Table of Contents

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 were 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 were 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 forums 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.

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 will 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. This will allow the state to progress toward a detailed proposal for executive or legislative action to expand coverage.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

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.

Current Rates of Uninsurance in the State [1.1]

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 System, respectively.[1,2.] 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 1). 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.

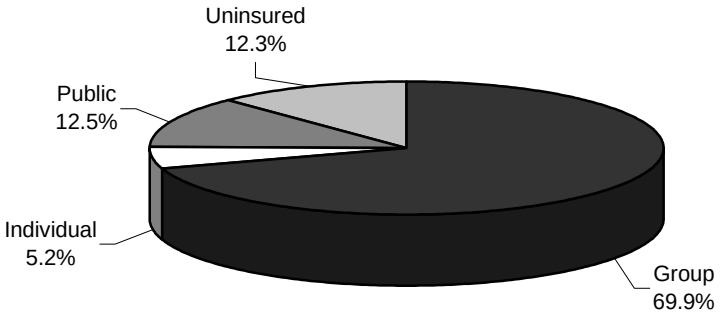
Table 1. Alternative Definitions of Insurances Rates

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."

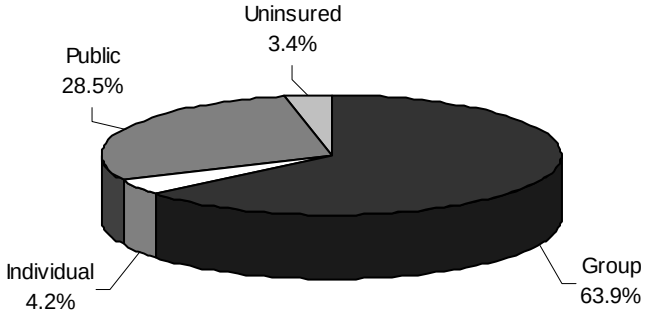
For adults ages 19-64 years the uninsurance rate was 12.3% (Figure 1), and for children ages 0-18 years the uninsurance rate was 3.4% (Figure 2). The Missouri County Level Study of adults 18 and older had similar findings with 12.33% uninsured. The 2001 National Survey of Children with Special Health Care Needs results indicated that 3.7% of Missouri's children under 18 years were uninsured. These findings are similar to the results of the Missouri Survey.

Figure 1. Sources of Health Insurance in Missouri, 2004 (Adults 19-64 years)



Source: Missouri Health Insurance Coverage and Access Survey, 2004

Figure 2. Sources of Health Insurance in Missouri, 2004 (Children 0-18 years)



Source: Missouri Health Insurance Coverage and Access Survey, 2004

Characteristics of the Uninsured [1.2]

Missouri's uninsurance rates among select population groupings are presented in Table 2 . The Missouri Survey found 9.1% of the males to be uninsured, whereas 7.8% of females are uninsured. Adults aged 19-24 have the highest rate of uninsurance at 20.1%, while children (ages 6 to 18) and the elderly have the lowest rates at 3.4% and 0.3%, respectively. Low-income families are more likely to be uninsured with the largest percentage of uninsurance occurring for individuals at 134-150% of the Federal Poverty Level (20.9%). Education is positively associated with health insurance coverage. Rates of uninsurance decreased incrementally as level of education increased, with 15.3% of people who did not complete high school being uninsured compared to 3.0% of those with postgraduate degrees. Married and widowed residents are more likely to have health coverage. There were no significant differences in uninsurance rates across groups, but Whites had the largest proportion of the uninsured population in Missouri. Those reporting poor health status are uninsured at a rate over twice those reporting excellent health status.

Relevant data for family composition and availability of public programs for the uninsured are presented in Figure 3 and Table 3. Figure 3 indicates the most common reason is they did not want it, did not need it or thought the coverage offered was inadequate. Table 3 indicates a good proportion (9%) of parents are uninsured, but eligible for a public program, which suggests the programs are available, but parents are not taking advantage of them.

Missouri's Immigrant Population [1.2]

The 2000 U.S. Census data showed that 2.7% of Missouri's population was foreign born. The highest concentration of foreign born residing in Missouri (5% to 6%) was in the counties of Sullivan, Jackson, Boone, Pulaski, McDonald, and St. Louis. Most of these counties had a greater concentration of Hispanic population. Sullivan, McDonald, and Daviess stand out as the counties with the highest concentration (5% to 6%) of population who do not speak English at home. Sullivan and McDonald were the counties with the highest concentration of Hispanics. Interestingly, Daviess was one of the few counties with 99% Whites. About 2% of all Missourians speak English less than very well. Their highest concentration (6.6% to 10.2%) was in the counties of McDonald, Sullivan, Pulaski, Scotland, Daviess, Jackson, Boone, Moniteau, and Morgan.

Table 2. 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/ Partner	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] where available

Source: Missouri Health Insurance Coverage and Access Survey, 2004

Figure 3. Uninsured and Eligible: Reasons for Not Enrolling in Employer-Sources of Health Insurance

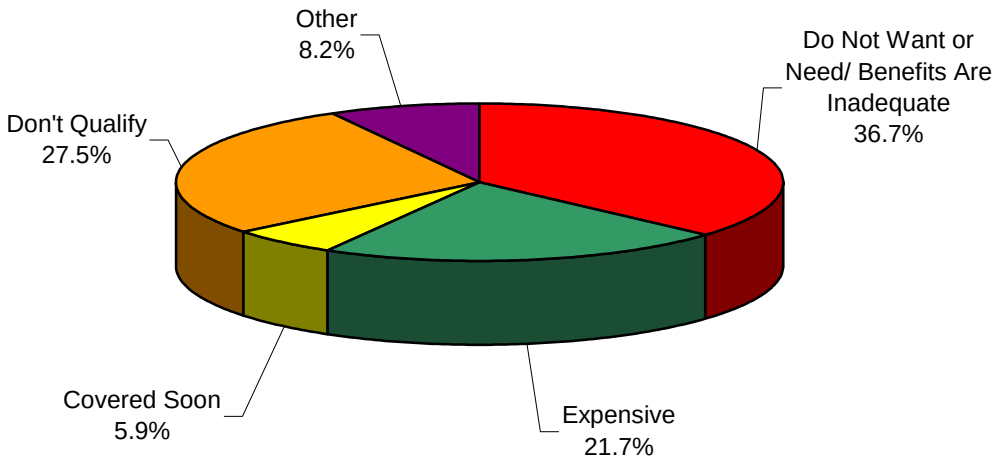


Table 3. Uninsured but Potentially Eligible for Public Programs			
	Private Insurance	**Public**	**Uninsured**
Children under 19 years in families with income <=300% FPL	51.8%	44.2%	4.0%
Parents in families with income <=75% FPL	21.2%	69.8%	9.0%

Source: Missouri Health Insurance Coverage and Access Survey, 2004

Table 4 displays rates of uninsurance across geographical regions within Missouri, with the Northeastern region of the state having the highest rate of uninsurance (13.1%), and the St. Louis metro area reporting the lowest (5.8%). Those living in a MSA (7.0%) have significantly lower rates of uninsurance than those living in a non-MSA (12.1%). However, though the rate of uninsured is higher in the more rural regions of the state, the estimated number of uninsured is higher in the urban and more populated regions.

Table 4. Rates of Uninsurance by Missouri Regions

Region	Percent	Population Estimatesξ Rounded
Northeast	13.1%	39,317
Northwest	8.9%	23,913
Southeast	11.9%	55,763
Southwest	10.4%	86,427
Central	9.8%	63,202
St. Louis Metro	5.8%	113,347
Kansas City Metro	7.9%	81,437
All Regions	8.4%	463,406
Non-MSA	12.1%	
MSA	7.0%	

Source: Missouri Health Insurance Coverage and Access Survey, 2004
ξ Based on 2002 U.S. Census Data

Summary of Uninsurance in Missouri [1.3]

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.

***Qualitative** Research Conducted by the MSPG [1.4 to 1.13]*

The following narrative is based entirely on the discussions of focus group participants.

Affordability, participation, dis-enrollment, and eligibility in public program [1.4-1.6]

Some participants without insurance stated they could not answer the question on affordability because they had no money and relied on free clinics. Participants who recommended a reasonable payment suggested a co-payment of between $10- $25 per adult visit and $10 per child visit. Participants objected to multiple co-payments for return visits in which the condition was still being treated and multiple co-payments for 2 or 4 week supply of medications. A $100 per month premium ($200 maximum) or 10% of monthly take-home income with $1000-$1500 deductible was suggested as affordable for those with regular employment, including laborers, retired, factory workers, and similar jobs. All felt they should be able to obtain coverage for catastrophic illness. Those who were offered COBRA complained the cost was too high, upwards of $650 per month for a family, and thus an option they usually rejected.

The majority of uninsured participants in these focus groups reported they made too much money each month to be eligible for public programs, such as Medicaid. In one instance, one participant made $.31 too much. Many of these uninsured participants have children who are enrolled in Medicaid programs. Parents of these children said they could not afford health care for their children if they were not covered by Medicaid. They also said even if they could not afford health care for their children, they would do whatever was necessary, including writing bad checks and manipulating the system, to assure their children received health care. The working poor who participated in these groups expressed resentment at those who do use public programs and do not attempt to work and help themselves financially.

A similar issue of having too much household income occurs in families having a disabled family member. Social security payments or other income results in ‘too much’ family income, even though the full-time caregiver (who is less than 65 years old) is uninsured.

