



Children's Health Care: The Missouri Perspective

Vision

In the fall of 2003, Citizens for Missouri's Children (CMC) convened a small group of people to participate in a "thought leaders session" to discuss the challenging issue of providing health care for all children in Missouri. The participants were chosen because they represent fore-runners in the field of health and CMC believed they shared the organization's values and vision and would contribute greatly to a wide-ranging discussion of the issues. The participants voiced only their own opinions during the session and not necessarily those of their organizations.

CMC's vision is for all children in the state of Missouri to receive high quality health care by 2014. The goal of the thought leaders session was to discuss what direction public policy should take in order to achieve this goal as well as to describe what this health care system would look like once implemented. This policy brief summarizes what CMC ascertained from the thought leaders session.

CMC, along with many child advocates and others, has worked to improve health care access for Missouri children for many years. Incremental gains have been made, most notably the 1998 implementation of the State Children's Health Insurance Program (SCHIP), called MC+ in Missouri. This program provides health insurance to children in households with incomes up to 300% of the federal poverty level who do not have access to other insurance. The other federal/state funded public health insurance program is Medicaid, authorized by federal legislation in 1965. It provides health care access to certain individuals and families with low incomes and resources. Since that time, legislative options and mandates have expanded the categories of eligibility to include Medicaid coverage for children and pregnant women in poverty, refugees, and children in state care. However, even with these public health insurance programs, there are still over 500,000 uninsured Missourians, including 90,000 children.¹

The Crisis of the Uninsured

Why is this the time to be contemplating health care reform? The percentage of people without health insurance is rising. Total health expenditures are rising along with the cost of health insurance premiums. Access to health insurance coverage through employers is decreasing while the pressure on public health care systems mounts. Even though the U.S. spends more on health care than any other industrialized nation, many health outcomes for children and adults are poor. CMC believes we have reached a crisis point. The time is now to begin discussing how to increase access to health care for Missouri's children.

The Crisis of the Uninsured

- ◆ Rising Rates of Uninsured Citizens
- ◆ Increasing Costs of Health Care
- ◆ Cost of Premiums Rising
- ◆ Access to Employer-Sponsored Insurance Decreasing
- ◆ Public Health System at Risk
- ◆ Health Outcomes Poor

45 million people are without health insurance in the U.S. including 8.5 million children

The United States has an incredibly complex health care financing system. Americans obtain health insurance coverage in many ways: through employers; the federal government; state programs; the military and other means. Payment for coverage comes from state and federal taxes, by individuals, and through employer-sponsored programs. Yet, in 2003 the percentage of the U.S. population without health insurance reached 15.6% up from 14.6% in 2001.²

In Missouri for the years 2001-2003, an average 10.9% of the total population was without health insurance cover-

age for the entire year, approximately 609,000 people.³ For the years 2000-2001, about six percent of all Missouri children were uninsured, approximately 90,000 children.⁴

Being uninsured is not just a problem for non-working or low-income families. About twenty-five percent of uninsured children lived in families with incomes above 250% of the federal poverty line, which equates to a little above \$47,000 in 2004 for a family of four.⁵ Most uninsured Americans are in working families.⁶ (See figure 1.)

Most uninsured Missourians (83 percent) have at least one person in the family who works either full- or part-time. Many uninsured Missourians (50 percent) have family members who work full-time for the entire year.⁷

