A REVIEW OF RECENT HEALTH CARE LEGISLATION: WILL NEW PROPOSALS REALLY "INSURE" MISSOURI?

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In September 2007, the Governor introduced a new health care initiative called *Insure Missouri*.[1] The initiative would extend health care coverage to approximately 190,000 uninsured low-income Missourians in three phases. The first phase involved an expansion of coverage to low-income working parents under 100% of the federal poverty level and was to be implemented by March 14, 2008 pursuant to an *emergency rule*. The Department of Social Services (hereinafter, "the Department") had obtained authorization in its budget legislation in 2007 to implement the program in fiscal year 2008. The Department also obtained a Medicaid State Plan Amendment from the Centers for Medicare and Medicaid Services (CMS) to implement Phase One, which was estimated to provide health coverage for nearly 55,000 working parents and caretakers. On February 22, 2008, the Department withdrew its emergency rule because there was insufficient legislative support to ensure that the program would continue beyond the remainder of the 2008 fiscal year, as authorized by the emergency rule. However, the proposed rule to implement the original Phase One of the Governor's plan is still pending.

Three pieces of recently-filed legislation (SB l283, HB 2398, and HB 2413) would provide authority to implement a program that has the *name* "Insure Missouri" but which is likely to be very different from what the Governor originally proposed. As described below, these bills are modeled after a new program called "*Healthy Indiana*" -- *which requires low-income workers to make "up-front" payments* into health savings accounts in order to obtain and retain health care coverage.[2] This approach could very well cost the State more money, increase administrative costs, and provide fewer services. At the same time, the increased out-of-pocket costs and other features of the new approach would reduce the level of participation in the program by low-income working families. Moreover, because these bills deviate in so many ways from federal requirements, they would require federal waivers that will limit *federal financial participation* in the program, in contrast to the Governor's original *Insure Missouri* plan.[3]

I. THE GOVERNOR'S *INSURE MISSOURI* PROPOSAL

The Governor's *Insure Missouri* proposal would expand access to health insurance in three phases:

- **Phase One** would expand coverage to low-income working parents and caretakers with incomes at or below 100% of the federal poverty level. This expansion is projected to cover 54,531 new individuals in this group in 2008.[4]

- **Phase Two** would expand coverage to working parents, caretakers, and childless adults up to 185% of the federal poverty level. This expansion is estimated to cover 48,836 additional low-income individuals in fiscal year 2009.[5] The Department estimates that 107,192 individuals in this group will be enrolled in this category by 2012.[6]

- **Phase Three** would provide assistance to small businesses that provide health insurance for their employees. While the details of this component are not

developed, the proposal could potentially enable the State to provide either "reinsurance" or premium assistance to small businesses for coverage of their employees. The State estimates that 28,064 individuals will participate in this phase of the program, which would begin in January 2009.[7]

The Governor proposed to use a combination of funding streams, including general revenue, provider taxes, disproportionate share hospital (DSH) payments, cost-sharing payments (e.g., premiums), and federal matching funds to fund the expansion of health coverage under *Insure Missouri*. In particular, the proposal would take advantage of the Missouri Medicaid/MO HealthNet program's unique funding structure, under which a substantial portion of state matching funds ("state match") that support Medicaid comes from provider taxes, in particular the federal reimbursement allowance (FRA) paid by Missouri hospitals.[8]

The Governor's proposal would use these state and federal Medicaid funds to pay private health plans to deliver health services to individuals who qualify for the program, which would be administered by the Department's MO Health Division. Pursuant to new flexibility under the federal Deficit Reduction Act of 2005, the low-income parents covered under Phase One would receive a reduced benefits package, as compared to the regular MO HealthNet benefits package, but the program would provide a majority of the current MO HealthNet-covered services.[9]

II. RECENTLY-FILED LEGISLATION (SB 1283, HB 2398 AND HB 2413)

As indicated above, several pieces of legislation have recently been introduced that would implement a very different version of *Insure Missouri* from that proposed by the Governor. While there are some key differences among these proposals, they are very similar overall. All three bills are modeled on the new *Healthy Indiana* program, under which individuals have a personal health care account from which they must pay their deductibles for health care services covered by the program. Individuals also receive specified preventative services that are covered automatically without any deductible. Individuals must pay initial payments into their health care accounts based on their incomes before they can receive any health care services and must **continue** to pay into these accounts in order to continue to receive health insurance coverage. The State also contributes funds to these accounts, although employers and philanthropic organizations **may** also make such contributions. This approach contrasts with MO HealthNet, under which the State or private managed care health care plans pay for services for low-income individuals without first requiring individuals to pay premium "contributions" into a health care account or meet their deductibles for health care services.

Brief Description of the *Healthy Indiana* Program

On January 1, 2008, the State of Indiana implemented a new program called *Healthy Indiana*. Financed by an increase in Indiana's cigarette tax and matching federal funds, the State introduced the concept of health savings accounts into its Medicaid program: Indiana calls these Personal Wellness Responsibility or POWER accounts.[10] On December 14, 2007, the Centers for Medicare and Medicaid Services approved a Section 1115 waiver for Indiana's *Healthy Indiana* plan.[11] The *Healthy Indiana* waiver is subject to the budget neutrality requirements and capped federal financing that is described later on in this paper.

In order to qualify for *Healthy Indiana*, individuals must be between the ages of 18 and 65, be uninsured for six months, and not have current access to employer-sponsored coverage.[12] Eligible individuals with incomes between 22 and 200 percent of the federal poverty level must then contribute some of their annual income into their POWER account based on a sliding scale, while the State of Indiana contributes the difference between $1,100 and the individual's contribution.[13] Private health insurers provide a basic commercial benefit package that covers medical costs that exceed $1,100.[14] Eligible individuals with incomes **over** 200 percent of the federal poverty level may "buy into" the *Healthy Indiana* plan at full cost, meaning the State will not contribute any funds to their POWER accounts, and these individuals must pay the full cost of health care out-of-pocket.[15] Medicare recipients, pregnant women, and disabled individuals eligible for the regular Medicaid program are not eligible to participate in the *Healthy Indiana* plan.[16] For enrollees who receive state-recommended preventative services, all POWER account funds remaining at the end of the year roll over and offset the next year's contribution.[17]

Because the program just began in January 2008, it is too early to assess the impact of the *Healthy Indiana* program. However, significant questions are already emerging about the *Healthy Indiana* plan -- questions which are also applicable to the proposals discussed in this paper.

