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.”

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. Traditionally, the Medicaid program served as a safety net for many of the uninsured. Even with expanded eligibility requirements, some families find they are too rich for Medicaid, yet too poor for private insurance. Until recently, 91,301 Missouri children like Kyle Koenig were not eligible for Medicaid benefits because their parents earned too much money. In May of 1998 the Missouri legislature approved a plan to expand Medicaid coverage to children in 300% of the federal poverty level ("FPL"). The U.S. Census Bureau set the FPL at an annual income of $16,050 to support a family of


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


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

four. 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

8. Bell, Senate Stalls, supra note 5.
10. Interview with Greg Vadner, Director, Missouri Division of Medicaid Services, in St. Louis, Mo. (Oct. 16, 1998).
Seventeen percent come from non-working families. Most uninsured children live in low to middle-income households. At low-income levels (below $30,000), the number of uninsured Caucasian pre-school children surpassed uninsured African-American children.

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

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. 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.
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. Twenty-two million workers in the American workforce do not have insurance. For children, this statistic translates into about three out of five living in two parent households where at least one parent works full time. Two-thirds of families with uninsured children have incomes above the federal poverty level.

Recent statistics show that only sixty-five percent of children are covered by private insurance—the sharpest decrease in eight years. 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. The economic recession of the 1980’s and early 1990’s, which forced cutbacks in employer provided health insurance, contributed significantly to this statistic. In 1994, only thirty-seven percent of children with a parent working full time had access to employer-provided health insurance.

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. Only forty-two percent of low-wage workers receive health benefits through their employer. In these jobs, health insurance is either not offered by the employer or is available at a high cost to workers. 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. Most employees with employer-provided insurance pay part of their health benefits

28. Id.
29. See GAO/HEHS 96-129, supra note 2, at 4.
30. Id. at 7.
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.
at an average cost of $1,900 per year.\textsuperscript{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.

\textit{B. Medicaid}

Medicaid is a social welfare program\textsuperscript{38} that provides health care benefits for the poor, pregnant women and their children, the elderly and permanently disabled persons.\textsuperscript{39} Formed in 1965 as an amendment to the Social Security Act,\textsuperscript{40} Medicaid developed as an expansion of the federal welfare program with a goal of increasing access to health care for specific disadvantaged groups.\textsuperscript{41} It has evolved as a federal-state partnership that finances medical services for eligible beneficiaries.\textsuperscript{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.\textsuperscript{43} However, federal law ultimately governs Medicaid.\textsuperscript{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.”\textsuperscript{45} The statute offers states a long list of optional services to include in their Medicaid plan and mandates minimum eligibility requirements.\textsuperscript{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

\begin{itemize}
\item \textsuperscript{37} Id.
\item \textsuperscript{38} \textit{Furrow et al.}, \textit{supra} note 25, at 684.
\item \textsuperscript{39} 42 U.S.C. § 1396 (1994).
\item \textsuperscript{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.
\item \textsuperscript{41} Colleen A. Foley, \textit{The Doctor Will See You Now: Medicaid Managed Care and Indigent Children}, 21 \textit{Seton Hall Legis. J.} 93, 97 (1997).
\item \textsuperscript{42} Id.
\item \textsuperscript{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. \textit{Id.} at 97-98.
\item \textsuperscript{44} \textit{Furrow et al.}, \textit{supra} note 25, at 865. \textit{See generally} 42 U.S.C. § 1396(a) (1994).
\item \textsuperscript{45} 42 U.S.C. § 1396 (1994).
\item \textsuperscript{46} \textit{Furrow et al.}, \textit{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).
\end{itemize}
strictly regulated and monitored by HHS. The statute also protects beneficiaries’ “free choice” of providers. States have the ability to “opt out” of these and other federal requirements through a waiver provision in the statute.