The cost of health care is on the rise: \$1.6 trillion spent in 2002

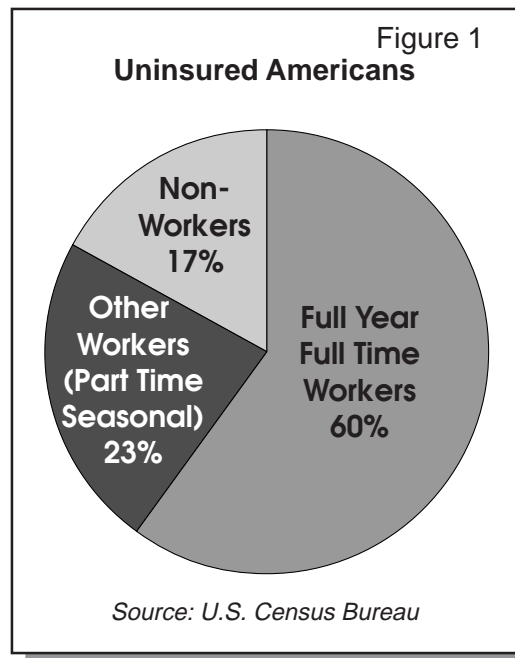
Expenditures on health care in the U.S. have nearly doubled (+88%) since 1992. The nearly \$1.6 trillion spent in 2002 represents 14.9% of the Gross Domestic Product, almost 3 times larger than the industry's share in 1960.⁸ Expenditures per person are growing as well: total health expenditures per capita were \$5,440 in 2002; almost doubling (+99%) since 1990, with much of this growth attributed to an increase in prescription drug costs.⁹

Americans, both insured and uninsured, are worrying about how to afford health care. Per capita consumer out-of-pocket spending on personal health care (excluding insurance premiums) rose from \$561 in 1992 to \$756 in 2002.¹⁰ In a Kaiser Family Foundation health survey done in 2002, about 3 in 5 Americans said they were very concerned about being unable to afford necessary health care when a family member gets sick.¹¹ Over a third (36%) of the uninsured in 2003 had problems paying medical bills in the past 12 months and almost a quarter (23%) had to change their way of life significantly to pay medical bills or were contacted by collection agencies about medical bills.¹²

Access to employer-sponsored health insurance coverage is decreasing

Most Americans receive their coverage through employer-sponsored plans. Of the 67.3 million children with health insurance coverage, the majority (77.8%) had private health insurance, while 29.0% had government health insurance (Medicaid & SCHIP).¹³ Percentages total over

100% because some children had both private and public insurance coverage.



However an increasing share of the workforce does not have access to health insurance benefits. In 2001, more than 20% of workers were not offered health coverage through their employers.¹⁴ Small firms are less likely to offer coverage than large firms (more than 500 employees), but even in large firms the number of uninsured workers has increased sharply. In 2001, 26% of the nation's uninsured worked for large firms or were dependents of these workers.¹⁵ Between 2001 and 2003, the proportion of Americans under age 65 covered by employer-sponsored insurance fell dramatically from 67% to 63%. Among children, employer coverage declined from 63.4% to 59.5 percent.¹⁶

Cost of health insurance premiums are rising

There are other problems with employer-sponsored health insurance coverage as well. Even if employees are offered coverage on the job, they can't always afford the premiums. Premiums are rising much faster than workers' earnings or inflation. Between spring of 2002 and spring of 2003, premiums across the U.S. increased 13.9%.¹⁷ (See figure 2.) The amount of contributions made by employees has increased substantially in recent years. In 2003, employees paid on average 16% of the single coverage premium, or \$42 monthly, and 27% of the family coverage premium, or \$201 monthly.¹⁸