Senior citizens or others who own property, particularly rural farmland, may be required to sell their assets in order to qualify for public programs. Confronted with this issue, these people report this is not a reasonable option. Some individuals find alternatives to eventually transfer their land asset to other family (over a minimum of two years) prior to attempting to apply for public programs. These individuals express concern that government workers tell them to sell and deplete all their assets and move into an apartment in order to qualify for financial assistance.

Participants also report some persons who are eligible for public programs will not enroll as a result of individual pride and unwillingness to 'take something for free'. Programs that do exist are often not known to clients as a result of insufficient program advertisement and/or overwhelming paperwork and complicated guidelines to apply.

Rather than dis-enroll, these participants do not have the opportunity to enroll. They identified barriers to participation including: burden of paperwork, income guidelines too low to qualify, requirement to cash in all assets (e.g. farmland in rural areas) in order to qualify, unaffordable co-payments while covered by Medicaid requiring supplemental insurance to cover costs, generalized fear of the government, and individual pride prohibiting an individual to take 'something free'.

MSPG conducted 34 interviews between April 30 and August 19, 2004. Key informants (e.g., FQHCs, free clinics, health care providers, county health departments, etc.) represented all areas of the state and a variety of health care backgrounds. Sixteen respondents said public insurance was not used more because people are not aware of its existence or not aware they might be eligible. As one key informant noted, "The CHIPs program? We've jokingly called it the best kept secret in Missouri." It was noted that government assistance should not be free because that leads to abuse of the system. One key informant said women come in on a regular basis to her clinic to replace lost antibiotics for their children. Because the cost to them is so low, there is no incentive to be responsible for the medication. The same key informant also pointed out the need to have some penalties associated with public assistance. For example, there should be some sort of cost or penalty for a woman who continues to have children while on Medicaid.

Employer Insurance Issues [1.7-1.9]

Some participants do not have the opportunity to enroll as opposed to refusing to enroll. They identify employer situations in which number of hours worked is limited yet linked to opportunity to receive benefits, coverage is not offered and/or affordable especially for small business or the self-employed, waiting periods are lengthy (3-6 months), part-time workers cannot receive benefits, and multiple exclusions exist for pre-existing conditions.

Most participants believed that employers should have a significant role in providing health insurance for employees. The waiting period needs to be eliminated; time off for hourly employees for sickness and doctor visits needs to be granted; part-time workers should be able to receive pro-rated insurance benefits; employers should not be allowed to manipulate workers' hours to avoid paying benefits. When asked to choose between better pay and having benefits, most participants felt benefits were a priority and they would accept lower wages in preference for benefit coverage. This was not true of young persons, less than 25 years old, who choose wages over benefits. In one community, employers provided each employee $136 per month to buy a benefit plan of their choice. A suggested alternative to employer insurance is creation of insurance networks among communities, including small businesses, to form an insurable pool by which to negotiate insurance packages and costs for health care.

Insurance credits, similar to income and education credits, and consideration of an insurance option to cover co-payments were suggested in one group. Income manipulation is generally not a concern to these participants since their incomes are so low and cash flow is very limited.

Barriers, benefit design, and underinsured [1.10-1.13]

No other barriers were identified. Cost is the issue.

Uninsured and underinsured participants reported they delay or forego health care, including medications, if they are unable to pay for services or buy needed medications. In the case of severe, intolerable health care problems, participants will use hospital emergency services, for which they can delay billing. They then accumulate large bills, make monthly payments as they are able, and field routine check up calls from collection agencies. Young people, new in the workforce, and who are no longer students covered by parents' medical plan, do not view health insurance as an important employment benefit. Therefore, they do not routinely see a provider and tend to manage a health care crisis by using the emergency room.

Access to health care and quality health care providers are particularly problematic in rural areas. People in smaller sized towns and rural areas are required to travel to metro areas to receive comprehensive, and in some cases, more affordable care. Only basic, stabilizing services are offered locally in these non-urban areas, and there was a lack of availability of specialist care.

Dental care and access to dentists was viewed as an even greater issue than health care access. Three main reasons account for problems associated with emergency or routine dental care: (1) the requirement for payment up front, prior to receiving any service from the dentist, (2) lack of a service safety net, such as emergency room services for health care, and (3) unwillingness of dentists in local communities to accept Medicaid patients (children and adults). Participants report they suffer more with dental problems than with health care needs, simply because dental care is completely unavailable to them.

SECTION 2. EMPLOYER-BASED COVERAGE

Quantitative Research by the MSPG [2.1]

The Missouri Survey found sizeable differences in access to coverage depending on the size of one's employer. One in four (25.8%) workers employed in small firms with 10 or fewer employees are offered coverage. In comparison, nine of ten workers in large firms with 50 or more employees are offered coverage (Table 5).

Table 5. Health Insurance Offer Rates by Selected Employer Characteristics

	Offer Rate
Overall Rate of Employers Offering Insurance Coverage	**74.2%**
Employer Size	
< 11 employees	25.8%
11-50 employees	70.4%
> 50 employees	90.3%
Employee Income (as % of FPL)	
<100%	33.8%
100-133%	38.4%
134-150%	49.1%
151-200%	65.0%
201-250%	75.3%
251-300%	68.7%
>300% (reference group)	82.4%
Type of Employment	
Permanent	77.1%
Temporary	47.9%
Seasonal	38.6%
Hours Worked	
<20 hours	48.5%
21-30 hours	37.8%
31-40 hours	81.9%
40+	79.3%

The most common source for health insurance coverage for Missourians is through their employer, followed by publicly funded health insurance including: Medicaid, SCHIP, and Medicare. Based on the Missouri Survey among the employed, 74.2% reported working for firms that offer coverage. This figure is higher than that reported elsewhere. The 2002 employer-based Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) data reported approximately 56.4% of Missouri's establishments offer health insurance. This is down from 57.1% in 2001 and 58.8% in 2000, but up from 1999, which was at 52.8%. The industry sector

influences the offer rate, as well, with education providing the highest rate of insurance and the industries of personal service and agriculture, the least (Table 6).

Table 6. Health Insurance Offer Rates by Industry Sector

	Offer Rate
Overall Rate of Employers Offering Insurance Coverage	**74.2%**
Industry Sector	
Education	88.3%
Manufacturing	87.8%
Government	87.7%
Health Care	84.2%
Transportation	81.5%
Finance	79.5%
Social Services	77.6%
Professional	69.7%
Retail	67.3%
Business Service	66.8%
Entertainment	56.5%
Construction	52.4%
Agriculture	39.2%
Personal Service	27.4%
Other	73.1%

Source: Missouri Health Insurance Coverage and Access Survey, 2004.

The employment characteristics and uninsurance rates are portrayed in Table 7. Survey results showed that self-employed residents of Missouri are uninsured at a rate nearly three times higher than those who are employed by someone else (19.1% vs. 6.6%). Missouri's unemployed also experience high rates of uninsurance at 15.0%. Part-time employees working 21-30 hours a week are significantly more likely to be uninsured when compared to those working 40+ hours a week. Temporary and seasonal workers have rates of uninsurance three times greater than those with permanent jobs (20.9% and 29.2% vs. 6.7%, respectively). Geographic location was not measured in the Household Survey.

Table 7. Uninsurance Rates and Population Estimates[1] by Employment Characteristics

	Uninsurance Rate	Pop Estimate	Sig
Total Population	**8.4%**		
Employment Status			
Self employed	19.1%	88,561	***
Employed by someone (reference group)	6.6%	212,450	
Unemployed/Unpaid	15.0%	126,457	***
Retired	2.4%	19,208	***
Student	11.0%	167,30	
Hours Worked per Week			
0-10	9.8%		
11-20	10.1%		
21-30	20.7%		***
31-40	7.1%		
40+ (reference group)	5.4%		
Type of Job			
Permanent (reference group)	6.7%		
Temporary	20.9%		***
Seasonal	29.2%		***
Size of Employer			
<10	24.8%		***
10-50	11.7%		**
51-100	12.2%		*
101+ (reference group)	5.0%		

Source: Missouri Health Insurance Coverage and Access Survey, 2004.
[1] where available
*p<.05, **p<.01, p<.001

Employers Offering Coverage [2.1]

Employees covered by employer-sponsored insurance were asked about the extent of their benefits and if their plan requires co-pays, a form of cost sharing that alleviates the financial burden on an employer. As displayed in Table 8, employer-sponsored insurance in Missouri appears to be quite comprehensive with 95.6% of respondents indicating prescription drug coverage and 86.6% reporting mental health care benefits. Dental (79.0%) and vision (65.9%) coverage are significantly less likely ($p < 0.001$) than mental and prescription drug benefits to be included in employer-sponsored insurance packages.

Cost sharing through the use of co-payments is widely used among Missouri employers that offer health insurance coverage. Of the 88.5% of respondents reporting co-payments as part of their insurance plans, 59.6% indicated the payments range from $11-$20 while 27.6% reported a range of $1-$10 (Table 8).