A. Key Features of Senate Bill 1283, House Bill 2398 and House Bill 2413.

Basic Structure: All of the aforementioned bills would create an *Insure Missouri* plan administered by the MO HealthNet Division. The Division would be responsible for promoting the plan, providing information to potential eligible Missourians, and enrolling them into the plan[18] The *Insure Missouri* plan would provide every participating individual a "health care home" and would cover a wide range of services – though not as broad as MO HealthNet or many private insurance plans. The term "health care home" is not defined in any of the bills.[19] Senate Bill 1283 and HB 2398 would require that at least eighty-five percent of the monies appropriated by the legislature be used to fund payment for health care services, while HB 2413 is silent on this point.

Funds for Preventative Services: Under SB 1283 and HB 2398, everyone in the *Insure Missouri* program who has made their required "contributions" (discussed below) would receive at least $500 of "qualifying preventative care" services. HB 2413 provides for only $300 of qualifying preventative services.[20] Any *additional* preventative care services would be subject to the deductible and payment requirements of the plan. SB 1283 and HB 2398 would require the *Insure Missouri* plan to consult with the federal Centers for Disease Control and Prevention in creating a list of recommended preventative care services and to provide that list to individuals who participate in the plan. HB 2413 does not contain such a requirement.[21]

Deductibles: The amount of the deductible is not specified or limited in the Senate bill, but the two House bills provide that the deductible for any qualified plan must not exceed **$2500.** As noted below, in all but one of the bills, the health care accounts only include $1000 *even* after the State contributions.

Entitlements: Under Senate Bill 1283, *Insure Missouri* would not be an "entitlement" program for noncustodial parents or for custodial parents with incomes **over one hundred percent** of the federal poverty level. This provision means that enrollment for individuals with incomes exceeding the federal poverty level could be capped depending upon whether the funds appropriated for the *Insure Missouri* plan are enough to cover all the individuals who qualify for the program. Individuals could be placed on a waiting list for the program, in contrast to traditional Medicaid/MO HealthNet under which individuals who meet the program's eligibility requirements are automatically covered. The two House bills would not allow the program to be an entitlement for individuals with incomes above **eighty-five percent** of the federal poverty level.

Subject to Appropriations: Under all three bills, the maximum enrollment of participants "is dependent on funding appropriated for the plan" by the General Assembly. Eligibility for the plan may be "phased in incrementally" based upon actions taken by the legislature during the appropriations process.

Eligibility: All three bills would allow an individual to be eligible for the program if he or she: (1) is at least 19 years old and less than 65 years old; (2) is a United States Citizen; (3) has resided in Missouri for at least 12 months; (4) has an annual income that is at or less than 225 percent of the federal poverty level; (5) is not eligible for "health insurance coverage through the individual's employer;" (6) has not had health insurance for at least six months; and (7) has household *earned* income above the TANF income eligibility limit ($292 per month for a family of three). These eligibility limitations would be subject to approval for federal financial participation by HHS.

Benefits Package: Like the Governor's proposal, the bills would provide a reduced benefits package in comparison with the MO HealthNet program, but would nevertheless cover a wide range of services. The program would cover: (1) mental health care services; (2) inpatient hospital services; (3) prescription drug coverage; (4) emergency room services; (5) physician and advanced practice nurse services; (6) diagnostic services; (7) outpatient services; (8) home health services; (9) urgent care center services; (10) preventative care services; (11) family planning services; (12) hospice services; (13) substance abuse services; (14) federally qualified health center and rural health clinic services; (15) durable medical equipment; (16) emergency transportation services; (17) personal care services; and (18) case management, care coordination and disease management.[22]

Like the Governor's proposal, the benefits package would *not* include dental, vision, rehabilitative services, non-emergency medical transportation, or EPSDT services for young parents between 18 and 21 years old.[23]

Pregnancy-Related Services and Medicare Participants: Pregnant women who need maternity services and individuals participating in the Medicare program would not be eligible for the *Insure Missouri* plan.[24]

Health Care Accounts: Senate Bill 1283 would require individuals with incomes over 100 percent of the federal poverty level and participating in the *Insure Missouri* plan to have "health care accounts." Payments to the health care account could be made for the individual's participation in the *Insure Missouri* plan by any of the following: (1) the individual; (2) an employer; (3) the State; or (4) any philanthropic or charitable contributor. **The funds in the health care accounts must be used to pay for the deductibles for health care services delivered to *Insure Missouri* participants.**

Individuals can make payments to their health care account by initiating employer withholding, after taxes, in equal distributions throughout the calendar year, by making their own contributions to the health care account, or in any other manner prescribed by the MO HealthNet Division. Employers can make payments to the account from funds that the employer is not already obligated to pay the employee (i.e., wages), but employer funds cannot be more than 50 percent of an individual's required payment to the health care account. All of the bills provide that funds in the account that are not used within a twelve-month period can be rolled over into the next plan period. Individuals losing eligibility for *Insure Missouri* and those who do not renew their participation in the program will have their remaining account funds refunded to them.[25]

All of the bills state that individuals cannot participate in the program "until an *initial* payment is made for the individual's participation in the plan." Individuals must "contribute" annual payments to their health care accounts in the amount of $1000 or on a sliding scale based upon the individual's annual household income, whichever is less (see below). A mandatory payment for the individual's participation cannot exceed one-twelfth of the annual payment required.

If any individual's required annual payment on the sliding scale is less than one thousand dollars, the **State** will contribute the remaining amount necessary to bring the account up to $1,000. If any required payment is not made within sixty days after the required payment date, the State must give notice to the individual regarding termination of his or her participation in the *Insure Missouri* plan. After the notice is given, the individual can be terminated from the *Insure Missouri* plan. In addition, HB 2413 provides that any individual terminated from the plan on grounds of fraud **or for nonpayment** of the required premium contributions may not reapply for participation in the plan **for six months**.

