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

BY FRANCIS CHOI, MICHAEL DISHER, AND DAVID F. MERRIMAN

INTRODUCTION

> In recent years, more than one out of every four dollars spent by the state of Illinois went to Medicaid,¹ and more than one out of five state residents got their healthcare through the

program. Nationally, Medicaid enrollment has soared during the COVID-19 pandemic and is currently at record levels.² As Medicaid has been a contentious fiscal issue for lawmakers over the years, efforts to constrain or cut Medicaid spending were commonplace in previous administrations.³ The program's spending and enrollment have grown dramatically for decades.





This paper provides a brief summary of the reasons for this growth and the potential to reduce Illinois' Medicaid spending. It also gives an overview of Illinois' trend in Medicaid spending relative to other states. Potential policy implications for lawmakers involved in the budgetary process are discussed.

A more complete exploration of these topics is available in a longer [IGPA white paper with the same title](#).

The beneficiaries of Medicaid include both healthcare providers, who would otherwise not have been compensated for the care provided, and Medicaid enrollees who get healthcare that they otherwise would have done without. Research suggests that the benefits to providers of uncompensated care actually exceed that of Medicaid enrollees.⁴ 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 vulnerable populations 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 growing and expensive, and we were intrigued by the possibility that thoughtful efficiencies might move Illinois toward a structurally balanced budget. After considering the data, we find that Illinois' experience with Medicaid is quite typical of other states. Although the federal

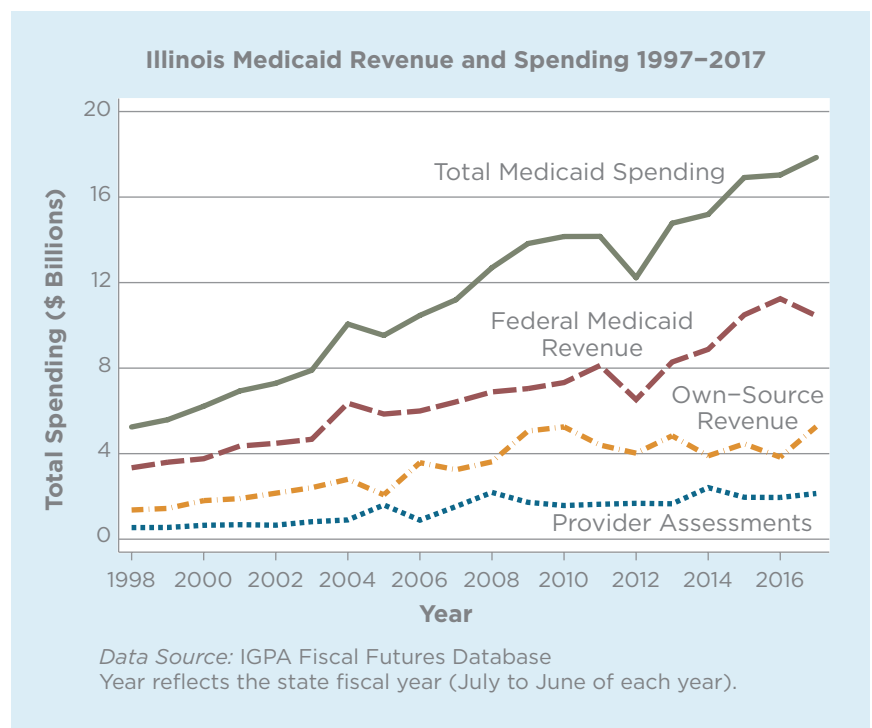
government shares a large and growing responsibility to pay for Medicaid, a substantial state fiscal responsibility remains. Because Illinois has controlled costs about as well or even better than other states, we are pessimistic about the possibility of substantial reductions in state fiscal commitments for Medicaid in the near future.