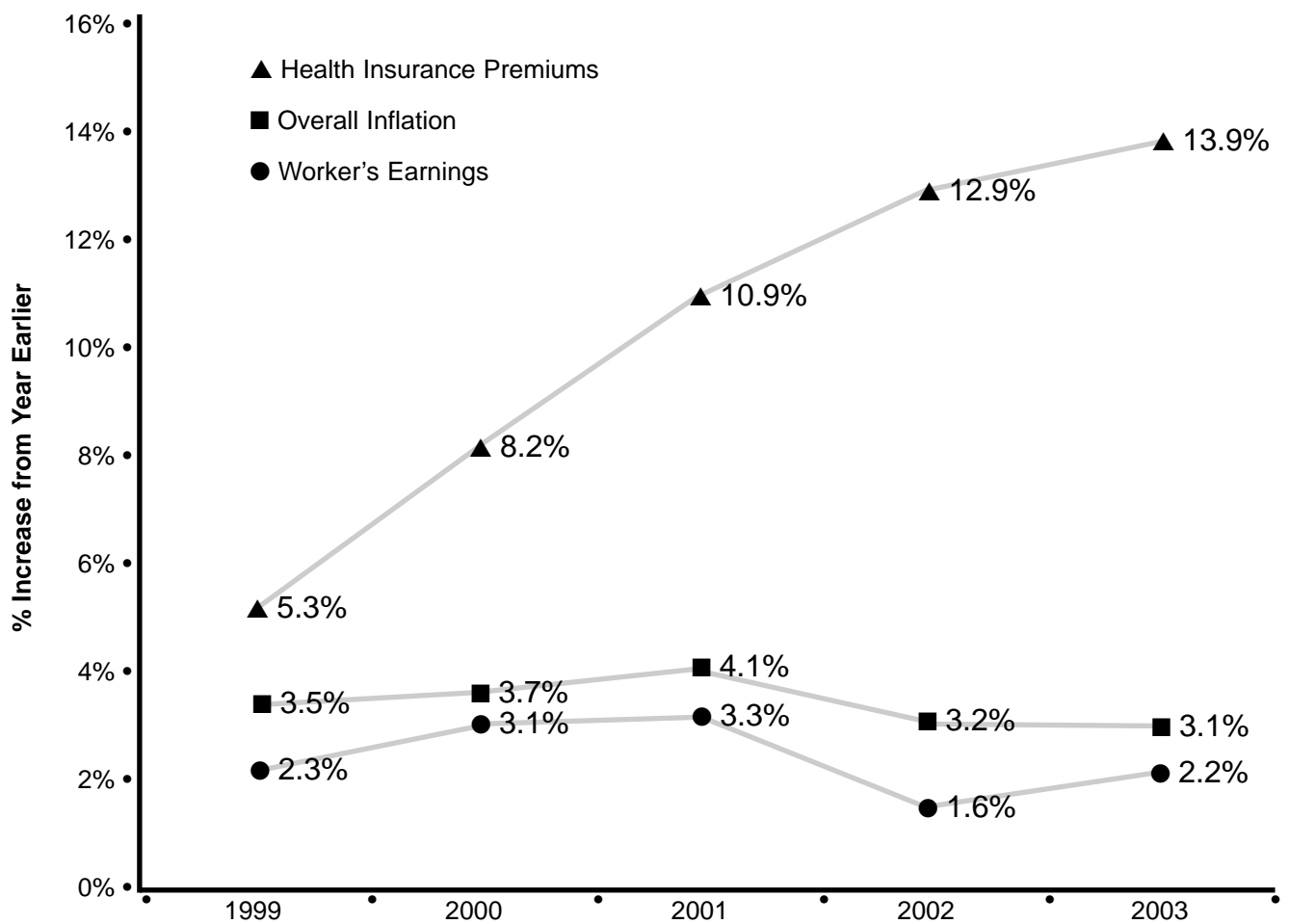
In response to premium increases, many employers are asking their employees to cover some of the new costs through increased employee share of the premium, increased dependent premiums, higher deductibles, increased co-payments for services and other restrictions to coverage. A number of labor disputes in 2003 were prompted by employers asking employees to share a higher percentage of the cost of health coverage. Losing a job, changing from full-time to part-time work, self-employment, retirement or divorce can all mean losing employer-sponsored coverage. For all these reasons reliance upon an employer sponsored health care system is risky and can lead to millions of uninsured workers and dependents.

Mounting pressure on public health care systems

Public programs (Medicaid and SCHIP) are being forced to fill the gaps in the employer-sponsored system by providing coverage for more and more working families. As the proportion of Americans under age 65 covered by