SB 1283 contains an important ambiguity regarding who is actually required to make payments into health care accounts. One provision says that individuals with incomes **over 100 percent** of the poverty level must have a health care account.[26] However, another provision states that participation in the *Insure Missouri* plan cannot begin until an initial payment is made for the individual's participation and clearly applies these payment requirements to individuals with incomes "**less than** 100% of the federal

poverty level."[27] If the intent of the bill is that only individuals with incomes over 100% of poverty have health care accounts (to which they must contribute payments), these two provisions would need to be clarified. It is also not clear how individuals with incomes *less* than the poverty level will pay their deductibles if they are not required to have health care accounts. As the bill is currently written, "preventative services" after the first $500 **are subject to deductibles** for individuals of all income levels, but the health care account requirement only applies to individuals with incomes above 100% of the poverty level.

In contrast to the Senate Bill, **House Bill 2398** would require individuals with incomes **over eighty-five percent** of the federal poverty level to have "health care accounts."[28] However, the bill is also ambiguous in that **all** individuals would receive payments from the State for $500 worth of preventative services, while any additional preventative services are covered but subject to "deductible" and "payment" requirements.[29] It is not clear how individuals with incomes at or below 85% of the poverty level would pay for their deductibles without a "health care account."

Unlike the other two bills, House Bill 2413 explicitly requires ***every*** individual who participates in the program to have a "health care account, from which they must pay their deductibles." Individuals must "contribute" annual payments to their health care accounts in the amount of $1000 or in *an amount not to exceed their deductible*, **or** on a sliding scale based upon the individual's annual household income, whichever is less (see below).

Sliding Scale Payments: As referenced above, each of the bills would require individuals to make payments based on a sliding fee scale. The sliding fee scale in SB 1283 would operate as follows:

Participant Income Eligibility Level (using 2008 poverty figures)	**Annual Participant Contribution for a 3-person household** (not including any deductibles)
100 percent of FPL or less ($17,600 or less per year) (noncustodial parents and other working adults)	1 percent of annual income (up to $176 annually)
101 to 125 percent of FPL ($17,776 to $22,000 per year)	2 percent of annual income (between $356 and $440 annually)

Participant Income Eligibility Level (using 2008 poverty figures)	**Annual Participant Contribution for a 3-person household** (not including any deductibles)
126 to 150 percent of FPL ($22,176 to $26,400 per year)	3 percent of annual income (between $665 and $792 annually)
151 to 200 percent of FPL ($26,576 to $35,200 per year)	4 percent of annual income (between $1063 and $1408 annually)
201 to 250 percent of FPL ($35,376 to $44,000 per year)	5 percent of annual income (between $1769 and $2200 annually)

Contributions made by enrollees to other public health care programs (such as premiums for SCHIP coverage for children) are deducted from the required contribution total.

There are slight variations in the other two bills' sliding fee scale:

HB 2398 would start the sliding fee scale **at 85%** of the federal poverty level up to **225%** (rather than 250%) of the poverty level. The **State's** contribution will be made in 12 monthly deposits, but the first deposit must equal 20 percent of the State's contribution to the health care account.

House Bill 2413 would apply the sliding fee scale to **all** income levels up to 225% of the federal poverty level. Individuals must "contribute" these payments to the individual's "*Insure Missouri* account." If any individual's required payment is less than one thousand dollars, the State is required to contribute the difference between the participant's contribution and the total amount that must be paid into the account ($1000 *or* the amount of the deductible).

Federal Approval: All of the bills would require the State to apply for a Section 1115 waiver and/or a Medicaid State Plan amendment to develop and implement the *Insure Missouri* plan. The two House Bills include more specific requirements for what must be included in waiver applications and require the Department to submit the waiver and/or State Plan Amendment to the Joint Committee on MO HealthNet for review and recommendations *before* submitting the waiver and/or State Plan Amendment to the federal government.[30]

B. Additional Features Unique to House Bill 2413.

House Bill 2413 includes some additional features that are not included in the other two "*Insure Missouri*" bills:

Incentives: House Bill 2413 would *permit* the State to include incentives "designed to encourage and promote healthy lifestyle choices which are medically appropriate, age appropriate and attainable for individual participants, taking into consideration any limitations on lifestyle choices" that exist based on medical conditions and the needs of the population served under the *Insure Missouri* program.

Requirement to Purchase Coverage in the Individual Insurance Market: Unlike the Governor's *Insure Missouri* plan and the other two bills, HB 2413 would require individuals approved for participation in the *Insure Missouri* program to "seek health care through a qualified plan available in the private individual heath insurance market from insurance agents and brokers." If the individual in question is "uninsurable," the individual will receive health care coverage **through the state's health insurance pool** (instead of receiving coverage through the qualified private insurance plans that provide coverage to the other *Insure Missouri* participants). Moreover, insurance agents who sell a qualified plan to an *Insure Missouri* participant will get **a commission equal to one percent of the premium** for the plan.

Transitional Participation: If an eligible individual participates in the *Insure Missouri* program without a "break in service" and his or her income later exceeds 225 percent of the federal poverty level, that person becomes eligible for "transitional participation." People eligible for transitional participation remain eligible for coverage at the same premium rates established for the program but are responsible for the entire cost of the premiums.[31]

***Insure Missouri* and the High-Risk Pool:** HB 2413 includes provisions that would modify the State's high-risk pool and link that program with the *Insure Missouri* initiative, providing premium subsidies (funded by state and federal Medicaid dollars) for "uninsurable" individuals covered by the high-risk pool.[32] The State would be permitted to establish a **premium subsidy** program for "low-income persons" eligible for participation in Missouri's high-risk pool and to have incentives designed to encourage and promote "healthy lifestyle" choices.[33] These provisions are discussed more fully in the next section.

III. DISCUSSION

The "*Insure Missouri*" plan described in these bills is fundamentally different from the Governor's proposal. Phase One of the Governor's plan would use state and federal Medicaid funds to provide health care coverage to uninsured working parents and caretakers with incomes below 100% of the federal poverty level. In contrast, the newly proposed legislation would apply "health savings accounts" to very low-income populations that have very little money to pay for health care costs out-of-pocket.

