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MEDICAID POLICY BRIEF

# Missouri Medicaid

## A Lifeline for Thousands of Women Faces Extinction

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The National Women's Law Center is a nonprofit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families, including health and reproductive rights, employment, education, and family economic security.

# Missouri Medicaid:
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### Introduction

Medicaid is the largest source of health care funding for the poor in the U.S., serving one in six Americans or close to 53 million people.[1] In Missouri, the Medicaid program plays a vital role in keeping people insured as it provides coverage to more than 900,000 Missourians. Medicaid guarantees eligible individuals coverage for primary, acute and long-term care services. The federal and state governments share financial responsibility for the program. There is currently no cap on the amount states can spend on Medicaid, and the federal government contributes to the costs of the program based on a formula that accounts for levels of poverty in each state. ***For 2005, the federal government is contributing 61% of Medicaid costs in Missouri.***

Because Medicaid is an entitlement program, anyone who meets the stringent eligibility requirements can enroll and there is no limit on the number of people allowed into the program. There are five main categories of eligible people: (1) Children, (2) Parents, (3) Pregnant Women, (4) People with Disabilities, and (5) the Elderly. Beyond these categories, eligibility is determined based on financial considerations, with a federally defined income threshold for each group and a limit on assets.[2] States may seek approval through an application to the federal government called a "waiver" if they want to alter their program in any way that would waive federal Medicaid requirements.

**For women, Medicaid is a particularly important program. Medicaid in Missouri provides vital health care access to low-income women *who comprise 79% of non-elderly, non-disabled adults.*[3]** Women are twice as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Parents, in particular, rely on Medicaid for their health insurance, as the program covers 40% of single mothers nationwide.

Recently enacted cuts proposed by the Governor and approved by the state legislature in Missouri have jeopardized funding for the program and have caused a loss of coverage for many needy people. After Governor Blunt proposed deep cuts to the program, the legislature, in the budget process, went beyond those proposals and agreed to massive cuts in Medicaid. Many of these cuts have already been instituted, with a complete overhaul of the program on the horizon. On July 1, more than 23,000 Missourians were cut from the state's Medicaid rolls because their incomes now exceed the newly set eligibility levels. In August, even more change went into effect causing reduced coverage for many needy parents, elderly and individuals with disabilities.

These changes are just the beginning of so-called Medicaid reform in the state. ***The program is targeted for complete elimination by June 30, 2008***, a task that is now the responsibility of the Missouri Medicaid Reform Commission. The current state legislative actions have jeopardized health insurance coverage for many low-income women and their families, and the decisions of the Commission could very well determine whether low-income families remain insured in Missouri.

# Medicaid's Role in Missouri

**Who Does the Medicaid Program Cover in Missouri?**
As required by federal law, the Medicaid program in Missouri covers several categories of people up to certain percentages of the federal poverty level (FPL), namely:

- *children up to 100% of FPL*
- *pregnant women up to133% of FPL*
- *adults with dependent children[4] up to 22% of FPL*,
- *aged, blind and disabled up to 74% of FPL*

These individuals are known as mandatory populations. States can go beyond these mandatory levels and cover more people. All states currently do so, and Missouri is no exception. The "optional" populations covered in Missouri prior to the recently enacted cuts include:

- *adults with dependent children up to 75% of FPL*
- *children up to 300% of FPL who do not have access to employer-related insurance, and who have been uninsured for 6 months*
- *pregnant women up to 185% of FPL*
- *women battling breast or cervical cancer up to 200% of FPL*
- *aged, blind and disabled up to 100% of FPL*

There are more women who rely on Medicaid for their health coverage in Missouri than men. In 2003, 58% of all beneficiaries were women and girls. Within different eligibility categories, particularly parents and the elderly, women make up the majority of enrollees. For parents in Missouri, the Medicaid program is an important safety net for single moms. **In fact, two thirds of moms on the program are in single headed households.** Similarly, the Medicaid program addresses the coverage gaps that low-income elderly women face. Because many elderly women on a fixed income can not afford private insurance to supplement Medicare, they turn to Medicaid for coverage of needed services. **Known as the "dually eligible," this population is overwhelmingly women, who comprised 72% of elderly beneficiaries in Missouri in 2003.**