Table 8. Benefits of Employer-Sponsored Health Care Coverage

	Insurance Type
Benefit options	**Employer sponsored**
Have Co-pay	88.5%
Have Dental Coverage	79.0%
Have Mental Health Coverage	86.6%
Have Prescription Drug Coverage	95.6%
Have Vision Coverage	65.9%
Co-pay Amounts	**Percent of Respondents Who Report a Co-pay**
$1-$10	27.6%
$11-$20	59.6%
$21-$50	12.3%
$50+	0.4%

Of the establishments with employer-sponsored health insurance in 2002, approximately 69% of the full-time employees were enrolled. This is reduced from 72.0% in 2001. In these same establishments, 31% of the part-time employees were eligible for the employer-based coverage, while only 15.9% participated. In 2001, 41.7% were eligible, but only 28% participated. It is important to note there was an increase in employers offering part-time employees insurance from 21.3% in 2000 to 41.7% in 2001, but a decrease to 31.1% in 2002. Continuing the same trend, there was an increase in part-time employee participation from 11.1% to 28.0% for the same time period, but a decrease to 15.9% in 2002. Similarly, the Missouri Survey found that 69.9% of the adults, ages 19-64 were enrolled in employer-based group insurance. The survey also indicated 5.2% of the adults and 4.2% of the children had individual coverage.

The Missouri Survey also examined why workers do not participate in employer-sponsored coverage. The most common reason was they did not want it, did not need it, or thought the

coverage offered was inadequate (36.7%). Several respondents (27.5%) did not qualify for employer-sponsored coverage while 21.7% reported the coverage was too expensive.

Employee income is also related to the availability of employer-sponsored health insurance. Approximately 33.8% of working people earning incomes below the poverty level are offered health insurance coverage. People earning more than 300% of the federal poverty level are over twice as likely (82.4%) to be working for firms that offer health insurance. Part-time and temporary employees are less likely to be offered coverage than their full-time or permanent counterparts.

The Missouri Survey also yielded data on family coverage. Respondents indicated that 63.9% of the children ages 0-18 were covered by employer-based group coverage. The Missouri Survey also showed that whether a Missouri resident purchases an individual or family health insurance policy is influenced by whether the individual purchases the coverage on his/her own or through an employer or group. Missourians who purchase coverage through an employer or group are more likely to have family coverage than individual or self-pay consumers (68.1% vs. 43.9%).

This Missouri Survey finding on family coverage is different from that reported in MEPS-IC for family coverage. MEPS-IC data from 1996 to 2000 indicated the percent of employees enrolled in a health insurance plan with family coverage hovered between 53% and 50%. In 2001 there was a sharp decline in family coverage enrollment to 36%. In 2002, the decline continues with 34.7% of employees enrolled in a plan with family coverage. This drop may be attributed to the rising premiums associated with family coverage in Missouri, especially for small firms, which have experienced the largest increase.

Qualitative Research by the MSPG [2.2 – 2.7]

A total of 64 small business employers from around the state participated in the focus group process; 48 participated in seven face-to-face focus groups, and 16 participated in individual phone interviews. Interviews and focus groups took place between April 14 and July 15, 2004. Fifty-three of the companies represented offered health insurance to at least some employees; 11 did not. A presentation of the questions asked to these small business representatives is provided followed by an overall discussion of themes from the data.

What is the most important factor that has influenced your decision to offer or not offer health insurance? [2.2]

The majority of employers that offered insurance said they did so because it was a recruiting and retention tool. “The main reason would be to hire and retain employees,” noted one owner. “That is the only reason.” Another employer said that “at the end of the day it comes down to money and you know they are not here because they like me and so I have to have a competitive package and for what I am asking them to do, the level of professionalism that I require.”

Several employers noted that health insurance has become so important that it is often the first thing a prospective employee asks about during interviews. Employers did not see insurance as strictly a business decision, however. Other reasons cited were employee need and because “it’s the right thing to do.” One employer put it this way: “Luckily our Board of Directors, as well as our Executive Director, we all see, we all read off the same page and we all think it is not

an option. A person has to have insurance to survive in the real world." Another told a story about an employee who had heart surgery a number of years ago: "I said, you owe me $75. He couldn't believe it. That is all of his out-of-pocket there was. It is not that way now. Now that is something that you feel good about from an employer's standpoint." One employer mentioned a trend that is occurring with greater frequency: "We seem to have a significant population that comes in that is in the middle-age to older bracket and it is because they cannot afford healthcare and so they actually are working for the insurance."

For those companies that did not offer insurance, the overwhelming factor was cost.

What kind of information would you find useful in making decisions about health insurance? [2.3]

There was unanimous support for information about health insurance plans that would help employers make more informed decisions. As one business owner admitted, "I am kind of flying by the seat of my pants and relying on my agent to keep me in line with the various regulations…Yeah, it would be very beneficial." The consensus was that a rating or report card of insurance companies would be very beneficial. This could include basic information about a sample plan so that "apples could be compared to apples," with specific information on premium prices, deductibles, and what is covered. In addition, employers said that ratings of the companies by customer satisfaction or complaints would be helpful so they would not necessarily be tempted to go with a company offering the lowest price. A suggestion was made to add a feature on the state government or other appropriate website where employers could lodge complaints about insurance companies. Some employers expressed a desire to learn more about medical savings accounts as well. Employers had a number of complaints about the way they are treated by insurance companies, not the least of which was the tendency to give no explanation when premiums are increased. One employer suggested it would be helpful if insurance companies reported to its customers where the money goes: "How much would actually go to insurance companies, as far as profit for them? How much of it goes to providers? Just where does all that premium money go to?" Another pointed out the same problem did not exist with property and casualty insurance and that health insurance was unique in *not* giving explanations for cost increases. Others felt slighted as well: "I think insurance companies should fight for our business to give us the best quote…They don't do that. They just wait until your policy is over in August and on July 15, they say okay we're raising your premiums $2000 and then they know that you need insurance so you are basically stuck." Some employers even questioned the legality of the policies of some insurance companies. One told this story about an insurance company: "What they do is that they go back and underwrite every claim from your enrollment sheet and if you don't mention one little tiny thing, they'll use that as an excuse to deny you coverage, to block you as the individual employee on this group from the plan…Why doesn't the state help get rid of these criminal organizations that are out there to just take your money and run."

"Low-balling" was mentioned several times (where insurance companies give initial low rates and then raise prices dramatically within the first year). This had happened to several employers and they were understandably bitter about the experience. One described his experience with an insurance company: "They low-balled us to get the coverage and then 30 days later they hit us…We had several employees with procedures on-going and we were basically forced to go back and our company picked up and it cost us close to $40,000 just for the 20 days interim

period to get the people with procedures their coverage and they were basically without insurance until the 9th."

The need to be an informed consumer of insurance was pointed out. As one employer said, "There are so many insurance companies out there. You see their sign hanging off a telephone pole and you usually get what you pay for." Nearly three-fourths of the employers who participated in the focus groups had fewer than 50 employees. Many of them felt that, although they are the backbone of American business, insurance companies are turning their backs on them in favor of large corporations. The dissatisfaction of focus group participants with insurance companies was confirmed by several employers and key informants who reported that the average stay with the same carrier is only 2.5 – 3 years. As one business owner said, "Our philosophy always was if we possibly can we will stay with the carrier we have. We don't want to put our employees through that every year. Nevertheless, we have probably done it five times in the last ten years out of necessity."

What incentives do you think would be effective in encouraging employers to offer health insurance? [2.6]

The most common response to this question was tax credits. None of the owners provided any specifics, except for one who suggested reduction of payments to Social Security and Medicare. For at least one business owner who does not offer insurance, tax credits would not be an incentive: "Of the last ten years, I've had to pay taxes about two years because our bottom line is so bad…If you're not paying taxes, how is that going to help me?" Several other suggestions were provided as well:

- Purchasing pools for small businesses.
- Promoting the benefits of offering insurance—better employee recruitment and retention, reduced absenteeism, etc.
- Government subsidies, such as the "1/3 model."
- Enacting tort reforms to help bring down insurance cost. One woman who participated in a focus group had a daughter in the delivery room while the focus group was going on. The doctor who was delivering the baby was planning to stop all obstetric services in his practice by November 2004 because of malpractice insurance costs.
- Accepting all businesses equally into the insurance system so the playing field is level and rates will be more affordable for all.
- Providing education to make sure small businesses can make good decisions about insurance, i.e., providing information on medical savings accounts which many businesses are interested in but few know much about.
- "Get the government out."

Themes from the Small Business Owner Focus Groups and Suggestions on How to Improve the System

Themes from Small Business Owners Focus Groups

A number of themes emerged from the focus groups, such as:

1. Cost is an overwhelming issue for employers. Cost is the "elephant in the living room." During the focus group discussions, it was so overpowering for some employers that it was difficult for them to get beyond it to discuss other issues surrounding health insurance.

2. Employers welcome the idea of more information so that they can make informed decisions about healthcare. Employers are frustrated and even resentful of the way they have been treated by insurance companies. They are receptive to information which would empower them.

3. One of the hidden costs of health insurance is the amount of time employers must spend dealing with it. For both business owners and their employees, the amount of time spent on insurance is increasing, particularly for those businesses that change carriers frequently.

4. Those employers that offer insurance very much want to continue doing so. They realize its importance to the success of their businesses and are not ready to give it up without a fight. Those employers that do not offer insurance have a strong desire to do so.

5. Employers are much more interested in tax credits than subsidies. To them, subsidies imply government involvement, which they oppose. When government involvement in health care was discussed during the focus groups, not a single business owner defended the government.

6. Employees need to be educated on how to use their insurance plans effectively. From using the emergency room only for emergencies to buying prescription drugs at a discount where possible, employees need to become better health care and health insurance consumers.