Research shows that *outside* of the Medicaid context, health savings accounts (hereinafter, "HSAs") and high deductible plans are most useful to people with high incomes who benefit from the tax breaks that come with HSAs.[34] They have little utility for the very low-income people who could benefit from *Insure Missouri*, and they are untested and unproven for Medicaid beneficiaries. Rather, HSAs and high-deductible plans are more likely to deter individuals from seeking necessary care in order to avoid using up the funds in their accounts and to avoid the high "out-of-pocket" cost-sharing inherent in such accounts.[35]

As demonstrated by the new *Healthy Indiana* program, such an approach may well cost **more** money than a straightforward expansion of Medicaid. A review of the terms and conditions of the *Healthy Indiana* waiver indicates that the cost per person will exceed the cost of coverage under a traditional Medicaid expansion while providing fewer benefits.[36] Moreover, as discussed below, these Missouri legislative proposals, *as currently drafted*, would limit the State's access to **federal** funds, in comparison to Governor Blunt's original *Insure Missouri* proposal. These legislative proposals would also create additional layers of bureaucracy that were not part of the Governor's original plan and are not part of the MO HealthNet program.

A. Financing

The Governor proposed to use a Medicaid "State Plan Amendment" (approved by CMS) to expand coverage to low-income working parents with incomes under 100% of the federal poverty level, using new flexibility to provide a more limited benefits package than would be required under traditional Medicaid. In contrast, the "*Insure Missouri*" proposals in the three aforementioned bills could not be accomplished through a state plan amendment, but would instead require a Section 1115 waiver in order to allow the State to avoid a number of federal requirements.

As discussed above, all three bills would require up-front "contributions" into special accounts as a condition of participation in the program. These new premiums for individuals with incomes below the poverty level would also require a waiver. Federal law does not allow such premiums below 150% of the federal poverty level and would **preclude** use of a Medicaid State Plan amendment. Moreover, **all** of the bills include multiple features (e.g., citizenship, residency, six-month waiting period) that **conflict with federal Medicaid law,** absent a waiver, and some which cannot be implemented even with a waiver (e.g., residency requirements). These provisions would also **preclude** the option of using a Medicaid State Plan Amendment to implement *Insure Missouri* and also would limit enrollment in the program.

As indicated above, Missouri would have to request a Section 1115 Medicaid waiver to cover the same low-income parents who would have been covered under the State Plan amendment previously approved to implement Phase One of *Insure Missouri*. Such a waiver would make Phase One subject to "budget neutrality" requirements which limit federal financial participation in State Medicaid programs.[37] Under the Governor's

original proposal, the State would receive additional federal funds for the cost of covering each of the approximately 54,000 low-income parents added to the program under Phase One, allowing for *any* unexpected increases in health care costs. Under a Section 1115 waiver approach, the federal contribution would be capped, and the State would have to **re-direct existing federal Medicaid funds** (such as disproportionate share hospital payments) to cover the *same* population (low-income parents) that could easily be covered under the approved State Plan Amendment.

It is one thing to require a shift of federal Medicaid funds when there is *no other way* to accomplish a policy objective, such as covering childless adults who are not normally covered by federal Medicaid funds. However, limiting Missouri's federal Medicaid funds is entirely unnecessary to expand coverage to low-income *parents* under the poverty level and therefore is a highly flawed approach. Adopting a "*Healthy Indiana*" approach for the low-income parents of Missouri instead of the Governor's original proposal would quite simply be a poor financial decision for the State.

Waivers and Budget Neutrality: A Brief Description

The type of waiver that the State will need is referred to as a "Section 1115" waiver.[38] Financing under Section 1115 waivers is very different from regular Medicaid financing. Under regular Medicaid rules, the federal government is obligated to share in paying for a state's Medicaid costs at the prescribed matching rate, whatever those costs turn out to be.[39] There is no cap or ceiling on the amount of federal funding that states can claim, as long as the claims are for legitimate Medicaid expenditures.[40] If costs rise for any reason (such as an economic downturn or increases in the costs of prescription drugs), federal funding levels automatically respond.[41]

However, when a state obtains a Section 1115 waiver, **the Centers for Medicare and Medicaid Services (CMS) does not allow the state to receive any more federal funds than it would have received in the absence of the waiver.** Rather, the federal government *limits* the amount of funds it will provide as a way to protect itself from incurring additional costs as a result of the waiver.[42] This requirement is called "**budget neutrality**."[43] Thus, if the initiative exceeds projected costs (for example, if health care expenditures rise faster than expected, as they have in the past due to unexpected increases in the costs of prescription drugs), the State must absorb the cost of any increased expenditures beyond those agreed to under the budget neutrality agreement. The State would have to shoulder the burden of any unexpected increases in health care costs, paying 100% of these increases instead of the 37% for which it is now responsible.[44] The waiver will likely require a *per capita* cap on the amount of federal funds that will be paid to Missouri over the course of the waiver.[45]

Therefore, if Missouri seeks to use a waiver to implement an expansion that it could not otherwise have accomplished, (such as covering childless adults or capping enrollment), it must find offsetting *federal* savings or redirect federal funds from an existing purpose to cover the newly eligible population.[46] Under **Phase One** of the Governor's *original* version of *Insure Missouri*, the State does *not need* a waiver to expand coverage to low-income parents under 100% of poverty and would not be subject to "budget neutrality" or capped federal financing. Budget neutrality requirements do not apply to State Plan Amendments that seek to expand coverage to traditional Medicaid eligibility groups such as low-income parents, and CMS has already approved a State Plan Amendment for the State to implement Phase One.

The use of a federal waiver for Phase One as necessitated by the experimental provisions in these bills discussed above would subject the State to unnecessary limitations on federal financial participation in Phase One of *Insure Missouri*.

B. Health Care Account Structure

All three bills would create a separate system of health care accounts that participants must use to pay for their health care services *before* the participant's health insurance would be available.[47] This system would create additional layers of bureaucratic monitoring that could detrimentally affect access to health and create additional costs. Individuals will have to navigate new systems in which they may have to exhaust funds in these accounts before they can actually receive coverage for services under their *Insure Missouri* health plans.