**What Does the Medicaid Program Cover?**
Missouri women rely on Medicaid for a range of services. The Medicaid program covers all mandatory benefits – including outpatient services, laboratory and x-ray services, nursing home care, physician services, EPSDT[5], and family planning. Depending on the population, the state also covers optional benefits such as dental care, clinic services, prescription drugs, case management services, and expanded pregnancy-related services. The state has also exercised its option to receive federal funding to provide breast and cervical cancer treatment to uninsured women under age 65 who are under 200% of FPL and have been diagnosed through the Centers for Disease Control screening program.

As mentioned earlier, states apply to the federal government through a waiver to make any changes to their Medicaid programs that alter federal requirements. Missouri has such a waiver to expand family planning services to low-income women who received Medicaid during their pregnancy and would have lost coverage at 60 days postpartum. Federal law requires pregnancy-related care, which includes family planning, for 60 days after a woman gives birth. After this coverage ends, most of these women would not qualify for health coverage as parents under Medicaid given that income eligibility levels for parents is significantly lower than it is for pregnant women.[6] This waiver extends family planning services only to these women for one year.

***Currently, Missouri Medicaid pays for 43% of all births in the state.***[7] Expanding family planning, as the waiver does, actually *saves* the state money in that it prevents unintended pregnancies, which would then be covered under Medicaid. It is estimated that for every $1 the government spends on family planning, $3 are saved in costs for covering pregnancy. The family planning waiver in Missouri is particularly critical because the state eliminated its state family planning program back in 2003. Approximately 30, 000 women were served by the program, which provided a range of services including contraception, cancer screenings and well-woman physical exams. It was estimated that well over 8,000 unintended pregnancies a year would result from the loss of this program.[8]

**Medicaid and the Uninsured**
Missouri has historically had fewer uninsured people than many other states. **In recent years however, with the decline in employer sponsored coverage,**

**the percentage of Missourians lacking insurance has risen at a faster rate than has been experienced across the country.**[9] Currently, there are over 620,000 uninsured Missourians.[10] High rates of uninsured people are detrimental not only to the individuals who must go without care, but also the economy of the state as a whole. Faced with little other choice, uninsured individuals often turn to emergency rooms for health care. This care is more expensive, the cost of which is shifted to the hospital. In St Louis alone, it is estimated that hospitals net loss from covering this care, which is known as "uncompensated care," is $160 million.[11] These costs are then passed on to private insurers who similarly shift the cost to area employers and insured populations. In Missouri, it is estimated that the costs of uninsurance to those who are insured amounts to between $110 and $291 for individuals or families. Those amounts are expected to double by 2010.[12]

## Changes to Missouri's Medicaid

The Missouri Medicaid program has been the focus of much of the state's attention recently. Major cuts to the program have already been instituted, with a complete overhaul of the program in the works. The major areas of change are:

1. *Reductions in Eligibility*
2. *Reductions of Benefits*
3. *Increased Cost-Sharing*
4. *Increased Enrollment Barriers*

**1. Reductions in Eligibility**

***Parents:*** The eligibility level for parents has been reduced to the mandatory level, which is 22% of FPL or $292 a month for a family of three. Prior to this cut, Missouri Medicaid provided health coverage for a mother and two children if the family income was $980 a month or less. ***This decrease represents the deepest cut in Medicaid eligibility for this population instituted by any state.*** It will cause roughly 70,000 low-income parents to lose their coverage.[13] Women will be disproportionately affected by this reduction as they make up the majority of parents eligible for Medicaid. Many of the eligible individuals are working parents who must rely on Medicaid for their health insurance because they do not have access to health insurance through their employer.

By providing health coverage for these populations, Missouri helps parents stay in the workforce, which is vital not only to the financial stability of low-income families but also to the economy of the state. It is estimated that cutting these parents will save almost $30 million in state spending. However, these "savings" translates to a loss of over $46 million in federal funds that come to the state (given that the federal government matches 61% of state costs). The Missouri Foundation for Health calculates that such a loss of federal revenues amounts to the elimination of over 1,000 Missouri jobs, the loss of over $90 million in business activity, $44 million in wage losses and a loss over $3 million in tax revenue for the state.

