in Figure 11, Illinois' share of Medicaid spending on managed care is the second lowest, with only Missouri being lower.

FIGURE 10

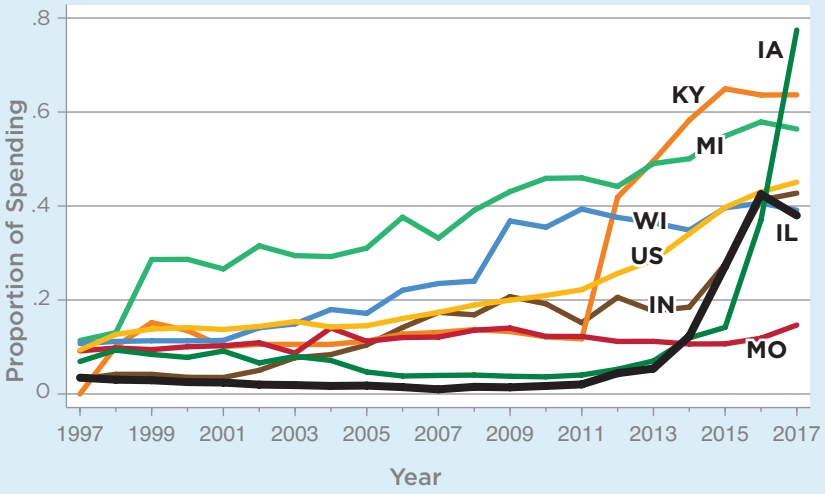
Managed Care Spending By State FY1997–2017



Data Sources: U.S. Centers for Medicare & Medicaid Services form CMS–64 and authors' calculations. Lines show total spending on managed care.

FIGURE 11

Proportion of Medicaid Spending on Managed Care By State FY1997–2017



Data Sources: U.S. Centers for Medicare & Medicaid Services form CMS–64 and authors' calculations. Lines show proportion of Medicaid spending devoted to managed care.

Overall, Illinois has shifted greatly toward managed care in the past decade—and this matches the behavior of nearby states and much of the nation. Illinois does have high managed care spending, but this is a reflection of Illinois' size.

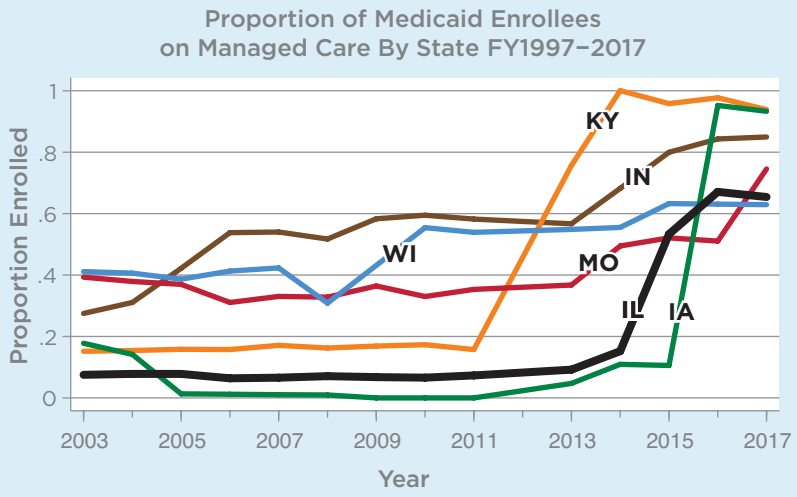
From 2003 to 2017, Illinois' managed care enrollment has been comparatively low (see Figure 12). In 2003, Illinois had the smallest share of enrollees on managed care plans—a mere 7.5%. By 2013, Illinois still only had 9.2% of enrollees on managed care and was still relatively low.

Illinois' enrollment in managed care expanded rapidly after 2014 and reached 67.1% in 2016. While Illinois underwent significant growth in managed care enrollment, it nevertheless was low compared to other states throughout this period. With the exception of Iowa, Illinois is unique in experiencing large growth in managed care enrollment within a very short time frame.

As shown in Figure 13, Illinois spending per managed care enrollee was less than $2,000 between 2003 and 2011. From 2011 to 2014, Illinois spending per managed care enrollee increased rapidly but remained low relative to nearby states, except in 2014. The growth in spending from 2011 to 2014 could be due to myriad factors, including demographic changes within the managed care population and increases in the types of spending contracted out to MCOs.