Health Insurance Premiums Are Rising

Figure 2

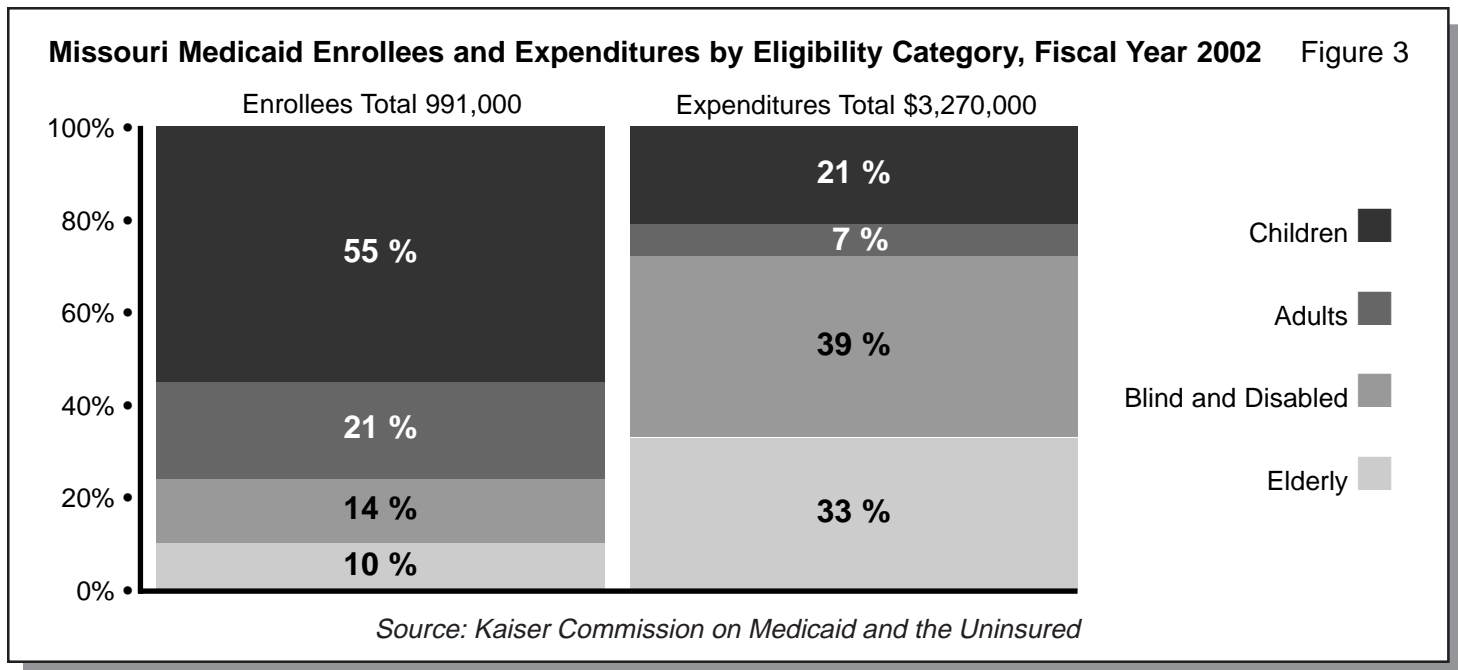


Source: Kaiser Family Foundation and Health Research & Educational Trust

employer-sponsored insurance fell between 2001-2003, the proportion of the under-65 population enrolled in public coverage increased from 9 percent to 12 percent. Children experienced an even larger increase in public insurance enrollment, which grew from 17.6% in 2001 to 24.1% in 2003.¹⁹ In recent years public sources of funding have accounted for an increasing share of total health care spending, from 41.8% in 1992 to 44.2% in 2002.²⁰ Federal Medicaid spending is estimated to grow by \$11.3 billion from 2003 to 2004.²¹ These increases are becoming an increasing drain on state and federal budgets, consuming a larger portion of the total budget each year. In a national study, The Henry J. Kaiser Family Foundation measured average annual growth in state Medicaid spending between fiscal years 1999 and 2001. In that study Missouri had the highest growth rate in Medicaid spending at 16%.²²

Inevitably the programs come under attack during budget appropriation battles particularly during economic downturns. In Missouri, the Medicaid/SCHIP appropriation for fiscal year 2003 was \$4.2 billion. The federal government contributes approximately 64% of this spending – about \$2.7 billion in 2003.²³

Children account for very little of the spending, yet are hurt when increased costs are used as a reason to cut funding to the programs. Higher spending on the disabled and elderly account for most of the increases. Non-elderly adults and children combined comprise less than 20% of the estimated spending increase.²⁴ In fiscal year 2000 Missouri children represented 55 percent of Medicaid enrollees but accounted for only 21 percent of spending.²⁵ (See figure 3.)



