



The  
Missouri  
Budget  
Project

**The High Price  
of Budget  
Cuts:  
Thousands  
More  
Missourians  
Lose Health  
Care**

January 2006

Shaping Policy...  
Protecting  
Missourians



**The High Price of Budget Cuts:  
Thousands More Missourians Lose Access to Health Care**  
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*The Missouri Budget Project is a statewide, nonprofit, nonpartisan organization that informs the public about the state's budgetary and tax policy options and their impact on low-income Missourians.*

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## **The High Price of Budget Cuts: Thousands More Missourians Lose Access to Health Care**

### *Introduction*

An analysis by the Missouri Budget Project released in January of 2004, shows that the most significant cause of Missouri's fiscal crisis over the past 5 years was a severe reduction in Missouri's tax base from the 1990s. During the economic prosperity of the 1990s, Missouri made a series of tax reductions including 14 state tax cuts and 21 new tax credits that reduced the base of tax collections by nearly \$1 billion annually.<sup>1</sup> The result is that by 2002, Missouri ranked 46<sup>th</sup> in the nation for state and local tax revenue as a percent of income. Missouri has nothing positive to show for its reduced taxes. Missouri has not enticed more jobs than our neighboring states, and it does not have better state services. Health care, education and other basic state services are desperately underfunded.

Missouri's state budget crisis is unparalleled since the Great Depression. Missouri revenue that had historically grown by 5% annually, slipped to an unprecedented decline of .6% per year. In fact, in fiscal year 2004 the state actually spent \$44 million less in general revenue than it expended in fiscal year 2001. As a result, Missouri Legislative and Gubernatorial leadership have been faced with unprecedented budget shortfalls. Core funding for state programs has been cut by nearly \$1.8 billion over five years and an additional \$1.1 billion has been withheld through mid-year reductions during the same period. The budget crisis has affected every aspect of Missouri's budget and services. The Departments of Social Services and Mental Health have borne the brunt, absorbing 58.1% of the core budget cuts in the last five years.

This paper describes the extent of the state's budget cuts, their consequences on access to health care for vulnerable Missourians, and their impact on all of us.

### *The depth and breadth of cuts*

Missouri's fiscal crisis began in state fiscal year 2001, with the convergence of the national recession, loss of federal funds through program reductions, federal tax cuts and increased federal mandates, and the impact of state tax cuts and tax credits passed in the late 1990s. The state responded by making a series of core reductions (ongoing cuts to the core of state

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<sup>1</sup> *Missouri's Fiscal Crisis Remains Severe: Revenue Options are available as compared to continued spending cuts*, Missouri Budget Project, January 2004 available at [www.mobudget.org](http://www.mobudget.org)

programs) and one-time withholdings (temporary reductions in state department spending authority). While the \$1.1 billion in withholds made throughout the crisis has had a definitive impact, the ongoing core reductions of nearly \$1.8 billion will have lasting consequences for the state. Those core reductions related to health care and their consequences are discussed in the following sections. (See Table 1 for Core Reduction Summary by Department)

Department	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	Total	Department cuts as % of total core cuts
Elementary & Secondary Education	20.1	62.1	58.0	22.6	18.4*	181.2	9.9%
Higher Education	9.6	99.7	42.9	1.3	6.7	160.2	8.7
Social Services	88.3	303.6	110.6	55.3	395.8	953.6	52.0
Mental Health	11.2	36.5	27.6	12.5	23.9	111.7	6.1
Health and Senior Services	3.4	12.1	13.6	2.4	+ \$71.5**	+39.9	
Public Safety	5.6	5.2	8.4	.9	3.8	23.9	1.3
Corrections	12.8	39.1	6.4	20.8	22.5	101.6	5.5
All other Departments	56.7	129.0	75.8	35.8	45.5	342.8	18.7
Total	207.8	687.3	343.2	151.6	476.7	1,835.1	

*\* \$31 million that funded vocational rehabilitation was moved to the Department of Health and Senior Services. This was not counted as a core cut.\*\* The Department of Health and Senior Services budget increased because programs and services were moved to that Department from another.*

***Cuts translate into the loss of Medicaid health insurance and the loss of other health services***

The breadth of these cuts is dramatic. They include severe cuts to Missouri’s Medicaid program, the elimination of the Women’s Comprehensive Health Care Program, and cuts to mental health care programs. As a result of these and other reductions and eliminations, more than **241,465** Missourians have lost access to health insurance, services, and state- sponsored health care programs in the last five years. A description of the people who are affected follows.

