Medicaid in Rhode Island

Our Investment for a Healthy Future

May 2006

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Acknowledgements

This report was written by Mark Hunter, Michael Miller, and Amy Rosenthal, policy staff for Community Catalyst.

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Executive Summary

- Medicaid in Rhode Island provides essential, cost-effective care for nearly 150,000 state residents, roughly 14% of the state population

- Medicaid spending, and the huge federal subsidies it draws, provides health benefits for the direct enrollees, security and well-being for families, financial support for the entire healthcare delivery network, support for jobs and wages across the entire economy, and a mechanism to reduce society's outlays related to uninsurance.

- On top of those benefits, there is also a monetary value associated with the productivity losses that are prevented by greater access to public insurance. The estimated savings Rhode Island achieves through prevented losses in productivity, between $95 and $192 million, is itself nearly equivalent to the state's cost of providing care.

- All together, Rhode Island gains $757 million in economic activity and productivity; wage, job, and tax growth; and prevented losses rising from uncompensated care for the uninsured because it covers an above average portion of state residents through Medicaid. Other intangibles, such as health system stability and having a compassionate society are not included in that figure. The cost to achieve this benefit, the state cost of Medicaid coverage for this group, is small, only about $175 million. The returns outweigh the costs *by a factor of 4.3 to 1.*

- Governor Carcieri's proposed cuts for FY 2007, on the whole, are unlikely to save the state budget as much as projected and will ultimately cost the state of Rhode Island more than making no changes to the Medicaid program.

- The proposed cost-sharing amendments amount to a tax increase, in effect if not in fact, unfairly targeted to the poorest and most ill in the state. As out-of-pocket costs rise, members, including children, are more likely to go without essential services or to feel compelled financially to drop coverage altogether (where more than 85% of people below 200% FPL can expect to remain uninsured.)

- Plans for Medicaid cuts have been precipitated by claims that the program's spending growth has reached "crisis" level. However, costs have grown 34% slower than have premiums for private health insurance and are a function of society-wide factors not intrinsic to the Medicaid program itself: an expanding, aging population that finds employer sponsored insurance increasingly rare and unaffordable due to medical price inflation.

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Introduction

The Medicaid program in Rhode Island provides essential, cost-effective, medical care for roughly 155,000 residents, over 14% of the state population.[1] Through the RIte Care program nearly 110,000 underserved children and their parents are able to receive the medical assistance they need to be able to enjoy basic health security. While RIte Care covers the bulk of enrollees, Medicaid also provides a vital safety net for over 40,000 elderly and disabled beneficiaries, many of whom require expensive health and long-term-care services.

Rhode Island's Medicaid system has been consistently regarded as a high-quality program, one that serves well the needs of its direct beneficiaries and the state more generally. Now, in proposals for the 2007 state fiscal year, Governor Carcieri has outlined plans that will eliminate Medicaid benefits for some, make services more expensive for others, and generally attempt to wring out savings from providers. These cuts follow from two common false premises: that Medicaid growth is out of control, and crowding out other state priorities, and that cutting people and programs from the Medicaid system is an efficient method of reducing state expenses. Neither is true.

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This report aims to provide a brief overview of the role of Medicaid in Rhode Island. We acknowledge that Medicaid is an expensive program which will require sustained increases in financial support. However, we will argue throughout that the program's effectiveness far outweighs its costs and that the factors precipitating the cost increases are both beyond the control of the program and precisely the same factors that warrant maintaining a commitment to Medicaid.

The remainder of the report is divided into four main sections. Part I will briefly highlight the program's most general characteristics; Part II outlines the Program's benefits to various community stakeholders; Part III discusses the Governor's FY2007 budget proposals; and Part IV examines some alternatives to Medicaid cuts that may serve to increase program efficiency and control costs in ways that do not directly harm beneficiaries. The conclusion underlines the importance of the Medicaid program in Rhode Island and places its costs in a wider context.

Part I : Medicaid Overview

Rhode Island is a national leader in expressing a commitment to equitable access to medical services. The state does this in two ways: first, by maintaining a high level of Medicaid eligibility for medical services; and second, by offering a reasonable benefit structure in line with other peer states. As a result, Medicaid covers a higher portion of residents in Rhode Island than in most other states leading to a far lower rate of uninsurance for the state's residents. The two tables below show the distribution of insurance coverage in Rhode Island and the United States average in 2003. At left is the general population, and at right are only low-income adults. For both, some individuals with Medicare, military or other government coverage are excluded.[2]

"Using estimates developed by the national Institute of Medicine, Rhode Island recovers between $95 and $192 million in lost productivity costs alone by insuring more of its residents."

Coverage for Total Population			
	Private	Medicaid	Uninsured
R.I.	71%	16%	11%
U.S.	69%	13%	16%
-note- numbers may not sum to 100%			

Coverage for Low-Income Adults			
	Private	Medicaid	Uninsured
R.I.	23%	40%	33%
U.S.	24%	26%	45%
-note- numbers may not sum to 100%			

Medicaid's Critical Role as Insurer

According to the latest U.S. Current Population Survey (CPS), there are 114,000 uninsured residents living in Rhode Island.[3] As a percentage of the *non-elderly* population (0-64 years), this is considerably less than most other states (12%, U.S. average is 18%).[4] Without Medicaid the number of uninsured in Rhode Island would be dramatically higher. Because the portion of state residents covered through employer sponsored and private plans is about the same as the national average, this uninsurance advantage is largely attributable to Medicaid coverage.

The impact of a low rate of uninsurance should not be underestimated. If Rhode Island was burdened with the average U.S. uninsurance rate, there would be roughly 50,000 more uninsured than currently exist. Using estimates developed by the national Institute of Medicine, Rhode Island recovers between $95 and $192 million in lost productivity costs alone by insuring more of its residents than the average state.[5] The state cost of Medicaid coverage for those additional "excess" beneficiaries ($3,500 per average enrollee) is roughly equal to this benefit, even in this one domain.[6] Once other domains are added, like health effects and broader economic impact, Medicaid spending becomes, at worst, "free" and, in reality, may ultimately put Rhode Island on a more sound footing.

