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Missouri Children's Health Initiative: Politics and the Push Towards Universal Access

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MISSOURI CHILDREN'S HEALTH INITIATIVE: POLITICS AND THE PUSH TOWARDS UNIVERSAL ACCESS

> Angela Koenig of Lemay worries about her diabetic son Kyle all the time. Medicaid dropped Koenig from its rolls in November 1997. She took a new job a few months later as a bill collector for MCI in Earth City. But she can't afford to pay $320 a month for family health insurance coverage. Koenig, son Kyle, 6, and her daughter Emalee, 2, are without insurance for the first time. "What if he rides his bike and falls and breaks his arm?" asked Koenig, 23. "We really need insurance."[1]

I. INTRODUCTION

Availability of and access to quality health care are regarded as among the most important basic human needs. Unfortunately, economic barriers to access, specifically for those deemed "uninsured," prevent many Americans (mostly children) from obtaining basic preventative health services.[2] Traditionally, the Medicaid program served as a safety net for many of the uninsured.[3] Even with expanded eligibility requirements, some families find they are too rich for Medicaid, yet too poor for private insurance.[4] Until recently, 91,301 Missouri children like Kyle Koenig were not eligible for Medicaid benefits because their parents earned too much money.[5] In May of 1998 the Missouri legislature approved a plan to expand Medicaid coverage to children in 300% of the federal poverty level ("FPL").[6] The U.S. Census Bureau set the FPL at an annual income of $16,050 to support a family of

1. Bill Bell, Jr., *Medicaid Expansion Passes in House, Awaits Carnahan's OK: About 90,000 Uninsured Children Would be Covered: Plan Would Cost $20 Million Yearly*, ST. LOUIS POST-DISPATCH, May 15, 1998, at A1.

2. GENERAL ACCOUNTING OFFICE, REP. NO. HEHS-96-129, HEALTH INSURANCE FOR CHILDREN: PRIVATE INSURANCE CONTINUES TO DETERIORATE (1996) [hereinafter GAO/HEHS 96-129].

3. Sara Rosenbaum, *Rationing Without Justice: Children and the American Health System*, 140 U. PA. L. REV. 1859 (1992).

4. Vernellia Randall, et al., *Section 1115 Medicaid Waivers: Critiquing the State Applications*, 26 SETON HALL L. REV. 1069, 1072 (1996). Some people of poverty do not meet Aid for Dependant Children ("AFDC") eligibility criteria. *Id.*

5. Bill Bell Jr., *Senate Stalls Passage of Plan to Expand Medicaid Coverage*, ST. LOUIS POST-DISPATCH, May 7, 1998 [hereinafter Bell, *Senate Stalls*].

6. S.B. 632, 89th Leg. Sess. (Mo. 1998) (codified as MO. REV. STAT. § 208.185 [hereinafter S.B. 632].

four.[7] Thus to qualify for Missouri Medicaid, the annual income for a family of four cannot exceed $48,150.[8]

The Missouri plan combines federal money available from the Balanced Budget Act of 1997 through the State Children's Health Insurance Program ("CHIP") with existing Medicaid funds to extend coverage to 90,000 uninsured Missouri children, some working parents, and pregnant women.[9] State officials hope the plan will ameliorate some of the harsh effects of welfare reform for this gap population.[10]

Part II of this comment discusses the general characteristics of uninsured children and their options for coverage including employer-provided insurance, Medicaid, and new federal funding through CHIP. Part III of this comment examines the evolution of children's health policy in Missouri through a discussion of recent attempts to improve access to health care and the political reality in which each developed. Part IV discusses the development of the 1998 Missouri Children's Health Initiative including an analysis of the CHIP grants available through the Balanced Budget Act of 1997, and § 1115 Medicaid waiver as funding sources. Part IV also examines the political forces that led to adoption of the program. Finally, part V analyzes Missouri Children's Health Initiative as a viable solution to the problem of uninsured, concluding that although the Initiative will provide much needed aid to working families and their children, politics in the Missouri led to the slow adoption of what many classify as a middle-class entitlement.

II. UNINSURED CHILDREN AND THEIR OPTIONS FOR COVERAGE

A. Who are the uninsured?

In 1994 national expenditures for health care totaled $949.4 billion dollars; this figure represents 13.7% of the gross domestic product, an increase from 7.4% in 1970.[11] Even with these significant expenditures, approximately eleven million children nationwide currently do not have health insurance.[12] In Missouri, 194,434 children are uninsured.[13] Surprisingly, over half of those uninsured come from families headed by a full-time worker while only

7. Annual Update of HHS Poverty Guidelines, 65 Fed. Reg. 10,856, 10,857 (1997).

8. Bell, *Senate Stalls*, *supra* note 5.

9. *See* S.B. 632, *supra* note 6.

10. Interview with Greg Vadner, Director, Missouri Division of Medicaid Services, in St. Louis, Mo. (Oct. 16, 1998).

11. Note, *The Impact of Medicaid Managed Care on the Uninsured*, 110 HARV. L. REV. 751 (1997).

12. Children's Defense Fund, *Key Facts About Uninsured Children* (visited Oct. 1998) <http://www.childrensdefense.org/health_keyfacts.html> [hereinafter Children's Defense Fund].

13. Missouri Medicaid § 1115 Waiver Amendment at App. 8, (Feb. 13, 1998) (on file with author) [hereinafter Section 1115 Waiver Amendment].

seventeen percent come from non-working families.[14] Most uninsured children live in low to middle-income households.[15] At low-income levels (below $30,000), the number of uninsured Caucasian pre-school children surpassed uninsured African-American children.[16]

Experts note that, "[c]hildren in poverty have a national economic impact . . . now and over the long term."[17] Uninsured children as compared to those with insurance, receive fewer routine medical and dental care visits, immunizations, and treatment for injuries and illnesses.[18] Thirty percent of the uninsured did not get necessary medical care in the past year, compared with seven percent of those insured continuously.[19] Studies show that lack of preventative care can have a lifelong impact on the health and productivity of this population.[20] Those without access to preventative care may be at risk for having disabilities, chronic illness, or birth defects undetected or under treated.[21] Uninsured children are also more likely than those with insurance to be hospitalized for complications from manageable illnesses.[22]

Several factors, including socio-economic and political developments within the past few decades, explain why children are uninsured. One major reason is that parents often do not enroll their children in employer-provided coverage or publicly provided insurance plans.[23] More commonly, decreased employer-provided health insurance, narrowly focused Medicaid eligibility requirements, and aggressive welfare reform have created a gap in health resources leaving the working poor largely uninsured.[24]

14. The Kaiser Family Foundation, *Uninsured in America: Key Facts About Gaps in Health Insurance Coverage Today* (1998) [hereinafter *Uninsured in America*].

15. *Id*.

16. Michael D. Kogan, Ph.D., et al., *The Effect of Gaps in Health Insurance on the Continuity of a Regular Source of Care Among Preschool-aged Children in the United States*, 274 JAMA 1429 (1995).

17. Marian Wright Edelman, *The Status of Children and Our National Future*, 1 STAN. L. & POL'Y REV. 17, 18 (1989) (*quoting* former Presidents Jimmy Carter and Gerald Ford, American Agenda: Report to the Forty-first President of the United States (Washington, D.C.: Committee for Economic Development, 1987)).

18. Anna Wermuth, *Kidcare and the Uninsured Child: Options for an Illinois Health Insurance Plan*, 29 LOY U. CHI. L.J. 465, 468 (1998).

19. *See Uninsured in America*, *supra* note 14.

20. *Id*.

21. Kogan, *supra* note 16, at 1429.

22. The Kaiser Commission on Uninsured Facts, *The Uninsured and Their Access to Health Care* (Sept. 1998) [hereinafter Kaiser Uninsured Facts]. These illnesses include diabetes and asthma. *Id*.

23. Center for Studying Health System Change, 14 Issue Brief 1(Aug. 1998).

24. Rosenbaum, *supra* note 3, at 1860.

A. Development of a Gap: Decrease in Employer-Provided Insurance

Characteristics of the uninsured population reflect the economic and political crises burdening the American health care system today. Ironically, seventy-five to eighty-five percent of the uninsured are employed themselves or dependents of someone who is employed but does not receive health insurance benefits through their employer.[25] Twenty-two million workers in the American workforce do not have insurance.[26] For children, this statistic translates into about three out of five living in two parent households where at least one parent works full time.[27] Two-thirds of families with uninsured children have incomes above the federal poverty level.[28]

Recent statistics show that only sixty-five percent of children are covered by private insurance—the sharpest decrease in eight years.[29] Surprisingly, this drop does not reflect the status of the poorest children in America; rather, the greatest decrease in employer-provided insurance has been in families where at least one parent works full time.[30] The economic recession of the 1980's and early 1990's, which forced cutbacks in employer provided health insurance, contributed significantly to this statistic.[31] In 1994, only thirty-seven percent of children with a parent working full time had access to employer-provided health insurance.[32]

These statistics represent the shift in the labor market away from high-paying, benefit-providing full-time jobs to low wage, no-benefit part-time jobs.[33] Only forty-two percent of low-wage workers receive health benefits through their employer.[34] In these jobs, health insurance is either not offered by the employer or is available at a high cost to workers.[35] Studies estimate that less than one-fourth of employees working for medium to large companies receives health benefits paid one hundred percent by the employer.[36] Most employees with employer-provided insurance pay part of their health benefits

25. BARRY R. FURROW, ET AL., HEALTH LAW CASES, MATERIALS AND PROBLEMS 728 (3d ed. 1997).

26. Kaiser Uninsured Facts, *supra* note 22.

27. Children's Defense Fund, *supra* note 12, at 1.

28. *Id*.

29. *See* GAO/HEHS 96-129, *supra* note 2, at 4.

30. *Id.* at 7.

31. Kaiser Commission on Medicaid and the Uninsured, *How Well Does Employment-Based Health Insurance System Work for Low Income Families?* 4 (Sept. 1998) [hereinafter Kaiser Commission].

32. *See* GAO/HEHS 96-129, *supra* note 2, at 7.

33. Rosenbaum, *supra* note 3, at 1870.

34. Kaiser Commission, *supra* note 31, at 4. Low-wage is defined as those workers earning less than $7 per hour. *Id.*

35. *See* GAO/HEHS 96-129, *supra* note 2, at 11.

36. Children's Defense Fund, *supra* note 12, at 1.

at an average cost of $1,900 per year.[37] Without access to health insurance via the employer, parents must choose to struggle to pay for expensive private insurance, turn to the state for coverage through the Medicaid program, or risk going uninsured.

