

Show Me Series: Report 5
Economic and Health Benefits
of Missouri Medicaid

The Missouri Foundation for Health (MFH) was created on January 6, 2000 as a part of a negotiated agreement among Blue Cross/Blue Shield of Missouri (BCBSM), the Missouri Department of Insurance and the Missouri Attorney General following the for-profit conversion of BCBSM. The Foundation received a significant portion of the assets of RightChoice, the for-profit created by the conversion. MFH is dedicated to improving the health of the people in the BCBSM service area, which encompasses 84 Missouri counties and the City of St. Louis.

In support of its mission, MFH undertakes policy studies on topics of significance to the Foundation service area and beyond. MFH has created the Show Me Series to convey information about current health related issues of interest to a broad audience ranging from members of the general public to policymakers.

Show Me Series: Report 5

Economic and Health Benefits of Missouri Medicaid

About the Author

Joel Ferber, JD, serves as Managing Attorney for Legal Services of Eastern Missouri in St. Louis.

Economic Research

Heather L. Bednarek, PhD, and Muhammad Q. Islam, PhD, Department of Economics, John Cook School of Business, Saint Louis University.

Editors

M. Ryan Barker, Policy Analyst, and Leslie Reed, Director of Policy Studies, Missouri Foundation for Health.

Acknowledgements

Special thanks for the assistance of Ann Lever and James Frost of Legal Services of Eastern Missouri, St. Louis; and Leighton Ku of the Center on Budget and Policy Priorities, Washington, DC.

Medicaid, a joint federal and state program, provides health insurance coverage to 47 million low-income Americans, including more than 900,000 Missourians.¹ Given that Missouri has a population of approximately 5.6 million people, Medicaid plays an integral role in the state's overall health care system. Additionally, for every dollar in state Medicaid spending, Missouri receives approximately \$1.57 in matching federal funds, and \$2.68 in federal funds for every state dollar spent under the State Children's Health Insurance Program (SCHIP).² These matching dollars from the federal government not only support economic activity and employment in the health sector but also trigger economic activity throughout the state and local economies. Finally, as a public health insurance program Medicaid helps to combat the rising rates of the uninsured, improves access to health care services, limits the state's uncompensated care burden and improves the overall health of people insured through the program.

This paper, prepared for the Missouri Foundation for Health (MFH), addresses both the costs and the benefits of the Medicaid program for the state of Missouri. It begins by breaking down Medicaid costs by health care service rendered and according to specific populations covered by the program. The study then looks at the economic benefits of Medicaid for the state of Missouri based on new data from the St. Louis University John Cook School of Business. The next section of the paper examines the impact of Missouri's Medicaid program on health related outcomes, access to health care and the uninsured rate. It concludes by summarizing the economic and public health benefits associated with insurance coverage through the Medicaid program.

Medicaid and SCHIP in Missouri: A Brief Explanation

The State Children's Health Insurance Program (SCHIP), created in 1997, provides additional funding for states to cover low-income children who were not already eligible for Medicaid programs. States were allotted a set amount of funds with which they could create a separate SCHIP program or expand their existing Medicaid programs. Missouri opted to use its SCHIP funds to expand its existing Medicaid program.

Generally traditional Medicaid rules apply to all children; however, those covered under the expansion may be required to pay premiums and co-payments depending on their family's income. To encourage states to extend health coverage to more children, the federal SCHIP funds were made available to states at a higher federal matching rate than traditional Medicaid. The term "SCHIP" is used at various points in this paper to refer to the children for whom the state receives the higher matching rate.

Different components of Missouri's Medicaid program have different names, such as MC+, Medical Assistance, Medical Assistance for Families, and Medical Assistance for Workers with Disabilities. One term used in this paper is MC+, which describes the part of Missouri's Medicaid program that serves children, families and pregnant women. MC+ includes the children that are funded by the federal SCHIP program, as well as individuals covered by regular Medicaid funds.

Medicaid is the major health insurance program for the poor in Missouri. It also functions as a major payer of long-term care for the elderly and disabled, making it the nation's largest funding source for nursing home care.³ According to state data, the biggest expenditure areas in Missouri's Medicaid program include pharmacy (\$932 million), nursing home care (\$719 million) and hospital care (\$758 million). By comparison, only \$247 million was spent on physician services, \$133 million on EPSDT (the preventative health program for children) and only about \$20 million on the entire Medicaid dental program in 2003.⁴ (See Table 1.)

Medicaid enrollment has grown substantially in recent years. Missouri, like many other states, expanded Medicaid coverage for low-income parents and children through the SCHIP program and new state options to cover additional low-income parents.⁵ However, this expansion of coverage is not the primary reason for Missouri's increasing Medicaid costs. The rapid enrollment growth stems in part from this expanded eligibility coverage, but also from the economic downturn, which has resulted in declining incomes and lower rates of employer-sponsored insurance.⁶

MEDICAID SPENDING IN MISSOURI

**Table 1. Missouri Department of Social Services
Division of Medical Services
FY 2003 Medicaid Expenditures**

Pharmacy	\$ 932,961,078	20.46%
Hospitals	758,856,188	16.64%
Nursing Facilities	719,173,688	15.77%
Managed Care	656,244,313	14.39%
Mental Health & State Institutions	581,832,322	12.76%
In-Home Services	308,766,299	6.77%
Physician-Related	247,619,541	5.43%
EPSDT Services	133,653,751	2.93%
Rehab & Specialty	129,352,442	2.84%
All Other	91,851,448	2.01%
TOTAL	\$ 4,560,311,070	100%

MEDICAID SPENDING IN MISSOURI

Medicaid, as an entitlement program, was designed to respond in a “counter-cyclical” manner to downturns in the business cycle. Federal funding for the program automatically rises as demand for assistance increases. In this way, Medicaid helps to combat rising numbers of uninsured. While increased Medicaid enrollment in response to an economic downturn contributes to rising Missouri Medicaid costs, the rising costs of serving the elderly and disabled (fueled in part by the growing cost of prescription drugs) stands as the biggest reason for the increasing costs of the program.⁷

As shown in Table 2., increasing the eligibility of children and parents has a relatively low cost compared with the Medicaid populations of seniors and persons with disabilities. Elderly and disabled individuals constitute only 23 percent of the Missouri Medicaid program, but account for 67 percent of its expenditures.⁸ It stands to reason that older individuals and persons with disabilities will have greater and more expensive medical needs. In fact, 60 percent of the nation’s Medicaid expenditure growth from 2000 to 2002 was for the elderly and disabled populations, even though they accounted for only 13 percent of enrollment growth in the program during this same period.⁹

The Medicaid program has been receiving attention in Missouri and across the nation as states struggle with budget shortfalls.¹⁰

**Table 2. Missouri Department of Social Services
Division of Medical Services
FY 2003 Costs for Various Medicaid Eligible Groups in Missouri**

	Enrollees	Annual Expenditures (dollars)	Average Monthly Cost per Enrollee (dollars)
Elderly	80,404	1,192,703,142	1,236.16
Persons with Disabilities	133,070	1,877,824,655	1,175.96
Children	519,470	1,006,738,562	161.50
Adults (non-disabled and under 65)	195,079	483,044,711	206.35

However, as noted previously, while Missouri does have to spend state funds to expand or sustain Medicaid coverage, these expenditures also bring in additional federal matching funds. In fact, according to the National Association of State Budget Officers, Medicaid constitutes more than 60 percent of all federal grants to the state of Missouri.¹¹ Furthermore, as this report will show, Medicaid has a beneficial effect on both Missouri's economy and the health status of its residents.

A number of recent studies have investigated the economic effect of Medicaid spending in states such as Wisconsin, North Carolina and Ohio.¹² The economic data presented here represents the first analysis of Medicaid spending specific to Missouri. Economists, Heather Bednarek and Muhammad Islam, from the St. Louis University John Cook School of Business used the IMPLAN model to examine the economic impact and multiplier effects of Missouri Medicaid spending. (The complete methodology for the study is described in Appendix A.)

The basis for determining the economic ramifications of Medicaid spending begins with the fact that any Missouri spending on the Medicaid or SCHIP program brings additional federal matching funds into the state. These additional federal funds trigger successive amounts of spending throughout the state and local economies, thereby increasing overall economic activity. Federal matching funds, therefore, have a measurable impact on state business activity, jobs, aggregate labor income, as well as state and local tax revenue.

