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SECTION A. EXECUTIVE SUMMARY

The state received official notice of award on October 6, 2003. The first year of the grant, the focus was on the development of data collection instruments and methodologies, procurement of contractors for grant related activities, and identifying and collecting information needed to develop preliminary policy options. By January 2004, all program staff were hired and five contracts were established to carry out the work of the research (i.e., household survey, focus groups, employer focus groups and key informant interviews), and to provide technical assistance and facilitation for the work with meetings.

During these research efforts, the state staff was trained and developed presentations using Current Population Survey (CPS) and Behavioral Risk Factor Surveillance Survey (BRFSS) data from the Multi-State Integrated Data system (MSID). Research of data using Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) and other data sources were also conducted. A literature review was conducted and document drafted on the cost drivers of health care insurance for the nation and Missouri.

In January 2004, the Advisory Council on the Accessibility and Affordability of Health Insurance Coverage (the Council) was established and convened for its first meeting. This council drafted a Guiding Principles document to guide the process, decision-making, and development of policy options. Presentations on the purpose of the grant and the role of the Council was accomplished at the first meeting, as well as a guest presentation on national trends and activities of other states by Jeremy Alberga from Academy Health. The second meeting (March 2004) entailed data presentations on MEPS-IC, BRFSS, and CPS; data and information sharing from Council members; and work on the guiding principles. Compilation and graphical presentation of data helped the Council gain a better understanding of the uninsured issue and the complexity of the problem. The third Council meeting (May 2004) consisted of a presentation on preliminary state data results, presentations from Council members and discussion on cost drivers. The Missouri Survey was completed in July 2004 and data sent to SHADAC for analysis and a written report. SHADAC presented the final data results of the 2004 Missouri Health Insurance Coverage and Access Survey (Missouri Survey) to the Council in October 2004. The focus group field research work was completed by the end of August, with written reports and an AC presentation in October 2004. Subcommittees were formed and have met to further address the policy options, the communications strategies, and to sustain the efforts of this initiative. The Council initiated discussions on policy options at the fourth meeting.

In August 2005, feedback was solicited from the citizens of Missouri on the accessibility and affordability of health insurance. To do this, the MSPG received a Limited Continuation Competition Grant to visit 21 communities to carry out public deliberation forums. These were scheduled throughout the state and would involve two types of meetings: community meetings and regional meetings. To successfully carry out these forums, a team of individuals was recruited to assist with training, planning, and the development of an Issue Book to be used at the forum to guide discussion. The name of the forums was “Covering the Uninsured in Your Community: Why it is Everyone’s Problem”. For these public deliberations, the top 10 themes were identified: Pooling encouraged; Prevention needed; Affordability; Accessibility; Consumerism; Medicaid concerns; Personal responsibility; Better health insurance products; Over-utilization and misuse;

and State involvement. This year's activities culminated with the citizens of Missouri providing us valuable insight and feedback. Change and innovative thinking in the system are clearly needed and wanted. That change must involve multiple stakeholders, including individuals, families, employers, pharmaceutical and insurance industries, hospitals and providers, and the state government. Most importantly, change will most likely occur if these key players apply solutions to this challenge within a community context. These insightful deliberations show that all stakeholders must become better integrated and work together to provide affordable and accessible health insurance for all Missourians.

During the first meeting, in April 2006, the MSPG and/or subcontractors provided to the Policy Workgroup an overview of the existing data sources used in the first year of the grant; oriented the group to the main purpose of the Policy Workgroup (i.e., determine if this option should move forward with a recommendation in a formal report to the Governor's Office). If the Policy Workgroup's recommendation is affirmative, the Policy Workgroup will be asked to outline an action plan for implementation. In the May meeting speakers from other parallel, and potentially competitive, initiatives in Missouri, such as Associated Industries of Missouri (AIM), were invited to provide their experiences. To facilitate the Policy Workgroup's understanding of modeling design, a Policy Option Feature Survey was designed to frame discussion for the June meeting. The survey prompted Policy Workgroup members to make choices about tradeoffs and particular issues for Missouri regarding these features. In July, the focus of the meeting was access, affordability, and risk for the target populations. The group from this discussion outlined the characteristics of the policy option. At the submission of this final report, the contractor is modeling the policy option and working closely with the Executive Director of the MCHCP. A meeting is scheduled in September 2006 to review the policy option.

If, indeed, based upon the recommendations of the Policy Workgroup, a funding source is identified and the executive branch approves of the policy option being pursued, it will be necessary to secure legislative support, as well, in order to pursue this policy option during the January-May 2007 legislative session. Deliberately, the Policy Workgroup has been populated with key legislators from both the Senate and the House of Representatives to groom champions who will be prepared to carry a legislative agenda forward with their peers.

SECTION B. BACKGROUND AND PREVIOUS HRSA SPG ACCOMPLISHMENTS

The Health Insurance Environment in the State – Data Support from the Missouri Health Insurance Coverage and Access Survey

It is well documented in the literature that people without health insurance are sick more often and die sooner than the insured. In the Institute of Medicine report *Hidden Cost, Value Lost: Uninsurance in America (2003)* it was cited that the poor health and premature deaths of persons without health care coverage costs the nation between $65 billion and $130 billion, respectively, annually. Paying for uncompensated health care for the uninsured puts a strain on a community's safety net and public health infrastructure and can affect the quality of medical care for everyone.

Missouri exceeds the national average in per capita health care expenditures (Table 1). Per capita for 2003, Missouri spent $5,395 on personal health care, while the nation's average is $4,951. Unless the state identifies ways to curb the rising costs associated with health care, it will be challenging to identify the funding necessary to sustain coverage, as well as expand coverage.

Table 1. Total Personal Health Care Spending in Missouri and other Payers (Millions of Dollars)

Total	Federal*	State and Local	Out of Pocket	Private Insurance	Other Private Funds	Medicare	Medicaid**
$29,444	$10,205	$3,385	$4,199	$10,484	$1,168	$5,831	$4,204

Source: Missouri Foundation for Health, 2003.[1]
* includes Medicare, the federal share of Medicaid and the State Children's Health Insurance Program (SCHIP).
**includes both federal and state spending

Missouri's rate of uninsurance has historically been relatively low, with current estimates ranging from 11.0% to 13.2%, according to the Current Population Survey and the Behavioral Risk Factor Surveillance Survey, respectively.[2,3.] Findings from the 2004 Missouri Health Insurance Coverage and Access Survey (i.e., the Missouri Survey), conducted between March 2004 and July 2004, indicate the overall level of uninsurance for the state of Missouri, across all age groups, was 8.4% (approximately 463,000 individuals) at the time of the survey (Table 2). People who were uninsured all or part of the year was the largest of the rates (10.9%), as the numerator comprises the number of full and part-year uninsured, in addition to anyone who was uninsured for *any* length of time during the period covered by the survey. Over 6% of the respondents were uninsured all year. Table 3 provides uninsurance rates by population characteristics.

Table 2. Alternative Definitions of Insurances Rates	
Definition	**Missouri Uninsured Rates**
Point-in-time	8.4%
Uninsured all year	6.6%
Uninsured part year	4.2%
Uninsured all or part year[1]	10.9%
[1]Uninsured all or part of the year is the sum of the previous two categories "Uninsured all year" and "Uninsured part year."	

Summary of Uninsurance in Missouri

Summarizing the information provided above, Missouri data yielded four very important observations that will be critical in developing policies related to health insurance coverage:

- Young adults (ages 19-24) comprise the age group that is most likely to be uninsured. This finding, consistent with national data, highlights a coverage gap that occurs as young adults lose their status as dependents of their parents.
- Residents who reported fair or poor health status were more likely to be uninsured. This suggests a need for strategies to improve access to coverage among those with the greatest need for medical services.
- Approximately 58.1% of Missouri's uninsured residents do not have a regular source of care. Uninsured individuals identified the emergency room as their regular source of care at a disproportionate level compared with their insured counterparts. This finding suggests that strategies to identify regular sources of care for the uninsured – rather than an expensive emergency room – may be a future issue that will need to be addressed. (It should be noted that the information reported here regarding uninsured residents' use of the emergency room is by self-report only and has not been statistically verified.)
- The uninsured report fewer doctor visits and overnight hospital stays when compared to their publicly and privately insured counterparts. The expense associated with these services seems to be the principal driver of these problems, regardless of insurance type. Over one-third (38.9%) of the uninsured reported having to forego health care due to cost.
- A number of themes emerged around the issue of employer-based insurance coverage. The following employment groups were the most likely to be uninsured: self-employed workers; unemployed or unpaid individuals; part-time, temporary or seasonal workers; employees of firms with 10 or fewer employees; and employees in agriculture and personal service industries.