B. Medicaid

Medicaid is a social welfare program[38] that provides health care benefits for the poor, pregnant women and their children, the elderly and permanently disabled persons.[39] Formed in 1965 as an amendment to the Social Security Act,[40] Medicaid developed as an expansion of the federal welfare program with a goal of increasing access to health care for specific disadvantaged groups.[41] It has evolved as a federal-state partnership that finances medical services for eligible beneficiaries.[42] The program is an example of what many describe as "cooperative federalism" whereby the federal government provides funding and oversight and the states handle administration, set eligibility guidelines, and provide matching funds.[43] However, federal law ultimately governs Medicaid.[44]

At minimum, the federal statute requires states to provide medical services to families with dependent children, the blind, aged, or disabled individuals "whose income and resources are insufficient to meet the costs of necessary medical services."[45] The statute offers states a long list of optional services to include in their Medicaid plan and mandates minimum eligibility requirements.[46] The federal government also places limitations on state administration of the program to protect Medicaid beneficiaries. For example, any state imposed cost-sharing devices such as co-payments or premiums are

37. *Id*.

38. FURROW ET AL., *supra* note 25, at 684.

39. 42 U.S.C. § 1396 (1994).

40. S. REP. NO. 404 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943. Congress established the Medicaid program as an amendment to the Social Security Act. *Id*.

41. Colleen A. Foley, *The Doctor Will See You Now: Medicaid Managed Care and Indigent Children*, 21 SETON HALL LEGIS. J. 93, 97 (1997).

42. *Id*.

43. For example, state Medicaid officials submit a comprehensive plan to the U.S. Department of Health and Human Services ("HHS") describing the scope and nature of its Medicaid program. States have flexibility in deciding eligibility guidelines, types and range of services, payment levels, and administrative procedures. *Id*. at 97-98.

44. FURROW ET AL., *supra* note 25, at 865. *See generally* 42 U.S.C. § 1396a(a) (1994).

45. 42 U.S.C. § 1396 (1994).

46. FURROW ET AL., *supra* note 25, at 870. The statute lists twenty-five categories of services the state may cover, including "any other medical care, and any other type of remedial care recognized under state law, recognized by the Secretary." 42 U.S.C. § 1395d(a) (1994).

strictly regulated and monitored by HHS.[47] The statute also protects beneficiaries' "free choice" of providers.[48] States have the ability to "opt out" of these and other federal requirements through a waiver provision in the statute.[49]

1. Eligibility Criteria

Historically, Medicaid eligibility has been linked to economic need.[50] Initially, the program targeted the "deserving poor"[51] and children whose families received Aid to Families with Dependent Children assistance ("AFDC").[52] The statute created two eligibility groups: the "categorically needy," and the "medically needy."[53] The categorically needy refers to individuals who receive cash assistance through AFDC or Supplemental Security Income ("SSI") or who are blind or suffer from severe disabilities.[54] States may also classify as "categorically needy" those individuals who financially qualify for AFDC or SSI but are not eligible for other reasons.[55] States have additional discretion regarding eligibility of the "medically needy."[56] In general, the medically needy fall within income brackets significantly above AFDC or SSI criteria but far below their ability to pay medical costs.[57] In both categories, federal law vests the states with sufficient leeway to determine eligibility.

Although experts project Medicaid spending will reach $243 billion this year and account for twenty percent of state budgets, eligibility requirements have been expanded.[58] Beginning in 1986, Congress expanded Medicaid

47. 42 C.F.R. 447.53-.54 (1998). States must keep cost-sharing devices to a "nominal" amount. For outpatient services, co-payments may not exceed two dollars per month per family. Also, any coinsurance cannot exceed five percent of the state's share of the payment and co-payments may not exceed three dollars.

48. 42 U.S.C. § 1396a(a)(23) (1994).

49. 42 U.S.C. § 1315 (1994). *See infra* notes 106-119 and accompanying text.

50. FURROW ET AL., *supra* note 25, at 865.

51. 42 U.S.C. § 1396a(a)(10)(A)-(C) (1994). "Deserving Poor" include the aged, blind, and the permanently disabled. *Id.*

52. 42 U.S.C. § 1396a(a)(10)(A) (1994). The Personal Responsibility and Work Opportunity Act of 1996 eliminated AFDC in favor of state block grants known as Temporary Assistance for Needy Families ("TANF"). Pub. L. No. 104-193, 111 Stat. 2105 (1996). For a more detailed discussion of the PRA, see *infra* notes 62-82 and accompanying text.

53. Foley, *supra* note 41, at 99.

54. 42 U.S.C. § 1396d(q)(2) (1994).

55. States have discretion as to whether to include these individuals. Foley, *supra* note 41, at 100.

56. 42 U.S.C. § 1396a(10)(C)(1994).

57. *See* Foley, *supra* note 41, at 101.

58. *See* GAO/HEHS 96-129, *supra* note 2, at 6; s*ee also* GENERAL ACCOUNTING OFFICE, REP. NO. 97-86, MEDICAID MANAGED CARE: CHALLENGE OF HOLDING PANS ACCOUNTABLE REQUIRES GREATER STATE EFFORT (1997) [hereinafter GAO/HEHS 97-86].

eligibility requirements to allow states the option of including greater numbers of pregnant women and children in the program.[59] In the late eighties, Congress passed amendments mandating states to increase eligibility requirements based upon income within a certain percentage of FPL.[60] Currently, the federal government mandates each state to increase age-eligibility standards to include children up to age nineteen by the year 2002.[61]

a. The Impact of Welfare Reform on Medicaid Eligibility

In 1996 Congress passed the Personal Responsibility and Work Opportunity Act ("PRA"), which redefined the nation's welfare system.[62] The PRA freezes the amount of federal welfare matching grants to states until the year 2002.[63] When reinstated, state awards will be contingent upon each state's success in moving people from welfare to work.[64] Likewise, instead of intense regulation of welfare programs, the PRA returns discretion to the states.[65] Although states formulate individual welfare reform plans, the federal government prescribes rigid time limits and work requirements linked to grant awards.[66]

Specifically, the PRA eliminates the regulation intensive AFDC in favor of block grants known as Temporary Assistance to Needy Families ("TANF").[67] The statute imposes a lifetime limit for individuals to receive TANF assistance.[68] Individuals qualify for welfare benefits for a maximum of sixty months throughout their lifetime.[69] Aside from a rigid eligibility timeline, the PRA imposes significant work requirements on those receiving TANF

59. GENERAL ACCOUNTING OFFICE, REP. NO. HEHS-95-175, HEALTH INSURANCE FOR CHILDREN: MANY REMAIN UNINSURED DESPITE MEDICAID EXPANSION (1995).

60. In 1988, states were required to cover pregnant women and infants at the federal poverty line. Medicare Catastrophic Care Amendment, Pub. L. No. 100-360, 102 Stat. 683 (1988). By 1989, states were required to additionally cover pregnant women and children age six and under within 133% of the poverty level. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2137 (1989).

61. GAO/HEHS 96-129, *supra* note 2, at 7.

62. *See* The Personal Responsibility and Work Opportunity Act of 1996, Pub. L. No. 104-193, 111 Stat. 2105 (1996).

63. Mary R. Mannix et al., *Implementation of Temporary Assistance for Needy Families Block Grants: An Overview*, 30 CLEARINGHOUSE REV. 868, 870 (1997).

64. *Id.* at 881.

65. *Id.* at 870.

66. *Id*. at 878, 881.

67. *Id*. at 870.

68. Specifically, beneficiaries may only receive TANF assistance for a maximum of sixty months throughout their lifetime. Mannix et al., *supra* note 63, at 878.

69. *Id*. The sixty month lifetime limit may be calculated consecutively or non-consecutively. *Id*.

dollars.[70] Under the PRA, those receiving TANF assistance must work in order for the state to obtain a federal block grant.[71] Although the statute enumerates several activities that meet the definition of work, states may formulate their own requirements.[72] The PRA links future federal block grants to states satisfying work participation requirements.[73] Beginning in 1997, receipt of federal dollars was contingent upon states demonstrating an increase in work participation of those families receiving assistance.[74]

These factors are important in a health care context. Prior to enactment of the PRA, Medicaid eligibility was linked to receipt of cash assistance (AFDC criteria).[75] Although the PRA dissolved this marriage, states must act as if it had not.[76] Specifically, even though TANF eligibility criteria differs from the former-AFDC, families remain eligible for Medicaid even if they are not eligible for TANF assistance.[77] This feature, known as "delinking," promises to protect families moving from welfare to work.[78] This section of the statute also allows states to raise their Medicaid eligibility rules to cover more working families.[79]

The PRA also offers temporary Medicaid coverage for those moving from welfare to work. Those surpassing income limits under AFDC maintain eligibility for transitional Medicaid for six months as long as their income stays below 185% FPL.[80] Therefore, many of those who take low-wage jobs that do not provide health insurance benefits will not receive permanent

70. *Id*. at 881. By fiscal year 2000, recipients must work a minimum of thirty hours per week. *Id*. at 882-83.

71. Mannix et al., *supra* note 63, at 881.

72. *Id*. at 883. For example, activities such as subsidized or unsubsidized employment, job training, high school or vocational education, community service, or providing childcare will satisfy the work requirement. *Id*.

73. *Id*. at 881.

74. For example, in 1997 states were required to show that twenty-five percent of those receiving TANF dollars were working. States were expected to show ninety percent work participation in two-parent households by 1999. *Id*.

75. National Health Law Program, et al., *The Welfare Law and Its Effects on Medicaid Recipients*, 30 CLEARINGHOUSE REV. 1008 (1997) [hereinafter National Health Law Program].

76. *Id*. at 1009.

77. Social Security Act § 1931(b)(1) (1994); Pub. L No. 104-193, § 114(a), 110 Stat. 2105, 2177-78 (1996).

78. Claudia Schlosberg & Joel Ferber, *Access to Medicaid Since the Personal Responsibility and Work Opportunity Reconciliation Act*, 31 CLEARINGHOUSE REV. 528 (1998). Section 1931 requires states to establish a new, separate category of Medicaid eligibility based on pre-welfare reform eligibility criteria. *Id*.

79. *Id.* at 531.

