

**ANALYSIS OF KEY MEDICAID PROVISIONS IN HOUSE-
PASSED HB 1011: REVIEWING THE IMPACT OF
PROPOSED MEDICAID CUTS**

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This paper provides an analysis of key Medicaid and SCHIP cuts contained in HB 1011, the budget bill for the Department of Social Services, as passed by the House. It also reviews the health and economic impact of these proposals.

The House-passed version of HB 1011 cuts Medicaid and SCHIP by lowering the income eligibility level for families to 50% of the federal poverty line (\$7836 in yearly income for a family of three), imposing new asset and cost sharing requirements, eliminating dental and optical services, terminating health coverage for General Relief recipients, and requiring prior authorization for psychotropic drugs.

These proposed cuts will have a detrimental impact on Medicaid beneficiaries, the health care system, and Missouri's economy. The Department of Social Services estimates that proposed **income and asset limitations would cause almost 65,000 low-income Missourians to become uninsured**, diminishing their access to health care and shifting costs to "uncompensated care." Federally funded health centers cannot fill the increased need that would result from this massive increase in uninsured, even with the additional state funds that are proposed in the budget.

The proposed Medicaid and SCHIP eligibility and service cuts **would deny Missouri over \$76.8 million in federal Medicaid and SCHIP funds causing significant losses in jobs and economic activity**. An analysis by economists at the St. Louis University John Cook School of Business shows that these cuts would cause Missouri to lose more than 2000 jobs, \$150 million in economic activity, \$73 million in wages, and \$5.4 million in tax revenue (based on those wages). New asset limitations are also likely to increase paperwork and bureaucracy resulting in additional costs that are not taken into account in the proposed budget.

I. The Impact of House-passed HB 1011 on Missouri’s Uninsured

Nearly 65,000 Missourians would lose health insurance under the House-passed version of HB 1011.

Table 1. A breakdown of the number of uninsured created by the House’s budget bill, based on Department of Social Services’ estimates, is as follows:

Proposed Eligibility Change	Uninsured
Elimination of Medical Assistance for General Relief Recipients	3200 people with temporary disabilities
Reduction of Parent Eligibility to 50% of the federal poverty level	39,000 low-income parents
New Assets Test for Families	1600 low-income parents
New Assets Test for SCHIP Children	881 children
New Cost-sharing for SCHIP Children In Families with Incomes Between 151% and 225% of the federal poverty level	20,000 children
Total Increase in Uninsured Missourians	64,681 people

The largest group of low-income Missourians that would become uninsured under the House-passed budget is the 39,000 low-income parents with incomes above 50% of the federal poverty level, \$7836 annually for a family of three. Moreover, thousands more Missourians—who are not counted in these calculations—are likely to lose Medicaid coverage and join the ranks of the uninsured because of the new administrative barriers related to new asset verification requirements.¹

Making nearly 65,000 more people ineligible for Missouri Medicaid would increase the percentage of state residents who are uninsured. **The rate of uninsured children in the United States and Missouri has remained steady, despite the decline in employer-based coverage, due to the Medicaid and SCHIP programs.**² Census data show that the rising rate of uninsured would have been far worse, if not for the role of Medicaid and SCHIP in responding to increased need during this present recession.³ If Medicaid eligibility is cut as proposed in HB 1011, Missouri’s rate of uninsured will rise with a corresponding negative impact on the health of low-income Missourians.

Because cutting Medicaid causes families to lose health insurance, cutting Medicaid negatively affects the health of Missouri’s low income, working families. There is significant evidence that *having health insurance* improves access to health care and

health outcomes.⁴ **The uninsured receive less preventative care, are diagnosed at more advanced disease states, and once diagnosed tend to receive less therapeutic care (drugs and surgical interventions) than people who have health insurance.**⁵ Moreover, a wide array of studies demonstrates that Medicaid and SCHIP coverage improve access to health care and improve health outcomes.⁶ Such coverage can decrease emergency room usage, reduce preventable hospitalizations, and improve access to primary health care.⁷ Studies also have found that Missouri's Medicaid program has had a number of positive impacts on children's health care.⁸

