

**MEDICAID IS *STILL* GOOD
MEDICINE FOR MISSOURI**

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As the 2005 legislative session approaches, the Medicaid program continues to be a topic of discussion and an area cited for potential budget cuts. This discussion echoes the debate that occurred during the 2004 legislation, in which substantial Medicaid cuts were proposed but most were avoided. It is undisputed that Medicaid is a major component of Missouri's health system. Medicaid is not only Missouri's major health insurance program for the poor; it is also a major payer of long-term care for the elderly and disabled and the State's largest funding source for nursing home care. This paper briefly examines the impact that Medicaid and the State Children's Health Insurance Program (SCHIP) have on our state and its health care system. As various policy options are considered, it is important to recognize the role that Medicaid plays in Missouri and the impact that these options may have on each of the areas discussed below.

- **Medicaid Reduces Missouri's Rate of Uninsured**

Medicaid and SCHIP have a significant impact on the number of people in Missouri without health insurance. Missouri's uninsured population, which is estimated to be over 620,000, would be higher if not for Medicaid and SCHIP.¹ Any Medicaid eligibility cuts would increase the number of uninsured people in Missouri.

Because of Medicaid and SCHIP, the percentage of uninsured children in the United States has remained steady, despite the decline in employer-based coverage.² Census data show that Missouri's rate of uninsured would have been far worse if not for the role of Medicaid and SCHIP in responding to increased need during the recent recession.³ The Center on Budget and Policy Priorities found that **from 2000 to 2002, the percentage of uninsured low-income Missouri children fell from 12.2 percent to 7.2 percent – a rate reduction that was entirely attributable to children** being enrolled in Medicaid and SCHIP.⁴ Thus, it is no accident that Missouri's rate of uninsurance is 4% below the national rate.⁵

Meanwhile, Missouri's percentage of uninsured adults has increased substantially in large part based on the Medicaid cuts that Missouri has already implemented. A new analysis by the Center on Budget and Policy Priorities indicates that Missouri's rate of low-income uninsured parents has grown substantially over the last three years. The Center found that:

In the year 2000, less than one-fifth (18.8%) of the low-income parents in Missouri lacked health insurance coverage. By 2003, the proportion without insurance had surged to almost one-third (29.6%). **The main reason was that Medicaid coverage fell sharply: the percentage of low-income Missouri parents covered by Medicaid fell from 30.8% in 2000 to 22.9%.** . . . This loss was compounded by a reduction in private health insurance coverage (including both employer-sponsored coverage and other private coverage) for low-income parents in recent years.

The key reason for the Medicaid loss was the fact that Missouri cut eligibility for low-income parents from 100 percent of the poverty line

to 77 percent in 2002 (eligibility levels were cut a little more this year, to 75 percent of the poverty line). The Missouri Department of Social Services estimated that this reduction in eligibility caused about 25,000 to 37,000 parents to lose their Medicaid coverage, and several thousand other Missourians lost Medicaid coverage because of other program changes.

In contrast, **for the overall nation, the percentage of low-income parents covered by Medicaid grew by 1.7 percentage points.** This growth was spurred by growth in the number of poor Americans in this time period and by drop-offs in employer-sponsored health insurance, which increased the demand for Medicaid coverage. At the national level, the slight growth in Medicaid coverage helped cushion the losses in private health insurance coverage, slowing the increases in the number of uninsured low income parents.⁶

It is clear that cutting Medicaid eligibility adds to the ranks of Missouri's uninsured while maintaining coverage helps combat rising rates of uninsurance. And, as indicated below, there are serious economic and health consequences from policies that increase Missouri's rate of uninsured.

- **Like Other Insurance, Medicaid Improves Access to Health Care and Health Outcomes**

By providing health insurance coverage to needy families, Medicaid and SCHIP confer important health benefits. Conversely, cutting Medicaid causes families to lose health insurance and negatively affects the health of Missouri's low-income working families.

It is well established that *having health insurance* improves access to health care and health outcomes.⁷ The uninsured receive less preventative care, are diagnosed at more advanced disease states, and, once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions) than people who have health insurance.⁸ Moreover, a wide array of studies demonstrates that Medicaid and SCHIP coverage improves access to health care and health outcomes.⁹ Such coverage can decrease emergency room usage, reduce preventable hospitalizations, and increase the use of primary health care.¹⁰ **Studies have found that Medicaid and SCHIP have had a number of positive effects on the health care of Missouri children, including reduced emergency room visits, reduced emergency room visits for asthma, a decline in preventable hospitalizations, and improved school attendance.**¹¹ Similarly, a recent study shows that enrollment in New York's SCHIP program was associated with improved access, continuity and quality of care, and a greater likelihood of receiving treatment from patients' "usual source" of primary care.¹² Meanwhile, studies also show that *cutting* Medicaid and SCHIP has a negative impact on the health of the people who lose coverage.¹³