*Table 2  
Summary of the People Impacted by Cuts to State Health Care Programs*

<b>Category of eligibility reduction</b>	<b>Number of Missourians affected in FYs 02-05</b>	<b>Number of Missourians affected in FY 06</b>
Medicaid Eligibility Cuts	55,642 Missourians	90,604
Medicaid Spend down changes	40,696 Missourians	15,723
Women's Health Care Cuts	30,000 Missourians	
Mental Health Care Cuts	8, 800 Missourians	
<b>Total Health Care Cuts</b>	<b>135,138 Missourians</b>	<b>106,327</b>

Source: Missouri Departments of Social Services and Mental Health, Budget Divisions.

\*Numbers are calculated based on 2004 Federal Poverty Guidelines, and 2002 caseloads. The number of people impacted annually conceivably grows over time as the federal poverty level is adjusted yearly based on inflation, and increases in the uninsured.

*Cuts to Health Care for Low Income Working Parents, People with Disabilities and Missouri Seniors*

Medicaid eligibility was cut deeply in FY 2005 (beginning July, 2004). An estimated 37,320 working parents lost Medicaid coverage when the state eliminated eligibility for those with incomes between 75 and 100 percent of the poverty line.<sup>2</sup> Parents in families of three with incomes between \$979 and \$1,305 per month lost access to health care. Since most jobs at this wage level do not provide affordable health coverage, it is likely that most of those parents are now uninsured. Approximately 70% of the adults cut from Medicaid in this program reduction were working mothers, while 30% were working fathers, all living in poverty.

Roughly 18,322 Missourians lost health care coverage when additional Medicaid programs for working parents were also cut. The Parent's Fair Share Program and Medicaid Program for Non-Custodial Parents were eliminated. These programs had previously served non-custodial parents, mostly fathers, who were making efforts to be responsible parents. To be eligible a parent had to meet three criteria: 1) were current or working to get current in their child support obligations; 2) were engaged with their children; and 3) were also working or in a training program to improve their financial independence.

FY 2006 (beginning July, 2005) brought even deeper cuts. Eligibility for low- income parents was lowered to 17-22% of the Federal Poverty level, as low as federal law allows. Other cuts included Extended Transitional Medicaid, medical assistance for people with temporary disabilities (General Relief) and for individuals who have a disability but are still able to work (Medical Assistance for Workers with a Disability).

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<sup>2</sup> All information on the number of people cut from these programs was provided by the Missouri Department of Social Services and is based on the total number of people who received services in state fiscal year 2002. The number losing coverage in any given month is slightly lower. However, the number of people impacted over time grows as federal poverty guidelines change and more individuals and families cycle in the economic changes that would have qualified them for Medicaid Programs under previous guidelines.

### *Cuts to Health Care for People with Disabilities and Seniors*

In addition to stricter eligibility guidelines, the Medicaid Spend Down Program, which primarily impacts seniors and people with disabilities, was structured in a way that causes greater hardship. The program previously allowed seniors and people with disabilities to access Medicaid by accruing a level of medical bills that would reduce their income to below the federal poverty level.<sup>3</sup> Now seniors must actually pay for the services, not just accrue charges. When they pay out-of-pocket to meet the poverty level criteria, many will be unable to pay for food or utilities. This prevents access to health care for a population likely to have the most compromised health. Missouri seniors and people with disabilities heavily depend on Medicaid to help offset the costs of prescription drugs and nursing home care. This change will affect 15,723 individuals in FY 2006

