Missouri Interim Report

Presented to Secretary Tommy Thompson, U.S. Department of Health and Human Services

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Executive Summary

The state received official notice of award on October 6, 2003. Since the inception of the grant, most of the focus so far has been 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 the Advisory Council and related meetings. The focus group field research work was completed by the end of August, and written reports and presentation to the Advisory Council will be made in October 2004. The household survey was completed in July and data were sent to SHADAC for data analysis and written report. SHADAC will present the data results to the Advisory Council in October 2004.

While these research efforts have been going on, the state staff was trained on and has developed presentations using CPS and BRFSS data from the Multi-State Integrated Data system (MSID). Research of data using MEPS-IC and other data sources has also been conducted. A literature review was conducted and document drafted on the cost drivers of health care insurance. Compilation and graphical presentation of data has helped the Advisory Council gain a better understanding of the uninsured issue and the complexity of the problem.

In January 2004, the Advisory (Policy) Council on the Accessibility and Affordability of Health Insurance Coverage was established and convened for its first meeting. This council has 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 Advisory Council were accomplished at the first meeting as well as a guest presentation on national trends and what other states are doing, by Jeremy Alberga, from Academy Health. The second meeting entailed data presentations on MEPS-IC, BRFSS, and CPS and data and information sharing from the Advisory Council members, and work on the guiding principles. The third Advisory Council meeting consisted of a presentation on preliminary state data results, presentations from Advisory Council members and discussion on cost drivers. Subcommittees have been formed and have met to further address the policy options, communications strategies and to sustain the efforts of this initiative. By the fourth meeting, the Advisory Council started a discussion on policy option characteristics.

The primary tasks remaining to be completed from the previous funding cycle involve the work of the Advisory Council, completion of data analyses and report, presentation of the data to the Advisory Council and writing the final report. The following is a brief summary of the status of the major project components.

Data Collection Activities

a) Quantitative data – Household Survey

The Missouri State Planning Grant (MSPG) contracted with the University of Minnesota, State Health Access Data Assistance Center (SHADAC) to provide front-end design and back-end data analysis, a written report, and small area analysis. Front-end technical assistance included the development of sampling frames and weighting schemes and modification to the Coordinated State Coverage Survey (CSCS) instrument for state specific questions. The contractor included 17 state specific questions on frequency of routine care, family planning services, dental, mental, vision, disability, long-term care, fear of losing coverage, affordability of coverage and bankruptcy. A sample design of N=7,000 was used to ensure adequate representation from minority groups.

The University of Missouri-Columbia, Department of Health Informatics conducted the telephone interviews using Computer Assisted Telephone Interview (CATI) program and standardized protocols. Staff from SHADAC, UMC and the Principal Investigator jointly participated in the interviewer training in January 2004. SHADAC staff observed interviewers in test mode; questions were fielded; and a training manual was developed. The CSCS Instrument entered into the field by March 2004. Data quality was tested by SHADAC at 200 and 1,000 completes. Fielding of the household survey was completed by July 2004.

The household survey will provide a detailed picture of the state's population who are uninsured, including demographic data, employment status and earnings, health insurance coverage status and type of health insurance, last 12 months of insurance coverage, type of employment, employer offer of health insurance coverage, employer contribution to health insurance, accessibility to dependent coverage, reasons for lack of health care coverage, general health, emergency room visits, and where they go for care. Results from the household survey will be available in October 2004.

b) Qualitative data – Focus groups with Consumers

The University of Missouri – Columbia, Sinclair School of Nursing conducted the consumer focus groups for the MSPG. Fourteen focus groups were conducted across the state. The process, forms and questions used were approved by the state and contracting university systems for IRB exemption. The questions asked of the participants included information on the kinds of problems they experienced in getting health care; difficulty in getting health care insurance; why they do not participate in public insurance programs for which they are eligible, such as Medicaid or Medicare; why they think uninsured individuals and families disenroll from public insurance programs, such as Medicaid, what the barriers are besides affordability that prevent the purchase of health insurance; how they feel when it is difficult to get the health care or health insurance coverage they need; if they do not have health insurance, how they get medical needs met; what the reasons are for having difficulty getting health care; what the reasons are that they or others they know have difficulty getting health insurance; what they would be able to pay for health insurance; what they would consider to be affordable health insurance ; what they think

could be done so people can get the health care they need; what they think can be done so they and others can have health insurance; whether workers want their employers to play a role in providing insurance; and what they would consider to be the essential services in a health insurance plan.