Table 3. Missouri's Uninsurance Rates and Weighted Counts[1] by Selected Population Groups							
	Uninsurance Rate	**Weighted Count**	**Sig.**		**Uninsurance Rate**	**Weighted Count**	**Sig.**
Total Population	8.4%						
Gender				**Race/Ethnicity**			
Male	9.1%			White ξ	7.9%	350,000	
Female	7.8%			African American	10.6%	67,180	
Age				Hispanic	10.4%	16,569	
0-5	2.6%	11,721		Asian	7.6%	2,039	
6-18	3.4%	39,275		American Indian	14.6%	3,657	
19-24 ξ	20.1%	87,689		Other	9.2%	18,898	
25-34	13.6	89,563	*	**Family Income (% FPL)**			
35-54	10.9%	170,830	***	< = 100%	14.3%	103,388	***
55-64	9.4%	62,493	***	101-133%	15.7%	60,011	***
65+	0.3%	1,835		134-150%	20.9%	41,584	***
				151-200%	12.4%	75,144	***
Level of Education				201-250%	9.0%	53,027	***
Less than HS ξ	15.3%			251-300%	7.8%	40,368	**
HS Graduate	11.9%			>301% ξ	3.6%	89,883	
Some College	7.0%		***	**Marital Status**			
College graduate	3.5%		***	Married ξ	6.7%		
Postgraduate	3.0%		***	Never Married	17.2%		***
				Living w/ Partne	13.5%		*
Health Status				Divorced	13.6%		***
Excellent	6.3			Separated	11.3%		
Very Good	8.2			Widowed	3.4%		**
Good	9.6						
Fair	11.0			**Employment Status**			
Poor	13.3			Self-employed	19.1%		***
				Employed	6.6%		
Type of Job				Unemployed	15.0%		***
Permanentξ	6.7%			Retired	2.4%		***
Temporary	20.9%			Student	11.0%		
Seasonal	29.2%						

ξ Reference group; p<.05, **p<.01, ***p<.001; For those reporting Hispanic ethnicity and some other race, Hispanic was selected as racial classification. Ages: (0-5, 6-18, and 65+) are not included in test of significance [1] available

Source: Missouri Health Insurance Coverage and Access Survey, 2004

The Health Insurance Environment in the State – Data Support from the Public Deliberation Forums

The Missouri State Planning Grant (MPSG) received a Limited Continuation Competition Grant to seek feedback from citizens in communities across the state. It was decided that 21 public deliberation forums would be scheduled throughout the state and would involve community meetings and regional meetings. The name of the forums was "Covering the Uninsured in Your Community: Why it is Everyone's Problem". At a public deliberation, participants were allowed to explore a number of options to help solve the problem and present solutions. Deliberation allows community members to weigh the consequences of each option in order to help solve the problem. The intent is to create a tension so that solutions present themselves. The analysis for the public deliberation forums data was completed by a simple tally method. The individual statements were reviewed to create a list of overall themes. The statements were then reviewed a second time to determine the most prevailing themes.

Without this effort to reach out to the public and gain their feedback, the MSPG would not be able to confidently move forward. As previously mentioned in Section 4, these forums validated our proposal to focus on the small business community. What is clear is that change and innovative thinking in the system are clearly needed and wanted and that this change must involve multiple stakeholders, including the individual, families, employers, pharmaceutical and insurance industries, hospitals and providers, and the state government. Most importantly, change will most likely occur if these key players apply solutions to this challenge within a community context. The forum participants' insightful deliberation shows that all stakeholders must become better integrated and work together to provide affordable and accessible health insurance for all Missourians.

Existing and Previous State Effort toward the Uninsured

Missouri's health care delivery system and its adequacy are best described by looking at the healthcare services infrastructure and support systems in the state. These systems include:

- Community Health Centers (Federally Qualified Health Centers)
- Disproportionate Share Hospitals (DSH), bad debt and charity care hospitals
- Healthcare Maintenance Organization Competition and Penetration
- Health Professional Shortage Areas and Physician Supply in Missouri
- Managed Care Participation

<u>Community Health Centers</u>

This indicator describes the presence or the absence of a federally qualified Community Health Center (CHC) in the area. It is based on the Health Resources and Services Administration, Uniform Data System. In 2004, there were 90 CHCs and satellite clinics, including CHC look alike clinics, in the state. It should be observed that the Community Health Centers, the primary health care access points for the uninsured, are not evenly distributed in Missouri. Although there are 90 CHCs or satellite clinics in Missouri, 74 out of 115 counties have no CHC or satellite clinic presence.

Since CHCs serve as primary health care providers for the uninsured and the other vulnerable populations, it is important to examine the availability of CHCs in the context of the potential

recipients of these services by region. Based on county level uninsurance rates from the Missouri Health Care Insurance and Access Survey (2004), and Medicaid data from the Missouri Department of Social Services, two indicators - the *Number of Uninsured and Medicaid Enrollees* and *the population density of the Uninsured and Medicaid Enrollees* - were computed for the seven regions. The second indicator suggested the two metro regions have a high density of the vulnerable population.

Disproportionate Share Hospitals, Bad Debt and Charity Care

Disproportionate Share Hospitals provide a greatly needed safety net in the state by providing charity care to indigent patients. Table 4 shows uncompensated care by region in 2002. As the table shows, the St. Louis Metro and Kansas City Metro areas reported the highest overall amounts; however the Southwestern region and Central region have the largest per capita rates of uncompensated care. In return, Missouri hospitals received over $455 million in DSH payments in 2001. Comparatively, the level of charity care and bad debt for these same hospitals in 2001 reportedly exceeded $835 million, with $235 million in charity care and over $500 million in bad debt.

Table 4. Reported Hospital Uncompensated Care by Region

Region	Uncompensated Care	Population	Per Capita
Northeastern	$14,294,392	190,030	$75
Northwestern	$16,277,723	188,721	$86
Southeastern	$47,899,963	326,042	$147
St. Louis Metro	$323,233,182	2,001,648	$161
Kansas City Metro	$178,685,751	1,093,687	$163
Central Region	$83,133,180	491,632	$169
Southwestern	$123,697,001	638,328	$194
Total	$787,221,192	4,930,088	$160

Note: Five counties with hospitals were missing uncompensated care data for 2002.
Source: Missouri Department of Health and Senior Services, Center for Health Information Management and Evaluation.

Hospitals

The data on the number of hospitals are represented by three categories: government operated, private, and church operated. According to 2002 data, there were 150 hospitals in Missouri; 50 were government operated, 98 were privately operated, and churches operated two. Table 5 depicts this distribution by the seven regions in Missouri. Forty-four counties in Missouri do not have a hospital. With the exception of the metro regions of Kansas City and St. Louis, two of every five counties in the remaining regions do not have a hospital. It is important to compare the presence of a hospital, however, relative to the population within that region.

Table 5. Community Health Centers and Hospitals by Regions

Area	Total CHCs & Satellites	Proportion of Counties Without CHC	Total Hospitals	Proportion of Counties Without Hospital	Population Estimates
Missouri Region	**90**	**79/115**	**150**	**44/115**	
Kansas City Metro	19	3/7	28	0/7	1,093,687
St. Louis Metro	14	5/7	37	1/7	2,001,648
Central	5	19/21	21	7/21	491,636
Southwestern	7	16/21	24	8/21	638,328
Southeastern	22	12/25	19	11/25	326,042
Northwestern	12	7/13	9	6/13	188,721
Northeastern	11	17/21	12	9/21	190,030

Source: Missouri Department of Health and Senior Services, Center for Health Information Management and Evaluation.

Health Maintenance Organization Competition and Penetration

The statistics from the Department of Insurance indicate Missouri had 21 licensed HMOs at the end of 2002. At the end of 2003, there were 19. Almost all of the HMOs operating in Missouri are working in selected portions of the state. Some are operating exclusively in the urban or urban adjacent counties. Some have greater enrollment in the eastern and some in the western part of Missouri. Less than five HMOs are operating in 17 counties located in the northeast, southeast and the northwestern regions of the state.

