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LEGAL SERVICES OF EASTERN MISSOURI
ON PROPOSED 13 CSR 70-4.120 (*INSURE MISSOURI*)

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I am writing on behalf of Legal Services Eastern Missouri (LSEM) to submit comments on the above-cited proposed rule to implement Phase I of *Insure Missouri*. 33 Mo. Reg. 440 (February 15, 2008). LSEM is a nonprofit legal services organization that provides civil legal assistance to low-income Missourians in 21 counties in the eastern part of our state. One of LSEM's service priority areas is "health," which includes helping individuals who are eligible for Medicaid, now called MO HealthNet, in Missouri. We assist low-income clients in obtaining MO HealthNet coverage and services from the State and the managed care plans with which the State contracts. The proposed rule takes a significant step forward in addressing the problem of the uninsured in our state. Therefore, **I strongly support the State's effort to move forward with the proposed rule to implement "Phase One" of Insure Missouri**. While the program would be improved through the modifications described below, the Department should move forward with this plan regardless of whether all of these improvements can be incorporated into the final rule. Moreover, the Department should resist any efforts to diminish the benefits package, increase cost-sharing or fundamentally alter the program to meet ideological goals, rather than provide meaningful health insurance to more than 54,000 low-income working families.

I. BACKGROUND

A. The Problem Addressed by the Proposed Regulation: Missouri's Uninsured and Why it Matters?

It is important for the State to address the problem of the uninsured for several reasons. While Missouri's rate of uninsured is lower than the rate of uninsured for the nation as a whole, Missouri's rate of uninsured is growing at three times the rate of the national average and there are well over 700,000 uninsured, in our state, including 127,000 uninsured children.[1] Recent census data indicates that there are more than 719,000 uninsured Missourians.[2] This is important for several reasons.

Addressing the problem of the uninsured will improve the likelihood that people will receive necessary medical treatment. It is well established that *having health insurance* improves access to health care and health outcomes.[3] The uninsured receive less preventative care, are diagnosed at more advanced disease states, and, once diagnosed, tend to receive less therapeutic care (such as drugs and surgical interventions) than people who have health insurance. The Institute of Medicine has found that 18,000 people die prematurely each year as a result of being uninsured.[4] For example, uninsured cancer patients are diagnosed later and die earlier than those with insurance.[5] Based on a

thorough review of health outcome studies, the Institute of Medicine also concluded that **uninsured adults were 25 percent more likely to die prematurely than adults with health insurance coverage.**[6] Moreover, uninsured patients are three times more likely to die in the hospital than insured patients.[7]

In addition to its role in improving access to health care and health outcomes, health insurance helps to combat a range of other related problems, including **cost-shifting**, and problems associated with **medical debt**. It is widely acknowledged that the uninsured population generates costs sometimes referred to as "uncompensated care" – care that is not paid for by private or publicly funded coverage.[8] These uncompensated care costs are transferred to other parts of the health system, driving up costs and straining health resources for people who have private insurance. This cost-shifting impact was documented in a study by Dr. Kenneth Thorpe of the Department of Health Policy and Management, Rollins School of Public Health, at Emory University.[9] This study examined the cost-shifting impact of the uninsured on health insurance premiums for individuals with private or employer-based coverage. This study found that 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. The study also found that premiums for individual health insurance coverage in Missouri will be $225 higher in 2010. Indeed, the reduction of cost-shifting is one of the stated reasons for the *Insure Missouri* initiative.

In addition, providing health insurance to the uninsured promotes financial stability among Missouri families by paying for the costs of their health care. Families who are uninsured are at greater risk than the insured for 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).[10] Therefore, by tackling the problem of the uninsured, the regulation addresses a problem with significant ramifications for our state and its residents.

Some Key Facts About Missouri's Uninsured

- 42% of adults *under* 100% of the poverty level are uninsured.
- Only 14% of adults under 100% of the poverty level have employer-sponsored coverage.
- 82% of Missouri's uninsured are adults.
- 18% of Missouri's uninsured are children.
- 71% of Missouri's uninsured households have at least one full-time worker.
- 82% of Missouri's uninsured households have at least one full-time or a part-time worker.
- 67% of Missouri's uninsured are low-income (under 200% of poverty), with 36% having incomes under 100% of the federal poverty level.

From Kaiser State Healthfacts.org.

B. Where Medicaid Fits In

The proposed regulation would appropriately take advantage of federal Medicaid funds to expand coverage to low-income uninsured parents. While Medicaid is only *one piece* of the puzzle, it is virtually impossible for any state to address the problem of the uninsured without using the federal Medicaid program as *part* of the solution. First of all, a high percentage of the uninsured have low incomes and are in the population that the Medicaid program was designed to serve.[11] Moreover, many low-income Missourians simply do not have access to employer-sponsored coverage and cannot afford private coverage. Therefore, publicly-funded coverage is a logical place to turn to help address this problem.

