Fiscal Focus

A Publication of the Illinois State Comptroller

DANIEL W. HYNES
COMPTROLLER

www.ioc.state.il.us

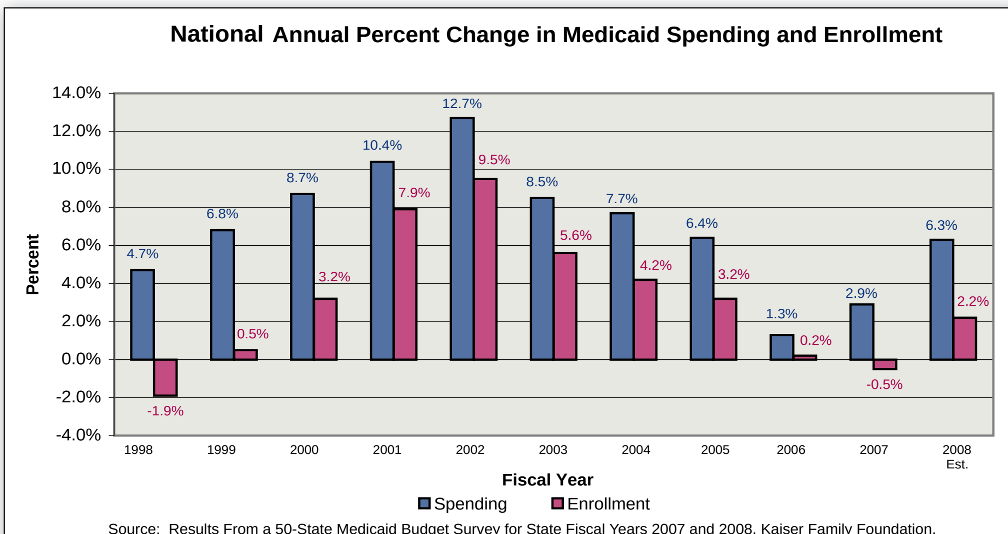
• JULY 2008 ISSUE •

In This Issue:

State Medicaid Programs Face Funding Challenges

After two years of slow growth nationwide, costs of the Medicaid program are ramping up again and having a significant impact on state budgets. Medicaid costs increases were surprisingly low in 2006 and 2007, inching up 2.9% and 1.3%, respectively. But that relative lull is expected to be short lived as experts now estimate that costs will rise 6.3% in 2008. While this increase is less than the sharp jumps in the first half of the decade, it is still alarming to the states (see chart).

The slow growth of 2006 and 2007 was affected by the positive performance of the national and state economies, the pick-up of some prescription drug costs by Part D of the Medicare program and by Medicaid regulations authorized by the Deficit Reduction Act of 2005 (DRA). The DRA required prospective beneficiaries to document their identity and citizenship when applying for Medicaid services. Without documentation, states were able to withhold Medicaid coverage. The result was that many states experienced an increase



Source: Results From a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008, Kaiser Family Foundation.

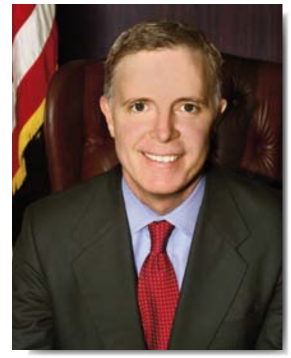
in backlogs of pending applications and flat or decreasing caseloads.

Analysts note that the slow growth in expenditures was accompanied by slow growth in enrollments. In 2006, Medicaid enrollments grew by 0.2% and in 2007, enrollments declined by -0.5%, the first decline since 1998. It is now estimated that 2008 may experience enrollment growth of 2.2%.

However, current estimates are projecting a sharp increase in Medicaid enrollments and expenditures starting in 2008. The national and state economies are slowing down, gasoline and food prices are rising,

Cover Story continued, page 3

FROM THE COMPTROLLER



Dear Readers:

The Medicaid program is a cornerstone of federal and state efforts to provide medical services to low income children, adults and the disabled. Created in 1965, Medicaid has served millions of Americans through a unique partnership that splits the costs of medical care between the federal and state governments. Medical costs have continued to increase over the years and attention has shifted to ways to balance government budgets.

At the federal level the tactic has been to curtail or limit the services that will be reimbursed. But that creates a dilemma for state governments. If states want to maintain their Medicaid programs in the face of federal cutbacks, then they have to assume more costs. States budgets are especially stressed if they have to absorb more costs in a period when the economy is bringing in less revenue and caseloads are increasing.

Illinois has seen both its Medicaid enrollees and liabilities increase over the years. Medicaid liabilities have grown from $4.3 billion in fiscal year 1994 to $8.2 billion in fiscal year 2007, and an average of 2.1 million persons per month are covered by Medicaid. According to a May 2008 report from the Illinois Auditor General, Illinois' Medicaid program suffers from payment delays and the carryover of unpaid bills. From fiscal year 2005 to fiscal year 2007, an average of $1.5 billion in unpaid medical claims was carried over into the next fiscal year. It is time for the state to take action.

Your comments about this or any of our other publications are welcome. Your input can be directed to (217) 782-6000 in Springfield, (312) 814-2451 in Chicago, or via the web site at www.ioc.state.il.us.

Sincerely,

Daniel W. Hynes
State Comptroller

Fiscal Focus

Fiscal Focus is one of the ways the Comptroller's Office strives to assist taxpayers and the people of Illinois. This report is designed to provide fiscal information of general interest.

Editorial Staff: Rick Cornell, David Griffith and Alexis Sturm. Writers & Analysts: Bill Dracos, Kevin Fitzpatrick, Loren Iglarsh, Stephanie Blair, David Griffith, Alexis Sturm, Jeanette Goza, Javier Cazares, Ryan Amerson, Colleen Kozubowski, Joe Enright, Michelle Young and Jessica Polos. Production: Rhonda Rathbone, Susan Hansen, Aimee Ayers-Mansfield, Frank Weitzel, Larry Hopkins and Mike Petropoulos.

Fiscal Focus is published by Comptroller Daniel W. Hynes, 201 State House, Springfield, Illinois 62706. Questions or comments may be directed to (217)782-6000.

Web Address: http://www.ioc.state.il.us

In compliance with the Americans with Disabilities Act, this document may be requested in alternative formats by contacting the Office of the Comptroller at (217)782-6000 or calling the IOC Telecommunications Device for the Deaf (TDD) number, (217)782-1308, or by visiting the Illinois state Capitol Building, 201 State House, Springfield, Illinois.

The Illinois Office of the Comptroller is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, marital status, national origin, ancestry, age or disability in employment or in the provision of any services, programs or activities.

Printed by Authority of the State of Illinois
7/15/08 - 2,900, Job 40245

Steps Toward Universal Healthcare

With 47 million Americans currently uninsured, health care ranks high on the agendas of many lawmakers. Given that they regulate health insurance for small businesses and individuals and administer assistance programs such as Medicaid and SCHIP, many believe that the states are better equipped to tackle the issue than is the federal government, who has yet to produce a nationalized healthcare system. Accordingly, several states have recently launched legislative initiatives aimed at providing some level of universal health care.

The most ambitious plan to date is that of Massachusetts. Signed in April 2006, this legislation requires that nearly all residents obtain some level of health insurance coverage. Measures were enacted to expand government subsidies for those earning less than three times the federal poverty level, and a new state agency was created to coordinate residents' ability to purchase private insurance using pre-tax income. Massachusetts' funding mechanism includes using federal Medicaid money – funds that originally subsidized hospitals that treat the poor – to aid low-income residents in purchasing private health insurance. As of April 2008, it was estimated that 355,000 residents, or likely around one-half of Massachusetts' uninsured population, had registered for coverage. Those who have not acquired insurance, but are considered able to afford it, will see a financial penalty with up to $912 deducted from their 2008 individual personal income tax returns.

A handful of additional states have also implemented universal health care initiatives, though on a smaller scale. For instance, in 2003 Maine passed legislation called Dirigo Health, which works to close an insurance gap that leaves approximately 160,000 residents without coverage. Based on the premise that providing

***Steps Toward Universal Healthcare** continued, page 8*

the housing market has slumped and stalled, and unemployment has increased. From April 2007 to April 2008, the number of unemployed nationally has grown from 6.8 million to 7.6 million and the unemployment rate increased from 4.5% to 5.0%. According to an April 2008 study by the Kaiser Family Foundation, a one percentage point increase in the national unemployment rate adds 600,000 children and 400,000 adults to Medicaid and the State Children's Health Insurance Program (SCHIP), increases Medicaid and SCHIP spending by $3.4 billion, and usually translates into a 3% to 4% drop in state general fund revenues. This creates a two-edged problem for state governments. As revenue collections slow or fall off, the states also face higher Medicaid caseloads and increasing costs.

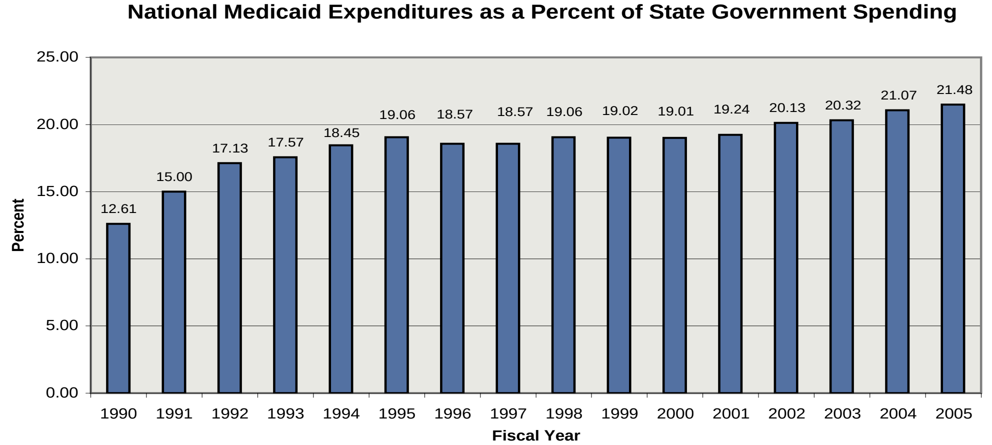
Despite the fact that the federal government provides billions of dollars a year to the states, Medicaid spending continues to be an increasing strain on state budgets. In 1990, Medicaid expenditures comprised 12.61% of total state expenditures, but by 2005 that percentage had increased to 21.48% (see chart). In some states, Medicaid accounts for 25% or more of the state's total expenditures. While Illinois' percentage is not quite that high, fiscal year 2007 Medicaid spending was $11.6 billion, or 21.1% of the $55.1 billion of total appropriated funds spent.

Medicaid Financing: a Federal/State Mix

The Medicaid program is financed by a unique federal and state partnership through which the federal government pays from 50% to 76% of the costs of services provided to Medicaid recipients. The technical term for this rate is the federal medical assistance percentage (FMAP) and it is the percent of federal reimbursement a state receives based on a formula that compares a state's personal income to the national average for three preceding years. The least wealthy states qualify for the 76% matching rate, the wealthiest states qualify for the 50% rate, while others fall in between (see table below).

Technically, Medicaid is a reimbursement program which means that the states must spend funds for medical assistance first. Then the federal government reimburses the states for their eligible Medicaid expenditures at their respective FMAP. For example, if a state spends $100 for eligible Medicaid services and its FMAP is 50%, the federal government would reimburse the state $50. The net effect is that the state contributes $50 and the federal government contributes $50.

National Medicaid Expenditures as a Percent of State Government Spending



Source: Medicaid Expenditures and State Budgets: Past, Present, and Future, *National Tax Journal*, June 2007.

Federal Medical Assistance Percentage (FMAP) Selected States, FFY 2008

State	Percent
Mississippi	76%
New Mexico	71%
Indiana	63%
Iowa	62%
Missouri	62%
Ohio	61%
Michigan	58%
Wisconsin	58%
California	50%
Illinois	**50%**
Minnesota	50%
New York	50%

The U.S. Department of Health and Human Services estimates that federal grants to states for Medicaid will total an estimated $252 billion in fiscal year 2008. In fact, Medicaid is such a large program that it is the source of 44.5% of the all of the federal grant dollars given to the states in a fiscal year.

Overview of Illinois' Medicaid Program

The Department of Healthcare and Family Services (DHFS) is the single state agency for the Medicaid program in Illinois which means that DHFS serves as the state source for submitting claims to the federal government and for receiving federal reimbursements. However, there are many other Illinois governmental entities (counties, school districts, other state agencies, etc.) that administer portions of the program. Some of the other entities include the Department on Aging, Department of Children and Family Services, Department of Corrections, Department of Human Services, Department of Revenue, Illinois Council on Developmental Disabilities, Illinois State Board of Education, University of Illinois, City of Chicago (schools; local public health departments), counties (local public health departments; juvenile probation agencies), and local education agencies (school districts and special education cooperatives).