The 2003 HMO data suggested that in Missouri, with the exception of Kansas City MSA, and Johnson and Gasconade counties, the rest of the counties have a concentrated HMO market (i.e., the market is non-competitive). The HMO market in Kansas City MSA, and Johnson and Gasconade counties is moderately concentrated (i.e., have some degree of competition). The rising premiums in the HMO market may be attributed to the managed care penetration and lack of competition in the majority of counties in the state. As cited in a study by Xirasager et al., HMO penetration rates and premium rates influence insurance uptake. Increasing HMO penetration enables access to lower cost HMO plans and also reduces the premiums for conventional insurance products.[4]

Health Professional Shortage Areas and Physician Supply

The inadequacy of the health care delivery system is evident when one looks at the areas of the state designated as Health Professional Shortage Areas (HPSA). In 2004 only four counties and the City of St. Louis were not designated as a HPSA. Of the remaining 110 counties, 28 had a geographic HPSA designation and 82 counties were low income/poverty HPSA designations.

Based on 2004 data, Missouri has 24,267 physicians. For the purpose of this report, 7 categories of physician fields were analyzed: primary pediatrics, obstetrics and gynecology, internal medicine, primary care and Specialist within the pediatric, medicine, and surgery fields. As portrayed in Table 6, three regions have no access to pediatric specialty care, necessitating the resident to travel to urban areas for this care. Further, the more rural regions of the state clearly have very limited access to OB/GYN, primary pediatrics, general internists and the specialty areas of medical and surgical in comparison to the metro area. However, the rate per 100,000 for general primary care physicians is greater in all of the regional areas except St. Louis and Northeast. It is important to compare physician presence in a region with total population of that region.

Table 6. Physician Supply in Missouri by Category and Regions (2004)

		Missouri	Kansas City	St. Louis	Central	SW	SE	NE	NW
Rate per 100,000	Primary Pediatrics	74.5	96.5	106.8	54.5	33.3	32	30.3	20.4
	OB/GYN	27.5	27.8	37.7	24.4	20.3	16.4	14.2	13.2
	General Internists	54.2	45.6	87.2	41.7	30.8	32	20.3	24.1
	General Primary Care	33.6	34	20.6	47.2	45.4	40.3	30	48.8
	Pediatric Specialty	5.6	12.1	6.8	3.1	2.5	0	0	0
	Medical Specialty	13.1	16.5	19.2	7.5	9	4.7	5.8	3.5
	Surgical Specialty	33.8	33.3	44.6	31	27.6	22.3	18.5	17.3
	Total Physicians*	235.4	247	307.3	216.7	188	151	124.2	133.4
	Full Time Physicians	193.5	204.1	244.7	175.9	162	130.5	108.1	109.8
	Population	787,221,192	1,093,687	2,001,648	491,636	638,328	326,042	190,030	188,721
	* This is the sum of all Physicians. The 7 Physician groups listed does not exhaust all the physician categories.								

Managed Care Participation

According to the Missouri Foundation for Health report, *Health Care Expenditures and Insurance in Missouri*, approximately half (1.55 million) of Missouri's residents were enrolled in an HMO during 2001. The remaining half were enrolled in network plans, such as preferred provider organizations or received coverage through an employer that self-insures. The Department of Insurance reported that Missouri enrollment in HMO plans through commercial, Medicare and Medicaid dropped to 1.4 million in 2002, or by 4.3% - the third decline in four years. This drop in enrollment is associated with rising premiums for HMO products, which increased 21% in 2001 and 14% in 2002, employee preference for fewer restrictions on provider choice, and the concentrated HMO market in the state.

The 2003 data from the Department of Insurance suggests another year of declined enrollment with about 22% (1.22 million) of Missouri's total population enrolled with HMOs. In 22 counties, less than 1% of the population is enrolled with HMOs. These counties are located in the northeast and southeast regions. These two regions also have the highest percent of uninsured. Higher enrollment rates of 15.0-38.3% were observed along Interstate-70 (this may be partly attributable to Medicaid or MC+ which primarily covers the I-70 corridor) and the parts of the southwest region.

History of Medicaid in Missouri

The total appropriation for Missouri's public healthcare program in its first fiscal year was $38.9 million, comprising approximately 4% of the state operating budget. In fiscal year 2005, the program's total state and federal appropriation was $4.88 billion, comprising more than 28% of the state's operating budget. This expansion has placed Missouri State government in a tenuous fiscal position, as state spending has jeopardized available monetary resources. This financial strain on our public healthcare program endangers the stability of the underling safety net. This places Missouri's most vulnerable at risk and results in a lack of access to quality care for all enrolled in the public healthcare program.

Twenty-five years passed from the inception of Missouri's public healthcare program before enrollment reached the mark of 500,000 participants in 1993. Eligibility expansions resulted in accelerated program enrollments during the 1990s. The result of this explosive expansion doubled Missouri Medicaid enrollment to more than 1 million recipients in the last 10 years alone. One of every six Missourians now receives pubic healthcare assistance paid for by the taxpayers of our state.

Since the inception of Missouri's public healthcare program in 1967, the nation has also experienced a trend of runaway healthcare costs. One aspect of the increased costs of healthcare is the rate of inflation. Throughout the seventies and eighties health care inflation was approximately 4% a year. Over time, healthcare inflation has become worse and is now over 7% a year. As a comparison, in 1967 the nation spent just over 5% of gross domestic product on healthcare while today the nation spends over 15% of gross domestic product on healthcare.

Healthcare inflation has made private health insurance unaffordable for many businesses and individuals. This situation combined with the expansion of Missouri's public healthcare program have extended the program beyond the original safety net and made the program a significant

cost driver in the state budget. While the framework of Missouri's public healthcare program has remained relatively static since its inception, public needs and healthcare costs have not. This antiquated framework requires urgent action to reform and transform this social welfare assistance program to ensure that fiscal balance is restored.

Enrollment and expenditure analysis conducted by groups external to state government have documented the vast expansion of the public healthcare program. A 2004 Kaiser Family Foundation study demonstrated that Missouri ranked number one in public healthcare program expenditure growth over the latest ten year period, ahead of other states like Massachusetts, New York, and California. While Missouri is facing difficult healthcare challenges, such as the prevalence of Missourians with poor health habits and a higher number of senior citizens, Missouri's expenditure growth remains a great concern to the sustainability of the core program and the vulnerable people it covers.

Sharply enhancing the urgency for a comprehensive transformation of Missouri's public healthcare program, federal regulators at the Department of Health and Human Services have indicated a desired trend for reducing the federal share of these expenditures. Missouri's reform efforts must begin with due diligence to mitigate challenges associated with emerging federal trends.

The 2005 Missouri Medicaid Reform Commission[5].

The Missouri Medicaid Reform Commission (the "Commission") derives its charge and legislative authority from 208.014, RSMo and Senate Concurrent Resolution 15 (2005) which states that the work of the Commission shall include but not be limited to "clear and concise policy recommendations on reforming, redesigning, and restructuring a new, innovative state Medicaid healthcare delivery system."

Missouri's public healthcare program was created in 1967 to supply basic public welfare assistance for individuals unable to obtain access to private healthcare. The Department of Social Services indicates that, at its inception, "the new services covered by the program included outpatient hospital care, physicians' services, and professional nursing home care. Implementation also provided first time coverage to the blind; permanently and totally disabled recipients; and greatly expanded services to Aid to Families with Dependent Children."

The Work of the Commission

The work of this Commission shall include but not be limited to clear and concise policy recommendations on reforming, redesigning, and restructuring a new, innovative state Medicaid healthcare delivery system.

Missouri's public healthcare program is a social welfare system that provides healthcare services for a wide range of Missourians who meet certain financial and/or medical requirements, and is funded from state, federal, and other sources. Broad eligibility categories include:

· Low Income Children and Families and Pregnant Women
· Low Income Elderly
· Low Income Disabled and the Blind

These groups represent those who are currently participating in the public healthcare program. The Commission recognizes defining those with the "greatest need" is difficult and raises serious questions such as: Does an unemployed Missourian have a greater need than a disabled Missourian? Does a poor Missourian have a greater need than an elderly Missourian? Throughout this transformation process, the Commission will work toward defining who has the greatest need to ensure the new public healthcare program cares for Missouri's most vulnerable.