Children are particularly well served by the Medicaid program. More than a quarter (26%) of Rhode Island's children receives Medicaid benefits. About 16% of the uninsured are children, ranking Rhode Island 10th best in the nation. Similarly, only 6.5% of all children are uninsured, with just three states having better coverage for their children.[7]

Recently, however, the number of uninsured has been increasing, rising by over 43,000 from 2000 to 2004.[8] This may suggest, as with much of the rest of the nation, that the Medicaid program has been unable to keep pace with the loss of employer sponsored insurance (ESI), placing strain on the state's healthcare delivery system and economy. Since the trend for ESI is downward, a greater number of people will either become uninsured or else seek assistance from public programs. The following table highlights the change in the various modes of coverage for the non-elderly adult population from 2000 to 2004.[9]

"…The number of uninsured has been increasing, rising by over 43,000 from 2000 to 2004.[1] This may suggest, as with much of the rest of the nation, that the Medicaid program has been unable to keep pace with the loss of employer sponsored insurance, placing strain on the state's healthcare delivery system and economy."

% change in coverage type for non-elderly residents '00-'04				
	ESI	Individual	Medicaid	Uninsured
# change	-28,700	-2,686	36,611	43,709
% change	-7.00%	-0.90%	3.00%	4.50%
Rhode Island's overall population grew 3.10% in this period				

The first row shows the number of non-elderly state residents that either gained or lost coverage in each of the four types of insurance. The second row describes the percentage point change in that type of insurance over the four-year period in question. Given the real cost to the state for increases in the number of the uninsured, coupled with the availability of federal financial participation to offset the cost of Medicaid, maintaining (or even expanding) Medicaid funding and eligibility to combat this trend may prove a prudent policy choice.

Eligibility

For nearly all categories of Medicaid eligibility, Rhode Island is in the top tier of states, joining national leaders like Illinois, Vermont, Massachusetts and Maine, among others, in its commitment to Medicaid expansion. Of particular note is the use of waivers and SCHIP funds to extend coverage to parents up to 185% of the federal poverty level (FPL), ranking Rhode Island 4th in that regard. In 2005, 185% FPL was $29,766 per year for a family of three. Rhode Island also ranks 4th best in the nation in children's eligibility, covering all children to 250% FPL and implementing this coverage in a family-friendly way. Most other states do not cover all children at the same eligibility levels, which can result in one child's receiving benefits while another in the same household does not.

The Enrolled Population

Compared to the national average, the composition of Rhode Island's Medicaid rolls is paradoxically weighted more heavily towards older and more expensive beneficiaries. Even with high eligibility levels, only 46% of Rhode Island's Medicaid enrollees in 2002 were children (only nine states had a smaller percentage.) The proportion of adults (25.5%) was equal to the national average, despite Rhode Island's higher eligibility limits. The ratio of elderly and disabled was higher in the Ocean State than elsewhere, a fact partly driven by Rhode Island's marginally greater share of elderly in the general population. The overwhelming majority of elderly Medicaid beneficiaries also receive Medicare services.

This group is often referred to as "dual eligible" and generally receives acute care services through Medicare while relying on Medicaid for long-term-care.[10]

% Medicaid Enrollment by Group : R.I. and U.S.				
	Children	Adults	Elderly	Disabled
R.I.	46.1	25.5	11.6	16.8
U.S.	49.6	25.6	10.5	14.2

Benefits, Financing, and Expenditures

The majority of Medicaid beneficiaries participates in the RIte Care plan and receives benefits through the participating managed care organizations (MCOs). In only a few areas does Rhode Island offer either a more comprehensive service or greater access to a service than neighbors Massachusetts and Connecticut. It is more often the case that covered benefits lag in Rhode Island compared to those two states.[11]

Cost sharing requirements in RIte Care vary depending on income and type of coverage. For all beneficiaries below 150% FPL, there is no monthly premium. For families between 150% and 185% FPL the monthly premium is $61 (2005 figures). Coverage for pregnant women or children from 185% to 200% FPL costs $77 per month, and $92 per month for coverage between 200% and 250%.[12]

Total Medicaid program costs in FY 2004 were about $1.4 billion, of which the state paid roughly $600 million or 42.9%.[13] Considering just state expenditures from the general fund that year, less than 22% was directed towards Medical Assistance.[14] In a state that spent an estimated $6.7 billion on all types of medical care in 2004, the state contribution to the care for the poor represented just 8.8% of that total.[15] Viewed in this way, Medicaid represents a tremendous value for Rhode Island: 8.8% of state healthcare dollars effectively covered 14% of the state population – a segment that includes some of the most medically and economically vulnerable residents.

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Medical Assistance spending has been growing less quickly than have premiums in the private sector. From 2004 to 2005, while aggregate Medicaid expenditures rose 7.48% from 2005 to the 2006 enacted budget, costs rose 9.27%. The Governor's recommended budget for FY07 represents a 13.18% *decrease* in expenses.[16] For comparison, in 2004, premiums for employer sponsored plans grew 11.2%, or 50% faster than Medicaid costs, even as Medicaid growth included additional enrollment, not just price increases.[17]

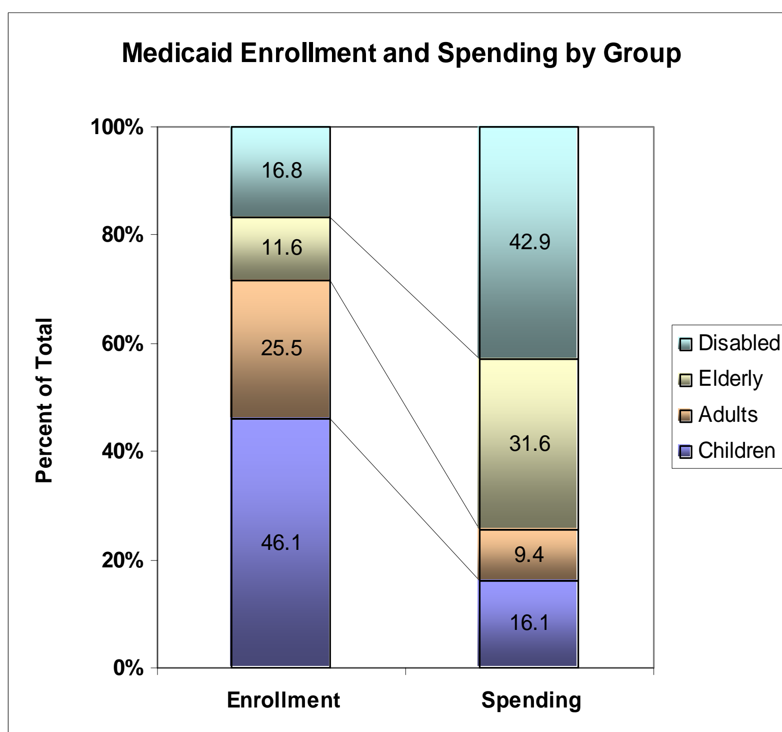
The federal government determines its contribution to state Medicaid spending through a formula known as the Federal Matching Assistance Percentage (FMAP). In Rhode Island the federal government paid 54.45% in FY 2006 and will pay 52.35% for FY 2007.[18] **That means for every state dollar spent, the federal government contributes $1.20. Put another way, in order to cut one state dollar, $2.20 in program expenses would need be cut and $1.20 returned to Washington.** However, real state "savings" will always be