80. National Health Law Program, *supra* note 75, at 1012.

Medicaid benefits under the PRA.[81] For this reason, state officials believe the Missouri Children's Health Initiative is vital to the success of welfare reform.[82]

2. Costs

Recent statistics from the United States Census Bureau show thirty- seven million Americans receive Medicaid benefits.[83] Providing these benefits costs the federal government nearly $160 billion in 1996 and accounted for eighteen percent of state budgets in fiscal year 1994.[84] These figures represent a gradual increase in Medicaid spending. During the 1980's Medicaid spending grew ten percent each year to match this growth.[85] Perhaps as a result of increased eligibility criteria, between 1988 and 1992, Medicaid costs doubled from $22.5 billion to $48.1 billion.[86]

Although Medicaid expenditures have increased, spending for children's health benefits totals less than one-fifth of the program's budget.[87] As employers offer private coverage with less frequency, Medicaid has become the coverage of choice for many families by default.[88] Since 1994, the number of non-AFDC children receiving Medicaid benefits has increased dramatically.[89] As a result, Medicaid is the largest source of third-party funding for children's health benefits.[90]

a. Medicaid Managed Care: An Experiment in Cost Control

The term "managed care" refers to organizational mechanisms that promote cost containment of health care services through a variety of measures including prepaid service contracts with providers and gatekeepers for referrals to specialty services among others.[91] Managed care combines cost control with promises of higher quality.[92] Health plans usually offer a wide range of preventative health care services in hopes of avoiding expensive diseases in the future.[93]

Along with the optimistic promises of a managed care paradigm come significant restrictions aimed at cost control. Specifically, many plans offer

81. *Id*.

82. Interview with Mike Hartmann, Deputy Chief of Staff of Governor Carnahan's Office, in Jefferson City, Mo. (Oct. 20, 1998); Interview with Greg Vadner, *supra* note 10.

83. *See* GAO/HEHS 97-86, *supra* note 58.

84. *Id*.

85. Foley, *supra* note 41, at 114.

86. *Id*. at 113.

87. Wermuth, *supra* note 18, at 482.

88. Rosenbaum, *supra* note 3, at 1859. *See* GAO/HEHS 96-129, *supra* note 2, at 6.

89. *Id*. In 1994, 62% of children on Medicaid had one working parent. *Id*.

90. Rosenbaum, *supra* note 3, at 1871.

91. FURROW ET AL., *supra* note 25, at 284.

92. *Id*.

93. Foley, *supra* note 41, at 118.

enrollees a limited network of health care providers from which to select a physician.[94] These providers typically contract with a Managed Care Organization ("MCO") to provide services at a discounted rate.[95] Often these providers are paid incentives for keeping costs down, potentially compromising patient care.[96] MCOs also rely on utilization review to regulate care decisions.[97] The utilization review process functions to review the medical necessity of care decisions by the health care provider.[98] These devices are particularly controversial when introduced to the Medicaid population.

Medicaid managed care, although relatively new, currently serves forty percent of all Medicaid recipients in forty-four states and the District of Columbia.[99] This trend reflects a shift in the general health care market toward managed care and a desire to keep Medicaid costs down.[100] Medicaid managed care operates on the same principles as traditional managed care, although delivery systems vary among the states.[101] Many states enroll their Medicaid beneficiaries in MCOs that administer the entire benefits package and receive reimbursement through a monthly capitation payment per enrollee.[102] Other states use primary care case management and assign beneficiaries to a primary care provider that manages the beneficiary's use of hospital and specialty care.[103] Child health advocates raise many concerns about both methods.

Even though Medicaid managed care demonstrates significant cost savings for states, the methodology is often criticized. As discussed above, through the Medicaid amendments, Congress enacted numerous restrictions to protect Medicaid beneficiaries from exploitation.[104] States are able to waive many of these protections when opting for a managed care delivery system under sections 1915(b) or 1115.[105]

94. *Id.*

95. *Id.*

96. FURROW ET AL., *supra* note 25, at 15-17.

97. *Id.* at 795.

98. *Id.*

99. Donna Cohen Ross & Wendy Jacobson, *Free & Low-Cost Health Insurance: Children You Know are Missing Out An Outreach Handbook*, Center on Budget and Policy Priorities 137 (1998). Managed care has been used in the Medicaid program since the early 1970's. FURROW ET AL., *supra* note 25, at 879-80.

100. Foley, *supra* note 41, at 121.

101. Ross & Jacobson, *supra* note 99, at 137.

102. *Id.*

103. *Id.*

104. *See supra* notes 47-49 and accompanying text.

105. 42 U.S.C. § 1915(b) (1994) (codified at 42 U.S.C. § 1396n(b)).

i. Section 1915(b) and 1115 Waivers

Section 1915(b) waivers allow states flexibility in using federal Medicaid funding. States may waive limited provisions of the Medicaid Act and accompanying regulations to effect cost containment goals.[106] Specifically, section 1915(b) waivers allow states to waive Medicaid requirements governing freedom of choice and home and community-based care.[107] These waivers encourage long-term policy changes as compared to the research-based focus of § 1115 waivers discussed below.[108] Because of their narrow focus, § 1915(b) waivers do not adhere to extreme fiscal guidelines present in § 1115 but instead, impose a rigid timetable for waiver review that results in a shorter evaluation period.[109] Although § 1915(b) waivers typically favor state autonomy, HHS affords the Health Care Financing Administration ("HCFA") substantive review powers.[110]

Review of § 1115 waivers provides a sharp contrast. Originally, waiver provisions were included in the 1965 Medicaid Act to encourage states to develop innovative solutions to the health care cost crisis through short-term research projects.[111] The legislative history of § 1115 waiver provisions reveals that Congress intended to limit these waivers to experimental or demonstration projects.[112] The review process has become more rigid because states have taken advantage of this liberal definition by attempting to use § 1115 waivers to fund long-term projects.[113] .

Unlike § 1915(b), § 1115 waivers come with significant restrictions and oversight from HHS. The statute allows the Secretary broad authority to waive statutory and/or regulatory provisions to assist states in promoting the objectives of Medicaid.[114] Because Congress intended § 1115 waivers to support demonstration or research based projects, HHS requires significant planning and analysis before a waiver is approved.[115] The Health Care

106. Elizabeth Andersen, *Administering Health Care: Lessons from the Health Care Financing Administration's Waiver Policy-Making*, 10 J.L. & POL. 215, 222 (1994).

107. *Id.* at 233.

108. *Id.* at 234.

109. 42 U.S.C. § 1396n(f)(2) (1994). HHS processes most Section 1915(b) waivers in six months. Anderson, *supra* note 106, at 234.

110. As part of granting a waiver, HCFA examines the state plan's cost-effectiveness and quality assurance measures. Anderson, *supra* note 106, at 234.

111. *Id.* at 225.

112. S. REP. NO. 1589, at 19 (1962), *reprinted in* 1962 U.S.C.C.A.N 1943, 1962.

113. Anderson, *supra* note 106, at 229.

114. *Id*. at 225. A key difference between § 1915(b) and § 1115 is that HCFA requires states to demonstrate that their § 1115 projects have budget neutrality, which is not required for § 1915(b) projects. *Id*.

115. *Id.* at 226-27 & n.59. A state requesting a waiver must initially submit a detailed proposal to HHS. This proposal must specify the Medicaid law and/or regulations to be waived.

Financing Administration has established a review process that many states find cumbersome.[116] Although the Clinton administration has made efforts to streamline the process,[117] review of § 1115 waivers involves complex bureaucratic procedures that often inhibit the development of "innovative solutions."[118] Also, because the process involves a federal bureaucracy, review of waiver applications is often political.[119]

C. CHIP & the Balanced Budget Act of 1997: New Options for States

In 1997, Congress passed the most dramatic change in children's health insurance since the 1965 Medicaid Act.[120] Backed by President Clinton, the Balanced Budget Act ("BBA") of 1997 included a $24 billion dollar program known as the State Children's Health Insurance Program ("CHIP") that promises to extend health insurance to more than 10 million uninsured children nationwide.[121] The funds will be available to states through block grants in approximately $4 billion dollar increments until the year 2007.[122]

To obtain CHIP funds, states must submit a Child Health Plan to HHS for approval.[123] States have three options for their Child Health Plan: (1) expand the Medicaid program to include previously ineligible children; (2) create a new state Child Health Plan targeting low-income children; or (3) serve low-

In addition, states must include an analysis of the project's effect on that state's Medicaid budget (the "budget neutrality rule"). *Id.*

116. The Health Care Financing Administration ("HCFA") convenes a technical review panel to review each state's proposal. The review panel then scores each application considering its design, objectives, costs, risks to participants and other factors. From this score, the panel recommends approval or rejection to the HCFA Office of Research Development ("ORD"). ORD incorporates these findings into a memo to the administrator who inevitably decides whether to grant the waiver. *Id.* at 227-32 & n.50.

117. Note, *The Impact of Medicaid Managed Care on the Uninsured*, 110 HARV. L. REV. 751, 755 (1997).

118. Anderson, *supra* note 106, at 225.

119. For example, HCFA's broad discretionary powers allow for withdrawal of a waiver at any time. 45 C.F.R. § 92.43 (1993).

120. *Clinton Backs Medicaid Plan to Insure Children*, ST. LOUIS POST-DISPATCH, June 18, 1997, *available in* 1997 WL 3349218.

121. U.S. DEP'T OF HEALTH & HUMAN SERVICES, HCFA ANNOUNCES STATE ALLOTMENTS FOR CHILDREN'S HEALTH INSURANCE PROGRAM (Sept. 10, 1997) [hereinafter HHS PRESS RELEASE]; Wermuth, *supra* note 18, at 494 (citing Balanced Budget Act of 1997, PL 105-33, 111 Stat 552 (1997)). States can only use this funding to enroll low income children. 42 U.S.C. § 1397bb(b)(1)(B)(ii) (Supp. III 1997). Children currently accessing employer provided health insurance are ineligible for SCHIP. 42 U.S.C. § 1397bb(b)(3)(C) (Supp. III 1997).

122. Wermuth, *supra* note 18, at 495. Grant amounts are determined using a formula that considers the state's total number of low-income children and the number of uninsured in that population multiplied by a geographic factor. 42 U.S.C. § 1397dd(b)(2)-(3) (Supp. III 1997).

123. 42 U.S.C. § 1397aa(b) (Supp. III 1997).

income children through a Medicaid expansion and new plan.[124] Unlike Medicaid, CHIP imposes only minimal restrictions on state plans.[125] Programs must target low-income children who are under age nineteen.[126] In addition, the BBA also allows states to decide policies for eligibility criteria, benefits, and cost sharing requirements.[127] Most importantly, states can utilize Medicaid Managed Care as a cost-containment strategy without obtaining a § 1115 waiver.[128] These minimal criteria make CHIP a state-friendly program.