Total appropriated Medicaid expenditures in Illinois reached $11.6 billion in fiscal year 2007. The majority of that spending (59.7%) came from the General Revenue Fund, but significant expenditures were made from the Cook Coun-

Cover Story continued, page 4

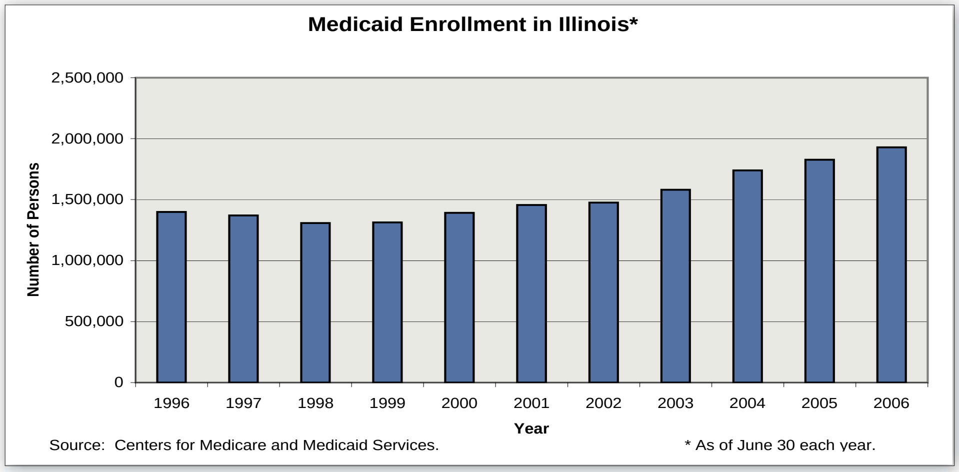
ty Provider Trust Fund (12.6%), the Hospital Provider Fund (10.4%), and the Long Term Care Provider Fund (5.7%). Smaller shares were provided by the Drug Rebate Fund (4.6%) and the Tobacco Settlement Recovery Fund (3.2%). [See article on page 11].

In every state that participates in Medicaid, federal guidelines require the provision of mandatory services to cover certain very low-income children, pregnant women, and some elderly and disabled people. Most importantly, these Medicaid services must be provided at no cost to children and pregnant women, and with nominal co-payments for adults. The federal government interprets this to mean no more than a $3 co-payment. No premiums are charged and no deductibles have to be met before coverage begins. Each state also has the discretion to provide other optional medical services beyond those mandated by the federal government.

Although the federal government provides guidelines for the states to follow, each state has the authority to administer its own program by establishing eligibility standards, determining the type, amount, duration and scope of services, and setting the rate of payment for services. This discretion allows states some control over their spending obligations. For example, some states limit the number of prescriptions, inpatient hospital days, and various therapies a patient can receive each month.

To increase the number of persons receiving medical services, some states have used waivers from the federal government to provide assistance to persons with higher incomes. For example, Governor Blagojevich met resistance when he attempted to unilaterally expand health care without the approval of the legistature's Joint Committee on Administrative Rules (see article on page 2).

The number of Illinoisans enrolled in Medicaid has been steadily increasing since 1998. Figures available from the federal Centers for Medicare and Medicaid Services (CMS) show a slight drop in Illinois' Medicaid enrollment from 1.4 million in 1996 to 1.3 million in 1998, but steady growth since then up to 1.9 million in 2006 (see chart). According to DHFS, 2.1 million people on average per month were covered by Medicaid in fiscal year 2007 (about 2.2 million unique individuals per year, or 17% of the state's population).



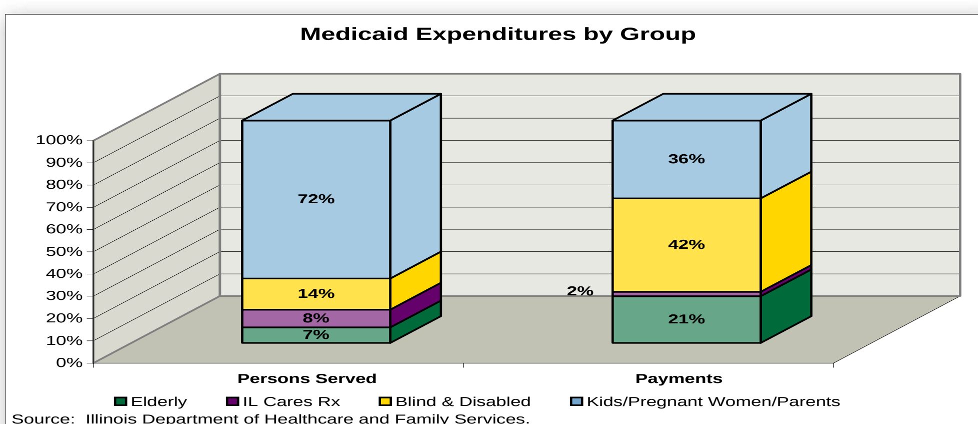
Source: Centers for Medicare and Medicaid Services. * As of June 30 each year.

Children, non-disabled, low-income adults and low-income pregnant women are the largest group representing 72% of the people who receive Medicaid services at some point during the fiscal year. The second largest group is the blind and disabled at 14% followed by Senior Care participants (prescription drug assistance) at 8% and low-income elderly persons with 7%.

Although children as a group are part of the largest component of beneficiaries in Illinois, they do not account for the majority of the spending. The elderly, blind and disabled that are in poorer health and need more services comprise 29% of the beneficiaries but account for 65% of the spending. It is the elderly, blind and disabled that receive the greatest proportion of Medicaid funds.

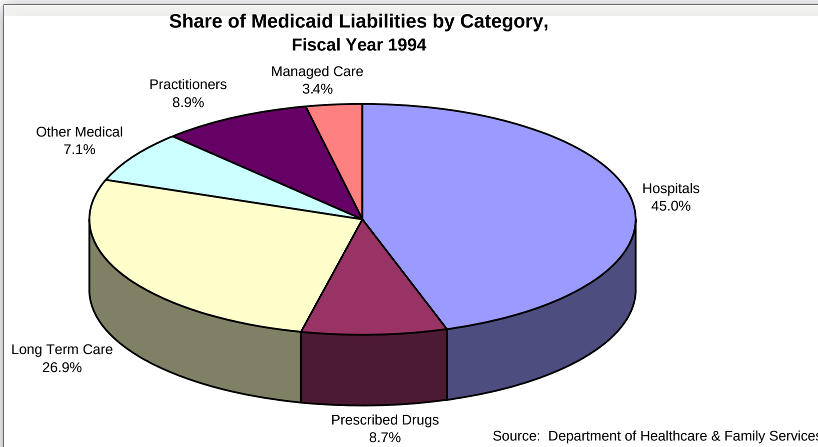
Illinois, like other states, has seen its health care liabilities increase over the years. The continued growth in the Medicaid program has absorbed many of the new revenues available to the state in each fiscal year. This growth can be attributed primarily to health care cost increases, programmatic expansions (such as All Kids and Illinois Cares Rx), and economic difficulties that increase participation.

One way to measure the growth in Medicaid is to look at changes in the program's liabilities over time. The liabilities are essentially the amount incurred for services provided within a fiscal year. The liability amounts eliminate any dou-

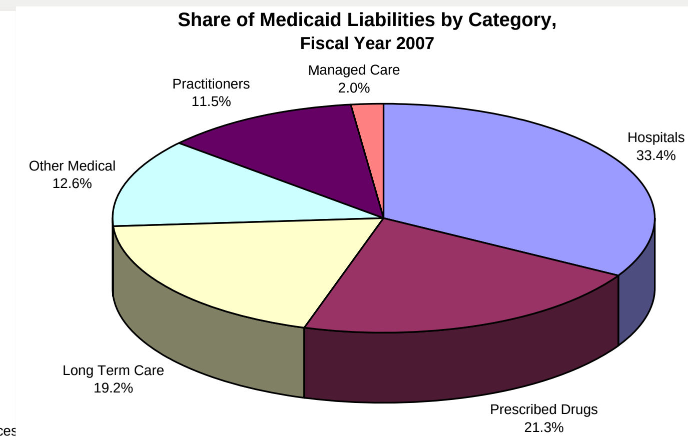


Source: Illinois Department of Healthcare and Family Services.

Cover Story continued, page 5



Source: Department of Healthcare & Family Services



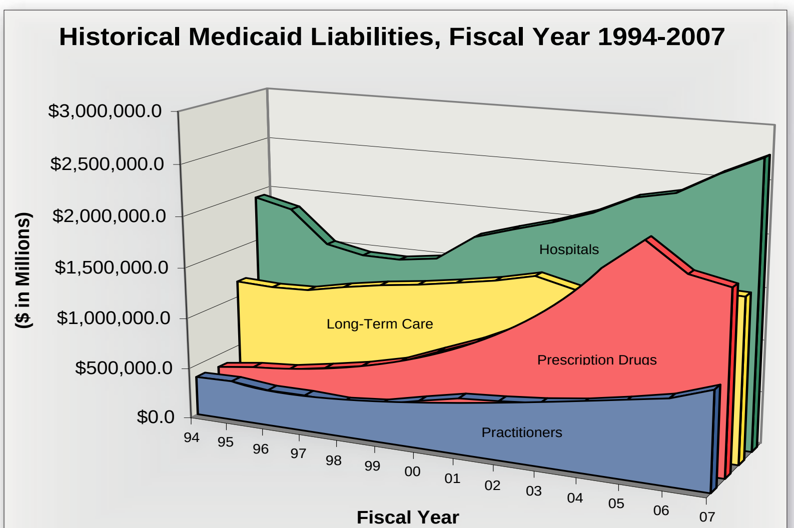
ble counting that might occur in appropriations numbers and adjust for deferred liabilities under Section 25 (see article on page 7). The liability numbers used here exclude the County Provider, Hospital Provider and University of Illinois Hospital Services Funds. Looking back over the last 14 fiscal years, total Medicaid liabilities at DHFS (formerly the Department of Public Aid) grew 91.2% between fiscal years 1994 and 2007, a trend growth of approximately 5.1% a year. However, not all categories of Medicaid increased at the same rate. For example, prescription drugs had the highest rate increase at 366.2% (trend rate = 12.6%), while hospitals and long-term care grew 42.0% (trend rate = 2.7%) and 36.1% (trend rate = 2.4%), respectively.

The chart below shows the growth of Medicaid liabilities for four major categories of services and illustrates the sharp increase for prescription drugs through fiscal year 2005. That trend was broken when the provisions of Medicare Part D went into effect. Although Medicare is a separate program from Medicaid Part D provided prescription coverage for dual eligibles (persons that qualify for both Medicare and Medicaid) which, in turn, reduced the amount of funds that states had to spend for drug coverage. Liabilities for prescribed drugs in Illinois' Medicaid program have dropped from $2.096 billion in fiscal year 2005 to $1.829 billion in fiscal year 2006 to $1.752 billion in fiscal year 2007. However, another provision of the federal legislation establishing Part D, often referred to as the "clawback provision," requires state governments to make payments to the federal government to offset some of their prescription drug savings. From fiscal year 2006 through March 2008, Illinois has made payments to the U.S. Department of Health and Human Services totaling $513 million.