less than $1.00, as costs from Medicaid cuts are, in many cases, merely shifted to other areas of the budget or to the private sector.

Different groups of Medicaid enrollees use different amounts and types of services. The table below compares the cost per enrollee in Rhode Island by group.[19]

Medicaid Spending Per Enrollee Per Group '06 est.				
	Children	Adults	Elderly	Disabled
R.I.	$2,865	$2,996	$22,460	$21,199

As noted above, Rhode Island's Medicaid program enrolls slightly more elderly and disabled individuals. As a result, total program expenditures are skewed towards these higher cost groups. For example, though the children in the RIte Care program comprise 46.1% of the total Medicaid enrollment, only 16.1% of all spending is directed towards their care. The elderly and disabled require a disproportionately large share of expenditures to maintain their health and well-being. The chart below shows the breakdown of enrollment and spending by each eligibility group.[20]



Despite what, on paper, appears to be somewhat generous eligibility standards, particularly for adults, those standards are not driving cost increases in the program. Adults and children are relatively inexpensive. However, as in other states, the larger costs of the elderly and disabled (the dual eligibles) claim a disproportionate share of Medicaid spending. **In fact, 75% of the costs are generated by only 28% of the beneficiaries**. Those costs are largely driven by factors external to Rhode Island's Medicaid program. For one, the failure of national policies to address the long-term care needs of America's aging

population has fostered an ever increasing reliance on Medicaid for long-term care. Indeed, in Rhode Island the percentage of nursing home residents with Medicaid as a primary payer is significantly higher than the national average.[21]

Though Rhode Island spends slightly more on average per enrollee than do other states, the overall result is a lower cost to the state for covering its uninsured population. In fact, Rhode Island's program is actually less expensive per enrollee than neighbors Connecticut and New York which, on the whole, have similar plans.

"…the positive outcomes of Medicaid spending ripple from individual recipients through their families, their communities, the larger economy, and ultimately, to the entire State."

Overall, Rhode Island's Medicaid program is a model showing that incremental increases in spending yield returns far beyond their cost. To the extent that the state's policies enroll more people and reduce uninsurance, Rhode Island reaps what might be thought of as "excess benefits" over and above that which an average state receives. Apart from the previously mentioned benefits of fewer uninsured residents and $95 - $192 million in productivity gains, the next section details the broader advantages of Medicaid spending to the entire state. **It is the position of this paper that the excess benefits that flow from the incremental spending on greater coverage are precisely what make Rhode Island's position so enviable and its Medicaid program so effective.**

Part II : The Benefits of Medicaid Spending

While Medicaid is primarily a publicly financed insurance plan for the underserved, it is in practical effect much more than this, since the effects of the Medicaid program extend far beyond the direct medical beneficiaries it aims to serve. Indeed, the positive outcomes of Medicaid spending ripple from individual recipients through their families, their communities, the larger economy, and ultimately to the entire State. These next several sections highlight these gains as they pertain to each major beneficiary group.

The Impact on Direct Beneficiaries

Positive health, well being, income, and education effects are among the many benefits of Medicaid coverage for the individual recipients of services. The research and literature linking improved medical outcomes with insurance coverage – particularly low-cost coverage for low-income people – is as vast as it is conclusive.[22] When lower-income individuals have greater access to care through insurance coverage, they are more likely to fill needed prescriptions, to have a regular source of care, to obtain care for serious conditions without problems or delay, and to receive more effective care for chronic conditions. Self reported quality of life increases with such access as well.[23]

The insured are also protected, though marginally so, from the devastating impact that high hospital and physician fees can have on a family's finances. In the United States between 50% and 65% of all bankruptcies follow directly from major medical issues and the inability to make timely, appropriate payments.[24] One need not be destitute to feel the painful effects of high medical prices. A family of three earning $2,700 a month can easily face difficult tradeoffs (such as rent, food, commuting expenses) if one family member

experiences a single serious medical event. In Rhode Island, the family would be covered under the RIte Care program. In most other states, this family would confront an agonizing sacrifice.

Medicaid beneficiaries, like others with any type of insurance, enjoy the protection their insurance gives them from high medical costs. Though the uninsured typically spend less in absolute terms, the cost of their medical care is far more likely to be a much larger proportion of family income than the insured.[25]

The Impact on Children

In many respects children are the most important beneficiaries of the Medicaid program. This is particularly true for Rhode Island, which has used SCHIP grants to fund Medicaid expansions for children and their families to relatively high levels. As noted above, a slightly higher percentage of all children in Rhode Island are enrolled in Medicaid compared to the nation, and about 30% higher compared to its neighboring states.[26]

Low-income children are particularly well served by access to affordable insurance. They have been shown to experience less psychological disturbances (including depression), more appropriate prescription medication use, and fewer periods of long absence from school. Overall, their educational attainment is higher.[27]

RIte Care's effectiveness for children is particularly noteworthy. Often, uninsured children suffer from a host of disadvantages such as lower self-assessed health status and greater frequency of unmet medical needs and delayed care. This can result in overuse of inappropriate venues of care, like hospital emergency departments, that make ensuring equitable access to care even more compelling for them than for an adult population. Compared to the U.S. average, Rhode Island has 52% fewer uninsured children as a percentage of all children. The state pays a relatively low price for the many benefits of extending Medicaid to the roughly 71,000 children who receive it: about $1,300 per child last year.[28]

"The extension of Medicaid benefits to adults with children up to 185% FPL also serves to encourage enrollment for children. Children whose parents lack health insurance are more likely to be uninsured themselves, even if they are eligible for public programs like Medicaid."

