

# **Missouri Health Coverage Assurance:**

## ***A Common Sense Vision for Medicaid Reform and a Better Health Care Delivery System***

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#### **Executive Summary**

Missourians are reeling as changes to the Missouri Medicaid program are implemented across the state. First to feel the pain are the individuals who are immediately losing health care coverage. Soon communities will notice jobs being lost as \$400 million in federal Medicaid matching funds stops flowing into our local economies. Those losing Medicaid coverage will join the ranks of the uninsured, now exceeding 46 million nationwide and over 750,000 in Missouri. The uncompensated costs for treating the uninsured will be shifted to health insurance policy-holders in the form of increased premiums. Community health clinics will face increasing demand for health care services that they do not have the capacity to meet. Delays in receiving treatment because of increased demand for appointments will range from several weeks to over a year in some areas.

The reason given for Medicaid reform? Cost. Yet, is it any wonder that there are cost increases in the Medicaid program? Problems in the Medicaid program are no different than the problems in our health care delivery system as a whole – inefficiency and inequity. The state Medicaid program is under stress because of multiple factors including increased enrollment as workers' wages and benefits continue to decline; increasing costs of medical care, especially prescription drugs; and increased utilization of services by older, sicker enrollees. It is short-sighted to assume that reductions in Medicaid eligibility and services covered will have long-term positive benefits if we do nothing to reform our entire health care delivery system.

The success of any Medicaid reform efforts cannot be measured in terms of reduced eligibility alone, but should be measured by increases in access to needed health care services and by the health outcomes of those covered by Medicaid. To develop a plan for the future of Missouri's Medicaid program that is fair, affordable, and sustainable will take compassion and compromise, planning and patience. But most important will be basic common sense and vision. While development and implementation of a national health care plan is the optimal way to address increasing concerns about health care costs and access, many states, driven by necessity and public out-cries, are experimenting with options. As Missourians, we have an opportunity to make the systemic changes needed to not only make Medicaid sustainable, but to include in the reform efforts those working families and small business owners who are currently uninsured and without options to acquire affordable health coverage.

This report introduces a plan that assures affordable and accessible health coverage for all. The Missouri Health Coverage Assurance Plan will offer primary, preventive health, and mental health, dental, and catastrophic coverage to all Missourians. The following are the key components of the plan:

- ***Inclusion and affordability*** – Assure affordable health, mental health and dental health coverage to all Missourians, regardless of pre-existing conditions. Premiums will be based on three affordability standards. Those below 100 percent of the Federal Poverty Level (FPL) will have subsidized premiums and no or very minimal co-payments; for those with incomes between 100 percent up to 300 percent of FPL, the annual premium will be based on the State Children's Health Insurance Program (SCHIP) premiums. For other employers, families and individuals, premiums will be based on annual household income as reported on the previous year income tax return. The increased affordability of insurance makes coverage available and reduces uncompensated care costs, medical debt, and personal bankruptcies. Health care costs will also be reduced for small and large businesses who will be allowed to buy in to the plan.

- ***Shared risk to keep costs down for everyone*** – It is widely understood that the most efficient and equitable way to provide health coverage is to ‘pool’ the risk broadly. Missouri should create an initial enrollee pool as recommended by the Missouri State Government Review Commission. A Missouri Health Care Administration should be established to administer a self-insured plan comprised of the current insurance plans of the (a) state institutions of higher education; (b) Missouri Departments of Transportation and Conversation; (c) the Missouri Consolidated Plan for state employees; and (d) the Missouri High Risk Pool. The new Missouri Health Coverage Assurance plan will be HIPPA compliant. Medicaid program resources and enrollees will be included, bringing the initial enrollee pool to approximately half of the state population.
  
- ***Utilize existing infrastructure*** – Experts agree that Americans, including Missourians, pay at least one of every five healthcare dollars for paperwork, nearly three times the administrative costs of more efficient, streamlined systems operated by most of the nations in the industrialized world. By utilizing the existing infrastructure of the current Missouri Consolidated plan - expanding on what is already there - the new Missouri Health Coverage Assurance plan can be established sooner and savings can be immediately realized by reduced administrative costs. The expertise of the combined administrative staff will enhance the effective transition to the new plan.
  
- ***Maximize current market resources*** – Reports indicate that Americans and Missourians pay more than people in other countries for health care, yet more people are without access to needed services here. This is an indication that money is not the problem. Rather, it is the distribution of the resources that is problematic. By combining the current assets of the Missouri Medicaid program with the self-insured plans of higher education, and other state plans, risk and resources will be shared more efficiently and equitably, creating a plan that assures affordable and accessible coverage for all Missourians and eliminating

expensive over-utilization of emergency rooms and the burden of uncompensated care on providers, health insurance policy holders and on the system as a whole.

- ***Build on employer-based system while allowing for private market plans*** – The new Missouri Health Coverage Assurance plan will allow employers to purchase coverage for employees and not penalize those with few employees. Where employer-based coverage is not offered, consumers can buy in to the plan at a reasonable cost, based on their household income. Consumers who desire and can afford additional coverage will not be prohibited from purchasing additional health insurance products.

By applying a little common sense, we can create a health insurance plan that is inclusive, cost efficient, affordable, and accessible to all. The new Missouri Health Coverage Assurance plan will combine Medicaid with other state plans. It will be available to every Missourian who wishes to join, based on their income. A larger plan will do what market experts recommend – spread the risk over a larger pool of people. The premium fairness and affordability and the bargaining power gained from a large pool will bring efficiencies and cost controls to the market including reduced administrative costs and utilization of existing institutional structures, and will allow for the equitable enactment of mandatory insurance coverage.