That is why, for example, the state of Massachusetts, which made a wide variety of changes to achieve near-universal coverage, built its program upon a strong Medicaid program, rather than trying to replace Medicaid solely with private market approaches, employer or individual mandates. Most importantly, the *federal Medicaid matching funds* and state flexibility that Medicaid offers make it a necessary component to address the low-income uninsured in any state. While Missouri must provide state matching funds to draw down federal Medicaid funds, it is reimbursed at a 63% rate under regular Medicaid rules and a 73% rate in the SCHIP program. Moreover, the state match that Missouri contributes is not all general revenue dollars. In fact, just about half of the *state* matching funds that Missouri spends is general revenue, with other funds coming from provider taxes and other funding streams.[12] Thus, the federal matching funds available through Medicaid are a funding stream that Missouri simply cannot ignore if it is to reduce the number of uninsured.

Using federal Medicaid funds is easiest when the state seeks to expand coverage to the traditional categories or groups covered by Medicaid such as low-income parents, children and people with disabilities. Federal law provides states with ample flexibility to increase the income levels for groups within these categories and to vary the benefits packages for some of these groups. The proposed *Insure Missouri* regulation takes advantage of this flexibility to provide a package that varies from traditional Medicaid rules. Medicaid expansion to non-traditional groups, such as childless adults, can be accomplished but, as discussed more fully below, requires a waiver of federal rules and must be negotiated with the federal government.

Another important reason why Medicaid is part of the solution to the problem of the uninsured is that *it works*. A wide array of studies demonstrate that Medicaid and SCHIP coverage improves access to health care and health outcomes.[13] Like private health insurance, publicly-funded coverage decreases emergency room usage, reduces preventable hospitalizations, and increases the use of primary health care.[14] In fact, *Missouri's* Medicaid and SCHIP programs have had a similar, positive impact on access to health care.[15] Moreover, *expansions* of Medicaid eligibility for children in the late 1980s and early 1990s led to a 5.1 percent reduction in childhood deaths while expansions of Medicaid coverage for pregnant women led to an 8.5 percent reduction in infant mortality and a 7.8 percent reduction in the incidence of low birth weight.[16]

Therefore, coverage funded through Medicaid and SCHIP can have a positive impact on people's health and their very ability to survive.

The Uninsured and Publicly-funded Health Insurance Coverage

According to a national study of the uninsured:

- 25% of the uninsured are eligible for public health insurance coverage (Medicaid or SCHIP). (While 74% of uninsured children are eligible, only 28% of uninsured parents and 8% of childless adults are eligible for public coverage.)

- **56% are *not eligible* for public programs but have incomes below 300% of the federal poverty level.** This group is composed primarily of parents and childless adults who work but may have difficulty obtaining or affording coverage. Many uninsured parents have children who qualify for public coverage, but do not qualify themselves because of low Medicaid eligiblity levels for parents. Childless adults are generally not eligible for public coverage. *Expanding public programs or providing financial assistance would be necessary to increase coverage of these low-income uninsured adults.*

- The remaining 19% live in families with incomes above 300% of the federal poverty level where coverage is likely to be more affordable.

John Holohan, Allison Cook and Lisa Dubay of the Urban Institute, Characteristics of the Uninsured: *Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?*, Kaiser Commission on Medicaid and the Uninsured, February 2007.

The proposed regulation has the potential to help thousands of low-income Missourians obtain access to health insurance, and it takes some steps that will enable our state to begin to grapple with the problem of the uninsured. Phase One is estimated to provide health coverage to nearly 55,000 low income working parents. This health insurance makes it more likely that low-income people will attain access to the health care that they need. The proposed regulation would provide meaningful health insurance to tens of thousands of Missourians who are currently uninsured, and have a substantial positive impact on their access to health care.

II. COMMENTS

A. The Final *Insure Missouri* Regulation Should be Revised to Cover the Most Low-income Uninsured Parents.

The proposed regulation, as it stands now, while extremely beneficial to thousands of low-income parents, leaves out a significant group of needy parents, i.e., those who have *unearned* income that takes them over the state's very low income eligiblity limits for parents ($292 per month for a family of three). It is likely that this

highly vulnerable group of uninsured Missourians will fall through the cracks between the existing MO HealthNet program and this new coverage initiative. Not all parents, or even all *working* parents, under the poverty level would receive health coverage under *Insure Missouri's* current program design.[17]

The proposed regulation would *not* raise the income limit from current levels to 100% of the federal poverty level. Rather, the program would expand coverage by "disregarding" a certain amount of earnings in determining the family's eligibility. The Agency intends to disregard all **earned** income between the current Temporary Assistance limits and 100% of the federal poverty level. However, the Department will not apply that same disregard to other sources of income such as child support or Social Security Disability benefits, even though *unearned* income can also cause a family to exceed the very low income eligibility limits of the current MO HealthNet program.[18] As a result, families who have some earned income and who also receive enough unearned income (e.g. child support or Social Security benefits) to take them over the *current* program's extremely low income eligiblity limits may not be eligible for the Insure Missouri program. A better approach, one that would treat families with all types of income equally, is to raise the income eligibility limits to 100% of the federal poverty level.