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

We first provide perspective on the level, growth, and sources of spending in Illinois' Medicaid program. Using data from the [University of Illinois' Fiscal Futures database](#), Figure 1 shows consistent, over time comparisons of Medicaid spending and sources of revenue in "nominal" dollars, not adjusted for the



FIGURE 1





rising cost of Medicaid services. As shown in the figure, total Medicaid spending grew from \$5.2 billion in 1998 to \$17.8 billion in 2017 but “own source spending” (from general tax revenues) grew much less, from \$1.4 billion to \$5.26 billion, primarily because the federal share of spending increased even faster than total spending. The rapid increase in federal spending was in part due to the expansion of Medicaid under the Affordable Care Act (ACA) which became law in 2010. While the federal government has matched Illinois spending at or near 50% for most years (the official federal match rate), under the ACA Illinois receives 90% for newly eligible adults, meaning for every dollar Illinois spends the state is reimbursed ninety cents.



BROAD CHANGES IN MEDICAID SPENDING AND ENROLLMENT

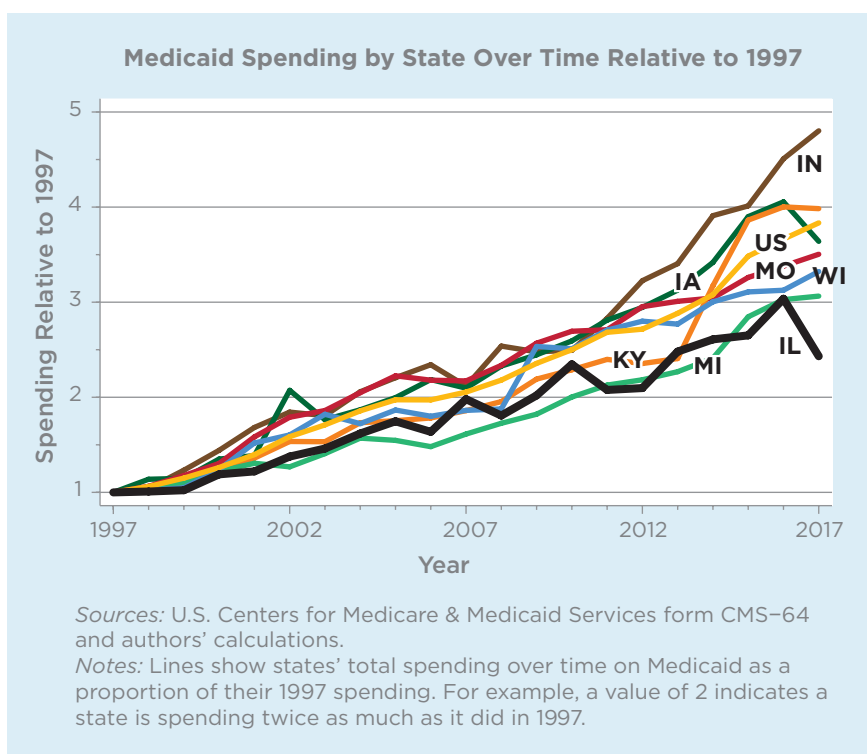
Changes in Spending

While Illinois has experienced rapid growth in Medicaid spending, this growth has been relatively slow compared to nearby states. Figure 2 shows states’ spending over time relative to 1997 levels. 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 and was also less than the increase in other nearby states.

Changes in Enrollment

Spending growth in Illinois has been primarily driven by increases in enrollment. While Illinois previously had below average enrollment per capita,