1. Eligibility Criteria

Historically, Medicaid eligibility has been linked to economic need. Initially, the program targeted the “deserving poor” and children whose families received Aid to Families with Dependent Children assistance (“AFDC”). The statute created two eligibility groups: the “categorically needy,” and the “medically needy.” 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. States may also classify as “categorically needy” those individuals who financially qualify for AFDC or SSI but are not eligible for other reasons. States have additional discretion regarding eligibility of the “medically needy.” In general, the medically needy fall within income brackets significantly above AFDC or SSI criteria but far below their ability to pay medical costs. 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. 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.
50. FURROW ET AL., supra note 25, at 865.
51. See infra notes 106-119 and accompanying text.
53. Foley, supra note 41, at 99.
55. States have discretion as to whether to include these individuals. Foley, supra note 41, at 100.
57. See Foley, supra note 41, at 101.
58. See GAO/HEHS 96-129, supra note 2, at 6; see 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.\(^51\)

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 benefits.


\(^60\) 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.


\(^64\) 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.\textsuperscript{70} Under the PRA, those receiving TANF assistance must work in order for the state to obtain a federal block grant.\textsuperscript{71} Although the statute enumerates several activities that meet the definition of work, states may formulate their own requirements.\textsuperscript{72} The PRA links future federal block grants to states satisfying work participation requirements.\textsuperscript{73} Beginning in 1997, receipt of federal dollars was contingent upon states demonstrating an increase in work participation of those families receiving assistance.\textsuperscript{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).\textsuperscript{75} Although the PRA dissolved this marriage, states must act as if it had not.\textsuperscript{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.\textsuperscript{77} This feature, known as “delinking,” promises to protect families moving from welfare to work.\textsuperscript{78} This section of the statute also allows states to raise their Medicaid eligibility rules to cover more working families.\textsuperscript{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.\textsuperscript{80} Therefore, many of those who take low-wage jobs that do not provide health insurance benefits will not receive permanent

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

\textsuperscript{71} Mannix et al., supra note 63, at 881.

\textsuperscript{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.

\textsuperscript{73} Id. at 881.

\textsuperscript{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.


\textsuperscript{76} Id. at 1009.


\textsuperscript{79} Id. at 531.

\textsuperscript{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.
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.
100. Foley, supra note 41, at 121.
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. Specifically, section 1915(b) waivers allow states to waive Medicaid requirements governing freedom of choice and home and community-based care. These waivers encourage long-term policy changes as compared to the research-based focus of § 1115 waivers discussed below. 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. Although § 1915(b) waivers typically favor state autonomy, HHS affords the Health Care Financing Administration (“HCFA”) substantive review powers.

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. The legislative history of § 1115 waiver provisions reveals that Congress intended to limit these waivers to experimental or demonstration projects. 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.

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. Because Congress intended § 1115 waivers to support demonstration or research based projects, HHS requires significant planning and analysis before a waiver is approved. The Health Care

107. *Id.* at 233.
108. *Id.* 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.
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.\textsuperscript{116} Although the Clinton administration has made efforts to streamline the process,\textsuperscript{117} review of § 1115 waivers involves complex bureaucratic procedures that often inhibit the development of “innovative solutions.”\textsuperscript{118} Also, because the process involves a federal bureaucracy, review of waiver applications is often political.\textsuperscript{119}

\textit{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.\textsuperscript{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.\textsuperscript{121} The funds will be available to states through block grants in approximately $4 billion dollar increments until the year 2007.\textsuperscript{122}

To obtain CHIP funds, states must submit a Child Health Plan to HHS for approval.\textsuperscript{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-