- **Medicaid Coverage Promotes Financial Stability Among Low-income Missourians**

In addition to its positive impact on health, Medicaid promotes financial stability among low-income families by paying for the costs of their health care. It is well-established that having health insurance, including Medicaid, improves families' financial well-being. "Families who are uninsured are at greater risk than the insured of high out-of-pocket medical spending due to injury or illness and its consequences (e.g., risk of impoverishment, bankruptcy, inability to afford other necessities, such as rent, food, clothing and transportation."¹⁴

It is increasingly acknowledged that uninsured families incur medical debt, which can cause serious problems. According to a Commonwealth Fund report, 41% of adults had problems paying their medical bills in the previous year or were paying off medical debt accrued over the last 3 years.¹⁵ Among those who said they had such medical bill problems, 27% said it caused them to be unable to pay for basic necessities such as food and heat, 44% said they used all or most of their savings to pay medical bills, and 20% said they had run up large credit card debts or had to take out loans against their home to pay these bills.¹⁶ A study by the Access Project of uninsured people found that 60 percent said they needed help paying for their medical care, and nearly half (46%) said they owed money to the facility where they received care. For those who received care in emergency rooms, the percentages were even higher.¹⁷ Another study reported that nearly half of all personal bankruptcies result from health problems or large medical bills.¹⁸

Providing health insurance through Medicaid and SCHIP combats these problems by paying for the medical care of individuals and families that can least afford it.¹⁹ Conversely, cutting Medicaid eligibility negatively affects the financial well-being of low-income people by making them uninsured, as indicated in the below-mentioned discussion of Medicaid cuts in North Carolina and Oregon.

Cutting Medicaid and SCHIP Negatively Affects Health Care and Financial Stability

North Carolina: The health impact of cutting Medicaid is demonstrated by a study of North Carolina's efforts to control costs by freezing eligibility for its State Children's Health Insurance Program.²⁰ In 2001, North Carolina temporarily froze enrollment in its SCHIP program, placing thousands of eligible children on a waiting list, reducing enrollment by 30% in nine months, and causing many previously Medicaid eligible beneficiaries to lose their insurance altogether.

Researchers found that those affected families in North Carolina reported substantial hardship, including unmet medical and dental needs, financial problems, and some unnecessary surgery due to complications. Many households delayed seeking needed care, and in some cases, their children endured unnecessary pain and suffering as a result.

Families used emergency rooms for their care and had difficulty obtaining and paying for needed medications. Many families reported trying to seek other health insurance coverage for their children when they were uninsured, but most were unable to afford the monthly premium costs -- even when it was available through their or their spouse's employer. Nearly all families suffered financial hardship due to out-of-pocket expenses for medical and dental care while their children were uninsured -- with many going without basic necessities in order to obtain their children's needed health care services. The families reported buying less and lower-quality food, delaying rent and utility payments, and losing the use of their car due to an inability to pay for repairs.

(Silberman et al., January 2003.)

Oregon: A study of Medicaid cuts in Oregon similarly revealed that people who lost Medicaid coverage had significant access problems, with 60% reporting an unmet health need and nearly 80% reporting an unmet *mental* health need. Those with chronic conditions were particularly adversely affected. Cuts in coverage to elderly and disabled beneficiaries found that these “elderly and disabled people were having problems obtaining needed drugs, which, in light of their significant medical needs, could result in considerable harm to their health and to higher costs due to compromised care.”

In addition, 60% of those surveyed who had lost their coverage reported that they cut back on food purchases to pay for their medications. Almost half (49%) reported having to skip paying other bills or paying bills late. One fifth reported going into debt to pay for some of their prescriptions.

(Mann and Artiga, June 2004)

- **Medicaid Reduces Missouri's Uncompensated Care Burden and Prevents Cost-shifting; Cutting Medicaid Increases Costs for Everyone.**

A loss of insurance coverage also increases the amount of “uncompensated care” - care that is not paid for by private or public insurance. These uncompensated care costs are transferred to other parts of the health system, driving up costs and straining health resources for people who are not covered by the Medicaid program.