A loss of insurance coverage also increases the amount of "uncompensated care" - care that is not paid for by private or public insurance -- thus transferring these health care costs to other parts of the health system, driving up costs and straining health resources for people who are not covered by the Medicaid program. In testimony before the House Interim Committee, the Missouri Hospital Association pointed out the substantial "cost-shift" that would occur if Missouri's rate of uninsured were higher.⁹ The St. Louis Regional Health Commission has also documented the uncompensated care burden that results when people become uninsured and the impact this cost-shift has on private insurers and the employers with whom they contract.¹⁰ This cost-shift ultimately affects people who have insurance and employers who provide insurance. As pointed out already, Medicaid and SCHIP are a significant reason why Missouri's rate of uninsured has not grown more over the last several years.

II. The Economic Impact of House-passed HB 1011's Proposed Medicaid Cuts

Medicaid brings significant federal matching dollars into the state. State Medicaid funds generate federal matching funds at a 61% rate for most individuals and a 72% rate for SCHIP children. Missouri Medicaid spending generates approximately \$1.6 in federal matching funds for every state dollar spent while SCHIP spending generates about \$2.7 in federal matching funds.

The reduced income eligibility, asset tests, optional services cuts, and cost-sharing in the House passed version of the House budget **would deny the state \$76.8 million in federal Medicaid and SCHIP funds in FY 2005.** The details are provided in Table 2 which follows.

Because the House budget would deny Missouri substantial federal funds, it would also cause a substantial loss of jobs and economic activity. A wide variety of studies in multiple states have shown that state Medicaid spending generates economic activity and jobs throughout state and local economies based on the "multiplier effect" from such spending.¹¹ Federal Medicaid dollars generate spending in the health sector, which generates other spending that flows throughout the state and local economies. When Medicaid services and eligibility are cut, these federal funds are lost, and hence, economic activity and jobs, are lost as well. A new report, just published by the Missouri Foundation for Health and based on an analysis by economists at the St. Louis University School of Business, documents the significant economic impact that Medicaid has in Missouri.¹²

An analysis of economic data by economists at the St. Louis University School of Business shows that proposed Medicaid eligibility and service cuts translate into losses totaling:

- 2049 jobs
- \$149.3 million in economic activity,
- \$72.7 million in wages,
- \$5.4 million in tax revenue (based on those wages).

The following chart breaks these down according to each proposed cut in eligibility.¹³ Thus, it is clear that the current version of the bill would continue to have a negative impact on jobs and economic activity.

Table 2. Economic Impact of Key Medicaid Cuts in House Passed HB 1011

Proposed Policy Change	Budget Cutbacks Proposed (millions)	Federal Funds Lost (millions)	Reduction in Economic Activity (millions)	Reduction in Jobs	Reduction in Income (millions)	Lost Tax Revenue (millions)
Lower Parents' Eligibility to 50% of poverty	\$ 18.7	\$29.5	\$57.26	786	\$27.9	\$2.08
Impose Asset tests on Families	\$1.4	\$2.2	\$4.29	59	\$2.1	\$0.15
Additional Cost-sharing for SCHIP Children	\$8	\$21.4	\$41.7	572	\$20.3	\$1.51
Asset test for SCHIP Children (\$25,000)	\$2	\$.54	\$1.04	14	\$.51	\$.038
Dental and optical services	\$6.9	\$10.9	\$21.13	290	\$10.3	\$0.77
Prior Authorization of Psychotropic Drugs	\$7.8	\$12.3	\$23.9	328	\$11.6	\$0.87
Total:	\$ 43	\$76.84	\$149.32	2049	\$72.71	\$5.42

III. Analysis of Specific Medicaid Cuts in the Proposed Budget

- **Restricting Income Eligibility for Parents**

The budget legislation proposes to reduce the eligibility of parents in the Medical Assistance for Families (MAF) Program from 77% to 50% of the federal poverty level, \$7836 annually for a family of three. This would mean that a parent working full-time earning \$5.15 per hour would no longer be eligible for health insurance through the Medicaid program. The Department of Social Services estimates that this cut **would cause over 39,000 low-income parents to lose their health coverage.**¹⁴ This cut would also **deprive Missouri of over \$29.5 million in federal funds** (while cutting about \$18.7 million in state spending).¹⁵

- **Additional Asset Requirements for Children and Families**

The bill also includes new asset tests for children and families. The bill would add an asset limit of \$1000 for MAF families and \$25,000 for children in the SCHIP program. While most of these children and families do not have such assets, this proposal would still cause significant numbers of Missourians to lose their Medicaid coverage.