\begin{itemize}
  \item In addition, states must include an analysis of the project’s effect on that state’s Medicaid budget (the “budget neutrality rule”). \textit{Id.}
  \item \textsuperscript{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. \textit{Id.} at 227-32 & n.50.
  \item \textsuperscript{117} Note, \textit{The Impact of Medicaid Managed Care on the Uninsured}, 110 HARV. L. REV. 751, 755 (1997).
  \item \textsuperscript{118} Anderson, \textit{supra} note 106, at 225.
  \item \textsuperscript{119} For example, HCFA’s broad discretionary powers allow for withdrawal of a waiver at any time. 45 C.F.R. § 92.43 (1993).
  \item \textsuperscript{120} \textit{Clinton Backs Medicaid Plan to Insure Children}, ST. LOUIS POST-DISPATCH, June 18, 1997, \textit{available in 1997 WL 3349218.}
  \item \textsuperscript{122} Wermuth, \textit{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).
  \item \textsuperscript{123} 42 U.S.C. § 1397aa(b) (Supp. III 1997).\end{itemize}
income children through a Medicaid expansion and new plan.\textsuperscript{124} Unlike Medicaid, CHIP imposes only minimal restrictions on state plans.\textsuperscript{125} Programs must target low-income children who are under age nineteen.\textsuperscript{126} In addition, the BBA also allows states to decide policies for eligibility criteria, benefits, and cost sharing requirements.\textsuperscript{127} Most importantly, states can utilize Medicaid Managed Care as a cost-containment strategy without obtaining a $1115 waiver.\textsuperscript{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.\textsuperscript{129} Low-income is defined as children in families at or below 200% FPL, unless the state increased Medicaid eligibility above 150% FPL.\textsuperscript{130} If a state sets higher Medicaid eligibility, the ceiling for CHIP may exceed 200%.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{134} In this sense, CHIP targets the gap population.

\textsuperscript{124} HHS PRESS RELEASE, supra note 121. See 42 U.S.C. § 1397aa(a) (Supp. III 1997).
\textsuperscript{125} HHS PRESS RELEASE, supra note 121.
\textsuperscript{127} 42 U.S.C. § 1397bb(b) (Supp. III 1997).
\textsuperscript{128} Wermuth, supra note 18, at 494-95.
\textsuperscript{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).
\textsuperscript{130} 42 U.S.C. § 1397jj(b)(1)-(2) (Supp. III 1997).
\textsuperscript{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.
\textsuperscript{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

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(e)(1)(A)-(D) (Supp. III 1997).
139. See supra notes 47-49.
142. S.B. 632, supra note 6.
or underinsured children and families. Until recently, many of these attempts were unsuccessful, combated by various coalitions who opposed any change in the status quo. 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. 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. Many of the uninsured resided in rural or otherwise underserved areas limiting their access to health providers. 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. 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. The findings of these groups provided the basis for much of the 1993 health legislation in Missouri. Specifically, two competing programs emerged during the 1993 session: a universal coverage bill and a bill promoting increased access.

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. 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].
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.
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.\textsuperscript{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.\textsuperscript{156} Increases on payroll and income taxes would fund the program.\textsuperscript{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.\textsuperscript{158}

A more moderate proposal, House Bill 564, known as the “access bill,”\textsuperscript{159} promised to extend availability of health care to more than 600,000 Missourians.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{163} The bill made additional Medicaid funding available for school health clinics that were to serve as a source of primary care for students.\textsuperscript{164} A statewide increase on alcohol and tobacco taxes and increased federal matching funds available through Medicaid funded these programs.\textsuperscript{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.\textsuperscript{166} The bill authorized advanced
practice nurses, nurse practitioners, and physician assistants to enter into written collaborative practice agreements with physicians to provide primary care and preventative health services. The program authorized physicians to develop written protocols to guide other health professionals in providing treatment. This guidance would relieve the nurses’ fear of prosecution by the State Board of Healing Arts for engaging in the unauthorized practice of medicine.

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

House Bill 564 also focused on increasing physician services to the poor and underserved populations. Specifically, the bill incorporated financial incentive arrangements for physicians serving resource shortage areas and removed the threat of malpractice suits for health providers who provided free care. The Health Access Incentive Fund earmarked funds to repay physicians’ student loans, provide liability insurance, scholarships, and technical assistance. The Missouri State Medical Association noted that physicians wanted to provide free care to the poor but were discouraged by the threat of lawsuits. 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. These programs promised to draw physicians into sixty areas in desperate need of medical services.

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).
179. Young, supra note 164.
These visionary programs would potentially extend access to health care to more than 600,000 Missourians. 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. In Missouri, the Speaker of the House controls the flow of legislation including appointing committee chairs, assigning bills to committees, and scheduling floor debate. Thus, Griffin’s sponsorship elevated the prestige and priority of the bill. Additionally, the bill received support from the Missouri Hospital Association, the Missouri Nurses’ Association, the Missouri Catholic Conference, and the Missouri State Labor Council.