1. Eligibility Requirements

In comparison to Medicaid waiver applications, CHIP's flexibility and freedom from rigid administrative oversight make it especially attractive to states. The statute mandates few eligibility criteria other than the requirement that the program target low-income children.[129] Low-income is defined as children in families at or below 200% FPL, unless the state increased Medicaid eligibility above 150% FPL.[130] If a state sets higher Medicaid eligibility, the ceiling for CHIP may exceed 200%.[131] Other than income-eligibility restrictions, the statute merely requires that states not deny coverage to a child because of a pre-existing medical condition.[132]

Along with setting eligibility criteria, states assume oversight responsibility for enrollment. Specifically, states must actively monitor enrollees to ensure that only low-income children are served; that those previously eligible for Medicaid are covered under traditional Medicaid and not CHIP; and that CHIP coverage will not replace employer-provided health insurance.[133] Finally, if states utilize CHIP funds for a Medicaid expansion, they must continue coverage for the newly covered population even if federal money runs out.[134] In this sense, CHIP targets the gap population.

124. HHS PRESS RELEASE, *supra* note 121. *See* 42 U.S.C. § 1397aa(a) (Supp. III 1997).

125. HHS PRESS RELEASE, *supra* note 121.

126. 42 U.S.C. § 1397aa(a) (Supp. III 1997). The statute defines "low income" as those whose annual family income does not exceed 200% of the FPL. 42 U.S.C. § 1397jj(c)(4) (Supp. III 1997).

127. 42 U.S.C. § 1397bb(b) (Supp. III 1997).

128. Wermuth, *supra* note 18, at 494-95.

129. 42 U.S.C. § 1397bb(b)(1) (Supp. III 1997). Children are "low-income" if they were previously eligible for state assistance or fall within specific eligibility criteria; however, they are excluded if they are incarcerated or receive insurance benefits through a parent's employer. 42 U.S.C. § 1397jj(b)(1)-(2) (Supp. III 1997).

130. 42 U.S.C. § 1397jj(b)(1)-(2) (Supp. III 1997).

131. 42 U.S.C. § 1397bb(b) (Supp. III 1997). Because states define "net income" for eligible beneficiaries, Missouri was able to increase Medicaid eligibility to 300% FPL. Vadner, *supra* note 10.

132. 42 U.S.C. § 1397bb(b)(A) (Supp. III 1997).

133. 42 U.S.C. § 1397bb(b)(3)(A)-(C) (Supp. III 1997).

134. Interview with Mike Hartmann, *supra* note 82.

2. Benefits and Cost-Sharing

Benefit requirements under CHIP vary depending on which option state plans employ. Under a Medicaid expansion for example, CHIP programs must offer complete Medicaid benefits to new enrollees.[135] Conversely, when utilizing a new plan, states have discretion and can only provide minimum benefits enumerated in the statute.[136] States must model these new plans after certain "benchmark" plans to ensure fairness. In particular, a new plan must reflect the benefits package of either: (1) the Blue Cross/Blue Shield plan in that state; (2) health benefits provided by the state to its employees; or (3) the largest non-Medicaid HMO in the state.[137] For this reason, a Medicaid expansion may appear less cumbersome.

However, cost-sharing limitations in the Medicaid statute apply for states using a Medicaid expansion.[138] As discussed above, the Medicaid statute places certain restrictions on cost-sharing measures to protect beneficiaries.[139] These restrictions do not affect states creating a new Child Health Plan. For new plans, states must ensure that cost-sharing devices do not favor higher income enrollees over low-income enrollees.[140] Furthermore, the plan cannot impose any cost-sharing devices on preventative care.[141] Therefore, with either plan option states face some governmental oversight.

Missouri has opted to expand its Medicaid program to include children in families earning up to 300% FPL.[142] As discussed below, the Missouri Children's Health Initiative developed after years of political struggle on the state and federal levels. Although the plan hopes to offer coverage to 90,000 children and their families,[143] questions remain as to whether the state is getting the most bang for its buck.

III. RECENT HISTORY OF HEALTH POLITICS IN MISSOURI

Beginning in 1993 the Missouri General Assembly entertained several different plans with the goal of improving access to health care for uninsured

135. 42 U.S.C. § 1397cc(d) (Supp. III 1997).

136. These benefits include inpatient and outpatient hospital services, physician surgical and medical services, laboratory and x-ray services, and well baby and well child services. 42 U.S.C. § 1397cc(c)(1)(A)-(D) (Supp. III 1997).

137. 42 U.S.C. § 1397cc(b)(1)(B) (Supp. III 1997).

138. 42 U.S.C. § 1397cc(e)(4) (Supp. III 1997).

139. *See supra* notes 47-49.

140. 42 U.S.C. § 1397cc(e)(1)(B) (Supp. III 1997).

141. 42 U.S.C. § 1397cc(e)(2) (Supp. III 1997).

142. S.B. 632, *supra* note 6.

143. Office of the Governor, Press Rel., *Carnahan Signs Children's Health Initiative*, (visited Oct. 20, 1998) <www.gov.state.mo.us/cgi-bin/news98.c. . .ren's??Health??Initiative&date=06/10/1998> [hereinafter *Carnahan Signs*].

or underinsured children and families.[144] Until recently, many of these attempts were unsuccessful, combated by various coalitions who opposed any change in the status quo.[145] This section of the comment will discuss three significant programs debated in the Missouri legislature that laid the foundation for the 1998 Children's Health Initiative.

A. HOUSE BILL 564: Increased Access to Health Coverage

After the 1992 general election, Governor Mel Carnahan commissioned a group of experts to study Missouri's health system.[146] At this time, seventeen percent of Missouri children were uninsured, and overall an estimated 1.1 million Missourians had inadequate health insurance or none at all.[147] Many of the uninsured resided in rural or otherwise underserved areas limiting their access to health providers.[148] The ShowMe Health Reform Committee used these statistics to produce a report that recommended, among other changes, that Missouri complete a movement toward universal access to health insurance coverage by 1999.[149] During the same time then-House Speaker Bob Griffin assembled a separate committee to study incremental reform with the goal of improving access to primary care using existing infrastructure.[150] The findings of these groups provided the basis for much of the 1993 health legislation in Missouri.[151] Specifically, two competing programs emerged during the 1993 session: a universal coverage bill[152] and a bill promoting increased access.[153]

Representative Gail Chatfield, a high-ranking House member and champion of health policy, promoted a plan patterned after the Canadian health system that would guarantee health coverage to all Missourians.[154] The bill

144. *See* H.B. 564, 87th Leg. Sess. (Mo. 1994); H. 811 89th Leg. Sess. (Mo. 1997); SB 632.

145. For example, the insurance industry and physician groups vigorously opposed reform efforts in 1994. *See infra* notes 212-22 and accompanying text.

146. MISSOURI DEP'T OF HEALTH, SHOWME HEALTH REFORM INITIATIVE, 1993 [hereinafter SHOWME HEALTH REFORM].

147. Alan W. Brass & Douglas A. Ries, *House Bill 564 Puts Children First*, ST. LOUIS POST-DISPATCH, Apr. 1, 1993; *Good, Bad Points in Health Bill*, ST. LOUIS POST-DISPATCH, Mar. 1, 1993, at 2B.

148. Fifty-five of the one hundred and thirteen Missouri counties have no physicians. Shera Gross, *Griffin's Health Care Delivery Bill Faces Final House Vote Wednesday: Sin Tax in Griffin's Bill Still Topic of Disagreement*, ST. LOUIS BUS. J., Mar. 29, 1993, *available in* 1993 WL 9321092.

149. SHOWME HEALTH REFORM, *supra* note 146, at 10.

150. Interview with Andrea Routh, a drafter of H.B. 564, in St. Louis. (Nov. 6, 1998).

151. *Compare* SHOWME HEALTH REFORM, *supra* note 146, with H.B. 564.

152. H.B. 191, 87th Leg. Sess. (Mo. 1993) (sponsored by Rep. Gail Chatfield) [hereinafter H.B. 191].

153. H.B. 564.

154. *See Good, Bad Points in Health Bill*, *supra* note 147.

proposed to scrap Missouri's current payment mechanisms and pool all health funding, both public and private, into a single pot.[155] Control over health spending would reside with a newly appointed board of governors, shifting financial decision-making away from private hospitals and the insurance industry.[156] Increases on payroll and income taxes would fund the program.[157] But, Chatfield's bill did not survive the legislative session. Opposed vigorously by physicians, private hospitals and the health insurance industry as fiscally unfeasible, the bill's single payer provisions proved fatal.[158]

A more moderate proposal, House Bill 564, known as the "access bill,"[159] promised to extend availability of health care to more than 600,000 Missourians.[160] Then-House Speaker Bob Griffin sponsored the compromise legislation which was drafted by health policy groups with the intention of increasing access to health services.[161] Provisions in the bill targeted underserved populations by expanding the state's Medicaid program, creating school health clinics, adopting collaborative practice arrangements, offering financial incentives to lure physicians into underserved areas, and extending liability protection for health providers serving the poor.[162]

Most notably, the bill expanded Medicaid eligibility for uninsured children up to age nineteen in 200% FPL and to pregnant women and their children in 185% FPL.[163] The bill made additional Medicaid funding available for school health clinics that were to serve as a source of primary care for students.[164] A statewide increase on alcohol and tobacco taxes and increased federal matching funds available through Medicaid funded these programs.[165] Surprisingly enough, the Medicaid expansion component received little criticism.

Still, the bill's collaborative practice provision, critical to the feasibility of school health program, fell under attack.[166] The bill authorized advanced

155. *Id.*; H.B. 191.

156. H.B. 191.

157. *See Good, Bad Points in Health Bill*, *supra* note 147.

158. Roger Signor, *Health Care For All? Bill Aims to Expand Medical Care and Cut Costs*, ST. LOUIS POST-DISPATCH, Feb. 28, 1993, at 1B.

159. Interview with Andrea Routh, *supra* note 150.

160. *Bill Would Hike Tobacco Taxes*, ST. LOUIS POST-DISPATCH, Feb. 16, 1993, at 4A.

161. The St. Louis Health Policy Institute and the Missouri State Medical Association Drafted H.B. 564. *See* Signor, *supra* note 158.

162. H.B. 564.

163. *Id.* At that time, 185% FPL was equivalent to an annual income of $26,548 for a family of four. Virginia Young, *Missouri School Bill on Children's Services Gets Nod From Hillary Clinton*, ST. LOUIS POST-DISPATCH, July 2, 1993, at 6A.

