A MISSOURI HEALTH POLICY AGENDA

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Pity the poor state of Missouri. Its citizens are so burdened with taxes (we rank thirty-fifth of fifty in personal taxation)[1] that the legislature cannot countenance any increases to support necessary social and health programs.[2] Our business tax situation is so oppressive (we rank fifteenth of fifty)[3] that business will flee the state if a fairer distribution of tax burden is enacted.[4] To assure that a "runaway government" does not overreact and actually *do* what government is supposed to do, the electorate voted in a constitutional requirement that any tax increase generating more than $75 million in revenue be submitted to a referendum.[5] And if these factors were not enough to assure impotent and ineffective government, a version of the Taxpayers' Bill of Rights—so erosive of responsible government that Colorado tolled its implementation—will likely be on the Missouri ballot in November.[6]

Against this background, I have been asked to speak to a Missouri "health policy agenda." This is a challenge under today's circumstances. Do I focus on the explicit agenda of the current state policy apparatus? Or look beyond that to the implicit agenda that drives today's state actions? Or posit an agenda based on the needs of the state's residents, particularly the most vulnerable?

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1. The Tax Foundation, *Missouri's State and Local Tax Burden Compared to U.S. Average (1970 – 2006)*, Apr. 11, 2006, *available at* http://www.taxfoundation.org/taxdata/show/464.html; Editorial, *Frankenstein's Monster*, ST. LOUIS POST-DISPATCH, Aug. 15, 2001, at B6 (stating that the combined state and local tax burden in Missouri is anywhere from thirty-first to forty-eighth among the states, depending on which study is used).

2. *See* Editorial, *supra* note 1.

3. CURTIS S. DUBAY & CHRIS ATKINS, 2006 STATE BUSINESS TAX CLIMATE INDEX, TAX FOUND. BACKGROUND PAPERS (NO. 52) 2 (Oct. 2006), *available at* http://www.tax foundation.org/files/bp52.pdf.

4. *See* Editorial, *supra* note 1.

5. MO. CONST. art. X, §16–24; *see also* RUSS HEMBREE, MO. LEGIS. ACAD., THE HANCOCK AMENDMENT: MISSOURI'S TAX LIMITATION MEASURE (Dec. 2004), *available at* http://www.truman.missouri.edu/uploads/Publications/MLA%2049-2004.pdf.

6. Amy Blouin, *Don't Be Fooled by Vague Spending Petition*, ST. LOUIS POST-DISPATCH, Apr. 20, 2006, at B9.

In the first instance, I can report and leave you to your own conclusions. In the second, provide a critique and analysis based on my own social prejudices. And in the third, shower you with a totally unrealistic and unachievable set of policies for Missouri today.

You see, like the nation as a whole, Missouri is in a phase of extreme partisanship. Empirical data is labeled "bad science" if it does not fit the partisan preconceptions of the recipient. Anecdotal data is blown off as "unscientific" and "politically-inspired." Missouri's tradition of stubbornness—the "Show Me" tradition and the Missouri mule—has become intransigence, and "Missouri Compromise" is an oxymoron.

Welcome to the health policy arena in Missouri, 2006.

What is at work here? I found the following parable re-told in Larry Churchill's little book *Rationing Health Care in America* useful in pursuing an answer to that question:

> Once upon a time there was a man who sought solitude, who felt he didn't need company of people; went to live alone in a hut he had found in the forest among the trees. At first he was content, but a bitter winter came and the hut proved drafty and uncomfortable. That led him to cut down the trees around his hut for firewood. The next summer he was hot and uncomfortable because his hut had no shade, and he complained bitterly of the harshness of the elements.
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> In his quest for self-sufficiency, he made a little garden and kept some chickens. For a time he ate well, but rabbits were attracted by the food in the garden and ate much of it. The man went into the forest and trapped a fox, which he tamed and taught to catch rabbits. But the fox ate up the man's chickens as well. The man shot the fox and cursed the perfidy of the creatures of the wild.
>
> The man was not neat . . . after all, one of the reasons he escaped to the forest was to avoid the judgment of others concerning his personal habits. He took to throwing refuse on the floor of the hut, and it accumulated to where it was difficult for him to move about, and attracted vermin. Since the man was clever with his hands and tools, he approached this problem by constructing an intricate set of ropes and pulleys from which he suspended the furnishings in the hut, keeping them above the mess. Alas, the weight proved too much for the rafters, and one day the hut collapsed. He built another, all the time grumbling about the inferior construction approach followed by the original builder.
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> He did go to town occasionally, and was heard to brag on the peacefulness of his woods, and the abundant game. The villagers began to come out to the woods to hunt and to picnic. Upset, the man cursed the intrusiveness of human beings.
>
> He posted his land and set traps to discourage trespassers. The boys from the village were put off by this anti-social behavior, and began to sneak out to the cabin at night and harass the man with noises and an occasional stone thrown on the roof. The man took to sleeping sitting in a chair with a shotgun

> on his lap to scare off the boys, and one night, his chair tipped over and he shot himself in the foot.
>
> The villagers were saddened when they heard the news, because they wished ill to no man. The word spread quickly, although the villagers had long past forgotten the man's name. In fact they had given him a name they chose because he was so stubbornly self reliant, and so prone to blame others for his misfortune, and so technically competent, and that was the name that spread through the village—Did you hear? He shot himself. The American shot himself.[7]

Technical competence, self-reliance, rugged individualism—these are cherished traits in the American character, and rightly so. They became ingrained in that character in an era when many were literally on their own on a frontier without social or political systems. They still exert a powerful tug at the American consciousness despite the changes of the past two hundred years.

A substantial part of today's political and policy agenda is rooted in these values—in a return to a simpler time before a more complex society required community rather than individual actions to maintain economic stability and quality of life.

Today's mantra—"personal responsibility"—represents a perversion of these values. Poor and underemployed? You're responsible—find yourself a better job! Unable to afford medical treatment? You're responsible—buy yourself some insurance! Can't get health insurance? You're responsible—start a Health Savings Account (HSA) and save for health care!

Perhaps no place is this more obvious than in Missouri in 2006.

Let's look back a bit—actually a lot—at efforts to secure access to needed health care for Americans.

There has always been a portion of the population that has had impaired access to needed health care because of poverty. Historically, these were also the people who lived in conditions that had negative impacts on their health.[8] Today, impaired access is much more pervasive.[9] Escalating costs of health care coupled with erosion of the employment-based health insurance model embraced in the U.S. after World War II has created a new and very different health underclass.[10] Eighty percent of the 45.5 million Americans and 707,000 Missourians who are without health coverage are in families with at least one

7. LARRY CHURCHILL, RATIONING HEALTH LAW IN AMERICA: PERCEPTIONS AND PRINCIPLES OF JUSTICE 21–22 (1987) (quoting PHILIP E. SLATER, THE PURSUIT OF LONELINESS: AMERICAN CULTURE AT THE BREAKING POINT xi–xii (1970)).

8. *See generally* Karen Davis, *Inequality and Access to Healthcare*, 69 MILBANK Q. 253, 253 (1991).

9. *Id.* at 261 (noting that race and geographic location were less important than insurance coverage in determining whether patients received ambulatory and inpatient care).