7. Low-balling is a serious issue which has hurt many small businesses in Missouri. The practice of giving initially low insurance rates, only to increase prices dramatically, needs to be dealt with by State insurance regulators.

8. Purchasing alliances are badly needed. Owners of very small businesses are desperate to find a more cost-effective way of providing insurance to their employees. They see large purchasing alliances as at least a step in the right direction.

9. Employers, particularly those in very small businesses, were frustrated and distressed about the health insurance predicament in which they have found themselves. The degree of concern seen on the faces and heard in the voices of these small business owners cannot be overstated. Perhaps this employer said it best: "I hope that all of us go and tell

> three and four other business-owner friends about it and we all go on the [SPG] website and print it [the report] off and send it to all of our legislators and let them know that, hey, the small business person out there is struggling, they are really upset about this insurance problem because I, for one, am."

Suggestions from Small Business Owners on How to Improve the System

During the course of the focus groups, employers made several excellent suggestions about how the system could be improved. For purposes of clarity, the suggestions are reiterated:

- Add a self-insured component to insurance plans. Purchasing catastrophic coverage and paying for routine care is yielding substantial savings for some companies.
- Send e-mail reminders to increase the number of employees who get physicals and routine screenings.
- Include case management in insurance plans. Providing ongoing management of chronic illnesses may yield significant long-term cost savings.
- Implement health insurance co-ops, similar to electric co-ops.
- Limit insurance companies in Missouri to a certain percentage profit and require any excess money go into a pool so that employer-based coverage may be expanded.
- Develop a government watchdog group to oversee the activities of insurance companies.
- For the uninsured, offer catastrophic coverage only. Even this limited coverage would help significantly with costs.

SECTION 3. HEALTH CARE MARKETPLACE

Existing Data on Utilization of Missouri Health Care [3.1]

Missouri exceeds the national average in per capita health care expenditures (Table 13). 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 13. 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.[3]
* includes Medicare, the federal share of Medicaid and the State Children's Health Insurance Program (SCHIP).
**includes both federal and state spending

Having a regular source of care is associated with fewer delays in receiving care, better preventive care, and enhanced treatment. The Missouri Survey found that persons uninsured are significantly less likely to have a regular source of care (58.1%) than those with insurance, regardless of whether the source is public (91.9%) or private (90.2%).

Of the respondents who indicated a regular source of care, a significantly higher proportion of the uninsured compared to the publicly insured and the privately insured indicated receiving care in the emergency room (10.8% vs. 3.2% and 2.1%) and in clinics (32.5% vs. 23.1%. and 12.9%). Persons with private coverage and those with Medicaid were significantly more likely than the uninsured to receive care in a doctor's office (84.0% and 71.6% vs. 52.6%).

The uninsured and publicly insured individuals are also more likely to use a public clinic than those with private insurance (45.0% and 38.2% vs. 13.1%). Likewise, approximately half (50.5%) of privately insured individuals use private clinics as a source of medical care in comparison to 27.3% of the uninsured and 33.8% of those with public coverage.

Uninsured individuals are more likely than their insured counterparts to have had no doctor visits (40.2% vs. 28.3%) in the past three months. Moreover, the most significant difference in utilization between insured and uninsured individuals were overnight hospital stays in the past 12 months where uninsured individuals' rate of overnight stays is less than half that of insured individuals (3.9% vs. 10.1%).

The barrier to needed medical services due to cost is a significant key health issue related to access to care and uninsurance. The Missouri Survey revealed a striking disparity in health care access between insured and uninsured residents of the state. Nearly 40 percent of uninsured respondents indicated a time when they needed health care but did not receive it due to cost. This percentage is significantly

smaller for privately and publicly insured individuals (5.5% and 7.2% respectively). This also suggests that, from an economic perspective, underinsurance is not a big issue for a majority of those with coverage.

The State's current health care delivery system and its adequacy [3.1]

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

Community Health Centers

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 14 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 14. 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 15 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 15. 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 specialists within the pediatric, medicine, and surgery fields. As portrayed in Table 16, 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 16. 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.

Adequacy as a Discussion Question in MSPG Consumer Focus Groups

Essential services identified by participants were consistently tied to preventive services, including annual health physicals with vision exam, age appropriate health screenings for women (mammogram and pap) and men (prostate), child well-checks and immunizations, mental health counseling, and routine supplies such as glasses, dentures, orthopedic equipment, and hearing aids. The consensus was that clients would take advantage of preventive services if covered or were free. Without coverage for these services, most participants forego these screenings for long periods, from a few years to never. Participants indicated dental care, including both prevention and treatment, is a priority health service that should not only be affordable, but also accessible in local communities.

Local community support was identified as a protective factor for improved mental health, management of physical illnesses, and help with individual social problems. Financial support and social marketing for existing community efforts among volunteers as well as participating providers was seen as critical to sustaining an effective local system. Recommendations from participants focused on making health care more affordable, including medication (high) price control, consistency of medication co-payments across levels and types of insurance, better coordination between medications prescribed by physician and medications covered by insurance plans (including Medicaid), and easy access to medications from Canada covered by insurance plans. Providers need to have flexible hours, including evening and weekend appointments or walk-in services.

Medicaid and Medicare recipients would likely define themselves as underinsured since they have coverage issues related to medication exclusions, lack of choice of providers, and unaffordable co-payments requiring supplemental insurance to meet health care costs. A definition of the uninsured needs to include the working poor (i.e. those who have jobs but make ‘too much’ to qualify for insurance). Definitions of “underinsured” and “uninsured” need to consider those who have other assets, primarily land, that account for “high income”.

State as a Purchaser of Health Care [3.4]

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 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 has 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 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].

In 2005, the Missouri legislature approved the formation of the Missouri Medicaid Reform Commission. The Commission was established by Senate Bill 539 and Senate Concurrent Resolution 15 to develop a framework by which Missouri's Medicaid system may be redesigned and transformed.

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

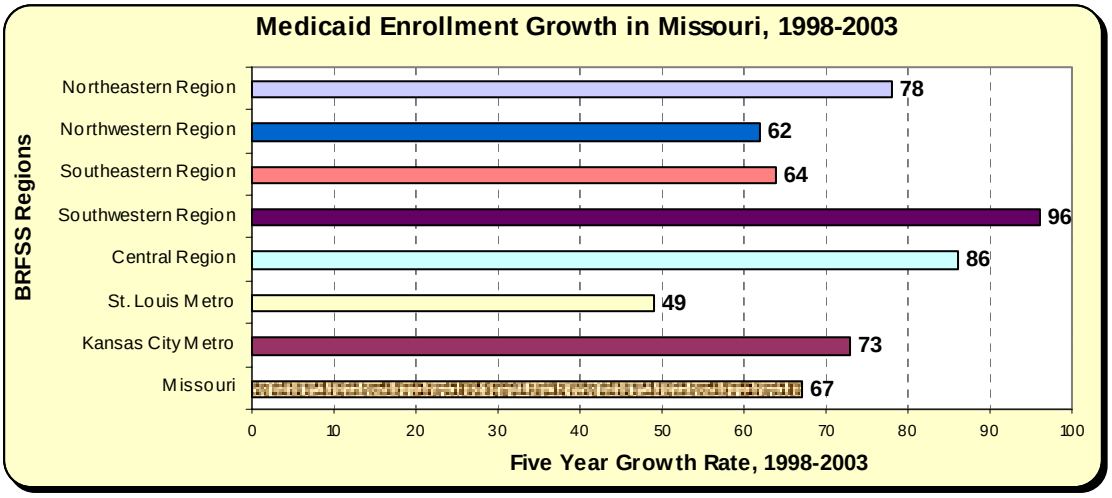
These groups represent those who are currently participating in the public healthcare program. The Commission recognizes defining those with the "greatest need" is difficult and raises serious questions such as: Does an unemployed Missourian have a greater need than a disabled Missourian? Does a poor 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.

Medicaid Enrollment and Growth

State data on Medicaid enrollment indicates that in December 2004, 1,015,799 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.

When looking at the data over a multiyear period, growth in Medicaid can be calculated. Using data reported on June 30th for years 1998-2003, a 67% growth in the Medicaid enrollment was determined. As indicated in Figure 4, most of the non-metro regional Medicaid five-year enrollment growth exceeded the state level growth. The highest growth is noticed in the southwestern region where it almost doubled (96%). The growth in Medicaid correlates mostly with the SCHIP expansion and then a downturn in the economy and loss of jobs and income for many residents.

Figure 4



Source: Missouri Health Insurance Coverage and Access Survey, 2004

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).

Existing Qualitative Data and Defining Adequacy of Existing Insurance Products [3.1]

Qualitative Data were collected from Small Business Focus Groups for the MSPG in March and April of 2004. They revealed that uninsured and underinsured participants delay or forego health care, including medications, if they are unable to pay for services or buy needed medications. In the case of severe, intolerable health care problems, participants will use hospital emergency services, for which they can delay billing. They then accumulate large bills, make monthly payments as they are able, and field routine check up calls from collection agencies. Young people, new in the workforce, and who are no longer students covered by parents' medical plan, do not view health insurance as an important employment benefit. Therefore, they do not routinely see a provider and manage a health care crisis by using the emergency room.

Data from the key informant interviews revealed that part of the debate surrounding health insurance is its scope. When asked, "What constitutes essential services?", the responses to this question illustrated the divide that exists about the role of insurance. Some key informants felt that essential services should be just that. As one said, "Insurance is there to take care of people. It's there to keep you from losing your house or your car and it's not there to pay your 40 or 50 or 60-dollar doctor visits." Others thought that benefit packages should be comprehensive in nature. Several essential services were mentioned frequently by key informants, but the most common response was prescription drugs, cited by 15 key informants as the most crucial service in a health insurance plan.