164. *Id.*

165. Will Sentell, *Missouri Health Care Bill Ignites Abortion Debate*, KAN. CITY STAR, Mar. 5, 1993, at B1. *See also* H.B. 564.

166. *See* Gross, *supra* note 148.

practice nurses, nurse practitioners, and physician assistants to enter into written collaborative practice agreements with physicians to provide primary care and preventative health services.[167] The program authorized physicians to develop written protocols to guide other health professionals in providing treatment.[168] This guidance would relieve the nurses' fear of prosecution by the State Board of Healing Arts for engaging in the unauthorized practice of medicine.[169]

Conservatives in the Senate resisted the provision (coupled with the school health component) on the issue of abortion.[170] Because the bill allowed school nurses to refer students for additional health services, conservative senators feared nurses would refer for abortions.[171] The House accepted amendments to the bill that mandated parental consent before certain services or referrals were provided.[172]

House Bill 564 also focused on increasing physician services to the poor and underserved populations.[173] Specifically, the bill incorporated financial incentive arrangements[174] for physicians serving resource shortage areas and removed the threat of malpractice suits for health providers who provided free care.[175] The Health Access Incentive Fund earmarked funds to repay physicians' student loans, provide liability insurance, scholarships, and technical assistance.[176] The Missouri State Medical Association noted that physicians wanted to provide free care to the poor but were discouraged by the threat of lawsuits.[177] To quell this fear, the bill contained a provision to create a state legal fund to pay up to $500,000 of a malpractice claim for health providers providing free care.[178] These programs promised to draw physicians into sixty areas in desperate need of medical services.[179]

167. H.B. 564 (codified as MO. REV. STAT. § 334.104 (1994)).

168. *Id*.

169. Gross, *supra* note 148. Missouri has narrow scope of practice law that previously limited activities of non-physician health providers. *Id*.

170. Sentell, *supra* note 165.

171. *Id*. (quoting Senator Klarich, "I don't want nurses to be abortion referral agents.")

172. This amendment chiefly targeted availability of contraceptive devices. MO. REV. STAT. § 383.125 (1994).

173. H.B. 564 included financial incentives and added malpractice protection for physicians treating the poor or serving underserved areas. H.B. 564 (*codified as* MO. REV. STAT. §§ 191.411, 105.711 (1994)).

174. MO. REV. STAT. § 191.411 (1994) created the "Health Access Incentive Fund" to encourage physicians to locate to underserved areas of the state. *Id*.

175. MO. REV. STAT. § 105.711 (1994).

176. MO. REV. STAT. § 191.411 (1994).

177. Alan Bavley, *Bill Will Cover Doctors Doing Volunteer Work: Fear of Lawsuits Has Kept Some Doctors From Donating Services*, KAN. CITY STAR, May 28, 1993, at C1.

178. MO. REV. STAT. § 105.711 (1994).

179. Young, *supra* note 164.

These visionary programs would potentially extend access to health care to more than 600,000 Missourians.[180] Therefore, gaining approval required competent leadership. Along with thirty-seven other co-sponsors, Speaker Griffin handled House Bill 564 which enjoyed heavy support from Governor Mel Carnahan.[181] In Missouri, the Speaker of the House controls the flow of legislation including appointing committee chairs, assigning bills to committees, and scheduling floor debate.[182] Thus, Griffin's sponsorship elevated the prestige and priority of the bill.[183] Additionally, the bill received support from the Missouri Hospital Association, the Missouri Nurses' Association, the Missouri Catholic Conference, and the Missouri State Labor Council.[184]

Yet with all of its supporters and political clout, House Bill 564 was not without opponents. In the Senate, Republicans attacked the school health piece in fear school nurses would refer pregnant students for abortions.[185] Conservative senators won the abortion battle with an amendment that required parental consent before school health clinics could provide family planning services.[186] Additionally, the bill faced opposition from the alcohol and tobacco industries who lobbied against the increase on excise taxes.[187] The General Assembly reached a compromise on the abortion issue but made no concessions to lobbyists on the taxes.[188]

The bill was approved by the General Assembly on May 11, 1993 and sent to the Governor for signing.[189] First Lady Hillary Clinton attended the bill signing via satellite and praised the work of the Missouri Legislature as an example for other states across the nation.[190]

180. Sentell, *supra* note 165.

181. H.B. 564 (Mo. 1993).

182. *See 90th General Assembly Rules of the House* (last visited Nov. 16, 1998). <http://www.house.state.mo.us/rule89/rule89htm>.

183. Sentell, *supra* note 165. According to health industry officials, Griffin's sponsorship elevated health reform to its highest profile in years. *Id*.

184. Will Sentell, *Missouri Senate Approves New Health-Care Plan Tobacco Tax to Help Pay for Expansion of Medical Programs*, KAN. CITY STAR, May 12, 1993, at C5.

185. *Id*. Senators Schneider and Klarich championed the abortion battle. *See also*, Sentell, *supra* note 165.

186. Sentell, *supra* note 184.

187. Specifically H.B. 564 included an increase of four cents on cigarettes, ten cents on smokeless tobacco, eighteen cents per gallon on beer; ten cents per gallon on wine, and one dollar per gallon on liquor. Sentell, *supra* note 165.

188. Sentell, *supra* note 165 (quoting Sen. Jim Mathewson). The tax increase would generate an estimated $58 million dollars over three years to fund the program. *Id*.

189. *Id*.

190. Young, *supra* note 163.

B. HOUSE BILL 1622: Another Attempt at Universal Coverage

Plans for universal coverage did not die in 1993. Hoping to ride on his success from the previous session, Speaker Griffin sponsored a new access bill to help move the state toward universal coverage.[191] House Bill 1622 attacked the problem of the uninsured by targeting industry barriers to access such as pre-existing condition restrictions, high-risk pooling, and exorbitant premiums.[192] Dubbed "the Griffin-Carnahan bill",[193] House Bill 1622 included many recommendations from the Governor's 1993 ShowMe Health Reform committee.[194] For instance, the committee recommended that the state mandate individual coverage in the way auto insurance is required for Missouri drivers.[195] To meet this mandate, health insurance would be available through employers, Medicaid, and state subsidies targeted at the gap population.[196] Additionally, industry barriers to coverage including access restrictions such as job loss portability, pre-existing conditions, and gender/age-based premiums would be prohibited.[197] Most significantly, the committee recommended that providers establish integrated service networks[198] ("ISNs") to formulate affordable benefits packages available to employers and individuals for a fixed price.[199] Griffin incorporated these recommendations into House Bill 1622, the health access bill for the 1994 legislative session.[200]

House Bill 1622 also attempted to increase access by eliminating economic barriers to health care.[201] Under the plan, patients would receive health care for one fixed fee, regardless of their sickness.[202] Patients in a given region could choose among different Integrated Service Networks which would perform functions of insurers and health providers.[203] These networks would organize health insurers, hospitals, physicians, and other providers to offer

191. H.B. 1622, 87th Leg. Sess. (Mo. 1994) [hereinafter H.B. 1622].

192. Kevin Q. Murphy, *Carnahan Reveals Plan Offering Health Care to Every Missourian*, KAN. CITY STAR, Feb. 9, 1994, at A1. To combat these industry access restrictions, the bill included a thirty day open enrollment provision preventing insurers from allowing any individual, regardless of health condition, to enroll in a health plan. *Id*. *See* H.B. 1622.

193. *Health Reform for Missouri*, ST. LOUIS POST-DISPATCH, Mar. 2, 1994, at 6B.

194. *Compare* SHOWME HEALTH REFORM, *supra* note 146, with H.B. 1622 (Mo. 1994).

195. Missouri Department of Health, *ShowMe Health Reform Committee Report* 10 (1993)

196. *Id*.

197. *Id*. at 4.

198. Integrated service networks ("ISNs") were to include a "network" of hospitals, insurance companies, and provider groups to deliver a range of services and accept a capitated premium based upon the "community rating". H.B. 1622; Roger Signor, *Doctor Urges Protect Against Carnahan Bill*, ST. LOUIS POST-DISPATCH, Mar. 9, 1994, at 1B.

199. *ShowMe Health Reform Committee Report*, *supra* note 195, at 9.

200. *See* H.B. 1622.

201. *Id*.

202. Signor, *supra* note 198.

203. *Id*.

standard benefits packages.[204] ISNs would set premiums based upon average costs from five geographic regions throughout the state.[205] This would come to be known as "community rating" and was among the more controversial provisions of the bill.[206]

Uniform premiums, according to Jay Angoff, then-Director of the Missouri Department of Insurance, would function as an incentive for insurance companies to cut overhead costs and pass savings on to consumers.[207] Instead of basing premiums on gender, age, or health status, insurers would be forced to offer a standard benefits package within the "community rating" of a particular region.[208] Thus, ISNs would control costs through market competition.[209] Insurance industry officials warned that restructuring would force them to consider withdrawing from the Missouri market.[210] To prevent such drastic consequences, the industry hired thirteen lobbyists to twist arms.[211] Additionally, the industry successfully enlisted the help of Republican Senator Franc Flotron who pushed twenty-two amendments written by General America Insurance Company.[212]

The Integrated Service Networks provision attracted more controversy from providers who resisted taking on administrative tasks.[213] Physicians opposed the measure as a conflict of interest requiring them to practice "cookbook medicine."[214] Dr. John T. Anstey, head of Missouri's largest physician group phrased the dilemma as such, "do I do what's best for my patients or for my health care network?"[215] Interestingly enough, among the bill's chief supporters was the Missouri Hospital Association who endorsed the bill as a step in the right direction.[216]

204. *Id*. ISNs would offer patients a network of health providers who would provide care at a fixed price regardless of sickness. *Id*.

205. H.B. 1622.

206. Murphy, *supra* note 192.

207. Shera Herrick, *Missouri-Fat Insurers Oppose Health Reform: General American Says its Expenses Distorted Insurers*, ST. LOUIS BUS. J., Apr. 18, 1994.

208. Murphy, *supra* note 192.

209. Herrick, *supra* note 207.

210. Virginia Young, *Carnahan Mourns Health Bill*, ST. LOUIS POST-DISPATCH, May 15, 1994, at 9A (quoting James Sherman, corporate relations executive for General American Insurance Company).

211. Herrick, *supra* note 207. The bill also faced intense opposition from the St. Louis Area Business Health Coalition who amended the bill yet continued to fight its adoption. Jay Angoff said Jim Stutz, the Coalition's director, "kept asking for more changes, and we'd make the changes exactly along the lines he suggested, and he'd still oppose the bill." *Id*.

212. Young, *supra* note 210.

213. Signor, *supra* note 198.

214. *Id*.