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. Conservative senators won the abortion battle with an amendment that required parental consent before school health clinics could provide family planning services. Additionally, the bill faced opposition from the alcohol and tobacco industries who lobbied against the increase on excise taxes. The General Assembly reached a compromise on the abortion issue but made no concessions to lobbyists on the taxes.

The bill was approved by the General Assembly on May 11, 1993 and sent to the Governor for signing. 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.

180. Sentell, supra note 165.
181. H.B. 564 (Mo. 1993).
183. Sentell, supra note 165. According to health industry officials, Griffin’s sponsorship elevated health reform to its highest profile in years. Id.
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 networks198 (“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

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.
194. Compare SHOWME HEALTH REFORM, supra note 146, with H.B. 1622 (Mo. 1994).
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.
203. Id.
standard benefits packages. ISNs would set premiums based upon average costs from five geographic regions throughout the state. This would come to be known as “community rating” and was among the more controversial provisions of the bill.

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. 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. Thus, ISNs would control costs through market competition. Insurance industry officials warned that restructuring would force them to consider withdrawing from the Missouri market. To prevent such drastic consequences, the industry hired thirteen lobbyists to twist arms. Additionally, the industry successfully enlisted the help of Republican Senator Franc Flotron who pushed twenty-two amendments written by General America Insurance Company.

The Integrated Service Networks provision attracted more controversy from providers who resisted taking on administrative tasks. Physicians opposed the measure as a conflict of interest requiring them to practice “cookbook medicine.” 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?” Interestingly enough, among the bill’s chief supporters was the Missouri Hospital Association who endorsed the bill as a step in the right direction.

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.
208. Murphy, supra note 192.
209. Herrick, supra note 207.
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. Worried about its ultimate fate, Governor Carnahan met with then-Senate Majority Leader J.B. “Jet” Banks to develop compromise language. Responding to pressure from the insurance industry, Senator Banks agreed to bring the bill to a vote if the community rating provision was amended. Specifically, the new language allowed big business to opt out of community rating and offer instead self-insured plans. 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. 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. In 1997, an estimated 175,000 Missouri children had no health insurance coverage. As a result, these children had limited access to primary care and preventative health services. House Bill 811, dubbed “Kids Care,” copied a Florida plan to pool uninsured children together in order to negotiate competitive benefit packages with insurers. 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.

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.
224. Id.
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” to place children in an insurance pool and spread risk in order to negotiate competitive premiums from HMOs and insurance companies. Because parents or employers would pay premiums, the corporation would require no state funding. Additionally, the state received financial support from the Robert Wood Johnson Foundation in the form of a planning grant. If approved, House Bill 811 would draw an additional $3 million dollars from the Foundation for implementation. Under the plan, more than 115,000 Missouri children would have the option to receive affordable health insurance benefits. Although the bill called for no state appropriation, critics categorized the bill as a hidden agenda toward a government subsidized insurance program. This accusation angered Governor Carnahan and other proponents of the measure because critics grossly misrepresented the program. “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.’”

Additionally, the bill faced tough opposition from conservatives on both sides of the aisle on the abortion issue. 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. Although the bill

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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.


231. Linton, supra note 230.

232. See Bell, supra note 225.


234. Young, supra note 225.

235. Id.

236. Id.

237. Id.
contained no mention of abortion or abortion referrals, legislators pushed for a strict prohibition.\footnote{Id.} 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.\footnote{Id.}

After conquering the abortion hurdle in the House, the bill faced more adversity in the Senate.\footnote{See Missouri Senate Panel Votes, supra note 233.} Concerns over the program’s funding resurfaced in a Senate committee.\footnote{Id.} 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.\footnote{Nicole Ziegler, Carnahan Calls GOP Move ‘Deceitful’, ST. LOUIS POST DISPATCH, May 17, 1997, at 14.} Prior to floor debate three Republican senators rushed to the Secretary of State’s Office and incorporated their own “Healthy Missouri Children Corporation.”\footnote{Id. The Senators were David Klarich (R-Ballwin), Peter Kinder (R-Cape Girardeau), and Bill Kenney (R-Lee’s Summit). Id.} Missouri law does not allow corporations of the same name to incorporate.\footnote{MO. REV. STAT. § 351.110(3) (1994).} 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.\footnote{Vadner, supra note 10.} The amendment would lay the political foundation for the Missouri Children’s Health Initiative the following session.