### *Impacts on Children: premiums and an “affordability test”*

Under SB 539 (passed in 2005) families with incomes above 150% of the federal poverty level (FPL), a little over \$24,100 for a family of 3, are required to pay premiums of up to 5% of their income for their children’s State Children Health Insurance Program (SCHIP). These premium requirements were mitigated in the budget process by setting up three tiers:

- Families with incomes between 151 and 185% of FPL pay premiums equal to 1% of the family income
- Families with incomes between 186 and 225% of FPL pay premiums equal to 3% of the family income
- Families with incomes between 226 and 300% of FPL pay premiums equal to 5% of the family income

A substantial body of research indicates that participation drops as premiums increase. Data from the states of Washington, Minnesota and Hawaii show that participation by the uninsured declined from 57% to 18% as premiums rose from 1% to 5% of family income.<sup>4</sup> In Texas, enrollment in SCHIP declined by 149,000 children when new cost-sharing changes were enacted.<sup>5</sup> In Missouri, a 2002 study showed that 15% of enrollees in a managed care setting with required co-pays did not seek needed care, compared to 9% of families without cost-sharing requirements.<sup>6</sup>

The drop-off in participation of low income families due to cost sharing does not mean that health insurance and health care are low priorities for those families. The drop-off is most often a reflection of families making difficult choices about competing basic necessities such as child care, transportation, and utilities. Now, as increasing numbers of working parents have lost their

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<sup>3</sup> In 2002 when the change occurred the eligibility level was 80% of the federal poverty level. It has since been increased to 90% of the federal poverty level, and is scheduled to be increased to 95% of the federal poverty level, or \$737 per month for one individual in fiscal year 2005.

<sup>4</sup> Ku, L & Coughlin, T.. “Sliding –scale Premium Health Insurance Programs: Four States’ Experiences.” Inquiry, Vol.36:471-480, 2000.

<sup>5</sup> Dunkelberg, A. O’Malley, M. Children’s Medicaid and SCHIP in Texas: Tracking the impact of budget cuts”, Kaiser Family Foundation, 2004.

<sup>6</sup> Behavioral Health Concepts, Inc., *Evaluation of the Medicaid Section 1115 Waiver: Report of Findings*. Prepared for the Missouri Department of Social Services, November 2002.

Medicaid coverage, meeting their own health needs will become another competing priority for their limited resources.

Unfortunately, the Missouri SCHIP program is structured so that if a child drops off because a premium isn't paid, children in families with incomes from 225-300% of FPL are not eligible for re-enrollment until he/she has been uninsured for 6 months or has a life threatening condition.

The early results of imposing premiums are alarming. The Department of Social Services sent letters to about 27,000 families (representing about 46,000 children), informing them that they needed to pay premiums beginning October 2005. By November 9, 2005 approximately 12,000 children became uninsured as a result of this policy.<sup>7</sup>

SB 539 also included an affordability test for children in families with incomes over 150% of the federal poverty level (just over \$24,100 for a family of 3). If these families have access to insurance coverage that costs up to \$342 per month, they are not eligible for SCHIP, even if they can't actually afford it. This "affordable" insurance is based on 133% of the average monthly premium for children in the Missouri Consolidated Health Plan. Federal SCHIP law assumes that low-income families cannot afford to pay more than 5% of their family income for health insurance and still meet their basic needs.<sup>8</sup> Under Missouri's affordability test, families would be expected to pay up to 17% of their income for private health insurance, if it is available to them.

#### *Increased cost-sharing provisions will also affect adults*

Rather than limiting co-pays to certain services, co-payments will now be required for nearly all Medicaid-covered health care services and prescription drugs to the extent allowable under federal law. Federal law excludes emergency services and services provided to children, pregnant women and "institutionalized individuals" from cost-sharing provisions.<sup>9</sup> However, women of child-bearing age could be adversely affected if they are not able to receive early prenatal care, increasing the risk of the baby having health problems.

The argument that cost-sharing mechanisms will only discourage the use of "unnecessary" medical services is faulty. The Rand Health Insurance Experiment shows that co-payments limited the use of medical care by both low-income adults and children and higher-income individuals.<sup>10</sup> However, the reduction was in care that the researchers rated as "effective", as well as care rated as "less effective".