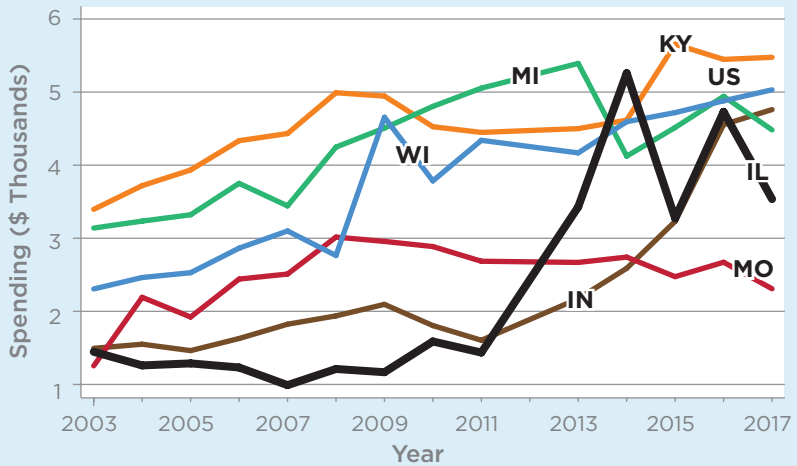
Several notable changes within Illinois' Medicaid system provide context for the facts discussed above. In 2011, Illinois launched the Integrated Care Program, which required that Illinois seniors and persons with

FIGURE 12



Data Source: U.S. Centers for Medicare & Medicaid Services form CMS–64 and authors' calculations. Managed care enrollment data comes from Kaiser Family Foundation. Lines show proportion of enrollees on managed care. MCO enrollment is annual, while total enrollment is annual through 2013 and monthly for 2014 to 2017. Because of this, the proportion of enrollees on managed care is overestimated after 2013.

FIGURE 13



Data Sources: U.S. Centers for Medicare & Medicaid Services form CMS–64 and authors' calculations. Managed care enrollment data comes from Kaiser Family Foundation. Lines show total managed spending divided by total managed care enrollment.

disabilities on Medicaid be under a managed care plan.[36] Because these individuals are more expensive to serve than the average Medicaid enrollee, this shift in the composition of the managed care population would almost certainly require increased spending per enrollee even without greatly increased enrollment. Also in 2011, the legislature passed Public Act 96-1501, which mandated that 50% of Medicaid beneficiaries entitled to full benefits become enrolled in managed care by FY2015.[37] By 2016, Illinois had moved more than 2 million Medicaid recipients (about 60%) into managed care.[38]

According to estimates by the Illinois Comptroller, managed care liability expanded from less than 3% of the Department of Healthcare and Family Services' expenditures in FY2010 to more than 55% in FY2017.[39] The state has sought to increase efficiency in the Medicaid program and reduce costs through managed care.

Research examining cost saving in the private insurance market does suggest that MCOs may reduce spending—but primarily because MCOs negotiate for lower prices from providers rather than because they lower healthcare utilization. When analyzing Medicaid programs, research conducted in 2011 finds that managed care contracting tends to save money if a state's Medicaid provider reimbursements are already relatively high, and tends to cost more money if their Medicaid provider reimbursements are already relatively low.[40] Thus, a significant factor in determining if Illinois could financially benefit from a shift to managed care is whether contracted MCOs can negotiate effectively compared to the fee-for-service system. However, because Illinois' Medicaid fee-for-service rates are already low, significant savings may prove quite difficult to achieve.

Managed care spending per enrollee reflects the capitation rates paid to MCOs and the composition of Illinois' managed care enrollment. Because MCOs, in general, are paid the same regardless of quality and quantity of service provision (within regulatory guidelines), managed care spending per enrollee is only loosely tied to the quality of care.[41] Moreover, because MCOs can cut costs by denying claims without necessarily losing any revenue, some suspect Illinois Medicaid MCOs are increasing profitability by excessively denying claims. As a result, some have recently pushed Illinois to put additional emphasis on fee-for-service provision of healthcare.[42]

Research about Medicaid MCOs is mixed or inconclusive about the potential for cost savings. The success of MCOs in reducing costs varies considerably across states due to differences in institutional factors and plan designs.[43] One often-cited finding is that managed care may reduce emergency room visits and inpatient hospital care via better access to primary care, but this differs with each state or plan context.[44] Observing single states' contexts may provide more useful insights for strategy and potential benefits in managed care. For example, as mentioned earlier, in 2011 Illinois was one of the states that expanded managed care to the elderly and disabled populations. The rationale is that moving high-need beneficiaries into managed care may increase the potential for cost savings.[45] Illinois also offers a mix of provider-owned managed care plans (e.g. Cook County's CountyCare) and insurer-owned managed care plans (i.e. BlueCross and BlueShield), which compete with one another and may implement different cost-savings strategies.