Without reform or additional resources states will begin to reduce eligibility, increase premiums and co-payments, or take away parent eligibility completely in an attempt to cut costs.

Poor health outcomes for Missouri’s children

The health of Missouri’s children is at risk and several health indicators point to problems with the system. In Missouri, low birthweight infants comprised almost 8% of total births but account for 71% of all newborn expenditures. The percentage of minority babies born at low birthweight is 12.6%, nearly double the rate for Caucasian babies.²⁶

Missouri ranks 31st among states in infant mortality with a rate of 7.7 deaths per 1000 live births.²⁷ The mortality rate for minority infants is almost twice as high at 14.8 per 1000 live births.²⁸ Missouri ranks 33rd among states in overall child death rates and ranks 43rd among states in the rate of teen deaths by accident, homicide, and suicide.²⁹ Missouri also has high rates of children with elevated blood lead levels, 12.3% of all children in Missouri.³⁰

Families also have a hard time accessing medical, dental, and mental health providers. There are not enough doctors and dentists that accept Medicaid or SCHIP patients. There are over 1,000 children enrolled in Medicaid/SCHIP in Missouri for every dentist that accepts enrollees of these programs in the St. Louis region.³¹ Reimbursements to providers are low, so there is no incentive for doctors or dentists to accept Medicaid/MC+ patients.

It is obvious that the current system is not only expensive but also flawed. There is no shortage of motivation for

reforming our current health care system. Up to this point we have incrementally reformed the system with piece-meal, patchwork solutions. All Missouri children would benefit from an investment in “big picture” systemic solutions. The participants spent the day discussing these systemic solutions.

Pillars of a Desired Health Care System

The participants were asked to tackle the following question: What are the pillars of an ideal health care system for all children? Four characteristics were identified: comprehensive, universal, of high quality, and accessible. A portion of the thought leaders session was spent determining exactly how those characteristics should be defined.

Children must receive comprehensive health services

A comprehensive health care system for kids would need to provide any health-related service a child needs through all the developmental phases of childhood. The system should ensure that a child reaches full physical and cognitive potential by including an extensive range of services from preventive to curative care. The system should also consider a child’s environment, including air

Pillars of an Ideal System

- ◆ Comprehensive Health Services
- ◆ Universal Eligibility for Services
- ◆ High Quality Services
- ◆ Accessible, Affordable, and Available Services

and water pollution, exposure to lead-based paint, and risk of violence. Services would need to be timely and with access to the highest level of technology for the field. Services need to be provided in an environment that is conducive to health and well-being.

All children must be eligible

The second pillar of an ideal health care system for kids is to be universal in its eligibility. Every child in Missouri must be eligible; no one can be left out or left behind. Children from neonatal to 18 years of age need coverage. A few argued that the 18-23-year-old population was at high risk because they fall into the insurance gap between child and adult. If these youth are not full-time college students or working in full-time jobs that offer health benefits they may have no health care coverage either through their parents or from their employers. The Commonwealth Fund found in a recent study that young adults (ages 19 to 23) are the largest and fastest-growing segment of the population without health insurance in the United States.³² This is a problem that must be addressed. The problem of children with chronic diseases adds to the age debate. Can we expect children with a chronic disease to find health insurance on their own after turning 18?

Finally the discussion focused on whether a parent's well being is linked to the health of a child? Should a universal system provide coverage for parents as well? The idea of a "universal" system might generate too much opposition to be politically feasible. The problem remains and CMC will have to grapple with whether to advocate for a system of healthcare for all or only for all kids.