Essential services identified by participants were consistently tied to preventive services, including annual health physicals with vision exam, age appropriate health screenings for women (mammogram and pap) and men (prostate), child well-checks and immunizations, mental health counseling, and routine supplies such as glasses, dentures, orthopedic equipment, and hearing aids. The consensus was that clients would take advantage of preventive services if covered or were free. Without coverage for these services, most participants forego these screenings for long periods, from a few years to never. Dental care, including both prevention and treatment, is a priority health service that should not only be affordable, but also accessible in local communities.

Recommendations from participants focused on making health care more affordable, including medication (high) price control, consistency of medication co-payments across levels and types of insurance, better coordination between medications prescribed by physician and medications covered by insurance plans (including Medicaid), and easy access to medications from Canada covered by insurance plans. Providers need to have flexible hours, including evening and weekend appointments or walk-in services.

Logical Next Steps

According to the small business participants in this process, the following would seem logical next steps that could be taken by the State to help address the uninsured problem:

- Provide businesses with a rating or "report card" of insurance companies that operate in Missouri.

- Offer training to businesses on how to incorporate self-insured components in their insurance plans. This may become an increasingly common method to rein in costs.

- Investigate the feasibility of State-supported purchasing alliances for small businesses. Assistance may be available at the federal level as well. In May 2004, the U.S. House of Representatives passed legislation allowing creation of Association Health Plans which allows companies to band together across state lines to increase buying power for health insurance. As of this writing, the bill is pending in the U.S. Senate.

- Maintain an ongoing review of the latest health care literature. New and innovative ideas are being developed all the time. For example, pharmacists in Australia travel door-to-door to physician's offices in much the same manner as pharmaceutical representatives. Instead of selling drugs, they sell information, giving physicians objective data so that the most cost-effective drugs may be prescribed, not just those being marketed by the pharmaceutical companies. A similar effort will soon be undertaken in the state of Pennsylvania. Americans pay more out of pocket for their health care than do people in any other industrialized country. Solutions will not come easy. As one focus group participant quipped when asked how insurance coverage could be increased in Missouri, "You guys figure it out and let us know."

- A final note: Efforts to simply increase insurance coverage do not address the underlying question of why health care costs are rising so rapidly. Until efforts are made to address *that* question, simply increasing the number of those insured, whether through tax credits or some other means, will be treating the symptoms rather than the cause.

Variation in Benefits and Self-Insurance [3.2 and 3.3]

The Household Survey did not measure these variables.

Universal Coverage [3.5, 3.6, and 3.8]

For the MSPG, universal coverage was not currently considered a viable option.

Considering the Safety Net in the Planning Process [3.7]

The policy option for the proposed Year 3 Pilot application is a small business buy-in to the Missouri Consolidated Health Care Plan (MCHCP) with a reinsurance option. Self-employed residents of Missouri are uninsured at a rate nearly three times higher than those who are employed by someone else (19.1% vs. 6.6%). Missouri's unemployed also experience high rates of uninsurance at 15.0%. Those

who are uninsured go without healthcare for a limited time or use the safety net. The burden on the safety net theoretically could be relieved if more small business employees, undoubtedly users of this system, were insured.

Other State's Experiences Considered

Cost containment through disease management (Idaho and Indiana). Missouri has implemented this on a small scale to date and is looking at Indiana's statewide approach for future development of the State's initiative.

Medicaid expansion for low-income families (Maine, Idaho and Kansas). As stated, Missouri has performed extremely well in ensuring that children are covered through Medicaid and SCHIP programs (300% of FPL).

High risk pooling small firms (Illinois, Iowa, South Dakota). States are increasingly looking to partner with the private sector to leverage employer funds for low-income workers. Other states are looking at state sponsored pools for small businesses.

Public/Private plan (Minnesota, Maine and Iowa). Health plans focus on businesses with 50 or less employees, the self-employed, unemployed, or individuals out of workforce or work less than 20 hours per week. Determination of private and state share needs to occur.

Rural infrastructure (Arizona). Creating a rural infrastructure may be an option worth pursuing, given Missouri's rural demographic.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

Policy Option Selected by the State [4.1]

Capitalizing upon the work and in consultation with the Council as the Missouri Survey Results were publicly released, DHSS sought to refine the draft list of policy options. This set of options had a range of impact from limited in scope to broad in nature and was presented to the group to stimulate discussion about what might work in Missouri. Group members were also encouraged to not limit themselves in thinking about what might work based on what they think will pass the legislature.

Finally, after extensive discussion the decision was made to more extensively investigate how to expand coverage to uninsured persons working in small firms in Missouri. The results of the 2004 Missouri Health Care Insurance and Access Survey indicated the overall level of uninsurance for the state of Missouri, across all age groups, was 8.4% (approximately 463,000 individuals.) For adults ages 19-64 years the uninsurance rate was 12.3%, and for children ages 0-18 years the uninsurance rate was 3.4%. The Missouri Survey also indicated that over one third of the uninsured work for small firms and another 19% are self-employed. This is of significance to the state as over 94% of the businesses in the state have a workforce of fewer than 50 employees.

This proposed policy option would allow small private businesses to purchase coverage for their employees through the Missouri Consolidated Health Care Plan (MCHCP). MCHCP is the plan made available to state employees, other public entities and non-profit organizations in Missouri. This option would test the utility of publicly funded reinsurance to help cover risks associated with high cost enrollees.

Questions 4.2 to 4.15 will be addressed during the pilot for the policy.

In Support of this Policy Option [4.16]

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, support is evident that the small business employee is found to be in most need of a targeted intervention. Given the budgetary climate in the state, there was strong interest in working with the small business owner. In addition, in our focus groups and small business interviews, small business owners were adamant about wanting to offer health insurance to their employees, but needing more affordable and accessible options.

Given the political and budgetary climate, a multi-faceted approach to expanding insurance to more citizens is necessary. Recently, public-private partnerships have shown promise in increasing the accessibility and affordability of health insurance through the private market. 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 the viability of using the Missouri Consolidated Health Care Plan with a reinsurance option to alleviate this problem in Missouri.

In addition, approximately 1,066,000 employees work in the small business workforce[6]. 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.

Actions taken toward this Policy Option [4.17]

Action taken toward this policy option occurred in 1998 when legislation was introduced, but ultimately failed, that would make the Missouri Consolidated Health Care Plan, which offers health insurance to pools of state and local government employees, 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 not Selected [4.18]

One of the most important principles of the MSPG is that an effort is made to create policy options based on sound evidence, tested approaches, and grounded in the reality of the State. Through the Policy Options Subcommittee Workgroup (which is comprised of the co-chairs, members, and MSPG staff), 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, Table 17 represents those policy options not selected, target population, numbers served, and reasons for their exclusion.

Table 17. Summary of Policy Options			
Policy Option[7]	**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.[8]	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 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.

Table 17. Summary of Policy Options, continued

Policy Option[9]	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 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[10]	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.

Table 17. Summary of Policy Options, continued			
Policy Option[11]	**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.

The Eligible but not Enrolled [4.19]

The pilot project, as awarded, will consist of an employer-based policy option. The State will conduct a detailed analysis and estimates of coverage and state cost impacts of selected employer-based policy options. This information is critical for the state in order to progress toward action and marketing of a product to expand coverage for the working uninsured. An important consideration revealed in the focus groups and the small business interviews is that the marketing of this insurance product must consider how the small business employer and employee use health insurance. As this next cycle of funding is only to fiscally model the buy-in reinsurance option to determine its economic feasibility, the implementation of a small business product must include messages specific to that audience. To encourage the eligible to enroll, a Social Marketing Campaign would allow exploration of a wide range of strategies and messages that may be appropriate and show the most promise to help the audience, the small business employer.

SECTION 5. CONSENSUS BUILDING STRATEGIES

MSPG worked toward consensus through a strong governance structure. Once the key stakeholders were in place, existing data sources were used to orient the staff and groups to what was known about uninsurance at the present time in Missouri and to not duplicate data collection efforts. 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.

Governance Structure [5.1]

The Governance structure for the MSPG is the Missouri Department of Health and Senior Services (DHSS). The Advisory Council on Accessibility and Affordability of Health Insurance Coverage 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. The membership and structure of this Advisory Council 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.

The Advisory Council maintains two subcommittees. Subcommittees were formed on a voluntary basis from the Advisory Council 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 those professionals on the Advisory 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 18 depicts the various agencies, organizations, and associations who served as members of the Council. Table 19 identifies the subcommittee, co-chairs' affiliation, major purpose, and activities. Note 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.

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 5.