Because Illinois' Medicaid fee-for-service rates are already low, significant savings may prove quite difficult to achieve.

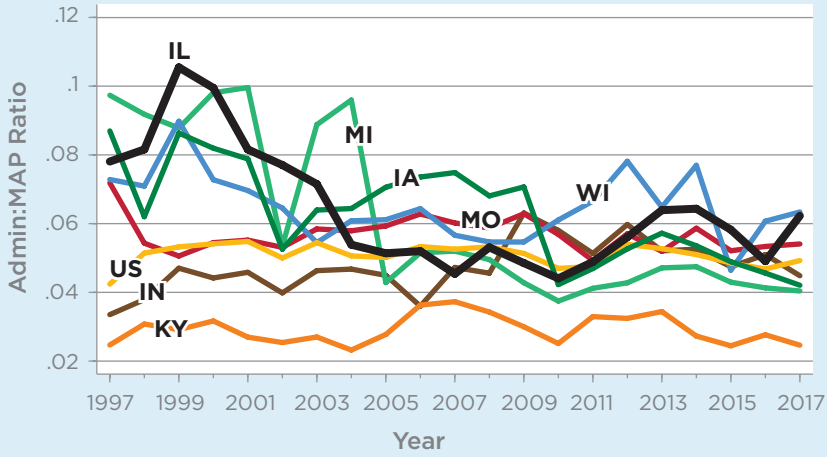
The response to the transition to managed care has been mixed, but relatively positive. Many healthcare providers support this transition and are optimistic that a shift to managed care will provide better healthcare per dollar spent.[46] However, there have been numerous concerns from healthcare providers and patients since the expansion of managed care. Many patients have found this transition to managed care to be confusing, and are frequently unaware of which is their assigned MCO, who is their primary care physician, or how their healthcare coverage operates.[47] Similarly, many healthcare providers have also found this transition to be confusing and tiresome. The administrative burdens are perceived as excessive and inefficient, and insufficient information is accessible to address providers' questions.[48] It is unclear whether these problems should be expected to endure, or if they are simply part of a bumpy transition process toward a better healthcare system.

Ratio of Administration to MAP Spending

Beyond overspending on services, excess administrative spending is another common complaint about the U.S healthcare system. Within Illinois' Medicaid program, administrative spending has become less important over time. Figure 14 shows the ratio of administrative spending to Medical Assistance Program (MAP) spending. MAP contains all non-Children's Health Insurance Program (CHIP), non-administrative spending within Medicaid and can be thought of as spending that is directly connected to medical services for Medicaid enrollees, rather than administrative expenses. Figure 14 shows how much is spent on administration for each dollar spent on MAP services.

FIGURE 14

Ratio of Administrative Spending to MAP Spending By State FY1997–2017



Data Sources: U.S. Centers for Medicare & Medicaid Services form CMS–64 and authors' calculations. Lines show ratio of spending on administration to spending on the Medical Assistance Program. Due to data quality concerns, 2-year rolling averages were used for Michigan.

In the late 1990s, Illinois spent about eight cents on administration per dollar of spending on MAP services compared to a national average of about four cents. In 1999, this value increased to almost 11 cents—the largest among nearby states during that year. During the first decade of the new century, Illinois significantly reduced administrative spending and transitioned from being a comparatively large spender on administration to being relatively average. During the 2010s, Illinois' administration to MAP ratio increased to 6 cents per dollar of MAP spending in 2017, leading Illinois to be spending relatively high amounts on administration compared to nearby states. However, this increase in ranking was not driven by increases in Illinois' spending,

but by declines in nearby states and reduced variation across states. While the administration to MAP ratio varied significantly across states in 1997 (ranging from 2.5% in Kentucky to 9.7% in Michigan), this variation was much smaller by 2017 (ranging from 2.5% in Kentucky to 6.3% in Wisconsin). States that previously were spending quite a lot on administration (Illinois, Michigan, and Iowa) all greatly reduced spending during this period. Given administration is a relatively small part of Medicaid, opportunities to greatly reduce costs here are likely limited.

Our analysis suggests that it will be extremely challenging for Illinois to reduce its fiscal commitments for Medicaid any time soon.

Illinois' growth in spending has been primarily driven by increases in enrollment, while spending per enrollee has grown comparatively little.