When all Missourians have coverage, there will be no costs for uncompensated care or ‘charity care’, providers will be compensated for services they provide, and bankruptcies caused by medical debt will no longer rob families of a future. This is a common sense solution to the problem of Medicaid cost containment, the rising cost of employer-sponsored health insurance and the cost-shifting of treatment costs for the uninsured, and the personal crisis of medical debt. Support for combining state health insurance plans is already growing, and Medicaid reform has begun. What are we waiting for? It is time to move forward to affordable health coverage – the Missouri Health Coverage Assurance plan.

## **Introduction**

People are talking about health care: costs, coverage, Medicaid, Medicare Part D, reimbursement rates, uncompensated care, charity care, and the uninsured. The reason is clear. According to the national Centers for Medicare and Medicaid (CMS), Americans spent about \$1.9 trillion, 16 percent of the nation's gross domestic product (GDP), on health care in 2004<sup>1</sup>. That is about \$6,280 per capita annually<sup>2</sup>, or more than double what most other industrialized nations are spending. Estimates are that \$29.6 billion was spent on health care in Missouri in 2003<sup>3</sup>. Health care costs are a growing line item in the federal and state budgets, hurt the bottom lines of businesses, and are now the leading cause of personal bankruptcies in the U.S.<sup>4</sup>, even for those with health insurance. There is growing consensus that some changes must be made. In response to the increasing concerns over health care affordability, a wave of Medicaid reform is sweeping the country; Medicare letters are being sent to worried, often confused senior citizens; businesses are struggling to provide employee coverage; and some insurance premiums are predicted to go up another 10 percent next year<sup>5</sup>, while coverage is steadily being reduced. Individuals and business owners, health care service providers and politicians are talking about reform, revisions, cuts, and cost-savings.

Systemic reform means political do-ability, however. Political do-ability unfortunately, has been elusive. And so, health care delivery system reform has been a series of 'adjustments' to the current fragmented system that include increasing cost-sharing with higher premiums and co-payments, reduced coverage and the new mantras of 'personal responsibility' and 'consumer-driven'. Strategies to reform our public health insurance systems have echoed these refrains. Reducing the number of people covered and coverage under state Medicaid programs will save money – in the short-term, but is not a viable long-term solution because cost increases are affecting the entire health care delivery system, not just the Medicaid program.

## **Missouri Medicaid Reform Efforts**

Budget relief may be what guided the 2005 Missouri legislature's actions. In 2005 the Missouri legislature passed Senate Bill 539 and initiated reform of the Missouri Medicaid program. Their strategy focused primarily on reducing enrollment by changing eligibility rules, increasing cost sharing and addressing inefficiencies such as waste, duplication of service, and abuses of the system, but only on the enrollee side of the program. To date, 100,000 people in Missouri have lost Medicaid coverage. In addition, the state's Medicaid program will end in 2008.

A Medicaid Reform Commission has been established and charged with discovering how to re-make Missouri's Medicaid program into an economically sustainable program in spite of the fact that the remainder of the U.S. health care delivery system may not be sustainable. Nearly one in every five U.S. health care dollars is currently going toward administrative costs alone, three times the amount spent on administrative paperwork by other industrialized nations <sup>6</sup>.

Even with the reductions in eligibility and other changes being implemented, the Missouri Division of Medical Services projects Missouri's Medicaid enrollment for 2006 will top 1.01 million people at a projected cost of \$6.663 billion state and federal dollars combined<sup>7</sup>. Further reductions in eligibility may be difficult to achieve, particularly among people with disabilities and the elderly in nursing homes, who represent the highest cost enrollees in the state's Medicaid program. Spending for these groups accounts for about 70 percent of Medicaid spending<sup>8</sup>. In addition, negative externalities like shifting the cost<sup>9</sup> for treatment of those who are newly uninsured because of reduced eligibility in Medicaid may produce greater inefficiencies in other sectors of the industry.

## **Economics of Health Care Delivery**

Consumer demand for health care services does not necessarily fit the model for other normal goods and services. The range of price elasticity of demand for health care

estimates is relatively wide, but it tends to center on  $-0.17$ , meaning that a 1 percent increase in the price of health care will lead to a 0.17 percent reduction in health care expenditures.<sup>10</sup> The price induced changes in demand for health care can in large part be attributed to changes in the probability of accessing any care rather than to changes in the number of visits once care has been accessed.<sup>11</sup> In addition, the studies consistently find lower levels of demand elasticity at lower levels of cost-sharing.<sup>12</sup> The demand for health care is also found to be income inelastic<sup>13</sup>. The estimates of income elasticity of demand are in the range of 0 to 0.2.<sup>14</sup> The positive sign of the elasticity measure indicates that as income increases, the demand for health care services also increases. The magnitude of the elasticity, however, suggests that the demand response is relatively small. Studies based on long time series data tend to report higher income elasticities.<sup>15</sup> The difference in estimates across time frames is due to the incorporation of the effects of changes in medical technology in studies that use long time series data.<sup>16</sup> The price schedule for health care services can be quite complicated, and the effective price that a consumer pays depends on many factors including coinsurance, deductibles, upper limits on out-of-pocket expenditures, premiums, and the price of the good or service itself.<sup>17</sup> A change in any of these factors will affect the out-of-pocket costs of health care to the consumer.<sup>18</sup>