The Commission believes that it is in the best interest of the state that all Missourians have affordable healthcare available to them. Therefore, substantial Medicaid and healthcare reform must take place in order for all Missourians to have the availability of quality healthcare. To ensure that the state can continue to provide Medicaid services, the legislature must move toward a reformed, effective Medicaid program. The Commission asserts that the manner in which it is communicated can determine the outcome and success. Each Medicaid reform proposal should be put through the basic test of the Three R's: Risk, Responsibility, and Reward.

- Does the reform proposal reduce risk to the state and/or individuals?
- Does the reform proposal encourage the state, employees, and/or individuals to take responsibility?
- Does the reform proposal result in tangible rewards?

In January 2006, the Commission released its final report[6] with a list of 18 recommendations and top 10 Executables. The Commission believes Missouri will have an infrastructure including a safety net that will support efforts to be the healthiest state (population) possible. Part of the vision must incorporate the creation of a culture of health. Missouri will become known for its dedication and passion for health with intended outcomes to include better health for each citizen, greater economic success for its businesses, more successful outcomes in education due to healthier children, creation of a "place" where people will want to live, work, play, learn and celebrate life. The top ten executables are:

1. Expand the MC+ coordinated care program to Northwest Missouri.
2. Implement a Chronic Care Improvement Program.
3. Implement and expand the MedStat program to reduce waste, fraud and abuse.
4. Upgrade the Medicaid Management Information System program.
5. Begin a pilot program for e-prescribing to reduce prior authorization concerns.
6. Evaluate and analyze ways to decrease ER over utilization.
7. Require the Division of Medical Services to participate in the Missouri Quality Award process.
8. Implement technological tools that will link the provider to Pharmacy Claim data.
9. Encourage the Missouri Consolidated Health Care Plan to offer optional long-term care insurance.
10. Establish the Joint Committee on Health.

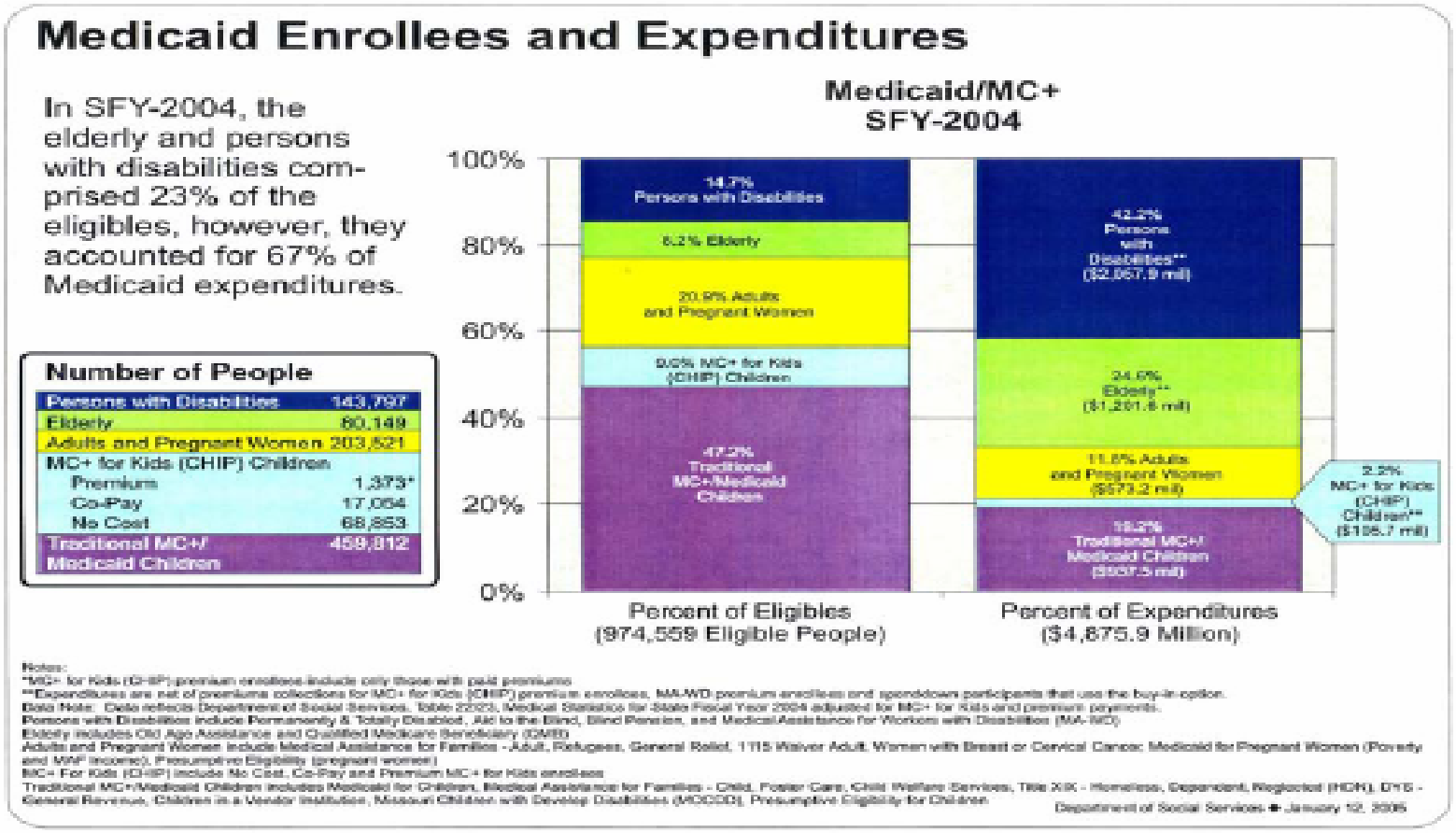
Medicaid Enrollment and Growth

Missourians were enrolled in Medicaid, serving nearly 18% of total state population. According to the Missouri Survey, 28.5% of the children ages 0-18 and 12.5% of adults ages 19-64 were enrolled in public health insurance. The survey results also indicated that 4.0% of children and 9.0% of parents who are potentially eligible for public coverage based on income levels and coverage status remain uninsured. Figure 1 illustrates Medicaid enrollees and expenditures.

State Employee Health Plan

The Missouri Consolidated Health Care Plan for State Employees (MCHCP), considered managed care, provides coverage for most of the state's employees, retirees and their dependents. Currently, 103,000 individuals are covered under the state program. This is comprised roughly of 46,000 active employees, 12,000 retirees and the remaining are dependents. In addition, MCHCP currently covers 3,900 individuals of non-state local governments (cities, counties, school districts, etc.). This is comprised of 2,890 employees and the rest mainly are dependents (there are very few retirees in this program).

Figure 1


Medicaid Enrollees and Expenditures
In SFY-2004, the elderly and persons with disabilities comprised 23% of the eligibles, however, they accounted for 67% of Medicaid expenditures.
Number of People
Persons with Disabilities 143,797
Elderly 80,149
Adults and Pregnant Women 203,521
MC+ for Kids (CHIP) Children
Premium 1,375*
Co-Pay 17,054
No Cost 68,853
Traditional MC+/ Medicaid Children 459,812
Medicaid/MC+
SFY-2004
100%
80%
60%
40%
20%
0%
14.7% Persons with Disabilities
8.2% Elderly
20.9% Adults and Pregnant Women
9.0% MC+ for Kids (CHIP) Children
47.2% Traditional MC+/Medicaid Children
42.2% Persons with Disabilities** ($2,067.9 mil)
24.6% Elderly** ($1,201.8 mil)
11.8% Adults and Pregnant Women ($573.2 mil)
2.2% MC+ for Kids (CHIP) Children** ($105.7 mil)
19.2% Traditional MC+/ Medicaid Children ($937.5 mil)
Percent of Eligibles (974,559 Eligible People)
Percent of Expenditures ($4,875.9 Million)
Notes:
*MC+ for Kids (CHIP) premium enrollees include only those with paid premiums
**Expenditures are net of premiums collections for MC+ for Kids (CHIP) premium enrollees, MAWD premium enrollees and spenddown participants that use the buy-in option.
Data Note: Data reflects Department of Social Services, Table 22(2), Medicaid Statistics for State Fiscal Year 2004 adjusted for MC+ for Kids and premium payments.
Persons with Disabilities include Permanently & Totally Disabled, Aid to the Blind, Blind Pension, and Medical Assistance for Workers with Disabilities (MA-WD)
Elderly includes Old Age Assistance and Qualified Medicare Beneficiary (QMB)
Adults and Pregnant Women include Medical Assistance for Families - Adult, Refugees, General Relief, 1115 Waiver Adult, Women with Breast or Cervical Cancer, Medicaid for Pregnant Women (Poverty and MAF Income), Presumptive Eligibility (pregnant women)
MC+ For Kids (CHIP) include No Cost, Co-Pay and Premium MC+ for Kids enrollees
Traditional MC+/Medicaid Children includes Medicaid for Children, Medical Assistance for Families - Child, Foster Care, Child Welfare Services, Title XIX - Homeless, Dependent, Neglected (HDN), DYS - General Revenue, Children in a Vendor Institution, Missouri Children with Develop Disabilities (MOCDD), Presumptive Eligibility for Children
Department of Social Services ✦ January 02, 2005