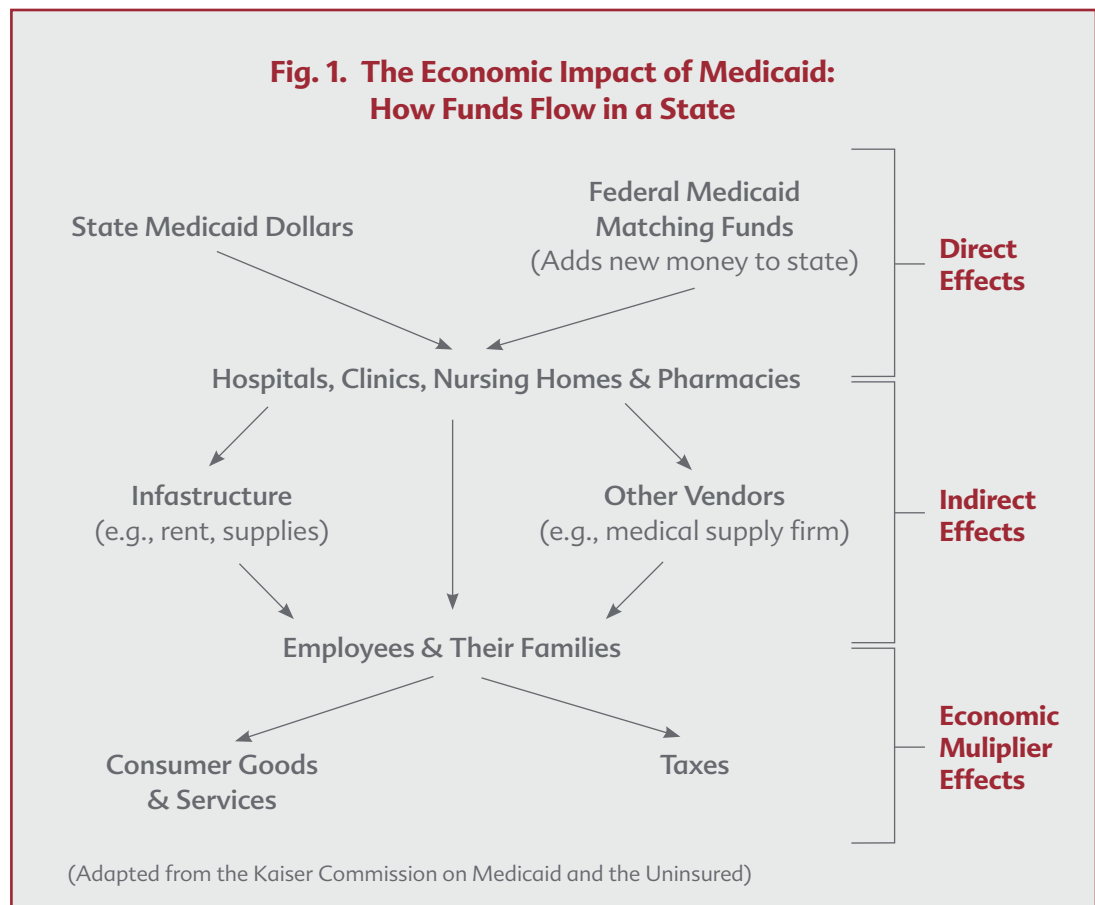
In concrete terms, Medicaid payments go to hospitals, nursing homes and other health-related businesses. These funds are then used to purchase goods and services and to support the income of workers in health-related occupations. These dollars generate successive rounds of earnings and purchases that continue to circulate through Missouri's economy. They create income and jobs for individuals not directly, or even indirectly, associated with health

ECONOMIC IMPACTS OF MEDICAID IN MISSOURI

ECONOMIC IMPACTS OF MEDICAID IN MISSOURI

care. For example, health care workers spend part of their salaries on new cars that add to the income of auto dealership employees, who in turn spend part of their salaries on washing machines, enabling appliance store employees to spend additional money on groceries, and so on. This ripple effect of spending is called the “economic multiplier effect.”¹³ (See Fig. 1.)

The IMPLAN-based analysis uses the concept of the multiplier effect to determine the economic impact of Medicaid spending for the state of Missouri. (See Table 3.) The investigation shows that every \$1 million in state Medicaid spending generates \$1.57 million in federal matching dollars which leads to the creation of 42.3 new jobs and over \$3 million in new business activity for Missouri. Spending on the SCHIP program has an even greater economic impact because of the higher federal matching rate. Every \$1 million in state spending on SCHIP draws down \$2.68 million in federal



dollars which results in 71.5 new jobs and over \$5.2 million in new business activity. The federal dollars also produce new money for wages which in turn creates a significant percentage of tax revenue for the state of Missouri.¹⁴

In state FY 2003, Missouri's Medicaid and SCHIP programs generated approximately \$2.75 billion in federal matching funds.¹⁵ By using county-specific multipliers developed with the IMPLAN model, the economic impact of these federal matching dollars for the Medicaid and SCHIP programs was determined for every Missouri County. (A complete county-by-county listing of the economic effects of matching funds for Medicaid can be found in Appendix B and for SCHIP in Appendix C.) For example, Boone County's share of the federal Medicaid matching dollars leveraged \$91.3 million in business activity; 1,294 jobs; and \$45.9 million in wages. The economic impact of the federal dollars for Missouri's SCHIP program can also be determined for individual counties. For instance, in Dunklin County federal funds from state SCHIP spending generated \$2.1 million in business activity; 42 jobs; and \$1 million in wages.

ECONOMIC IMPACTS OF MEDICAID IN MISSOURI

Table 3. Impact of a \$1 Million Change in Medicaid Spending on Economic Activity, Jobs and Income (Wages)

	MEDICAID EXPENDITURES		LEVERAGES		
	STATE MEDICAID SPENDING	GENERATED FEDERAL MATCH	BUSINESS ACTIVITY	JOBS	WAGES
Medicaid	\$1,000,000	→ \$1,574,000	\$3,062,272	42.3	\$1,491,534
SCHIP	\$1,000,000	→ \$2,678,000	\$5,209,709	71.5	\$2,537,521

ECONOMIC IMPACTS OF MEDICAID IN MISSOURI

As policymakers consider different options in balancing the state budget, the economic and health benefits of Medicaid should be taken into account. Reductions in state spending for Medicaid will result in a decrease in federal matching dollars. This in turn would diminish Medicaid's economic multiplier effect and, therefore, reduce its contribution to business activity, jobs and wages in each county of the state. Furthermore, cutbacks in Medicaid will increase the number of individuals without health insurance. As elaborated below, having no coverage affects a person's ability to access health services and ultimately has a negative impact on their health. (Appendix D presents several different scenarios that have been proposed for containing the cost of Medicaid. It discusses the economic and health outcomes that each of these would have in Missouri.)

MEDICAID AND SCHIP: COVERING THE UNINSURED

In 2003, 47 percent of uninsured adults postponed seeking medical care (compared with 15 percent of insured adults), and 35 percent say they needed but did not get medical care in the past year (compared with 9 percent of insured adults).²⁰

The Medicaid and SCHIP programs have helped to offset the decline in employer-sponsored coverage and the rising numbers of uninsured across the nation and in Missouri. Recent U.S. Census data show that nationally the ranks of those without health insurance grew from 41.2 million in 2001 to 43.6 million in 2003.¹⁶ During this same period, Missouri's rate of uninsured rose from 9.9 percent to 10.9 percent (a statistically significant increase, but below the national average).¹⁷ The primary factor for this recent increase in the uninsured population stems from the erosion in private health insurance coverage which is influenced by a weakened economy, a rise in unemployment and increasing costs for health care.¹⁸ If not for the role of Medicaid and SCHIP during this period, Missouri's rate of uninsured would have grown much higher.¹⁹

The Center on Budget and Policy Priorities recently examined the Medicaid and SCHIP programs in Missouri. The Center found that from 2000 to 2002 the percentage of uninsured low-income Missouri children fell from 12.2 percent to 7.2 percent.²¹ This rate reduction was entirely attributable to children being enrolled in Medicaid and SCHIP. It is also worth noting that decreases in the number of uninsured children occurred despite an economic downturn that eroded private health insurance coverage. In contrast

to Missouri children, the number of low-income parents who were uninsured rose sharply from 18.8 percent in 2000 to 25.1 percent in 2002.²² Both private insurance coverage and Medicaid coverage for Missouri parents fell during this period as the state imposed more restrictive financial eligibility requirements for parent coverage and eliminated coverage for non-custodial parents.²³

A 2003 study by the Kaiser Family Foundation, titled “Sicker and Poorer: The Consequences of Being Uninsured,” reviewed research findings from the past 25 years on the relationship among health insurance, medical care utilization and health outcomes. The Kaiser report concludes that “the uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions).”²⁴ In addition, “having health insurance would reduce mortality rates for the uninsured by 10-15 percent, and better health would improve annual earnings by about 10-30 percent and would increase educational attainment.”²⁵ The price of not covering the uninsured includes 18,000 preventable deaths per year in the United States.²⁶ Increasing the number of individuals and families that have access to health insurance, including Medicaid and SCHIP would not only create long-term savings, but would result in a healthier and more productive state and nation.²⁷

MEDICAID AND SCHIP: COVERING THE UNINSURED

Uninsured children are 70 percent more likely than insured children not to receive medical care for common conditions like ear infections and 30 percent less likely to receive medical attention when they are injured.²⁸

HEALTH BENEFITS FROM HAVING INSURANCE COVERAGE

A recent study showed that enrollment in New York's children's health insurance program resulted in significantly improved immunization rates, as well as increases in screenings for anemia, lead, vision and hearing for children 1-5 years of age. Twenty-five percent of parents reported that their child's health was improved after enrollment.³³

Having insurance coverage, whether through the private sector or the Medicaid program, clearly improves the health and well-being of Missouri's residents. National research shows positive health consequences resulting from Medicaid coverage. In fact, a recent report prepared by the Health Policy Institute of Georgetown University extensively reviewed the medical literature regarding the health impact of public health insurance.²⁹ The study found that Medicaid and SCHIP coverage promoted health care access, increased health care utilization and improved health outcomes.

That literature review showed a clear causal link between enrollment in public health coverage programs and improved access to care. Additionally, when compared to persons without health insurance, individuals covered by public health insurance are:

- ❖ more likely to have a usual place to go for medical care and to have that medical home be a private physician's office rather than a hospital emergency room;
- ❖ less likely to delay seeking care due to cost or insurance considerations and will have fewer unmet health care needs;
- ❖ more likely to see a physician at least once during the year; and
- ❖ more likely to make better and more efficient use of the health care system.³⁰

In Missouri, while there have only been limited attempts to measure the impact of the Medicaid program on health outcomes, the state has measured the impact of the SCHIP program on various health indicators.³¹ One analysis shows positive improvements in such areas as reduced emergency room visits, a decline in preventable hospitalizations and improved school attendance. In addition to improved health outcomes, the MC+ program has had positive impacts on children's access to health care. Specifically, an examination of access to health care prior to and after MC+ enrollment found that after one year of enrollment there was a 21 percent decline in parents reporting that they were unable to obtain medical care for their child when needed.³²

Furthermore, the Missouri MC+ analysis showed:

- ❖ A 14 percent decline in parents reporting that it was difficult or very difficult to obtain an appointment for their children,
- ❖ A 19 percent increase in parents reporting that it was easy or very easy to obtain an appointment for their children,
- ❖ A 22 percent decrease in parents reporting that it was difficult or very difficult to get their child to a doctor,
- ❖ A 32 percent increase in parents reporting that it was easy or very easy to get their child to a doctor and
- ❖ A 39 percent decrease in the average number of school days missed.³⁴

The Missouri Medicaid program covers approximately 900,000 individuals, including more than 500,000 children; 130,000 individuals with disabilities; and nearly 80,000 elderly Missourians.³⁵ For those individuals, having insurance coverage provides greater access to health care services and improves their health outcomes.³⁶ Ultimately, society assumes a greater cost for those without any source of health insurance as opposed to those individuals with access to public health insurance programs such as Medicaid and SCHIP.