Change in Medicaid Liabilities by Major Category
($ in Thousands)

	FY 1994	FY 2007	Growth 1994-2007	Trend Growth 1994-2007
Hospitals	$1,936,226.8	$2,749,509.0	42.0%	2.7%
Prescription Drugs	375,785.8	1,751,751.5	366.2%	12.6%
Long Term Care	1,158,386.8	1,576,691.0	36.1%	2.4%
Other Medical	303,799.5	1,017,585.2	235.0%	9.7%
Practitioners	382,476.0	945,126.9	147.1%	7.2%
Managed Care	148,240.9	166,065.0	12.0%	0.9%
Renal/Hemophilia/Sexual Assault	0.0	22,224.2	NA	NA
	$4,304,915.8	$8,228,952.8	91.2%	5.1%

Excludes the County Provider, Hospital Provider and U of I Hospital Services Funds.
Source: Department of Healthcare & Family Services



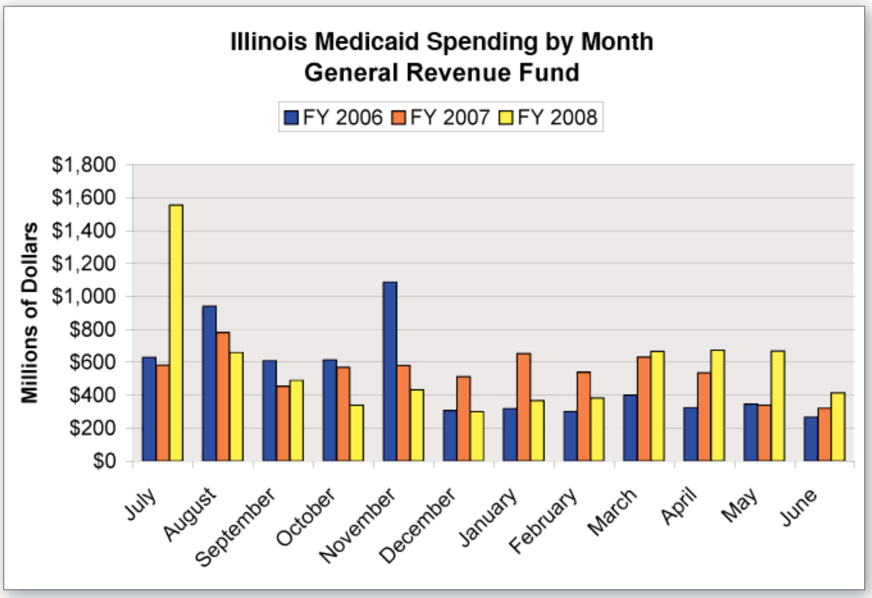
Excludes County Provider, Hosptial Provider and U of I Hospital Services Funds.
Source: Department of Healthcare & Family Services

Surprisingly, the liability for long-term care has not increased as sharply in Illinois, and that may be attributable to the efforts of other state programs. For example, the Department on Aging administers the Community Care Program for persons age 60 and older that provides home and community-based services as an alternative to premature nursing home placements. The Department of Human Services operates the Home Services Program for persons with severe disabilities under the age of 60 that provides homemaker services and personal assistants to try to keep them from moving into nursing homes. There is also a community reintegration component to help disabled persons who live in nursing homes to move back into communities with the services and support they need.

Cover Story continued, page 6

Proposed Federal Regulations

In the midst of an economic slowdown which is already stressing state budgets, the federal government has proposed changes to Medicaid that could pass more costs onto the states if they elect to keep their programs intact. The Centers for Medicare and Medicaid Services (CMS) released proposed rule changes touted to give states "unprecedented flexibility" in administering their Medicaid programs. But public interest groups such as the National Governors Association and the National Conference of State Legislatures are arguing that the proposals would shift billions of dollars in Medicaid costs to the states. Early estimates from CMS suggested that federal payments to the states would be reduced by approximately $15 billion over the next five years, but March 2008 estimates by the Committee on Oversight and Government Reform of the U.S. House of Representatives indicate that states could lose nearly $50 billion over the five-year period.



The proposed changes are included in seven regulations proposed by CMS. Two of the regulations would reduce Medicaid reimbursements for services provided by public hospitals and teaching hospitals. Another regulation would restrict how states can raise revenues to fund their share of Medicaid, and the remaining regulations would narrow the scope of allowable Medicaid coverage for outpatient hospital services, rehabilitation services, school-based administrative and transportation services and case management services.

The proposed rules would:

1) clarify that providers participating in intergovernmental transfers must be part of a unit of government, and impose cost limits on payments to public hospitals and other safety net providers thereby reducing the Medicaid reimbursements they receive (see article on page 9).

2) prohibit federal Medicaid funding for graduate medical education, eliminating support for training medical interns and residents.

3) redefine the types of expenditures that will be considered intergovernmental in nature, revise the meaning of a unit of government and shift to a facility-specific cost structure rather than permitting aggregation by class of provider. Such restrictions on medical provider taxes could reduce the amount of funds raised via provider taxes, thus reducing the level of state matching funds and ultimately the amount of medical services that can be funded.

4) narrow the scope of allowable Medicaid coverage for outpatient clinic and hospital services which could lead providers to limit or eliminate services that were previously reimbursed.

5) narrow the scope of coverage of rehabilitation services for Medicaid-eligible people with disabilities which could, among other things, take money away from counseling and rehabilitation services provided to children in foster care and juvenile justice programs.

6) halt payments for school-based administrative and transportation services which could stop payments for school administrative costs associated with enrolling children in Medicaid and scheduling and coordinating services and bar schools for billing Medicaid for home-to-school transportation for special education students who receive school-based Medicaid services.

7) restrict federal reimbursement for case management services which could unfortunately affect those most in need of such services: namely, the mentally ill, aged or disabled, and children and adults needing protective services.

Opposition to the new rules reached Congress which quickly approved a moratorium on the changes until June 30. A moratorium through March 2009 on six of the seven rules was included in the recent war supplemental spending bill (Public Law 110-252). The remaining rule, covering outpatient hospital services payments, went into effect.

Potential Impact on Illinois

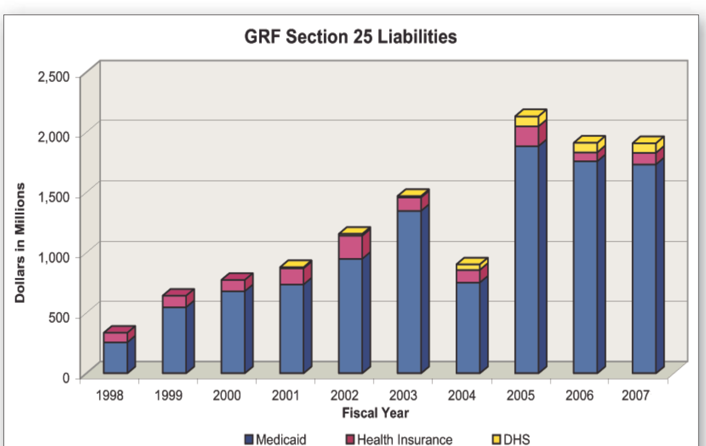
Based on survey responses received from 43 out of 50 state Medicaid directors, the Committee on Oversight and Government Reform estimates that states could lose nearly $50 billion over a five-year

Cover Story continued, page 16

The Section 25 Budget "Loophole"

Section 25 of the State Finance Act requires that expenditures for liabilities incurred within a given fiscal year be paid from that same year's appropriation. Therefore, all payments related to a specific fiscal year should be paid by the close of the state's lapse period two months after the end of the fiscal year. The Act goes on to provide exceptions to the fiscal year limitation. These exceptions are made for liabilities such as Medicaid, state employee and retiree health insurance and certain spending from the Departments of Human Services and Public Health. The exceptions are referred to as "Section 25 liabilities" and are paid from a future year's appropriation, creating a significant budgetary "loophole".

For the past several years, significant amounts of General Revenue Fund (GRF) liabilities have been carried over into the next fiscal year. (It should be noted that GRF Section 25 liabilities do not include all Medicaid liabilities and that total Medicaid liabilities are generally higher than the total for GRF liabilities.) Deferred GRF liabilities experienced a five-fold increase, growing from $337 million in fiscal year 1998 to $1.9 billion in fiscal year 2007 (see chart). GRF Medicaid liabilities account for most of the Section 25 liabilities and represent the driving force behind the growth in these liabilities. Of the $1.9 billion in Section 25 liabilities in fiscal year 2007, over $1.7 billion was due to Medicaid.



The fiscal year 2007 GRF Medicaid liabilities are a six-fold increase from the $257 million in liabilities at the end of fiscal year 1998 as deferrals generally increased over the early part of the last 10 years. In fiscal year 2004 GRF Medicaid deferred liabilities decreased to $753 million, but that followed short-term borrowing of $850 million in June 2004 specifically to pay Medicaid bills to take advantage of the temporary higher federal Medicaid match rate. Without the borrowing, Section 25 liabilities for fiscal year 2004 would have been higher and spending would have carried over into fiscal year 2005. Appropriations were reduced for GRF Medicaid in fiscal year 2005 and that was the primary reason Medicaid liabilities increased to almost $1.9 billion at the end of that year. Fiscal years 2006 and 2007 showed a small reduction in the amount of GRF Medicaid liabilities, but still remain far higher than they were in the early part of the decade.

Health insurance liabilities totaled $93 million at the end of fiscal year 2007, an increase of $13 million or 16.3% over fiscal year 1998 liabilities of $80 million. Over the past decade, health insurance liabilities have fluctuated from a low of $74 million in fiscal year 2006 to a high of $192 million in fiscal year 2002. Department of Human Services Section 25 liabilities have increased from $10 million in fiscal year 2001 to $80 million in fiscal year 2007.

Section 25 was used initially to help Medicaid vendors by allowing the state to make payments if vendors' bills arrived or were adjudicated after the close of the state's lapse period (eliminating the need and delays of the Court of Claims process).

Although the intentions behind Section 25 were to deal with a specific problem, it has evolved into a budgeting tool. It provides a "cushion" so that when the state has fiscal difficulty, the state can budget an insufficient amount of Medicaid appropriations to cover the costs for a given fiscal year knowing that any remaining bills will be paid from the next year's appropriations. The budget can still appeared balanced on a cash basis, as expected revenues are enough to cover expected expenses, without the state providing sufficient funding for the Medicaid program.

Using this ability to defer bills to future years also creates a budget hole for the next year that is difficult to climb out of. This was quite apparent in fiscal year 2005 when overall GRF spending was increased from fiscal year 2004 (appropriations up $353 million) while GRF Medicaid expenditures were reduced (appropriations down $505 million). So non-Medicaid spending increased in fiscal year 2005 with appropriations up $858 million and, as a result, deferred spending under Section 25 increased by over $1 billion.

As the decline in fiscal year 2004 liabilities demonstrates, current Section 25 liabilities are due to insufficient funding and well in excess of the amounts for which the Section 25 Act was intended.

One of the repercussions of insufficient funding is the state must delay payments to providers. In some cases these delays can extend several months. In the Auditor General's May 2008 audit of the Medicaid Payment Process, DHFS officials said that payments are delayed throughout the year to ensure that they do not run out of appropriation authority to meet critical essential payments, and that they are limited by the amount appropriated to them. The report noted that it took DHFS an average of 57 days to submit claims for payment to the Comptroller. ■

health care to all will help recapture some of the $270 million now lost in emergency room and uncompensated care, Maine hopes to insure all residents by 2009, although the program is strictly voluntary.

In addition to questions over how many individuals will participate in universal health care programs, funding the sizeable costs of such programs remains the major roadblock to their success in both Maine and Massachusetts. Maine's Dirigo Health has enjoyed both successes and setbacks over the last few years. It has supplied thousands of residents with subsidized health care, but enrollment had to be capped due to lack of funding. While Maine recently passed a new tax on beer, wine, and soda, as well as an increased tax on claims paid by insurance companies and the self-insured to provide additional money to its program, it is unclear if this will be a long-term solution. At its one year anniversary (July 1, 2008), Massachusetts' program had cost the state $625 million, up significantly from the $472 million that was estimated. Low-income residents who qualify for low or no cost coverage are the primary reason for the increase in spending. So as of July 2008, Massachusetts was looking to plug a $100 million hole in its health care budget. Proposals to close the hole include higher premiums and a higher cigarette tax, and the Governor is pushing for additional penalties on businesses not offering health coverage to all workers, an assessment on insurance companies' reserve accounts, and more support from hospitals.

Whether or not full implementation of universal health care programs can be achieved without a broad-based tax increase on businesses and individuals is uncertain. Concerns over financing problems are the primary reasons that similar proposals ran aground last year. Though two-thirds of state governors proposed plans to reduce the number of uninsured in 2007, apprehension over cost, along with opposition from insurance companies and other business lobbies, halted most proposals.

Last year in Illinois, for instance, Governor Rod Blagojevich proposed funding a universal health care plan through a 3% payroll tax and a gross receipts tax on Illinois businesses earning more than $1 million in annual receipts. This funding mechanism was contentious because it would have applied not only to a business's profits, but to all of its receipts and was seen by many as potentially devastating to Illinois' business community. The inability to find an agreeable source of financing for the program led to an impasse between the Governor and the legislature. Eventually, Governor Blagojevich took unilateral action, expanding enrollment for state health care programs without approval of the legislature or a way to pay for it. A lawsuit questioning Blagojevich's constitutional authority to widen eligibility for the state's subsidized insurance programs was filed, and in April 2008, an injunction against the expansion of the FamilyCare Program was issued.

In other states, Governor Edward Rendell of Pennsylvania failed to convince his legislature to cover the state's 900,000 uninsured through an employer assessment, while the voters of Oregon defeated a tobacco tax referendum which would have expanded children's health care. The most notable proposal to fail, however, was the bipartisan measure introduced in California.

If passed, this compromise legislation would have achieved near universal coverage for Californians. According to the National Conference of State Legislatures, the legislation would have included an individual insurance mandate with sliding scale subsidies to families under 250% of the federal poverty level and sliding scale tax credits for those up to 400%. It would have expanded eligibility for California's Medicaid program, required insurers to sell plans no matter the risk, limited premiums to a percentage of income, and required health plans to offer benefits for healthy behavior and chronic care management. Funding mechanisms for this plan would have included employer contributions, state and federal funds, a new hospital fee, and a tobacco tax increase. Had it succeeded, this legislation would have been the largest universal health care initiative of its kind. However, the state's Senate Health Committee rejected the plan in January 2008 over the enormous cost and long-term financing concerns, while the state is currently dealing with an enormous deficit.