FIGURE 2



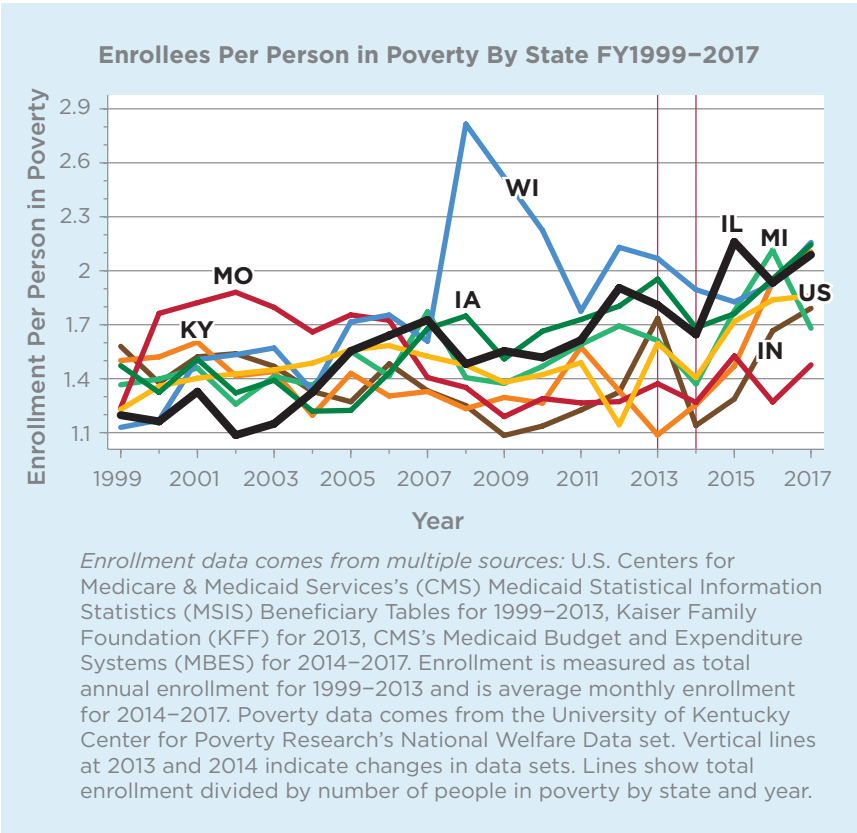


by 2017 the enrollment levels were similar to the national average and relatively high among nearby states. Because many individuals with resources above the poverty level are enrolled in Medicaid the ratio of Medicaid enrollment to people in poverty exceeds one. Illinois' enrollment has grown significantly relative to the number of people in poverty (see Figure 3) - growing from a relatively low 1.2 enrollees per person in poverty in 1999 to an above-average level of 2.1 in 2017. Much of Illinois' spending growth is because of increasing enrollment among the poor and the near poor.

Changes in Spending Per Enrollee

While enrollment has grown, spending per enrollee changed relatively little. In 1999, Illinois spent about \$5,069 per Medicaid enrollee. This decreased to \$4,938 by 2012. From 2012 to 2014, spending per enrollee increased. Due to changes in the way data are compiled, the precise amount is unclear (with our best estimates between \$520 and \$569). From 2014 to 2017, spending per enrollee

FIGURE 3





declined from \$6,509 to \$6,087. Compared to nearby states and the nation as a whole (Figure 4), the overall picture is that spending per enrollee has been remarkably stable and increasingly frugal. This is even more

striking after considering price changes. In a period where overall prices grew by 48% and health services prices grew between 61% and 191%, nominal spending grew by less than 20%. Given these various price