Moreover, given that there are working families with child support and other income sources who are *just as poor as those families who have only earned income*, the State should use eligibility criteria that allow families with these other income sources to be eligible for the program if their total income is under the federal poverty level.[19] Otherwise, the State will continue to leave some of the *neediest* parents without any health insurance. Certainly, parents at these very low income levels (just over $292 a month for a family of three) do not have access to employer-sponsored health insurance and do not have the means to purchase private health insurance. Therefore, **the final regulation should allow all families with income below 100% of the federal poverty level to participate in *Insure Missouri*.**

This problem is even more pronounced in light of the fact that the current income standard for parent coverage remains at a **flat amount** (e.g., $292 per month for a family of three), which is **not indexed to the poverty level** (in contrast to every other Missouri Medicaid program). This current rule appears to be causing thousands of low-income parents to lose coverage each year, and many of these will likely not be covered by *Insure Missouri* under the proposed regulation. This population cannot typically afford to purchase private health insurance. Current Missouri policy is creating a built-in category of uninsured people that will grow each year. *Insure Missouri* provides an excellent opportunity for the State to address this problem by making the program available to these very poor families. The State should cover this very vulnerable low-income population *before* it starts expanding coverage to new groups such as childless adults or individuals with higher income levels. Moreover, if the State is to address the problem of its low-income uninsured, improve health access, and reduce cost-shifting, this group of low-income parents should not be left behind. The proposed regulation

should be modified to ensure that this important group of needy families has access to health insurance coverage through *Insure Missouri*.

B. Avoid Premiums and other Cost-Sharing

The first phase of *Insure Missouri* appropriately does not include **premiums**, but it does authorize the nominal co-payments allowed under federal Medicaid law. If the State is to achieve the program's projected enrollment, it is important to avoid cost-sharing policies that discourage participation in the program. Research examining the impact of premiums in public health insurance programs has found that participation falls off sharply as the premium amount increases.[20] Low-income people who are struggling to pay for housing, utilities, food, transportation, child care, and other expenses have very limited financial ability to pay for health insurance premiums and other "out-of-pocket" costs for their health care.[21]

Federal law does *not* allow premiums for individuals at or below 150% of the federal poverty level, and the State should not seek waivers to evade these requirements. The State should also be mindful of the administrative costs involved in collecting premiums and in terminating assistance for people who fail to make their premium payments in a timely manner. Indeed, some states have abandoned policies that imposed premiums because the administrative costs of collection outweighed the benefits of imposing premiums and because premiums had an adverse impact on program participation.[22] For these reasons, the State should resist any effort to impose premiums for this group of very low-income parents.[23] The final regulation should include no more cost-sharing than is already authorized by the proposed regulation.

Similarly, it is important that **co-payments** and other out-of-pocket expenses be as limited as possible because they may cause low-income participants to forego necessary health care services. Research shows that increasing co-payments on Medicaid beneficiaries reduces their access to health care.[24] This effect on access is especially true for individuals with chronic health problems who need more health treatment and could be subject to a co-payment for each visit or service needed.[25]

Cost-sharing will also be difficult for the State to administer and may well cost more for the state to administer than the payments collected. In fact, a report from the State of Arizona concluded that it would cost the state more money to implement new cost-sharing options available under the Deficit Reduction Act (DRA).[26] The DRA requires states to ensure that, on a quarterly or monthly basis, families pay no more than 5% of their income toward cost-sharing. It will be difficult for the State or managed care plans to determine whether individuals exceed this amount every month, or even every three months. Furthermore, new cost-sharing will discourage utilization of *necessary* health care services by the people whom this program is designed to help. And the Agency will certainly have to develop bureaucratic mechanisms for complying with this requirement if it seeks to adopt new cost-sharing options beyond what is already being proposed in the regulation.

For all of these reasons, the Department should modify the proposed regulation to eliminate even the "nominal" co-payments that it would allow but should certainly not adopt any additional cost-sharing beyond what is allowed under the proposed regulation.[27]

C. Provide a Comprehensive Benefits Package

Insure Missouri will provide a reduced benefits package as compared to the regular MO HealthNet benefits package. Although it will include a *majority* of the current MO HealthNet services,[28] the program will *not* cover maternity care, home and community-based services, Comprehensive Substance Abuse Treatment (C-Star), podiatry services, community psychiatric rehabilitation services, non-emergency medical transportation, or EPSDT services (for parents under age 21).[29] Individuals enrolled in *Insure Missouri* who need maternity care would be transferred to the Medicaid for Pregnant Women category of MO HealthNet, which covers pregnant women up to 185% of the federal poverty level.[30] The program also will not include dental care, vision services, and hearing aids which were provided under the Missouri Medicaid program before the 2005 legislative changes.[31] Thus, *Insure Missouri* also will not cover the limited amount of vision and dental services that the MO HealthNet program *now* provides (such as one eye exam and one pair of eyeglasses every two years and dental services related to trauma and disease).