The extension of Medicaid benefits to adults with children up to 185% FPL also serves to encourage enrollment for children. Children whose parents lack health insurance are more likely to be uninsured themselves, even if they are eligible for public programs like Medicaid. A national study revealed that roughly half of the uninsured children in the U.S. were eligible for Medicaid or SCHIP coverage in their state. Those children are less likely to enroll when their parents also lack health coverage.[29]

The Impact on the Healthcare Delivery System

Spending on Medicaid is ultimately directed towards the providers of care. Medicaid represents the injection of over $1 billion into Rhode Island's healthcare delivery system to support hospitals, physicians, and allied health providers.

The availability of Medicaid funding will also tend to provide better access to facilities and services for the entire population that is *not* covered by Medicaid. Because certain facilities rely on Medicaid for a disproportionately large share of their operating budget, the availability of Medicaid dollars keeps those systems running for all, even for those with private insurance coverage. The withdrawal of significant Medicaid funding could easily suppress the ability of hospitals, particularly those in underserved areas, to make new hires and could result in layoffs or hospital unit cutbacks. One review found that hospital service levels for both Medicaid *and* private patients fell following Medicaid cutbacks, and that Medicaid-dependent hospitals were more likely to close.[30]

In addition, the healthcare sector in Rhode Island is a larger employer than in all but one other state.[31] With roughly 60,000 state residents in healthcare jobs, the federal financial participation generated by Medicaid spending supports about 10% of the healthcare workforce.[32] During Medicaid cutbacks, hospitals with more slim financial margins – trusted safety net providers – are particularly vulnerable. Reducing eligibility inevitably results in increases in uncompensated care and cost at these facilities as a result of more uninsurance. The quality of care also suffers. Without a continuous and focused source of care, such as in RIte Care, the burden rests on the individual to manage what are increasingly complex conditions.

"The impact of every additional $100 million in state Medicaid spending generates $230 million in general business activity, creates 2,200 jobs, $80 million in salaries and wages, and increases tax revenue by about $8 million."

The Impact on the Broader Economy and the Business Community

Federal matching funds for Medicaid spending represent a massive government subsidy for the State and residents of Rhode Island. In 2004, this sum amounted to $845 million in transfers, by far the largest federal grant to the state. Because the federal match is generated externally to the state, it can be treated as pure economic profit to Rhode Island, a source of funds that spurs economic activity that would be otherwise unavailable in Medicaid's absence. Rhode Island, according to methodology developed by the Tax Foundation, is a "net beneficiary state."[33] The state receives more in federal grants than its citizens and businesses send to Washington in the form of taxes, at a ratio of about 1.02 to 1.00. In recent years this is becoming smaller. Maximizing this ratio of grants to taxes, and thus the portion of services for Rhode Islanders that are effectively financed by people in other states, is clearly in the interest of state residents. Medicaid cuts have the opposite effect; they do not much reduce the in-state cost of providing medical care to the indigent and will not reduce what Rhode Islanders pay in federal taxes but will reduce the federal contribution to the state's economy.

The impact of $845 million dollars coming into the state should not be underestimated. In addition to the direct benefit to program enrollees and the providers who serve them, the economic ripple effect of Medicaid spending is felt across the state. Economic models of this effect produce noteworthy results – *the impact of every additional $100 million in state Medicaid spending generates $230 million in general business activity, creates 2,200 jobs, $80 million in salaries and wages, and increases tax revenue by about $8 million.*[34]

The Impact on the State of Rhode Island

Perhaps Medicaid's largest benefit to the state of Rhode Island is the reduction in the number, and costs of, the uninsured. The *non-medical* costs of uninsurance, largely in the form of lost productivity, is startlingly large. In the total absence of Medicaid, even assuming a generous take up rate of private insurance offers, some 120,000 Rhode Islanders would become uninsured.[35] As a consequence, the state would experience between $228 and $461 million in economic losses. These losses could be incrementally avoided by insurance expansions.[36]

For the uninsured, economic losses are only part of the story. Though the uninsured use fewer medical services than the insured, they do still require care which is often beyond the means of low-income families. Previous research suggests that the uninsured pay only about 35% of the cost of their care out-of-pocket.[37] The rest is financed from one of three sources: from providers in the form of charity care or bad debts; from government support such as disproportionate share hospital (DSH) payments; and from the privately insured in the form of higher premiums that cover cost-shifted prices set by providers. In Rhode Island, the cost of care for the uninsured in 2005 was an estimated $158 million, $102 million of which was paid by sources other than the uninsured themselves.[38] With increases in the number of uninsured and medical prices, this cost will grow in the coming years.

Cutting Medicaid is not the choice between paying for care or paying nothing – it is a choice between paying for quality care with massive federal assistance or passing the cost of less effective care onto the sick, providers, and the privately insured.

"*Cutting Medicaid is not the choice between paying for care or paying nothing – it is a choice between paying for quality care with massive federal assistance or passing the cost of less effective care onto the sick, providers, and the privately insured.*"

The goods that result from the availability of Medicaid only start at the healthcare benefits gained by the program's enrollees. The chart below provides a brief summary of the multiple levels of impact of Medicaid spending.

Level of Impact	Type of Impact
Direct	Greater access to care, more appropriate use of services, higher quality care, higher quality of life, and greater financial stability
Children	Greater access to care, fewer delays for serious conditions, fewer prolonged school absences, more likely to enroll if parents are covered
Healthcare system	Injection of $1+ billion into system, supports critical safety net providers, supports services for *all* hospital users, system is larger employer than in most states
Economy	Federal Medicaid dollars are externally generated profit for R.I., ripple effect amounts to roughly $140 million in state benefit for every $45 million in state Medicaid spending
Society	Avoids the non-medical costs of uninsurance and avoids the cost and system stress of providing medical care for uninsured

Part III : Governor Carcieri's FY 2007 Budget Proposal

In February, 2006, Governor Carcieri proposed many changes to the state's Medicaid system that, all together, were estimated to reduce program expenses by roughly $174 million compared to the FY 2006 enacted budget.[39] The list of suggested amendments is long, and not all are covered here. We highlight those proposals which appear to be the least efficient in actually reducing the state's costs or seem to cause unwarranted hardship for those affected.