Although the price elasticity of demand<sup>19</sup> for medical care in general is relatively low, preventive care and pharmacy benefits are among those medical services with higher price elasticities.<sup>20</sup> There are a number of available substitutes for preventive care and in some population groups, preventive medical services may be seen more as a luxury than a necessity. In addition, the opportunity cost of obtaining preventive care is much higher than it is when the patient is sick, particularly if the illness keeps the individual out of work.<sup>21</sup> It is also likely that, since the benefits of preventive care accrue in the long-term, they are often discounted. The increased elasticity of demand for primary and preventative health care is more specific to the low to moderate income cohorts who are relatively healthy. The reductions in eligibility for the state Medicaid program recently enacted in Missouri have a disproportionate impact on relatively healthy parents of

children enrolled in the State Children's Health Insurance Program (SCHIP), who represent 68,000 of the 104,000 people losing eligibility.<sup>22</sup>

### ***Missouri's Approach to Medicaid Reform is Not Economically Sound***

The strategy to reduce eligibility for parents of SCHIP enrolled children is contraindicated as a cost saving mechanism because in Missouri this group utilizes less health care at a lower than national average cost,<sup>23</sup> and loss of coverage may lead to underutilization of regular preventative measures, poor long-term health outcomes and exacerbation of chronic conditions. The elimination of Medicaid for relatively healthy parents of SCHIP enrolled children will not recover the cost savings necessary for program stability, nor promote prevention and utilization of primary care. By eliminating access to relatively inexpensive prevention services, chronic and catastrophic illness rates and costs may actually increase, thus producing negative externalities on other segments of the market, specifically emergency rooms and the insured in the form of higher fees for health-related services and higher insurance premiums.

There is evidence that cost sharing in the form of higher premiums and co-payments, which makes medical care more expensive for consumers, significantly reduces per capita medical expenditures.<sup>24</sup> However, cost sharing worked to cut use by reducing the number of treatment episodes and not by reducing the intensity of treatment once an individual accessed the medical system.<sup>25</sup> This indicates that greater utilization may be necessary for some groups and may, in part, be provider-driven. Any successful strategy to contain costs, increase efficiencies and promote equity must take into account these factors.

### ***Market Forces***

Inefficiencies and inequities in the delivery of health care services are recognized across the board. Cost increases and delivery issues in the Medicaid program mirror concerns in the health care delivery market as a whole. Some suggest that market forces, if given full reign, will produce the efficiencies needed. However, this assumes a market for health

care with perfect competition and no market failures.<sup>26</sup> It is widely recognized that the market for health care violates both of these assumptions.<sup>27</sup> Competition in the health care market is imperfect because 1) consumers may not be able to choose among many competing producers, and producers do not necessarily compete for each of those consumers; 2) the products are not homogeneous and vary widely by price, service, and quality; and 3) both producers and consumers face barriers to entering the market for health care such as institutional restrictions, contracts, preexisting health conditions.<sup>28</sup> Market failures include 1) monopoly power; 2) externalities, both positive and negative; 3) elements of public goods (e.g. emergency rooms must treat those who present for service regardless of ability to pay)<sup>29</sup>; 4) lack of information; and 5) transaction costs.<sup>30</sup>

### ***Moral-Hazard***

An additional factor that may be driving health care reform efforts, including Medicaid reform, is moral hazard. In his article '*The Moral-Hazard Myth*' in the August 29, 2005 New Yorker, author Gladwell discusses how the moral hazard concept may be driving our current approach to health care delivery reform. Moral hazard is the term economists use to refer to the fact that having insurance causes people to use more health care services.<sup>31</sup> Gladwell contends that, according to economists, if insurance is meant to make life more secure, then having insurance can cause people to take more risks than they otherwise would.<sup>32</sup> This theory seems refuted by the fact that health care demand is price inelastic. Elderly and the disabled are not over-utilizing by choice. Neither are cancer patients nor high-risk pregnant women. Their utilization, once they are engaged in the health care delivery system, is driven by provider recommendation<sup>33</sup> and by their health conditions. The demand for primary and preventive services may be more price elastic. However, the positive externalities associated with a healthier citizenry and thus, workforce, benefit us all. The cost savings associated with earlier intervention in the disease process is also widely recognized, and could minimize the negative externalities associated with treatment of the uninsured.

Theories like moral hazard and over-utilization focus reform strategies in a direction that may not reduce health care delivery system costs overall because of the negative

externalities of shifting the cost<sup>34</sup> for their care in an emergency room to other consumers. Strategies to reduce costs, according to this reasoning, may be unrealistic when applied to populations who have greater need for medical care, including all of us when we age or become sick. This theory assumes that health care delivery system problems are driven by over-utilization, not by inefficiencies and inequity. It is also based on the assumption that most or all health care decisions are driven by choice to consume, not by necessity. Most consumers, because of transaction costs and opportunity costs involved,<sup>35</sup> will not over-utilize health care services. Particularly for low-wage-earning populations, who may not have the benefit of paid leave for doctor visits, the transaction costs of accessing health care services include missing work, finding a way to get to an appointment, securing child care, each a disincentive to over-utilize health care services. Marginal costs such as prescriptions may also act as disincentives to accessing care until absolutely necessary.

To gain maximum efficiency and cost containment in the Missouri Medicaid program, a broader strategy that addresses negative externalities such as cost-shifting associated with emergency room utilization by the uninsured,<sup>36</sup> multiple levels of administrative costs and other inefficiencies must be implemented. There is some consensus that distributing risk across a broader pool of healthier people will gain the greatest efficiencies in health care delivery and provide the negotiating clout needed to reduce costs, especially for prescription drugs. In 1995, municipalities and other entities were allowed to join the Missouri Consolidated Health Care Plan, "building a larger pool of members and greater bargaining power for lower cost medical services."<sup>37</sup> Recommendations presented in this paper build on this and other strategies to increase efficiencies and contain costs in the Missouri Medicaid program and assure access to affordable health coverage for all Missourians.