10. Kao-Ping Chua, *The Case for Universal Health Care*, Feb. 10, 2006, http://www.amsa.org/uhc/CaseForUHC.pdf.

full-time worker.[11] They are not wealthy, but they are not destitute either. But they are denied access to health care because they cannot afford it directly (almost nobody can), nor can they afford health insurance.[12]

In earlier times, the solution to meeting the health care needs of those who were poor and could not afford care was a system of charity care provided by local government hospitals and clinics, teaching institutions, religious organizations, and private physicians.[13] This informal system was often inefficient and insufficient, but was all there was at the time. As the population grew and medicine gained capability to actually treat illness, this voluntary system was strained both because of demand and cost. Early in the last century, the problem of a fragmented, often inaccessible system was recognized, and the first of a long line of proposals to assure all had access to needed care appeared in the platform of the Progressive Republican or Bull Moose Party in the 1912 Presidential campaign.[14] The party lost and so did the proposal for an improved way of assuring that people had access to health care. That was the first loss, but not the last. Some dozen times since 1912, the issue of payment for health care through some kind of governmental or public-private partnership has come on the national radar screen, enjoyed a moment of popular support, and been ultimately defeated.[15]

The exception to this history of rejection has been Medicaid and Medicare, both enacted in 1965.[16] These programs are well-known to this audience, although Medicaid is often misinterpreted by the public, who believe it provides care for all those without financial access to needed health care.[17] It was never intended to do that, but neither was it intended to do all it currently does.[18] In 1965, Medicaid was a lagniappe to the states to court support for the

11. CARMEN DENAVAS-WALT ET AL., U.S. DEPT. OF COM. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005 (Aug. 2006), *available at* http://www.census.gov/prod/2006pubs/p60-231.pdf.

12. *See* Laura B. Benko, *Outlook '03: Even with Unrelenting Cost Increases, Some Sectors Enjoy a Healthier Prognosis*, MOD. HEALTHCARE, Jan. 6, 2003, at 26 (noting that health insurers increased rates by 13.7% in 2002 and were expected to raise rates an average of 15.4% in 2003); *see also Health Insurance Premiums up 87 Percent Since 2000*, CHI. SUN-TIMES, Sept. 26, 2006, at 72 (cost of health insurance averages $4,242 a year for individuals and $11,480 for families).

13. *See* WALTER J. TRATTNER, FROM POOR LAW TO WELFARE STATE: A HISTORY OF SOCIAL WELFARE IN AMERICA 32–40 (6th ed. 1974) (discussing how local government units and various private charities developed in Eighteenth Century to provide healthcare to the poor).

14. *See* Karen Davis, *Universal Coverage in the United States: Lessons From Experience of the 20th Century*, 78 J. OF URB. HEALTH 46, 47 (2001).

15. *Id*. at 49 (stating that throughout the 20th Century, political obstacles prevented the implementation of universal health insurance coverage despite the fact that it surfaced as a major public policy issue in numerous eras).

16. *Id*. at 47.

17. *See* TRATTNER, *supra* note 13, at 327.

18. *Id*. at 326.

program with real political appeal—Medicare.[19] Medicaid provided access to a medical benefit for a very limited part of the poverty population, those receiving benefits under specified welfare programs.[20]

As the employment-based approach to providing health insurance eroded under the pressures of cost increases and a shift toward a service economy, access to health care became more constrained.[21] In response, the scope of the Medicaid program was expanded, although not all states opted for the same expansions.[22] In addition, the program was enlarged by mandates that certain services be covered.[23] Over time, Medicaid became the states' and Congress' means to avoid facing the deterioration of access in the United States and acting in a comprehensive fashion as other developed countries had done.

States were free to structure much of their approach to Medicaid within broad federal guidelines, and great variation across states came to characterize the Medicaid program.[24] From 1993 to 1998, Missouri Medicaid grew slowly both in numbers of enrollees and in cost.[25] In the late 1990s, Missouri was one of the states that expanded its Medicaid program to encompass more and more of its citizens who were working, but uninsured.[26] Missouri Medicaid came to be a series of programs supporting medical care for different population groups with different eligibility requirements, varied income criteria, specific target populations, and different levels of federal financial participation.[27]

19. *Id*. Medicaid and Medicare grew out of a common program under the provisions of the Kerr-Mills Act of 1960. *Id.* This program established a health insurance plan for the elderly under a public assistance format, which required states to match federal funds. *Id*. When states refused to provide matching funds under the Kerr-Mills program, Medicare was implemented to provide medical insurance to the elderly under full federal funding. *Id.* Medicaid, on the other hand, was established under a federal grant system, which allowed the states to allocate federal funds. *Id.* at 326–27.