The plans, along with potential challenges, appear below under the headings "eligibility rollbacks," "premium increases," "increased cost sharing," and "preferred drug lists."

Eligibility Rollbacks

The Plan[40]
The Governor has proposed eliminating Medicaid eligibility for parents between 133% FPL and 185% FPL, the current limit. Scaling back to 133% would cut an estimated 6,800 people off from benefits. That means that a *family* of three, not an individual, who earns $21,500 a year would become ineligible for standard coverage. This change is expected to save $22.5 million in total program costs.

The Governor has also proposed eliminating coverage for roughly 3,000 immigrant children. This action is slated to achieve $4.1 million in state savings, or roughly $1,360 for each child cut.

Potential Adverse Effects
Families with incomes in the range of the cuts are less likely to have affordable offers from their employers and, as such, the overwhelming majority (approaching 80%) will remain uninsured.[41] In addition to shifting the costs of these cuts onto the poor, the provider community, and private insurance holders, removing adults from coverage undermines the program's goals of enrolling children.

Projected state savings from the eligibility rollback is roughly $10.5 million, about 45% of the $22.5 million cut. Even at this point, Medicaid cuts defy a certain rational mathematics. In order to save the state $10.5 million, Rhode Island must forgo $12 million in federal funds. Already the cut would withdraw more from the healthcare delivery system than the state aims to save.

In addition, the costs of pregnancy are a disproportionately large share of Medicaid spending for children and families compared to the number of pregnant women among all Medicaid beneficiaries. In Rhode Island pregnant women are covered up to 250% FPL. Thus, any woman subject to this eligibility reduction from 185% to 133% would again qualify for Medicaid if she were to become pregnant. As a result, the high costs of pregnancy do not "leave" the program, and the Governor's estimated savings may be overstated.

"*In order to save the state $10.5 million, Rhode Island must forgo $12 million in federal funds. Already the cut would withdraw more from the healthcare delivery system than the state aims to save.*"

State residents with private health insurance will end up paying more – up to $10 million – to the extent that the newly cut Medicaid beneficiaries remain uninsured. State healthcare costs go up even for those lucky few able to secure employer sponsored or individual coverage after being dropped from Medicaid. This occurs because the move from Medicaid to private plans requires replacing the federal match with employer and individual contributions to insurance. In either case, more in-state dollars are spent on care than would have otherwise been the case, leaving fewer dollars to purchase other goods and services. Finally, Rhode Island's provider and business communities will suffer the combined effect of the Medicaid spending cut with $53 million in lost business activity.[42]

"To reach a $10 million 'savings'… Rhode Island must first saddle 6,800 low-income state residents with less effective medical care…; must send $12 million back to Washington D.C.; lose $53 million in business activity and 515 jobs; and shift $7.5 million in health-care costs onto the uninsured and already strained providers."

Therefore, to ostensibly reach a $10 million "savings" for the state, Rhode Island must first saddle 6,800 low-income state residents with less effective medical care, to the detriment of their own and their family's health; must send $12 million back to Washington D.C.; lose $53 million in business activity and 515 jobs; and shift $7.5 million in healthcare costs onto the uninsured and already strained providers.

The proposal to end coverage for 3,000 immigrant children is perhaps the most troubling of all, largely because the projected savings are so meager – just $4.1 million state dollars. Children without insurance are 2.35 times more likely than children with insurance to have unmet health needs, and are 70% more likely to not receive care for acute conditions such as ear infections and asthma.[43]

A recent review of Medicaid and SCHIP cuts and their effect on hospital emergency department (ED) use concluded that recent uninsurance does result in a change in volume and distribution of ED use and that "efforts that reduce eligibility and enrollment will achieve cost savings largely by reducing access and shifting costs away from Medicaid/SCHIP."[44] In other words costs are only "saved" because they no longer appear as a budget line – the essential medical care will continue to be provided, and will be financed through other less efficient means.

Premium Increases

The Plan

In addition to the rollbacks in eligibility, the Governor plans to implement a premium arrangement for families between 133% FPL and 150% FPL. This proposal would require an estimated 1-3% of a family's income in premiums and is expected to raise $3.0 million in new revenue.

An additional amendment proposes to recalculate the premium amounts for families with slightly higher incomes. By law, such payments are not to exceed 5% of a family's income. The average family currently pays 3-4%. The new rates will have the effect of pushing more people up to the 5% limit.

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Potential Adverse Effects
Increased premiums in Medicaid/SCHIP programs tend to decrease overall enrollment and increase the number of uninsured.[45] As noted earlier, a parent's eligibility and enrollment in public programs impacts the enrollment of their children. Therefore, premium increases will negatively affect both coverage and access to care for children as well as for their parents.

"Cost-shifting amounts to a regressive tax on the low-income sick which undermines the Medicaid program's explicit goal of increasing coverage."

An April, 2006 study quantified the effects of premium increases on children in the Arizona SCHIP. The results corroborate the findings presented above. The authors estimate that for every $10 increase in monthly premium, roughly 10% of children would disenroll. Aside from completely undermining the goals of the program, the premium increase led to a system-wide financial penalty as total expenditures increased by about 6% following the premium hike.[46]

As with the enrollment cuts described above, the estimated savings resulting from new premiums are likely over-stated because not all beneficiaries will have the same response to the higher costs. Those with higher expected utilization or costs of services are more likely to stay in the program and be willing to pay the increased premium. Those in good health, who do not expect to use many costly services, may see the premium increase as a "bad deal" and be more likely to lapse. This plan would reduce the overall number of beneficiaries and drive the average cost per beneficiary up, all while inducing more discontinuity of care and churning effects

Cost-shifting amounts to a regressive tax on the low-income sick which undermines the Medicaid program's explicit goal of increasing coverage**.** Rather than supporting Medicaid through general revenues, to which everyone contributes, this plan proposes to finance an increasing part of services on the backs of the poor. Even within that group, cost-sharing measures apply most heavily to those who are ill and need the most services. Those with chronic conditions, who tend to be older, are often the hardest hit. And, finally, because of the lost federal match, beneficiaries end up paying roughly twice what the state intends to save. For example, for every $1 increase in a drug co-pay (a dollar the state no longer "spends" as is it born by the beneficiary) saves the state government a maximum of 46 cents.