HEALTH BENEFITS FROM HAVING INSURANCE COVERAGE

MEDICAID'S ROLE IN RESTRAINING INCREASES IN HEALTH CARE COSTS

A study found that higher enrollment in Minnesota's expanded Medicaid program was associated with a cumulative 5-year savings of \$58.6 million in uncompensated care for the state's hospitals — a savings that exceeded the costs of services provided to expanded Medicaid enrollees.⁴¹

The uninsured population often turns to hospitals for care not paid for by either public or private insurance, otherwise known as “uncompensated” care. Such costs must be picked up by the overall health care system and are often shifted to local governments that may have to cut services or raise taxes to address this uncompensated care burden. The St. Louis Regional Health Commission has documented that in FY 2002, “St. Louis hospitals had a net loss of approximately \$160 million for the cost of uncompensated care.”³⁷ The Commission also found that “hospitals cover these losses by increasing their charges and contracted rates with private insurers who in turn pass the additional costs on to area employers.”³⁸ Additionally, unlike Medicaid spending, shifting costs to uncompensated care does not offer matching funds from the federal government.

Because uninsured individuals use more expensive emergency room treatment, the lack of access to health insurance puts financial pressure on hospitals that can lead to higher premiums for those who do have insurance.³⁹ An increase in the uninsured also strains local resources, requiring cities and counties to raise taxes, close health facilities or divert resources from other pressing needs to combat the rising costs of uninsured health care.⁴⁰ Thus, the loss of health insurance, whether private or public, increases the state's uncompensated care burden and ultimately affects those who have insurance coverage.

Lack of health coverage makes a significant difference to the more than 500,000 uninsured Missourians. Having no health insurance affects individual's job decisions, financial security, access to medical care and health status.⁴² Missouri's Medicaid program positively affects not only enrollees but the state as a whole.

By providing health insurance coverage, the Medicaid and SCHIP programs prevent a variety of health problems. These programs also have a profound economic effect on the state in terms of business activity, jobs and wages. More importantly, the Medicaid and SCHIP programs give enrollees access to necessary health care services. This access to services translates into improved health status and positive health outcomes. Providing coverage for low-income Missourians through the Medicaid and SCHIP programs ultimately creates a stronger and healthier state.

CONCLUSION

APPENDIX A

Computing State and County Level Economic Impacts for Missouri Using the IMPLAN Input-Output Model

Heather L. Bednarek, PhD, and Muhammad Q. Islam, PhD

Department of Economics, John Cook School of Business, Saint Louis University

Expenditures by the state of Missouri have both direct and indirect impacts on economic activity such as output, employment, labor income and tax revenues across the state. Any changes that the state makes to the current level of funding affects the amount of federal “matching funds” that it receives for a program such as Medicaid. The economic impact of a change in federal dollars for Medicaid is computed using the IMPLAN model, a widely recognized and frequently used economic model from the Minnesota IMPLAN Group (MIG) that was originally developed by the U.S. Forest Service. The current version of IMPLAN (version 2.0) was developed in 2000. The software reads the database for the state of Missouri, creates a complete set of social accounting matrices, the input-output accounts, and derives the predictive multipliers. The software enables the user to make changes in the final demand for goods and services in various sectors of the economy in order to provide results for the impact assessment. In short, IMPLAN helps estimate the broader economic impacts of a given type of business or social investment in a state, county or other geographic region.

An input-output model is a general accounting system for the economy in a geographic region, such as a state or county. Input-output accounting describes commodity flows from producers to intermediate and final consumers. The total industry purchases of commodities, services, employment compensation, value added and imports are equal to the value of the commodities produced. Purchases of final goods drive the model. Industries produce goods and services for final demand and purchase goods and services from other producers. These other producers in turn purchase goods and services. This buying of goods and services (indirect purchases) continues until spillovers from the region (imports and value added) stop the cycle.

After specifying the level of the economy to be studied, the input-output model is constructed from the IMPLAN databases for that region. The IMPLAN model allows the construction of input-output models both at the aggregated state level and at the disaggregated county level. To study the impact of changes in Medicaid expenditures at the state level, a model was constructed for the state of Missouri. The current version of IMPLAN allows one to differentiate among 528 industrial sectors. For the purposes of this study, four health care-related sectors – Doctors and Dentists, Nursing and Protective Care, Hospitals, and Other Medical and Health Services – were aggregated to form a Health Care Services sector for the state of Missouri. Changes in Medicaid expenditures were then introduced into the IMPLAN model as a change in demand for Health Care Services. Once this change is introduced, then all of the other industries in the model adjust to the change. The input-output model accounts for these adjustments across all sectors and derives the impacts on several measures. We focused on the following measures:

- ❖ *Industrial output.* This is a measure of overall business activity. It is based on the gross sales of firms for a year or, in the case of public sector activities, the total expenditures of the public entities. It is a measure that is placed on the productivity or services of the entities that are analyzed. This study uses FY2003 Medicaid expenditures as the base for estimating industrial output.
- ❖ *Labor income.* One component of economic activity is labor income, which can be further divided into earnings and salaries of workers and normal returns to proprietors.

- ❖ **Jobs.** The model measures the number of jobs, not the number of fully employed persons. In manufacturing, nearly all of the jobs are full-time, full-year. In other sectors, like retail trade and recreation and tourism, many jobs are part-time or seasonal. The model does not differentiate among full, part-time or seasonal jobs.
- ❖ **Tax revenue.** The model estimates changes in state and local tax revenue due to changes in the overall level of business activity and labor income. These then generate changes in the income of workers and profits of businesses, changes in sales and excise taxes collected, as well as changes in miscellaneous other tax revenue, including personal and business property taxes collected from individuals and property owners.

The IMPLAN model differentiates economic activity further into the following:

- ❖ **Direct effects.** These are the amounts that are directly associated with the industry or sector being studied or measured. In this case the changes in Medicaid expenditures are examined as they affect the Health Care Services sector in the state of Missouri.
- ❖ **Indirect effects.** These are the amounts associated with a change in inputs for firms that are directly affected by the change in expenditures. These could be raw commodities, manufactured goods, utilities, transportation and other businesses or professional services that would be purchased by health care providers, including doctors and dentists, hospitals and other clinics, among others.
- ❖ **Induced effects.** These are the economic outcomes that result from workers being affected in the direct industry (Health Care Services). The change in demand for inputs (the indirect values) to the Health Care Services sector (the indirect values) translates into a change in the amount that workers (from the input industries) spend from their paychecks in the region. These values are also called household values or household effects.

- ❖ **Total effect.** This is the sum of the direct, indirect and induced values. It generates the multiplier effect of transactions in the region that are attributable to the direct activity that was first measured.

After the economic relationships have been designed, the IMPLAN model calculates the economic multipliers for output, employment, labor income and the impact on tax revenue as a result of the change in economic activity in question. In this study, the *total effect multiplier* is reported. This value is simply the total value divided by the direct value in any of the categories (output, employment, income) that are reported. The change in tax revenue is calculated based on the state and local tax rates assessed on business and personal income, personal and business property taxes, sales and excise taxes. The ratio of total economic activity to the direct activity is calculated, thereby measuring how much the entire state economy reacted per a one-unit change in the direct measure. The total multiplier is used to compute the aggregate economic impact of changes in “federal matching” Medicaid expenditures due to changes in state Medicaid expenditures.

County Level Impacts

Changes in state Medicaid expenditures affect counties across the state in different magnitudes. Some of the larger counties, such as Jackson County, St. Louis County and St. Louis City are large urban population centers with a greater share of Medicaid eligible households compared to smaller rural communities. To study the impact of changes in Medicaid expenditures at a local level, IMPLAN models were constructed for every county in the state. The number of industrial sectors at the county level varies depending on the size of the county and the diversity of the county economic base. As with the state model, county level IMPLAN models were constructed by aggregating across the four health care related sectors to construct a Health Care Services sector for each county. Medicaid expenditures were allocated to each county in proportion to the actual reported FY2003 county Medicaid expenditures of the total state FY2003 Medicaid expenditures.⁴³ The aggregate effects on output, employment, and income were then calculated for each county using the same procedure described above for state level effects.

It should be noted that county-level impact multipliers are generally smaller than the state-level impact multipliers and expenditures. This is because businesses located in one county are likely to purchase inputs from many other counties in the state, and labor income earned in one county are likely to spillover as expenditures in the surrounding counties. These inter-county spillovers result in smaller county-level impact multipliers. The state-level multipliers net out the inter-county spillovers, and thus are generally larger than individual county level multipliers.⁴⁴ As a result, the sum of the county level economic impact of a change in Medicaid expenditure is smaller than the impact computed using the state level IMPLAN model.

Impact of Reduced Federal Matching Funds for Medicaid

Medicaid expenditures in the state of Missouri are financed from the state's own funds and matching grants from the federal government. The amount the state receives from the federal government depends on the federal matching rate for the state of Missouri. For general state expenditures on Medicaid the proposed matching rate for 2005 is 61.15 percent and 72.81 percent for the SCHIP program. The matching rate can be used to compute the federal matching funds that will flow into the state. For each one dollar that the state spends on Medicaid, the federal government will contribute $((1/(1-\text{matching rate})) - 1)$ toward Medicaid expenditures in the state. Therefore, for every dollar of its own revenue that Missouri allocates towards general Medicaid expenditures, the federal government allocates an additional \$1.574 to the state to spend on Medicaid. Similarly, for each dollar of its own revenue that the state allocates for the SCHIP program, the federal government allocates an additional \$2.678 to the state.⁴⁵

The federal matching funds are a significant source of revenue for the state. Cuts in state revenue allocated to Medicaid result in the loss of a substantial amount of federal matching funds. In FY2003 Missouri spent \$4.49 billion on Medicaid.⁴⁶ Out of that, approximately \$1.744 billion came from state revenue while the remaining \$2.745 billion came from federal matching grants.^{47, 48}

If the state were to cut approximately 5 percent from the state portion of general Medicaid spending, the state would save about \$87.2 million. This cut in state Medicaid expenditures will trigger a loss of \$137 million in federal matching funds. The loss in federal matching funds will adversely affect economic activity, employment in the state and also lead to a reduction in state and local tax revenue. Because the SCHIP program has a higher matching rate than Medicaid, a reduction in state SCHIP expenditures will lead to a proportionately larger loss of federal matching funds and a proportionately larger loss of economic activity, employment and tax revenue.