Recent research in Minnesota indicates that co-pays have a significant impact on patients' adherence to prescribed medication, and create a considerable financial burden for the medical system.<sup>11</sup> The Minnesota study concludes that the large costs incurred by increased use of

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<sup>7</sup> Gary Sherman, Director of the Department of Social Services at the Medicaid Reform Commission work session, November 9, 2005

<sup>8</sup> Ferber, J. *Summary of Medicaid Cuts Adopted in the 2005 Legislative Session* May 2005.

<sup>9</sup> *ibid*

<sup>10</sup> Newhouse, J., *Free for All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996.

<sup>11</sup> Mendiola, M, Larson, K., Pereira, A. and Kurvers, M. *Medicaid Patients Perceive Copays as a Barrier to Medication Compliance*, Department of Medicine, Hennepin County Medical Center, Minneapolis, MN, 2004

emergency services will overshadow the money generated by co-pays. The RAND Health Insurance Experiment found that co-payments led to a larger reduction in the use of effective medical care by low-income adults and children than by those with higher incomes. Low-income adults showed a 41% reduction in episodes of effective care, compared to 29% of higher-income adults. Forty-four percent of low-income children had reduced episodes of effective care, compared to 15% of higher-income children.<sup>12</sup>

The Rand study also found that co-payments did not significantly harm the health of middle and upper-income people, but led to poorer health outcomes for low-income adults. For example, co-payments increased the risk of dying by about 10% for low-income adults at risk of heart disease.<sup>13</sup>

### *Women's Comprehensive Health Care*

Women's access to health care was reduced by eliminating the Women's Comprehensive HealthCare/State Family Planning Program. Administered through the Department of Health & Senior Services, the program previously allocated \$3.6 million dollars to local health care clinics to provide 30,000 low-income and uninsured women with vital health care services. These services included annual pap smears; breast and cervical cancer screenings; physical examinations including screenings for anemia, high blood sugar, cholesterol and sexually-transmitted diseases; HIV risk assessments and prevention; and counseling on an array of women's physical healthcare needs.

According to a recent survey of former state family planning providers, undertaken by the Missouri Family Health Council, 10 Missouri clinics in rural and urban areas of the state have closed as a result of the loss of Women's Comprehensive Health Care funding.<sup>14</sup> According to the same survey, 25 other clinics have reduced clinic hours. Nearly all have reduced the number of patients served, implemented or increased fee schedules, or closed satellite offices. The result is that low-income women in Missouri have less access to preventive care and screenings, which will likely result in higher rates of preventable disease and more severe cases of breast and cervical cancer in Missouri women.

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<sup>12</sup> Newhouse, J. *Free for all? Lesson from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996.

<sup>13</sup> *ibid*

<sup>14</sup> Survey findings released by the Missouri Family Health Council on June 1, 2004 at a press event in Jefferson City, MO. More information can be obtained at [www.mfhc.org](http://www.mfhc.org).

***Table 3: Areas of Clinic Closings***

Bollinger County Health Department  
Clinton County Health Department  
Gasconade/Osage County Health Department  
Jackson County Health Department  
Nodaway County Health Department  
Pulaski County Health Department  
Saline County Health Department  
St. Charles County Health Department  
Texas County Health Department  
Washington County Health Department

***Mental Health Care Cuts***

A multiple year series of budgetary and personnel cuts are decreasing direct services to those with mental illness. Thousands of Missourians have lost services. Attempts to restore some of the \$87.8 million in core cuts were partially successful, but the Department of Mental Health sustained \$58.2 million in net reductions between Fiscal Years 2001-2005. In addition almost 600 jobs have been eliminated. Consolidations, administrative efficiencies and other cost-saving measures were used to make some cuts, but services were also reduced. Fewer people with mental health needs are now served at state-operated facilities and private community facilities that operate with state funding.