## **What Is Medicaid and How Does It Work?**

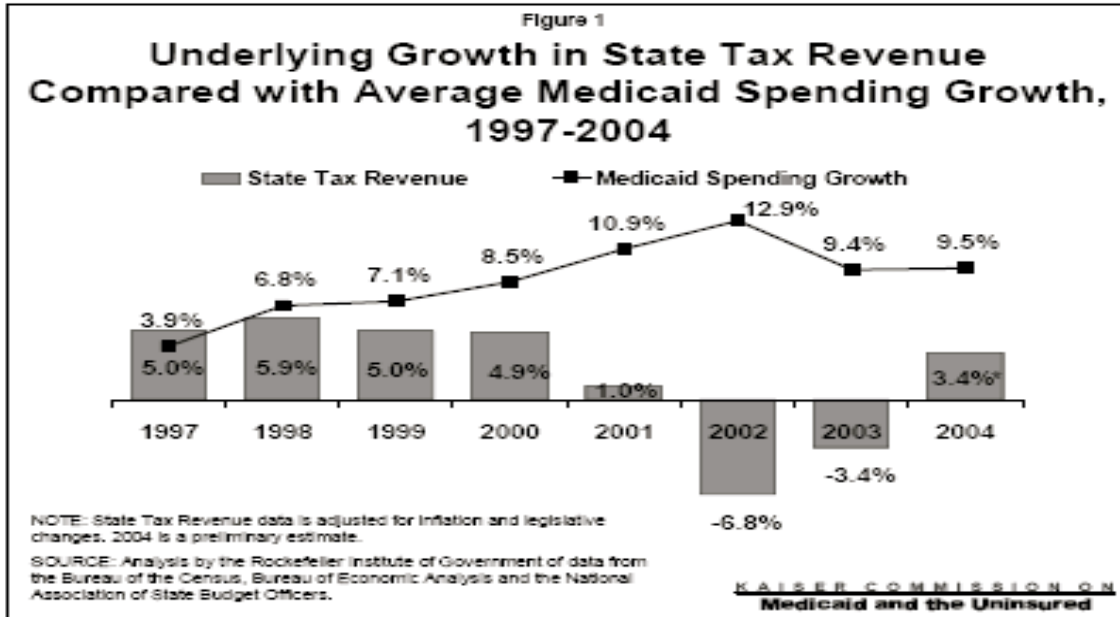
Medicaid was established by federal law in 1965 as a federal/state partnership to provide health insurance coverage for specific groups of people including the elderly, poor children and their parents, the disabled and the blind, who are excluded from the private marketplace because of pre-existing conditions, affordability and other factors. Medicaid was intended to be a temporary program that would evolve into a national health care plan. Covering 53 million Americans at an annual cost projected to be \$329 billion in 2005, Medicaid is the now nation's largest health insurance program.<sup>38</sup>

Two basic features of the Medicaid program are 1) it is an entitlement program, meaning that anyone who meets eligibility requirements is guaranteed enrollment; and 2) it is an open-ended, federally matched program. The federal government guarantees to match state contributions. Currently, the federal government establishes minimum eligibility and covered services requirements. States can choose to cover other services, referred to as optional services. The federal government also guarantees half of Medicaid's administrative costs and a certain percentage of the total programmatic costs based on the federal matching rate (FMAP), which is computed by a formula that takes into account the average per capita income for each state relative to the national average, and cannot be below 50 percent.<sup>39</sup> The amount of the match varies each year. Missouri's is projected to be 61.93 percent, or \$1.68 for each state dollar spent in FY 2006.<sup>40</sup> Like any health insurance program, payments for services are made to providers at a contracted rate.<sup>41</sup>

Medicaid is counter-cyclical.<sup>42</sup> When the economy is doing poorly and tax revenues are down, Medicaid enrollment increases because more people are also facing economic troubles. The result is increasing program deficits largely reflective of diminished economic performance and significant loss of state revenues. Spurring the current Medicaid concerns are recent declines in the stock market coupled with job losses that led to reduced revenues from both income and capital gains taxes. Additionally, the recession

decreased sales tax revenues, which account for more than 30 percent of all state tax revenues.<sup>43</sup>

**Figure 1: State Tax Revenue Compared to Growth in Medicaid Spending**



*Kaiser Commission on Medicaid and the Uninsured, 2004*

Both Medicaid enrollment and costs have been growing at a time when most states are short of revenue. Complicating the situation for state policy-makers is the fact that all states except Vermont are required to maintain a balanced budget.<sup>44</sup> However, this alone does not explain the large increase in Medicaid enrollment. Even as the economy begins to recover, Medicaid expenditure growth has expanded faster than overall inflation and state revenue growth because Medicaid expenditures are also tied to the medical market where annual cost increases have surpassed growth in wages and general price inflation. Average state revenues increased by only one percent in 2001 and decreased by 6.8 percent in 2002, while during those same years Medicaid spending growth averaged around 12 percent per year.<sup>45</sup> In 2003, state revenue growth dropped an additional 3.4 percent and began a slight recovery in 2004, with average state revenue growing 3.4 percent. However, Medicaid spending growth increased 9.5 percent in 2003 and again in 2004.<sup>46</sup>

The Medicaid program responds to increases in overall health care costs. Medical cost growth rates have decreased from a high of 11.3 percent in 2001, but even the 2004 growth rate of 8.2 percent remains above the general economic growth rate of 5.6 percent.<sup>47</sup> Much of the increase in health care costs can be traced to increases in spending on prescription drugs, outpatient hospital care, and physician care.<sup>48</sup> Increases in Medicaid expenditures follow the national growth in medical costs that have been occurring over the last five years.