It is not clear how these new systems of accounts and "qualifying preventative services" would intersect with the original *Insure Missouri* proposal, under which HMOs and other insurers have already submitted bids to provide a comprehensive benefits package that *already include* **preventative services without deductibles.** Certainly, the previous Request for Proposals (RFPs) and bids from health insurers for coverage under Phase One would need to be modified.

The bill does not indicate whether the State or a separate entity would administer these accounts, whether the HMOs would administer them for a separate fee, or whether some other mechanism would be used. It is not clear whether the HMOs would receive reduced capitation rates because individuals would have to pay for certain health care costs out of their health accounts before the HMO actually has to pay for health care services.

In light of these concerns, the Governor's original approach would surely be less expensive and more efficient than establishing a new plan that requires administrative resources to monitor contributions to and expenditures from individual accounts**.**

C. Participant "Contribution" Payments and Additional Cost-sharing

All three bills impose premium and other cost-sharing provisions that go well beyond what is authorized under federal Medicaid law and the Governor's original *Insure Missouri* proposal. The Deficit Reduction Act of 2005 **does *not* allow premiums below 150% of the federal poverty level** and caps all cost-sharing at 5% of income. Two of the three bills require premium ("contribution") payments at all income levels and the other (HB 2398) starts the payments at 85% of the poverty level.

The imposition of premium "contribution" requirements on individuals with very low incomes will substantially limit participation in the program, as demonstrated by the applicable research and Missouri's experience with the SCHIP program.[48] Research examining the impact of premiums in public health insurance programs has found that participation falls off sharply as the premium amount increases.[49] 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.[50] The required "contributions" will

simply make the plans inaccessible for many individuals who would otherwise be eligible, causing them to remain uninsured.[51] Moreover, it is reasonable to assume that participation would be even further reduced because the program (requiring up-front and ongoing payments into health care accounts, paying for health care with funds from these accounts before insurance kicks in, etc.) is more complicated to navigate than standard private insurance or MO HealthNet. Therefore, **the original projected enrollment of over 54,000 people in Phase One would have to be adjusted significantly downward** since the Governor's original proposal did not include premium contributions for this group of working families.

In addition to the premiums, the bills would also require **deductibles** from all individuals eligible for the program. These deductibles **could be as high as $2500** a year under the two House bills (and an unspecified amount in the Senate bill which, theoretically, could be even higher). Individuals who would qualify for the program could have **incomes** just over $3500 **annually**, as the current income limit for MO HealthNet parent coverage is $292 per month for a family of three. The low-income families that would be eligible for Phase One simply cannot afford to pay deductibles for their health insurance. Moreover, **the health care accounts** in two of the three bills (SB 1283 and HB 2398) **will only include $1000.** Therefore, the structure of the new plan could cause low-income individuals to forego necessary medical treatment because they will not have sufficient funds to pay their deductibles.

INDIVIDUALS WITH SERIOUS MEDICAL NEEDS COULD GO WITHOUT CARE.

As indicated above, the cost-sharing in these bills could make it difficult for people to enroll in light of the financial burden of making their monthly contribution. In addition, the structure of the health care accounts and deductibles, as the bills are currently written, could cause some parents and others covered under the plan to go without necessary medical treatment.

Let's say a parent in a family of three with an income of 150% of the federal poverty level ($26,400 per year)* becomes ill after **four months** in the program. Such an individual would have to make a contribution of 3% of family income, or $792 annually ($66 per month) into his or her health savings account in order to participate in the new program. The State would contribute the difference between $792 and $1000 or $208 a year. Both the individual and the state would make these contributions on a monthly basis.

After 4 months, the participant in the program will have made four contributions, or $264. Under HB 2398, the State would have paid in about $90 (20% of its annual contribution in the first month plus equal amounts in the in all of the remaining months). The participant would thus have about **$354** in his or her account. Yet, he or she could have to meet a deductible of **$2500** before obtaining coverage through the insurance plan for medical treatment , and there would be insufficient funds in the account to pay the deductible. With limited funds, the family would not be able to cover the deductible, leaving the parent without **any** coverage for necessary health care services.

As pointed out above, even if the state and the individual were to contribute the entire $1000 in the account at the beginning of the year, this would still fall short of the $2500 deductible allowed under the legislation.

*This example uses 2008 poverty figures.

There would also be **administrative** costs involved in collecting premiums and 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 participation in the Medicaid or SCHIP programs.[52]

The cost-sharing provisions of the legislation would be even more difficult to administer because federal law precludes the State from imposing cost-sharing (premiums, co-pays and deductibles) that exceeds 5% of family income. The State will surely find it administratively burdensome to implement the proposed deductibles and premiums and still adhere to the federal limitations on cost-sharing. While Missouri could ask CMS to "waive" the 5% limitation, it is highly unlikely that CMS would grant such a waiver. In fact, CMS has made it clear that Indiana must comply with these requirements under its *Healthy Indiana* waiver.[53] Of course, it is difficult to understand why Missouri would even want such a waiver since it would so dramatically limit the benefit of an *Insure Missouri* initiative. Most likely, the State will have to absorb significant administrative costs to ensure that the combination of premiums and deductibles, as well as any co-pays, do not cause participants' out-of-pocket contributions to exceed 5% of their family income.[54]

D. Risk of "Adverse Selection"

The requirement that very low-income individuals make up-front contributions for their health care coverage means that **individuals with health problems would be more likely to participate** than those who are healthy. Individuals are less likely to use their limited resources to purchase health insurance, as opposed to food and housing, when they do not have an immediate need for health care services. Moreover, the requirement that individuals be without coverage for six months before they can enroll increases the likelihood that they will have a "pent-up" demand for health care when they finally do enroll. This "adverse section" would drive up the cost of coverage for the State and could make private health plans less likely to participate in the new program. In contrast, the Governor's original plan would make it more likely that eligible low-income Missourians would participate, regardless of their health status.