Specific cuts have included:

- A \$4.7 million reduction in support for alcohol and drug treatment and prevention programs. This has resulted in the loss of substance abuse treatment funding for approximately 4,000 individuals.
- An \$11 million reduction in funding to provide services for people with mental retardation and developmental disabilities. Such services include respite care, day habilitation, and therapy. As of July 2004, the department had a list of more than 4,000 individuals waiting for residential and non-residential services. They must instead rely on care by their families — or go without needed specialized care.
- The state's "family stipend" program — which helped some 800 families to care for their children with serious disabilities at home rather than institutionalizing them — was reduced in fiscal year 2003 *and completely eliminated in fiscal year 2004. The average annual stipend under this program was \$766 in 2002.*

***Elimination of Medical Services***

Individuals who are still insured through Medicaid will lose significant services. SB 539 made many medical services, which had been required under State law, optional for adults who are neither blind nor pregnant. Now-optional services eliminated in the FY 2006 budget include dental services, dentures, podiatry, orthopedic devices, hearing aids, eyeglasses and comprehensive day rehabilitation services

FY 2006 budget legislation also eliminated additional rehabilitation and specialty services that are not specifically referenced in SB 539.<sup>15</sup> These include an artificial larynx, augmentive communication devices, wheel chair batteries and accessories, hydraulic patient lifts, decubitus care equipment (to prevent tissue breakdown), hydraulic patient lifts, orthotics, hospital beds and specialized mattresses, diabetes self-management training, all other durable medical equipment (e.g. catheters, canes, crutches, walkers, nebulizers, parenteral nutrition, infusion pumps, etc.)

Some of the services that were made “optional” in SB 539 were funded in the FY 2006 budget. These include ambulance services, hospice, wheel chairs, prosthetics, oxygen and respiratory equipment, diabetic supplies and equipment, ostomy supplies and one eye exam every 2 years.

The breadth of healthcare cuts have harmed individuals in every county in Missouri. Appendix A details the total number of individuals affected by program area in each county.

### *The Human Impact of Cuts*

There is a direct relationship between the state’s decision to reduce healthcare eligibility or eliminate coverage and the growth of the number of low-income families who are uninsured in Missouri. Several national studies concur and indicate the very real consequences of cutting Medicaid eligibility. Most recently, Leighton Ku of the national Center on Budget & Policy Priorities analyzed the U.S. Census Bureau’s Current Population Surveys. The analysis found that:

- The number of uninsured low-income parents in Missouri grew dramatically between 2000 and 2003, from 18.8% of that population to 29.6% - a 10.8% increase.
- The increase in uninsured low-income parents was directly attributable to the loss of Medicaid eligibility, which fell by 7.9%.
- The increase of uninsured in Missouri was much more significant than the national average due to the decline in eligibility for Medicaid.<sup>16</sup>

As Ku’s analysis indicates, Medicaid insurance is intended to fill the gap when access to employer-sponsored health insurance falters, such as in times of economic downturn. Nationwide, Medicaid was successful between 2000 and 2003 in ensuring that low-income parents remained covered by health care in times of economic crisis. However, Missouri was largely **unsuccessful** in this endeavor as a direct result of the significant reductions in state Medicaid eligibility.

Further, according to the Kaiser Family Foundation, employer-sponsored health insurance also dropped by 4.5% during this time, which added 177,027 adults to the uninsured in the state. Due to the simultaneous eligibility reductions in Medicaid and the loss of employer-sponsored coverage, the overall rate of the working uninsured in Missouri has increased dramatically in recent years. In 2001, 576,328 Missourians (11.78% of the state population) were uninsured.<sup>17</sup> In 2005, this number rose to 726,000, 12.6% of the state population.<sup>18</sup> This does not include the

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<sup>15</sup> Ferber, J., *Summary of Medicaid Cuts Adopted in the 2005 Legislative Session*, May, 2005

<sup>16</sup> *Memo on the Erosion of Health Insurance Coverage for Low-Income Parents in Missouri, 2000 to 2003*, from Leighton Ku, PHD, MPH, Senior Fellow, the Center on Budget & Policy Priorities, December 7, 2004

<sup>17</sup> Thorpe, K., PhD., *Health Care Expenditures and Insurance in Missouri*, MFH Report, 2004.