- In testimony before the House Interim Committee, the Missouri Hospital Association pointed out the substantial “cost-shift” that would occur if Missouri's rate of uninsured were higher.²¹ MHA estimated a cost shift of more than \$144 million dollars if Missouri's rate of uninsured were comparable to the higher *national* rate of uninsured.²²
- The St. Louis Regional Health Commission (RHC) has documented the uncompensated care burden that results when people become uninsured and the impact this cost-shift has on private insurers and the employers with whom they contract.²³ The RHC found that **in fiscal year 2002, “St.**

Louis area hospitals had a net loss of approximately \$160 million of the cost of uncompensated care for Medicaid and uninsured patients.”

The RHC found that “hospitals cover these losses by increasing their charges and contracted rates with private insurers who in turn pass the additional costs onto area employers.”²⁴

- The Georgetown Health Policy Institute estimated a \$93 million annualized cost-shift from the implementation of proposed cuts to Medicaid in the state of Connecticut.²⁵
- **A Kaiser study showed that emergency room visits increased by 17% in the three months after Medicaid cuts were implemented** in the state of Oregon compared to the year before.²⁶ Clinics also reported difficulties meeting patient needs stemming from both losses in coverage and, for those who remained covered, from reductions in benefits and increases in co-payments.²⁷

Governor-elect Blunt has similarly recognized this cost-shifting impact in the context of discussing Medicaid’s low reimbursement rate. The Governor-elect’s health care plan includes the following discussion of the impact of the cost-shifting that results from uncompensated care:

Reduce Cost Shifting. Although many fail to see the connection, low physician reimbursement rates affect the cost of employer-provided and "private pay" insurance. When health care providers are forced to take a loss on Medicaid and Medicare patients, that loss is shifted to other patients. This increases costs for everyone.²⁸

This cost-shift is that much more dramatic when health care providers receive *no* reimbursement and are forced to absorb the *entire* cost of their patients’ care. **Policymakers similarly ought to “see the connection” and recognize that when they cut Medicaid, they increase costs for everyone else by shifting costs of the cuts to employers, insurers, and patients.**

As previously discussed, Medicaid and SCHIP are a significant reason why Missouri’s rate of uninsured has not grown more over the last several years. Any proposal to cut eligibility ought to examine the “cost-shifting” impact of such proposals and analyze whether the harm from shifting costs in this manner outweighs the “savings” to state general revenue anticipated from such cuts.

- **Medicaid Benefits Missouri’s Economy**

Medicaid and SCHIP have a substantial and positive economic impact on our state and local economies. Medicaid brings significant federal matching dollars into the state. State Medicaid funds generate federal matching funds at a 61% rate for most individuals and a 72% rate for SCHIP children. 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, leads to economic ripple effects as these health care providers pay rent, purchase food, pay taxes and so on.

An analysis of economic data by economists at the St. Louis University's John Cook School of Business found that every \$1 million that the state spends on Medicaid spending generates over \$3 million in business activity and 42 jobs.²⁹ Expenditures on SCHIP would have even larger effects. The SLU Business School recently 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).**³⁰

The St. Louis University analysis is consistent with seventeen other studies that are reviewed in a new Kaiser Commission report. Kaiser concludes that, "[a]ll 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."³¹ Clearly, there are substantial economic ramifications to any decisions to cut or expand Medicaid.

- **Access to Medicaid Promotes Welfare Reform**

Welfare reform at both the federal and state levels has involved moving parents off of cash welfare and into employment. Providing access to work supports such as Medicaid and child care has been an integral part of welfare reform. Maintaining health coverage for people moving from "welfare to work" is an essential welfare reform strategy because so many low-wage jobs do not provide health insurance – a significant reason why Missouri and so many other states expanded health coverage for low-income working families in the 1990s. In fact, most of Missouri's uninsured are members of working families, many of whom cannot afford to purchase private employer-sponsored health insurance.³²

Missouri has even received welfare reform "bonus" payments from the federal government for providing access to Medicaid and SCHIP for families who make the transition from welfare to work.³³ Assuring continued access to health coverage through Medicaid bolsters Missouri's ongoing efforts to help people leave the welfare rolls and move into self-sustaining employment because it helps them receive coverage for themselves and their families *and* helps them stay healthy, making them better and more productive workers.

Cutting Medicaid by Erecting New Barriers to Coverage Can Have the Same Negative Impact as Direct Eligibility Cuts; However, the Imposition of Procedural Barriers Causes *Eligible* People to Lose Coverage and Increases State Administrative Costs.