E. New System does less for Prevention than the Governor's *Insure Missouri* Plan.

As noted above, the bills all use the *Healthy Indiana* model by providing "first-dollar" coverage (coverage that is not subject to a deductible) of a specified amount of "qualifying preventative services" while subjecting any other preventative and specialty care services to deductibles. While the goal of this approach is to focus on "prevention," the plan does **less** for prevention than the original *Insure Missouri* plan which would pay managed care plans and other insurers to provide **all** medically necessary services in the benefits package, including preventatives services, without a $300 or $500 cap on preventative services that can be received without having to meet a deductible. Under

the Governor's proposal, the State would have paid the plans a capitated amount to provide a "health care home" for these individuals to help facilitate **prevention** and coordinate their medical services.

Because individuals with high-cost medical conditions may well exceed the caps on preventative services and would have to pay separately from their health care accounts to which they must contribute, it may be more difficult for them to obtain medically necessary services under the system contemplated by the aforementioned legislation. Therefore, the Governor's original *Insure Missouri* plan does more for prevention than the proposals in any of the three bills.

F. Additional Eligiblity Requirements Would Limit Coverage

All three bills include **additional** eligibility requirements beyond what the Governor originally proposed and beyond what federal Medicaid law allows. These additional requirements include the following provisions:

- The bills would **limit the program to U.S. citizens**, thus barring refugees, asylees, lawful permanent residents, and others who are lawfully present in the U.S. from participating in the program. It is doubtful that these provisions could be implemented, even with a waiver.

- The bills would impose a 12-month Missouri residency requirement, in violation of Medicaid law and the Constitution as interpreted by the U.S. Supreme Court.[55] In fact, CMS did **not** allow the State of Indiana to implement this requirement because the Supreme Court has determined that such residency requirements are unconstitutional.[56]

- The bills would require individuals to be uninsured for six months. Under Medicaid/MO HealthNet, individuals do not have to be uninsured, but if they have insurance, Medicaid/MO HealthNet is the payer of last resort. There is also no six-month waiting period for coverage, and in fact, individuals can receive three months of "prior quarter" coverage (coverage for the three months preceding the month of application).

- The individual must not be eligible for health insurance coverage through an employer (regardless of the affordability of such coverage—including co-pays and deductibles, the available benefits package of such coverage, and whether it covers pre-existing conditions, etc.). Under Medicaid/MO HealthNet, being "eligible" for health insurance through an employer does not bar an individual from coverage.

These provisions would bar many people who need health insurance from participating in the program. For example, some individuals with low incomes have employers that **offer** employer–sponsored insurance, but they remain uninsured because the costs of the employer-sponsored coverage are prohibitive. Missouri's SCHIP coverage declined

dramatically when the State began applying an "access to affordable insurance" requirement (known as "the affordability test") to its SCHIP program and had to correct that provision last year in SB 577. Thus, the "*Insure Missouri*" legislation may well deny coverage to uninsured individuals merely because an employer **offered** coverage, regardless of whether the insurance offered was affordable. Like the premium requirements, these new eligibility requirements would significantly limit the number of participants who would be eligible for the program in comparison with original enrollment projections.

Individuals would also likely have to document these new eligibility requirements when they apply and re-apply for *Insure Missouri* coverage (e.g. documenting uninsurance, documenting ineligibility for insurance through an employer, and documenting twelve months of Missouri residency) Additional paperwork related to these new eligibility factors will also limit participation in the program and add to the State's administrative costs.

G. Additional Concerns Specific to House Bill 2413

1. Purchasing Private Coverage through the Individual Insurance Market: HB 2413 would provide coverage in a way that no state has done using federal Medicaid funds: The only way that *Insure Missouri* participants would be able to obtain coverage would be to enter the private health care market and seek out qualified health care insurance plans on their own *through private insurance brokers*. This approach is quite different from having the State contract directly with private plans to provide a *defined package* of benefits to individuals who are eligible for the program which is administered by the State. Such an "individual market" approach is entirely unproven and raises many more questions than even the previously discussed "health account" mechanism. Private insurance is unaffordable and unavailable to most low-income uninsured individuals, many of whom have chronic health conditions.[57] Coverage through the Medicaid program is a more efficient way to cover this population in light of the lower administrative costs as compared to private coverage.[58] 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."[59]

It is not clear how the State would ensure that there are sufficient private insurers available to provide the mandatory benefits package outlined above or that individuals are able to **find** a plan providing the *Insure Missouri* benefits package. It is also unclear how the State will monitor whether these private insurance plans comply with state and federal Medicaid requirements, including the quality assurance and data reporting requirements applicable to Medicaid managed care plans.

2. Using Medicaid to fund the High-Risk Pool: HB 2413 introduces new provisions that would enable the State to use state and federal Medicaid funds to cover "uninsurable" individuals under the State's high-risk pool. While the details are quite complicated and would need to be developed further in policy and regulations, this

proposal is very different from the Governor's *Insure Missouri* initiative which proposed to provide publicly-funded health care coverage to *uninsured* working parents and childless adults below certain income levels rather than to subsidize coverage for individuals who qualify for the State's high-risk pool because they are deemed to be **"uninsurable**" (i.e., because they have high-cost medical conditions). Focusing federal Medicaid funds specifically on those individuals who are "uninsurable" – as opposed to **uninsured** --would require federal waivers and would likely have a far more limited impact than simply covering low-income uninsured individuals below specified levels of poverty. If the intent is still to provide coverage to **all** low-income uninsured individuals under specified income levels, then it is unclear why coverage would be provided differently for uninsurable individuals (i.e., through the high risk pool).

Another concern is that there might be insufficient funding both to expand coverage to low-income uninsured Missourians as the Governor proposed *and* to subsidize the high-risk pool. While making the high-risk pool more affordable is a worthy goal, focusing federal Medicaid funds on individuals with high cost medical conditions as opposed to expanding coverage to all uninsured individuals below specified levels – **regardless of health status** --- certainly would not "spread risk" in the way that expanding health care insurance coverage "across the board" would. The Governor originally proposed to leverage federal Medicaid funds in a way that would make a *significant dent* in Missouri's uninsured population, covering nearly 190,000 people *without* regard to their health status. Focusing on *uninsurable* individuals would not appear to be the most efficient use of state and federal Medicaid dollars, even if CMS would approve it.