Health care services should be of the highest quality

It was easily resolved that an ideal system of health care for kids would provide services of the highest caliber. The following characteristics define a high quality system:

- ◆ Services should be outcome-based and tied to the best practices of the field
- ◆ Services should be patient focused, easy to access and understandable
- ◆ Services should be culturally competent
- ◆ Quality of care should be measured in the outcomes of patients individually as well as measured by marked improvements in trends on a population by population basis
- ◆ Services should be holistic, treating not only the physical health of patients but also the mental, environmental, and overall wellness of the individual
- ◆ Services should be tailored to meet individualized needs
- ◆ The system should provide opportunities for consumers to give continuous feedback to providers with a public health and private advocacy system to assure the integrity of the system. There must be a high degree of consumer satisfaction with services

- ◆ A high quality system has adequate financial and human resources
- ◆ There must also be standards for uniform quality ensuring that all Missouri children receive the same high level of services.

The system must be accessible, affordable, and available

There are many barriers to accessing health services all around the state even for children with adequate health insurance coverage. Some of these access issues include:

- ◆ Location of services
- ◆ Transportation to and from health providers
- ◆ Availability of off-hour/ after school and after work appointments
- ◆ Language barriers, and
- ◆ Bad information about when and where to seek care.

Perhaps the largest obstacles to accessing services are the affordability and availability of providers. Co-payments, premiums, or cost sharing of any kind can deter families from accessing health care services for their children. The fear of incurring massive amounts of medical debt can keep people from receiving services. Affordable services are key to a successful health care system.

Availability of providers limits access to healthcare as well. Currently few doctors accept Medicaid/MC+ patients. Many physicians and dentists report that low levels of reimbursement discourage them from taking Medicaid/MC+ patients. There are reports of year-long waiting lists for dental services in many parts of the state. The system must include enough providers to ensure that all kids who need care can access providers. It must include high enough reimbursements in order to attract and retain providers. Providers must be able to cover the cost of providing these services or they won't participate.

Finally it is imperative that all children, regardless of citizenship status, have access to services. Currently the application for MC+ in Missouri asks for the Social Security numbers of applicants even though this is not a federal requirement. Many immigrant children do not have a Social Security number even if they are of legal resident status. Their parents are often wary of the process of obtaining a Social Security number and avoid it. This results in many eligible immigrant children going without coverage.

The Process of Reform

After defining the pillars of an ideal system of health care for Missouri kids the participants shifted to discussing the process of reform. They outlined the strengths and weaknesses of the current public health system, obstacles to reform, opportunities to seize upon, and the next steps toward obtaining healthcare for all of Missouri's children.

Discussion Points

- ◆ Strengths of Current System
- ◆ Weaknesses of Current System
- ◆ Obstacles to Reform
- ◆ Opportunities for Reform
- ◆ Next Steps

Strengths of current system

The group began by identifying elements of the current system that could be retained. The current public system covers most Missouri kids and keeps Missouri's total numbers of uninsured children pretty low at about 90,000 kids. Approximately 12% of American children are without health insurance while roughly 6% of Missouri's kids are uninsured.³³ No agreement was reached on whether Medicaid/SCHIP should simply be reformed and expanded or whether an entirely new system should be created. Simply because the system provides health insurance does not mean it is providing *health services*. However it was noted that Medicaid and SCHIP are all we have in Missouri now and that they currently provide an expansive system of coverage. It was also noted that community health centers, community-based nurses, and city/county health department clinics do a good job of reaching families and children and improving public health problems. Should a new system build upon these local providers?

The state of Missouri is fortunate to have many top ranked medical, dental, public health and social work schools from which to draw well-educated professionals. It also means we have many well-ranked hospitals including several renowned children's hospitals. However these advantages do not translate into an abundance of providers accepting public health insurance recipients nor to excellent overall health outcomes. The state of Missouri also has several health conversion foundations including the Missouri Foundation for Health, which provide resources for health projects around the state. There are highly skilled child advocacy groups promoting systematic improvements and other non-profit organizations that provide high-quality health care services to low-income populations throughout the state. These groups are resources that should be built upon. Finally there does seem to be awareness among the general public and our legislators that health care is a vital and fundamental need for all of Missouri's citizens.

Weaknesses of current system

The participants then turned to identifying the shortcomings of the current system. First and foremost they discussed the issue of Medicaid HMOs and other for-profit health entities making a profit off the public system.