\section*{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.\footnote{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].} 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.\footnote{Carnahan Signs, supra note 143.} More children will be included in the Medicaid program and matched with a primary care provider to coordinate all health services.\footnote{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 from 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 Missourian 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+. Missouri acquired a § 1915(b) waiver from HHS to develop its Medicaid managed care program in 1982. The program began as a demonstration project in Jackson County, Missouri serving 40,045 individuals. While the Jackson County project continued to grow, Missouri Medicaid officials expanded MC+ in 1995 to include more Missouri counties. Since 1982 Medicaid managed care has saved Missouri taxpayers an estimated $1.5 million per year and today serves more than 200,000 Missourians. MC+ offers enrollees a standardized benefits package, a large network of providers, liberalized grievance procedures, and limited co-payments. Although MC+ is mandatory for AFDC recipients in certain geographic areas, traditional fee-for-service benefits are available for certain populations. Like Missouri, many states use savings from managed care to expand Medicaid eligibility.

259. See supra note 255 and accompanying text.


261. Id. at 53-54.


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.\footnote{267}{HHS Approves Missouri Plan, supra note 246.} The state is using CHIP funds in tandem with its § 1115 waiver to expand the existing Medicaid program.\footnote{268}{S.B. 632.} The goal of the program is to decrease the number of uninsured children by increasing Medicaid eligibility.\footnote{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).} When utilizing the Medicaid expansion option, state plans must comply with requirements in the BBA and federal Medicaid law.\footnote{270}{Id.}

Although generally, CHIP affords states significant flexibility, the BBA places certain requirements on state plans.\footnote{271}{See generally 42 U.S.C. § 1397cc(c)(2)(A)-(D) (Supp. III 1997).} For example, health insurance plans must provide minimum benefits\footnote{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).} and may not exclude members based upon diagnosis or pre-existing conditions.\footnote{273}{42 U.S.C. § 1397bb(b)(1)(B)(ii) (Supp. III 1997).} Under a Medicaid expansion model, the benefits offered must comport with those required by the existing Medicaid program.\footnote{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)).} 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.\footnote{275}{Wermuth, supra note 18, at 500.} A Medicaid expansion model also triggers cost sharing protections in the Medicaid statute.\footnote{276}{Id. at 504.} Any cost sharing requirements imposed must be nominal and cannot exceed five percent of a family’s annual income.\footnote{277}{Id. at 505.} Most notably, and important for Missouri, providers cannot deny services because of an individual’s inability to pay cost sharing requirements.\footnote{278}{Section 1115 Waiver Amendment, supra note 13, at 16.}

As stated above, CHIP provides funding to states for plans that target low-income children.\footnote{279}{See supra notes 129-31 and accompanying text.} 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%.\footnote{280}{Section 1115 Waiver Amendment, supra note 13, at 13.} Without the waiver Missouri would have had to design...
a new program to obtain CHIP funds. 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. HHS approved this waiver in April of 1998—four long years after the original application. 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+. The state sought to use § 1115 to replace its existing §1915(b) waiver and integrate the new CHIP funding into a Medicaid expansion. 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.

Since 1995 the state has enjoyed success through cost-saving measures of MC+. Combining savings from MC+, declining welfare rolls with new federal dollars, state officials reasoned that Medicaid could be expanded. Key waiver requests were divided between service related and cost related provisions to make the expansion possible. 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. Also important was HCFA’s acceptance of the state’s

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.  
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.
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.
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).
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 needy327 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.
329. Id.
330. See supra notes 58-61.
331. See supra note 312 and accompanying text.
332. Id.
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. 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. House Bill 811, which received heavy support from insurers and required no state funding, failed in a juvenile prank by Republican senators. 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. 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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