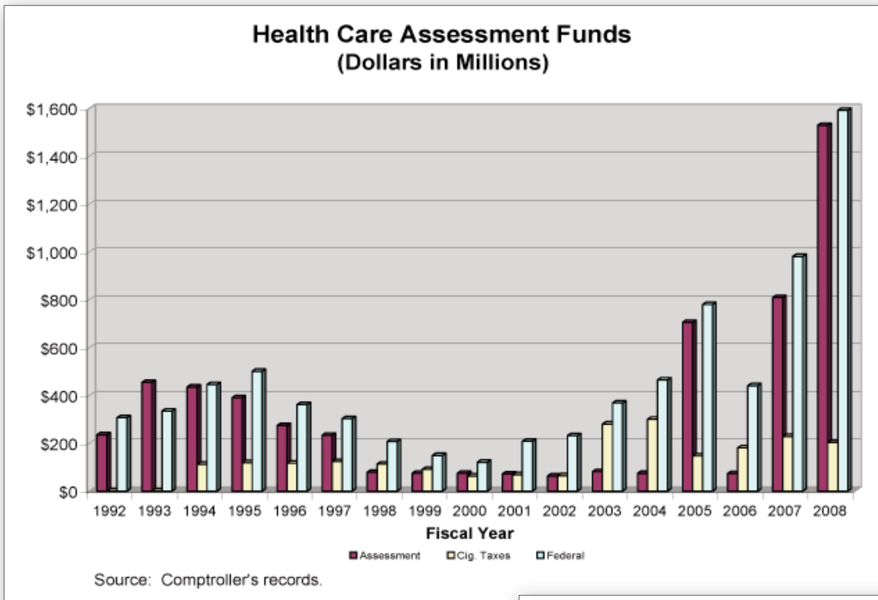
Despite the uphill battle, some states succeeded recently in passing legislation to expand health care. On July 8th of this year, New Jersey took the first step toward universal health care by expanding its subsidized health insurance program and mandating that all children have coverage by July of 2009. Connecticut's Charter Oak Program, which began accepting applicants on July 1, 2008, provides health insurance for residents who are between the ages of 19 and 64, are not eligible for other state health insurance programs, and have been without coverage for at least six months. And despite heavy opposition to a proposed insurance mandate, New Mexico Governor Bill Richardson signed a law this March which makes it harder for insurance companies to rescind coverage when patients develop serious medical conditions.

Kansas, subject to budget appropriations, will increase SCHIP eligibility from 200% of the Federal Poverty Level to 250% over the next two years. Colorado's Centennial Care Choices requires insurance companies to develop low-cost health insurance plans for those residents who earn too much to qualify for Medicaid but are not covered by private insurance. Minnesota's Health Care Transformation Task Force, a panel of appointed health care experts, has been given the task of developing a universal health care plan by 2011, while the state of Washington hopes to achieve universal health care coverage for all of its residents by 2012, beginning with the expansion of SCHIP, the ability of families with higher incomes to buy into public programs, and coverage for all immigrant children.

In Illinois, Governor Blagojevich renewed his efforts to expand healthcare in his fiscal year 2009 budget address, proposing again a 3% payroll tax on employers to pay for the expansions. Whether any of this legislation will pass is thus far unknown; however, it seems apparent that more and more states are trying to move toward universal health care in the absence of a sweeping federal plan. ■

Medicaid Provider Assessments and Intergovernmental Transfers

Providers of medical services are tapped through Medicaid assessments and intergovernmental transfers (IGTs) to help meet the growing costs of the Medicaid program. On average, providers benefit from helping fund Medicaid as their payments are returned with additional federal reimbursements that allow the state to raise rates and increase Medicaid payments.

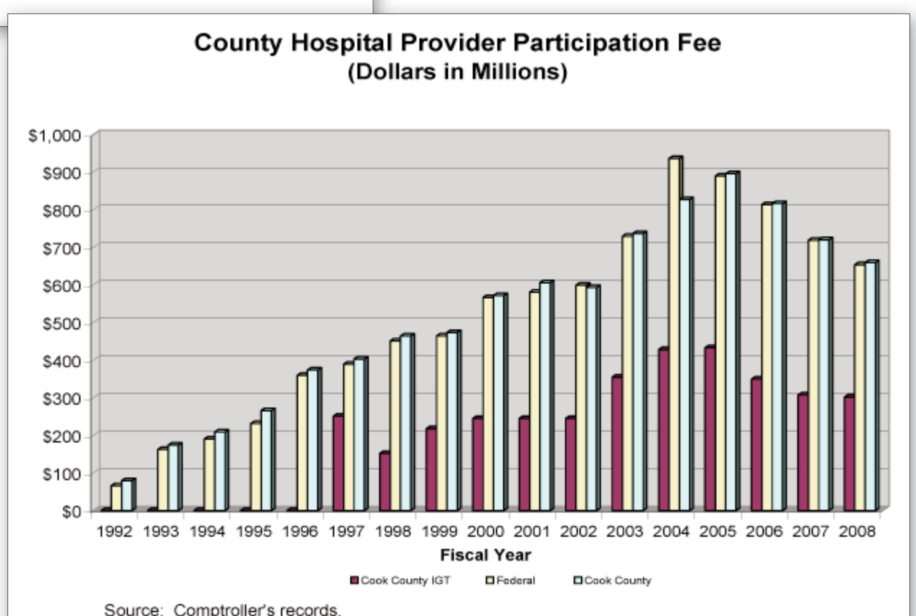


Hospital Assessments

In fiscal year 1992, Illinois first imposed provider assessments on private hospitals as a source of Medicaid matching funds. The original hospital assessment was equal to 5% of fiscal year 1991 (the base-year) Medicaid spending plus 50% of the difference between the hospital's anticipated annualized spending and its total base-year Medicaid spending. Due to changes in the federal law, the assessments had to be amended in fiscal year 1993 to become general levies on hospital providers with no relation to Medicaid payments. The new assessment rate was 2.5% of hospital revenues during most of fiscal year 1993 declining to 1.25% of revenues at the end of fiscal year 1997 when the hospital provider assessment was eliminated. During the five-year period this fee was in effect, $1.4 billion in revenues was collected and was matched by $1.3 billion in federal aid.

A second hospital assessment was imposed for fiscal years 2004 and 2005 at a rate of $84.19 per occupied bed day. Deposits of $637 million from this assessment were matched by $508 million in federal contributions in fiscal year 2005.

The latest hospital assessment, enacted in 2005, imposed a 2.5835% fee on each provider's inpatient and outpatient adjusted gross hospital revenue for fiscal years 2006 through 2008. The collections of these assessments occurred in fiscal years 2007 and 2008. In fiscal year 2007, deposits of $733 million from the assessment were matched by $614 million in federal contributions. Two years worth of assessments were collected in fiscal year 2008 with $1.463 billion in assessments supplemented by $1.199 billion in federal matching funds.



Cook County and University of Illinois Intergovernmental Transfers

Consistent with federal law, Illinois has also used intergovernmental transfers to support Medicaid services. As the name implies, an IGT is a payment between government entities. When local and university health care entities transfer funds to the state under a federally approved IGT, these monies can be used for expanded Medicaid payments supplemented by federal matching funds. IGTs have had an additional attraction as Upper Payment Limits allowed Medicaid payments to providers to exceed the cost of service as long as payments do not exceed what Medicare would have paid for the services.

In the largest Illinois IGT, Cook County makes contributions based on a federal law that provides that local governments may

Medicaid Provider continued, page 10

Medicaid Provider concluded from page 9

contribute up to 60% of the state's share of Medicaid program costs. Illinois is one of many states that have long-standing arrangements for significant local funding. The federal financial participation from this program helps fund the Cook County Bureau of Health Services, which is the third largest local government hospital system in the United States and is the largest provider of medical care to the uninsured, underinsured, and Medicaid populations in Illinois. Federal regulations issued in 2001 contained a phased reduction of the higher Medicaid reimbursement rates using Upper Payment Limits. However, supplemental federal payments are available to Cook County's hospitals. This is to avoid the serious impact a drastic reduction in resources would have on these hospitals that serve a large portion of Medicaid and indigent patients.

Based upon claims for services to Medicaid-eligible individuals and a formula in state law, Cook County makes payments to the County Provider Trust Fund. Matching federal funds are drawn, and Medicaid payments are made to the county's hospitals and clinics. In fiscal year 2008, Cook County paid $660 million to the state to support the Medicaid program which was matched by $654 million in federal aid deposited into the County Provider Trust Fund. These deposits allowed Medicaid payments of $1.250 billion from this fund. The Cook County IGT peaked at around $900 million per year in fiscal years 2004 and 2005 with the ensuing reduction reflecting the impact of the 2001 federal regulations.

The University of Illinois IGT is based on federal regulations that set maximum payments to state-owned hospitals. A contribution from the University of Illinois, an annual $45 million General Revenue Fund transfer, and the federal financial participation are deposited into the University of Illinois Hospital Services Fund. This balance is then used for reimbursement to the University of Illinois Hospital. In fiscal year 2008, $78 million from the University of Illinois plus a $45 million transfer from the General Revenue Fund were matched by $148 million in federal aid. These monies allowed payment of $245 million for the University of Illinois hospital and a $26 million transfer to the General Revenue Fund.

Other Assessments and IGTs

The other current assessment programs are levied on nursing homes and ICFs/MRs (intermediate care facilities for the mentally retarded). These assessments started at 15% of prior year receipts in fiscal year 1992 and have since been replaced with a quarterly $1.50 per-bed per-day nursing home license fee and an assessment of 6% of ICFs/MR revenue. These fees have generated around $50 million annually into the Long Term Care Provider Fund and around $20 million annually into the Care Provider Fund for Persons with Developmental Disability.

Starting in fiscal year 1994, cigarette revenues not assigned to other funds have also been deposited into the Long Term Care Provider Fund. In fiscal year 2004, counties that operate nursing facilities agreed to contribute to the Medicaid costs of residents through IGTs. These agreements reduced the gap between Medicare and Medicaid rates for these nursing homes.

In fiscal year 2008, the Long Term Care Provider Fund received $48 million from assessments, $203 million from cigarette taxes, $43 million from county nursing home IGT agreements, $60 million in transfers from the Hospital Provider Fund, and $372 million in federal matching funds and spent $726 million for skilled and intermediate long term care. The Care Provider Fund for Persons with Developmental Disability received $19 million in fee revenues matched by $21 million in federal aid and spent $43 million for intermediate care facilities and alternative community programs through the Department of Human Services.

Conclusion

Although always at risk of federal cost cutting pressures as the federal government attempts to get its budget in order, revenues from special assessments and IGT agreements have provided vital funds to meet the ever growing needs of the Medicaid program. Assessment revenues reached a record level of $1.529 billion in fiscal year 2008. IGT revenues from Cook County, the University of Illinois, and counties that operate nursing homes peaked at $1.031 billion in fiscal year 2005 and have since fallen to $781 million for fiscal year 2008. When combined with federal matching funds and $203 million from dedicated cigarette taxes, these revenue sources generated $2.02 billion in Medicaid expenditures (this figure excludes the small amount of additional fiscal year 2008 expenditures that could be made during lapse period), $245 million in reimbursements to U. of I. hospital plus additional reimbursements to county nursing homes, and $328 million to the General Revenue Fund in support of Illinois' Medicaid program.

Efforts are underway to continue the hospital assessment program. A new plan that applies to fiscal years 2009 thru 2013 has passed the General Assembly and is waiting approval by the Governor. Once passed into law, federal approval will be necessary before federal funds will be made available. The new assessment rate is $218.38 annually per occupied hospital bed excluding Medicare beds paid in twelve equal monthly installments. ■

Medical Assistance Spending

In fiscal year 2007, appropriated spending for medical assistance administered by the Department of Healthcare and Family Services totaled more than $11.6 billion, over $6.1 billion or 110.8% higher than the $5.5 billion spent ten years ago in fiscal year 1998. Growth in spending from the General Revenue Fund of $2.8 billion or 68.3% accounted for 46.1% of the growth while spending from other funds increased $3.3 billion or 237.1% accounting for 53.9% of the increase.

The largest portion of spending was paid to hospitals. Nearly $2.6 billion was paid to hospitals from the General Revenue Fund with an additional $1.5 billion paid from the County Provider Trust Fund, $1.2 billion from the Hospital Provider Fund, and $225 million from the University of Illinois Hospital Services Fund. Together, $5.5 billion went to hospitals in fiscal year 2007 accounting for 47.4% of all medical services expenditures by the state.