***Aged and Disabled:*** The eligibility level for low-income elderly and people with disabilities has been reduced to 85% of FPL, which is about $678 per month for an individual. The state was at the end of a three year phase in of coverage up to 100% of FPL for this population. Approximately 9,000 elderly and disabled Missourians between 85% and 100% of FPL will lose their coverage as a result of this eligibility reduction.

The elderly and disabled population will also be affected by another significant policy change. Thousands of individuals will be transferred to the Medicaid spend-down program.[14] These individuals will face higher spend down amounts than they have now, meaning that they will have to spend more substantial portions of their incomes before than can qualify. The Medicaid spend down category is a vital component of the program for those with significant health care needs. For individuals who are elderly or disabled, this option provides a lifeline to coverage for their high recurring medical expenses.

Changes to this population's eligibility will disproportionately affect women, who make up the majority of elderly beneficiaries. Among seniors over the age of 85, most of whom have particularly extensive health care needs, an even higher proportion are women. Much of this population requires long term care services, which include a range of services for people who have functional

limitations or chronic health conditions. Because the Medicare program lacks comprehensive coverage for many of these services and private insurance often excludes such coverage from its plans, Medicaid is left to take up the slack. Those low-income individuals in need of extensive nursing home care, for example, rely on Medicaid for their coverage. Medicaid is currently the nation's largest provider of nursing home care, which is one of the most expensive types of health care.[15]

***Low-income workers:*** The state also discontinues coverage for two needy groups of low-income workers. First, it eliminates coverage for a second year of transitional medical assistance (TMA). TMA is a program that provides Medicaid coverage to those individuals who are transitioning from welfare into the workforce and, as a result, make too much money to qualify for Medicaid. This program is a vital safety net for these low-income workers whose jobs do not provide access to employer sponsored insurance.

The state also eliminates Medical Assistance for Workers with Disabilities (MAWD). This program provides coverage to people with disabilities who are transitioning back into the workforce. It is estimated that the elimination of this eligibility category will cause almost 10,000 workers to lose health coverage.

***Blind Individuals, Pregnant Women and Children:*** Three categories of eligible populations will not face direct eligibility cuts as a result of Medicaid changes. The state retains the eligibility standard of 100% for persons who are eligible because of blindness. Likewise, the eligibility levels for pregnant women and children are not tampered with.

Although children's eligibility is not directly altered, it is important to note that often parents' eligibility affects whether their kids get covered. Research has shown that children are more likely to have health coverage when their parents are also covered. In Missouri, Medicaid enrollment of children grew as parents became enrolled in the program.[16]

***Optional Populations:*** Beyond these cuts, the state essentially places ***all*** optional populations at risk for a loss of coverage by stipulating that ***all eligibility groups not mandated by federal law are now "subject to appropriations" each year.*** Essentially, Missouri is promising only to cover mandatory populations. This would mean eliminations beyond what was described above could result. This would put coverage at risk for many needy populations, including pregnant women over 133% of FPL and individuals eligible because of blindness.

**2. Reduction in Benefits**

Missouri has targeted many necessary services for elimination. Exempting only the blind, pregnant women and children, the following services are among those that could be eliminated by the legislature through the appropriations process:

- Dental services
- Dentures
- Podiatric services
- *Optometric services*
- Orthopedic services
- *Prosthetics*
- Hearing aids
- *Hospice*
- Wheel chairs
- Eyeglasses

Some of these services will be covered through 2006 (and are noted in italics), but could face elimination thereafter because the new policy removes the state's legal requirement that these services be covered.

***The loss of benefits will be felt by over 375,000 individuals,*** close to half of beneficiaries. Under federal Medicaid law, the services that are being cut are known as optional services. However, even so-called "optional benefits" are vital health care. The term "optional" is a statutory term that has little to do with whether these services are necessary. In fact, ***many so-called optional benefits are essential to delivering quality and comprehensive health care to individuals.*** Many of the services suggested for elimination – such as orthopedic services – have been added as our medical system has evolved and are now critical components of appropriate care.