CONCLUSION

The Governor's *Insure Missouri* initiative uses a reasonable mix of public funds and private health plans to alleviate the problem of Missouri's uninsured. That approach (which relies on state and federal Medicaid funding streams) is one that is *proven* and one that will effectively reduce the state's uninsured population and improve access to health care. In contrast, 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. Moreover, the proposals in these bills would put the State at an *unnecessary* financial disadvantage in that they would require the State to pursue waivers that limit federal financial participation in the program. The Governor's original proposal for Phase One – *already approved by the federal government* -- would have no such limitations. Finally, the many new requirements in the aforementioned legislation would limit the number of individuals that could benefit from the *Insure Missouri* initiative.

Endnotes

[1] The author would like to thank James Frost for his assistance with this paper.

[2] 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).

[3] While all of the bills create a *framework* for a health care coverage initiative, they are all dependent on appropriations by the General Assembly. The legislature would have to appropriate the funds for these initiatives, just as it would under the Governor's proposal. The Governor obtained appropriations authority to implement Phase One of his proposal for FY 2008 but, as noted above, withdrew the rule to implement the program.

While these bills also address a number of other health care issues beyond the *Insure Missouri* coverage initiative, this paper only discusses the "*Insure Missouri"* components of the legislation.

[4] Department of Social Services, *Insure Missouri: Estimated Enrollment and Cost*, September 27, 2007 (hereinafter "Insure Missouri Estimated Costs Fact Sheet") (available at http://www.insuremissouri.org/news/pdf/092707cost.pdf).

[5] *Id.*

[6] *Id.* This group would be phased in incrementally according to their income level but enrollment in this group could be capped if enrollment exceeds projections or available funding is insufficient. *See* State of Missouri, Office of Administration, RFP No. B3Z08082, October 5, 2007 ("Insure Missouri RFP"), at 5-6.

[7] Insure Missouri Estimated Costs Fact Sheet, *supra*.

[8] The National Associations of State Budget Officers reports that in fiscal year 2006, Missouri was projected to fund approximately 20.5% of its Medicaid program with general revenue while funding 17.7% of the Medicaid program with other state funds, which includes Missouri's provider tax. National Association of State Budget Officers, *Fiscal Year 2005: State Expenditure Report*, Fall 2006, at 49, Table 28 (available at: http://www.nasbo.org/Publications/PDFs/2005%20State%20Expenditure%20Report.pdf).

[9]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 would 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.

The Governor's proposal would 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, dental, vision, or EPSDT services (for parents under age 21). 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. 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. Insure Missouri RFP at 6.

[10] *Id.*

[11] Families USA, *Indiana: The Healthy Indiana Plan*, updated February 2008 (available at http://familiesusa.org/assets/pdfs/state-medicaid-waivers/indiana-waiver.pdf).

[12] *Id.*

[13] *Id.* at 4. Individuals under the federal poverty level must contribute 2 percent of their annual income to their POWER account. Individuals between the federal poverty level and 125 percent of the federal poverty level must contribute 3 percent of their annual income into their POWER account. Individuals between 126 and 150 percent of the federal poverty level must contribute 4 percent of annual income into their POWER account. Parents and caretaker relatives between 151 and 200 percent of the federal poverty level must contribute 4.5 percent of their annual income into their POWER account. Childless adults between 151 and 200 percent of the federal poverty level must contribute 5 percent of their annual income into their POWER account. *Id.* at 4.

[14] The Commonwealth Fund, *States in Action: A Bimonthly Look at Innovations in Health Policy*, February/March 2008, at 7-8.

[15] *Id.* at 1.

[16] *Id.* at 1.

[17] *Id.*

[18] Under SB 1283 and HB 2398, the MO HealthNet Division would be responsible for promoting the plan, providing information to potential eligible Missourians, establishing standards for consumer protection, and, in cooperation with the Department of Insurance, Financial Institutions and Professional Registration, overseeing the marketing practices of the *Insure Missouri* plan. The MO HealthNet Division would ensure that enrollment in the plan is "distributed throughout Missouri in proportion to the number of individuals throughout Missouri who are eligible for participation in the [*Insure Missouri*] plan." House Bill 2413 would require the Department to establish standards for consumer protection and for providing enrollment into the *Insure Missouri* program through the department's web site and Family Support Division offices. House Bill 2413, Sections 1.5 and 2.4.

[19] For a discussion regarding the importance of defining a health care home, *see* Joel Ferber and James Frost, *MO HealthNet and SB 577: A Preliminary Analysis of Revisions to the Missouri Medicaid Program*, July 27, 2007, pages 2-3.

[20] The bill uses the term "prevention and wellness services." HB 2413, Section 3.1(15).

[21] Instead, HB 2413 requires "prevention and wellness services," which are defined as "medically appropriate" and age appropriate care that is provided to an individual to prevent and diagnose disease, and promote good health and a healthy lifestyle." HB 2413, §1.1(4).

[22] Regarding the family planning services mentioned above, these services include contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396, et seq) but does **not** include abortion or abortifacients, except as required in federal Medicaid law (42 U.S.C. 1396, et seq). *Id.*

[23] The benefits package for HB 2413 is substantially the same as the other two bills except that HB 2413 specifically identifies "ambulatory surgical center services," "laboratory and radiology" services, and "prevention and wellness services."

[24] Pregnant women with incomes up to 185% of the federal poverty level can receive these services under MO HealthNet.

[25] HB 2413 requires that in the case of individuals who lose eligibility or do not renew participation in *Insure Missouri*, the refunded money may not include the "healthy lifestyle incentive moneys" remaining in the health care account. As noted above, the bill allows the State to create incentives for healthy lifestyles but does not indicate any specific payments that would be contributed into "health care accounts" for healthy behavior, or which behaviors would be rewarded with such incentives.

[26] SB 1283, § 208.1321.1.

[27] § 208.1324.1(b)(v).

[28] HB 2398, §208.1321.

[29] § 208.1309.2.