The second largest portion of medical spending by the state was for prescription drugs. With $698 million from the General Revenue Fund, $536 million from the Drug Rebate Fund, and $375 million from the Tobacco Settlement Recovery Fund, a total of $1.609 billion was spent by the state in fiscal year 2007 for drugs. The $1.609 billion accounted for 13.8% of total state medical spending.

Long-Term Care also garners a significant portion of medical spending. In fiscal year 2007, $1.514 billion was spent for this purpose accounting for 13.0% of total state spending. Slightly over $852 million in spending was from the General Revenue Fund with a little over $661 million from the Long Term Care Fund. Altogether Hospital, Drug and Long-Term Care Spending accounted for 74.2% of total medical spending in fiscal year 2007.

In fiscal year 2008, appropriated spending for medical assistance (through July 9th) has totaled more than $13.4 billion, $1.8 billion or 15.5% higher than fiscal year 2007. Of the $1.8 billion increase, $1.2 billion was from the Hospital Provider Fund due to higher spending on the Hospital Provider Assessment Program. Spending for the General Revenue Fund was up slightly over $800 million to $7.756 billion, an increase of 11.5%.

Medical Expenditures
(Dollars in Millions)

General Revenue Fund	Fiscal Year 1998	Fiscal Year 2007	Change Amount	Change Percent
Hospital Inpatient	$1,411.9	$2,579.3	$1,167.4	82.7 %
Prescribed Drugs	582.8	698.1	115.3	19.8
Long Term Care	917.2	852.4	-64.8	-7.1
Physicians	320.6	767.0	446.4	139.2
Department of Human Services	296.8	409.1	112.3	37.8
HMO's	231.0	216.1	-14.9	-6.5
Medicare Part B	79.6	236.3	156.7	196.9
Comm. Health Centers	71.2	235.9	164.7	231.3
Dentists	33.0	157.0	124.0	375.8
Institutions for Mental Diseases	0.0	126.3	126.3	N/A
Transportation	52.1	94.4	42.3	81.2
Appliances	32.7	71.9	39.2	119.9
DSCC	0.0	60.5	60.5	N/A
Supportive Living Facilities	0.0	58.8	58.8	N/A
Home Health	52.8	49.5	-3.3	-6.3
Hospice Care	21.4	55.0	33.6	157.0
Independent Labs	13.7	43.8	30.1	219.7
Optometrists	2.1	18.8	16.7	795.2
Medicare Part A	13.4	21.6	8.2	61.2
Medicare Part B Expansion	0.0	13.9	13.9	N/A
Podiatrists	0.4	3.9	3.5	875.0
Chiropractors	0.1	1.5	1.4	1,400.0
Other Related Medical	51.4	182.7	131.3	255.4
Total, General Revenue Fund	$4,132.8	$6,953.8	$2,821.0	68.3 %
Other Funds				
Cook County Provider	920.6	1,464.6	544.0	59.1
Long Term Care Provider	288.8	661.1	372.3	128.9
Drug Rebate	0.0	535.7	535.7	N/A
Tobacco Settlement Recovery	0.0	374.7	374.7	N/A
U of I Hospital Services	115.8	225.0	109.2	94.3
Special Education Medicaid Matching	0.0	120.2	120.2	N/A
Family Care	0.0	25.0	25.0	N/A
Care Provider Fund for Persons with DD	31.5	40.0	8.5	27.0
Hospital Provider Fund	19.3	1,215.2	1,195.9	6,196.4
Other	16.2	32.2	16.0	98.8
Total, Other Funds	$1,392.2	$4,693.7	$3,301.5	237.1 %
Total, Medical Spending All Funds	$5,525.0	$11,647.5	$6,122.5	110.8 %

Source: Comptroller and Department of Healthcare and Family Services records.

Note: the dollar amount of appropriated expenditures for medical assistance shown here is larger than the dollar amount for Medicaid liabilities discussed in the cover story. The reported liability amounts are lower because they exclude spending related to the County Provider, Hospital Provider and the University of Illinois Hospital Services funds. The appropriated expenditure amounts include all expenditures for medical assistance from many state funds including the County Provider Fund, the U of I Hospital Services Fund, and other funds as shown at the bottom of the table. Also, the expenditures reflect bills presented for payment within a given fiscal year. Delaying bills or catching up on bills as allowed under Section 25 of the State Finance Act can create situations where liabilities do not match expenditures (see article on page 7). For a more detailed explanation of the intergovernmental transfer programs associated with Cook County and the University of Illinois and how they increase the amount of funds available to be spent for medical assistance, see the article on page 9. ■

Medically Uninsured in the United States

Of the 299 million people estimated to have been living in the United States in 2006, 47 million representing 15.8% of the population had no health insurance according to the 2007 Annual Social and Economic Supplement to the Current Population Survey conducted by the US Census Bureau.* For the 84.2% that were insured, the majority obtained it through their employer, a small percentage purchased health insurance individually, and the remaining insured persons received their health insurance coverage through a government funded program. According to the Institute of Medicine of the National Academy of Sciences, the United States is the only wealthy, industrialized nation that does not have a universal health care system.

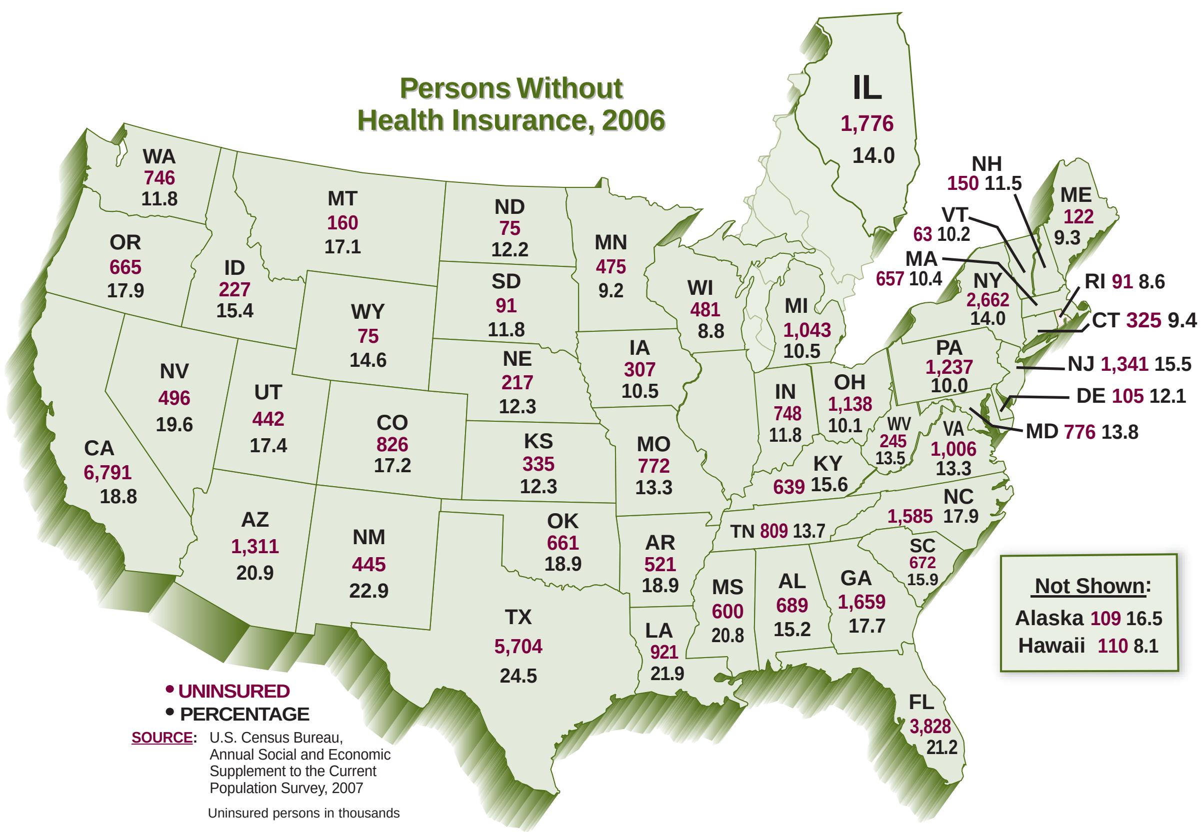
Based on estimates available from the Census Bureau, Illinois ranked 24th with 14.0% of its population (1.8 million persons) being uninsured in 2006. Texas, at 24.5%, had the highest rate of uninsured residents, while Hawaii boasted the lowest number of uninsured residents at 8.1%.

Illinois had a higher percentage of uninsured population than other Midwestern states. Missouri ranked 29th with 13.3% of its population being uninsured and Indiana ranked 35th with an uninsured population of 11.8%. Iowa tied with Michigan and ranked 39th with 10.5% of its population being uninsured. Minnesota and Wisconsin ranked 47th and 48th respectively with 9.2% and 8.8% uninsured populations.

Large urban states were mixed as well. California ranked 10th with 18.8% and New York tied Illinois for 24th with 14.0%. On the lower end of the scale, Ohio and Pennsylvania ranked 43rd and 44th respectively with 10.1% and 10% of their populations being uninsured. As can be seen from the map, states in the South and West tend to have higher percentages of medically uninsured people than states in the Midwest and Northeast.

The number of uninsured persons in the United States continued to increase. In 2001, 39.8 million people (14.1% of the population) were uninsured, compared to 47.0 million people (15.8%) in 2006. Oregon showed the largest percentage point increase in its uninsured population going from 12.8% to 17.9%. Washington boasted the largest percentage point decrease going from 13.0% to 11.8%. From 2001 to 2006, Illinois' estimated number of uninsured persons increased from 1.6 million to 1.8 million persons, and its percentage of uninsured increased from 13.1% to 14.0%. ■

* *The Annual Social and Economic Supplement to the Current Population Survey is conducted in February, March and April, and the estimate of the number of people without health insurance more closely approximates the number of people who were uninsured at that specific point in time rather than the number of people uninsured for the entire year.*



A Brief Overview of All Kids

All Kids, Illinois' health insurance program for children that began on July 1, 2006, is the new name for the former KidCare program that was initiated back in 1998. Congress enacted the State Children's Health Insurance Program (SCHIP) in 1997 to address the growing number of uninsured children by providing grants to the states to expand health insurance coverage to children whose families earned too much to qualify for Medicaid. Illinois responded by establishing the KidCare program in 1998.

SCHIP did not replace Medicaid. Rather, SCHIP covered uninsured children who were not eligible for state Medicaid programs, including children who were older than Medicaid-covered children, or whose families had higher incomes than that of Medicaid-eligible children. The federal law gave states three options for providing insurance coverage for children. States could use federal funds to support a separate children's health insurance program, or they could expand coverage available under Medicaid up to 200 percent of the federal poverty level, or use a combined approach. Illinois chose a combination of both with KidCare; expand Medicaid and establish a separate program.

Timeline in Illinois

Before KidCare, children age 5 and older were eligible only if their family income was at or below 100% of the federal poverty level (FPL). In 1998 the KidCare program included all children if their family income was up to 133% of the FPL. The next year KidCare expanded the eligibility requirements to children in families with income up to 185% of the FPL. Due to this expansion, KidCare enrollment increased over several years by 162%. Starting in 2003, KidCare expanded again to 200 percent of the FPL and enrollment increased over the next few years by 24%.

Beginning in 2006, Kidcare was revamped to provide comprehensive health insurance for every child in Illinois and renamed All Kids. Children in families with incomes up to 200% of the FPL are eligible regardless of available insurance, and children in families with incomes above 200% of the FPL are eligible if they have been uninsured for 12 months. All Kids also offers health care coverage to pregnant women and their babies and helps subsidize employer or private insurance plan premiums for certain families with limited incomes.

The Department of Healthcare and Family Services claims that 1.3 million children were enrolled in All Kids in fiscal year 2007, and 8.3% increase over the 1.2 million in fiscal year 2006.

Program Summary

Children can get health insurance through the All Kids program if they live in Illinois, are under the age of 19, and meet the insurance requirements. Uninsured children in families at any income level are eligible for direct coverage. Children with health insurance are eligible for All Kids if their family income is less than 200% of the FPL. Premiums and cost-sharing are determined by family income relative to the FPL and family size.

All Kids consists of five plans: All Kids Assist, All Kids Share, All Kids Premium, Moms and Babies, and All Kids Rebate. Reading down the columns on the accompanying chart provides a summary of the health insurance costs associated with differing family sizes and income levels.

For example, a family of four with a gross annual income of $28,000 ($2,333/month) would qualify for All Kids Assist and would not have to pay any premiums or co-payments for their children. However, a family of four that has a $60,000 annual income ($5,000/month) would qualify for All Kids Premium Level 2 and would have to pay a monthly health insurance premium of $80 and a maximum of $500 per child for hospital costs.