Increased Cost Sharing

The Plan
As noted above, RIte Care is not the only Medicaid program targeted for cuts. New co-payments for pharmaceuticals will be levied on the largely elderly population which remains in the non-RIte Care fee-for-service Medicaid system and who are also ineligible for Medicare Part D. Projected revenue from this new fee is $1.4 million.

Potential Adverse Effects
Generally, cost sharing reduces the use of essential health services and has in some cases been shown to increase the overall cost of providing health care.[47] There is research that

demonstrates the effect of cuts in one Medicaid program area leading to new costs in other areas. One study found that after implementing a $10 co-pay for physician services, ambulatory care decreased by 8% but inpatient hospital care increased by 17%, resulting in an overall system cost increase of 3-8%.[48] Another older review found that a $1 co-pay per service reduced immunizations by 45%, pap-smears by 21.5% and obstetrical care by 58%.[49] The logic of cost sharing is completely counterintuitive as it serves to reduce utilization of preventative services and thereby reduce overall efficacy.

Imposing new co-payments on prescription medication for the low-income elderly, however, is particularly pernicious as the greatest burden of cost sharing falls disproportionately on the most ill, who require the most prescription drugs. Because of this, co-pays on prescription drugs result in a general decline in medication use, which can acutely affect the elderly given their greater prevalence of co-morbid conditions. A report in 2001 found that the use of essential drugs among the poor and elderly declined following the implementation of cost sharing policies which led to higher rates of "serious adverse events" and greater use of hospital emergency facilities.[50]

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Preferred Drug Lists

The Plan

The Governor's proposal would establish a Preferred Drug List (PDL) for the non-RIte Care segment of Medicaid that focuses on the elderly and disabled. The PDL is projected to reduce program expenditures by $3.6 million, saving $1.6 million in state funds and affecting roughly 20,000 enrollees.

Potential Adverse Effects

PDLs can be an appropriate way for Rhode Island to achieve modest cost savings provided that the formulary is structured in ways that respect the doctor-patient relationship, allows for exceptions with limited bureaucratic involvement, and is generally sensitive to the delicate medical needs of some of society's most disadvantaged and ill members.

For some pharmaceuticals, efficacy for any given patient is notoriously variable and difficult to predict. Psychotropic drugs are one such example. Plan administrators are, to their credit, exempting psychotropic agents from the PDL while patient and disability advocates continue to push for more such exemptions.

Failure to properly manage the transition to a PDL, or designing one poorly, could result in the reduction of the modest savings projected or, even, a plan that is more costly than the status quo. One study examined a group of Medicaid cardiovascular patients recently subject to a PDL and found a significant increase in both hospital and ambulatory physician visits in the six month study period following implementation compared to a non-Medicaid control. The average overall Medicaid costs for cardiovascular patients increased as a result.[51]

Conclusion

Even a strict analysis of just state budget expenditures shows the Governor's proposals are unlikely to achieve the desired savings while imposing significant hardship on beneficiaries. When viewed through the lens of the impact on public *and private* spending, the economic effects, the stress on the delivery system and other intangibles – such as the desire for a compassionate society – the reasons not to cut are clear.

"*Even a strict analysis of just state budget expenditures shows the Governor's proposals are unlikely to achieve the desired savings while imposing significant hardship on beneficiaries."*

Part IV : Alternatives to Medicaid Cuts

This paper has demonstrated that the Governor's proposed healthcare cuts are fundamentally inefficient. In all cases the proposed changes either directly harm the health prospects of beneficiaries, place additional stress on the healthcare delivery system, or both, while yielding saving for the state of only negligible amounts of money. Indeed, in some cases the cuts may prove to be *more expensive* than continuing on the current course.

A more rational approach to Medicaid budgeting would include four components: 1) an overall commitment to providing resources to do the job Rhode Island is asking the program to accomplish; 2) addressing the underlying cost growth mechanisms by appropriate means, *not* just within the program; 3) focusing on maximizing federal participation; and 4) focusing on improving program efficiency.

It is undeniable that the current course is one that is growing increasingly expensive. To some extent as Medicaid covers more people, costs will naturally go up. Moreover, Medicaid's role in society is expanding as a result of faltering ESI and rising demand for long-term care. The challenge, then, is for resources to grow commensurate with the program's growing role as insurer (or, alternately, to develop policies that will either keep people privately insured or else make insurance more affordable).

Concurrently, it is always prudent to explore options that can either slow Medicaid's growth rate or ease the funding pinch in ways that do not harm beneficiaries and do not merely shift costs onto other segments of the Rhode Island economy.

However, while it is important to look for ways to craft a more efficient Medicaid program, one must always be realistic about the factors driving Medicaid cost growth and policy actions meant to constrain them. Increases in Medicaid expenditures are generally conditioned on two elements: enrollment growth and medical service (including pharmaceutical) price inflation. The underlying components of these factors are not influenced by Medicaid policy changes. Lawmakers could, of course, scale back eligibility, or institute caps on state-funded portions of the programs to hold down enrollment. But, doing so does not alter the fundamental driver of enrollment growth – that more people are eligible for the program because they lack affordable insurance (due to a decline in ESI) and have low incomes (due to stagnant wage growth). Likewise, Medicaid administrators could adjust reimbursement to providers to hold down price growth. But, Rhode Island's rates are already low by national standards[52] and doing so only ignores, but does not affect,

the trend in rising prices. If the cost drivers exist external to the Medicaid program, it seems sensible that the solutions will be found there as well.

If there is a take-away message about cost-constraint policies, it is that they can only do so much. While an important player in the healthcare system, Medicaid does not control the factors that cause costs to rise as they historically have. The trend may be tempered through carefully crafted interventions though it seems unlikely that the program growth rate will ever fall below that of the tax base that supports it. To expect anything more is highly unlikely. So long as Medicaid remains the de-facto choice for affordable healthcare coverage in Rhode Island, then the people, businesses, and local governments should be expected to support it together. In other words, the state should be willing to pay at least as much as the next best option (which is the cost of care for the uninsured, the lost productivity, the lost federal match, the additional stress on providers, the poor health outcomes that result, and so on).

"If healthcare cost drivers exist external to the Medicaid program, it seems sensible that the solutions will be found there as well."