215. *Id*.

216. Murphy, *supra* note 192.

Concerns about the community-rating requirement initially stalled the bill in the House after a 91-61 vote.[217] Worried about its ultimate fate, Governor Carnahan met with then-Senate Majority Leader J.B. "Jet" Banks to develop compromise language.[218] Responding to pressure from the insurance industry, Senator Banks agreed to bring the bill to a vote if the community rating provision was amended.[219] Specifically, the new language allowed big business to opt out of community rating and offer instead self-insured plans.[220] Thus, the bill was resurrected in the Senate, although it ultimately died after forty-five minutes of debate on the last day of the legislative session.[221] The insurance industry's powerful lobby quashed yet another attempt at universal access in Missouri.

C. HOUSE BILL 811: Pooling Uninsured Children to Receive Private Benefits

After the legislature's rejection of the universal coverage bill in 1994, policy makers targeted health reform to serving uninsured children.[222] In 1997, an estimated 175,000 Missouri children had no health insurance coverage.[223] As a result, these children had limited access to primary care and preventative health services.[224] House Bill 811, dubbed "Kids Care," copied a Florida plan to pool uninsured children together in order to negotiate competitive benefit packages with insurers.[225] Backed by the House Budget Chair, Speaker of the House, Senate Majority Leader and Governor Carnahan, along with child advocates, school nurses and two major health insurers, the plan enjoyed widespread support at the outset.[226]

217. Virginia Young, *Carnahan Health Bill Dies in House: Griffin Blames Defeat on Special Interest Foes*, ST. LOUIS POST-DISPATCH, Apr. 19, 1994, at 1A.

218. Virginia Young, *Carnahan and Banks Resurrect Health-Insurance Reform Bill*, ST. LOUIS POST-DISPATCH, May 10, 1994, at 2B.

219. *Id*.

220. *Id*. Companies with over two hundred employees could offer self-insured plans. *Id*. Self-insured plans are any plans of risk retention in which a program or procedure has been established to meet the adverse results of financial loss. These can include risk pooling. ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW, A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES AND COMMERCIAL PRACTICES 1.3(c) n.13-14 (1988).

221. Young, *supra* note 210.

222. H.B. 811, 89th Leg. Sess. (Mo. 1997) [hereinafter H.B. 811].

223. Kevin Murphy, *Carnahan Offers Insurance Plan for 'Kids Care': Legislation Would Create Nonprofit Unit to Seek Medical Coverage Bids*, KAN. CITY STAR, Mar. 6, 1997, at C3.

224. *Id*.

225. *See* Kim Bell, *Child Health Insurance Bill Advances*, ST. LOUIS POST-DISPATCH, Apr. 23, 1997, at 15A; Virginia Young, *There's Still Time: Carnahan Says All Major Bills are 'In Position'*, ST. LOUIS POST-DISPATCH, May 14, 1997, at 2B. *See* H.B. 811. See *also* Murphy, *supra* note 192.

226. Representative Shelia Lumpe, House Budget Chair, co-sponsored the legislation. House Speaker Steve Gaw supported the bill publicly and procedurally in the House. *See* Bell, *supra* note 225. *See also* Kevin Murphy, *Gaw Vows to Resurrect Kids Care: Bill That Would Make*

Under the Kids Care plan, the state would incorporate "the Healthy Missouri Children Corporation"[227] to place children in an insurance pool and spread risk in order to negotiate competitive premiums from HMOs and insurance companies.[228] Because parents or employers would pay premiums, the corporation would require no state funding.[229] Additionally, the state received financial support from the Robert Wood Johnson Foundation in the form of a planning grant.[230] If approved, House Bill 811 would draw an additional $3 million dollars from the Foundation for implementation.[231] Under the plan, more than 115,000 Missouri children would have the option to receive affordable health insurance benefits.[232] Although the bill called for no state appropriation, critics categorized the bill as a hidden agenda toward a government subsidized insurance program.[233] This accusation angered Governor Carnahan and other proponents of the measure because critics grossly misrepresented the program.[234] "Carnahan called the GOP criticism 'sort of pitiful. We're attempting to set up a mechanism to get low rates so parents can buy insurance to cover uninsured children. It does not have government money in it.'"[235]

Additionally, the bill faced tough opposition from conservatives on both sides of the aisle on the abortion issue.[236] Anti-abortion legislators warned that if not amended, the bill authorized the Corporation's Board of Directors to use state money to fund abortion counseling and referrals.[237] Although the bill

Insurance for Children Cheaper Failed to Pass, KAN. CITY STAR, June 4, 1997, at C3. Kids Care was the centerpiece of Governor Carnahan's 1997 legislative package. *Id*. Supporters of the Bill included Citizens for Missouri's Children. *See Hearing Before House Committee on Children, Youth and Families* (visited Oct. 29, 1999) <http://www.house.state.mo.us/bills97/hb811.htm>.

227. The bill vested the corporation's management powers with a Board of Directors composed of the directors of five state departments including the Departments of Elementary and Secondary Education, Health, Mental Health, Insurance, and Social Services. *See Hearing Before House Committee on Children, Youth and Families* supra note 226.

228. *Id*.

229. Murphy, *supra* note 192.

230. The mission of the Robert Wood Johnson Foundation is "to improve the health and health care of all Americans." The Foundation is concerned with access to care, substance abuse and chronic illness. *See Basic Information About the RWF* (visited Aug. 24, 1999) <http:/www.rwjf.org/jabout2.htm>; Lois Linton, *Kids Care Proposal Raises Many Questions*, ST. LOUIS POST-DISPATCH, May 12, 1997, at 7B.

231. Linton, *supra* note 230.

232. *See* Bell, *supra* note 225.

233. *Missouri Senate Panel Votes to Advance Kids' Insurance*, CAP. MKT. REP. 10:16:00, May 7, 1997, *available in* WESTLAW 5/7/97 CMREP 10:16:00 [hereinafter *Missouri Senate Panel Votes*].

234. Young, *supra* note 225.

235. *Id*.

236. Bell, *supra* note 225.

237. *Id*.

contained no mention of abortion or abortion referrals, legislators pushed for a strict prohibition.[238] Kids Care was eventually passed in the House by an 86-67 vote after an amendment prohibiting the Board from funding "abortion related services" was adopted.[239]

After conquering the abortion hurdle in the House, the bill faced more adversity in the Senate.[240] Concerns over the program's funding resurfaced in a Senate committee.[241] Although the bill went to the full chamber for debate, the Kids Care bill died on the last day of the legislative session in an unprecedented move by the Senate.[242] Prior to floor debate three Republican senators rushed to the Secretary of State's Office and incorporated their own "Healthy Missouri Children Corporation."[243] Missouri law does not allow corporations of the same name to incorporate.[244] Before revealing that he gutted the bill at the Secretary of State's Office, Senator David Klarich offered an amendment to expand the Medicaid program to cover children in 300% FPL.[245] The amendment would lay the political foundation for the Missouri Children's Health Initiative the following session.

IV. EXPLANATION OF MISSOURI CHILDREN'S HEALTH INITIATIVE

The Children's Health Initiative builds upon Missouri's existing Medicaid program by expanding eligibility requirements to include more uninsured children, working parents, and women through new federal funds available through CHIP and a § 1115 waiver.[246] In what has been touted as a "monumental step" towards a better future for children's health, the Missouri plan innovatively combines existing systems to meet the health care needs of the gap population.[247] More children will be included in the Medicaid program and matched with a primary care provider to coordinate all health services.[248]

238. *Id*.

239. *Id*. After two and a half hours of debate, the amendment was adopted by a 137-10 vote. *Id*.

240. *See Missouri Senate Panel Votes*, *supra* note 233.

241. *Id*.

242. Nicole Ziegler, *Carnahan Calls GOP Move 'Deceitful'*, ST. LOUIS POST DISPATCH, May 17, 1997, at 14.

243. *Id*. The Senators were David Klarich (R-Ballwin), Peter Kinder (R-Cape Girardeau), and Bill Kenney (R-Lee's Summit). *Id*.

244. MO. REV. STAT. § 351.110(3) (1994).

245. Vadner, *supra* note 10.

246. Unites States Department of Health and Human Services, Press Rel., *HHS Approves Missouri Plan to Insure More Children* (visited Nov. 22, 1999) <http://www.os.dhhs.gov/news/press/1998pres/980428a.html> [hereinafter *HHS Approves Missouri Plan*].

247. *Carnahan Signs*, *supra* note 143.

248. Missouri Department of Social Services, *MC+ for Kids Fact Sheet* (on file with author). These children will receive all medically necessary services including preventative care and

Specifically, the Children's Health Initiative targets children whose family income does not exceed 300% FPL and who are without health insurance for six months.[249] Children under the age of nineteen who meet these criteria will receive health benefits through the Medicaid program.[250] State officials estimate that more than 90,000 children will benefit from the plan.[251] Although the program focuses on children, more than 80,000 adults moving from welfare to work will keep their Medicaid benefits through the state's § 1115 waiver.[252] In addition, the waiver allows pregnant women eligible for Medicaid maternity benefits to continue receiving family planning services for two years following the birth of their children.[253]

This omnibus health access program receives funding from three significant sources.[254] The success of Missouri's Medicaid managed care delivery system ("MC+") and § 1115 waiver will generate much of the state funding.[255] The state will contribute an additional $20 million to the program annually.[256] Combined with CHIP funding, more than $100 million are available to fund the program in the first year alone.[257] Premiums and co-pays from upper income beneficiaries will cover the remaining costs.[258]

The sections that follow analyze the Missouri Children's Health Initiative in detail, describing the existing infrastructure, the SCHIP provisions of the 1997 BBA, and Missouri's § 1115 Medicaid waiver. Finally, this section will address political forces that led to the plan's adoption.

A. Medicaid in Missouri

specialized therapies, including behavioral health services. Additionally, the program will benefit parents transitioning form welfare to work. *Id*.

249. *Id*. Families within the 300% threshold include: a family of three earning $39,990 per year; a family of four earning $48,150; and a family of five earning $56,310.

250. S.B. 632.

251. *See Carnahan Signs*, *supra* note 143 (comments of Governor Carnahan).

252. *See HHS Approves Missouri Plan*, *supra* note 246. Without the waiver, federal law would discontinue Medicaid benefits after one year for workers moving off the welfare rolls. *Id*.

253. Section 1115 Waiver Amendment, *supra* note 13, at 9.

254. These include savings from welfare reform and MC+, the state's approved § 1115 waiver, and CHIP funds. These sources are discussed *infra* notes 259-302 and accompanying text.