Rising health care costs affect both private and government-sponsored insurance programs. In 2005, average private health insurance premiums increased on average in the range of 8 to 10 percent, down from an average 12 percent increase in 2004. In turn, employers increased deductibles and co-payments or discontinued benefits altogether for the fourth year in a row.<sup>49</sup> These cost increases have made employer-sponsored health insurance a less affordable option for both the employers and employees. Newly released census data show a continued decrease in the percentage of people covered by employment-based insurance, from 61.3 percent of people in 2002 to 59.8 percent in 2004.<sup>50</sup> The increases in medical costs could account for some of the growth in Medicaid, especially the number of children enrolled in SCHIP as lower earning workers look for ways to provide coverage for their children.

### **Medicaid in Missouri**

Over the last three years, all 50 states have implemented some Medicaid cost-containment measures. After slowly expanding Missouri's Medicaid program over the course of several years, the Missouri legislature reduced eligibility for the elderly, the disabled and the parents of children enrolled in the state SCHIP program, and eliminated Medical Assistance for the Working Disabled and General Relief programs. Increased premiums were also implemented for approximately 46,000 children in families with incomes between 150 and 300 percent of the federal poverty level (FPL)<sup>51</sup> who are covered by Missouri's State Children's Health Insurance Program (SCHIP). In addition,

the legislation ended the state’s Medicaid Program by 2008 which forces reform measures to be adopted.

The chart below gives a breakdown of the number of Missourians losing health insurance coverage in each of the affected categories following enactment of the 2005 legislation and other Medicaid budget cuts implemented through departmental regulations changes.

**Table 1. Policy Changes and Groups Who Lost Coverage (2005)**

<b>Policy Change</b>	<b>Lost Coverage</b>
Reduction of Family Coverage to Temporary Assistance Eligibility levels <sup>9</sup> (17% to 22% of the federal poverty level)	68,219 low-income parents
Elimination of Extended Transitional Medical Assistance	1,150 low-income workers
Elimination of Medical Assistance for General Relief Recipients	3,046 people with temporary disabilities
Elimination of Medical Assistance for Workers with Disabilities (MAWD) recipients	9,529 working disabled individuals
Reduction of Income Eligibility to 85% of the federal poverty level	8,660 elderly and disabled individuals
Implementation of new Premiums and “Affordability” test in the State Children’s Health Insurance Program	unknown
Annual reinvestigations and related paperwork requirements	13,609 individuals (including 8,998 children)
Total number of Missourians losing health insurance coverage in FY 2006 as a result of eligibility changes and other new requirements	104,213 individuals

*Source: Legal Services of Eastern Missouri, 5/2005 Based on data from the Missouri Division of Medical Services, 2005<sup>52</sup>*

The 2005 legislative action established a legislative commission to gather information about options for reforming the state’s Medicaid Program to create a system that offers coverage to those who need it, while controlling costs. The actions taken by Missouri legislators reflect a national trend of reform of the Medicaid system<sup>53</sup> To date, states have utilized a range of policy options to contain costs in their Medicaid programs including:

- Increased cost sharing in the form of co-payments and premiums
- Reducing eligibility
- Restructuring or reducing health care benefits
- Disease management and case management programs
- Controls on costs of prescription drugs
- Premium assistance for employer-based insurance participation
- Tightening of fraud and abuse controls for providers and beneficiaries
- State government provided re-insurance
- Freezing or reducing provider and managed care organization payments<sup>54</sup>

These actions are within the range of cost containment actions taken by the private insurance industry and by employers who still provide insurance to their employees.

In addition to actions taken by most states to reduce Medicaid program costs, the federal government is attempting to reduce spending on domestic programs including Medicaid. Cost containment has been named as the primary reason for reform by both state and federal policy-makers. Claims are that cost increases are driven by over-utilization, waste, fraud and abuse of the system by both consumers and providers of health care services. However, to date, most efforts to reform Missouri's Medicaid program are aimed at reducing the number of people receiving health insurance coverage through Medicaid and reductions in the services covered by the program. Waste, fraud and abuse of the system by providers of health care services has received little attention, and it appears that no consideration has been given to how over-all cost increases in health care delivery are driving Medicaid program costs.

***How does Missouri Medicaid enrollment and spending compare to other states?***

Missouri's average annual growth in Medicaid spending between FY 1991 and FY 2001 was 16 percent compared to a national average for the same period of 11 percent.<sup>55</sup> For FY 2001, Missouri Medicaid enrollment was 19 percent of the state population, while the national average was 17 percent.<sup>56</sup> Even with the reductions in eligibility and other changes enacted in 2005, enrollment in Missouri's Medicaid program, according to the

state Division of Medical Services, will continue to be around 20 percent of the total state population in 2006.<sup>57</sup>

**Table 2. Comparison Distribution of Medicaid Enrollees by Enrollment Group, FY2001**

	MO #	MO %	US #	US %
Children	562,200	54.5	23,380,500	49.7
Adults	233,300	22.6	11,538,000	24.5
Elderly	99,100	9.6	5,132,900	10.9
Blind and Disabled	137,700	13.3	7,009,300	14.9
Total	1,032,300	100.0	47,060,700 <sup>1</sup>	100.0 <sup>1</sup>

Kaiser Family Foundation, [www.StateHealthFacts.org](http://www.StateHealthFacts.org)

**Table 3. Missouri Medicaid Payments per Enrollee by Enrollment Group, FY, 2001**

	Mo \$	Nat'l average \$
Children	1,410	1,315
Adults	1,287	1,736
Elderly	11,244	10,619
Blind and Disabled	10,201	10,642
Total	3,516	4,011

Kaiser Family Foundation, [www.StateHealthFacts.org](http://www.StateHealthFacts.org)<sup>58</sup>

Missouri's Medicaid program had, over several years, expanded coverage beyond the federally mandated minimum required services and groups, and this expansion also accounts for some of the differences in state-by-state costs. However, as shown on the chart above, Missouri spends less than the national average on individual adult enrollees, the group most affected by the 2005 Medicaid eligibility reductions.