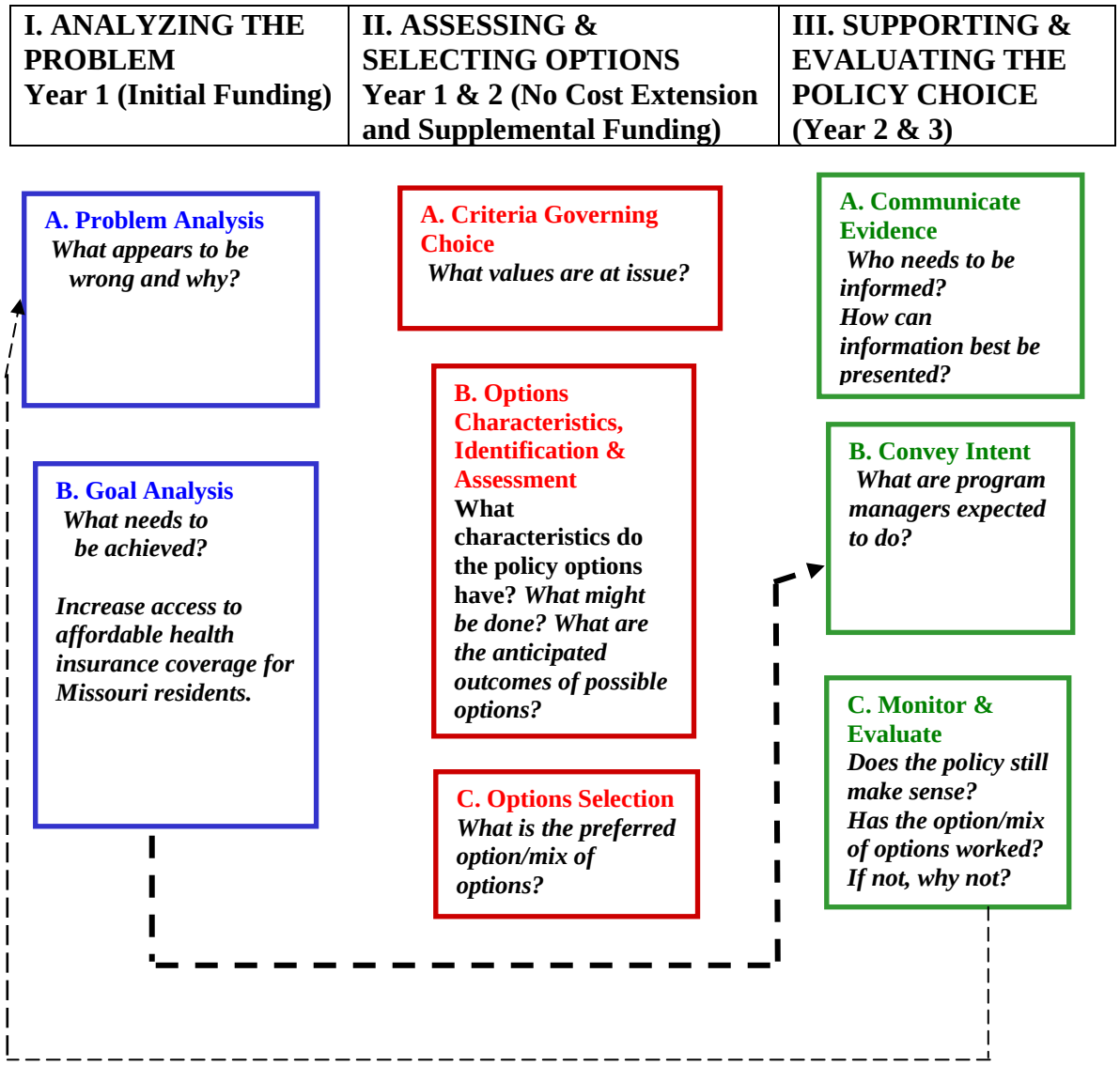
Table 18. Organizational Members of the MSPG Advisory Council

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

Table 19. 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.

Figure 5. Policy Analysis Framework Applied to the Missouri State Planning Grant (MSPG) in the Development of Policy Options



Quantitative and Qualitative Data Collection [5.2]

The MSPG views the qualitative and quantitative data collected on Missouri's uninsured as complementary in nature and supportive of the policy option for the small business community.

The Missouri Survey completed in March 2004 was the largest and most comprehensive survey on health insurance coverage and access ever conducted in Missouri. The data has proven extremely useful in developing policy options and determining the focus of this application. In addition to the characteristics of the uninsured and the employer information, the data provided key insights on why they do not have coverage – the barriers, beliefs, and cultures that influence their participation in health insurance coverage.

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.

Other Activities to Build Public Awareness [5.3]

One particular goal of the MSPG was to inform and educate, through a variety of methods, health care consumers, providers, payers, small business owners, legislators, other stakeholders, and the public on the project findings and the benefits of health insurance coverage for all citizens. Additionally, for the initiative to be successful, the interest of policy makers had to be garnered. Building of public awareness was accomplished through public presentations at conferences, development of a website (www.insuremissouri.org), special meetings, public deliberation forums throughout the state, and discussions of publishing data findings in scholarly journals.

Planning Effect on Policy Environment (5.4 and 6.9)

The policy and economic environment 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 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. Health insurance – public and private - is receiving much attention in Missouri. There is a strong philosophical emphasis on personal responsibility for health and health care and on the economic vitality of the state balanced with the state's desire to assist as appropriate and economically feasible with the health needs of its citizens.

Given the breadth and scope of the state's discussions on health care costs and health insurance, it is difficult to ascribe cause and effect specifically to the MSPG planning efforts upon the policy environment specifically. It was, however, one avenue for key decision makers to engage in those conversations and thus was one part of the matrix of evolving thought within the state on this issue of uninsurance.

Key "products" or initiatives within the state related to health care and health insurance, at this time, include:

- State's public mental health authority's commitment and planning process to move toward a public health model
- Governor-appointed Medicaid Reform Commission designed to examine and propose redesign for the state's primary public health 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

SECTION 6. LESSSONS LEARNED AND RECOMMENDATIONS TO STATES

Use and Importance of State-Specific Data [6.1]

The household survey data were invaluable to the progress of the MSPG in that it:

- provided the largest and most comprehensive survey on health insurance coverage and access ever conducted in Missouri. The data were specific to Missouri and planning a policy option would have been difficult without an understanding of the status of uninsurance.
- gave the project a sense of credibility, with over 7,000 households tested, it was more useful and representative than existing data sources.
- once released, caused heightened discussion and debate about uninsurance in Missouri among advocacy groups and stakeholder organizations.
- serves as a foundation on which to build and demonstrates a consensus of support for expanding options for small businesses.
- provides the substance on which to build a comprehensive social marketing campaign to inform Missourians about uninsurance. In addition to the characteristics of the uninsured and the employer information, the data provided key insights on why they do not have coverage – the barriers, beliefs, and cultures that influence their participation in health insurance coverage.

Most Useful Data Collection Activities [6.2]

MSPG staff indicated the public deliberation forums were most instructive. Not to dismiss the importance of the other data collection efforts, but the forums were real and for several of the staff they were able to understand the problem better and as one person put it, “get their hands around the issue”.

Data Collection Activities not Conducted [6.3]

MSPG conducted all data collection activities proposed.

Improving Data Collection [6.4]

To improve attendance rates at the public forums, it was important that representatives from the community initiate discussions with them and make a personal invitation. Community members viewed this as more of their project and their opportunity to provide input rather than another group coming in to collect data.

Data Collection Activities Needed [6.5]

No additional data collection activities currently identified.

Organizational and Operational Lessons Learned [6.6]

The Missouri Survey Data were released in October 2004. One of the most important lessons learned from this is that although everyone agrees there is an uninsurance problem, some may not agree on the severity of the problem and how the data were collected. Particularly, in Missouri, the concern centered on the Insurance Coverage in Missouri for Children (0-18). Our data indicated a 3% uninsured rate for children. This caused concern in several stakeholder groups with the belief that the rate was much higher and reporting of a lower rate may decrease pressure on policymakers to address the issue.

The concern over the 3% rate was handled with the understanding of the problem it creates for the challenger. For example, this low of an estimate is troubling to advocate groups who have a particular cause, poses a threat to the relationship between legislators and those advocate groups, and there is great loyalty to current data estimates (e.g., CPS, BRFSS.). It was quickly recognized that a "we own the problem" attitude often exists in the health profession. Another important observation was the need to define and clarify the nature of roles and expectations between state government and private organizations. There was ultimately skepticism about the methodology of data collection (e.g., phone surveys, point-in-time).

The MSPG developed a toolkit and made a presentation on this issue at the state planning grant conference. The suggestions presented included:

- Do not panic! Keep the focus on the uninsured and not on data disputes.
- Get your facts together – create a "Fielding Questions about the Data" sheet.
- Train your staff to understand the concern and use techniques to de-escalate the tension.
- Use this as an opportunity to build relationships, mend relationships, and forge new ones.
- Be prepared to verbally explain your data collection, methodology, and results.
- Share the data. People can rightfully expect government to be "transparent".
- Focus on the fact there are still uninsured children out there and that the number is only an estimate.

Recommendations to other States [6.8]

A major recommendation is to truly understand the problem you are trying to solve. Efforts to simply increase insurance coverage do not address the underlying question of why health care costs are rising so rapidly. Until efforts are made to address *that* question, simply increasing the number of those insured, will be treating the symptoms rather than the cause. Similarly, the Advisory Council frequently discussed issues of health care access and the grant-funded issue of uninsurance had to be reinforced in order to maintain the groups' focus on that issue. While health care access is a significant and impactful issue, the problem to be "solved" and discussed within the context of this grant was uninsurance.

Several other recommendations, tips, or strategies have proven useful and are as follows:

1. Make sure that if you are using two vendors to collect and analyze your data that each knows what their specific role is on the project and there is a clear line of communication that is independent of your staff. If there is a certain skill one does not have, then the other needs to know it.