The Department of Social Services estimates that almost **2500 Missourians -- 1600 parents and 881 children -- would lose health coverage if the new assets test were imposed** in these programs.¹⁶ The new asset tests would deprive Missouri of **nearly \$2.2 million in regular federal Medicaid funds and about \$.54 million in federal SCHIP Funds** (while saving about \$1.6 million in state general revenue).

Furthermore, the Department's projections underestimate the number of children and parents who will lose Medicaid and SCHIP because they fail to take into account those people who will lose coverage – not because they have excess assets – but because they are unable to navigate the administrative barriers created by asset requirements. Imposing an asset limit means imposing additional paperwork requirements. Caseworkers must ask more questions and locate additional documentation and verification. Research indicates that these paperwork requirements create administrative barriers to enrolling in Medicaid and SCHIP and cause people who are *eligible* for the programs to lose coverage.¹⁷

Missouri and other states eliminated asset tests for these Medicaid beneficiaries because they were administratively burdensome and resource-intensive for the State agency and created barriers to health care access for children and families. Only two states (Oregon and Idaho) have assets tests in their SCHIP programs.¹⁷ (Missouri currently has a “net worth” test but not an assets test, in its SCHIP program.) Thirty states impose an assets test in their family Medicaid programs.¹⁸ A Kaiser Commission review of state experiences in eliminating the assets

test noted states' overwhelmingly positive experiences in eliminating the assets test.¹⁹ In particular, Missouri state officials reported that “[d]ropping the assets test was an important part of a package of changes that resulted in savings, because the process took less paper and less time.”²⁰

Why Many States Have Eliminated the Assets Test in their Family Medicaid programs

States have given the following reasons for eliminating the assets test in their Medicaid Programs for children and families:

- Not having an asset test made the program “easier to administer.” (Mississippi)
- Eliminating the asset test “was a removal of a procedural barrier and efforts required by agency eligibility staff have been reduced.” (New Mexico)
- Dropping the asset test for families “made the workload more manageable for eligibility workers. It was simplifying while still considering all the factors important to eligibility.” (Massachusetts)
- “By not having an asset test, we could ask fewer questions and the eligibility workers’ jobs would be easier.” (District of Columbia)
- **“The cost the eligibility agency was incurring exceeded the cost of benefits that might have been denied.** These families are usually young, and we would rarely see younger families with assets. The process is slow and cumbersome to verify bank account balances and the cash value of life insurance. It delays the eligibility process and resulted in so few denials that it was cheaper to make them eligible for the benefit without checking.” State officials further noted that the most important impact on families is the “expediency in getting them certified. There is a reduction in time and in the hassle factor.” Making an eligibility decision on applications used to take 45 days, but the new standard is 20 days, “and most are processed now in 5 days.” (Oklahoma)

(Oklahoma officials reported that they had previously spent \$3.5 million in general revenue dollars for administrative activities related to the verification of assets and noted that removing the asset test for families has “dramatically reduced” staff time required to process an application.)