When assessing the near and long-term future of Medicaid in Missouri, four points are of critical importance. They are: 1) the performance of the Medicaid Program compared to the over-all health care delivery system; 2) the value of the Medicaid Program to individuals' and communities' economic stability; 3) the health status of the population that receives health insurance coverage through Medicaid; and 4) identifying and assessing the full range of Medicaid Program cost drivers. A critical analysis of the Medicaid Program through each of these lenses follows.

***Missouri's Medicaid program compares favorably to other coverage plans.***

Currently, Americans spend about \$1.7 trillion annually on health care.<sup>59</sup> Estimates are that \$29.6 billion was spent on health care in Missouri in 2003.<sup>60</sup> Health care costs are a growing line item in the federal and state budgets. These have hurt the bottom lines of businesses, and are now the leading cause of personal bankruptcies in the U.S., even for those with health insurance.<sup>61</sup> Medicaid is just one of a number of health insurance programs available to consumers. To fully evaluate the effectiveness of the Medicaid program, context is important.

The World Health Organization ranks the United States 37<sup>th</sup> in the world on health system performance,<sup>62</sup> yet the U.S. per capita spending on health care is around \$5,400 annually, compared to an average of \$2,696 in other industrialized nations.<sup>63</sup> The U.S. also spends an average of \$1,000 per capita per year on health-related paperwork, three times the amount spent by other nations.<sup>64</sup> Administrative costs for the Medicaid Program average between 4 and 6 percent.<sup>65</sup> Missouri's Medicaid Program had administrative costs of 4.4 percent in 2003.<sup>66</sup> In contrast, in 2003 health maintenance organizations (HMO's) had administrative costs of between 8 and 12 percent, and for the same time period, the commercial health insurance industry regarded administrative costs of 15 to 20 percent as efficient.<sup>67</sup>

Because Medicaid is health insurance coverage for at-risk populations, participation in the program reduces the chance that an individual will be uninsured. This, in turn, acts to reduce the negative externalities associated with shifting the cost of treatment of the uninsured on to providers who may pass this on as increased fees for services or as increases in premiums to those with insurance. A recent study showed that the majority (over 65%) of people who lose Medicaid coverage become uninsured.<sup>68</sup> The other individuals that lose coverage either buy into employer sponsored insurance (28%), become eligible for Medicare (4%), or purchase individual health plans (2%).<sup>69</sup> Those who become uninsured are more likely to face decreased access to health care; minimal preventive care; and a higher rate of emergency room use, which places families at a greater risk for substantial medical debt.<sup>70</sup>

During the recent recession, Medicaid was a major factor in limiting the growth in the number of uninsured because it was available to families who lost health insurance when they lost their jobs, or when an employer or employee dropped health insurance benefits because of affordability issues.<sup>71</sup> Also, Medicaid sets an example for restraining per capita growth in spending compared to private insurance companies. Medicaid per capita growth in the cost of acute care was just 6.9 percent from 2000 to 2003, compared with 9.0 percent for all Americans with private insurance coverage and 12.6 percent in employer-sponsored health insurance.<sup>72</sup>

***Overall, Medicaid has a positive economic impact on the state and local economies.***

Medicaid and SCHIP have a substantial and positive economic impact on our state and local economies.<sup>73</sup> Medicaid brings significant federal matching dollars into the state. In 2005, state Medicaid funds generate federal matching funds at a 61% rate for most individuals and a 72% rate for SCHIP children.<sup>74</sup> Missouri Medicaid spending generates almost \$1.6 in federal matching funds for every state dollar spent while SCHIP spending generates nearly \$2.7 in federal matching funds. These federal matching funds are an important source of funding for hospitals, doctors, pharmacists, and nursing homes in every part of the state -- funding which, in turn, has a positive multiplier effect on communities.<sup>75</sup>

An analysis of economic data by economists at the St. Louis University (SLU) John Cook School of Business found that every \$1 million of state Medicaid spending generates over \$3 million in business activity and 42 jobs.<sup>76</sup> SCHIP federal matching funds have an even larger impact. A SLU Business School study found that in fiscal year 2004, federal matching funds to the State of Missouri generated almost \$6 billion in economic activity, supported 79,892 jobs in the state, and increased wages and other income earned by Missourians by \$2.8 billion, which generate \$211 million in tax revenues (based on those wages)<sup>77</sup>.

The St. Louis University analysis is consistent with seventeen other studies that are reviewed in a new Kaiser Commission report. Kaiser concludes that, "all of the studies

provide evidence that Medicaid spending has a positive impact on state economies. It is clear from the studies conducted thus far that, in addition to providing valuable health coverage for low-income people, state Medicaid spending also yields significant economic benefits for states. As a result of Medicaid's unique matching arrangements, these benefits may be larger than state spending alone."<sup>78</sup>

***Many enrollees with Medicaid coverage are elderly, frail or disabled.***

Individuals and families enrolled in Medicaid, who are poorer and often sicker than those who are privately insured, depend on the Medicaid program for preventive, medical, and long-term care services.<sup>79</sup> Although pregnant women, children and their parents make up the majority of Medicaid participants, they account for a relatively small proportion of the program costs.<sup>80</sup> The most expensive groups to cover are seniors and people with disabilities. Children and adults account for 73 percent of Medicaid enrollees but just 24 percent of the program's expenditures.<sup>81</sup> The elderly and disabled account for 17 percent of enrollees and 68 percent of the costs.<sup>82</sup> The elderly and the disabled, in general, utilize more health care services, especially prescription drugs. The reductions in eligibility implemented in Missouri have little impact on the costs associated with these high utilizing groups and what actions do affect these groups are likely to be redesigned because of political pressure and lack of feasibility.