It should be noted that the results presented in this study understate the overall economic impact of Medicaid and the impact of cuts in state Medicaid spending to the extent that FY2003 state Medicaid expenditures understate future state Medicaid expenditures.

The economic impact of the lost federal matching funds is estimated using the IMPLAN model. Lost federal matching funds reduce output, employment, labor income and tax revenue in the state and these adverse impacts are reported in the text of the report. Medicaid expenditures are distributed among the counties according to the shares of Medicaid expenditures reported for FY2003.⁴⁹ Given differences in Medicaid eligible populations in different localities in the state, urban regions such as St. Louis City, St. Louis County and Jackson County receive larger shares of Medicaid expenditures. Cuts in Medicaid spending, therefore, have comparatively larger economic effects in these communities. The IMPLAN model is used to estimate how the loss in federal matching grants affects economic activity in each county in Missouri.

APPENDIX B

Economic Impact of Federal Matching Dollars for Existing State of Missouri Funding for Medicaid, FY 2003

Heather L. Bednarek, PhD, and Muhammad Q. Islam, PhD

Department of Economics, John Cook School of Business, Saint Louis University

Missouri County	Impact on Business Activity	Impact on Jobs	Impact on Wages
Adair	\$26,683,160	445	\$13,029,532
Andrew	\$8,927,150	228	\$4,848,088
Atchison	\$10,632,955	217	\$5,365,889
Audrain	\$18,693,499	322	\$9,160,610
Barry	\$27,309,180	519	\$13,734,270
Barton	\$9,230,192	188	\$4,825,712
Bates	\$12,748,097	278	\$6,447,681
Benton	\$15,303,322	322	\$7,190,623
Bollinger	\$11,422,371	266	\$5,698,081
Boone	\$91,257,434	1294	\$45,913,295
Buchanan	\$77,583,174	1055	\$40,255,212
Butler	\$64,797,544	1055	\$32,766,753
Caldwell	\$5,587,695	129	\$2,781,410
Callaway	\$26,254,000	512	\$12,832,372
Camden	\$24,937,289	366	\$12,553,120
Cape Girardeau	\$56,324,620	845	\$27,963,785
Carroll	\$8,201,366	191	\$4,187,541
Carter	\$8,228,722	192	\$4,469,394
Cass	\$39,928,461	765	\$20,656,798
Cedar	\$13,579,767	355	\$6,784,122
Chariton	\$6,803,388	183	\$3,280,858
Christian	\$27,914,311	629	\$14,140,188
Clark	\$4,087,588	69	\$1,857,469
Clay	\$77,866,176	1035	\$39,979,830
Clinton	\$10,501,579	206	\$5,314,310
Cole	\$36,675,513	526	\$19,217,586
Cooper	\$11,040,423	273	\$5,673,806
Crawford	\$20,910,045	539	\$11,090,582
Dade	\$5,889,013	105	\$2,588,344
Dallas	\$11,401,127	281	\$5,532,338
Daviess	\$4,087,858	93	\$2,161,344
DeKalb	\$6,453,183	154	\$3,340,465

Missouri County	Impact on Business Activity	Impact on Jobs	Impact on Wages
Dent	\$16,519,960	371	\$8,140,853
Douglas	\$10,767,255	255	\$5,524,522
Dunklin	\$56,305,976	1126	\$27,039,615
Franklin	\$52,260,993	888	\$25,570,110
Gasconade	\$11,070,294	251	\$5,658,787
Gentry	\$7,143,809	154	\$3,627,135
Greene	\$204,529,624	2920	\$101,338,165
Grundy	\$9,412,536	182	\$4,494,637
Harrison	\$8,845,290	220	\$4,359,525
Henry	\$20,314,461	337	\$10,368,026
Hickory	\$7,960,934	229	\$4,408,229
Holt	\$3,590,922	77	\$1,968,401
Howard	\$7,382,789	159	\$3,450,301
Howell	\$42,160,641	801	\$20,342,244
Iron	\$16,080,509	449	\$9,009,714
Jackson	\$619,475,010	7794	\$315,012,997
Jasper	\$112,833,226	1749	\$55,247,615
Jefferson	\$99,750,990	1790	\$49,098,122
Johnson	\$24,488,177	503	\$12,259,177
Knox	\$3,152,519	56	\$1,409,560
Laclede	\$26,644,872	481	\$13,831,101
Lafayette	\$41,235,309	847	\$20,954,164
Lawrence	\$28,488,312	567	\$13,890,377
Lewis	\$5,825,711	158	\$3,130,837
Lincoln	\$23,337,793	517	\$12,010,330
Linn	\$10,266,248	235	\$5,287,932
Livingston	\$13,085,027	262	\$6,491,241
Macon	\$13,479,625	308	\$6,388,294
Madison	\$12,661,176	307	\$5,923,939
Maries	\$5,854,990	148	\$3,195,215
Marion	\$36,120,764	607	\$17,925,762
McDonald	\$13,305,975	265	\$6,223,330
Mercer	\$1,870,488	36	\$818,180
Miller	\$17,608,235	383	\$8,781,012
Mississippi	\$17,685,413	490	\$9,024,929
Moniteau	\$6,803,101	156	\$3,476,556
Monroe	\$5,698,113	121	\$2,549,893
Montgomery	\$10,187,597	280	\$5,339,325
Morgan	\$14,672,925	242	\$6,656,104
New Madrid	\$27,047,695	654	\$14,122,857
Newton	\$35,826,196	517	\$19,286,204
Nodaway	\$9,259,526	188	\$4,579,680

Missouri County	Impact on Business Activity	Impact on Jobs	Impact on Wages
Oregon	\$11,483,151	240	\$6,321,827
Osage	\$5,498,880	115	\$2,823,505
Ozark	\$7,151,970	170	\$3,864,756
Pemiscot	\$27,650,155	566	\$12,341,131
Perry	\$12,881,679	276	\$6,607,021
Pettis	\$34,811,082	619	\$17,900,944
Phelps	\$47,729,318	852	\$22,266,453
Pike	\$14,231,533	349	\$7,382,176
Platte	\$23,357,913	365	\$11,858,496
Polk	\$34,182,127	678	\$17,236,697
Pulaski	\$22,526,537	471	\$11,017,374
Putman	\$3,469,979	78	\$1,309,737
Ralls	\$5,202,853	132	\$2,943,360
Randolph	\$26,205,536	504	\$12,965,966
Ray	\$11,351,583	206	\$5,306,501
Reynolds	\$15,366,300	334	\$7,850,109
Ripley	\$19,069,117	374	\$8,609,888
St. Charles	\$86,236,590	1203	\$43,609,835
St. Clair	\$7,946,455	194	\$4,100,793
St. Francois	\$60,029,398	1082	\$30,150,753
Ste. Genevieve	\$9,123,999	195	\$4,522,000
St. Louis	\$583,070,385	7295	\$297,065,120
Saline	\$31,701,656	584	\$15,857,452
Schuyler	\$3,027,863	43	\$1,513,785
Scotland	\$3,578,244	73	\$1,481,732
Scott	\$53,122,961	788	\$24,819,720
Shannon	\$7,938,402	168	\$3,816,975
Shelby	\$4,390,808	76	\$2,007,607
Stoddard	\$33,727,775	743	\$16,209,871
Stone	\$16,052,559	321	\$7,897,962
Sullivan	\$6,963,598	154	\$3,351,430
Taney	\$28,478,283	433	\$14,265,676
Texas	\$18,604,910	429	\$9,286,384
Vernon	\$32,365,893	634	\$15,990,784
Warren	\$11,890,541	214	\$5,877,219
Washington	\$28,903,640	445	\$13,328,541
Wayne	\$17,206,841	485	\$9,410,388
Webster	\$19,194,820	272	\$9,237,591
Worth	\$1,611,533	30	\$722,835
Wright	\$16,741,597	356	\$8,171,029
St. Louis City	\$504,189,127	6642	\$254,217,009

APPENDIX C

Economic Impact of Federal Matching Dollars for Existing State of Missouri Funding for SCHIP, FY 2003

Heather L. Bednarek, PhD, and Muhammad Q. Islam, PhD

Department of Economics, John Cook School of Business, Saint Louis University

Missouri County	Impact on Business Activity	Impact on Jobs	Impact on Wages
Adair	\$988,943	16	\$482,906
Andrew	\$330,862	8	\$179,682
Atchison	\$394,083	8	\$198,873
Audrain	\$692,827	12	\$339,514
Barry	\$1,012,145	19	\$509,025
Barton	\$342,093	7	\$178,853
Bates	\$472,476	10	\$238,967
Benton	\$567,178	12	\$266,502
Bollinger	\$423,341	10	\$211,185
Boone	\$3,382,223	48	\$1,701,659
Buchanan	\$2,875,421	39	\$1,491,956
Butler	\$2,401,555	39	\$1,214,416
Caldwell	\$207,094	5	\$103,086
Callaway	\$973,037	19	\$475,599
Camden	\$924,237	14	\$465,249
Cape Girardeau	\$2,087,528	31	\$1,036,406
Carroll	\$303,963	7	\$155,200
Carter	\$304,976	7	\$165,647
Cass	\$1,479,846	28	\$765,591
Cedar	\$503,299	13	\$251,436
Chariton	\$252,150	7	\$121,597
Christian	\$1,034,572	23	\$524,070
Clark	\$151,496	3	\$68,842
Clay	\$2,885,910	38	\$1,481,750
Clinton	\$389,214	8	\$196,961
Cole	\$1,359,284	19	\$712,251
Cooper	\$409,185	10	\$210,285
Crawford	\$774,977	20	\$411,044
Dade	\$218,261	4	\$95,930
Dallas	\$422,554	10	\$205,042
Daviess	\$151,506	3	\$80,105
DeKalb	\$239,171	6	\$123,806