Operating Structure of the MSPG and Involvement of Stakeholders (Year 1)

The Governance structure for the MSPG is the Missouri Department of Health and Senior Services (DHSS). Two bodies of key policy makers and stakeholders have guided this initiative from its inception: the Advisory Council (2004-2005) and the Policy Workgroup (discussed in Section C).

Established in January 2004, the Advisory Council on Accessibility and Affordability of Health Insurance Coverage (the Council) was responsible for establishing guiding principles, reviewing the study results and cited best practices literature, and helping to shape policy recommendations and options to the State. Throughout this year, all MSPG Staff, Advisory Council and Subcommittee members reviewed data from the Current Population Survey (CPS), Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), and the Behavioral Risk Factor and Surveillance Survey (BRFSS). These data guided the initial assumptions about the uninsured in Missouri while the household data were being collected. Within the first year, insurance data specific to Missouri was compiled (quantitative data) and in the second year, forums (qualitative data) were scheduled to build and expand upon current knowledge of the uninsured. Throughout the tenure of the MSPG, a website was maintained and printed materials were created.

The membership and structure of this AC were representatives from various statewide organizations and agencies, state departments, and legislators with previous experience or involvement in data, evaluation and formulating recommendations for policy and action. This information will be taken to the Executive and Legislative branches of the government. Invitation for selection to the Advisory Council was determined by the state. The Center for Health Policy at University of Missouri-Columbia assisted in planning and directing all Council functions. Table 7 depicts the various agencies, organizations, and associations who served as members of the Council.

Table 7. Organizational Members of the MSPG Advisory Council

St. Louis University, School of Public Health	Missouri Senate
Missouri School Boards' Association	Missouri House of Representatives
Missouri Hospital Association	Missouri Governor's Office and Lieutenant Governor's Office
University of Missouri-Columbia	Missouri Department of Mental Health
Missouri Physicians for a National Health Program	Missouri Consolidated Health Care Plan
Missouri Association of Health Plans	Missouri Primary Care Association
Missouri Association of Local Public Health Agencies	Missouri Chamber of Commerce
Missouri Department of Health and Senior Services	Citizens for Missouri's Children
Missouri Division of Medical Services	National Federation of Independent Business
	Missouri Department of Insurance

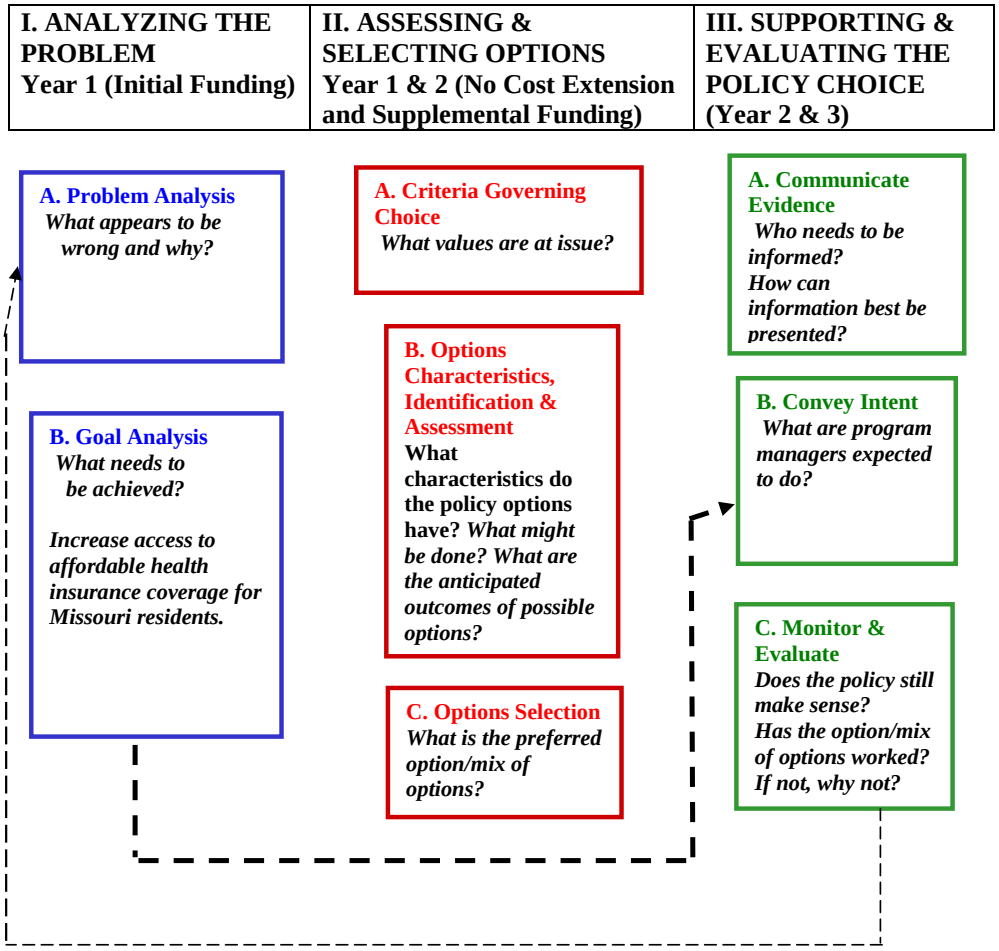
The Council maintained two subcommittees. Subcommittees were formed on a voluntary basis from the membership and included selected individuals from the community as needed at the subcommittee leadership and members' discretion. This grant and all activities were planned, implemented, and evaluated by the MSPG staff, but it is imperative that those professionals on the Council and Subcommittees with various expertise and abilities be provided the opportunity to direct and lead this process. The MSPG staff recruited co-chairs for each subcommittee. The co-chairs of the subcommittees provided logistical and philosophical direction to their respective subcommittees, but assistance was provided from the MSPG staff as necessary. At least one representative from the MSPG attended subcommittee meetings. Co-chairs were responsible for sending initial communication to subcommittee members, making arrangements for all meetings, communicating with Project Director about meeting dates, logistics, and progress, and providing minutes of each meeting to the Project Director. Table 8 identifies the subcommittee, co-chairs' affiliation, major purpose, and activities. Note that these activities were given as suggestions only and assisted the subcommittee co-chairs with a starting place and a way to orient them regarding the intent of the grant.

Table 8. List of Subcommittees	
Subcommittee **Co-chairs' Affiliation**	**Major Purpose and Activities**
Policy Options *Missouri Primary Care Association and Center for Health Policy (University of Missouri-Columbia)*	Responsible for synthesizing information learned during first grant year to design the policy option proposal to present to Advisory Council and include in final report. Use the agreed upon Guiding Principles for the Missouri State Planning Grant as a framework or amend them as necessary to make them applicable to the Policy Options Subcommittee. Review existing data sources, other states' policy options, and the Interim Report questions.
Communication *University of Missouri-Columbia Health Care and Internal Medicine Physician*	Communicates with public (especially for the "public feedback" of the policy options) legislators, employees, media (journals, conferences), and federal entities about grant progress and outcomes. Examine other states' communication models for State Planning Grant Activities.