- Dropping the asset test had streamlined the process and removed a significant barrier: “There were families who had not gone through the entire process because it was long, complex and intrusive. The state further stated: “Without a doubt there have been savings [from dropping the asset test].” (Pennsylvania)

- “Dropping the asset test was a very good thing in terms of access. A lot of the tests in place represented barriers to the program. The net effect of the hoops was to weed out people who did not follow through because the process was complex and error prone.” (Ohio)
- “We are glad we don’t have it [the asset test]. **It would cost more in administrative costs than the savings in denying care to low-income people.**” (Rhode Island)
- The process of applying is now “less intimidating.” (Delaware)

Kaiser Commission on Medicaid and the Uninsured (April 2001).²¹

To summarize, imposing a new assets test would make the program more burdensome for families and the state agency. Thousands of **eligible children and families would lose health insurance through Medicaid if new assets test were implemented in the MC+ program and substantial federal funds would be lost.** There would also be *additional financial costs to the state* and administrative burdens for caseworkers if such tests were imposed.

- **New Premiums in the SCHIP program**

The budget bill would greatly expand the use of premiums and co-payments in Missouri’s SCHIP program. Under the current system, only families with incomes over 225% of the federal poverty level (just over \$35,000 in annual income for a family of three) must pay premiums in the Missouri SCHIP program. That group currently includes only about 2200 SCHIP participants. SCHIP families with incomes above 185% of the federal poverty level (over \$28,000 in annual income for a family of three) have co-payments *but no premiums*. Under the House Budget bill, families with incomes over 150% of poverty (about \$23,500 in annual income for a family of three) would have to pay a premium and co-payments to obtain SCHIP coverage for their children.

The Department of Social Services estimates that some 20,000 SCHIP children will lose their eligibility for health coverage because their families will be unable to pay the premiums required in the program.²² Others will lose coverage because of the administrative burdens associated with the new premium requirements. The Department also estimates a loss of more than \$21 million in federal SCHIP funds as a result of the new premium requirements for this population.²³

- **Elimination of Optical and Dental Services**

The Bill recommends cutting certain optional Medicaid services, including dental and optical care. While eliminating these two services would save the state about \$7 million in general revenue, it would also **deprive the state of about \$11 million in**

federal matching funds. At the same time, these optional services have a positive health impact on the people who receive them. It is widely acknowledged, for example, that preventative dental care can forestall greater health problems and more costly medical expenses which can mean higher costs in other parts of the Medicaid budget later on.²⁴ Similarly, vision services help facilitate employment opportunities for low-income adults who need to see in order to perform such job functions as reading, driving, using a computer or a cash register, avert work-related injuries, and prevent permanent disabilities and blindness (which can occur if conditions like glaucoma go unidentified or untreated).²⁵ Policymakers need to consider the health impact of reducing or eliminating these types of services, not simply the short-term financial impact.

- **Requiring Prior Authorization of Psychotropic Drugs**

The budget bill would require prior reauthorization of psychotropic drugs for people with mental illness. This controversial measure could make it difficult for persons with mental illness to obtain medically necessary and life-sustaining medications. There is certainly a risk that new prior authorization provisions could prevent the receipt of needed medications on a timely basis for people with severe mental illness.²⁶

While the budget bill asserts that this new prior authorization requirement would save over \$7.7 million in state general revenue, it **would also cause Missouri to lose over \$12.2 million in federal matching funds. Moreover, there is no evidence that physicians are over prescribing psychotropic medications. Any cost savings are likely to occur from reductions in necessary -- even lifesaving -- care.**

The proposal includes no details about what the prior authorization requirements would be or the qualifications of the individuals determining whether a treating physician or psychiatrist's recommendations are to be granted or denied. Delays in responding to authorizations for new medications or modifications of prescriptions to people with mental illness could be life-threatening

Federally Qualified Health Centers (FQHCs) Cannot Address the Needs of 68,000 new Uninsured that would result from House Bill 1011

The proposed budget provides \$5 million in new funds for federally qualified health centers (FQHCs) to help them serve the 65,000 new uninsured Missourians that will result from budget cuts to Medicaid. However, FQHCs cannot make up for cuts to Medicaid. There is no assurance that families losing Medicaid because of budget cuts will be able to get the care they need at an FQHC since not all areas of the state are served by FQHCs.