**3. Increased Cost Sharing**

Cost-sharing refers to the out-of-pocket payments, usually in the form of co-payments, that beneficiaries are required to make in connection with the receipt of a covered service under their health insurance plan. The majority of states use co-payments – fixed amounts that must be paid by the beneficiary at the time the service is received – as their primary cost-sharing device. Some states also impose premiums,

which are prepaid payments made to a health plan by beneficiaries.[17]

Missouri will now place various cost-sharing burdens on Medicaid beneficiaries. In terms of premiums, the state will now require families with incomes above 150% of FPL to begin paying premiums for their children's coverage. A family of three making just over $24,000 will face a premium ranging from 1% to 5% of income. Research has shown that premiums reduce low-income people's access to care by discouraging them from participating in health insurance. One multi-state study showed that premiums set as low as 1% of family income led to a 15% reduction in participation in publicly funded health insurance programs, while a 3% premium led to almost a 50% decrease in enrollment.[18]

The new policy also allows Medicaid to impose co-payments on nearly all Medicaid covered health care services and prescription drugs. Federal Medicaid law forbids co-payments for certain populations and for select services. No co-pays may be charged for children under age 18, terminally ill individuals in hospices, inpatients in nursing facilities, services for pregnant women, as well as family planning and emergency services. However, for all other populations and services, states can impose only "nominal" cost-sharing. Missouri had been exercising its option to apply nominal co-pays on many services, including physician services rendered in a hospital outpatient clinic or emergency room, inpatient hospital services, and drugs and medicines.

Many more services will now be subject to cost sharing. The new law authorizes the imposition of nominal co-pays (ranging from .50 to $3.00) on all services. Services that will be affected include ambulatory surgical care, lab tests and x-rays, clinic services and nurse practitioner services. The only exempted services (besides those protected by federal law) are mental health services, personal care services and home and community based services.

Co-payments have been shown to have negative effects on access to care. A comprehensive study found that low-income adults and children reduced their use of *appropriate* medical care services by 44% when they were forced to make co-payments.[19] This study also found that co-payments lead to poorer health among low-income adults as compared to those not subject to this form of cost-sharing.

Having to pay even a nominal co-pay will be difficult for many families. Even though Missouri retains the "nominal" amount, co-pays are applied so broadly and on so many services, that it will result in higher out-of-pocket payments for beneficiaries. By shifting the burden of the cost of health care to beneficiaries, Missouri is putting severe financial stress on women and their families. These families already bear a greater burden of out-of-pocket costs for their health care. On average, non-elderly, non-disabled adults who are insured through Medicaid with incomes below the federal poverty level spend ***three times as much (by percentage of income) on out-of-pocket payments*** as the amount spent by middle class adults in private coverage.[20]

Because these co-payments stay within the confines of federal law, the state has not had to apply for a waiver. However, one provision of the new legislation will require the state to get permission from the Centers for Medicare and Medicaid (CMS). The law allows providers to refuse to treat individuals who have unpaid debt resulting from not paying a previous co-pay on services rendered. Federal law currently protects patients from being denied care by requiring that physicians provide services even to those who can not immediately pay the co-pay. Under this legislation, this protection will be lost.

The new co-pays will also have repercussions for providers. They will result in a reduction of reimbursement because payments to providers will be reduced by the amount of the co-pay. The only exception will be in pharmacy dispensing fees – all co-payments on drugs will be in addition to the amount Medicaid pays pharmacists for the service rendered. A reduction in provider reimbursement rates could hinder access by discouraging physicians and other providers from participating in the Medicaid program.

**4. Increased Enrollment Barriers**

The legislation implements new administrative measures to tighten up rules and increase documentation requirements of people seeking to qualify for Medicaid. It requires the Department of Social Services to conduct annual reinvestigations in eligibility for Medicaid, and it requires verification and documentation as part of this process. Documentation, which may include a long list of paperwork, is required within 10 days or the

beneficiary risks of termination of benefits. It is estimated that over 13,000 Missourians will lose coverage because of this administrative barrier.