Prior to reducing services or eligibility, Rhode Island should exhaust reasonable options that tend to increase the scope of federal financial participation in Medicaid funding and take advantage of funding opportunities from within the state. One such way to accomplish this would be to alter the rate of the current hospital assessment up from 3.56%. Provided there is sufficient room below the upper payment limits for the system, and consistent with federal "hold-harmless" and equity provisions, such a move could raise in the tens of millions.

Constraining Costs via Program Efficiency

In addition to revenue maximization strategies, states across the country have undertaken various initiatives aimed at increasing the efficiency of the Medicaid program. Generally speaking, Medicaid expenditures follow the familiar "expenses = price * quantity" formula. Programs can be aimed either at reducing the cost of providing a service or reducing how much of that service consumers demand. Many such proposals center on prescription drugs which, while not the largest driver of increasing costs, are the fastest growing cost center.

Another area which may provide substantial cost savings, but will require some more investments, is new strategies for delivering care to the high-needs elderly and disabled. This group, even among the already high-cost elderly and disabled, require the most resource intensive medical services of all Medicaid beneficiaries and are, therefore, the highest cost users. Because of this high cost, even modest percentage reductions in spending can result in large nominal savings.

First, we can invest more in community-based providers rather than larger institutions, especially for non-emergent care. There are interesting alternative models in small scale in various parts of the country. The Commonwealth Care Alliance (CCA) in Massachusetts, Wisconsin's Community Health Partnership, and Axis Health Care are examples of effective pre-paid clinical care systems. Also, many CMS-backed Programs for All-inclusive Care for the Elderly (PACE), and some of UnitedHealthCare's EverCare products

operate similarly. The common aims of all is better coordination of dual eligible and other high needs individuals through integration of physical, behavioral and long-term services, more consumer participation, specialized primary care networks, and an exclusive focus on this discrete population. Many also utilize team based service delivery and reorient care towards the home.

For these reasons care delivered in such venues costs less than comparable care in some current Medicaid delivery channels. Two pilots coordinated by CCA demonstrate the potential for better outcomes and increased cost savings. Within the Boston Community Medical Group, 250 individuals with severe disabilities in a coordinated program had a per member / per month (pmpm) cost of $2,834, compared to $3,868 in the fee-for-service (FFS) system, a 27% decline. Costs for medical equipment, home health services, primary care and other tertiary services all rose in this population, but acute care expenses declined, resulting in substantial net savings.[53] A larger study of the Brightwood program showed similar declines. In that program, total medical expenditures declined from $834 pmpm to $580 pmpm following the introduction of a coordinated care initiative. Acute hospital expenditures alone fell from $220 to $88. The cost to the plan of the restructuring was estimated to be $86 pmpm. Net savings were over $2,000 a year for each enrollee.[54]

Approximately 10% of the dual eligible and disabled population requires specialized care that may be provided more effectively outside of current practice.[55] In Rhode Island this could capture between 4,000 and 6,000 beneficiaries. Assuming the percentage declines in costs demonstrated by pilot programs hold for larger groups, we anticipate that a prepaid clinical coordination program brought to scale would reduce costs approximate 20%. While there are costs associated with launching and coordinating such a program, due to the existing MCO framework in which Rhode Island operates, costs here would likely be less than in other states.

Other initiatives targeting population health, such as anti-smoking and HIV awareness campaigns, are not only good for the general residents of the state, but can also produce Medicaid cost savings as well. The success of comprehensive tobacco control programs in states such as California and Massachusetts particularly could serve as a model, potentially reducing smoking and its related diseases twice as quickly as national averages.[56] States are also taking innovative steps towards lowering the costs of prescription drugs by pooling purchases across state agencies and with other states, and by using their larger purchasing power to negotiate better rebates from pharmaceutical manufacturers.

The most ambitious cost-containment ideas are those aimed at linking spending with quality of care, particularly in hospitals. These initiatives are now operating in both the public and private sectors. An increasing number of "pay-for-performance" programs are demonstrating quality improvements and the potential for reduction in unnecessary costs, such as second hospitalizations following a preventable hospital-acquired infection. And of course, the quality benefits to the patients with these programs are priceless.

"*An increasing number of 'pay-for-performance' programs are demonstrating quality improvements and the potential for reduction in unnecessary costs, such as second hospitalizations following a preventable hospital-acquired infection. And of course, the quality benefits to the patients with these programs are priceless."*

The cost-containment ideas presented here represent just a small sample of efficacious actions that work not just through the Medicaid program, but target the fundamentals of cost-growth on a wider scale. The Governor might adopt and develop formal policy around any number of cost-constraining programs that could offset portions of the burdensome cuts currently proposed. Doing so would demonstrate a more sound appreciation for the true determinants of Medicaid cost growth, and a commitment to addressing them in reasonable systematic ways.

Final Thoughts

Throughout the last decade, the Rhode Island General Assembly has engaged beneficiaries, providers, and state residents in helping to create a public health care system that provides quality care, supports the commercial market, and acts as a critical economic engine for the state. The Medicaid cuts proposed by Governor Carcieri this year will do great damage to Rhode Island's entire health care system, by forgoing valuable federal matching funds, cutting access to care, and thus, creating a real and serious, decline in health and well being across the state.

Rhode Islanders rely on Medicaid because of their age, because they may live with a disability, and because private insurance is everywhere becoming more expensive. Recent survey data released by the Kaiser Commission on Medicaid and the Uninsured estimates that, nationwide, less than 9% of low-income adults (200% FPL or below) would have access to either employer sponsored or private coverage in the absence of public insurance.[57]

The quality of Rhode Island's health care depends on Medicaid, as a critical part of the health care tapestry – as does the health of Rhode Island's economy.

The General Assembly has the power to save both Rhode Island's health and its economy by rejecting the cuts proposed by the Governor, which clearly will end up costing more money over the long term.