Should a public system be completely non-profit? What efficiencies or inefficiencies do for-profit entities bring to the public table?

The sheer number of HMOs, PPOs, private and public insurance plans has created an administrative nightmare of abundant paperwork and complicated procedures that not only confuse patients but providers as well. Replacing the current convoluted system with a single system of centralized records and paperwork would be an extreme improvement. Discussion ranged from advocating for rebuilding the public health infrastructure to removing private health insurance from the system altogether and adopting a single payer system. However no agreement was reached on the issue of exactly what form a new system should take.

Other problems cited ranged from lead-based paint exposure to the high cost of prescription drugs. They also noted that the current system discriminates against persons with some specific illnesses or chronic conditions such as mental illness and substance abuse. Legislation is needed that would provide parity for all treatments. The Mental Health Parity Act passed by the Missouri General Assembly in May 2004 mandates that insurers treat mental health needs the same as physical health needs, but there is still work to be done on other treatment needs. This legislation does not cover those individuals insured by companies who fall under federal ERISA guidelines.

Obstacles to reform

After discussing the many problems within the current system, the participants turned their attention to the external factors that could affect an agenda to provide all kids with health care.

Even though CMC believes that this is the time to discuss health care for all kids, the participants were able to document threats to a reform agenda. Many of the threats referred to come from the political arena. Several participants noted that some legislators believe assistance with health care coverage should be only a temporary aid, similar to the nation's welfare program — Temporary Assistance for Needy Families. This attitude may come from a belief that all public programs should come with time limits for recipients so that the state does not create a permanent public dole. Several participants noted that if time limits were adopted the problem of the uninsured would never be fully solved. Instead there will be cyclical patterns of eligibility and ineligibility. Some people will be covered some of the time, merely exacerbating the current situation.

A few participants also noted that Missouri has a fiscally conservative inclination and there is very little political will to create a public health insurance system with a high price tag. It was discussed that many Missourians still

hold a staunch view that obtaining health insurance from the private market is a more efficient and less expensive way to cover the uninsured and that it's not the responsibility of the government to provide health insurance coverage. Advocating for health care for all kids may mean having to confront these viewpoints.

One of the biggest threats to creating a comprehensive and universal system of health care for kids was a lack of political will to create a system expansive enough to ensure all kids would be covered. One possible counter-argument made by several participants is that children are not really capable of obtaining their own health insurance. Children can't determine what socio-economic status they are born into. If they are lucky their parents work at jobs that provide health benefits. If they aren't lucky then they are born into low-income families whose jobs don't provide health benefits. Should the government or the community have any responsibility for stepping in and providing health care for these kids?

Another potential threat to change may center around the role of for-profit health care entities and their influence on the political system. These private organizations can give money to candidates and create relationships with regulators. They have political influence to change the system in a way that benefits them. Child advocacy organizations can only do so much to counter the political clout of well-funded private for-profit groups and can not match their campaign spending.

A variety of other threats were mentioned, including nursing shortages, the high cost of pharmaceuticals, and the increase in "niche providers" skimming off well-paying patients. Finally, several participants mentioned the impact that retiring baby boomers will have on the health care system. These include increased pension costs and a boom in hospital construction that siphons resources away from health care and toward construction of healthcare facilities.

Obstacles at the federal level

The current public health system is under attack at not only the state level but also at the federal level. This year there have been three separate budget process reform bills that could cut a total of \$1.8 trillion over the next ten years from programs such as Medicaid (nearly \$40 billion) and SCHIP. These bills could also change the ground rules for passing a budget, making it easier for Congress to pass more tax cuts that are not paid for and make it harder to increase spending on needed programs. It is unlikely that the Senate will act on these budget bills this year, but the proposals are just the first steps in a long-term campaign to severely restrict the size and spending on needed social programs.

The House budget resolution for fiscal year 2005 includes a cut of \$2.2 billion from Medicaid and billions in cuts from other unspecified social programs for low income children and families. While the Senate budget resolution does not include such cuts and there has not been any conference resolution for over six months, it is clear the House is determined to cut Medicaid in coming years.