The Missouri law imposes another significant barrier with the implementation of an affordability test. In order to get coverage for their children, parents must prove that they do not have access to "affordable" health insurance, which is defined as spending up to $335 a month on a health plan. By pursuing this policy, the state is saying that it is acceptable for a mother with two children at 150% of federal poverty who makes just $2,000 a month to contribute 17% of her income to health coverage for her child. If the mother cannot provide verification that she has no such access, her child will be deemed ineligible for Medicaid.

Although the intention of such policies is to prevent ineligible individuals from attaining coverage, studies have shown that complex administrative procedures discourage eligible people from enrolling. In essence, administrative barriers create the same negative outcomes as direct cuts in eligibility, particularly for beneficiaries who face a loss of coverage. These policies also create administrative costs for the state, given the time and staffing that is needed to implement them, and could therefore affect the ultimate goal of budgetary savings.

## The Medicaid Commission and Long-Term Reform

In addition to all these changes, the newly passed legislation established a Commission to reform Missouri Medicaid in the long-term. Under the legislation, the Medicaid program will end on June 30, 2008 and it is the Commission's charge to develop "clear and concise policy recommendations on reforming, redesigning, and restructuring a new, innovative state Medicaid healthcare delivery system." The Commission is made up of ten members, five from the Senate and five the House of Representatives. There are six Republicans and four Democrats on the Commission.

With the program slated to end in 2008, the state must now determine how best to provide a health care safety net to poor Missourians in the future. In making this determination, it is important to consider the following important roles the Medicaid program has played in the state:

***Medicaid in it current structure is an efficient vehicle for providing health insurance.*** Medicaid is even more efficient than even the private insurance market. When compared to the private insurance, Medicaid costs have risen much more slowly. In fact, they have risen at ***nearly half the rate*** of private insurance costs.[21] In terms of average medical expenditures, spending for the Medicaid program was nearly ***thirty percent lower for adults*** and ten percent lower for children than the medical costs associated with private health insurance.[22] Furthermore, increases in Medicaid eligibility led to decreases in avoidable hospitalization,[23] thereby helping to save money in the long-run. When it comes to overall efficiency, no single program has done as good a job as Medicaid in helping to control health care spending, or has more successfully limited administrative costs.[24]

***Medicaid is working exactly as it was designed to work.*** The program's enrollment has increased significantly due to weak economic times and decreases in the availability of employer-sponsored insurance. Nationwide, Medicaid enrollment for families (non-disabled adults and children) grew by 11.6 percent between 2000 and 2002 and by another 7.1 percent between 2002 and 2003.[25] Structured as an entitlement program, Medicaid is designed to work as a safety net that expands during weak economic times.[26] When the economy is in recession and states are short on money, unemployment figures rise.[27] As a result, a greater number of people become eligible for Medicaid benefits.[28] Studies have shown that in 2002, if Medicaid had not responded to the weak economy by providing coverage to the unemployed, the number of uninsured would have been several millions higher.[29]

Besides unemployment, another impact of a weak economy is that many employers scale back on providing insurance for employees, a move that has the greatest impact on low-income, working families. From 2000 to 2003 there was a 14 percent decrease in employer-sponsored coverage for families with

incomes below the federal poverty line.[30] There was an eleven percent decrease for families between 100% and 200% of the FPL and overall losses of employer sponsored coverage for the low-income workers more than doubled that of higher-income workers.[31] Furthermore, even when employers offer coverage, monthly premiums are often too high for low-income workers to afford.[32] In recent years, many employers have increased the amounts that workers must pay out of pocket. These increases make available insurance in the private market unaffordable for many low-income families. The Medicaid program exists as a safety net not only for those who have lack access to private insurance, but also for those for whom that insurance is unaffordable.