255. Bell, *supra* note 1.

256. *Id*.

257. The BBA has generated an additional $51 million dollars annually for Missouri's child health plan. *See HHS Approves Missouri Plan*, *supra* note 246; Savings from the § 1115 waiver and decreased welfare dependency contributed the remaining funds. Bell, *supra* note 1.

258. Virginia Young, *Missouri Gets Federal Approval for Plan to Expand Medicaid to Cover Thousands Benefits Would be Offered to Middle-Income Families*, ST. LOUIS POST-DISPATCH, Apr. 29, 1998 at A1. Specifically, parents would pay co-pays ranging from $5 to $10 per visit and monthly premiums of $15 to $50. S.B. 632.

As mentioned above, Missouri utilizes a Medicaid managed care delivery system known as MC+.[259] Missouri acquired a § 1915(b) waiver from HHS to develop its Medicaid managed care program in 1982.[260] The program began as a demonstration project in Jackson County, Missouri serving 40,045 individuals.[261] While the Jackson County project continued to grow, Missouri Medicaid officials expanded MC+ in 1995 to include more Missouri counties.[262] Since 1982 Medicaid managed care has saved Missouri taxpayers an estimated $1.5 million per year and today serves more than 200,000 Missourians.[263] MC+ offers enrollees a standardized benefits package, a large network of providers, liberalized grievance procedures, and limited co-payments.[264] Although MC+ is mandatory for AFDC recipients in certain geographic areas, traditional fee-for-service benefits are available for certain populations.[265] Like Missouri, many states use savings from managed care to expand Medicaid eligibility.[266]

259. *See supra* note 255 and accompanying text.

260. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, OFFICE OF MANAGED CARE, MEDICAID BUREAU, NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS 53(1993) [hereinafter HHS, 1993 STATE MEDICAID].

261. *Id*. at 53-54.

262. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, OFFICE OF MANAGED CARE, 1995 NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS (1995) [hereinafter HHS, 1995 NATIONAL SUMMARY].

263. See HHS, 1993 STATE MEDICAID, *supra* note 260, at 55-56; U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, OFFICE OF MANAGED CARE, 1996 NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS 90(1996) [hereinafter HHS, 1996 NATIONAL SUMMARY]. *See also* Vadner, *supra* note 10.

264. Section 1115 Waiver Amendment, *supra* note 13, at 14-15, 44.

265. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, OFFICE OF MANAGED CARE, 1994 NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS 77 (1994). For example, those Medicaid patients who reside in nursing homes and or who have been Medicaid eligible for less than three months cannot use MC+. HHS, 1996 NATIONAL SUMMARY, *supra* note 263, at 90.

266. U.S. Dep't of Health and Human Services, Press Rel., *President Clinton Announces a Series of New Efforts to Enroll Uninsured Children in Health Insurance Programs* (visited Aug. 24, 1999) <http://www.os.dhhs.gov/news/press/1998pres/980218d.html> [hereinafter *President Clinton Announces*]. For example, Colorado, Alabama, and South Carolina have also used this approach. *Id*.

B. Missouri's Plan: CHIP under a Medicaid Expansion Model

Missouri is the first of twelve state plans to be approved for CHIP funding since the program's inception.[267] The state is using CHIP funds in tandem with its § 1115 waiver to expand the existing Medicaid program.[268] The goal of the program is to decrease the number of uninsured children by increasing Medicaid eligibility.[269] When utilizing the Medicaid expansion option, state plans must comply with requirements in the BBA and federal Medicaid law.[270]

Although generally, CHIP affords states significant flexibility, the BBA places certain requirements on state plans.[271] For example, health insurance plans must provide minimum benefits[272] and may not exclude members based upon diagnosis or pre-existing conditions.[273] Under a Medicaid expansion model, the benefits offered must comport with those required by the existing Medicaid program.[274] Additionally, once benefits are extended to children through a Medicaid expansion, if federal CHIP dollars are discontinued, the state must continue to provide coverage until the enrollee reaches age nineteen.[275] A Medicaid expansion model also triggers cost sharing protections in the Medicaid statute.[276] Any cost sharing requirements imposed must be nominal and cannot exceed five percent of a family's annual income.[277] Most notably, and important for Missouri, providers cannot deny services because of an individual's inability to pay cost sharing requirements.[278]

As stated above, CHIP provides funding to states for plans that target low-income children.[279] Because "low-income" includes only those children at 200% FPL or below, Missouri had to obtain a § 1115 waiver to fund an expansion to 300%.[280] Without the waiver Missouri would have had to design

267. *HHS Approves Missouri Plan*, *supra* note 246.

268. S.B. 632.

269. MISSOURI DIV. OF MEDICAL SERVICES, MISSOURI MEDICAID TITLE XXI STATE PLAN 1, *submitted to* HCFA Sept. 1997, *revised* Feb. 13, 1998 (on file with author).

270. *Id*.

271. *See generally* 42 U.S.C. § 1397cc(c)(2)(A)-(D) (Supp. III 1997).

272. Benefits packages must include inpatient and outpatient hospital services, doctor's surgical and medical services, lab tests and x-ray, well-baby and well-child care, and childhood immunizations. 42 U.S.C. § 1397cc(c)(2)(A)-(D).

273. 42 U.S.C. § 1397bb(b)(1)(B)(ii) (Supp. III 1997).

274. Wermuth, *supra* note 18, at 501 & n.266 (citing Abigail English, Nat'l Center for Youth Law, *Expanding Health Insurance for Children and Adolescents: A Preliminary Analysis of the Balanced Budget Act of 1997* 10 (Sept. 1997)).

275. Wermuth, *supra* note 18, at 500.

276. *Id*. at 504.

277. *Id*. at 505.

278. Section 1115 Waiver Amendment, *supra* note 13, at 16.

279. *See supra* notes 129-31 and accompanying text.

280. Section 1115 Waiver Amendment, *supra* note 13, at 13.

a new program to obtain CHIP funds.[281] The following section discusses the § 1115 waiver which allows the state to expand Medicaid through the existing MC+ program.

C. Missouri's § 1115 Waiver

Missouri filed a § 1115 waiver with HHS in 1994, the essence of which targeted a Medicaid expansion to cover uninsured children and families up to 200% of FPL.[282] HHS approved this waiver in April of 1998—four long years after the original application.[283] During this wait, the state amended its application significantly to expand benefits to uninsured children in 300% FPL through its existing Medicaid managed care system, MC+.[284] The state sought to use § 1115 to replace its existing § 1915(b) waiver and integrate the new CHIP funding into a Medicaid expansion.[285] The § 1115 waiver would continue the MC+ program, targeting children up to 300% FPL, adults transitioning from welfare to work, and uninsured women leaving Medicaid.[286]

Since 1995 the state has enjoyed success through cost-saving measures of MC+.[287] Combining savings from MC+, declining welfare rolls with new federal dollars, state officials reasoned that Medicaid could be expanded.[288] Key waiver requests were divided between service related and cost related provisions to make the expansion possible.[289] As a technical matter, the state waived service-related requirements of Medicaid like comparability, uniformity, freedom of choice, and cost-sharing that are vital to maintaining the MC+ system.[290] Also important was HCFA's acceptance of the state's

281. 42 U.S.C. § 1397aa(a).

282. Section 1115 Waiver Amendment, *supra* note 13.

283. *See HHS Approves Missouri Plan*, *supra* note 246.

284. Section 1115 Waiver Amendment, *supra* note 13, at 3.

285. *Id*.

286. *Id*.

287. *See generally* Office of the Governor, Press Rel., *Medicaid Waiver Will Help Cover More than 90,000 Children* (visited Oct. 20, 1998) <www.gov.state.mo.us/cgi-bin/news98. . .e??Than??90,000??Children:Date=04/28/1998>.

288. Telephone Interview with Greg Vadner, Director of Missouri Division of Medical Services (Jan. 25, 1999). *See generally* § 1115 Waiver Amendment, *supra* note 13 (waiver allows Missouri access $151 million in new federal funds).

289. Section 1115 Waiver Amendment, *supra* note 13.

290. A comparability waiver prevents HCFA from mandating Missouri to provide equal availability to amount, duration, and scope of services. *Id*. at 64-66; 42 U.S.C. § 1902(a)(10)(B) (1994); 42 C.F.R § 440.230-.250 (1998). Similar rationale explains waiver of uniformity and freedom of choice provisions. Uniformity would require the state to offer the same benefits to all recipients throughout the state. *See* § 1115 Waiver Amendment, *supra* note 13, at 64-66; 42 U.S.C. § 1902(a)(1) (1994); 42 CFR § 431.50 (1998). As discussed earlier, MC+, the state's primary Medicaid delivery system, is not available statewide. HHS, 1995 NATIONAL SUMMARY, *supra* note 262, at 71 (indicating a goal of providing managed care state-wide). Under freedom of choice, Medicaid recipients must have "free choice" of providers. 42 U.S.C. §

waiver of upper income limitations which allowed Medicaid to expand to 300% of the federal poverty level.[291]

Politically, the waiver was important to maintaining Missouri's current funding system.[292] Encoded in the § 1115 waiver amendment is a request that HHS "validate Missouri's current funding base and revenue sources."[293] This seemingly innocuous language refers to Missouri's permissive hospital tax authorized under federal Medicaid regulations.[294] Federal regulations allow states to impose a tax on certain health providers without decreasing federal contribution to the Medicaid program.[295] In the early 1990's, Missouri was drawing down an estimated $600 million dollars through this tax.[296] This money was used to serve the uninsured population in disproportionate share hospitals.[297]

HCFA became suspicious of this funding structure and investigated Missouri's hospital tax for several years.[298] Eventually, the issue became a stalling point in the state's § 1115 waiver.[299] For this reason, high-ranking state officials intervened in the waiver process in hopes of gaining approval.[300] During this same time, President Clinton directed HHS and HCFA to streamline the waiver process to improve efficiency.[301] Eventually, the state reached an agreement with HCFA to promulgate a regulation that certified the legality of the tax structure.[302] In this respect, politics influenced approval of Missouri's § 1115 waiver.