Furthermore, President Bush has proposed in his budget recommendations for FY 2004 and FY 2005 to convert many social programs into block grants including Medicaid and SCHIP. No bills have been introduced in either the House or Senate up to this point, but it is clear this will be a continued focus of the Bush administration after the November election. The proposed block grants would be based on 2002 spending levels with annual inflationary adjustments. If these programs are converted to block grants, and if states continue to experience increases in state spending on Medicaid and SCHIP beyond inflationary increases, then the federal government would not match the new spending level.

Funding our current public health programs is a political battle and it seems there is little political will to fund a more comprehensive healthcare system. However, perhaps public pressure can turn the tide.

Opportunities for reform

While there are threats to the current system and to potential change, many opportunities exist for reform as well. The public seems unhappy with health care and the economy right now. Health insurance premiums are rising and the problem of being uninsured is spreading beyond low-income families. When the public perceives a crisis, an opportunity for change exists.

Health policy is a hot topic in the campaigns of many candidates including the presidential election. All the Democratic presidential candidates had extensive health policy reform agendas as vital components of their platforms. Many politicians feel the need to discuss health policy in response to problems with the current system and public pressure. Many politicians feel the need to talk about children's needs perhaps because children are viewed by society as innocent bystanders deserving of care.

Missouri is in a unique position to reform its health insurance system for children for several reasons. It lags behind on many health indicators including infant mortality rates, low birth weights, and high rates of lead poisoning. There is no shortage of causes for people to rally behind. Some legislators seem to be willing to support a plan if one is put forward. They see that there may be an opportunity not only to improve our current system but also to do what is right for children. Finally many of the participants viewed Missouri as a key state in the presidential election. This could bring resources into the state in the form of funding and grass roots advocacy campaigns. It also provides an opportunity to highlight candidates' positions on health policy issues. All these opportunities must be analyzed and critically utilized if our current health care system is to be successfully reformed.

Next steps

Providing health care for all Missouri children is clearly a complex goal. The participants in the thought leaders session took the first step toward this goal by articulating the pillars of an ideal healthcare system for kids, as well as identifying the obstacles and opportunities for reform. The next steps include carrying out additional research on those obstacles and opportunities. Research needs to be done to examine what is driving rising healthcare costs so that appropriate policy interventions can be crafted. Research is also needed on exactly who the uninsured children in Missouri are, where they live, and why they don't have access to health insurance coverage. Finally, more research is needed on access to health services when children are covered, tackling the issues surrounding provider availability in Missouri.

It is also important to better articulate the goal of health care for Missouri children to answer the questions of how

Next Steps

1. Research:
 - ◆ Healthcare cost drivers
 - ◆ Who the uninsured children in Missouri are
 - ◆ Access to health services with insurance coverage
 - ◆ Successful models of coverage expansions
2. Define the ideal structure of a reformed system,
3. Analyze the federal role in reforming current system,
4. Promote reforms that strengthen health care for children.

to reform the structure of the health care system, and what is the best way to provide health care to all children. Is a single-payer system the best way and even if it is, is that politically feasible? If not, what are other more viable options? How have other states managed to provide health insurance coverage/ health care to all their children? Would any of these methods work in Missouri? Advocates need to analyze the federal role in reforming the current public health systems as well.

A future meeting of the participants in the original thought leaders session as well as other leaders in the health policy field may be useful. CMC will continue to advocate to immediately increase the number of children receiving health care. CMC will also work toward systematic solutions, so that all Missouri children receive the health care they so desperately need and deserve.

Who were the participants in the "Thought Leaders Session?"

1. **John Bentley, MD**
Medical Director, Jordan Valley Community Health Center, Springfield, MO
2. **Frank Ellis, MPH**
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6. **Karl Wilson, Ph.D.**
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7. **Beth Griffin**
Executive Director, Citizens for Missouri's Children

* Participants were not acting as representatives of their organizations.

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Citizens for Missouri’s Children is a statewide public interest organization. Its mission is to be a voice for children, especially those children with greatest need.

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Our mission is to advocate
the rights and well-being of
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