[30] House Bill 2398 would require the State to apply for a Section 1115 waiver and/or a Medicaid State Plan Amendment to develop and implement the *Insure Missouri* plan. House Bill 2398, § 208.1345. The waiver must include provisions: (1) requiring participants to establish a health care account in which the participant and the State shall deposit funds that can be used by the participant for health care expenses and premiums; and (2) allowing any individual health plan that is available in the private market and meets the established *Insure Missouri* criteria to be available to the participants.

HB 2413 would require the waiver or State Plan Amendment must include at least the following items: (1) a provision that allows for "transitional participation" in the program; (2) a provision that allows federal Medicaid funds to be used to provide health care coverage to **uninsurable individuals** through the State's health insurance (high risk) pool; and (3) a provision that allows premium rates for coverage for such individuals which "exceed the standard risk rates" of Missouri's high risk pool.

[31] The money in the participant's *Insure Missouri* account would either be rolled over into a health savings account or paid directly to the participant depending on whether the health insurance plan is a deductible or nondeductible plan.

[32] The bill would permit the Missouri high-risk pool to offer at least one plan for "uninsurable individuals eligible under the insure Missouri program". HB 2413, § 376.985. This provision would presumably refer to individuals with "high-cost" medical conditions who meet the financial eligibility requirements of the *Insure Missouri* program. The high-risk pool must offer health care coverage at "standard risk rates" provided that the Department of Social Services pay "all or a portion" of the premium for the coverage to the extent authorized under the *Insure Missouri* program, that the participant will cover any premium costs that exceed the allowable payment by the Department, and that for *Insure Missouri* participants that are eligible for federal participation, the coverage can exceed the standard risk rates of the high-risk pool. HB 2413, § 376.986.6.

[33] For individuals with incomes of 300 percent of the federal poverty level or less, the premium is to be equal to the "standard risk rates." For individuals who have incomes of more than 300 percent of the federal poverty level, the "sliding scale" premium is to be equal to an amount between 100 and 125 percent of the standard risk rates. HB 2413, § 376.986.5.

[34] Edwin Park and Robert Greenstein, *GAO Study Confirms Health Savings Accounts Primarily Benefit High-Income Individuals*, Center on Budget and Policy Priorities, September 20, 2006; Paul Fronstin and

Sara R. Collins, *Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey*, March 2008. Health savings accounts come with several tax breaks that are attractive to higher-income individuals. Contributions to health savings accounts are tax-deductible and withdrawals from these accounts are tax-free if the funds are used to pay for out-of-pocket medical expenses. No other type of accounts, even retirement accounts, have these two advantages at the same time. Additionally, the savings from using HSAs increase as one's tax bracket increases. For example, one who is in the 35 percent tax bracket saves 35 cents in taxes for every dollar invested in HSAs while one who is in the 15 percent tax bracket only saves 15 cents for every dollar invested in HSAs. Park and Greenstein, supra. Thus, the tax advantages are greater for higher-income individuals than they are for lower-income individuals.

[35] While the legislation discussed in this paper would create accounts modeled on HSAs, it is not likely that they would qualify as HSAs under federal law or provide any tax breaks to individuals who have these accounts. See Letter from Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, to E. Mitchell Roob, Jr. Secretary, Indiana Family and Social Services Administration, December 14, 2007, and Attached Special Terms and Conditions for the Healthy Indiana Plan ("Weems letter") at 20.

[36] Judith Solomon, Healthy Indiana paper, note 2, supra.

[37] For a discussion of the waiver financing issues, *see* Cindy Mann and Joan Alker, *Federal Medicaid Waiver Financing: Issues for California*, Kaiser Commission on Medicaid and the Uninsured, July 2004, at 2-3 and 7-11 (available at http://www.kff.org/statepolicy/upload/Federal-Medicaid-Waiver-Financing-Issues-for-California-Report.pdf). This topic is also discussed in the above-cited paper on *Insure Missouri*, at pages 6-7.

[38] Section 1115 is the section of the federal Social Security Act that authorizes states to seek waivers of the federal laws governing the Medicaid program.

[39] Cindy Mann, *Financing under Federal Medicaid Section 1115 Waiver: Federal Policy and Implications for New Hampshire*, Georgetown University Health Policy Institute, September 9, 2004 (available at http://www.endowmentforhealth.org/_docs/42.pdf), at 8.

[40] *Id.*

[41] *Id.*

[42] *Id.* at 10.

[43] See Kaiser Commission on Medicaid and the Uninsured, Medicaid Section 1115 Waivers: Current Issues, January 2005 ("Current Issues"). Cindy Mann, *supra;* Judy Waxman, Medicaid Reform Commission, Testimony of Judy Waxman, September 12, 2005 ("Waxman Testimony"); *Leighton* Ku, *Medicaid in Missouri: The Possible Role of Waivers*, Power Point Presentation to the Missouri Medicaid Commission, September 2005 (hereinafter "Ku Commission Presentation").

[44] Mann, *supra,* at 10.

[45] Mann, *supra*, at 9-10.

[46] *See* Kaiser Commission, Current Issues; Mann *supra*, Waxman Testimony*;* Ku Commission Presentation.

[47]As indicated above, HB 2413 used the term "prevention and wellness services".

[48] For a discussion of the impact on premiums upon participation, *see* Joel Ferber, *Insure Missouri: Early Observations*, Legal Services of Eastern Missouri, October 11, 2007, at 11-12 (available at: http://www.masw.org/programs/attachments/Insure%20MO.pdf). For a discussion of the impact of

premiums on enrollment in Missouri's SCHIP program, *see*, Joel Ferber, *Measuring the Decline in Children's Participation in the Missouri Medicaid Program: An Update*, Legal Services of Eastern Missouri, September 2006.

[49] 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.

[50] 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

[51] While employers or philanthropic organizations can *voluntarily* make payments into these accounts, they are not required to do so.

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

[53] See Weems letter, Attached Waiver Terms and Conditions, at 19-20..

[54] The bill does not specify any co-pays but the original *Insure Missouri* included small co-pays for Phase One. There is no reason to think that the modified *Insure Missouri* proposal would not include co-pays.

[55] *Shapiro v. Thompson*, 394 U.S. 618 (1969).

[56] Weems letter at 3.

[57] *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.

[58] 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).

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