Medicaid is the single largest source of funding for FQHCs, contributing over one third of operating revenues.²⁷ Cuts to Medicaid will hurt FQHCs. With a patient load primarily composed of uninsured and Medicaid patients--39% are uninsured and

35% have Medicaid--FQHCs are particularly sensitive to Medicaid reductions.²⁸ When Medicaid eligibility is cut, FQHCs care for more uninsured patients. Similarly, when Medicaid optional services are cut, FQHCs have less Medicaid revenue available to fund care for those without insurance.²⁹

Medicaid also funds the specialty care that FQHCs do not provide. FQHCs provide comprehensive preventive and primary health care, frequently including dental care, and services that patients need to help access health care including transportation, case management, and disease management. However, FQHCs do not offer specialty care or high tech diagnostic services such as oncology, neurology, pulmonology and cardiology. When FQHCs attempt to refer their patients for specialty care, they face long waits for care because of the lack of specialty providers who accept uninsured and Medicaid patients.³⁰ Cuts in Medicaid eligibility and services will make it even more difficult for FQHCs to refer their patients who need specialty care. In addition, these patients would have no coverage for necessary hospitalizations.

The bottom line is that providing \$5 million in state funds to FQHCs will not make up for the far more substantial loss in state *and* federal matching funds that will result from the proposed Medicaid cuts, and will not combat the dramatic increase in uninsured that will result from these cuts.

- **Elimination of State-Funded Medical Assistance for General Relief Recipients**

The budget bill would eliminate the state-funded medical assistance program for recipients of General Relief benefits **causing some 3200 General Relief recipients to lose their health coverage.** General relief recipients are individuals whom the state has determined to be disabled for ninety days or more. The program provides them with health care coverage until they are able to return to work or until they become eligible for regular Medical Assistance should their disability become permanent. This proposal would cut about \$15.7 million in general revenue and leave many of the state's neediest residents without health insurance.

Conclusion

The House-passed HB 1011's proposed Medicaid and SCHIP provisions, if implemented, would have severe negative consequences. Proposals to limit eligibility and services would raise Missouri's rate of uninsured, increase the amount of uncompensated care resulting in cost shifting to employers and other who purchase private insurance, decrease access to health care, and diminish the health status of low-income Missourians. Moreover, the substantial loss of federal funds would hurt Missouri's economy.

¹ Separately proposed legislation, HB 1566, would create even more uninsured children through the imposition of a new “affordability” test that is not currently included in the House budget proposal. The impact of applying “affordability requirements to additional SCHIP children is discussed in the fiscal note to HB 1566.

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

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

⁴ Kaiser Commission on the Future of Medicaid and the Uninsured, *The Uninsured and their Access to Health*, January 2003.

⁵ See Jack Hadley, Sicker and Poorer: *The Consequences of Being Uninsured: Executive Summary*, The Kaiser Commission on Medicaid and the Uninsured, February 2003. www.kff.org/uninsured/20020510-index.cfm, 1.

⁶ O’Brien and Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*, Covering Kids and Families, June 2003.

⁷ Id. (and citations therein).

⁸ Department of Social Services, State of Missouri, *Since MC+ Began*, February 10, 2003.

⁹ Missouri Hospital Association, *Missouri Medicaid Briefing*, House Interim Committee on Medicaid Cost and Containment, October 10, 2003, at 37.

¹⁰ St. Louis Regional Health Commission, *Missouri’s Medicaid Program and its Impact on Missouri Business*, April 2003.

¹¹ National Conference of State Legislatures, *State Medicaid and Health Multiplier Studies: Reports, News Accounts, and Sources and Explanations of Economic Models* (and citations therein), July 22, 2003. NCSL lists eight different state multiplier studies analyzing the impact of Medicaid and SCHIP spending in Alaska, Montana, North Carolina, Ohio, South Carolina, Texas, Utah, and Wisconsin respectively. Other states that have recently conducted such studies are Georgia, Arkansas, Montana, Mississippi, Idaho, Virginia, Florida, and Arizona. In addition to these *state* studies, the Merrick School of Business of the University of Baltimore analyzed the economic impact of Medicaid spending in all fifty states for the Washington D.C.-based Families USA, using a multiplier analysis.

¹² MFH Report.