<sup>18</sup> *Paying a Premium, The Added Cost of Health Insurance, Families USA*, June 2005.

more than 100,000 Missourians who will be affected by reducing eligibility for Medicaid insurance in FY 2006.

Losing access to insurance, whether it is employer-sponsored, private, or Medicaid, has very real and significant human and societal consequences for the tens of thousands of Missourians mentioned above. Some of these include increases in preventable deaths and the spread of contagious disease, lack of productivity in the workforce due to illness, and cost increases in employment-based and private health insurance. According to the Institute of Medicine, being uninsured has become the 6<sup>th</sup> leading cause of preventable death of people aged 25-64, resulting in 18,000 deaths per year.<sup>19</sup>

The Missouri Budget Project is cooperating with 20 other organizations across the state to collect information that will help assess the impact of Medicaid cuts on Missourians. Surveys are available at [www.mobudget.org](http://www.mobudget.org), or can be obtained by calling 314.652.1400.

Early returned surveys portray a wide range of men and women who face daunting challenges without Medicaid. Julie, a young woman, is afraid to go to college because her wheelchair might break and repairs won't be covered. Don is a middle aged man who suffers from diabetes, high blood pressure, fibromyalgia and depression. His medications cost \$4000 per month. He plans to cope by playing roulette with the multiple medications he needs, buying several that he can afford and hoping that a doctor will give free samples for what he cannot afford. Janice suffers from multiple sclerosis. Her husband has diabetes and works, but has no insurance. She has to meet a \$630 per month spend down, and will have to choose between meeting her health needs, her husband's health needs, or paying rent. Mary is an elderly woman who retired from the Marine Corps. She can no longer get care and prescriptions at the local clinic, but can't afford to drive 90 miles each way to the Veterans Hospital in St. Louis.

Medicaid is a lifeline for these individuals and for tens of thousands of other Missourians.

Additionally, cuts to mental health care specifically through reductions in Medicaid and Community Mental Health Care programs have significant and well-documented negative consequences. Individuals who lose access to treatment for mental illness are more likely to become homeless, utilize emergency rooms for treatment or have increased stays in correctional facilities. A study of the impact of reductions in mental health services in one Connecticut Corporation showed that a 30% reduction in service resulted in a 37% increase in costs incurred for medical care and increased sick days. Further, according to the American Journal of Psychiatry, antidepressant treatment can reduce overall health care costs by 70%, and comprehensive community mental health care can reduce public expenditures on hospital care by 40%.<sup>20</sup>

**Clearly, access to Medicaid and other state health care programs for individuals in Missouri has significant results for the entire state, and the health of society as a whole.**

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<sup>19</sup> *The Costs and Consequences of Being Uninsured*; Karen Davis, PHD, the Commonwealth Fund; *m* Medical Care Research and review 60, 2 (June 2003)

<sup>20</sup> Mental Health data taken from *Can't Make the Grade: The Consequences of Cutting Mental Health Funding*, National Mental Health Association, [www.mnha.org](http://www.mnha.org)

### *Health care cuts hurt the economy*

The increased costs for employers resulting from uninsured workers, increased sick days and lack of productivity are not the only economic consequences of cutting Medicaid. There are more extensive ramifications of Medicaid cuts including the impact on: individuals who have private insurance; the health care industry in the state; and the overall Gross State Product.

The health care industry and ancillary industries benefit directly from Medicaid expenditures. Medicaid payments contribute to the overall income of health care providers including doctors, pharmacists, hospitals, nursing homes, mental health clinics and others. The Federally Qualified Health Clinics in Missouri report that state and federal Medicaid funding encompasses nearly 50% of their overall income sources. Providers throughout the state rely on these funds to deliver services. The health care industry in Missouri is compromised when Medicaid is cut. Several national studies demonstrate the impact of Medicaid on the economic activity in local communities and states. Most recently, a Missouri specific study cites that with every \$1 million expended in Medicaid, the State is able to generate an additional \$3-5 million in business activity, creating between 42-71 jobs.<sup>21</sup> Cutting several hundred million from Medicaid (as Missouri has in the last 4 years) will compromise thousands of Missouri jobs.