1902(a)(23)(1994); 42 CFR § 431.51 (1998). Because MC+ and managed care operate under provider networks, the freedom of choice requirement is incompatible with the established delivery system. *See id.* Instead, Medicaid recipients have "free choice" among health plans, in effect giving them access to all Medicaid providers. *Id.* Another key requirement for MC+ is the capitation contract provision under cost related waivers. HHS, 1996 NATIONAL SUMMARY, *supra* note 263, at 78. MC+ like most managed care systems operates under a capitated reimbursement system. *Id.* If not waived, the capitation contract provision would circumvent the provider reimbursement system which is vital to the existing MC+ system. *Id.*

291. Section 1115 Waiver Amendment, *supra* note 13.

292. Telephone Interview with Greg Vadner, *supra* note 288.

293. Section 1115 Waiver Amendment, *supra* note 13, at 1.

294. *See* 42 C.F.R. § 433.68 (1997).

295. *See* 42 C.F.R. § 433.57 (1997). Funds generated under a permissive provider tax structure will not be calculated against the state, thus drawing down more federal dollars. *Id.*

296. Telephone Interview with Greg Vadner, *supra* note 288.

297. *Id.* Disproportionate Share Hospitals ("DSH") are hospitals that serve more than the geographical average of uninsured patients. 42 C.F.R. § 447.53 (1997).

298. Telephone Interview with Greg Vadner, *supra* note 288.

299. *Id.*

300. Interview with Mike Hartmann, *supra* note 82. Governor Carnahan, realizing the waiver was vital to the state's future, worked with the Vice President and President's office to expedite the waiver process. *Id.*

301. *See generally President Clinton Announces*, *supra* note 266.

302. Telephone interview with Greg Vadner, *supra* note 288.

D. Political Forces Behind the Missouri Children's Health Initiative

Because the Children's Health Initiative involved the allocation of new federal funds and significantly altered an existing program, legislative approval was required to implement the plan.[303] The most hotly debated aspects of the plan included the upper income eligibility[304] and cost sharing requirements.[305] Opponents of the plan attacked the expansion to 300% stating that wealthier parents would drop existing coverage and "buy a big-screen TV instead" of paying for health insurance.[306] As a precaution, several provisions of the bill limit the practice of dropping private coverage to get public benefits, known as "crowd out."[307]

Additionally, the issue of cost-sharing became a sticking point for many legislators.[308] Republicans argued over the amount of premiums for wealthier families, eventually settling on an amount equal to the average co-payments and premiums allotted by the Missouri consolidated health care plan (the state employee insurance package).[309] For example, families earning up to 185% of the FPL are exempted from co-payment requirements.[310] Families earning between 226% and 300% of FPL must pay $65 monthly premiums and $10 co-payments.[311] Even with these cost-sharing requirements, legislators struggled to accept the expansion to 300% FPL.

Further, the plan faced criticism that an expansion to 300% FPL amounted to an entitlement.[312] Opponents argued that if unsuccessful, Missouri would be stuck with a program it can't afford and "become the next Soviet Union."[313] Although federal funds are guaranteed until the year 2007, Missouri legislators

303. Young, *supra* note 258.

304. Upper income eligibility refers to children in families who earn less than 300% FPL. *See* S.B. 632.

305. Interview with Mike Hartmann, *supra* note 302.

306. Young, *supra* note 258 (quoting Rep. Pat Naeger (R-Perryville)).

307. Section 1115 Waiver Amendment, *supra* note 13, at 15. For example, children in upper incomes are eligible for benefits only if they have been uninsured for six months. Additionally, parents must provide proof that their children were denied coverage from private insurers. S.B. 632.

308. Senator Betty Sims (R-Ladue) endorsed adding premiums and co-payments to the Bill. Bill Bell, Jr., *Compromise Accelerates Bill to Expand Medicaid*, ST. LOUIS POST-DISPATCH, May 13, 1998, at A1.

309. S.B. 632.

310. *See* MC+ for Kids Fact Sheet, *supra* note 248.

311. *Id.*

312. Senator Larry Rohrbach, for example, categorized the initiative as creating a social welfare state that would be impossible to dismantle. Bell, *Senate Stalls*, *supra* note 5.

313. Bell, *supra* note 1.

were reluctant to commit to a plan that may not get federal support in the future.[314]

Interestingly, the same plan to expand Medicaid to 300% FPL was approved by Republicans during the debate over the Healthy Missouri Children's Corporation in the 1997 session.[315] Carnahan challenged the Senate to a straight vote on the measure stating that those who filibustered the program "do not want to cover our uninsured children, but they do not have the political courage to admit that straight up."[316] The press that followed Governor Carnahan's counterattack noted this contradiction.[317] Eventually, the General Assembly was able to pass the measure at the end of the legislative session.[318]

V. MISSOURI CHILDREN'S HEALTH INITIATIVE: A PRODUCT OF POLITICS

The Missouri Children's Health Initiative, specifically the Medicaid expansion component, has faced criticism on many levels. Most notably the expansion has been criticized by those who believe the state has created a middle class entitlement, pushing a covert agenda towards universal coverage.[319] This section of the comment addresses those criticisms arguing that as a product of the Democratic process, Children's Health Initiative reflects partisan politics in Missouri.

It is no secret that throughout the 1990's health reform has been a priority of the state.[320] As discussed *supra* part III, the legislature has undertaken several plans to reform health care in Missouri.[321] At least two of these reform efforts required no state funding.[322] These plans were not approved by the legislature.[323] On the contrary, the General Assembly approved two programs authorizing an expansion of the Medicaid program.[324] While conservatives criticize the expansions as a covert operation toward universal coverage, the

314. *Id*. Rep Bill Linton (R-Wildwood) opposed the bill fearing the state would be stuck with the program if federal funding ends. *Id*.

315. Scott Charton, *Carnahan Assails GOP on Insurance Proposal They're Fighting Plan They Backed Before, He Says*, ST. LOUIS POST-DISPATCH, May 10, 1998, at D3.

316. *Id*. (quoting Governor Mel Carnahan).

317. *Id*.

318. Bell, *supra* note 1.

319. Charton, *supra* note 315 (explaining that Republicans worry that the proposed income eligibility will induce the middle class to drop private insurance in favor of Medicaid).

320. *See generally* H.B. 564; H.B. 191; H.B. 1622 and H.B. 811.

321. *Id*.

322. *See generally* H.B. 1622 and H.B. 811.

323. *Id*.

324. *See generally* H.B. 564 and S.B. 632.

Medicaid expansions were the only health reform bills the bipartisan legislature would pass.[325]

A. A Middle-Class Entitlement?

Critics of the Children's Health Initiative oppose the expansion as a middle-class entitlement outside the scope of the Medicaid program.[326] They argue that when enacted, Congress intended for Medicaid to serve the needy[327] and therefore, an expansion to 300% FPL goes beyond the program's original purpose. Although not intended as insurance for the middle class, one Missouri official believes that in the wake of welfare reform and corporate downsizing, expansions of Medicaid and Medicare are the logical solution to the health care crisis.[328] He notes, as do other commentators, that the United States is the only industrialized country besides South Africa that does not provide universal coverage.[329] Further, although serving families in higher income levels may surpass Congress' original intent for Medicaid coverage, subsequent amendments to the statute suggest the definition of needy has changed.[330] Thus, the Missouri plan reflects federal policies that target the uninsured.

As discussed *supra* part IV, conservatives in Missouri resisted the expansion to 300% FPL as a middle class entitlement.[331] During debate over Senate Bill 632, legislators feared middle-income Missourians would drop their private insurance to take advantage of attractive Medicaid benefits.[332] Cost-sharing requirements and anti-crowd out provisions in Senate Bill 632 represent a compromise to that faction. Under these protections, families earning between within the 226-300% FPL must demonstrate that they are without access to affordable employer-sponsored health care and cannot enroll in the program without proof they sought coverage from at least two insurance carriers.[333] Additionally, if those enrolled in the program fail to pay a premium or co-payment, they are dropped from the program for six months.[334] These "protections" defy provisions in federal Medicaid law and the BBA and may fall under scrutiny from advocacy groups or the courts.[335]

325. *Id*.; Bell, *supra* note 1.

326. *See supra* notes 312-14 and accompanying text.

327. *See supra* note 40-43 and accompanying text. Therefore eligibility requirements were set at 133% of FPL. *Id*.

328. Vadner, *supra* note 10.

329. *Id*.

330. *See supra* notes 58-61.

331. *See supra* note 312 and accompanying text.

332. *Id*.

333. S.B. 632 (codified as amended at MO. REV. STAT. § 208.185).

334. *Id*.

335. *See supra* notes 46-49 and accompanying text.

B. Health Reform in Missouri: A Product of Partisan Politics

As discussed *supra* section III, throughout Missouri's recent political history the legislature steadfastly opposed the suggestion of providing universal coverage.[336] Whether as a response to the insurance industry, the pro-life lobby or mere political maneuvering, legislators from both parties have allowed politics to interfere with health reform.

Attempts to restructure the insurance industry at little or no cost to the state were rejected under the force of the insurance lobby.[337] House Bill 811, which received heavy support from insurers and required no state funding, failed in a juvenile prank by Republican senators.[338] Ironically, the Legislature had few problems approving expansions of the Medicaid program. Aside from fears of creating a welfare state, the legislature has allowed the pro-life lobby to increase the cost of doing business in Jefferson City.

Health reform has been paralyzed by a mentality of abortion-referral paranoia. Specifically, pro-life legislators from both sides of the aisle consistently derailed or detained valuable health legislation to engage in unrelated fights over abortion.[339] Instead of standing firm against the powerful pro-life lobby, legislators submitted to single-issue politics fearing a challenge on Election Day. There is no measure of how much these tactics cost the state each year.

Finally, conservatives in both houses of the General Assembly have been quick to criticize plans to improve health care in Missouri without offering any alternate solutions. Although this faction recognizes access to health insurance as problem of national importance, they have thrown up roadblocks to reform each session. If legislators had the interests of the uninsured working poor and taxpayers at the forefront of their policy debates, Missouri would have had affordable health reform years ago.

336. *See supra* notes 146-222 and accompanying text.
337. *See supra* notes 222-45 and accompanying text.
338. *See supra* notes 242-44 and accompanying text.
339. *See supra* notes 146-246 and accompanying text.

IV. CONCLUSION

Without a doubt, Missouri's Medicaid expansion is a victory for all children and families. Governor Carnahan considers passage of the Children's Health initiative as one of his finest victories for Missouri children.[340] The plan was in the works for four years and was the centerpiece for Carnahan's 1998 legislative package.[341] Estimates tally 90,000 children, previously uninsured, will receive coverage through the initiative.[342] Hopefully, other state legislatures will be able to put politics aside and lend a hand to the other ten million uninsured children in the United States.

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340. *See Press Release, Medicaid Waiver Will Help Cover More than 90,000 Children*, *supra* note 287.

341. *Id.*

342. *Id.*

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