It is important to **include as comprehensive a benefits package as possible** for the low-income Missourians who qualify for *Insure Missouri*. These individuals simply will not have sufficient incomes to pay for non-covered services "out-of-pocket" and would be likely to forgo treatment for medically necessary services that are not covered. Another reason why it will be important for the program to provide comprehensive coverage (rather than leaving critical health services uncovered) is the proposed reduction in DSH funds *now* used to fund hospitals that provide uncompensated care. If there are major gaps in coverage, then the program will not be as effective in reducing the amount of uncompensated care, and there may be insufficient DSH funds to pay for the costs of care for people who are under-insured as well as those who are still uninsured.

The program would be greatly improved if **vision and dental services** were covered *at least to the extent* that they are covered in the MO HealthNet program. These are particularly important services that will help the State meet its goal of having a program focused on "prevention." In fact, proper dental care is essential to the general health and well-being of MO HealthNet recipients. According to the Surgeon General's report, "Oral Health in America," dental diseases threaten the health of low-income people by leading to such medical problems as systematic infections, untreated periodontal disease, deep abscesses, lack of energy and stamina, and depression."[32] Because dental health is closely related to other health needs, untreated dental conditions can result in *higher* costs in other parts of the state's Medicaid program, including the costs of emergency room care.[33]

Similarly, vision services facilitate employment for low-income adults who need to see to perform job functions (such as reading, driving, using a computer or a cash register) properly. Vision services also help prevent work-related injuries (to which vision impairments are a leading contributor) and avoid permanent disabilities and blindness which can occur if conditions like glaucoma go unidentified or untreated.[34] Annual dental **and** vision examinations are important for Missourians with diabetes, both for managing the disease and preventing complications related to the disease. These are important preventative services integrally related to the overall health and well-being of the low-income individuals that the program would serve.

And to the extent that *Insure Missouri* is supposed to be more like private insurance or the Missouri Consolidated plan, many private plans in fact cover dental insurance. Even the Missouri Consolidated Plan covers dental care as it relates to trauma or disease as part of mandatory medical coverage.[35] The Missouri Consolidated Plan also covers annual vision exams and **rehabilitation services** that *Insure Missouri* will not provide.[36] Therefore, the Department should modify the regulation to add these services to the *Insure Missouri* benefits package.

The program would also benefit from the inclusion of **non-emergency medical transportation (NEMT)** services, especially in rural areas where access to physicians and other providers is limited. Low-income residents in those areas may find it very difficult accessing providers without the transportation services that Medicaid has traditionally provided. A report from Missouri's Office of Rural Health notes that rural Missourians typically have to travel excessive distances to obtain many types of specialty care, including cardiology, rheumatology, and endocrinology.[37] If individuals cannot make their medical appointments because they cannot afford transportation and do not have providers close to where they live, then they will not receive the preventative care that *Insure Missouri* is supposed to provide. The managed care plans, however, will still get paid their capitated rate for covered services whether or not they actually provide these services to individuals who have difficulty traveling to their medical appointments. Nonemergency medical transportation is a service that is available to low-income individuals in the current MO HealthNet program and ought to be made available to the very low-income parents covered by Phase One of the program. Without coverage of non-emergency medical transportation, the program will discriminate against rural Missourians by affording them far less access to necessary health care.

The proposed regulation should be modified to include all of these medically necessary services.

D. Consider Initiatives to help low-income elderly and disabled individuals

I recommend that the Department also consider expanding coverage to people with disabilities, whether through *Insure Missouri* or the regular MO HealthNet Program. While the *Insure Missouri* initiative would be an excellent first step toward covering low-income uninsured *parents* under the federal poverty level, the Department should also

consider changes to help elderly and disabled individuals who are only eligible for the Spenddown program and who have to endure higher out-of-pocket health care costs and burdensome administrative requirements in order to obtain coverage of their health expenses. Consistent with Phase I of *Insure Missouri*, **the Department should modify the proposed regulation to expand coverage of elderly and disabled Missourians or propose a new regulation to increase their eligibility to 100% of the federal poverty level** along with the working parents that are covered by *Insure Missouri*.[38]

E. Preserve *Insure Missouri s* General Approach to Coverage.

Insure Missouri is not perfect. The proposed regulation would be improved significantly by addressing the concerns raised above. Overall, however, the basic approach of *Insure Missouri* is sound. *Insure Missouri* would appropriately provide direct Medicaid-funded health insurance to low-income people who do not otherwise have access to such coverage. While these programs are not perfect, Medicaid and SCHIP coverage have demonstrable success in improving access to health care for low-income people.[39]