20. *Id*. at 327.

21. Davis, *supra* note 14, at 50.

22. *See* Saundra K. Schneider, *The Impact of Welfare Reform on Medicaid*, 28 PUBLIUS: J. FEDERALISM 161, 161–62, 171 (1998).

23. Colleen M. Grogan, *The Influence of Federal Mandates on State Medicaid and AFDC Decision-Making*, 29 PUBLIUS: J. FEDERALISM 1, 2–3 (1999).

24. Schneider, *supra* note 22, at 170–171.

25. *See* Anne B. Martin, Lekha S. Whittle & Katharine R. Levit, *Trends in State Health Care Expenditures and Funding: 1980–1998*, 22 HEALTH CARE FINANCING REV. 111, 131 (2001) (noting that Medicaid spending grew 4.9% in 1998, the first year since 1993 that growth accelerated).

26. *See* M. Ryan Barker, *Missouri Medicaid Basics* (Mo. Found. for Health, St. Louis, Mo.), Winter 2005, at 3, *available at* www.mffh.org/medicaidbasics.pdf ("Missouri has a Specified Low Income Medicare Beneficiary (SLMB) program that pays the Medicare Part B premiums for person whose income is more than 100 percent of the FPL, but less than 135 percent of the FPL.").

27. *See id*.

At the end of fiscal year 2004, the elements of the Missouri program included:[28]

- Medical Assistance—Aged, Blind, or Disabled
- Qualified Medicare Beneficiary
- MC+ for Children (non-SCHIP)
- MC+ for Kids (SCHIP)
- Medical Assistance for Adults
- MC+ for Pregnant Women

More significant than the categories themselves were the eligibility standards Missouri applied in each category. Liberal standards applied to each program. For example, the combined children's programs covered those under 18% up to 300% of the federal poverty level (FPL) with co-pay or premium requirements for the higher income families.[29] The Medical Assistance for Families program covered parents or caregivers of children with incomes to 75% of poverty.[30] Disabled individuals who were working and had incomes up to 250% of poverty qualified for Medical Assistance for the Working Disabled.[31] Taken together, the various elements of Missouri Medicaid covered about 975,000 people at the end of 2004, 56% of them children.[32]

The breadth of coverage achieved by Missouri Medicaid came at a cost. The state's Medicaid budget published in the 2004 Annual Fiscal Report approached $5 billion, $1 billion of which was state general revenue funding, while the rest was made up by federal payments, funds for the tobacco settlement, and provider taxes.[33]

In 2005, a "Perfect Storm" hit Missouri Medicaid. The elements were a sluggish state economy with decreased tax receipts, a sweep of the Governorship and the General Assembly by conservative, small government, no-tax Republicans, continued escalation in health care costs, and an increase in the uninsured as more lost employment-based health coverage.

The storm found form in Senate Bill 539,[34] a Medicaid reform measure, and in the fiscal year 2006 state budget.[35] Senate Bill 539 imposed substantial

28. *Id*. at 3–5.

29. *Id*. at 4.

30. *Id*. at 5.

31. MICKEY WILSON ET AL., MO. COMM. ON LEGIS. RES., OVERSIGHT DIV., APPLICATION PROCESS AND ELIGIBILITY VERIFICATION OF MEDICAID 3 (Dec. 2, 2004).

32. Barker, *supra* note 26, at 2; TIMOTHY D. MCBRIDE, MO. FOUND. FOR HEALTH, COMPARISON OF MISSOURI UNINSURANCE SURVEY DATA SOURCES 6 (Jan. 2006), *available at* http://www.mffh.org/ShowMe8-final.pdf.