One strategy for cutting Medicaid is to erect new administrative barriers to coverage, such as increasing eligibility verification requirements. The obvious effect of these types of rules is to *reduce coverage*. More restrictive enrollment practices have led to substantial losses in enrollment in several states. For example, new procedural barriers caused enrollment of children to drop by more than 149,000 in the Texas SCHIP program.³⁴ While these types of cuts are intended to save money, there is substantial research that imposing additional procedural obstacles, such as new verification requirements, causes *eligible* people to lose Medicaid coverage.³⁵ Moreover, requiring families to comply with added paperwork and reporting procedures which reduce the number of people participating in the program increases the cost of uncompensated care when uninsured people seek needed medical attention and results in serious financial burdens for low-income families who pay for treatment on their own.³⁶ Thus, **more low-income Missourians who are in fact financially eligible for coverage would become uninsured if the verification process is made more stringent than it is now**, with an array of consequences for their health and well-being and for Missouri's health care system and its economy. It is clear that proposals to cut Medicaid by increasing verification requirements can have the same impact as direct cuts to eligibility, and that impact must be evaluated accordingly. Of course, these types of policies also have the additional impact of increasing state administrative costs. As the Kaiser Commission has noted:

While requiring families to comply with added paperwork and reporting procedures may save money by reducing the number of people participating in the programs, it should be noted that costs also are incurred as a result of making such changes. **In addition to the large costs associated with uncompensated care when uninsured people seek needed medical attention, and the serious financial burdens low-income families must shoulder to pay for treatment on their own, there are expenses associated with the administrative tasks necessary to implement more labor-intensive procedures.** Where financial pressures have already resulted in state workforce reductions or hiring freezes, it is important to keep in mind that changes such as increasing reporting and verification requirements are likely to require more staff time.³⁷

Such costs should be factored into any analysis of the "savings" from new verification proposals. So too should the fact that cutting eligibility in this manner will mean a loss of coverage and diminished health access for *eligible* families.

Conclusion

It is clear that Medicaid plays a substantial role in our state. Medicaid has a significant positive impact on Missouri's rate of uninsured and on the health and financial well-being of its residents. Medicaid also directly benefits the economy and Missouri jobs, enhances welfare reform, and reduces the state's level of uncompensated care, thereby preventing further cost-shifting that increases overall health care costs. Cutting Medicaid has significant ramifications in all of these areas. Whether such cuts are in the form of direct cuts to Medicaid eligibility or services or are the result of aggressive verification practices, the consequences are the same. Policymakers should consider all of these issues as they look to balance the budget and make health policy in our state.

¹ A new Missouri Department of Health and Senior Services study estimates Missouri's rate of uninsured to be approximately 463,000, using a different methodology than that employed by the Census Bureau. Department of Health and Senior Services News Release, *New Survey Shows Nearly a Half Million Missourians Have no Health Insurance*, November 18, 2004.

² See Robert Mills, *Health Insurance Coverage in the United States: 2002*, Current Population Reports P60-223, U.S. Census Bureau, September, 2003.

³ For further discussion of Missouri-specific findings on the impact of Medicaid and SCHIP on Missouri's rate of uninsured, see Joel Ferber, *Economic and Health Benefits of Missouri Medicaid*, Missouri Foundation for Health, April 2004, ("MFH Report") and the citations therein.

⁴ See MFH Report at 8-9. Subsequent data show that Missouri's rate of uninsured children has crept back up based on a significant increase in the number of low-income children in the state without a corresponding increase in Medicaid and SCHIP participation.

⁵ Missouri's rate of uninsured was 11.3% for 2002-2003 while the national rate was 15.4% for 2002-2003. Table 9 (Percentages of People Without Health Insurance Coverage by State Using 2- and 3-year Averages: 2001-2003 (available at www.census.gov/hhes/hlthins/hlthin03/hi03t9.pdf)

⁶ Leighton Ku, Memorandum to Interested Parties, Center on Budget and Policy Priorities, December 7, 2004 (emphasis added).

⁷ Kaiser Commission on the Future of Medicaid and the Uninsured, *The Uninsured and their Access to Health*, January 2003.

⁸ See Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured: Executive Summary*, The Kaiser Commission on Medicaid and the Uninsured, February 2003. www.kff.org/uninsured/20020510-index.cfm,1.

⁹ Ellen O'Brien and Cindy Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*, Covering Kids and Families, June 2003.

¹⁰ Id. (and citations therein). See also Katie Plax and Joel Ferber, *Medicaid and SCHIP Improve the Health of Missourians*, Washington University School of Medicine, April 20, 2004, for a more detailed review of the medical literature on Medicaid and SCHIP's impact on health.