¹³ These economic data were computed by Heather Bednarek, Ph.D and Muhammad Islam, Ph.D, John Cook School of Business, at St. Louis University, based on proposed state budget cuts in the House budget bill, and estimates from the Department of Social Services. This economic analysis only includes the specific cuts to eligibility and services that are directly mentioned in the table; it does not discuss issues such as the differences between the House and the Governor on increases needed for “pharmacy inflation,” or issues such as third party liability and general relief cuts, which do not have a *direct* impact on federal matching funds. The table captures the economic impact of *federal funds* that the state would lose from cutting these Medicaid services and eligibility groups. It does not consider any economic loss attributable to the cuts in *state* funds for these eligibility groups and services. The methodology for determining the economic impact of Medicaid cuts using the IMPLAN economic model is described in detail in the MFH report, Appendix A.

¹⁴ Department of Social Services, Division of Budget and Finance, *Impact of Medicaid Eligibility Cuts in House Bill 1011 Introduced* (“Budget and Finance Analysis”), February 19, 2004.

¹⁵ See Changes from the Governor Recommendation Introduced Appropriations Bills, House Appropriations Staff, February 10, 2004.

¹⁶ Budget and Finance Analysis. Furthermore, additional children (those whose families are cut off of MAF) could also lose coverage even though they would still be eligible for other Medicaid coverage. It is not clear that in, practice, all such children would automatically be transferred to another Medicaid category when their family loses eligibility for MAF. Other eligible children could lose coverage because their parents do not apply because they believe that the whole family is ineligible due to the asset test.

¹⁷ Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge, A 50 State Update on Eligibility, Enrollment, Renewal and Cost-sharing Practices in Medicaid and SCHIP*, July 2003; Ellen O’Brien and Cindy Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*, Covering Kids and Families, June 2003, at 9; Laura Cox, *Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children’s Health Coverage Programs*, Center on Budget and Policy Priorities, December 28, 2001.

¹⁷ Center on Budget and Policy Priorities, February 13, 2004. Texas has proposed an asset test for families with incomes above 150% of the federal poverty line but implementation of that test has been postponed.

¹⁸ Center on Budget and Policy Priorities, *Asset Limits for Pregnant Women and Section 1931*.

¹⁹ Vernon Smith et al., *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, Kaiser Commission on Medicaid and the Uninsured, April 2001.

²⁰ *Id.* at ii.

²¹ *Id.* 1-15.

²² Budget and Finance Analysis.

²³ If the additional SCHIP premiums are imposed, the state will lose federal funds for two reasons: (1) The state will lose federal funding for the estimated 20,000 SCHIP recipients who would lose coverage; (2) For the recipients remaining on the program, the state can only receive federal matching funds for Medicaid payments made by the state, which will be lower if the recipient pays a premium -- no federal matching funds are received for the premiums that are collected, only for the amount that Medicaid pays.

²⁴ See, e.g., U.S. Dept. of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*, 2000.

²⁵ See Leighton Ku, *The Significance of Vision Benefits in Medicaid*, Center on Budget and Policy Priorities, December 2002.

²⁶ For further discussion of the risks involved in restricting access to medications used to treat mental illness, see National Mental Health Association, Issue Brief Series: Access to Medications, *Issue Brief #1: The Case for Open Access to Medications*. See also Kirsten Dunham, *Impact of FY 2005 Budget Proposals on Health, Mental Health and Community-based Services for Children and Adults with Disabilities*, February 23, 2005.

²⁷ Report of the House Interim Committee on Medicaid Cost and Containment at 43.

²⁸ See, Sarah Rosenbaum and Peter Shin, *Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid’s Role*, Kaiser Family Foundation, May 2003. See, Sarah Rosenbaum and Peter

Shin, *Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role*, Kaiser Family Foundation, May 2003.

²⁹ See, Sarah Rosenbaum and Peter Shin, *Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role*, Kaiser Family Foundation, May 2003.

³⁰ See, Saint Louis Regional Health Commission, *Building a Healthier Saint Louis: A Report on the Integrity of Saint Louis' Health Care Safety Net*, 147-149.