Although there was a delay in getting into the field, all focus groups and written report were completed by August 2004. Presentation of the results will be made before the Advisory Council in October 2004.

c) Qualitative data – Focus groups with Small Business Employers

Southwest Missouri State University, Ozarks Public Health Institute conducted focus groups with small business employers and key informant interviews. As with the contractor for the consumer focus groups, the Ozarks Public Health Institute worked with the SPG Project Director in the development of the questions. The process, forms and questions used were approved by the state and contracting university systems for IRB exemption. Sixty-four small business employers were interviewed using a focus group format for discussion; and 34 key informant interviews were conducted. The questions asked of the participants included information on whether their business offered insurance or not; if they did, whether they had employees that declined to participate and why; how they make decisions regarding offer of health insurance to their employees; and factors in decisions regarding employer contribution, employee contribution, benefit package, etc. For businesses that did not offer health insurance, the participants were asked what it would take for their company to offer coverage; how much they would be willing to pay per employee; what the minimal coverage would be if they offered coverage; and how likely they would be influenced by expansion or development of purchasing alliances, subsidies or tax incentives. All participants were asked about the most important factors that influence their decision to offer or not offer health insurance.

The key informant interviews included questions that solicited participant opinion on why some people do not have health insurance; what the barriers are, besides affordability, that prevent people from getting insurance; what keeps people from using public insurance they are eligible for; what role businesses play in the uninsured problem; what role the government plays in the uninsured problem; what role the insurance industry plays in the uninsured problem; what constitutes essential services in a health insurance benefit package; how employer-based insurance plans could be improved; and the kinds of policy recommendations or changes that are needed for closing the health insurance gap.

Although there was a delay in getting into the field, all focus groups, key informant interviews and the written report were completed by August 2004. Presentation of the results will be made before the Advisory Council in October 2004.

d) Quantitative data – Employer-based Surveys

Missouri has elected to use the data from the Medical Expenditure Panel Survey-Insurance Coverage (MEPS-IC) to inform the state regarding the characteristics of establishments that offer health insurance coverage and to study the trends in coverage by the different industries,

establishment firm sizes and by the average wage offered. Data from the Current Population Survey (CPS) was also used to examine the health insurance coverage practices by the various industries.

The state is also a participant in the Multi-State Integrated Data System through the University of Arkansas, Center for Health Information. The Behavioral Risk Factor Surveillance System data as well as the CPS data has been examined for trends.

Advisory Council on Affordability and Accessibility of Health Insurance Coverage

The Center for Health Policy (CHP) with the University of Missouri-Columbia was selected as the facilitator for this part of the grant project. Project staff from SPG and the CHP meets regularly to discuss meeting logistics, agenda planning, and Advisory Council meeting debriefing and next steps.

The structure of the groups involved in the development of policy options consists of the Advisory Council members, an Executive Workgroup and 3 subcommittees – Policy, Communications and Sustainability. The subcommittees provide the mechanism for more focused work and discussion. The Advisory Council members received a letter of invitation to participate from the Governor in December 2003. The first Advisory Council meeting was January 9, 2004, which allowed a guest from Academy Health to participate and present. Subsequent meetings were held in March, May and June 2004. The first three meetings of the Advisory Council served as the orientation period for the project and allowed for the presentation of data from varying state agencies and organizations as well as data on the uninsured using MEPS-IC, BRFSS and CPS.
By the fourth meeting of the Advisory Council, a preliminary list of potential policy options was created.

The website for the MSPG was posted in December 2003 and can be viewed at www.insuremissouri.org. Maintenance and updating of this website is ongoing.

Due to the complexity of the issue and enormity of the data, the State Planning Grant Advisory Council and the Policy Options, Communications and Sustainability subcommittees are still in the initial stages of development of policy options. To date, policy subcommittee and Advisory Council members are exploring the various options cited in the literature on expanding coverage. However, many of the decisions regarding the best approaches for Missouri cannot be reached until the findings from the quantitative and qualitative data collection activities have been interpreted, policy options proposed field-tested, and fiscal modeling on selected options conducted.

The details of the policy options put forward for consumer input and field-testing will be forthcoming in the final report of the Missouri State Planning Grant.