***Most cost increases in the Medicaid program can be attributed to increases in the overall increase in health care delivery.***

A Robert Wood Johnson Foundation survey of state Medicaid directors confirms that the primary cost drivers in the Medicaid program across the country are prescription drugs, long-term care and increased enrollment as wages and benefits shrink.<sup>83</sup>

The greatest cost increases in the Medicaid program may be prescription drugs. Medicaid spending on prescription drugs increased by an average of 18 percent per year between 1999 and 2002.<sup>84</sup> The national Centers for Medicare and Medicaid Services (CMS) project that prescription drug costs will increase at a rate of 12.7 percent through 2011.<sup>85</sup>

The second cost driver is long-term care, especially payments to home health agencies and nursing homes. Medicaid fills the gaps for those eligible for Medicaid and Medicare by paying their Medicare premiums, coinsurance, and deductibles. Approximately 42 percent of all Medicaid expenditures are currently for individuals who also have Medicare coverage. Medicaid essentially underwrites Medicare by paying for services such as nursing home care and prescription drugs.<sup>86</sup>

An additional cost driver is increased enrollment in the Medicaid program attributable to recent weakness in the economy. For fiscal year 2002, the Congressional Budget Office (CBO) estimates that an unemployment rate of 4.5 percent will increase Medicaid enrollment by 700,000 people or 1.6 percent.<sup>87</sup> The Urban Institute calculated that if unemployment moved to 6.5 percent, Medicaid enrollment would increase by nearly 1.6 million people or 3.2 percent.<sup>88</sup> In addition, states, including Missouri, have aggressively enrolled children in the State Children's Health Insurance Program (SCHIP) as a means of providing cost-saving preventative health care. This aggressive effort also identified many more children eligible to be covered under Medicaid as well.

## **Conclusion**

Medicaid reflects the same problems as other segments of the U.S. health care delivery industry – inefficiencies, inequities, and the negative externalities of cost-shifting.<sup>89</sup> If Medicaid expenditures are reduced through reductions in eligibility, the health care costs of the newly uninsured individuals and families will be shifted onto providers and other consumers. Many of these costs show up as uncompensated care which in turn forces up the cost of private health insurance for us all and increases the need to compensate hospital emergency rooms and other so-called safety net providers.<sup>90</sup> This cost-shifting impact was most recently documented in a study by Dr. Kenneth Thorpe of the Department of Health Policy and Management, Rollins School of Public Health, at Emory University. The study examined the cost-shifting impact of the uninsured on health insurance premiums for individuals with private or employer-based coverage. The findings were published in a report by Families USA, entitled *Paying a Premium: The*

*Added Cost for the Uninsured.*<sup>91</sup> The study found that as a nation, the premium costs for family health insurance coverage provided by private employers will include an extra \$922 in 2005 due to the costs of care for the uninsured while the premiums for individual coverage cost an extra \$341.<sup>92</sup> For Missouri, specifically, the study found that in 2005, health insurance premiums in Missouri for a family with private, employer-sponsored coverage are \$291 higher due to the unpaid cost of health care for the uninsured.<sup>93</sup> Premiums for individual insurance coverage in Missouri are \$110 higher in 2005. By 2010, health insurance premiums for families in Missouri with private, employer sponsored coverage will be \$609 higher due to the unpaid cost of health care for the uninsured.<sup>94</sup> Premiums for individual health insurance coverage in Missouri will be \$225 higher in 2010.<sup>95</sup> These figures were computed prior to the implementation of Missouri's new Medicaid policies. It is reasonable to assume that Missouri's health insurance premiums will likely increase even more in response to the large number of people newly uninsured by the loss of Medicaid coverage.

### **Policy Recommendations**

#### ***Restore the Medical Assistance for Workers with Disabilities (MAWD) Immediately***

The actions taken by the state legislature in 2005 may not realize the savings anticipated. In addition, some of the changes will have unintended, negative consequences that cost more in terms of human suffering and loss of public morale. Though more difficult to measure, societal well-being has implications for productivity and prosperity. In particular, elimination of the Medical Assistance for Workers with Disabilities is especially short-sighted. This program allows people with disabilities to become active participants in their communities, within the restraints of their individual disability. This program should be re-instituted for the benefit of those who would otherwise perhaps be confined to a more costly nursing home and not have an opportunity to contribute to community life.

### ***Use Purchasing Power to Control Costs and Restore Coverage of Durable Medical Equipment and Supplies***

In addition, the elimination of durable medical supplies from Medicaid program support should also be closely examined. Eliminating services like batteries for wheel chairs and other life and quality of life sustaining necessities for those with disabilities could put certain people at greater risk. A better approach would be for the state to contract for durable medical supplies utilizing the purchasing power associated with large buying pools. This could save money and maximize autonomy for the thousands who need this equipment and supplies to maintain their health. The Medicaid reimbursement or support for durable medical equipment should be re-instated, and the state should immediately contract for the needed equipment and medical supplies using all the clout of bulk purchasing available to maximize savings.