Public funds make up 46% of spending in Missouri's health care industry, and total private and public health care expenditures in Missouri create 16% of Missouri's Gross State Product.<sup>22</sup> Medicaid is particularly pivotal in Missouri's economic production because it is a joint federal and state-funded program. For each dollar Missouri expends, it is able to generate nearly \$2 in federal funds.

Eventually, the costs of care for the uninsured are passed on to all of us. Our taxes pay for the State's contribution to uncompensated health care. And larger numbers of uninsured Missourians result in higher insurance premiums for private or employer-sponsored health insurance. In 2005, it is estimated that Missourians' private health insurance premiums increased by 2.9% or between \$110 and \$291 for individuals or families due to the cost of health care for the uninsured. By 2010, this will result in a 4.9% increase.<sup>23</sup>

### *Is Missouri's Medicaid insurance program out of control?*

Missouri is not an extraordinary Medicaid spender compared to other states. In fact, Missouri ranks **38th** nationally when one considers the amount of state general revenue funds spent on Medicaid as a share of personal income.<sup>24</sup> In terms of state general fund Medicaid expenditures per state resident, Missouri ranked 34<sup>th</sup> in the nation in 2003.<sup>25</sup> Missouri's Medicaid administrative expenditures were also well below the national average.

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<sup>21</sup> Missouri Foundation for Health *Show Me Series Report 5: Economic and Health Benefits of Missouri Medicaid* available at [www.mffh.org](http://www.mffh.org)

<sup>22</sup> *Health Care Expenditures & Insurance in Missouri*, Kenneth E. Thorpe, PHD, Missouri Foundation for Health, October 2003.

<sup>23</sup> *Paying a Premium, The Added Cost of Care for the Uninsured*, Families USA, June 2005

<sup>24</sup> Center on Budget & Policy Priorities Analyses of NASBO data on SFY 2003 state general fund Medicaid expenditures and state personal income data from the Bureau of Economic Analysis.

<sup>25</sup> Analysis of Census Bureau data on state and local expenditures and Bureau of Economic Analysis data on personal income.

Further, recent growth patterns demonstrate that Medicaid is better at keeping inflationary costs down compared to other health care programs. The Kaiser Commission on Medicaid and the Uninsured reports that Medicaid spending growth per enrollee averaged 6.9% between 2000 and 2003, while private health care insurance spending grew by 9%, and employer-sponsored insurance costs grew by 12.6%.<sup>26</sup> In fact, the annual state cost per Medicaid enrollee further demonstrates the affordability of this program: the annual cost to the state for adult coverage is just \$1,056 per year and for children is just \$336 per year.<sup>27</sup>

### *Conclusion*

It is a myth that people who don't have health insurance simply don't want to pay for it. In *The New Physician*, Howard Bell reports that 75 percent of uninsured adults say the main reason they are uninsured is because they cannot afford the premiums. The uninsured are twice as likely to live in households having difficulty paying rent, food and utility bills.<sup>28</sup> Families are facing higher transportation costs, as gas prices rise. Heating costs are also predicted to rise in the coming winter. Low-income working families increasingly struggle to meet their basic shelter needs and also provide for their health needs and those of their children.

Medicaid is just one part of the complex health care system that has evolved in the United States. Medicaid's growing cost cannot be addressed without examining it in the context of that larger health care system and its dynamics. It is common sense that Medicaid isn't "fixed" by merely cutting the health insurance of tens of thousands of Missourians. Without insurance, these Missourians will still get sick; those with chronic diseases or disabilities will still need treatment. Cutting Medicaid merely shifts costs, decreases the use of prevention, increases treatment cost and exacerbates human suffering. It is a good thing for individuals and families to have health insurance. Our leaders need to come together with open minds to find real solutions that result in every Missourian being insured.