Analysis of Uncompensated Care in Missouri

University of Minnesota, State Health Access Data Assistance Center (SHADAC) was contracted to develop estimates of hospital care expenditures in Missouri in order to determine the impact of changes in public program enrollment on hospitals' provision of uncompensated care. The goal of this research project is to derive estimates of hospital uncompensated care expenditures over a five-year period in the state of Missouri. These estimates will allow the state to examine the potential savings in hospital uncompensated care that result from state-level access expansions. The unit of analysis for the research will be all individual counties and the city of St. Louis for Missouri. The type of subjects will be the aggregate data for Medicaid/public assistance enrollees. The other data that will be studied includes hospital financial information, hospital utilization data, hospital characteristics and demographic data.

The data required for the analysis will be taken from existing administrative and survey data and include the following county-specific Medicaid/public program enrollment figures: bad debt and charity care figures for every hospital in the state; inpatient and outpatient hospital utilization data with county identifiers, hospital characteristics including total hospital admissions, number of licensed hospital beds, total operating expenditures per year, and designation as government-run, church-run, or private; and population characteristics such as per capita income, poverty rate, unemployment rate, percent of population that is nonwhite, and percent of population that is elderly (this may be taken from Census data).

Section 1. Uninsured Individuals and Families

Quantitative Research

The analysis of the current level of uninsurance in Missouri, using the Coordinated State Coverage Survey (CSCS) instrument is currently underway, and the State does not yet have the results to address the question. As such, the annual Behavioral Risk Factor Surveillance System (BRFSS) and Current Population Survey (CPS) from the U.S. Census Bureau are the primary data sources used for describing the rate of uninsured and the characteristics of the uninsured in this section.

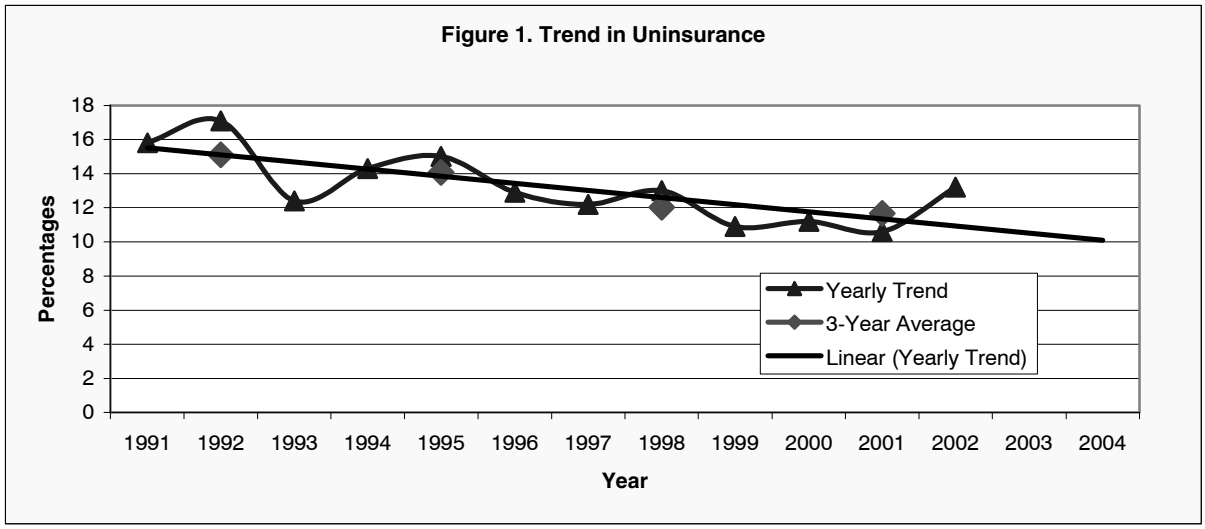
Current Rate of Uninsured

Using the U.S. Census Bureau report of the percent of people without health insurance coverage for the entire year, comparisons of two-year moving averages (2000-2001 and 2001-2002) show that the proportion of people in Missouri without health insurance coverage rose by 1%, from 9.9% to 10.9%. At the national level, for the same two-year moving time period averages, the percent remained relatively stationary moving from 14.4 to 14.9% (Table 1).

Table 1. Percent of People Without Health Insurance Coverage for the Entire Year. Source: U.S. Census Bureau

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Missouri	12.6	13.2	14.6	9.2	6.9	10.8	9.9	10.9
U.S.	15.4	15.6	16.1	15.0	14.3	14.0	14.4	14.9

The Behavior Risk Factor Surveillance System (BRFSS) trend data from the Centers for Disease Control (CDC) website depicts a downward trend. In 1992, the uninsured rate was as high as 17.1%. With continuous efforts, the rate was 10.6% in 2001. However, the uninsured rate increased sharply from 10.6% in 2001 to 13.2% in 2002 (Figure 1).