2. During focus group or key informant recruitment, do not use cold-calling; use the contacts you create while forming your advisory council and stakeholders and any other community liaison or contacts (e.g., local public health departments, community coalitions, agencies)

3. Understand any potentially conflicting Institutional Review Board (IRB) issues between research collaborators.

4. Recruitment of small business employers to participate in focus groups is more difficult than any other target population.

5. Understand the questions that you have to answer for your Interim Report and the questions you need for your data collection. Get a copy of other states' questions first.

6. Create a list of guiding principles for the operation of your grant (advisory council); this will ground you. By doing this, you will work through a lot of the values and opinions your stakeholders have about the issue of uninsurance.

7. Have an identified process for achieving consensus. You have to do more than just discuss the issue. You have to get at the underlying values that drive what policy options are the most viable. We used a framework with the AC by Jack Needleman [12] that allowed us to fully explore the characteristics of policy options and led to the creation of facilitation questions.

8. Identify those who have the time to commit to your project. This project does not have immediately achievable objectives, but rather is focused on collaborative discussion and planning. This may be the biggest hurdle and most frustrating for your stakeholders.

9. Make sure no particular interest group drives or is perceived to drive your process and the work remains data and option driven.

10. Make sure an unbiased group leads the analysis to achieve buy-in across all groups and avoid questions about the validity of the information and the importance of the research. Skilled facilitation is necessary to run the advisory group meetings.

11. Form subcommittees around particular issues of your grant (e.g., policy subcommittee, communications subcommittee). Have monthly planning meetings with agendas to stay on top of objectives that need to be met for each of these. Make sure you link the objectives of the subcommittees with each other.

12. Remember to also consider the "stories" and the people behind the numbers. This issue is about how it impacts the individual person and not about statistics in the end.

13. Write a procedural manual for the co-chairs of your subcommittees. Everyone needs to know of the eventual end product.

14. Expect political changes during the year.

15. Get legislators on your advisory council early.

16. Work with a government or legislative liaison or someone who knows how the system works.

17. Identify the key stakeholders. Recognize those who can get things done may not reenter the picture until you are ready to talk policy.

18. Preexisting data sources may overshadow the newly collected data that you have through your household survey. This data will undoubtedly be compared to popular data sets (e.g., CPS, BRFSS, and MEPS.)

19. Know when other surveys are being conducted at the same time.

20. Stay on top of your subcontractors with bi-monthly electronic reporting forms. If they don't submit, call them.

21. Develop a webpage as one of your first activities. This will allow you as project director to understand the scope of the grant.

22. Recognize the need for the subcontractors to make this "their project". Do not let the project get away from you. You must find a balance between hiring them to do the job, but making sure they stay true to the objectives of the work. In the end, it is your grant.

23. Work toward making the project a true effort of stakeholders instead of only the Project Staff.

24. Create a matrix of the interim (final) report contents and make assignments, due dates, and the source of the information. Write your interim report throughout the year; do not wait until the end. Revisit this document often.

25. Interview other SPGs early and throughout the first year.

Change in Political and Economic Environment [6.9]

Refer to 5.4 on page 43.

Change in Project Goals [6.10]

The MSPG did not see a major change in project goals during the grant period.

Next Steps [6.11]

In the pilot year, the MSPG will:

- utilize the experiences of the first two years of this grant as a base for the pilot project.
- share information from the employer focus groups with the Department of Insurance and other identified stakeholders.
- disseminate the findings of our research in scholarly presentation and publications in Missouri and nationally.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

Federal Waiver Authority [7.1 – 7.2]

The buy-in to Missouri Consolidated Health Care Plan (MCHCP) for small business employers does not require a Federal Waiver authority or other changes in Federal law. However, this initiative may require state statutory changes and this will be explored during FY06.

Additional Research Needed [7.3-7.4]

The Missouri public voiced their concerns regarding the issue of uninsurance upon not only their personal and collective health and quality of life, but the economic viability of businesses as well as the economic vitality of the overall economy if effective and affordable solutions are not enacted. Further, past the sheer issue of insurance, Missouri citizens clearly want quality and affordable 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 identified by U.S. Preventive Services Task Force.
2. Develop a compendium of evidence-based practice specific to options for expanding health insurance coverage with accompanying evaluative results following implementation and/or pilot.
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 I: BASELINE INFORMATION

Population: The 2004 population estimate for Missouri is 5,754,618.[13]

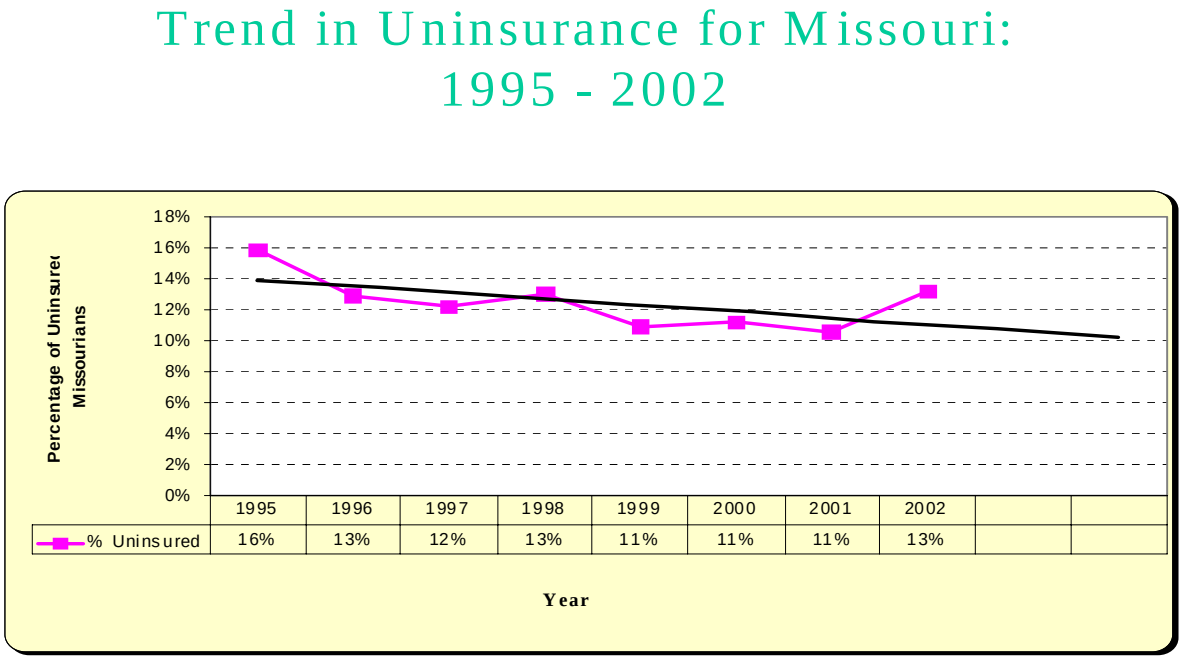
Number and percentage of uninsured (current and trend): 460,000 or 8.4% (Missouri Survey).

Missouri does not have trend data from the Missouri Survey. The two tables below represent trend table from 1999 to 2001.

Table #. Number and percentage of uninsured, *Sources: BRFSS, 1999-2001 and CPS, 1999-2001*

BRFSS				CPS			
	1999-2001 (combined)		1999-2001 (Average)		1999-2001 (combined)		1999-2001 (Average)
Subtotal	12,381,258	100%	4,127,086	Subtotal	16,516,987	100%	5,505,662
Yes	11,015,028	89%	3,671,676	Yes	14,892,376	90%	4,964,125
No	1,346,318	11%	448,773	No	1,624,611	10%	541,537

Figure 6 represents the trend in uninsurance for Missouri, 1995-2002.



Note: CDC, Behavioral Risk Factor Surveillance System data suggest a downward trend in the uninsurance rate between 1995 and 2002. However, a sharp annual increase is observed in 2002.

Source: Behavioral Risk Factor Surveillance System 1995-2002

Figure 6.

Average Age of Population:

The median age in Missouri is 36.1 years. [14]

Percent of population living in poverty:

Table 20. Families and Individuals Living in Poverty			
Poverty	**Number**	**Missouri**	**U.S.**
Families below poverty level	127,317	8.6%	9.2%
Individuals below poverty level	637,891	11.7%	12.4%

Table 21. Family Income and Federal Poverty Levels			
Family Income (% FPL)			
	Uninsured Rate	**Weighted Count**	**Sig.**
< = 100%	14.3%	103,388	***
101-133%	15.7%	60,011	***
134-150%	20.9%	41,584	***
151-200%	12.4%	75,144	***
201-250%	9.0%	53,027	***
251-300%	7.8%	40,368	**
>301% ξ	3.6%	89,883	

Primary Industries

Table 22. Primary Industries in Missouri, Source: MEPS, 2001.	
Retail and other Services	46%
All other Categories	19%
Professional Services	17%
Agriculture, Fishing, Forestry, Conservation	12%
Mining and Manufacturing	5%