Activities and Accomplishments of the HRSA SPG (Year 1)

At the first meeting, presentations on the purpose of the grant and the role of the Council was accomplished, as well as a guest presentation on national trends and activities of other states by Jeremy Alberga from Academy Health. The second meeting (March 2004) entailed data presentations on MEPS-IC, BRFSS, and CPS; data and information sharing from Council members; and work on the guiding principles. Compilation and graphical presentation of data helped the Council gain a better understanding of the uninsured issue and the complexity of the problem. The third Council meeting (May 2004) consisted of a presentation on preliminary state data results, presentations from Council members and discussion on cost drivers. The Missouri Survey was completed in July 2004 and data sent to SHADAC for analysis and a written report. SHADAC presented the final data results of the 2004 Missouri Health Insurance Coverage and Access Survey (Missouri Survey) to the Council in October 2004. The focus group field research work was completed by the end of August, with written reports and an AC presentation in October 2004. Subcommittees were formed and have met to further address the policy options, the communications strategies, and to sustain the efforts of this initiative. The Council initiated discussions on policy options at the fourth meeting. To assist these groups in gaining consensus on policy directions, the Policy Analysis Framework was chosen as the theoretical model to stimulate discussion with the Advisory Council as shown in Figure 2.

Figure 2. Policy Analysis Framework Applied to the Missouri State Planning Grant (MSPG) in the Development of Policy Options



Activities and Accomplishments of the HRSA SPG (Year 2)

In August 2005, feedback was solicited from the citizens of Missouri on the accessibility and affordability of health insurance. To do this, the MSPG received a Limited Continuation Competition Grant to visit 21 communities to carry out public deliberation forums. These were scheduled throughout the state and would involve two types of meetings: community meetings and regional meetings. To successfully carry out these forums, a team of individuals was recruited to assist with training, planning, and the development of an Issue Book to be used at the forum to guide discussion. The name of the forums was "Covering the Uninsured in Your Community: Why it is Everyone's Problem". For these public deliberations, the top 10 themes were identified: Pooling encouraged; Prevention needed; Affordability; Accessibility; Consumerism; Medicaid concerns;Personal responsibility; Better health insurance products; Over-utilization and misuse; and State involvement. This year's activities culminated with the citizens of Missouri providing us valuable insight and feedback. Change and innovative thinking in the system are clearly needed and wanted. That change must involve multiple stakeholders, including individuals, families, employers, pharmaceutical and insurance industries, hospitals and providers, and the state government. Most importantly, change will most likely occur if these key players apply solutions to this challenge within a community context. These insightful deliberations show that all stakeholders must become better integrated and work together to provide affordable and accessible health insurance for all Missourians.

Policy Workgroup, 2005-2006

Through the work of the Advisory Council and Policy Subcommittee, findings from the 2004 Missouri Health Care Insurance and Access Survey, and the feedback from the Public Deliberation Forums, it is evident that a targeted intervention is needed by the small business Employee. Because of the demographics of the large number of uninsured small business employees there was strong interest in working with the small business owner. Also, public-private partnerships have shown promise in increasing the accessibility and affordability of health insurance through the private market. The results of our focus groups and small business interviews are evidence that small business employers are adamant about wanting to offer health insurance to their employees, but needing more affordable and accessible options. In addition, approximately 1,066,000 employees work in the small business workforce[7]. It is estimated from the Missouri Household Survey that we have 36.5% who work in small businesses and are uninsured (not including self-employed). The potential reach of an intervention aimed at the small business employee is approximately 389,000 small business employees.

The Governor and the Legislature are sympathetic to the plight of the small business owner who struggles to pay insurance premiums for their employees. They are interested in exploring a variety of options to increase health insurance coverage in Missouri including the viability of using the Missouri Consolidated Health Care Plan as an infrastructure for such coverage expansion. Legislative action similar to this policy option was in 1998 when legislation was introduced, but ultimately failed, that would make the Missouri Consolidated Health Care Plan available for businesses, including sole proprietorships - with fewer than 50 employees. This legislation was introduced again in 2005 with SB 277, but was unsuccessful.

Policy Options Considered, but not Selected

One of the most important principles of the MSPG is that an effort is made to create policy options that are based on sound evidence, tested approaches, and are grounded in the reality of the State. Through the work of the Policy Options Subcommittee Workgroup in Year 1, a review of the literature with respect to best practices and current recommendations was conducted. Through this research and policy option, discussions with the Council and the validating work of the Year 2 Policy Workgroup, there are policy options not selected, target population, numbers served, and reasons for their exclusion (Appendix 21.

SECTION C. PILOT GRANT ACTIVITIES

The Missouri Department of Health and Senior Services (MDHSS) in an application to HRSA in March 2005, proposed to pilot a buy-in option to the Missouri Consolidated Health Care Plan (MCHCP) combined with a reinsurance option. This work would support the State progress toward a detailed proposal for executive and legislative consideration, which is reasonable and amenable to the State in order to expand coverage. On September 2, 2005, Missouri received notification of this pilot award. The Governor appointed members to a Policy Workgroup, including the Executive Directors of the MCHCP, Missouri State Chamber of Commerce, the National Federation of Independent Business, the Missouri Primary Care Association, Mercy Health Plan, and the Missouri Department of Insurance. Also included are one senator and two representatives from the Missouri legislature. Two small business employers/representatives are members, as well.

A key consideration to this potential policy option is the potential of premium offsets for lower income employees, particularly 200% FPL and below. If premium offsets are pursued for this target population, a federal waiver under Medicaid will be explored with Missouri's Medicaid agency, Department of Social Services/Division of Medical Services, to determine the potential of accessing federal matching funds in order to expand coverage in future funding years. However, as previously noted, at the time of submission of this final report, the Policy Workgroup is still formulating their thoughts regarding recommending this particular policy option.

Policy Workgroup, 2005-2006

On September 2, 2005, Missouri received notification of this pilot award. The MSPG staff proposed an initial list of stakeholders for a Policy Workgroup. The purpose of this Policy Workgroup is to assist the state in formulating the parameters and characteristics of the small business buy-in option, explore methods/sources of funding, and finalize recommendations to DHSS as to the viability of the proposed policy option in Missouri. A list of approved members for the Policy Workgroup finalized through all necessary executive levels of approval was received February 2006 (Table 9). The approval and appointment process took longer than originally anticipated in the grant workplan.

Table 9. Organizational Members of the MSPG Policy Workgroup	
Missouri Senate Missouri House of Representatives Missouri Governor's Office and Missouri Consolidated Health Care Plan Missouri Department of Health and Senior Services Small business representatives	Missouri Primary Care Association Missouri Chamber of Commerce National Federation of Independent Business Missouri Department of Insurance

In the first meeting of the Policy Workgroup on April 3, 2006, it was vital that the membership understand their role as advisory to the Department of Health and Senior Services specific to the selected policy option, become oriented to the task, and expectations and the intended outcomes of the project (i.e., determine if this option should move forward with a recommendation in a formal report to the Governor's Office). In the May meeting speakers from other parallel, and potentially competitive, initiatives in Missouri, such as Associated Industries of Missouri (AIM), were invited to provide their experiences. To facilitate the Policy Workgroup's understanding of modeling design, a Policy Option Feature Survey was designed to frame discussion for the June meeting.

On June 5, 2006, the Missouri Department of Health and Senior Services, Division of Community and Public Health requested a twelve-month no-cost extension to complete the agreed upon objectives of the Pilot Grant proposal for the Missouri State Planning Grant. On July 11, 2006, notice of the award was received and the funding period begins September 1, 2006 and completes August 31, 2007. The primary purpose for requesting this extension is to finalize the agreed-upon activities of the current grant.

Elements of the New Policy Option

At a July 2006 meeting, the Policy Workgroup drafted Summary Principles (Figure 3) to guide them in this work and a preliminary proposal of design elements (Table 10) that will be entered into an econometric analysis to assess its effects on health insurance coverage and costs. These parameters are being used by Deb Chollet of Mathematica to model the policy option with the final Mathematica report due in December 2006.

At the September 18, 2006 meeting, Deborah Chollet of Mathematica presented key elements of the modeling process to date. The process of modeling the option raised the consideration of rating structure for this product, indicating that if a community rating structure were used the result may be an affordable product without reinsurance or premium offset with significant take-up. Discussion of the Policy Workgroup was that community-rating structures had not worked

well in Missouri in the past and discussion turned to a tiered rating structure currently used by MCHCP with their local government business.