33. Barker, *supra* note 26, at 9.

34. S.B. 539, 93d Gen. Assem., Reg. Sess. (Mo. 2005).

35. STAFF OF MO. SEN. APPROPRIATIONS COMM., 93D GEN. ASSEM., 2005 ANNUAL FISCAL REPORT (Mo. 2005) [hereinafter 2005 ANNUAL FISCAL REPORT].

changes in the scope and coverage of the programs, sunset the program entirely in 2008, and created a legislative commission to lay the groundwork for a new approach to supporting health care for Missouri's medically needy.[36] The budget implemented the cut-backs in Medicaid coverage, and the net result at implementation on September 1, 2005 was to add more than 100,000 Missouri residents to the ranks of the uninsured.[37]

The cuts evoked a loud and generally negative response among those who advocate for an effective and accessible health system. It is not my purpose today to revisit the continuing arguments and acrimony surrounding the Medicaid cuts, but to focus on another aspect of what is happening in Missouri. Having created a *tabula rasa* by sunsetting Medicaid, the General Assembly created an *opportunity* to re-think the issue of society's responsibility for the health of its members.

The Medicaid Reform Commission met for several months in late 2005 and early 2006, conducted hearings, heard from consultants, and produced a report containing eighty-two recommendations for consideration by the public and the legislature as efforts began to craft a "replacement" for Missouri Medicaid.[38] Those recommendations represent a starting point for discussing a future health policy agenda for Missouri.

Many of the Commission recommendations are for common sense inclusions that would strengthen any revision of a state program for the medically needy. These include expanded use of electronic medical records, provisions for alternatives to the emergency room as a source of primary care, expanding support for health clinics, expanding use of chronic care case management, improving health literacy, providing incentives for provider participation in government programs, and increasing emphasis on preventive services.[39]

When the report introduces ideas for structural change, however, it becomes more controversial. Among the Commission's structural recommendations are the following:[40]

- Imposition of tiered co-pays is recommended by the Commission as a step to "promote personal responsibility and healthy lifestyles."
- Another tiering recommendation would categorize benefits and make certain benefits available only to certain categories of patients, a move

36. S.B. 539 (enacted at MO. ANN. STAT. § 208.640 (West 2004 & Supp. 2006)).

37. Leighton Ku & Judith Solomon, *Is Missouri's Medicaid Program Out-Of-Step and Inefficient?* (Ctr. on Budget & Pol'y Priorities, Washington, D.C.), Apr. 5, 2005, at 1, *available at* http://www.cbpp.org/4-4-05health.pdf.

38. MEDICAID REFORM COMM'N, MEDICAID REFORM COMMISSION REPORT 2, 5, 68–72 (2005).

39. *Id*. at 19, 26, 52, 68.

40. *Id*. at 6, 60.

> away from medical necessity to fiscal expediency as the determinant of health care.

Opponents of the approach point out the empirical evidence that co-payments are a detriment to care and health, particularly for those with limited financial resources. That issue will be central to debate concerning any proposal put before the General Assembly as a replacement for Missouri Medicaid.

What is required if Missouri is to write a new approach to the issue of the uninsured and medically indigent on the blank slate provided by the sunset provision? The debate will be lively and polarized. Are you for single-payer because you don't trust the private sector to clean up its own mess? Or are you for vouchers and HSAs because you don't trust government—period? In either case, you are focused on means, not ends. What is lacking in Missouri is an accepted *goal* for public policy. That is the point from which to start, not anecdotes of abuse and zero tolerance to adequately fund an effective program of medical assistance.