***Medicaid costs are rising because health care costs are rising.*** The health care system as a whole has seen a significant increase in health care related costs, affecting both the public and private health insurance market. In a ten year period, health care costs more than doubled, with an average increase of 6 percent per year from 1990 to 2000.[33] In 2004 alone the premiums for employer health insurance increased by 11.2 percent, or nearly four times the rate of inflation.[34]

The rise in premiums is indicative of a much bigger problem, as it is reflective of the drastic increase in general health care costs that have led to the erosion of employer-based insurance.[35] From 2002 to 2003 costs grew by 13.4 percent for acute care services and by 8.4 percent for long-term care services. Between 2000 and 2003 Medicaid drug costs rose by 17.1 percent.[36] The rise in cost is largely driven by advances in medical technology, as well as a piecemeal system that delivers care in a less than efficient way. How to control growth is a major national policy challenge and only a comprehensive approach to contain health care costs will adequately address it; reforming Medicaid alone will do nothing to address this larger issue.

***Medicaid shoulders the burden of covering the most expensive services***. Because both the Medicare program and the private insurance market lack comprehensive coverage of long term care services, Medicaid is left to fill this coverage gap. These services are in high demand by people with disabilities and the elderly, who comprise 23% of beneficiaries in Missouri's Medicaid program yet account of 67% of its expenditures.[37] This is a trend reflected nationwide - the majority of the Medicaid population (close to 75%) is made up of relatively healthy, low-income families and children who account for only 30% of spending. For example, in 2003 estimated Medicaid spending per child was $1,746, while per-person spending on the frail elderly (the highest-cost group) was $12, 828.[38] As it is currently the nation's largest provider of nursing home care, Medicaid is covering one of the most expensive types of health care.[39] A single year of nursing home care, for example, costs anywhere from $60,000 to $80,000 per person.[40] Furthermore, the demand for long-term care services is expected to grow significantly over the next several decades, particularly in 2030 when the baby boomer generation (the population most likely to need long-term care services) reaches age 85. By 2040, the over 85 population is projected to go from about 4 million to over 14 million.

***Without Medicaid, many more Missourians would be uninsured.*** The Medicaid program serves a vital role as safety net insurance for many Missourians who would otherwise be uninsured. A decline in both the *availability* and *affordability* of employer-sponsored coverage has left many families with no other choice but to turn to Medicaid for health insurance coverage. Without this coverage, these individuals would delay routine care and overuse emergency room services, which are far more costly. This care, which is uncompensated, is passed along to those in the private insurance system, increasing health care costs for all. Ninety thousand Missourians have already lost their Medicaid coverage due to the recently implemented cuts in eligibility. [41] Many of these individuals will have no other source of insurance and will join the ranks of the uninsured.

***The federal-state matching structure is important to maintaining the economic security of the state of Missouri.*** Under the current system, the federal government pays 61% of program costs, no matter how much the program grows. This money is an important source of revenue to both the Medicaid system and the state. Altering this financial arrangement between the state and federal governments could have dire consequences for Missouri, particularly if the state agrees to a limit on federal funding. Under such a structure, the state would have to cover 100% of any unpredicted health care costs, as compared to only the 39% it is now

required to cover. The state is placing itself at great risk by letting the federal government out of this financial obligation. The federal matching funds that trickle into Missouri are a vital source of funding for many parts of the health care system, namely hospitals, doctors, pharmacists, and nursing homes. Every $1 million in state Medicaid spending generates $1.57 million in federal matching dollars, and creates 42 new jobs and $3 million in new business activity for the state of Missouri.[42]

## Conclusion

In order to understand why Medicaid budgets are growing, the Commission needs to examine the program as whole and not in isolation from the many issues of the larger health care market. Furthermore, the Commission needs to weigh the cost to beneficiaries and to the state's economy of cuts to the Medicaid program. Eliminating a vital safety net program like Medicaid will place an undue burden on low-income families, increase the number of uninsured, increase the use of expensive emergency room care and ultimately hurt Missouri's economy because of the loss of federal funds and an increase in uncompensated care. Furthermore, targeting cuts to low-income families is counterproductive. While parents and their children constitute the vast majority of Medicaid beneficiaries, they are relatively inexpensive to care for. The current delivery system works efficiently for this population. Dramatic delivery reforms for families will not save enough money to justify the individual hardship or the financial risk to the state that could ensue should Medicaid expenses increase for any reason. The states should explore ways to save money that does not jeopardize patients or the economy of Missouri.

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