Thus, at the submission of this final report, many of the elements of the policy option have not been decided (i.e., benefit structure, projected costs) and following the September 18 meeting, several of the parameters are being revisited (e.g., target population). There remain many questions about the planning and operation of the product. This new product will operate under the existing structure of the MCHCP and details about their requirements for operation still need to be discussed. Indeed, at the time of the submission of this final report, there is growing skepticism within the Policy Workgroup regarding the ability of the group to consensually finalize a proposal in sufficient detail to allow legislative action, which may be necessary during the upcoming January-May 2007 legislative session.

Working with the Policy Workgroup

The Policy Workgroup has met since April 2005 and the work is narrower in scope than the first two years, specifically concentrating on defining the parameters of the identified policy option. Some organizational lessons include:

- Allowing time and process for new membership to embrace chosen policy option.
- Pivotal to engage key decision makers with the process and intent of work during executive and legislative leadership transitions.
- Strategically include potential opponents of policy implementation. At minimum, strive for open communication regarding reasoning behind specific policy parameters with potential opponents.
- Understand other initiatives within state to address issue of uninsured and seek to interact and compliment those initiatives.
- Know key leaders and decision makers within state interested in this issue and keep abreast of their activities, partnering and publications.

The policy and economic environment within the state has changed significantly since the first meeting of the MSPG Advisory Council and their deliberations to determine effective and viable options to address the issue of uninsurance within the state. It was clear from the onset that many of the Advisory Council and the current Policy Workgroup members were in key positions and/or held strong beliefs regarding the extent and impact of the issue of uninsurance, as well as the most viable and sometimes contradictory approaches to addressing the issue. In addition, other key "products" or initiatives within the state related to health care and health insurance, were occurring and include:

- Governor-appointed Medicaid Reform Commission designed to examine and propose redesign for the state's primary public insurance program
- Proposal of legislation during 2005 legislative session which would have allowed greater availability for coverage via use of existing public insurance systems
- Key health foundation within the state has published a variety of policy briefs on the views of voters regarding health care coverage and a plan for universal coverage
- Passage of tort reform legislation including caps on civil damages
- Variety of public forums and conferences on health care policy, system redesign, quality and prevention
- Legislation unanimously approved by the House and Senate and effective August 28, 2006 (Revised Missouri Statute 376.421) will increase access to healthcare by relaxing the requirements for small businesses that band together to purchase health insurance as a group. The bill expands eligibility for association health plans by decreasing the requirement for the number of members in an association from 100 to 50.

FIGURE 3
MISSOURI STATE PLANNING GRANT
POLICY WORK GROUP

SUMMARY PRINCIPLES

DRAFT for DISCUSSION

In an effort to provide coverage to uninsured employees in small firms in Missouri, the Policy Work Group of the Missouri State Planning Grant Program proposes the establishment of an independent purchasing pool for small business employers to secure coverage for their employees, potentially within the infrastructure of the Missouri Consolidated Health Care Plan (MCHCP).

The Policy Work Group met throughout the year in 2006 to decide on key design elements of a program that would accomplish this objective. The proposal and various design elements will be entered into an econometric analysis to assess its effects on health insurance coverage and costs. The following are the guiding principles that have framed the discussion on the policy options, to date. The program developed should meet the following objectives:

1. *Produces outcomes.* The program should increase health insurance coverage of previously uninsured employees working in small firms.
2. *Administrative simplicity.* The program should be designed to achieve administrative simplicity and low administrative costs.
3. *Cost efficient and affordable care.* The program should be designed to provide affordable coverage that appeals to both small firms and their employees.
4. *Maintain current private sector offerings.* The program is not meant to displace current private sector health insurance products or discourage innovations in the small group market.
5. *Limitations on state financial liability.* The State's financial commitment to the program should be predictable and capped to limit future liability.
6. *Stable financing.* The financing for this program should be predictable and stable over a period of time to encourage participation among employers and assure stability and integrity of the program.
7. *Political feasibility.* The program must be designed so that it can be justified to and supported by both the executive and legislative branches of Missouri government, and viewed positively by the Missouri citizenry.
8. *Voluntary participation.* The program is designed as an option to health coverage for small employers. It will be designed to encourage participation, but participation is voluntary.

Table 10. Preliminary Proposal for MCHCP Small Business Employer Purchasing Pool	
Parameter	**Description**
1. Small group	• Employer of 2 to 50 employees • Has not provided coverage in 6 months
2. Retain State mandates	• Yes
3. Administration of plan	• Marketing • Optional Broker per participant payment
4. Employer choice of contractors and benefit design	• Multiple carrier choices by employer • 2 benefit plan options • Participation requirement (less than 5 employees - 100%; greater than 5 - 75%)
5. Coverage	• Primary and preventive care o FQHC Network o Rural Health Clinic • Acute Care o Network o Safety Net Hospital
6. Employer contribution requirement?	• 50% of subsidized premium (single) • Premium offset to employer
7. Premium offset	• Employee applies for premium offset • Less than 200% FPL may be able to access federal matching funds • Greater than 300% FPL pay full premium; sliding scale less than 300% FPL
8. Enrollment caps to limit fiscal exposure?	• Yes
9. Opportunities to reduce medical costs and improve quality (COE, e-health, wellness)	• Tiered pharmacy (2 carriers per region, best practice) • Experimentation with tele-health • What are the best practices of health insurance plans, leading edge, cost management and quality improvement, Disease management for (Diabetes, Asthma, Depression, Smoking, Obesity, Consumerism/patient education) • Incentives to assess their health early and participation in a protocol
10. Capacity for Patients	• Private physicians • FQHC, safety net hospitals, rural health clinics

SECTION D. IMPLEMENTATION STATUS

To date, many of the elements of the policy option have not been finalized (i.e. benefit structure, projected costs). There remain many questions about the planning and operation of the product. This potential new product is intended to operate within the architecture of the MCHCP and details about their requirements for operation largely remain to be discussed.

Assuming the Policy Workgroup makes a recommendation that the policy option is feasible, a significant challenge will be in identifying an appropriate funding source and mechanism in an austere economic climate with multiple competing priorities. It will be the work of the Policy Workgroup to make recommendations in this regard and assist in determining barriers to implementation, as well as methods/strategies for overcoming these barriers.

The work of the Policy Workgroup will not complete until late November 2006. This policy option will require executive level approval and then legislative approval and action must occur during our legislative session from January to May 2007. Thus, no fully defined, approved product will be available to market until late spring or summer 2007. Deliberately, the Policy Workgroup has been populated with key legislators from both the Senate and House and representation from the Governor's office to identify issues and questions early in the process and to groom champions who will be prepared to carry a legislative agenda forward with their peers. If approved, the MSPG would focus attention on planning the strategies of a marketing campaign.

Challenges during the Planning and Pilot Year

State-wide, there is heightened interest in the issue of uninsurance. The HRSA SPG project has been one vehicle for increasing the interest level in this issue amongst several parallel projects and organizations facilitating discussion. The gubernatorial administrative change which occurred during a previous grant year also resulted in executive office administrative changes including the department directors for the state public health and insurance authorities, both of whom needed to be updated on the status of this project amongst their many other and varied responsibilities. There was a consistent need to assure our policy workgroup members remained engaged and informed, particularly those representing small business interests. Likewise, as parallel discussions occurred within the state regarding the issue of uninsurance and particularly offering insurance coverage for small business employees, it was important and challenging to remain abreast of all of these happenings and gauge the opportunities for complimentary work or, conversely, opinion that may jeopardize this proposed policy option. The Policy Workgroup benefited from key engaged legislators, as well as the continuity and significant engagement of the executive director of Missouri Consolidated Health Care Plan. Throughout the discussions, the issue of no clearly identified funding stream for implementation of this policy option has been a consistent concern. However, the upswing in Missouri's economy and state budget situation during recent months has enabled the policy option to be given due consideration with the potential of identifying an appropriate funding stream.

The MSPG anticipates several issues and challenges in the coming year:

1. Establish reform concepts amenable for state policy and economic environment.
2. Maintain balance between affordability for employer/employee, personal responsibility and state's economic vitality.
3. Understand the interplay of existing and planned initiatives within the state which impact the work of the MSPG.
4. Maintain ongoing, active communication with external stakeholders.
5. Designing a policy option that will ultimately be attractive and "sale-able" to small business employers
6. Identify available, acceptable and sustainable funding and funding mechanism.
7. Secure legislative support in order to implement during January-May 2007 legislative session.