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<sup>26</sup> Kaiser Family Foundation at [www.kff.org](http://www.kff.org)

<sup>27</sup> Department of Social Services Annual tables.

<sup>28</sup> Bell, Howard, *The New Physician*, September 2000

**Appendix A: People Impacted by Missouri Health Care Cuts by County**

<i>County</i>	<i>Comprehensive Women's Health Care cuts<sup>29</sup></i>	<i>Medicaid cuts or new/increased spend down FY02-05</i>	<i>Medicaid cuts or new/increased spend down FY 2006</i>
Adair	107	491	560
Andrew	135	251	169
Atchison	198	150	159
Audrain	187	534	472
Barry	256	886	901
Barton	60	369	340
Bates	176	402	338
Benton	70	615	640
Bollinger	103	321	409
Boone	611	2103	2512
Buchanan	1996	1962	1897
Butler	172	1536	1486
Caldwell	71	194	204
Callaway	53	777	796
Camden	148	758	775
Cape Girardeau	513	1130	1224
Carroll	98	284	284
Carter	55	246	321
Cass	197	1001	1095
Cedar	123	480	505
Chariton	122	164	151
Christian	536	1011	960
Clark	118	198	173
Clay	314	1705	1915
Clinton	218	257	218
Cole	313	827	1116
Cooper	40	319	333
Crawford	100	601	664
Dade	17	193	214
Dallas	264	385	430
Daviess	84	210	165
De Kalb	76	196	204
Dent	36	583	516
Douglas	124	457	530
Dunklin	187	1481	1654
Franklin	423	1269	1418
Gasconade	63	272	297

<sup>29</sup> Numbers in this column are for the Women's Comprehensive Health Care/Family Planning Program only.

Gentry	69	189	121
Greene	963	4496	4993
Grundy	133	256	294
Harrison	108	287	250
Henry	118	625	597
Hickory	121	317	304
Holt	41	118	107
Howard	121	214	226
Howell	531	1196	1467
Iron	64	449	434
Jackson	1154	9448	10700
Jasper	531	2797	3098
Jefferson	965	2409	2760
Johnson	133	637	692
Knox	25	118	118
Laclede	303	864	1024
Lafayette	177	581	615
Lawrence	324	883	835
Lewis	355	172	209
Lincoln	208	674	729
Linn	151	348	344
Livingston	127	328	338
McDonald	80	735	772
Macon	223	351	360
Madison	83	391	391
Maries	23	186	209
Marion	449	739	725
Mercer	35	80	76
Miller	122	772	711
Mississippi	354	666	668
Moniteau	191	204	269
Monroe	129	182	176
Montgomery	75	276	226
Morgan	207	473	502
New Madrid	369	762	771
Newton	227	1222	1066
Nodaway	368	266	230
Oregon	114	422	385
Osage	21	171	237
Ozark	81	328	362
Pemiscot	133	850	1036
Perry	118	344	354
Pettis	202	825	884
Phelps	183	947	1117
Pike	147	371	410
Platte	709	480	517
Polk	447	816	788

Pulaski	139	611	706
Putnam	60	154	156
Ralls	119	174	158
Randolph	305	623	738
Ray	83	345	274
Reynolds	36	309	325
Ripley	104	731	789
St. Charles	724	1975	2564
St. Clair	57	283	329
St. Francois	552	1646	1746
St. Genevieve	97	302	323
St. Louis County	2204	7547	9655
Saline	409	489	543
Schuyler	10	98	123
Scotland	10	111	97
Scott	820	1326	1342
Shannon	108	446	455
Shelby	189	155	158
Stoddard	289	1134	1036
Stone	152	719	881
Sullivan	70	173	205
Taney	523	1012	947
Texas	169	759	707
Vernon	206	533	583
Warren	131	404	449
Washington	282	885	956
Wayne	100	658	719
Webster	275	671	721
Worth	18	74	50
Wright	204	750	672
St. Louis City	1398	6353	8373
<b>Total</b>	30,000	96338	106327