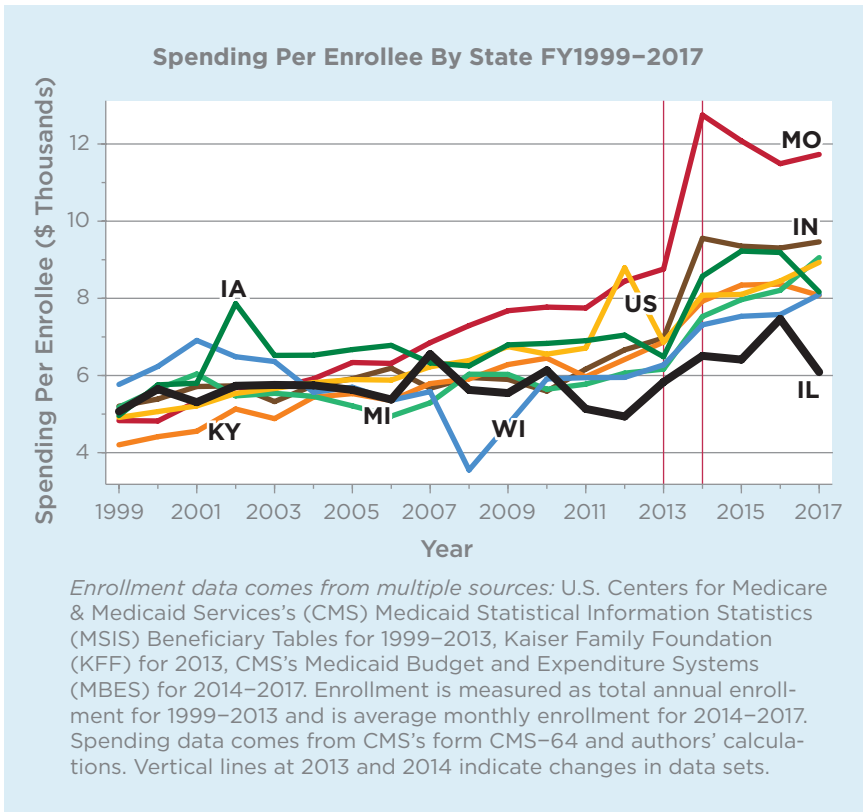
changes, we believe that spending per enrollee *adjusted for healthcare inflation* significantly declined from 1999 to 2017.

Analyzing Major Changes in Spending

Spending has not grown uniformly across medical service categories. Before 2012, Illinois' Medicaid spending was distributed across medical service categories in a relatively stable manner among (1) home and community-based services (HC), (2) inpatient hospital services, (3) nursing facilities, (4) intermediate care facilities, and (5) managed care. However, after 2012, Illinois made a large shift towards managed care (see Figure 5), while spending on other services began to decline.

Managed care is often advocated as a way to cut costs while retaining quality of care. Unlike fee-for-service models, managed care organizations (MCOs) do not receive more money for providing more services, so the use of MCOs may incentivize efficient use of healthcare services. In 2017, Illinois spent more on managed care than all nearby states except Michigan and Kentucky. However, as a proportion of total Medicaid spending, Illinois only devoted 38% of its Medicaid spending to managed care—below the national average of 45%. Illinois' shift towards managed care, while fast, matches nearby states. Whether this shift toward managed care will reduce costs is unclear. Research shows that MCOs save money when they can negotiate down relatively high provider reimbursement rates⁵ but Illinois already has low provider

FIGURE 4



reimbursement rates and thus has limited ability to lower cost through MCO negotiations.

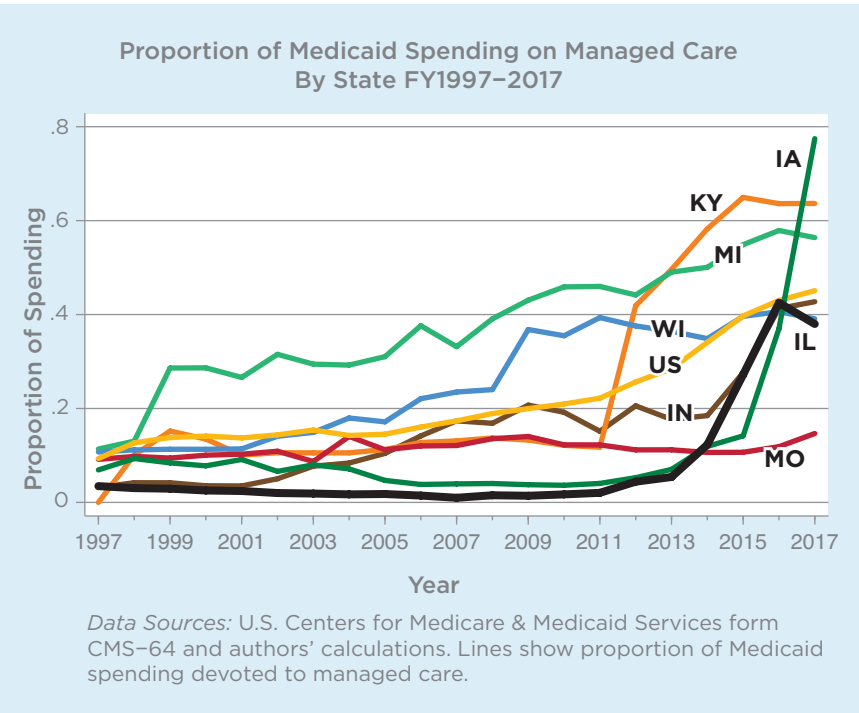
Reductions in administrative spending are another way the U.S. healthcare system might be made more efficient. Within Illinois' Medicaid program, administrative spending has become less important over time. In the late 1990s, Illinois spent about 8 cents on administration per dollar of spending on medical assistance program (MAP) services (compared to a national average of about 6 cents). This ratio declined to 6 cents on administration per dollar on MAP by 2017 (while the national average increased to 5 cents). Illinois' administrative spending is not an outlier and has been declining.⁶