CONCLUSION

This paper has examined Medicaid finance in Illinois compared to neighboring states using several sources of data. Illinois' Medicaid program makes up a large portion of the state budget and has increased significantly over time. While Illinois has spent more (nominally) on Medicaid over time than other states in the region, Illinois' growth in spending has been lower than nearby states as well as the U.S. average. Until the ACA, Illinois' Medicaid enrollment increased more relative to the U.S. and its six neighboring states over time. It is still somewhat high compared to nearby states, except for Kentucky. Illinois' average enrollment per person in poverty increased significantly during the entire observed period. While available enrollment data are inconsistent and difficult to interpret, we believe that Illinois' spending per enrollee has been relatively stable and that, after accounting for increases in the cost of healthcare, Illinois now spends less per enrollee than in the past. Illinois' growth in spending has been almost entirely driven by increases in enrollment. Managed care spending has grown rapidly, but Illinois still spends proportionally less on managed care than other states.

Our analysis suggests that it will be extremely challenging for Illinois to reduce its fiscal commitments for Medicaid any time soon.

Illinois' growth in spending has been primarily driven by increases in enrollment, while spending per enrollee has grown comparatively little. Thus, reducing Medicaid significantly would seem most feasible by reducing the number of people enrolled. But given the numerous benefits of Medicaid (e.g., increased access and utilization of care,

increased diagnosis and treatment of chronic conditions, improvements in mental and financial well-being, etc.)[49] large cuts in enrollment are likely to be socially harmful. Cutting Medicaid enrollment might save the state money, but will likely make the state worse off overall, to the detriment of Illinois' most vulnerable populations.

Saving money by reducing spending per enrollee would also be difficult. Illinois already spends relatively little on its Medicaid enrollees, so large savings from reducing spending per enrollee seem unlikely. Given that enrollment growth has varied greatly, with most of the enrollment growth occurring among non-disabled children and adults, one might suspect that Illinois can save money by focusing on certain populations (e.g., the blind/disabled, the elderly, children, adults, foster kids). Our analysis of specific groups through 2012 yields similar results. Among non-disabled children, adults, and the elderly, we find that Illinois is at or near the bottom in spending per enrollee when compared to nearby states. With regards to the disabled, Illinois is relatively average both in spending per enrollee and enrollment trends.

"Policymakers cannot cut Medicaid payments much below what they are now. Thus, unless policymakers cut Medicaid eligibility, Medicaid spending growth is unlikely to fundamentally change without changes in the underlying medical care system."
— Katherine Swartz

Analyses like these have led other researchers to similar conclusions. Katherine Swartz of Harvard University notes that "policymakers cannot cut Medicaid payments much below what they are now. Thus, unless policymakers cut Medicaid eligibility, Medicaid spending growth is unlikely to fundamentally change without changes in the underlying medical care system."[50] Medicaid is expensive because healthcare is expensive; thus, increasing efficiency in U.S healthcare generally is needed to improve efficiency in Medicaid specifically. Analysis from Princeton University's Janet Currie in "Medicaid: What Does It Do, and Can We Do It Better?" similarly suggests to us that there are few easy means for states to unilaterally save money on Medicaid.[51] Renegotiating managed care contracts appears to be the most reasonable way to do so. Given that there is evidence that MCOs had large gains in profits after the ACA,[52] this is worth looking into, and CMS may be helpful in discerning how that can be done best.

Our claim that it will be difficult for Illinois to save money in a socially beneficial way is magnified by the calculus of match rates. While it is one thing to argue that it is socially beneficial to offer free healthcare to the poor and disabled, it is another to argue that it is worthwhile *to the state* when 50% to 90% of it is funded by the federal government.

For instance, cutting any ACA-related spending is particularly questionable. Match rates for newly eligible adults are

currently 90% meaning for every dollar Illinois spends they are reimbursed 90 cents of healthcare from the federal government. Consequently, every dollar Illinois spends on ACA enrollees only needs to be worth approximately 10 cents to be beneficial to the state. Given this, it is unlikely increases in spending driven by ACA enrollment were harmful to the state. The minimum amount of benefits reaped to be financially worthwhile is very low, and the research suggests there have been numerous benefits.[53] This logic applies to a lesser degree for all of Illinois' Medicaid spending. Illinois' FMAP in 2017 was 51.3%, implying every dollar of Medicaid spending on the disabled, the blind, or low-income children and parents, only needs to be worth approximately 49 cents to the state for it to be in its self-interest. Along a similar line, because Medicaid is heavily funded by the federal matching funds, for every dollar the state cuts from the Medicaid program, the immediate budgetary savings are only about 49 cents. While there is almost certainly wasteful spending in the program that should be removed,[54] the match rate system sets the bar high regarding what spending is worth cutting.

Illinois' Medicaid spending has increased greatly, but it has grown less in Illinois compared to nearby states and has not grown tremendously once one accounts for medical inflation.[55] Given this, the amount of funding that is matched by the federal government, and the large benefits of the program, unfocused Medicaid cuts designed simply to save money are likely to have costs that exceed benefits.