I propose the following preconditions to the development of an effective health policy:

- *Public acceptance that there is a problem.* This is the "political will" issue. If one is employed and insured, the issue of the uninsured is not really on one's radar. Sure, a response to an opinion survey might indicate that it is an issue, but a response to a tax proposal to fix it is different. Until there is an effective effort to make the insured voter understand the ripple effects of uninsurance on them, change is unlikely.
- *Political consensus on a goal.* Absent a goal, efforts around the uninsured issue will continue to be driven by expediency, special interest lobbying, and ideology. More about this later.
- *Business buy-in.* The political impotence of the uninsured is often decried. Another group with undeniable political clout is also being affected by the idiosyncratic approach to paying for health services—the business sector. If their angst over eroding sales and profits can be harnessed in support of health care reform, it will happen.

Even if these preconditions were to be met, there remains the Missouri mythology of barriers to effectively addressing the uninsured issue.

Missouri Myth # 1: It would cost too much to cover the uninsured in the state. This is a prevalent myth in political circles from the national level to the local level in this country. One of the first policy initiatives undertaken by the Missouri Foundation for Health (MFH) was to find out how much Missouri was actually spending on health.[41] We contracted with Professor Ken Thorpe at Emory University to examine that question, using a comprehensive

41. *See* KENNETH E. THORPE, MO. FOUND. FOR HEALTH, HEALTH CARE EXPENDITURES AND INSURANCE IN MISSOURI (2003), *available at* http://www.mffh.org/ShowMe2_FINAL.pdf.

definition of health expenditure. That study documented $30 billion in expenditures, representing about 16% of the state's domestic product.[42] We then proposed a second question to Professor Thorpe—how much more would it cost to cover everybody in the state? The answer was surprising—Thorpe's study predicted it would cost $1.3 billion less under the assumptions he used.[43] The major assumption was a single-payer plan covering all Missourians, and the savings were substantially generated from decreased administrative costs.[44]

Missouri Myth #2: Missourians are unwilling to increase taxes to support state health care programs. The tax averse nature of Missourians is legendary—surely they would not support tax increases to deal with the uninsured and underinsured. Again, MFH contracted with a national polling firm, Lake Snell Perry & Associates, to sample a statistically significant subset of the Missouri population to determine their attitudes on tax increases for health care.[45] A large percentage of respondents (74%) favored differential tax treatment for corporations that did not provide a health insurance benefit.[46] When asked about funding sources for programs for the uninsured, 44% favored closing tax loopholes for corporations, while about a quarter focused on "sin taxes" and casino earnings as potential sources.[47] Missouri voters are willing to examine tax increases, but usually for somebody else's taxes![48]

Missouri Myth #3: People above 100% of poverty can find affordable and adequate health insurance in the private market. This myth holds that there are affordable insurance options in the private marketplace that provide adequate coverage for those with an income of $19,350 for a family of four.[49] Since the average cost of family coverage in the private market in the state is $9,600 a year, the affordability for the poverty family is at best questionable, and perhaps mythic.

42. *Id*. at 5; *see* Press Release, U.S. Dep't Com., Bureau of Econ. Analysis, Western States Led Economic Growth in 2005 (June 6, 2006) (computing $30 billion in expenditures divided by approximately $183.5 billion in state domestic product), *available at* http://bea.gov/bea/newsrelarchive/2006/gsp0606_fax.pdf.

43. KENNETH E. THORPE, MO. FOUND. FOR HEALTH, A UNIVERSAL HEALTH CARE PLAN FOR MISSOURI 3 (2003), *available at* http://www.mffh.org/ShowMe3.pdf.

44. James R. Kimmey, *Preface* to THORPE, *supra* note 43.

45. LAKE SNELL PERRY & ASSOCIATES & TARRANCE GROUP, MO. FOUND. FOR HEALTH, MISSOURIANS' ATTITUDES ON HEALTH CARE: A BI-PARTISAN ANALYSIS OF SURVEY FINDINGS (Winter 2005), *available at* http://www.mffh.org/ShowMe6-web.pdf.

46. *Id*. at 8.

47. *Id*. at 11.