The *Insure Missouri* approach embodied in the proposed regulation makes far more sense than "premium assistance" programs. These programs have not been very effective in enrolling low-income uninsured working parents who do not typically have access to employer-sponsored coverage.[40] Moreover, private insurance is simply unaffordable and unavailable to many low-income uninsured individuals, many of whom are likely to have chronic conditions.[41] Coverage through the Medicaid program is also an efficient way to cover this population in light of the lower administrative costs as compared to private coverage.[42] In fact, the Urban Institute found that, even after "accounting for the fact that children and adults covered by Medicaid have a higher incidence of health problems and thus tend to require more care, it is less expensive to provide coverage through Medicaid than private insurance."[43]

The Department has appropriately developed an initiative that relies on publicly-funded health coverage. The *Insure Missouri* approach (which relies on federal Medicaid funding streams), even with its shortcomings, is one that is *proven* and one that will actually work. In contrast, approaches like giving people with very low incomes health savings account or a voucher to buy private insurance are untested and are unlikely to be effective in improving their access to health care. For example, converting *Insure Missouri* into a program like *Healthy Indiana --- which requires low-income workers to make "up-front" payments* into health savings accounts in order to obtain and retain their coverage --- could cost the state more money, increase administrative costs, and provide fewer services while the increased out-of-pocket costs would reduce the level of participation in the program by low-income working families.[44]

At the same time, however, the *Insure Missouri* program is "market-based," in that private health insurance companies (essentially HMOs) would be paid to provide health care to program participants. In fact, the *Insure Missouri* proposal uses a

reasonable mix of public funds and private health plans in way that will help alleviate the problem of Missouri's uninsured.

In addition to providing health insurance to low-income individuals who cannot afford it, it is especially striking that this initiative would cover so many uninsured individuals with so few general revenue dollars in comparison to the overall cost of the program. It is important to take advantage of the opportunity to leverage substantial federal funds without having to use new general revenue to draw down the great majority of those funds.[45] While the *Insure Missouri* initiative would be improved by expanding it to other very low-income parents and adding important benefits like dental and vision care, the basic approach is correct. Therefore, **the Department should go forward with the initiative that is authorized by the proposed regulation**.[46] The Department should resist modifications that would authorize untested and unproven initiatives that will be far less beneficial to low-income working Missourians.[47]

Conclusion

In conclusion, the proposed regulation would begin to address the critical problem of the uninsured in our state. The Department should move forward with the proposed regulation with as many of the above-mentioned modifications as can reasonably accomplished under current circumstances and available funding.

Endnotes

[1] St. Louis University Center for Health Policy Analysis, *Policy Brief #1: Uninsured Increase Significantly in Missouri in 2006*, August 28, 2007.

[2] See Kaiser Family Foundation, State HealthFacts.org.

[3] Kaiser Commission on Medicaid and the Uninsured, *The Uninsured and their Access to Health*, January 2003.

[4] Committee on the Consequences of Uninsurance, *Hidden Costs, Value Lost*, Institute of Medicine, June, 2003.

[5] Kaiser Commission on Medicaid and the Uninsured, *Fact Sheet: The Uninsured and Their Access to Health Care*, November 2004.

[6] Institute of Medicine, *Insuring America's Health*, National Academy Press, 2002.

[7] *Id.*

[8] A 2006 report conducted by the Urban Institute for the Missouri Foundation for Health estimated that Missouri's uncompensated care costs range from $666 million to $753 million. Missouri Foundation for Health, *Cover Missouri Project: Data Book 2, The Cost of Care for Missouri's Uninsured, September 2006.*

[9] The findings were published by Families USA in a report entitled *Paying a Premium: The Added Cost for the Uninsured*, June 2005 (available at:

http://familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf). 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. The study also found that: (1) 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. Premiums for individual insurance coverage in Missouri are $110 higher in 2005. (2) 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. Premiums for individual health insurance coverage in Missouri will be $225 higher in 2010.

[10] 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 19 (and the citations therein). 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. 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. Among those who said they had such medical bill problems, 27 percent said it caused them to be unable to pay for basic necessities such as food and heat, 44 percent said they used all or most of their savings to pay medical bills, and 20 percent said they had run up large credit card debts or had to take out loans against their home to pay these bills. Id. 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 percent) said they owed money to the facility where they received care. For those who received care in emergency rooms, the percentages were even higher. 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. Other studies show that about half of all personal bankruptcies result from health problems or large medical bills. David Himmelstein, et al., *Market Watch: Illness and Injury As Contributors to Bankruptcy*, Health Affairs, Health Affairs (February 2004) (available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.63); M.B. Jacoby, et al., "Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts," 76 *NYU Law Review*, 375, 2000.

[11] According to the Kaiser Family Foundation, 31% of Missouri's uninsured are under the poverty line while 67% are considered to be low-income.

[12] According to the National Association of State Budget Officers, Missouri spent just under $6.5 billion on its Medicaid program in FY 06, including $1.3 billion in general revenue funds, about 1.1 million in other state funds and about $4 billion in federal funds. The FY 07 estimates show that the amount of "other state funds" ($1.4 million) exceeds the general revenues funds ($1.1 million). National Association of State Budget Officers, *Fiscal Year 2006: State Expenditure Report*, Fall 2007, at Table 28 (available at: http://www.nasbo.org/Publications/PDFs/fy2006er.pdf)

[13] O'Brien and Mann, *supra.*

[14] *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.