APPENDIX

TABLE 1

Illinois Medicaid Revenue and Spending 1998-2017

Year	Medical Provider Assessments ($ billion)	Federal Medicaid Revenue ($ billion)	Own-source Spending ($ billion)	Total Spending ($ billion)
1998	0.54	3.34	1.37	5.25
1999	0.55	3.60	1.44	5.59
2000	0.65	3.76	1.80	6.22
2001	0.68	4.36	1.90	6.93
2002	0.66	4.48	2.15	7.29
2003	0.82	4.67	2.41	7.90
2004	0.90	6.36	2.80	10.06
2005	1.60	5.85	2.07	9.53
2006	0.89	6.00	3.58	10.47
2007	1.53	6.42	3.25	11.20
2008	2.19	6.89	3.62	12.70
2009	1.72	7.04	5.06	13.83
2010	1.57	7.33	5.25	14.16
2011	1.63	8.12	4.40	14.16
2012	1.68	6.53	4.02	12.23
2013	1.66	8.29	4.83	14.78
2014	2.41	8.88	3.90	15.19
2015	1.96	10.49	4.46	16.91
2016	1.95	11.25	3.84	17.03
2017	2.14	10.45	5.27	17.85

ENDNOTES

1 Own-source funding is funding collected by Illinois from its own sources via imposition of a tax or fee.

2 Provider taxes are taxes on healthcare providers.

3 Annual enrollment is used in 1997 while monthly enrollment is used in 2017 due to data availability changes over time.

4 For more detail about the components of Illinois' state budget and recent trends in spending and revenues, see Merriman, David and Xiaoyan Hu. (April 2021 Illinois' Fiscal Challenges: Where Are We Now and How Do We Proceed? University of Illinois: Institute of Government and Public Affairs https://perma.cc/63BF-WNDF.

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[19] Sommers, et al., *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*.

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[30] Please note that appendix Table 1 and Figure 1 are based on data from the Illinois Comptroller. Figure 1 refers to State of Illinois fiscal years (July 1 to June 30th). Figures 2 through 14 are based on U.S. Center for Medicare & Medicaid Services (CMS) data and refer to federal fiscal years (October 1 to September 30). We acknowledge that when the two data sets overlap, they sometimes are less than perfectly consistent. For example, in some years CMS data indicates substantially higher total Medicaid spending than Comptroller data. Unfortunately, we lack information that might resolve inconsistencies.

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[32] An additional difficulty is that we are not aware of any data source that consistently measures enrollment over time. Sources vary in how they define a beneficiary, account for potential overlap between the Children's Health Insurance Program (CHIP) and Medicaid enrollment, and the time frame they examine (annual or monthly). From 1999-2013, we have data from CMS and Kaiser Family Foundation on total beneficiaries enrolled at some point during the year; from 2014-2017, we have data from CMS on monthly enrollment. For 2014-2017, we measure enrollment by averaging enrollment across all months within the year. Because of enrollment turnover, this average monthly enrollment measure will be lower than total annual enrollment. For example, if 1 million people are enrolled in both January and February, but 200,000 of the January enrollees were replaced by a different set of 200,000 enrollees—total

enrollment over the period will be 1.2 million, but average monthly enrollment will only be 1 million.

[33] Civic Federation. Civicfed.org. (2018). *Institute for Illinois' Fiscal Sustainability*. [online] Available at: https://perma.cc/7ZJX-MGGU [Accessed 15 July 2021]. This decline in enrollment is corroborated by Illinois Department of Healthcare and Family Services (HFS) data, which show Medicaid enrollees with comprehensive benefits declining from 3.23 million people in 2015 to 3.14 million people in 2017 (*Civic Federation,* 2018). Illinois Department of Healthcare and Family Services data referenced comes from chart in following article: https://perma.cc/7ZJX-MGGU.

[34] We caution readers that, as described above, data series about enrollment are inconsistent and that may be reflected in the ratio shown in figure 6 because Medicaid enrollment is used as the numerator. We are highly skeptical of the huge increase in Wisconsin's ratio in 2008 shown in our data.

[35] Bureau of Labor Statistics. (2021). *Consumer price index - all urban consumers*, 1999-2017 [Time series]. Retrieved from http://data.bls.gov.

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[49] Sommers, et al. *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*.

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Pg. 2 - Pediatrician and infant patient, #178180540 by michaeljung

Pg. 3 - Pediatric care, #1287924870 by Drazen Zigic

Pg. 4 - Hospital lobby, #1248607560 by andresr

Pg. 5 - Stethoscope and currency, #624701856 by The Crimson Ribbon

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