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- ¹¹ Department of Social Services, State of Missouri, *Since MC+ Began*, February 10, 2003.
- ¹² Peter G. Szilagyi, et al, “Improved Access and Quality of Care after Enrollment in the New York State Children’s Health Insurance Program (SCHIP),” *Pediatrics*, Vol. 113, No. 5, May 5, 2004.
- ¹³ Pam Silberman et al., *The North Carolina Enrollment Freeze of 2001: Health Risks and Financial Hardships for Working Families (“Enrollment Freeze”)*, January 2003. Another study showed that two years after losing Medicaid, individuals who lost Medicaid were more likely than those who remained covered by Medicaid to: (1) lack a usual source of care; (2) encounter difficulty in obtaining medical care; (3) be very dissatisfied with their ability to obtain needed care; and (4) report no physician visits in the previous 12 months. O’Brien and Mann, *supra*, at 15.
- ¹⁴ Ellen O’ Brien and Cindy Mann, *supra*, at 19 (and the citations therein).
- ¹⁵ Sara R. Collins et al., *Health Care Costs and Instability of Insurance: Impact on Patients’ Experiences with Care and Medical Bills*, The Commonwealth Fund, Invited testimony, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives, Hearing on “A Review of Hospital Billing and Collection Practices,” June 24, 2004, at 3, 13.
- ¹⁶ *Id.*
- ¹⁷ Mark Rukavina, the Access Project, Testimony before the House Energy and Commerce Subcommittee on Oversight and Investigations, U.S. House of Representatives, Hearing on “A Review of Hospital Billing and Collection Practices,” June 24, 2004.
- ¹⁸ M.B. Jacoby, et al., “Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts,” 76 *NYU Law Review*, 375, 2000.
- ¹⁹ See O’Brien and Mann, *supra*, at 19-20 for a review of studies showing how public health insurance coverage reduces families’ financial burdens.
- ²⁰ Pam Silberman et al., “Enrollment Freeze.”
- ²¹ Missouri Hospital Association, *Missouri Medicaid Briefing*, House Interim Committee on Medicaid Cost and Containment, October 10, 2003, at 37. MHA’s findings are consistent with other research on this issue. See also MFH Report at 11-12 (and citations therein).
- ²² Missouri Hospital Association, (MHA) Missouri Medicaid Briefing, House Interim Committee on Medicaid Cost Containment, October 10, 2003, at 37.
- ²³ St. Louis Regional Health Commission, *Missouri’s Medicaid Program and its Impact on Missouri Business*, April 2003.
- ²⁴ *Id.*
- ²⁵ The Anthem Foundation of Connecticut, *Families at Risk: Costs of Proposed Medicaid and Husky A Changes to the Connecticut Economy*, March 2004, n. 19 and accompanying text.
- ²⁶ Cindy Mann and Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon’s Medicaid Program*, Kaiser Commission on Medicaid and the Uninsured, June 2004.
- ²⁷ *Id.*

²⁸ Matt Blunt, Governor, *A Prescription for Missouri* (available at http://mattblunt.com/blunt_contents/issues/prescription.shtml), The Blunt plan further states that as “a result [of cost shifting], the cost of health insurance for the self-employed skyrockets and employers find it increasingly difficult to provide insurance for their workers.” Matt Blunt Governor, *A New Direction*, at 29 (available at http://mattblunt.com/blunt_contents/issues/newdirection.pdf)

²⁹ MFH Report at 7.

³⁰ These figures were recently computed by economists at St. Louis University’s John Cook School of Business, updating the figures they computed for the aforementioned MFH report that was released in April 2004. See MFH Report Appendices A, B, and C for the discussion of the economic impact of Medicaid spending in FY 2003 and the methodology for determining the economic impact of Medicaid spending.

³¹ *The Role of Medicaid in State Economies: A Look at the Research*, Kaiser Commission on Medicaid and the Uninsured, April 2004 (emphasis added).

³² Families USA, *Who’s Uninsured in Missouri and Why?*, November 2003.

³³ About \$1 million of Missouri’s \$10.9 million bonus payment for FY 2003 was based on Medicaid and SCHIP enrollment of former TANF recipients. See Department Health and Human Services, Office of Family Assistance, Table 1: High Performance Bonus Awards for Performance Year 2003 by Category Amount (available at <http://www.acf.hhs.gov/programs/ofa/HPB/2003/tab1.htm>.)

³⁴ Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Kaiser Commission on Medicaid and the Uninsured, October, 2004, at 6-8.

³⁵ See e.g., Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge, A 50 State Update on Eligibility, Enrollment, Renewal and Cost-sharing Practices in Medicaid and SCHIP* (“*New Tensions*”), July 2003; Ellen O’Brien and Cindy Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*, *Covering Kids and Families*, June 2003, at 9; Laura Cox, *Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children’s Health Coverage Programs*, Center on Budget and Policy Priorities, December 28, 2001.

³⁶ Donna Cohen Ross and Laura Cox, *New Tensions*, at 16.

³⁷ *Id.* (emphasis added).