Missouri County	Impact on Business Activity	Impact on Jobs	Impact on Wages
Dent	\$612,270	14	\$301,720
Douglas	\$399,061	9	\$204,752
Dunklin	\$2,086,837	42	\$1,002,154
Franklin	\$1,936,920	33	\$947,691
Gasconade	\$410,292	9	\$209,728
Gentry	\$264,767	6	\$134,430
Greene	\$7,580,366	108	\$3,755,839
Grundy	\$348,851	7	\$166,582
Harrison	\$327,828	8	\$161,575
Henry	\$752,903	12	\$384,264
Hickory	\$295,052	8	\$163,380
Holt	\$133,088	3	\$72,954
Howard	\$273,624	6	\$127,877
Howell	\$1,562,576	30	\$753,933
Iron	\$595,983	17	\$333,922
Jackson	\$22,959,252	289	\$11,675,149
Jasper	\$4,181,874	65	\$2,047,611
Jefferson	\$3,697,015	66	\$1,819,696
Johnson	\$907,591	19	\$454,355
Knox	\$116,840	2	\$52,242
Laclede	\$987,524	18	\$512,614
Lafayette	\$1,528,281	31	\$776,612
Lawrence	\$1,055,846	21	\$514,811
Lewis	\$215,915	6	\$116,036
Lincoln	\$864,955	19	\$445,132
Linn	\$380,492	9	\$195,984
Livingston	\$484,963	10	\$240,581
Macon	\$499,588	11	\$236,766
Madison	\$469,254	11	\$219,556
Maries	\$217,000	5	\$118,422
Marion	\$1,338,723	23	\$664,372
McDonald	\$493,152	10	\$230,652
Mercer	\$69,325	1	\$30,324
Miller	\$652,604	14	\$325,446
Mississippi	\$655,464	18	\$334,486
Moniteau	\$252,139	6	\$128,850
Monroe	\$211,186	4	\$94,505
Montgomery	\$377,577	10	\$197,888
Morgan	\$543,814	9	\$246,691
New Madrid	\$1,002,453	24	\$523,427
Newton	\$1,327,806	19	\$714,794
Nodaway	\$343,181	7	\$169,734

Missouri County	Impact on Business Activity	Impact on Jobs	Impact on Wages
Oregon	\$425,594	9	\$234,302
Osage	\$203,802	4	\$104,646
Ozark	\$265,069	6	\$143,237
Pemiscot	\$1,024,782	21	\$457,392
Perry	\$477,426	10	\$244,872
Pettis	\$1,290,183	23	\$663,453
Phelps	\$1,768,965	32	\$825,249
Pike	\$527,455	13	\$273,601
Platte	\$865,701	14	\$439,505
Polk	\$1,266,873	25	\$638,834
Pulaski	\$834,888	17	\$408,331
Putman	\$128,606	3	\$48,542
Ralls	\$192,830	5	\$109,088
Randolph	\$971,241	19	\$480,550
Ray	\$420,717	8	\$196,672
Reynolds	\$569,512	12	\$290,944
Ripley	\$706,748	14	\$319,103
St. Charles	\$3,196,138	45	\$1,616,287
St. Clair	\$294,515	7	\$151,985
St. Francois	\$2,224,836	40	\$1,117,460
Ste. Genevieve	\$338,158	7	\$167,596
St. Louis	\$21,610,008	270	\$11,009,957
Saline	\$1,174,941	22	\$587,716
Schuyler	\$112,220	2	\$56,105
Scotland	\$132,618	3	\$54,917
Scott	\$1,968,866	29	\$919,879
Shannon	\$294,216	6	\$141,466
Shelby	\$162,734	3	\$74,407
Stoddard	\$1,250,033	28	\$600,777
Stone	\$594,947	12	\$292,718
Sullivan	\$258,088	6	\$124,212
Taney	\$1,055,475	16	\$528,721
Texas	\$689,543	16	\$344,176
Vernon	\$1,199,559	24	\$592,657
Warren	\$440,692	8	\$217,824
Washington	\$1,071,239	16	\$493,988
Wayne	\$637,727	18	\$348,772
Webster	\$711,407	10	\$342,368
Worth	\$59,727	1	\$26,790
Wright	\$620,484	13	\$302,838
St. Louis City	\$18,686,477	246	\$9,421,901

APPENDIX D

The Economic and Health Effects of Medicaid Cost-Containment Options

Requiring Additional Co-payments for Targeted Medicaid Recipients

One strategy to achieve Medicaid savings is to impose additional co-payments on Medicaid recipients (such as charging \$2 or \$3 for a prescription or for a visit to the doctor's office). New co-payments could lead to substantial reductions in Medicaid recipients accessing beneficial health services, resulting in negative health effects for enrollees. Additionally, this approach would have an unfavorable economic impact on the state as a whole.

A study by the RAND Corporation found that low-income children's use of effective health care services fell by more than 40 percent when co-payments were introduced. These children also had more health problems than children who were not subject to cost-sharing (e.g., they were more likely to be anemic and to have dental problems).⁵⁰ Another study published in the *Journal of the American Medical Association* found that emergency room use rose by 88 percent for low-income adults with the initiation of cost-sharing, and adverse health problems (e.g., institutionalization, hospitalization and death) rose by 78 percent.⁵¹ Even under existing cost-sharing rules, low-income Medicaid recipients spend a greater portion of their income on out-of-pocket medical expenses than middle class, privately insured adults.⁵² Medicaid beneficiaries would have difficulty affording increased or new co-payments, resulting in their avoiding or delaying needed health care services.

Increasing co-payments also has a negative economic impact because states do not receive federal matching funds for the co-payments made by Medicaid recipients. The state receives a federal match only for its direct Medicaid costs (i.e., what the state Medicaid program actually pays for Medicaid services). Reduced federal matching funds in turn decrease Medicaid's economic multiplier impact on Missouri's business activity, jobs

and wages. Therefore, the creation of new or increased co-pay requirements would result in both negative health consequences and a decrease in federal matching dollars flowing into the Missouri economy.

Creating Stricter Administrative Procedures for Determining Medicaid Eligibility

Missouri policymakers have contemplated, and in certain cases already implemented, measures designed to tighten up the rules and increase the documentation required of persons seeking to qualify for the Medicaid and SCHIP programs. Although such procedures are meant to preclude Medicaid enrollment by ineligible individuals, studies show that complex enrollment practices more often deny coverage to children and families who are eligible.⁵³

One example of these types of procedures is a current program requirement that the parents of Missouri children with family incomes from 225% to 300% of the Federal Poverty Level obtain documentation in the form of actual price quotes from two different insurance companies as a part of the eligibility determination process. In order to establish their children's eligibility, these parents must prove that they do not have access to affordable health insurance that provides the same coverage and co-payments as the SCHIP category for which they are applying.⁵⁴ Applicants have difficulty obtaining reliable price quotes because the private sector does not commonly offer insurance with the same coverage and benefits as SCHIP. When applicants fail to secure such verification the children become Medicaid ineligible, resulting in a lack of insurance coverage for some children whose families meet all of the financial eligibility criteria.

A recent assessment of proposed verification paperwork in California's Medicaid program concluded that almost all of the people who would lose coverage because of the

added administrative barriers would have been eligible for the program.⁵⁵ Imposing additional procedural barriers will depress enrollment among eligible Missouri children and families and result in the same negative costs associated with direct cuts in Medicaid eligibility (i.e., more uninsured Missourians, increased negative health outcomes, reduced federal funds and lost jobs and other economic activity).

Additionally, as shown in a recent study published in Health Affairs, complex enrollment procedures result in higher administrative costs.⁵⁶ This fiscal consequence undermines the intent of achieving budgetary savings. While not as significant as the negative health costs of these types of measures, additional implementation costs should be recognized when considering proposals to impose new procedural barriers in the Missouri Medicaid and SCHIP program.⁵⁷

Eliminating Coverage for Specific Medicaid and SCHIP Populations

During difficult budgetary periods, policymakers often consider eliminating or cutting back Medicaid coverage for specific populations such as parents, people with disabilities or certain groups of children. These actions, regardless of population, would have considerable health and economic consequences for Medicaid enrollees and Missouri as a whole.

For instance, North Carolina temporarily froze enrollment in its SCHIP program, resulting in thousands of eligible children being placed on a waiting list and reducing enrollment by 30 percent in 9 months. A study of these cutbacks found that effected families reported substantial hardship, including unmet health and dental needs, financial problems and some unnecessary surgery due to complications. Additionally, families increased their use of emergency rooms for health services and had difficulty obtaining and paying for necessary medications.⁵⁸

Other research has found that compared to those covered by Medicaid, groups whose Medicaid has been eliminated were more likely to:

- ❖ lack a usual source for medical care,
- ❖ encounter difficulty in obtaining needed medical care and
- ❖ report no physician visits in the previous 12 months.⁵⁹

These cutbacks in coverage affect the health of individuals and also have an economic impact for Missouri. For example, eliminating Medicaid coverage for “optional parents” (parents who are not required to be covered under federal law) in Missouri would cut \$29.7 million in state spending and eliminate health coverage for 77,000 low-income parents. This state funding cut would mean \$46.7 million in lost federal matching funds which results in:

- ❖ the elimination of 1,248 Missouri jobs,
- ❖ the loss of almost \$91 million in business activity,
- ❖ Missouri wage losses of \$44 million and
- ❖ a loss of \$3.3 million in tax revenue for the state.⁶⁰

Reducing or eliminating coverage for any Medicaid population results in negative health effects for individuals and measurable economic losses for Missouri.