All Kids Health Insurance - Income Limits and Cost Sharing

Income Qualifications - Monthly Income Limits by Family Size										
Family Size	All Kids Assist [1]	All Kids Share [2]	Premium Level [3]						Moms & Babies [4]	All Kids Rebate [5]
			Level 1	Level 2	Level 3	Level 4	Levels 5-7	Level 8		
1	Up to $1,153	$1,154 – 1,300	$1,301 – 1,733	$1,734 – 2,600	$2,601 – 3,467	$3,468 – 4,333	$4,334 – 6,933	$6,934 or more	NA	$1,154 - $1,733
2	Up to $1,552	$1,553 – 1,750	$1,751 – 2,333	$2,334 – 3,500	$3,501 – 4,667	$4,668 – 5,833	$5,834 – 9,333	$9,334 or more	$0 - $2,333	$1,553 - $2,333
3	Up to $1,951	$1,952 – 2,200	$2,201 – 2,933	$2,934 – 4,400	$4,401 – 5,867	$5,868 – 7,333	$7,334 – 11,733	$11,734 or more	$0 - $2,933	$1,952 - $2,933
4	Up to $2,350	$2,351 – 2,650	$2,651 – 3,533	$3,534 – 5,300	$5,301 – 7,067	$7,068 – 8,833	$8,834 – 14,133	$14,134 or more	$0 - $3,533	$2,351 - $3,533
5	Up to $2,749	$2,750 – 3,100	$3,101 – 4,133	$4,134 – 6,200	$6,201 – 8,267	$8,268 – 10,333	$10,334 – 16,533	$16,534 or more	$0 - $4,133	$2,750 - $4,133
Costs - Monthly Premiums and Annual Co-Payments										
Monthly Premium	None	None	1 child: $15. 2 children: $25. Ea. add'l child: $5.	$40 per child	$70 per child	$100 per child	$150 – 250 per child	$300 per child	None	Private or Employer's Plan
Max Monthly Premium	N/A	N/A	$40 for 5 or more children	$80 for 2 or more children	$140 for 2 or more children	$200 for 2 or more children	No cap	No Cap	None	Private or Employer's Plan
Max per Child per Year Co-Payments	No co-payments	$100 per family for all services	$100 per family for all services	$500 per child for hospital services	$750 per child for hospital services	$1,000 per child for hospital services	$5,000 per child for hospital services	No Max	None	Private or Employer's Plan

Source: Illinois Department of Healthcare and Family Services, updated for 2008.

All Kids Program Components

[1] All Kids Assist - family income less than 133% of the federal poverty level.

[2] All Kids Share - family income 134%-150% of the federal poverty level.

[3] All Kids Premium - family income greater than 150% of the federal poverty level. Level 1 = 151-200%, level 2 = 201-300%, level 3 = 301-400%, level 4 = 401-500%, etc.

[4] All Kids Moms & Babies - no co-payments or premiums for pregnant women and their babies up to one year of age with family income of up to 200% of the federal poverty level.

[5] All Kids Rebate - full or partial reimbursement (up to $75 per person per month) of private health insurance premiums with family income of 134% - 200% of the federal poverty level.

Medicaid Legislation in Illinois

Medicaid has become the nation's number one source of public health insurance for low income families, the disabled and poor senior citizens. National statistics from fiscal year 2007 estimate that 44 million people in low-income families are Medicaid recipients and nearly 14 million elderly and disabled people benefit from Medicaid. In Illinois, there are more than 2 million people enrolled in Medicaid. The public healthcare program is jointly financed with state and federal funds; and in Illinois, Medicaid is administered by the Department of Healthcare and Family Services.

As discussed in the cover story, the states have a certain amount of leeway in structuring their Medicaid program. Among other areas, states have flexibility in covered services, who will be eligible and determining reimbursement rates to providers. As a result, each state has a wide variety of Medicaid related issues addressed by proposed legislation.

State Issues

One issue concerns the state failing to pay Medicaid providers on time. In Illinois under Section 25 of the State Finance Act, the state can pay Medicaid providers the following year which helps to "balance" the state budget. Essentially, Medicaid debt from one year is allowed to roll over into the following year. For the last few years, well over $1.0 billion in Medicaid bills has been carried over to the following fiscal year. Deferring Medicaid payments not only increases the likelihood that providers will not get paid on time, but some evidence suggests that the substantial delays in reimbursement has forced providers to stop treating new Medicaid patients. [See article on Section 25 Deferred Liabilities.]

Other Medicaid issues under discussion in Springfield recently include expansion of coverage to additional beneficiaries, increase in reimbursement rates to providers, and increasing the number of services covered by Medicaid. As discussed in the story on page 2, Governor Blagojevich has proposed expansions of health care coverage to most of Illinois' uninsured. Additionally, care providers such as hospitals, doctors, and dentists continue to lobby for higher reimbursements when services are provided to Medicaid patients as reimbursements from Medicaid are generally lower than those from private insurance or Medicare.

Proposed Medicaid Legislation

Within the last couple of years there have been several attempts by members of the Illinois General Assembly to reform Medicaid. Several bills filed with the 95th Illinois General Assembly (2007-2008) have attempted to modify portions of the Illinois Medicaid program.

The first of these is House Bill 3397 which is legislation that was drafted by Comptroller Dan Hynes and introduced by Representative William Davis. This legislation amends Section 25 of the State Finance Act to eliminate the ability to carryover certain bills into future fiscal years. Instead, it allows payment during a 4-month lapse period after the end of the fiscal year for Medicaid and certain other bills, an extension of the traditional two month lapse period. Despite passage by a committee in the spring of 2007, it remains in House Rules.

Senate Bill 292 was introduced in the spring 2007 legislative session. Senate Bill 292 amends Section 25 of the State Finance Act concerning the carryover of certain types of bills to future fiscal years. It eliminates this Section 25 "loophole" on June 30, 2010. This bill and the identical Senate Bill 2060 have been referred to the Rules Committee with no further action.

Another bill that seeks to address Medicaid payment reform was Senate Bill 1533 which was introduced in the Illinois Senate in early February 2007. This bill amends Section 25 of the State Finance Act by providing a cap of the dollar amount of bills that can be carried over into future fiscal years under the Section 25 loophole. This cap gradually ramps down with a complete phase out by fiscal year 2017. Beginning in fiscal year 2018, Medicaid and other specific bills are allowed to be handled in a 3 month lapse period, a small extension beyond the traditional lapse period. This bill was referred to the Rules Committee where it has not moved.

Several bills were proposed to provide rate enhancements for various Medicaid providers or work to expand the number of people covered. These bills were discussed this spring but there was not final action on them. Among these, Senate Bill 2403 provides enhancements for long-term care facilities. Senate Bill 2492 focuses on reimbursements for psychiatric services at hospitals. House Bill 5613 focuses on reimbursements for ambulance services. Senate Bill 1925 works to expand Medicaid coverage to most persons in Illinois who have income less than 100% of the federal poverty level. ■

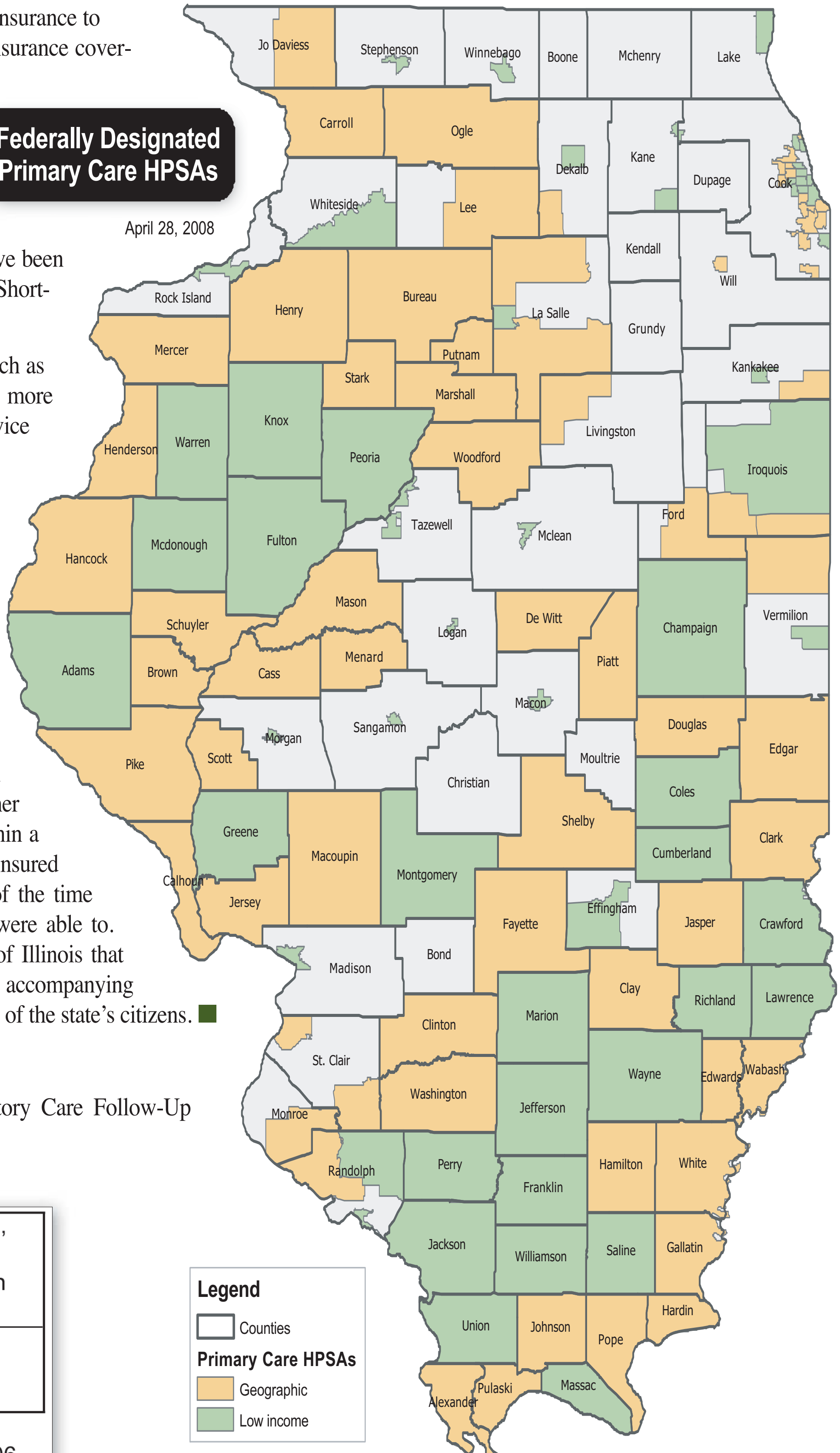
Access to Medical Providers

Although Illinois in recent years has provided health insurance to more people through its Medicaid program, having insurance coverage does not guarantee easy access to medical providers. Numerous counties in Illinois do not have their own hospital, requiring patients to drive significant distances for emergency services. Also common is relatively few numbers of doctors to serve the area's population. As shown in the accompanying map, many areas of the state have been designated primary medical care Health Professional Shortage Areas (HPSAs) by the federal government.

An area can be designated an HPSA due to criteria such as limited providers within the geographic area (usually more than 3,500 people per primary care physician) or a service area with high levels of low income households. [The national standard is a population-to-physician ratio of 1,500-to-1.] This designation allows potential providers in those areas to be able to apply for financial assistance for their education and allows providers to receive a bonus payment for Medicare services.

Unfortunately, even being able to find a provider does not guarantee that a prospective patient will be able to receive care. For instance, a 2005 study[1] in the Journal of the American Medical Association looked at the ability for Medicaid patients (versus other types) to receive follow up medical appointments within a week of a visit to an emergency room. It found that insured callers were able to schedule an appointment 65% of the time while only 35% of people with Medicaid coverage were able to. Given the high rates of Medicaid coverage in areas of Illinois that already suffer from a limited number of providers (see accompanying table), this can result in limited access to care for many of the state's citizens. ■

1 "Insurance Status and Access to Urgent Ambulatory Care Follow-Up Appointments," *JAMA*. 2005; 294(10):1248-1254.



Map prepared by the Illinois Department of Public Health, Center for Rural Health
Source: Health Resources and Services Administration, Shortage Designation Branch, http://hpsafind.hrsa.gov

Percent of Residents Enrolled in Medicaid, by Age and Rurality

Age	Urban % on Medicaid	Rural % on Medicaid
0-18	21.4	28.3
19-64	6.0	11.3
65 and Over	7.3	4.1

Source: Current Population Survey, 2005-2006 (as reported by the Kaiser Family Foundation) period following implementation of the regulations. By far the most onerous of the regulations was the implementation of cost limits on public providers which could cost states over $21 billion. The next largest proposed change was the elimination of Medicaid funding for graduate medical education which could cost states an additional $10 billion. Results of the survey for Illinois and selected other states are shown on the table below.