Missouri sought and was awarded a No-Cost Extension through August 31, 2007 thus we are not yet coming to a close. However, at the end of the NCE timeframe, if the policy option is pursued we would anticipate all functions to be embedded into the infrastructure of Missouri Consolidated Health Care Plan with enabling legislation. The data collection and analysis regarding state level and characteristics of uninsurance may end if a determination to continue, at the state level, is not reached with identification of funding source and responsible entity.

SECTION E. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT AND HRSA

The Missouri public, and through the HRSA SPG focus groups and survey, voiced their concerns regarding the issue of uninsurance upon their personal and collective health and quality of life, the economic viability of businesses, as well as the economic vitality of the overall economy if effective and affordable solutions are not enacted. Further, thinking more broadly than simply the issue of insurance coverage, Missouri citizens clearly want quality and affordable health care with an emphasis on prevention and wellness components. Thus, recommendations to the federal government include:

1. Reform Medicaid and Medicare enabling legislation to require coverage for recommended clinical screening and preventive services, at minimum as identified by U. S. Preventive Services Task Force.
2. Develop a compendium of evidence-based practice and best practices specific to options for expanding health insurance coverage with accompanying evaluative results following implementation and/or pilot. For example, this may take the form of an update to the March 2004 National Conference of State Legislatures (NCSL) document entitled “State Options for Expanding Health Care Access”.
3. Develop a database of model state legislation to accompany the compendium noted in #2 to allow states to more easily assess and/or adopt enabling legislation.

Appendix 1. Summary of Policy Options (as of August 2005)

Policy Option[8]	Target Population	Estimated Number of People Served	Reason for Exclusion by MSPG
Strengthen Medicaid and SCHIP outreach and enrollment efforts	Children	998,926	It was discussed that the state is doing fairly well compared to other states in reaching children. The major political and policy considerations that worked against this choice are the financing of an expansion given the state's budget environment. Given the rate of uninsured for children in Missouri, the subcommittee members were not sure the state needed to do much more on strengthening Medicaid and SCHIP for children.
Expansion of safety net direct care services.[9]	Users of Safety Net	8.4% of MO population or 460,000	While the expansion of the safety net (FQHCs) is a possibility, several members of the subcommittee raised the question as to whether this was a state or federal issue. No strong consideration is being given to this option at this time.
Reform High Risk Pool	Denied COBRA Coverage; Consumers with Preexisting Conditions	4,000	Currently, Missouri is not compliant with federal standards and the federal health care tax credit, which helps people pay for health coverage if job is outsourced (over seas), up to $3000. Missouri is unable to access this tax credit since 1997. The subcommittee discussed reform, but agreed that this was a Department of Insurance issue.
Private Insurance reform – expand definition of dependent	Dependents up to age 21 years	Not Available	This policy option for expanding the coverage for young adults is being given strong consideration, but no consensus has been reached. This option is being researched further by members of the subcommittee Not a major policy option at this time.

Appendix 1, continued

Policy Option[10]	Target Population	Estimated Number of People Served	Reason for Exclusion by MSPG
Enact/broaden state continuation of coverage laws.	People who lose their jobs	Not Available	There currently is a state law for state continuation. The issue with COBRA is that it is not affordable. This could be an option if a mechanism to provide premium assistance to individuals is selected as well. Not a major policy option at this time.
Increase Medicaid reimbursement rates for primary and specialty care	Patients who use safety net, clinics, hospitals	998,926	The subcommittee members agreed that reimbursement rates for Medicaid should be increased from the 50-60% of Medicare rate to the full Medicare reimbursement rate. While this policy option was given strong consideration by members of the subcommittee, it was agreed to table this option for the committee to work on as it was being addressed elsewhere. Not a major policy option at this time.
Expand Medicaid eligibility to 21 years[11]	Dependents up to age 21 years	52,237 additional people	The major political and policy considerations that worked against this choice are the financing of an expansion given the state's budget environment. Given the rate of uninsured for children in Missouri, the subcommittee members were not sure the state needed to do much more on strengthening Medicaid and SCHIP for children.
Publicly funded re-insurance for private coverage	Consumers who have private insurance	Not Available	Missouri has something similar to this option but no one is in the pool. Works on theory but may not apply. Not a major policy option at this time.
State tax incentives	*Small businesses under 10 employees*	Potential reach of 389,000 small business employees.	On the surface, this option appeared appealing; however, a concern was raised that this type of option might also affect growth of the small business. For example, if the small business goes to 11 employees, then it was no longer eligible for incentive. This then could be a disincentive for small business expansions or growth. Additionally, there already is an incentive in the state. If the incentive is a tax credit, it may be cheaper for state to assist with or pay the premium than to give tax credits. Plus, tax credits is an after the fact – they have the money up front. Not a major policy option at this time.

Appendix 1, continued			
Policy Option[12]	**Target Population**	**Estimated Number of People Served**	**Reason for Exclusion by MSPG**
Set up state funded/assisted coverage program	Missouri uninsured	463,000	This option received strong consideration because it would spread the risk across the entire pool of insurers. A factor that will need to be addressed is that insurers should not be able to deny coverage. A tiered system approach could help capture other funds. Not feasible for Missouri at this time.
Universal health insurance	All Missourians	5,754,618	While this policy option was favored strongly by the group members, it was recognized that for this option to work, everyone has to participate. Plus, cost controls would need to be in place. Strong factors impacting the selection of this option are financing, administrative ease and provider capacity. The Missouri Foundation for Health has published multiple reports on the issue of the uninsured, including one on universal health coverage options, indicating adequate state resources for universal coverage. The key issue is how the funds are allocated. MSPG determined not currently a viable option.

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Appendix 2: Project Management Matrix

Overall Goal: To develop reform concepts for the Missouri State Planning Grant and to develop policy options and coverage and cost estimates to support the policy development options.

Action Steps	**Timetable** ⓣscheduled ✓ completed ☞ in process	**Responsibility**	**Evaluation**
1. Hire contractor.	✓ December 2005	Paula Nickelson (Principal Investigator)	Contracts with vendor(s)
2. Develop reform concepts for the MSPG • Participate in 4-5 conference calls with MDHSS project staff to identify the reform concepts that will be explored in the literature review.	October 2005 ✓	Beverly Tremain Vendor (SHADAC/ Mathematica)	Hold meeting
3. Develop the policy option • Review the "grey" literature, including state reports and privately funded research. • Draft and send for review an issue brief on small employer purchasing pools/reinsurance. • Finalize issue brief. • Assist with planning of a kick-off meeting with MDHSS staff, Center for Health Policy, and other stakeholders • Attend the first Policy Workgroup meeting	December 2005 ✓ January - February 2006 ✓ February 2006 ✓ December – March 2005 ✓ April 2006 ✓	Vendor (SHADAC/ Mathematica) Beverly Tremain	Completed issue briefs Attended meeting
4. Develop coverage and cost estimates to support policy development • Develop a model that will include a coverage module, estimating the coverage effects of the selected policy option by subpopulation • Contractor will prepare the data and develop the model • Present the preliminary results of the model in a meeting with MDHSS staff, the MSPG Policy Workgroup third meeting and other stakeholders identified.	April - July 2006 ☞	Vendor (SHADAC/ Mathematica) Beverly Tremain	Model refined Meeting attended
5. Report the results and make policy recommendations • **Make final revisions to the report** • **Present to MDHSS and the Policy Workgroup at third meeting.**	September – December 2006 ⓣ	Vendor (SHADAC/ Mathematica) Beverly Tremain	Results presented to Policy Workgroup Final report submitted

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Appendix 3: Reports

There are no reports at this time.

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[7] Source: Missouri Department of Economic Development
[8] There is no approval or implementation on these policy options.
[9]increased Medicaid eligibility; Medicaid reimbursement enhancements to safety net providers – (maintaining cost-based reimbursement to FQHC and DSH for hospitals; and creating a DSH for specialty care and PCP who serve a disproportionate number of Medicaid and uninsured patients); State grants to FQHCs to provide services to the uninsured; State funded grants-preference toward the Medicaid route because of matching funds.
[10] There is no approval or implementation on these policy options.
[11] Reinstate for parents up to 100%; possibly add childless adults; Increase income eligibility for all categories to 250-300%.
[12] There is no approval or implementation on these policy options.