Eliminating Optional Services from the Medicaid Program

One of the areas often targeted for elimination are the “optional services” under federal Medicaid law. In fact, states spend approximately 65 percent of funding on optional services. The majority of this spending pays for services (i.e., pharmacy and long-term care) provided to elderly and disabled residents. Without this “optional spending” millions of the poorest and sickest people would be without essential health and long-term services.⁶¹ Two benefits frequently looked at for elimination in Missouri and nationwide include dental and optical services. Removal of these services would result in detrimental health effects as well as significant loss of federal matching funds which means a corresponding loss of jobs and economic activity.

Dental health has a significant impact on overall health. According to the Surgeon General’s report, “Oral Health in America,” dental diseases threaten the health of low-

income people by leading to such medical problems as systemic infections, untreated periodontal disease, deep abscesses and depression.⁶² Because dental health is related to other health needs, untreated dental conditions also result in higher costs in other parts of the state's Medicaid program, including the costs of emergency room care.⁶³

Vision services facilitate employment for low-income adults who need glasses in order to perform job functions properly. Vision benefits also help avert work-related injuries and prevent permanent disabilities and blindness which can occur if conditions such as glaucoma go unidentified or untreated.⁶⁴ Additionally, the elimination of dental and vision services would have a substantial effect on Missouri's economy. Eliminating dental and optical services would cut \$6.9 million in state Medicaid spending for these two services. This reduction in state funding means a loss of \$10.9 million in federal matching funds which results in:

- ❖ the loss of 290 Missouri jobs
- ❖ an elimination of over \$21 million in business activity and
- ❖ the loss of \$10.3 million in wages and \$795,000 in tax revenue.⁶⁵

The elimination of essential health care services from the Medicaid program results in significant health and economic costs for Missouri.

ENDNOTES

- 1 Kaiser Commission on Medicaid and the Uninsured, The Medicaid Program at a Glance January 2004, <http://www.kff.org/medicaid/2004-04.cfm>.
- 1 Missouri, Department of Social Services, Testimony before the House Interim Committee on Cost-Containment 9 September 2003.
- 2 This is based on the 2005 federal matching rate for Medicaid equal to 1.574 and the SCHIP 2005 federal matching rate of 2.678.
- 3 Kaiser Commission on Medicaid and The Uninsured, The Medicaid Program at a Glance.
- 4 Missouri, Department of Social Services, Division of Medical Services, data request January 13, 2004.
- 5 To a lesser extent, Missouri has expanded coverage for the elderly and disabled by increasing the poverty level at which elderly and disabled persons become eligible for Medicaid, and by implementing the Medicaid for Working Disabled (MAWD) program. Missouri, Department of Social Services, Division of Family Services, Income Maintenance Memorandum #77 27 June 2002 and Income Maintenance Memorandum #78 28 June 2002. However, it also cutback on the scope of coverage in its Medicaid spenddown for the elderly and disabled population, by reducing the extent to which medical expenditures are reimbursed in that program. Missouri, Department of Social Services, Division of Family Services, Income Maintenance Memorandum #119 20 September 2002.
- 6 Diane Rowland, Medicaid Issues and Challenges, Kaiser Commission on the Future of Medicaid and the Uninsured, Testimony before the Committee on Energy and Commerce Subcommittee on Health, United States House of Representatives 8 October 2003, 12.
- 6 John Holahan and Brian Bruen, "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" Kaiser Commission on Medicaid and the Uninsured September 2003, <http://www.kff.org/medicaid/kcmu4139report.cfm> 1-2, 4-7.
- 7 Holahan and Bruen 13.
- 7 Missouri, Department of Social Services, Our Community Challenge: Serving Society in a Pressured Economy, 14 October 2003, 8.
- 8 Missouri, Department of Social Services, Testimony before the House Interim Committee on Cost-Containment 9 September 2003.
- 9 Barbara Lyons, "Medicaid: Recent Spending and Cost Containment Trends" (presentation to the Eleventh Annual Funding State Services Conference, Washington D.C.), Kaiser Commission on Medicaid and the Uninsured 16 November 2003, 6.
- 9 Holohan and Bruen, 1-2.
- 10 Missouri's budget shortfall for FY 2005 is estimated to be anywhere from \$600 million to \$1 billion. Virginia Young, "House GOP Chiefs See Budget as Half-full, Holden as Half-Empty," St. Louis Post-Dispatch 21 September 2003, B-1.
- 10 Missouri, Office of the Governor, Draft and Preliminary FY 2005 Budget Estimated Shortfall 30 September 2003.
- 11 National Association of State Budget Officers, 2002 Expenditure Reports 2003, 6, 49.
- 12 Families USA, Medicaid: Good Medicine for State Economies 2003, <http://www.familiesusa.org/site/DocServer/GoodMedicineReport.pdf?docID=275>.
- 12 Kerry E. Kilpatrick, et al, "The Economic Impact of Proposed Reductions in Medicaid Spending in North Carolina," April 2002, <http://www.healthlaw.org/pubs/2002.NC.econimpact.doc>.
- 12 Robert Greenbaum and Anand Desai, "Uneven Burden: Economic Analysis of Medicaid Expenditure Changes in Ohio," The Ohio State University-School of Public Policy and Management April 2003, <http://ppm.ohio-state.edu/ppm/ohiomedicaidcuts03.pdf>.
- 12 The Perryman Group, Medicaid and the Children's Health Insurance Program (CHIP): An Assessment of Their Impacts on Business Activity and the Consequences of Potential Funding Reductions April 2003, <http://www.texmed.org/pmt/lel/cln/Perryman.pdf>.
- 12 Steven C. Deller, "Economic Impact of Reducing Medicaid and BadgerCare Expenditures," Wisconsin Council on Children and Families February 2003. <http://www.wccf.org/pdf/econimpact.pdf>.
- 13 Families USA, 11.
- 14 Wages are also referred to as "labor income," which includes both employee compensation and proprietor's income as discussed in the Appendix A.
- 15 Missouri, Department of Social Services, Table 14. Medicaid Claims for Missouri. Program and Service Delivery January 2004. <http://www.dss.mo.gov/re/pdf/serv03.pdf>
- 16 United States, Census Bureau, Health Insurance Coverage in the United States: 2002 (Washington, D.C.: GPO, September 2003) 1, 8.

- 17 United States, Census Bureau Table 4.
- 18 Center on Budget and Policy Priorities, Number of Americans Without Health Insurance Rose in 2002 30 September 2003, <http://www.cbpp.org/9-30-03health.htm>. The number and percentage of people covered by employment-based health insurance dropped in 2002, from 62.6% to 61.3%, driving the overall decrease in health insurance coverage. The number of people covered by government health insurance program rose in 2002, from 25.3 percent to 25.7 percent, largely because of an increase in the number and percentage of people covered by Medicaid (from 11.2 percent to 11.6 percent).
- 19 Center on Budget and Policy Priorities, 3.
- 20 Kaiser Commission on Medicaid and the Uninsured, Access to Care for the Uninsured: An Update September 2003, <http://www.kff.org/uninsured/4142.cfm> 3.
- 21 Leighton Ku and Matt Broaddus, "Analysis of the Census Bureau's Current Populations Survey" (personal Communication to Joel Ferber), Center on Budget and Policy Priorities December 2003.
- 22 Leighton Ku and Matt Broaddus.
- 23 Figures from the Missouri Department of Social Services show that 24,987 people lost coverage as a result of the reduction in Medical Assistance for Families (MAF) eligibility to 77% of the poverty level, while 32,539 people lost coverage overall due to the 2002 cutbacks in Medicaid eligibility. Missouri, Department of Social Services, Chart on MAF (Section 1931)/1115 Waiver Parent closings 11 July 2002.
- 23 Missouri, Department of Social Services, Unduplicated Eligibles in SFY 2002 Whose Eligibility was Eliminated or Changed as of July 2002 by County August 2003.
- 24 Jack Hadley, "Sicker and Poorer: The Consequences of Being Uninsured," The Kaiser Commission on Medicaid and the Uninsured February 2003, <http://www.kff.org/content/2002/20020510/may10pres.pdf>, 1.
- 25 Hadley, "Sicker and Poorer," 1.
- 26 Karen Davis, "Time for Change: The Hidden Cost of a Fragmented Health Insurance System," Invited Testimony, Senate Special Committee on Aging, Washington, D.C, 10 March 2003, 27 March 2003 http://www.cmf.org/programs/insurance/davis_senate_committeetestimony_622.pdf, 17.
- 27 Davis, "Time for Change," 17-18.
- 28 Kaiser Commission on Medicaid and the Uninsured, The Uninsured and their Access to Health Care February 2003, <http://www.kff.org/uninsured/1420-05.cfm>.
- 29 Ellen O'Brien and Cindy Mann, "Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP," Covering Kids and Families June 2003, http://www.kidsouth.org/pdf/maintaining_the_gains.pdf.
- 30 O'Brien.
- 31 Missouri, Department Of Social Services, Since MC+ Began 10 February 2003.
- 32 Behavioral Health Concepts, Evaluation of Medicaid Section 1115 Waiver 1 September 1999 to 31 August 2000.
- 33 Jane L. Holl, et al, "Evaluation of New York State's Child Health Plus: Access, Utilization, Quality of Care, and Health Status," Pediatrics 105.3 (2000): 711-718.
- 34 Behavioral Health Concepts.
- 35 Missouri, Department of Social Services, Missouri State Fact Sheets, <http://www.dss.mo.gov/mis/pdfs/ftsheets.pdf>.
- 36 Kaiser Commission on Medicaid and the Uninsured, Access to Care for the Uninsured: An Update 1-4.
- 36 Kaiser Commission on Medicaid and the Uninsured, The Uninsured and their Access to Health Care.
- 37 St. Louis Regional Health Commission, Missouri's Medicaid Program and Its Impact on Missouri Business April 2003.
- 38 St. Louis Regional Health Commission.
- 39 For a detailed study on the costs of not covering the uninsured, see Jack Hadley and John Holahan, "Who Pays for the Uninsured and How Much?" Urban Institute February 2003. See also Institute of Medicine (IOM), A Shared Destiny: Community Effects of Uninsurance 2003.
- 40 For a discussion of the various ways in which access to health services and consequent benefits are compromised for persons other than those who lack coverage in communities with higher uninsured rates, see Institute of Medicine 1, 90-99. This impact can include a reduced capacity of community health centers to provide ambulatory care to all of their patients – insured or uninsured; increased emergency department (ED) overcrowding and reduced availability of ED services, including the reduced availability of ED specialists; increased financial stress on regional trauma centers, resulting in closure of existing trauma centers, or failure to open new trauma centers reduced availability of on-call specialty services to hospital emergency departments and decreased availability of primary care providers to obtain specialty referrals for patients who are members of medically underserved groups.