### ***Create the Missouri Health Coverage Assurance Plan***

The author and members and supporters of the Missouri Association for Social Welfare Health Access Project support the development of a national health plan that is affordable, fair, and accessible to all citizens. However, we acknowledge the current lack of political will and the vast complexities of the issue. In the absence of a viable national effort, many states are taking responsibility by developing plans that are more equitable and efficient than our current system. Missouri, now leading the nation in restricting access to Medicaid coverage, should instead, lead by enacting common sense, visionary reform of our health care delivery system with the creation of the Missouri Health Coverage Assurance plan as a model for the nation.

The state Medicaid program is under stress because of multiple factors including increasing enrollment, increasing costs of medical care, utilization of services by older, sicker enrollees, and the over-all market inefficiencies. The problems in the Medicaid program are reflective of problems in the entire health care delivery industry. As such, it is short-sighted to assume that reductions in eligibility and services covered will have any long-term positive benefits. Negative externalities associated with shifting costs to other consumers for uncompensated care are impacting other segments of the market, driving

costs up even further. It is clear that successful reform of Medicaid requires that over-all systemic problems in Missouri's health care delivery system be addressed.

In addition to the work of the Missouri Medicaid Reform Commissioners, the Missouri State Government Review Commission has been hearing testimony from department heads, business leaders and average citizens about ways to make our government function more effectively and efficiently. The members of this commission have made several recommendations that are worthy of attention if we are to achieve the maximum efficiency and equity in our health care delivery system that our citizens and business community demand.

Among the recommendations of interest to those of us who support health care delivery system reform is Proposal #2 of Task Force B of the Missouri State Government Review Commission. This is a proposal to assess the feasibility of establishing a state Division of Health Care Administration by combining the self-funded state entities of the Missouri Consolidated Health Plan (for state employees and their dependents), Missouri Department of Transportation, Missouri Conservation Department and Higher Education insurance plans to create a large self-funded plan.<sup>96</sup> This state insurance plan should be implemented and expanded to include the more than 1.01 million Missourians projected to be covered through the state Medicaid program in 2005, and the projected \$6.663 billion dollars of Medicaid funding including the more than \$4 billion in federal dollars.

This new entity, the Missouri Health Coverage Assurance plan, will improve access to affordable health insurance, including mental health coverage and maximize return of federal tax dollars to Missouri. The new entity should be a public/private corporation that is HIPAA compliant and should offer health insurance to all Missourians under the age of 65, and/or those not eligible for the federal Medicare program. To guard against "cherry-picking" and "cream-skimming" by the insurance industry that would lead to segregation of higher cost individuals in the state plan, premiums should be determined by state and/or federal income tax filings of the previous year, and should not exceed the limitations enacted by the new state Medicaid legislation of 1 percent, 3 percent and 5

percent of an individual or family household income for families up to the 300 percent federal poverty level (FPL). The premium fairness and affordability and bargaining power gained from a large pool will bring efficiencies and cost controls to the market including reduced administrative costs and utilization of existing institutional structures, and will allow for the equitable enactment of mandatory insurance coverage.

This public/private corporation should explore opportunities to apply for the necessary federal waivers to insure Missourians who are Medicaid eligible by recovering the federal dollars as premiums for this population; insure high risk pool participants; include all state employees and employees of local governmental entities, including the higher education self-insured pools. The new plan should be a self-insured-model state health insurance plan that does not eliminate the need for other, additional private insurance products which can be available to consumers with need and ability to obtain additional coverage.

By integrating all segments of the state population into one basic health insurance plan, the risk pool will be expanded, thus distributing high cost participants over a much larger pool and driving down costs for coverage. In addition, federal matching dollars could be utilized to pay premiums for those eligible for coverage through what will be the restructured state Medicaid program. Further, the issues of lack of insurance coverage, cost shifting and uncompensated primary care of the uninsured will be addressed, freeing even more resources for actual coverage. Additional resources for this plan could be obtained by establishing a trust fund for re-insurance for the plan using some of the anticipated revenues from an increase in the state tobacco tax. This is justified as a use for the increased revenues because tobacco use is a leading cause of increased utilization of the health care delivery system. Recent estimates from the Missouri Hospital Association and others conclude that an increase in the state tobacco tax of 80 cents a pack could mean increased revenues of up to \$439 million annually<sup>97</sup> for some time.

We have a choice. On one hand, there is the idea of what the insurance industry refers to as 'social insurance'.<sup>98</sup> This is the historical model that promotes sharing or pooling risk

across a large population so all can afford the cost of keeping the population as a whole healthy and cared for, as Medicaid was meant to do for the elderly, the poor and children. On the other hand, there is the ‘actuarial’ approach.<sup>99</sup> This is when you pay more if you need more service or care. This approach penalizes those of us who have unfortunate genes or an accident, or who become old and frail. This approach accepts that millions of people would not have insurance. This approach is costing us all more in the long run while covering fewer people.

Leaving people out of the health care delivery system as a solution to the problem of increasing costs expresses a vision for our society that only some people - those who don’t need it and won’t use much - should have access to health insurance, while those who really need health care cost too much and so should be excluded. In other words, continued rationing of health care by income, race, age and health status, allowing for-profit insurance companies to serve as gatekeepers to the health care system.<sup>100</sup> Is this really our shared vision for health care coverage?

We are at a cross-road. Members of the Missouri Medicaid Reform Commission are writing their recommendations for re-designing the state Medicaid program. Medicaid does not operate in a vacuum. Problems with Missouri’s Medicaid program are only reflections of the problems in our health care delivery system as a whole. Missourians have an opportunity to redesign our health care delivery system in a way that takes the positive aspects from workable models, addresses the inefficiencies and inequities of current systems, and assures all Missourians affordable, appropriate and accessible health coverage. The Missouri Health Coverage Assurance plan is a common sense solution for all Missourians.

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