[15] 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. Department of Social Services, State of Missouri, *Since MC+ Began*, February 10, 2003; Plax and Ferber, *supra.*

[16] See *Medicaid's Accomplishments*, citing Currie and Jonathan Gruber, "Health Insurance Eligibility, Utilization of Medical Care and Child Health," *Quarterly Journal of Economics* 11 (1996): 431-66; Janet Currie and Jonathan Gruber, "Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women" *Journal of Political Economy* 104(6)(1996): 1263-96; Jonathan Gruber, "Health Insurance for Poor Women and Children in the U.S. "Lessons form the Past Decade" in James M. Poterba, ed., *Tax Policy and the Economy*, vol. 11 (Cambridge, MA: MIT Press 1997).

[17] While the proposed income eligibility rules for *Insure Missouri* have not been published, the Department's proposed state plan amendment filed with CMS (SPA), eligibility rules for Insure Missouri have not been published, the Department's proposed state plan amendment filed with CMS (SPA), its enrollment estimates, and preliminary discussions suggest that Phase 1 of the program will not cover all working families under the poverty level and would likely reach just over half of the low-income parents who lost coverage in the last four years. Approximately 100,000 low-income Missouri parents at or below 100% of the federal poverty level have lost coverage since 2002. *Insure Missouri* would cover about 55,000 of these individuals in Phase I. See Joel Ferber, *Insure Missouri: Early Observations*, October 11, 2007, at 9-11 (and citations therein) (hereinafter, "Early Observations").

[18] Missouri Proposed State Plan Amendment 07-16, Attachment 2.6-A, Supplement 12, Page 2, filed October 15, 2007. See also Virginia Young, "Whatever His Reason, People Like Blunt's Plan; Some Debate Why the Governor Wants It, But Other Just Say Thanks," *St. Louis Post-Dispatch*, September 23, 2007 (regarding the proposed plan's differential treatment of earned and unearned income).

[19] This inequity is demonstrated by the fact that a family with $200 in earnings and $500 in child support would likely be ineligible for the program while a family with $700 in earnings alone would be eligible under the proposed requirements. A family with only $700 in these dire financial circumstances needs the health insurance that Insure Missouri could provide, regardless of the source of their limited income. See "Early Observations" Appendix for concrete examples of how the new income rules would work.

[20] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-income Population*, Kaiser Commission on Medicaid and the Uninsured, March 2003, at 5; Leighton Ku and Victoria Wachino, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Finding*s, Revised July 7, 2005, at 7-9. For example, one multi-state study found that participation in three states' publicly funded health insurance programs declined from 57% to 18% as premiums rose from 1% to 5% of family income. Hudman and O'Malley at 5. The same study showed that even premiums set as low as 1 percent of a family's income were estimated to lead to a 15 percent reduction in enrollment. Ku and Wachino at 7-8. And a study of Oregon's premium policies showed that one-half of those enrolled lost coverage due to new premium policies, and *about three-quarters of those who were dropped became uninsured*. Id. at 8.

[21] See Ku and Wachino, *supra*, at 6-7; Linda Blumberg et al., Lowering Financial Burdens and Increasing Health Insurances Coverage of those with High Medical Costs, Urban Institute, December 2005, at 3-4, (available at http://www.urban.org/UploadedPDF/311261_financial_burdens.pdf.

[22] Ku and Wachino, *supra*, at 9.

[23] This recommendation includes resisting efforts to require up-front payments into "health savings accounts" or other such mechanism as a condition of obtaining health coverage under the program.

[24] Joseph Newhouse, "Free for All: Lessons from the Rand Health Insurance Experiment," Cambridge: Harvard University Press, 1996 (hereinafter, "Lessons"), discussed in Leighton Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 7, 2003 (hereinafter" Cost-Sharing"); Joel Ferber, *Economic and Health Benefits of Missouri Medicaid*, Missouri Foundation for Health, Spring 2004; Robyn Tamblyn, et al. "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons," *Journal of the American Medical Association*: 285(4): 421-429, January 2001. Other studies demonstrate similar negative consequences from the

imposition of cost-sharing on low-income people. See Ku, Cost-Sharing, *supra*, for an excellent overview of the research in this area.

One can also foresee examples of individuals who just do not have the money to make the co-payments. Most low-income adults have very little accumulated savings. Most of the time they are healthy, but sometimes they have episodes of illness that can require substantial amounts of health care and reduce their income at the same time. Let's say that a construction worker has an accident or develops a serious illness. He might have one or two ER visits, a few doctor's office visits, a few prescriptions and some rehabilitation, etc. The same medical problem also makes him unable to work for a few weeks. The combined co-payments could be a real challenge for his family's suddenly constrained income. Their limited savings must instead be used to pay for food and rent. It is understandable that he wouldn't be able to afford his co-payments during this crisis.