The potential impact on Illinois for the five-year program is $2.5 billion according to the state's Medicaid director. Like the national total, the largest impact ($1.3 billion) will be from the reduced payments to public hospitals.

Continued Increases Expected

Whether or not the performance of the national economy meets the technical definition of a recession, rising gasoline and food prices, the stalled housing market, and increases in unemployment are expected to drive up Medicaid enrollments. At the same time, these conditions will negatively affect state general fund revenues. According to an April report from the Center on Budget and Policy Priorities, some states had to adjust their fiscal year 2008 budgets in mid-year, and 28 states are facing shortfalls in their fiscal year 2009 budgets because of sagging revenues.

State governments and the federal government will continue to face the increases in Medicaid enrollments and expenditures in the short-term. Unfortunately for the states, the timing of the federal government's proposals to push more costs onto the states could not have come at a worse time. States that want to maintain their Medicaid programs without cutting services will face enough difficulties with economy-driven caseload increases and revenue decreases, to say nothing about the impact of reductions in federal funding.

To put it another way, even though Congress successfully blocked the implementation of most of the proposed rules until the end of March 2009, the states will still face Medicaid spending pressures. Although the short-term impact of Part D of the Medicare program on state budgets has been to reduce expenditures for prescription drugs, that has been offset somewhat by the clawback payments states are required to make to the federal government. However, liabilities for other components of the Medicaid program such as hospital care, physician services and long-term care continue to escalate. The Medicaid funding/spending issue needs to be faced head on, hopefully without increasing the liabilities deferred to future fiscal years. ■

Estimated Losses of Federal Funds Re: Proposed Medicaid Regulations, 5-Year Totals for Selected States
($ in Millions)

State	Cost Limits Public Hospitals	End Graduate Medical Education	Limit Outpatient Hospital Services	Restrict Hospital Provider Payments	Limit Rehabilitation Services	End School Admin. & Transportation	End Case Management	Total
California	$ 4,718.0	$ 1,240.0	$ 1,332.0	$ 2,700.0	NS	$ 650.0	$ 119.0	$ 10,759.0
Illinois	**1,300.0**	**74.0**	**700.0**	**9.3**	**NS**	**429.0**	**26.0**	**2,538.3**
Michigan	1,254.4	545.8	None	10.0	1,729.0	116.8	254.0	3,910.0
New York	2,750.0	3,375.0	NS	NS	1,010.0	220.0	NS	7,355.0
Texas	2,200.0	348.0	NS	11.5	356.3	49.0	431.0	3,395.8
Wisconsin	15.0	50.0	NS	None	NS	54.0	75.0	194.0
Total (43 states)	$ 21,126.4	$ 9,807.4	$ 2,087.6	$ 5,103.9	$ 5,226.7	$ 3,255.7	$ 3,134.4	$ 49,742.1

NS = Impact acknowledged but dollar amount not specified.

Source: Committee on Oversight and Government Reform, U.S. House of Representatives, *The Administration's Medicaid Regulations: State-by-State Impacts*, March 2008.

GENERAL FUNDS REVENUES, EXPENDITURES AND BALANCES
(Dollars in Millions)

	April 2008	Ten Months FY 2008	Change From Prior Year $	Change From Prior Year %
Total General Funds				
Available Balance	$ 210	$ 642	$ 52	8.8 %
Revenues	4,760	27,293	2,297	9.2
Expenditures	4,646	27,611	2,266	8.9
Ending Balance	$ 324	$ 324	$ 83	34.4 %
General Revenue Fund				
Available Balance	$ 27	$ 224	$ 158	239.4 %
Revenues	4,350	23,795	2,173	10.0
Expenditures	4,347	23,989	2,310	10.7
Ending Balance	$ 30	$ 30	$ 21	233.3 %
Common School Special Account Fund				
Available Balance	$ 92	$ 36	$ (5)	(12.2) %
Revenues	146	1,502	19	1.3
Expenditures	162	1,462	6	0.4
Ending Balance	$ 76	$ 76	$ 8	11.8 %
Education Assistance Fund				
Available Balance	$ 60	$ 375	$ (88)	(19.0) %
Revenues	178	1,217	61	5.3
Expenditures	46	1,400	(65)	(4.4)
Ending Balance	$ 192	$ 192	$ 38	24.7 %
Common School Fund				
Available Balance	$ 31	$ 7	$ (13)	(65.0) %
Revenues	470	3,083	160	5.5
Expenditures	475	3,064	131	4.5
Ending Balance	$ 26	$ 26	$ 16	160.0 %

Note: Total General Funds excludes interfund transfers while the individual funds include such transfers. Numbers may not add due to rounding.

GENERAL FUNDS REVENUES
(Dollars in Millions)

	April 2008	Ten Months FY 2008	Change From Prior Year $	Change From Prior Year %
Revenues:				
State Sources:				
Cash Receipts:				
Income Taxes:				
Individual	$ 1,570	$ 8,463	$ 879	11.6 %
Corporate	389	1,509	64	4.4
Total, Income Taxes	$ 1,959	$ 9,972	$ 943	10.4 %
Sales Taxes	586	5,996	67	1.1
Other Sources:				
Public Utility Taxes	134	987	63	6.8
Cigarette Taxes	29	292	0	0.0
Inheritance Tax (gross)	31	321	101	45.9
Liquor Gallonage Taxes	11	132	2	1.5
Insurance Taxes and Fees	36	233	(12)	(4.9)
Corporation Franchise Tax and Fees	25	191	29	17.9
Investment Income	17	171	0	0.0
Cook County IGT	15	208	4	2.0
Other	42	373	3	0.8
Total, Other Sources	$ 340	$ 2,908	$ 190	7.0 %
Total, Cash Receipts	$ 2,885	$ 18,876	$ 1,200	6.8 %
Transfers In:				
Lottery Fund	$ 60	$ 537	$ 40	8.0 %
State Gaming Fund	35	489	(6)	(1.2)
Other Funds	70	442	(244)	(35.6)
Total, Transfers In	$ 165	$ 1,468	$ (210)	(12.5) %
Total, State Sources	$ 3,050	$ 20,344	$ 990	5.1 %
Federal Sources	$ 510	$ 3,973	$ (37)	(0.9) %
Total, Base Revenues	**$ 3,560**	**$ 24,317**	**$ 953**	**4.1 %**
Short Term Borrowing	1,200	2,400	1,500	166.7
Cash Flow Transfer - Hospital Provider Fund	0	300	(156)	(34.2)
Transfer from Budget Stabilization Fund	0	276	0	0.0
Total, Revenues	$ 4,760	$ 27,293	$ 2,297	9.2 %

GENERAL FUNDS ANALYSIS OF EXPENDITURES
(Dollars in Millions)

Expenditures:	April 2008	Ten Months FY 2008	Change From Prior Year $	Change From Prior Year %
Awards and Grants:				
Healthcare & Family Services	$ 675	$ 5,874	$ 34	0.6 %
Elem. & Sec. Education:				
State Board of Education	521	5,271	299	6.0
Teachers Retirement	93	931	254	37.5
Total, Elem. & Sec. Education	$ 614	$ 6,202	$ 553	9.8 %
Human Services	244	2,631	121	4.8
Higher Education	24	710	(38)	(5.1)
All Other Grants	91	1,246	153	14.0
Total, Awards and Grants	$ 1,648	$ 16,663	$ 823	5.2 %
Operations:				
Other Agencies	$ 442	$ 4,674	$ 288	6.6 %
Higher Education	49	1,320	26	2.0
Total, Operations	$ 491	$ 5,994	$ 314	5.5 %
Regular Transfers Out	$ 390	$ 2,608	$ 133	5.4 %
All Other	$ 2	$ 11	$ (4)	(26.7) %
Vouchers Payable Adjustment	$ 915	$ (365)	$ (540)	N/A
Total, Base Expenditures	**$ 3,446**	**$ 24,911**	**$ 726**	**3.0 %**
Cash Flow Transfer - Hospital Provider Fund	1,200	2,400	1,240	106.9
Transfers to Repay GRF Short-Term Borrowing	0	300	300	N/A
Total, Expenditures	$ 4,646	$ 27,611	$ 2,266	8.9 %

COMPARISON OF SPENDING FOR OPERATIONS BY OBJECT
(Dollars in Millions)

	April 2008	Ten Months FY 2008	Change From Prior Year $	Change From Prior Year %
Personal Services:				
Regular Positions	$ 219	$ 3,130	$ 153	5.1 %
Other Personal Services	16	164	15	10.1
Total, Personal Services	$ 235	$ 3,294	$ 168	5.4 %
Contribution Retirement	36	367	59	19.2
Contribution Social Security	14	157	10	6.8
Contribution Group Insurance	105	913	(21)	(2.2)
Contractual Services	40	556	37	7.1
Travel	2	17	1	6.3
Commodities	10	102	8	8.5
Printing	0	6	0	0.0
Equipment	2	16	(2)	(11.1)
Electronic Data Processing	2	27	(6)	(18.2)
Telecommunications	4	48	8	20.0
Automotive Equipment	2	25	6	31.6
Other Operations	39	466	46	11.0
Total, Operations	$ 491	$ 5,994	$ 314	5.5 %

COMPARISON OF SPENDING FOR AWARDS AND GRANTS
(Dollars in Millions)

	April 2008	Ten Months FY 2008	Change From Prior Year $	Change From Prior Year %
State Board of Education:				
General State Aid	$ 388	$ 3,262	$ 160	5.2 %
All Other	133	2,009	139	7.4
Healthcare & Family Services	675	5,874	34	0.6
Human Services	244	2,631	121	4.8
Higher Education:				
Student Assistance Commission	12	416	18	4.5
Community College Board	8	268	(6)	(2.2)
Other	4	26	(50)	(65.8)
Teacher's Retirement	93	931	254	37.5
Children and Family Services	34	561	83	17.4
Aging	36	336	41	13.9
Revenue	2	20	2	11.1
All Other	19	329	27	8.9
Total, Awards and Grants	$ 1,648	$ 16,663	$ 823	5.2 %

GENERAL FUNDS REVENUES, EXPENDITURES AND BALANCES
(Dollars in Millions)

	May 2008	Eleven Months FY 2008	Change From Prior Year $	Change From Prior Year %
Total General Funds				
Available Balance	$ 324	$ 642	$ 52	8.8 %
Revenues	3,622	30,915	3,419	12.4
Expenditures	3,572	31,183	3,713	13.5
Ending Balance	$ 374	$ 374	$ (242)	(39.3) %
General Revenue Fund				
Available Balance	$ 30	$ 224	$ 158	239.4 %
Revenues	3,280	27,075	3,300	13.9
Expenditures	3,281	27,270	3,760	16.0
Ending Balance	$ 29	$ 29	$ (302)	(91.2) %
Common School Special Account Fund				
Available Balance	$ 76	$ 36	$ (5)	(12.2) %
Revenues	149	1,650	20	1.2
Expenditures	149	1,610	13	0.8
Ending Balance	$ 76	$ 76	$ 2	2.7 %
Education Assistance Fund				
Available Balance	$ 192	$ 375	$ (88)	(19.0) %
Revenues	112	1,329	65	5.1
Expenditures	54	1,454	(94)	(6.1)
Ending Balance	$ 250	$ 250	$ 71	39.7 %
Common School Fund				
Available Balance	$ 26	$ 7	$ (13)	(65.0) %
Revenues	468	3,551	244	7.4
Expenditures	475	3,539	243	7.4
Ending Balance	$ 19	$ 19	$ (12)	(38.7) %

Note: Total General Funds excludes interfund transfers while the individual funds include such transfers. Numbers may not add due to rounding.