"*Throughout the last decade, the Rhode Island General Assembly has engaged beneficiaries, providers, and state residents in helping to create a public health care system that provides quality care, supports the commercial market, and acts as a critical economic engine for the state.*"

Notes

[1] The Kaiser Family Foundation, statehealthfacts.org. Data Source: Compiled by the Health Management Associates from state Medicaid enrollment reports, for the Kaiser Commission on Medicaid and the Uninsured. Data as of June 2004, published September 2005.
[2] Data for total population from U.S. Census Bureau, Current Population Survey, March Supplement 2004 through 2005. Note that these data report population averages from 2003-4, and may differ from reported figures elsewhere in this document. Data for low-income (<100% FPL) population from [2] The Kaiser Family Foundation, statehealthfacts.org. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).
[3] U.S. Census Bureau, Current Population Survey, March Supplement 2004 through 2005.
[4] The Kaiser Family Foundation, statehealthfacts.org. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).
[5] Institute of Medicine, "Hidden Costs, Value Lost: Uninsurance in America," 2003.
[6] The Kaiser Family Foundation, statehealthfacts.org. Data Source: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2006. FY 2002 figures were inflated at 8% per year to reach present value.
[7] U.S. Census Bureau, Current Population Survey, March Supplement 2004 through 2005.
[8] The Kaiser Family Foundation, statehealthfacts.org. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).
[9] Ibid.
[10] The Kaiser Family Foundation, statehealthfacts.org. Data Source: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2006.
[11] Based on qualitative analysis performed by Community Catalyst.
[12] "Income Guidelines for RIte Care or RIte Share" RI Department of Human Services / Medical Assistance Program. April 2005.
[13] Table 28, Medicaid Expenditures, 2004 State Expenditure Report, National Association of State Budget Officers; available at http://www.nasbo.org/Publications/PDFs/2004ExpendReport.pdf.
[14] Ibid.
[15] The Kaiser Family Foundation, statehealthfacts.org. Data Source: State Health Expenditure Accounts, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2005; available at http://www.cms.hhs.gov/statistics/nhe/#state. The 2000 state personal health spending was inflated at its 1980-2000 growth rate, 8.4%, over four year to reach a common base year with state spending, 2004, which was $592 million.
[16] "Budget Analysis Fiscal Year 2007" House Fiscal Advisory Staff (of Rhode Island) available at http://www.rilin.state.ri.us/gen_assembly/HouseFinance/2007BudgetAnalysis.pdf
[17] "Health Insurance Costs" Ntnl. Cltn. on Health Care. available at http://www.nchc.org/facts/cost.shtml
[18] FY2006: Federal Register, November 24, 2004 (Vol. 69, No. 226), pp. 68372, at http://aspe.os.dhhs.gov/health/fmap06.htm. FY2007: Federal Register, November 30, 2005 (Volume 70, Number 229), pp. 71856-71857, at http://aspe.os.dhhs.gov/health/fmap07.htm.
[19] The Kaiser Family Foundation, statehealthfacts.org. Data Source: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2006.
[20] Ibid.
[21] The Kaiser Family Foundation, statehealthfacts.org. Data Source: Charlene Harrington, Ph.D.; Helen Carrillo, M.S.; and Cassandra Crawford, M.A., Table 6, "Nursing, Facilities, Staffing, Residents, and Facility Deficiencies, 1997 Through 2003," Department of Social and Behavioral Sciences, University of California, San Francisco, August 2004. Available at http://www.nccnhr.org/uploads/CHStateData04.pdf . Based on the Online Survey, Certification, and Reporting system (OSCAR), Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.
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[23] Ibid.
[24] "Health Insurance Costs" Ntnl. Cltn. on Health Care. available at http://www.nchc.org/facts/cost.shtml
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[29] Institute of Medicine "Health Insurance is a Family Matter." 2002.
[30] Dranove, D. and D.W. White "Medicaid-dependent hospitals and their patients: how have they fared?" *Health Services Research* 1998 Jun;33(2 Pt 1):163-85.
[31] "Current Employment Statistics (CES)" report, accurate as of January 2006. U.S. Department of Labor, Bureau of Labor Statistics.

[32] Using the Families USA calculator, we estimate that about 15,500 jobs are created through FFP we assume at least 33% of these are in the three fields classified as healthcare industry by the BLS while the rest are in associated support industries. The resulting 5,167 jobs are over 8% of the 63,200 employed in the healthcare workforce in January, 2006. If 50% of the created jobs were explicitly healthcare, and not related industries, that would be 12.1% of all healthcare employment. 10% seems a reasonable middle.
[33] http://taxfoundation.org/research/topic/56.html
[34] "Medicaid: Good Medicine for State Economies 2004 Update" Families USA, May 2004. See also tax calculator available http://www.familiesusa.org/issues/medicaid/states/medicaid-calculator.html?state=Rhode_Island.
[35] We assume a 20% take up rate. A recent report concluded that less than 9% of low-income (<200% FPL) individuals could gain access to insurance absent public coverage. As Rhode Island covers some people higher than this, we use a higher figure, 15%, plus 1/3rd, to produce a conservative error. Please note that in reality, we may overestimate take up by 100%, and subsequently underestimate the financial loss resulting there from. See, "What Happens When Public Coverage Is No Longer Available?" Long, S.K., and J. Graves. The Urban Institute and Kaiser Commision on Medicaid and the Uninsured.
[36] Institute of Medicine, "Hidden Costs, Value Lost: Uninsurance in America," 2003. The cost of lost productivity per uninsured has been inflated to present value.
[37] Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays For It?" *Health Affairs, Web Exclusive*, February 12, 2003, pp. W3-66 – W3-81, at p. W3-70. See also Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 10, 2004).
[38] "Paying a Premium: The Added Cost of Care for the Uninsured" Families USA / Ken Thorpe, June 2005.
[39] "Budget Analysis Fiscal Year 2007" House Fiscal Advisory Staff (of Rhode Island) available at http://www.rilin.state.ri.us/gen_assembly/HouseFinance/2007BudgetAnalysis.pdf
[40] For the remainder of this section details of budget proposals are all found in the aforementioned document, "Budget Analysis Fiscal Year 2007" House Fiscal Advisory Staff. Other claims are cited as appropriate.
[41] "What Happens When Public Coverage Is No Longer Available?" Long, S.K., and J. Graves. The Urban Institute and Kaiser Commision on Medicaid and the Uninsured.
[42] We again rely here on the Families USA "Medicaid: Good Medicine for State Economies 2004 Update" and the associated calculator. This figure is the effect of the $22.5 million cut.
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[53] "Improving Care and Managing Cost for Medicaid and Dually Eligible Disabled Populations" presentation of Robert J. Master, MD, 2005.
[54] Ibid.
[55] The comments of Dr. Norbert Goldfield, Medical Director Health Information Services, 3M.
[56] "Comprehensive Statewide Tobacco Prevention Programs Save Money" Eric Lindblom, Campaign for Tobacco Free Kids, February 24, 2005.
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