[25] See Ku and Wachino, *supra*, at 6-7. Another consideration is that adults are more likely to need multiple medications for chronic diseases than kids. In fact, some private insurers or employers have begun to eliminate co-pays for certain drugs, like those for diabetes or hypertension, to encourage their use. The idea is that lower (or no) co-pays for certain chronic disease medications, such as those for diabetes, can improve adherence and reduce negative repercussions and reduce total health costs. See, e.g. http://www.managedcaremag.com/archives/0707/0707.medmgmt.html. Therefore, if DSS chooses to impose co-pays for medications, it could consider ways to limit or eliminate co-payments for chronic disease medications (e.g., additional caps on total cost-sharing for medications or permitting 3 month prescriptions for 1 month's co pay). It would be far preferable however to avoid co-pays (beyond the current dispensing fee) for prescription drugs for the low-income Missourians that would be covered by *Insure Missouri*.

[26] Arizona Health Care Cost Containment System, *Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005*, December 13, 2006.

[27] It is also not clear what the *benefit* of increasing co-payments would be. SB 577 provides that co-payments in Missouri's Medicaid program must now be *in addition to* the regular provider reimbursement, instead of having provider payments reduced by the amount of the co-payments (as was the case under SB 539). So the State does not benefit financially from additional co-payments. Mo Rev. Stat. § 208.152.4.

Another issue to be mindful of is the increased possibility of errors with adopting more complex co-payment and premium rules. Certainly under the new federal PERM rules, increasing complexity in the system increases the possibility of errors that could potentially lead to federal sanctions. In our experience, the SCHIP premium and affordability rules are areas in which mistakes occur, for example, if premiums are applied improperly to individuals who were not in the premium group, or if they are charged the wrong premiums. The risk of such errors for the State are more severe under PERM.

Also, if the Agency establishes different co-payment amounts for different income levels, and does *in fact* choose to *reduce provider payments* based on the size of the co-payments, there will be greater opportunities for payment errors. If there is supposed to be a $3 co-pay for a person under 150% and a $10 co pay for someone above 150% FPL (and the payment to the provider is reduced by $3 in the first case and $10 in the second), there is greater risk that the system will make a mistake related to the different cost sharing levels, and thus, a greater risk that an error will found under PERM. Simpler systems are less prone to errors. It will also be *more confusing for providers* if one group of *Insure Missouri* participants pays $3 while another pays $10.

If the agency does *not* reduce provider payments in this manner, then it will simply allow providers to be paid more for treating "higher-income" families, which does not make much sense. If the State establishes differential co-payments based on income, *and* combines it with "enforceability" (allowing providers to deny service to individuals who do not make their co-pays), the provider then "profits" from treating "higher income" patients (as compared to lower-income patients). Meanwhile the patient is simply without care if he cannot afford the higher co-pay.

[28] Covered services include prescription drugs; emergency services; physician and advanced practice nurse services; in-patient and outpatient hospital services; laboratory, radiology and other diagnostic services; emergency transportation; home health services; durable medical equipment; mental health and substance abuse services; family planning services; personal care services; hospice services; federal qualified health center (FQHC) services; services provided by local public health agencies; and transplant services). Insure Missouri RFP at 33-37 and Attachment 2. Contracting private insurance carriers will be responsible for pre-transplant and post-transplant follow-up care while the MO HealthNet agency would pay for covering the other costs of transplant services, including the costs of surgery, in-patient hospital stays, and other charges incurred during a transplant stay. Insure Missouri RFP at 36-37 and Attachment 2.

[29] EPSDT stands for Early Periodic Screening and Treatment Services. EPSDT provides comprehensive coverage of health care screenings and medically necessary services for children under age 21. Missouri is required to cover this service for individuals in its regular Medicaid/MO HealthNet program but would seek to provide a less comprehensive benefits package under *Insure Missouri*. That benefits package would not include EPSDT services for young parents. Children ages 18 and below will still receive EPSDT services under the regular MO HealthNet program.

[30] Because pregnant women would be disrenrolled from the *Insure Missouri* program, the State will need to ensure a seamless transition to MO HealthNet so as not to interrupt the continuity of care. For example, it is possible that an Insured Missouri participant who becomes pregnant will no longer be covered by her current health carrier, and will be transferred to fee-for-service coverage under MO HealthNet. She would then have to choose a new health plan, with different provider networks, if the *Insure Missouri* plan does not participate in Mo HealthNet. This could create an additional layer of complexity and disrupt access to health care.

[31] The MO HealthNet program covers services that are not specifically listed on the Insure Missouri Website, such as family planning services, Hospice Services, EPSDT for individuals under age 21, transplant services, and personal care services.

[32] U.S. Dept. of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*, 2000.

[33] Leighton Ku, *The Importance of Dental Benefits in Medicaid*, Center on Budget and Policy Priorities, December 2002 (and the citations therein); Ferber, *Economic and Health Benefits of Missouri Medicaid*, *supra*, at 25.