Employers Offering Coverage

Table 23. State of Missouri, private-sector data by firm size, 2002							
	Number of Employees						
	<10	**10-24**	**25-99**	**100-999**	**1000 +**	**< 50**	**50 +**
Number of establishments	71,248	17,097	11,377	9,423	19,832	95,253	33,725
Percent of number of establishments	55.2%	13.3%	8.8%	7.3%	15.4%	73.9%	26.1%
Percent of establishments that offer health insurance	33.1%	62.7%	83.7%	96.6%	100.0%	42.5%	95.8%
Percent of establishments that offer health insurance that offer at least one health insurance plan that required no contribution from the employee for single coverage	79.1%	45.6%	44.0%	25.1%	15.1%	65.4%	20.3%
Percent of establishments that offer health insurance that offer an exclusive-provider plan that required no contribution from the employee for single coverage						14.9%	7.7%
Percent of establishments that offer health insurance that offer a mixed-provider plan that required no contribution from the employee for single coverage						39.5%	15.8%
Percent of establishments that offer health insurance that offer an any-provider plan that required no contribution from the employee for single coverage						12.4%	1.6%
Percent of establishments that offer health insurance that offer at least one health insurance plan that required no contribution from the employee for family coverage	38.4%	27.1%	22.2%	14.6%	6.5%	33.2%	10.2%
Percent of establishments that offer health insurance that offer an exclusive-provider plan that required no contribution from the employee for family coverage						7.4%	5.3%
Percent of establishments that offer health insurance that offer a mixed-provider plan that required no contribution from the employee for family coverage						20.0%	7.8%
Percent of establishments that offer health insurance that offer an any-provider plan that required no contribution from the employee for family coverage						6.8%	1.3%
Percent of establishments that offer health insurance that offer two or more health insurance plans				43.8%	53.8%	7.5%	47.6%
Percent of establishments that offer health insurance that required a waiting period before new employees were eligible for health insurance at establishments	50.2%	85.7%	95.2%	85.1%	80.2%	66.5%	83.1%

Table 23, continued	Number of Employees						
	<10	**10-24**	**25-99**	**100-999**	**1000 +**	**< 50**	**50 +**
Average length of waiting period (in weeks) before new employees were eligible for health insurance at establishments that offer health insurance	6.02	6.93	11.27	7.33	6.63	7.19	7.14
Number of employees	247,627	192,492	333,334	403,793	1,099,443	591,870	1,684,818
Percent of number of employees	10.9%	8.5%	14.6%	17.7%	48.3%	26.0%	74.0%
Percent of employees in establishments that offer health insurance	43.5%	71.3%	88.0%	99.1%	100.0%	65.1%	98.1%
Percent of employees eligible for health insurance in establishments that offer health insurance	79.3%	80.6%	75.1%	79.0%	68.8%	78.7%	71.7%
Percent of employees eligible for health insurance that are enrolled in health insurance at establishments that offer health insurance	85.2%	70.5%	79.1%	74.7%	86.4%	76.6%	82.9%
Percent of employees that are enrolled in health insurance at establishments that offer health insurance	67.6%	56.8%	59.4%	59.1%	59.4%	60.3%	59.5%
Percent of enrollees that are enrolled in self-insured plans at establishments that offer health insurance				41.5%	90.0%	10.9%	71.0%
Percent of employees working in establishments that offer two or more health insurance plans				48.6%	80.7%	8.6%	69.0%
Number of full-time employees	163,445	149,124	254,218	311,341	931,105	433,840	1,375,394
Percent of number of full-time employees	9.0%	8.2%	14.1%	17.2%	51.5%	24.0%	76.0%
Percent of full-time employees at establishments that offer health insurance	50.7%	78.4%	94.3%	98.9%	100.0%	72.4%	99.2%
Percent of full-time employees eligible for health insurance at establishments that offer health insurance	96.8%	90.3%	88.3%	93.7%	74.2%	91.1%	79.9%
Percent of full-time employees eligible for health insurance that are enrolled in health insurance at establishments that offer health insurance	86.9%	72.2%	81.2%	78.2%	88.9%	78.7%	85.5%
Percent of full-time employees that are enrolled in health insurance at establishments that offer health insurance	84.1%	65.2%	71.7%	73.3%	66.0%	71.7%	68.3%
Number of part-time employees	84,183	43,368	79,116	92,451	168,337	158,030	309,424
Percent of number of part-time employees	18.0%	9.3%	16.9%	19.8%	36.0%	33.8%	66.2%
Percent of part-time employees at establishments that offer health insurance	29.4%	47.2%	67.6%	100.0%	100.0%	45.0%	93.2%

Provider Competition, Insurance Market Reforms, Eligibility, and Use of Federal Waivers

Table 24. Missouri Insurance Market Reforms, Source: National Association of Health Underwriters, 2001	
Individual Market Reforms	
Guaranteed Issue	
Pre- Ex Conditions	None
Rating Structure	NRS
Small Group Market Reforms	
Guaranteed Issue	X
Pre-Ex Conditions	6/12
Rating Structure	25%
Group Size	3-21
S-CHIP Approach	
Medicaid	X
Combination	
Other	
Medically Uninsurable	
Risk-Pool	
Guaranteed Issue	
Open Enrollment	
MSA	X
Note. NRS, No Rating Structure; "X", either have one or more carriers voluntarily offering guaranteed issue or have mandated that there be a carrier of last resort in the state; 6/12, how many months a preexisting condition may be excluded from coverage; %, the percentage a carrier is allowed to increase rates; MSA, Medical Savings Account.	

Table 25: Federal Poverty Guidelines by Program, SFY05*	
Program	**Federal Poverty Level**
Medical Assistance for Families	75%
Medicaid for Pregnant Women	185%
MC+ for Kids (non SCHIP)	
Up to age 1	185%
Age 1 to 5	133%
Age 6 to 18	100%
MC+ for kids (SCHIP)	
Uninsured children up to age 19	
No cost	185%
$5 co-pay	225%
$62 to $252 monthly premium (No more than 5% of their income), plus $10 co-pay and $9 prescription co-pay	300%

Table 26. Monthly Income Rates as Percentage of 2004 Poverty Guideline, Source: Missouri Department of Social Services.

Unit Size	Federal Poverty Level (FPL)					
	75%	**100%**	**133%**	**185%**	**225%**	**300%**
1	$582	$776	$1032	$1,436	$1,746	$2,328
2	$781	$1,041	$1,385	$1,926	$2,342	$3,123
3	$980	$1,306	$1,737	$2,416	$2,939	$3,918
4	$1,179	$1,571	$2,090	$2,907	$3,535	$4,713
5	$1,377	$1,836	$2,442	$3,397	$4,131	$5,508

Table 27. Missouri Waivers, Source: Centers for Medicaid and Medicaid Services, May 7, 2004		
Comprehensive State Health Reform Waivers Under 1115 Authority		
Waiver	**Approval Date**	**Expiration Date**
Missouri Managed Care Plus (MC +)	April 29, 1998	March 1, 2007
General Managed Care & Selective Contracting Waivers Under 1915(b) Authority		
Managed Care Plus	October 1, 1995	March 14, 2004
Home and Community Based Services Waivers Under 1915(c) Authority		
Missouri HCBS Waiver: Aged/Disabled	July 31, 1998	-
Missouri HCBS Waiver: MRDD	July 1, 2001	-
Missouri HCBS Waiver: AIDS	July 1, 2002	-
Missouri HCBS Waiver: Individuals with Disabilities	December 21, 1999	-
Missouri HCBS Waiver: CHDD	-	-
Missouri HCBS Waiver: Physical Disabilities	-	-
Missouri HCBS Waiver: ICF/MR	-	Pending

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

All data and reports may be viewed at the MSPG website, www.insuremissouri.org. On the main page, click on "Data" in the left hand column. This page continues to be updated as new data are analyzed.

Appendix III. Summary of Policy Options

Policy Option[15]	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.[16]	Users of Safety Net	8.4% of MO population or 463,000	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 III, continued			
Policy Option[17]	**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[18]	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 III, continued			
Policy Option[19]	**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.

Endnotes

[1] U.S. Census Bureau, Current Population Survey, 2004 Annual Social and Economic Supplement, Accessed at http://ferret.bls.census.gov/macro/032004/health/h06_000.htm November 05, 2004

[2] National Center for Chronic Disease Prevention & Health Promotion, *Behavioral Risk Factor Surveillance System*, Prevalence Data, Missouri – 2002. Accessed at http://apps.nccd.cdc.gov/brfss/display.asp?cat=HC&yr=2002&qkey=868&state=MO on September 14, 2004.

[3] Thorpe, K. E. (2003). Show Me Series Report 2: Health Care Expenditures in Missouri, Retrieved February 15, 2005. Available Path: http://www.mffh.org/ShowMe2_FINAL.pdf

[4] "Reducing the Numbers of the Uninsured: Policy Implications from State-Level Data Analysis". Journal of Public Health Management Practice, 2005, 11(1), 72-78.

[5] Missouri Medicaid Reform Commission, Available path: http://www.house.mo.gov/medicaidreform/

[6] Source: Missouri Department of Economic Development

[7] There is no approval or implementation on these policy options.

[8] 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.

[9] There is no approval or implementation on these policy options.

[10] Reinstate for parents up to 100%; possibly add childless adults; Increase income eligibility for all categories to 250-300%.

[11] There is no approval or implementation on these policy options.

[12] Framework for Policy Makers, Available Source: http://www.ahrq.gov/data/safetynet/lewin.htm

[13] U.S. Census Bureau, 2004 Population Estimates

[14] U.S. Census Bureau, 2004 Population Estimates

[15] There is no approval or implementation on these policy options.

[16] 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.

[17] There is no approval or implementation on these policy options.

[18] Reinstate for parents up to 100%; possibly add childless adults; Increase income eligibility for all categories to 250-300%.

[19] There is no approval or implementation on these policy options.