GENERAL FUNDS REVENUES
(Dollars in Millions)

Revenues:	May 2008	Eleven Months FY 2008	Change From Prior Year $	Change From Prior Year %
State Sources:				
Cash Receipts:				
Income Taxes:				
Individual	$ 958	$ 9,421	$ 842	9.8 %
Corporate	89	1,598	78	5.1
Total, Income Taxes	$ 1,047	$ 11,019	$ 920	9.1 %
Sales Taxes	596	6,593	75	1.2
Other Sources:				
Public Utility Taxes	97	1,084	36	3.4
Cigarette Taxes	29	321	0	0.0
Inheritance Tax (gross)	21	343	104	43.5
Liquor Gallonage Taxes	13	144	3	2.1
Insurance Taxes and Fees	11	244	(8)	(3.2)
Corporation Franchise Tax and Fees	19	210	27	14.8
Investment Income	19	190	1	0.5
Cook County IGT	94	302	5	1.7
Other	34	406	(6)	(1.5)
Total, Other Sources	$ 337	$ 3,244	$ 162	5.3 %
Total, Cash Receipts	$ 1,980	$ 20,856	$ 1,157	5.9 %
Transfers In:				
Lottery Fund	$ 58	$ 596	$ 35	6.2 %
State Gaming Fund	35	524	(1)	(0.2)
Other Funds	121	562	(181)	(24.4)
Total, Transfers In	$ 214	$ 1,682	$ (147)	(8.0) %
Total, State Sources	$ 2,194	$ 22,538	$ 1,010	4.7 %
Federal Sources	$ 526	$ 4,499	$ 163	3.8 %
Total, Base Revenues	**$ 2,720**	**$ 27,037**	**$ 1,173**	**4.5 %**
Short Term Borrowing	0	2,400	1,500	166.7
Cash Flow Transfer - Hospital Provider Fund	902	1,202	746	163.6
Transfer from Budget Stabilization Fund	0	276	0	0.0
Total, Revenues	$ 3,622	$ 30,915	$ 3,419	12.4 %

GENERAL FUNDS ANALYSIS OF EXPENDITURES
(Dollars in Millions)

Expenditures:	May 2008	Eleven Months FY 2008	Change From Prior Year $	Change From Prior Year %
Awards and Grants:				
Healthcare & Family Services	$ 668	$ 6,542	$ 362	5.9 %
Elem. & Sec. Education:				
State Board of Education	464	5,735	340	6.3
Teachers Retirement	93	1,023	278	37.3
Total, Elem. & Sec. Education	$ 557	$ 6,758	$ 618	10.1 %
Human Services	246	2,877	141	5.2
Higher Education	64	774	(56)	(6.7)
All Other Grants	79	1,326	156	13.3
Total, Awards and Grants	$ 1,614	$ 18,277	$ 1,221	7.2 %
Operations:				
Other Agencies	$ 458	$ 5,131	$ 298	6.2 %
Higher Education	43	1,364	(6)	(0.4)
Total, Operations	$ 501	$ 6,495	$ 292	4.7 %
Regular Transfers Out	$ 314	$ 2,922	$ 352	13.7 %
All Other	$ 0	$ 11	$ (8)	(42.1) %
Vouchers Payable Adjustment	$ (35)	$ (400)	$ (390)	N/A
Total, Base Expenditures	**$ 2,394**	**$ 27,305**	**$ 1,467**	**5.7 %**
Cash Flow Transfer - Hospital Provider Fund	902	3,302	1,946	143.5
Transfers to Repay GRF Short-Term Borrowing	276	576	300	N/A
Total, Expenditures	$ 3,572	$ 31,183	$ 3,713	13.5 %

COMPARISON OF SPENDING FOR OPERATIONS BY OBJECT
(Dollars in Millions)

	May 2008	Eleven Months FY 2008	Change From Prior Year $	Change From Prior Year %
Personal Services:				
Regular Positions	$ 225	$ 3,355	$ 169	5.3 %
Other Personal Services	16	180	15	9.1
Total, Personal Services	$ 241	$ 3,535	$ 184	5.5 %
Contribution Retirement	38	405	72	21.6
Contribution Social Security	14	171	8	4.9
Contribution Group Insurance	101	1,014	(27)	(2.6)
Contractual Services	41	597	1	0.2
Travel	2	19	1	5.6
Commodities	10	111	7	6.7
Printing	1	7	0	0.0
Equipment	1	17	(3)	(15.0)
Electronic Data Processing	1	28	(7)	(20.0)
Telecommunications	4	52	5	10.6
Automotive Equipment	2	27	6	28.6
Other Operations	45	512	45	9.6
Total, Operations	$ 501	$ 6,495	$ 292	4.7 %

COMPARISON OF SPENDING FOR AWARDS AND GRANTS
(Dollars in Millions)

	May 2008	Eleven Months FY 2008	Change From Prior Year $	Change From Prior Year %
State Board of Education:				
General State Aid	$ 387	$ 3,649	$ 206	6.0 %
All Other	77	2,086	134	6.9
Healthcare & Family Services	668	6,542	362	5.9
Human Services	246	2,877	141	5.2
Higher Education:				
Student Assistance Commission	9	425	27	6.8
Community College Board	54	322	(28)	(8.0)
Other	1	27	(55)	(67.1)
Teacher's Retirement	93	1,023	278	37.3
Children and Family Services	14	574	77	15.5
Aging	34	371	46	14.2
Revenue	3	23	3	15.0
All Other	28	358	30	9.1
Total, Awards and Grants	$ 1,614	$ 18,277	$ 1,221	7.2 %

GENERAL FUNDS REVENUES, EXPENDITURES AND BALANCES
(Dollars in Millions)

	June	Twelve Months	Change From Prior Year	
	2008	FY 2008	$	%
Total General Funds				
Available Balance	$ 374	$ 642	$ 52	8.8 %
Revenues	2,923	33,838	3,566	11.8
Expenditures	3,156	34,339	4,119	13.6
Ending Balance	$ 141	$ 141	$ (501)	(78.0) %
General Revenue Fund				
Available Balance	$ 29	$ 224	$ 158	239.4 %
Revenues	2,559	29,634	3,557	13.6
Expenditures	2,540	29,810	3,891	15.0
Ending Balance	$ 48	$ 48	$ (176)	(78.6) %
Common School Special Account Fund				
Available Balance	$ 76	$ 36	$ (5)	(12.2) %
Revenues	155	1,805	21	1.2
Expenditures	217	1,827	38	2.1
Ending Balance	$ 14	$ 14	$ (22)	(61.1) %
Education Assistance Fund				
Available Balance	$ 250	$ 375	$ (88)	(19.0) %
Revenues	125	1,454	(48)	(3.2)
Expenditures	303	1,757	167	10.5
Ending Balance	$ 72	$ 72	$ (303)	(80.8) %
Common School Fund				
Available Balance	$ 19	$ 7	$ (13)	(65.0) %
Revenues	559	4,110	80	2.0
Expenditures	572	4,111	68	1.7
Ending Balance	$ 6	$ 6	$ (1)	(14.3) %

Note: Total General Funds excludes interfund transfers while the individual funds include such transfers. Numbers may not add due to rounding.

GENERAL FUNDS REVENUES
(Dollars in Millions)

	June	Twelve Months	Change From Prior Year	
Revenues:	2008	FY 2008	$	%
State Sources:				
Cash Receipts:				
Income Taxes:				
Individual	$ 899	$ 10,320	$ 912	9.7 %
Corporate	262	1,860	110	6.3
Total, Income Taxes	$ 1,161	$ 12,180	$ 1,022	9.2 %
Sales Taxes	622	7,215	79	1.1
Other Sources:				
Public Utility Taxes	73	1,157	26	2.3
Cigarette Taxes	29	350	0	0.0
Inheritance Tax (gross)	30	373	109	41.3
Liquor Gallonage Taxes	14	158	2	1.3
Insurance Taxes and Fees	54	298	(12)	(3.9)
Corporation Franchise Tax and Fees	15	225	32	16.6
Investment Income	22	212	8	3.9
Cook County IGT	0	302	(5)	(1.6)
Other	68	474	(8)	(1.7)
Total, Other Sources	$ 305	$ 3,549	$ 152	4.5 %
Total, Cash Receipts	$ 2,088	$ 22,944	$ 1,253	5.8 %
Transfers In:				
Lottery Fund	$ 62	$ 657	$ 35	5.6 %
State Gaming Fund	40	564	(121)	(17.7)
Other Funds	116	679	(260)	(27.7)
Total, Transfers In	$ 218	$ 1,900	$ (346)	(15.4) %
Total, State Sources	$ 2,306	$ 24,844	$ 907	3.8 %
Federal Sources	$ 316	$ 4,815	$ 112	2.4 %
Total, Base Revenues	**$ 2,622**	**$ 29,659**	**$ 1,019**	**3.6 %**
Short Term Borrowing	0	2,400	1,500	166.7
Cash Flow Transfer - Hospital Provider Fund	301	1,503	1,047	229.6
Transfer from Budget Stabilization Fund	0	276	0	0.0
Total, Revenues	$ 2,923	$ 33,838	$ 3,566	11.8 %

GENERAL FUNDS ANALYSIS OF EXPENDITURES
(Dollars in Millions)

	June	Twelve Months	Change From Prior Year	
Expenditures:	2008	FY 2008	$	%
Awards and Grants:				
Healthcare & Family Services	$ 413	$ 6,954	$ 452	7.0 %
Elem. & Sec. Education:				
State Board of Education	1,190	6,925	516	8.1
Teachers Retirement	93	1,116	303	37.3
Total, Elem. & Sec. Education	$ 1,283	$ 8,041	$ 819	11.3 %
Human Services	148	3,026	152	5.3
Higher Education	43	817	(43)	(5.0)
All Other Grants	83	1,409	172	13.9
Total, Awards and Grants	$ 1,970	$ 20,247	$ 1,552	8.3 %
Operations:				
Other Agencies	$ 402	$ 5,534	$ 282	5.4 %
Higher Education	9	1,372	(32)	(2.3)
Total, Operations	$ 411	$ 6,906	$ 250	3.8 %
Regular Transfers Out	$ 279	$ 3,201	$ 228	7.7 %
All Other	$ 2	$ 13	$ (6)	(31.6) %
Vouchers Payable Adjustment	$ 193	$ (207)	$ (441)	N/A
Total, Base Expenditures	**$ 2,855**	**$ 30,160**	**$ 1,583**	**5.5 %**
Cash Flow Transfer - Hospital Provider Fund	0	3,302	1,946	143.5
Transfers to Repay GRF Short-Term Borrowing	301	877	590	205.6
Total, Expenditures	$ 3,156	$ 34,339	$ 4,119	13.6 %

COMPARISON OF SPENDING FOR OPERATIONS BY OBJECT
(Dollars in Millions)

	June	Twelve Months	Change From Prior Year	
	2008	FY 2008	$	%
Personal Services:				
Regular Positions	$ 195	$ 3,550	$ 132	3.9 %
Other Personal Services	16	197	15	8.2
Total, Personal Services	$ 211	$ 3,747	$ 147	4.1 %
Contribution Retirement	38	444	85	23.7
Contribution Social Security	13	184	8	4.5
Contribution Group Insurance	56	1,070	(50)	(4.5)
Contractual Services	35	632	7	1.1
Travel	2	21	1	5.0
Commodities	7	118	8	7.3
Printing	1	7	(1)	(12.5)
Equipment	2	19	(2)	(9.5)
Electronic Data Processing	2	30	(8)	(21.1)
Telecommunications	3	55	5	10.0
Automotive Equipment	2	29	7	31.8
Other Operations	39	550	43	8.5
Total, Operations	$ 411	$ 6,906	$ 250	3.8 %

COMPARISON OF SPENDING FOR AWARDS AND GRANTS
(Dollars in Millions)

	June	Twelve Months	Change From Prior Year	
	2008	FY 2008	$	%
State Board of Education:				
General State Aid	$ 775	$ 4,424	$ 297	7.2 %
All Other	415	2,501	219	9.6
Healthcare and Family Services	413	6,954	452	7.0
Human Services	148	3,026	152	5.3
Higher Education:				
Student Assistance Commission	0	425	25	6.3
Community College Board	25	347	(3)	(0.9)
Other	18	45	(65)	(59.1)
Teacher's Retirement	93	1,116	303	37.3
Children and Family Services	11	585	82	16.3
Aging	35	405	47	13.1
Revenue	2	25	4	19.0
All Other	35	394	39	11.0
Total, Awards and Grants	$ 1,970	$ 20,247	$ 1,552	8.3 %

DID YOU KNOW...

- On average 2.1 million Illinoisans per month are covered by Medicaid.
- An estimated 1.8 million or 14% of Illinoisans were uninsured in 2006, 24th highest in the United States.
- In fiscal year 2007, Medicaid/medical assistance spending of $11.6 billion was 21.1% of total state appropriated spending.
- According to an estimate by the Kaiser Family Foundation, a one percentage point increase in unemployment nationally adds 600,000 children and 400,000 adults to the Medicaid and SCHIP roles and increases those programs' spending by $3.4 billion.
- Over $1.7 billion of fiscal year 2007 Medicaid bills (from the General Revenue Fund) were delayed and paid in fiscal year 2008 under a "loophole" in Section 25 of the State Finance Act.
- In June, the U.S. Congress acted to delay implementation of several rules proposed by the Centers for Medicare and Medicaid Services that would have reduced federal support of Illinois' Medicaid system by up to several billion dollars over the next five years. ■

COMPTROLLER DANIEL W. HYNES

Contact us at our web address: http://www.ioc.state.il.us

Fiscal Focus

COMPTROLLER DANIEL W. HYNES
Capitol Building
Springfield, Illinois 62706