- 41 Lynn Blewett, "Demonstrating the Link Between Uncompensated Care and Public Program Participation" (presented at National Academy of State Health Policy, Portland, OR, 5 August 2003). Forthcoming in Medical Care Research and Review.
- 42 The Kaiser Commission on Medicaid and the Uninsured, The Uninsured and their Access to Health Care.
- 43 Missouri, Department of Social Services, Table 14.
- 44 B. Song, G. Doekson, M. Woods, and D. Schreiner, "Multiplier Analysis for Agriculture and Other Industries," Oklahoma State University. Oklahoma Cooperative Extension Service December 1992.
- 45 These proportions were calculated based on the 2005 federal matching rate for Medicaid equal to 1.574. This assumes that all the state Medicaid expenditures receive the federal matching funds. It does not account for a lower matching rate for state Medicaid administrative expenditures. However, this is a small share of total Medicaid expenditures. It also does not take into account the considerably higher match rate for SCHIP (SCHIP 2005 federal matching rate is 2.678) that currently consists of approximately 2.2% of all Medicaid expenditures.
- 46 Missouri Department of Social Services, Table 14.
- 47 Missouri, Department of Social Services, Table 14.
- 48 More recent data on Medicaid expenditures for the state and counties were not available. The FY2003 state Medicaid expenditures are used as the baseline to determine how cuts in state Medicaid expenditures affect business activity, income and employment in the state and in each individual county.
- 49 Missouri Department of Social Services, Table 14.
- 50 Joseph Newhouse, Free for All? Lessons from the Rand Health Insurance Experiment (Cambridge: Harvard University Press, 1996).
- 51 Robyn Tamblyn, et al, "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons," Journal of the American Medical Association 285.4 (2001): 421-429.
- 52 Leighton Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities 7 May 2003.
- 53 Donna Cohen Ross and Leighton Ku, "Quarterly Status Reporting Could Jeopardize the Health Coverage and Hundreds of Thousands of Eligible Low-Income Californians," Center on Budget and Policy Priorities 23 December 2002, 5-6.
- 53 Laura Cox, Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs 28 December 2001.
- 53 Michael Perry, et al, "Medicaid and Children: Overcoming Barriers to Enrollment-Findings from a National Survey," Kaiser Commission on Medicaid and the Uninsured January 2000.
- 53 O'Brien 9.
- 54 Missouri, Department of Social Services, Family Support Division, Family HealthCare Programs Manual—Sections 0920.020.00 through 0920.020.10.15 <http://www.dss.mo.gov/dfs/iman/index.html>.
- 55 Ross and Ku.
- 56 G. Fairbrother, et al, "Cost of Enrolling Children in Medicaid and SCHIP," Health Affairs 23.1 (2004): 242-243.
- 57 Missouri already has sufficient mechanisms to ensure that ineligible people are not enrolled in the program. For example, caseworkers verify income at each application, annual review and reported change. As part of the verification process caseworkers check the Division of Employment Security's system to see what earnings are reported to that state agency by employers.
- 58 Pam Silberman, et al, The North Carolina Enrollment Freeze of 2001: Health Risks and Financial Hardships for Working Families January 2003.
- 59 O'Brien 15.
- 60 Tabulated using Missouri Department of Social Services estimates for the program costs for 2004 state fiscal year and 2005 federal matching rates and the IMPLAN model.
- 61 Rowland, Medicaid Issues and Challenges, Kaiser Commission on the Future of Medicaid and the Uninsured.
- 62 United States, Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General (Washington, D.C.: GPO, 2000).
- 63 Leighton Ku, "The Importance of Dental Benefits in Medicaid," Center on Budget and Policy Priorities December 2002.
- 64 Leighton Ku, "The Significance of Vision Benefits in Medicaid," Center on Budget and Policy Priorities December 2002.
- 65 Tabulated using Missouri Department of Social Services estimates for the program costs for 2004 state fiscal year and 2005 federal matching rates and the IMPLAN model.

BIBLIOGRAPHY

- Barker, M. Ryan. "Innovative State Programs to Cover the Uninsured: Lessons for Missouri." Missouri Foundation for Health. June 2003. <http://www.mffh.org/Policy%20Report/ShowMe.7.031.pdf>.
- Behavioral Health Concepts. Evaluation of Medicaid Section 1115 Waiver. 1 September 1999 to 31 August 2000.
- Blewett, Lynn. "Demonstrating the Link Between Uncompensated Care and Public Program Participation" (presented at National Academy of State Health Policy, Portland, OR, 5 August 2003). Forthcoming in Medical Care Research and Review.
- Bruen, Brian and John Holahan. "Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government." Kaiser Commission on Medicaid and the Uninsured. November 2003. <http://www.kff.org/medicaid/4152.cfm>.
- Center on Budget and Policy Priorities. Number of Americans Without Health Insurance Rose in 2002. 30 September 2003. <http://www.cbpp.org/9-30-03health.htm>.
- Cox, Laura. Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs. 28 December 2001.
- Crispin-Little, Jan. "Economic Impact of Medicaid and CHIP on the Utah Economy." David Eccles School of Business. January 2003. <http://www.business.utah.edu/bebr/onlinepublications/MedicaidChipEconImp.pdf>.
- Currie, Janet and Jonathan Gruber. "Health Insurance Eligibility, Utilization of Medical Care and Child Health." The Quarterly Journal of Economics 111.2 (1996): 431-466.
- Currie, Janet and Jonathan Gruber. "Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women." Journal of Political Economy 104.6 (1996): 1263-1296.
- Davidoff, A.J., et al. "The Effect of Changing State Health Policy on Hospital Uncompensated Care." Inquiry 37.3 (2000): 253-67.
- Davidoff, Amy, et al. "Medicaid Eligible Children Who Don't Enroll: Health Status and Access to Care and Implications for Medicaid Enrollment." Inquiry 37.2 (2000): 203-218.
- Davis, Karen. "Time for Change: The Hidden Cost of a Fragmented Health Insurance System." Invited Testimony. Senate Special Committee on Aging. Washington, D.C. 10 March 2003. 27 March 2003 http://www.cmf.org/programs/insurance/davis_senatecommittee testimony_622.pdf.
- Deller, Steven C. "Economic Impact of Reducing Medicaid and BadgerCare Expenditures." Wisconsin Council on Children and Families. February 2003. <http://www.wccf.org/pdf/econimpact.pdf>.
- Doeksen, Gerald A. and Cheryl St. Clair. "Economic Impact of the Medicaid Program on Alaska's Economy." Alaska Department of Health Care Services. March 2002. <http://www.hss.state.ak.us/dhcs/PDF/economicimpact2001.pdf>.
- Dubay, Lisa and G.M. Kenney. "Health Care Access and Use Among Low-Income Children: Who Fares Best?" Health Affairs 20.1 (2001): 112-121.
- Dubay, Lisa, et al. "Medicaid Expansions for Pregnant Women and Infants: Easing Hospitals' Uncompensated Care Burdens?" Inquiry 32.3 (1995): 332-44.
- Fairbrother, G., et al. "Cost of Enrolling Children in Medicaid and SCHIP." Health Affairs 23.1 (2004): 237-243.
- Families USA. Medicaid: Good Medicine for State Economies. 2003. <http://www.familiesusa.org/site/DocServer/GoodMedicineReport.pdf?docID=275>.
- Fisher, James, et al., v. Steve Roling. No. 034-287 (St.L. City Circuit Court). 29 September 2003.
- Fox, Michael H., et al. "Changes in Reported Health Status and Unmet Need for Children Enrolling Kansas Children's Health Insurance Program." American Journal of Public Health 93 (2003): 579-582.
- Greenbaum, Robert and Anand Desai. "Uneven Burden: Economic Analysis of Medicaid Expenditure Changes in Ohio." The Ohio State University-School of Public Policy and Management. April 2003. <http://ppm.ohio-state.edu/ppm/ohiomedicaidcuts03.pdf>.
- Hadley, Jack. "Sicker and Poorer: The Consequences of Being Uninsured." The Kaiser Commission on Medicaid and the Uninsured. February 2003. <http://www.kff.org/content/2002/20020510/may10pres.pdf>.
- Hadley, Jack and John Holahan. "Who Pays for the Uninsured and How Much?" Urban Institute. February 2003.
- Hakim Rosemarie B. and B.V. Bye. "Effectiveness of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries." Pediatrics 108.1 (2001): 90-97.
- Holahan, John and Brian Bruen. "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" Kaiser Commission on Medicaid and the Uninsured. September 2003. <http://www.kff.org/medicaid/kcmu4139report.cfm>.
- Holl, Jane L., et al. "Evaluation of New York State's Child Health Plus: Access, Utilization, Quality of Care, and Health Status." Pediatrics 105.3 (2000): 711-718.
- Institute of Medicine. A Shared Destiny: Community Effects of Uninsurance. 2003.
- Kaestner, R., et al. "Medicaid Eligibility and the Incidence of Ambulatory Care Sensitive Hospitalizations for Children." Social Science and Medicine 52 (2001): 305-313.
- Kaiser Commission on Medicaid and the Uninsured. Access to Care for the Uninsured: An Update. September 2003. <http://www.kff.org/uninsured/4142.cfm>.

Kaiser Commission on Medicaid and the Uninsured. Dual Enrollees: Medicaid's Role for Low-Income Medicare Beneficiaries. February 2003. <http://www.kff.org/medicaid/4091-index.cfm>.

Kaiser Commission on Medicaid and the Uninsured. The Medicaid Program at a Glance. January 2004. <http://www.kff.org/medicaid/2004-04.cfm>.

Kaiser Commission on Medicaid and the Uninsured. Synthesizing the Evidence on Children's Access to Care. (unpublished and undated).