48. *See* LAKE SNELL PERRY & ASSOCIATES, MO. FOUND. FOR HEALTH, A PROFILE OF MEDICAID IN MISSOURI: REPORT ON SURVEY FINDINGS 3 (Winter 2004), *available at* http://www.mffh.org/ShowMe4FINAL.pdf.

49. M. RYAN BARKER, MO. FOUND. FOR HEALTH, PROFILES OF MEDICAID REFORM: A LOOK AT OTHER STATES 23 (Fall 2005), *available at* http://www.mffh.org/ShowMe7-web.pdf.

Missouri Myth #4: Imposing premiums on low-income families for participation in SCHIP will not hurt children's access to needed care. The revisions to Medicaid in 2005 significantly changed the State Children's Health Insurance Program (SCHIP) program in Missouri. Prior to the changes in the program, only families with incomes between 226% and 300% of the FPL were required to pay premiums.[50] Under the revised Missouri Medicaid, the threshold for required premium payments dropped to 151% of FPL.[51] In addition, those families were also brought under the "affordability test" previously applied only to those above 226% of FPL.[52] Under that provision, a family found to have "access" to employer coverage deemed affordable cannot quality for SCHIP even though the family is willing to pay the SCHIP premium.[53] Estimates of the number of children in families unable to meet the premium and/or affordability requirements are in the 20,000 range.[54] Myth busted!

Missouri Myth #5: The state spends $5.5 billion of its $19.2 billion budget on Medicaid.[55] This one is true, sort of. Although the $5.5 billion figure was often put forth as a fact underlying the effort to cut the size of the program, and the fact that it represented more than a quarter of the state's budget, these numbers are from the all sources budget and include federal funds as well as other funds above state general revenues.[56] When the state's general revenue budget is considered, Medicaid accounted for a bit over $1.4 billion of a $7.8 billion general revenue budget, or 18%. This ranks Missouri eleventh among the states in general revenue expenditure for Medicaid.[57] However, when per capita general revenue expenditures are compared, Missouri ranks thirty-fourth in level of expenditure.[58]

These are presented as Missouri's myths, but they are more pervasive than that, suffusing health policy in other states and in Washington. They reflect that the preconditions for progress remain unmet.

Like the American's cabin in the parable, we have constructed a hundred ways to cope with the mess that is American health care, but are unwilling to

50. MO. ANN. STAT. § 208.640 (West 2004).

51. S.B. 539, 93d Gen. Assem., Reg. Sess. (Mo. 2005) (enacted at MO. ANN. STAT. § 208.640 (West 2004 & Supp. 2006)).

52. *Id.*

53. Joel Ferber, *Measuring the Decline in Children's Participation in the Missouri Medicaid Program* (Legal Servs. E. Mo., St. Louis, Mo.), Mar. 2006, at 1, *available at* http://www.masw.org/policy/2006/reports/Childrens_participation.pdf.

54. *Id.*; *see also* 2005 ANNUAL FISCAL REPORT, *supra* note 35, at iii..

55. 2005 ANNUAL FISCAL REPORT, *supra* note 35, at iii, 65.

56. *Id.* at 65; Ku & Solomon, *supra* note 37, at 2.

57. Ku & Solomon, *supra* note 37, at 2.

58. *Id.* at 3.

pitch in and attack the mess itself. We seem willing to try *anything* to avoid the *right* thing!

The *wrong thing* is to continue to push *personal responsibility* as the solution without providing *personal authority*. In contemporary terms, the authority that is lacking is financial access. In order for individual decisions to drive the market, to achieve "consumer driven health care," individuals have to be able to participate—and today, more than 45 million lack the means to do so.[59]

59. *Economic Recovery Failed to Benefit Much of the Population in 2004* (Ctr. on Budget & Pol'y Priorities, Washington, D.C.), Aug. 30, 2005, at 3, *available at* http://www.cbpp.org/8-30-05pov.pdf.