[34] Leighton Ku, *The Significance of Vision Benefits in Medicaid*, Center on Budget and Policy Priorities, December 2002 (and the citations therein); Ferber, *Economic and Health Benefits of Missouri Medicaid*, *supra*, at 25.

[35] See, e.g., Missouri Consolidated Health Plan, State Member Handbook, at 19, 28. The Consolidated plan also provides a separate comprehensive dental benefit through Delta Dental that members can purchase separately. The program would be improved if the state purchased such coverage for persons eligible for *Insure Missouri*.

[36] Id. at 20, 23, 26, 39.

[37] In fact, about 40 percent of the state's population is in the rural counties and, therefore, could have difficulty getting to hospitals, physicians and other providers. Missouri Department of Health and Senior Services, Office of Primary Care and Rural Health, *Missouri Office of Rural Health Biennial Report 2004-2005*, available at: http://www.dhss.mo.gov/PrimaryCareRuralHealth/RuralHealthReport04-05.pdf. According to this same report, 40% of rural counties do not have a hospital within their boundaries and only 5% of these counties have over 100 beds in those facilities. This shortage of hospital services means that individuals could have to travel great distances to receive medically necessary care. Id. at 11.

[38] In addition, the State could restore services that were cut in 2005 for seniors and persons with disabilities, e.g. hearing aids, podiatry services, and therapies, as well as the dental and optometric services that the Governor has proposed to fund. These restorations would supplement last year's efforts to help low-income working people with disabilities through the new Ticket to Work Health Assurance program by helping those who are unable to work and have significant out-of-pocket health care costs.

[39] See Notes 13-16, *supra*, and accompanying text.

[40] "Premium assistance" programs in Medicaid have had very low participation in other states because low-income people have limited income *and* very limited access to employer-sponsored coverage. *See* Joan Alker, *Premium Assistance Programs: How are they Financed and Do States Save Money?* Kaiser Commission on Medicaid and the Uninsured, October 2005, at 2, 8, and 14; Cynthia Shirk and Jennifer Ryan, *Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?*" National Health Policy Forum, July 17, 2006. Overall, premium assistance enrollees constitute less than one percent of total population in Medicaid and SCHIP, and an even smaller percentage of program spending. Shirk and Ryan, at 3. The reality is that "many low-income workers do not have coverage available through their employer" and that "the cost of coverage may be prohibitive for low-income workers, even when a state subsidy is provided." Shirk and Ryan, *supra*, at 13.

[41] *See* Judith Solomon, *Would Tax Incentives Be An Effective Way To Expand Health Coverage For Low-Income Children And Families?*, Center on Budget and Policy Priorities, July 31, 2007 for a review of the research in this area. One recent study found that 72 percent of low-income people (i.e., those below 200 percent of the poverty line) who tried to purchase coverage in the individual market found it very difficult or impossible to find affordable coverage while 26 percent of those who tried to purchase a plan were refused coverage or charged a higher price than others seeking similar coverage because of a pre-existing health condition. *Id.* Other studies show that individual market coverage can cost one-third of a low-income family's income when both premiums and plans' high out-of pocket costs are considered. Id. (and citations therein). In contrast, Congress has limited cost-sharing under SCHIP and Medicaid to 5% of family income.

[42] Private health insurance has administrative costs that, on average, are about twice those of public insurance --- for private coverage as compared to 7 percent for Medicaid. Leighton Ku, *Comparing Public and Private Health Insurance for Children*, Center on Budget and Policy Priorities, May 11, 2007 (and citations therein).

[43] Leighton Ku, *Comparing Public and Private Health Insurance for Children*, *supra* (and citations therein).

[44] For a discussion of the "Healthy Indiana" program, *see* Judy Solomon, *Paying More for Less: "Healthy Indiana" Plan Would Cost More than Medicaid While Providing Inferior Coverage*, Center on Budget and Policy Priorities, January 24, 2008 (available at: http://www.cbpp.org/1-24-08health.pdf

[45] In FY 2009, general revenue would constitute only 10% of overall funding of Insure Missouri, decreasing to 5% in FY 2012. See Missouri Hospital Association Memorandum from Daniel Landon dated January 28, 2008.

[46] There are other implementation issues besides those that are addressed in this testimony. See Ferber, *Early Observations*, supra. It is not clear, for example, how health care services are going to be provided in counties that do not receive sufficient bids from managed care plans, for example because they are unable to develop adequate provider networks. To be truly meaningful and comply with federal requirements, the program must be "statewide" and thus the state must indicate how it will provide coverage in counties that do not have sufficient managed care networks.

[47] For example, an approach adopted in recently filed legislation would appear to require individuals to pay money up front in health savings accounts before they could access coverage and services under Insure Missouri, and meet more onerous eligibility requirements (e.g. being a United States citizen, being a Missouri resident for twelve months, being uninsured for six months, not being eligible for health insurance coverage through an employer). This approach would create unnecessary complexity and administrative costs, and would limit enrollment because of the up-front premiums that individuals would have to pay to obtain and maintain their coverage.