CONCLUSION

This paper has examined Medicaid finance in Illinois compared to neighboring states using several sources of data. While Illinois has spent more 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. Illinois' average enrollment per person in poverty increased significantly during the entire observed period, while spending per enrollee (accounting for inflation) declined. Cost increases are thus primarily driven by enrollment increases. Illinois has rapidly shifted towards managed care to address these cost increases but still spends proportionally less on it than other states.

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

FIGURE 5



any time soon. Reducing costs significantly would likely require cutting enrollment — a politically challenging move that would likely be socially harmful given Medicaid's numerous benefits. Cutting spending per enrollee also appears unlikely, given Illinois' low spending levels, especially after adjusting for healthcare inflation.

Our claim that it is going to be difficult for Illinois to save money in a socially beneficial way is magnified by the calculus of match rates. Given that most of Medicaid is funded by the federal government, to save a dollar on Illinois' budget requires cutting more than two dollars' worth of spending. Medicaid spending has increased greatly in Illinois, but it has grown less compared to spending in nearby states and has not grown



rapidly once medical inflation is taken into account.⁷ 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.



ENDNOTES

- ¹ 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>.
- ² See Sara Kliff, 2021 Medicaid Enrollment Surpassed 80 Million, a Record, During the Pandemic, *New York Times*, June 21, 2021, <https://perma.cc/WS5P-ZCC6>.
- ³ Rubenfire, A. (2015). Illinois Governor Proposes \$1.5 billion in Medicaid Cuts. Modern Healthcare. Available at: <https://perma.cc/92FY-SQJW>; Garcia, M. (2012). Quinn Signs Medicaid Cuts, Cigarette Tax Hike. Chicago Tribune. Available at: <https://perma.cc/S6WD-VASE>.
- ⁴ Finklestein et. al's (2015) analysis of the Oregon Health Insurance Experiment found that 60% of Medicaid spending is a transfer to providers for uncompensated care for the low-income uninsured population, while recipient willingness to pay for Medicaid is between \$0.5 and \$1.20 per dollar of the costs of providing Medicaid
- ⁵ Duggan, M. and Hayford, T. (2013). Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local Level Mandates. *Journal of Policy Analysis and Management*, 32,3, pp. 505-535. Available at: https://onlinelibrary.wiley.com/doi/pdf/10.1002/pam.21693?casa_token=imRFzZSznu-4AAAAA:x4wmiHghV5iUZO5MTcTwJm-drcpxTkyXuQN7XOfvjPhdOnUsS7XKCuw-b7Erv3qykUPZYvQj2cBdBOA3E.
- ⁶ For more about administrative costs, see Choi, Francis, Disher, Michael, and Merriman, David. (July 2021) Illinois' Medicaid Program is Expensive, but Spending Will be Tough to Cut. University of Illinois: https://igpa.uillinois.edu/report/illinois%E2%80%99-medicaid-program-expensive-spending-will-be-tough-cut_full.
- ⁷ Bureau of Labor Statistics. (2021). Consumer price index - all urban consumers, 1999-2017 [Time series]. Retrieved from <http://data.bls.gov>.

Acknowledgments

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Publisher's Note

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