Kaiser Commission on Medicaid and the Uninsured. The Uninsured and their Access to Health Care. February 2003. <http://www.kff.org/uninsured/1420-05.cfm>.

Kasper, Judith D. et al. "Gaining and Losing Health Insurance: Strengthening the Evidence for Effects on Access to Care and Health Outcomes." Medical Care Research and Review 57.3 (2000): 298-318.

Keane, Christopher R., et al. "The Impact of the Children's Insurance Program by Age." Pediatrics 104.5 (1999): 1051-1058.

Kenney, Genevieve, Jennifer Kenny, and Alexandra Tebay. "Children's Insurance Coverage and Service Use Improve." Urban Institute. July 2003. http://www.urban.org/UploadedPDF/310816_snapshots3_no1.pdf.

Kilpatrick, Kerry E., et al. "The Economic Impact of Proposed Reductions in Medicaid Spending in North Carolina." National Health Law Program. April 2002. <http://www.healthlaw.org/pubs/2002.NC.econimpact.doc>.

Ku, Leighton. "Charging the Poor More for Health Care: Cost-Sharing in Medicaid." Center on Budget and Policy Priorities. 7 May 2003.

Ku, Leighton. "The Importance of Dental Benefits in Medicaid." Center on Budget and Policy Priorities. December 2002.

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

Ku, Leighton and Matt Broaddus. "Analysis of the Census Bureau's Current Populations Survey" (personal Communication to Joel Ferber). Center on Budget and Policy Priorities. December 2003.

Lave, Judith R., et al. "Impact of Children's Health Insurance Program on Newly Enrolled Children." JAMA 279.22 (1998): 1820-1825.

Long, Stephen H. and Susan M. Marquis. "The Effects of Florida's Medicaid Eligibility Expansion for Pregnant Women." American Journal of Public Health 88.3 (1998): 371-376.

Lyons, Barbara. "Medicaid: Recent Spending and Cost Containment Trends" (presentation to the Eleventh Annual Funding State Services Conference, Washington D.C.). Kaiser Commission on Medicaid and the Uninsured. 16 November 2003.

Mann, Cindy. Medicaid Block Grant: Implications for State Budgets (presentation). 16-17 November 2003.

Midwest Research Institute. The Continuing Use of Assistance by Former Missouri AFDC Recipients, for the Missouri Department of Social Services through the Local Investment Commission. 3 August 2000.

Missouri. Department of Social Services. Adult Medicaid Reductions Adopted by the House Appropriations Committee on Health, Mental Health and Social Services. 27 February 2003.

---. ---. Budget Request FY 2002. 2002.

---. ---. Chart on MAF ((Section 1931)/1115 Waiver Parent closings). 11 July 2002.

---. ---. Elimination of MC+ for Children (CHIP) Adopted By the House Appropriations Committee on Health, Mental Health and Social Services. 27 February 2003.

---. ---. FY 2004 Budget. 2004.

---. ---. Medicaid Expenditures by Large Eligibility Groups, FY 2002. 2002. <http://www.dss.mo.gov/mis/pdfs/medicaidexpyfy02.pdf>.

---. ---. Missouri State Fact Sheets. <http://www.dss.mo.gov/mis/pdfs/ftsheets.pdf>.

---. ---. Our Community Challenge: Serving Society in a Pressured Economy. 14 October 2003.

---. ---. Quick Facts About DSS. February 2004. <http://www.dss.mo.gov/mis/qfact.htm>.

---. ---. Since MC+ Began. 10 February 2003.

---. ---. Table 14. Medicaid Paid Claims for Missouri. Program and Service Delivery. January 2004. <http://www.dss.mo.gov/re/pdf/serv03.pdf>.

---. ---. Testimony before the House Interim Committee on Cost-Containment. 9 September 2003.

---. ---. Unduplicated Eligibles in SFY 2002 Whose Eligibility was Eliminated or Changed as of July 2002 by County. August 2003.

---. ---. Division of Family Services. Income Maintenance Memorandum #77. 27 June 2002.

---. ---. ---. Income Maintenance Memorandum #78. 28 June 2002.

---. ---. ---. Income Maintenance Memorandum #119. 20 September 2002.

---. ---. Family Support Division. Family HealthCare Programs Manual—Sections 0920.020.00 through 0920.202.10.15. <http://www.dss.mo.gov/dfs/iman/index.html>

---. Office of the Governor. Draft and Preliminary FY 2005 Budget Estimated Shortfall. 30 September 2003.

Missouri Hospital Association. Missouri Medicaid Briefing, House Interim Committee on Medicaid Cost Containment. 10 October 2003.

- Missouri House of Representatives. House Substitute for Missouri Senate Bill 695. 2003. <http://www.senate.state.mo.us/03info/summs/hs/SB695.htm>.
- Moody, James R. and Associates. Missouri's Budget Problems: Causes and Possible Solutions. January 2003.
- Moss, Nancy E. and Karen Carver. "The Effect of WIC and Medicaid on Infant Mortality in the United States." American Journal of Public Health 88.9 (1998): 1354-1361.
- Mueller, Margie. Division of Medical Services. Personal Communication 12 January 2004.
- National Association of State Budget Officers. 2002 Expenditure Reports. 2003.
- Newacheck, Paul, et. al. *Health Insurance and Access to Primary Care for Children*." NEJM 338.8 (1998): 513-519.
- Newhouse, Joseph. Free for All? Lessons from the Rand Health Insurance Experiment. Cambridge: Harvard University Press, 1996.
- O'Brien, Ellen and Cindy Mann. "Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP." Covering Kids and Families. June 2003. http://www.kidsouth.org/pdf/maintaining_the_gains.pdf.
- Overpeck, Mary D. and Jonathan B. Kotch. "The Effect of U.S. Children's Access to Care on Medical Attention to Injuries." American Journal of Public Health. 85.3 (1995): 402-404.
- Perry, Michael, et al. "Medicaid and Children: Overcoming Barriers to Enrollment-Findings from a National Survey." Kaiser Commission on Medicaid and the Uninsured. January 2000.
- The Perryman Group. Medicaid and the Children's Health Insurance Program (CHIP): An Assessment of Their Impacts on Business Activity and the Consequences of Potential Funding Reductions. April 2003. <http://www.texmed.org/pmt/lel/cnl/Perryman.pdf>.
- Ross, Donna Cohen 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." Kaiser Commission on Medicaid and the Uninsured. July 2003. <http://www.kff.org/medicaid/4125-index.cfm>.
- Ross, Donna Cohen and Leighton Ku. "Quarterly Status Reporting Could Jeopardize the Health Coverage and Hundreds of Thousands of Eligible Low-Income Californians." Center on Budget and Policy Priorities. 23 December 2002.
- Rousseau, David. Medicaid: A National Perspective (presentation to the Missouri Association of Health Plans' 2003 Health Care Summit). 25 September 2003.
- Rowland, Diane. Medicaid Issues and Challenges, Kaiser Commission on the Future of Medicaid and the Uninsured Testimony before the Committee on Energy and Commerce Subcommittee on Health. United States House of Representatives. 8 October 2003.
- Rowland, Dianne. "Health Challenges Facing the Nation." Statement for the Joint Economic Committee. United States Congress. Kaiser Commission on Medicaid and the Uninsured. 1 October, 2003.
- Seninger, Steve. "Economic Impact of Medicaid on Montana and on the Billings, Butte, and Miles City Healthcare Market Areas." National Association of Social Workers-Montana Chapter. January 2003. http://www.naswmt.com/pdf/Seninger_Study.pdf.
- Serveller McNeil-Terry, et al., v. Steve Roling. No. 024-1662 (St.L. City Circuit Court). 29 September 2003.
- Silberman, Pam, et al. The North Carolina Enrollment Freeze of 2001: Health Risks and Financial Hardships for Working Families. January 2003.
- Smith, Dennis. Letter from Dennis Smith, Center for Medicaid and State Operations, to State Medicaid Directors. 13 June 2003.
- Song B., G. Doekson, M. Woods, and D. Schreiner. "Multiplier Analysis for Agriculture and Other Industries." Oklahoma State University. Oklahoma Cooperative Extension Service. December 1992.
- St. Louis Regional Health Commission. Missouri's Medicaid Program and its Impact on Missouri Business. April 2003.
- Szilagyi P.G., et al. "Evaluation of New York State's Child Health Plus: Children Who Have Asthma." Pediatrics 105.3 (2000): 719-727.
- Tamblyn, Robyn, et al. "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons." Journal of the American Medical Association 285.4 (2001): 421-429.
- United States. Census Bureau. Health Insurance Coverage in the United States: 2002. Washington, D.C.: GPO, September 2003.
- . Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Washington, D.C.: GPO, 2000.
- University of South Carolina. Moore School of Business. Division of Research. Economic Impact of Medicaid in South Carolina. January 2002. <http://research.moore.sc.edu/Research/studies/Medicaid/medicaid-econimpact.pdf>.
- White v. Martin. Case no. 02-4154-CV-C-NKL (W.D.Mo). 3 October 2002.
- Young, Virginia. "House GOP Chiefs See Budget as Half-full, Holden as Half-Empty." St. Louis Post-Dispatch 21 September 2003, B-1.



**Missouri Foundation for Health
publications available at
www.mffh.org**

The Missouri Foundation for Health has produced several publications related to the topic of this paper, which may be of interest to the reader. They are:

- ❖ Show Me Series: Report 1:
Innovative State Programs to
Cover the Uninsured:
Lessons for Missouri
- ❖ Show Me Series: Report 2:
Health Care Expenditures
and Insurance in Missouri
- ❖ Show Me Series: Report 3:
A Universal Health Care Plan
for Missouri
- ❖ Show Me Series: Report 4:
A Profile of Medicaid in Missouri:
Report on Survey Findings
- ❖ Health Expenditures in Missouri

Foundation publications are available at www.mffh.org or by request at 1.800.655.5560 or 314.345.5500.



Spring 2004

Grand Central Building, Suite 400
1000 St. Louis Union Station, St. Louis, Missouri 63103
1.800.655.5560 Toll-Free
www.mffh.org