The comparison of the uninsured rates for the seven geographic areas of Missouri, (Table 2), shows the highest percentage of uninsured is in the southern areas of the state. The St. Louis Metro, Kansas City Metro and the Northwest region have rates of uninsured below the state average. County to state comparisons showed 83 counties with uninsured rates higher than the state average.

Table 2: Percentage of Uninsurance for Missouri Regions, Source: Missouri BRFSS, County Level Study, 2003							
Percentage and Region							
12.31	10.27	9.58	13.04	17.41	17.36	12.07	15.39
Missouri	Kansas City Metro	St. Louis Metro	Central	Southwest	Southeast	Northwest	Northeast

In the Kaiser Commission report on *Medicaid and the Uninsured,* it showed that in Missouri 13.4% of the non-elderly adults and 6.2% of the children were uninsured in 2000-2001 compared to 18.2% and 12.2% nationally. Among the low income, 29% of the non-elderly adults and 12.7% of the children were uninsured, which is lower than the nation (38.0% and 21.6% respectively). For children, the Kaiser Family Foundation reported that 5.5% of children are uninsured (Table 3).

Table 3. Health Insurance Coverage of Children for Missouri, Source: Kaiser Family Foundation, 2001-2002.					
Percent Distribution by Coverage Type					
Children (in thousands)	**Private**		**Public**		**Uninsured**
	Employer	Individual	Medicaid	Other	
1,481	65.1	5.2	24.1	.1	5.5

Characteristics of the Uninsured

Most of the uninsured in Missouri are between the ages of 18 and 24 years old (28%). More males (15.3%) are uninsured compared to females (11.3%). A comparison of uninsurance rates for white and black adults indicates a disproportionate number of black adults without health insurance coverage (12.0% vs. 24.69%, respectively). The uninsurance rate for Hispanic adults (18.70%) was also higher than for white adults. Of working adults, over 368,000 (14.5%) are uninsured. When looking at the uninsured population collectively, the Current Population Survey (CPS) data for 1999-2001 indicated that 54% of the uninsured children, less than 19 years of age, came from homes with household incomes greater than $40,000. Sixty-six percent were under 300% FPL, and 57% of the working uninsured were under the 200% FPL. Education has a dramatic impact on uninsurance as those with a college degree experience had only a 4.6% rate. Individuals with less than high school (26%), high school diploma or GED (16.4%), or post high school (11.8%) education experienced more than double the uninsurance rate as the college graduate (Table 4).

Table 4. Characteristics of the Uninsured			
Federal Poverty Level (CPS, 1999-2001)	**Uninsured (%)**	**By Employment Status (BRFSS, 1999-2001)**	**Uninsured (%)**
Less than 100% FPL	17	Employed	51
100% to 199% FPL	26	Self-employed	15
200% to 299% FPL	23	Out-of-work <1 year	8
300% to 399% FPL	13	Unable to work	5
400% to 499% FPL	9	Student	5
500% FPL or More	12	Retired	4
By Marital Status (BRFSS, 1999-2001)	**Uninsured (%)**	**By Income (dollars) (BRFSS 2002)**	**Uninsured (%)**
Married	40	<15,000	22.7
Never Been Married	31	15,000-24,000	23.2
Divorced	19	25,000-34,999	16.2
Unmarried Couple	4	35,000-49,999	10.5
Widow	3	50,000	4.4
Separated	2		
By Age (years) (BRFSS 2002)	**Uninsured (%)**	**By Race (BRFSS 2002)**	**Uninsured (%)**
18-24	27.8	Hispanic	18.7
25-34	14.9	Black, non-Hispanic	24.6
35-44	15.3	White, non-Hispanic	12.0
45-54	11.7	Others	15.2
55-64	11.4	Multi Racial	12.1
65+	1.9		
		By Education (BRFSS 2002)	**Uninsured (%)**
Gender (BRFSS 2002)	**Uninsured (%)**	No high school degree	26.0
Male	15.3	High school graduate	16.4
Female	11.3	Some college or Associate Degree 2 yr	11.8
		College Graduate 4 yr	4.6

Based on the data available to date, the population groups that have risen to the top of importance to the state are young adults between the ages of 18-24 years and the working poor.

Qualitative Research

Fourteen consumer focus groups were conducted across the state. The narrative below provides key findings from the participant responses and their recommendations.

Some participants without insurance stated they could not answer the question of "What is affordable coverage?" 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 a 2-or 4-week supply of

medications. A $100 per month premium ($200 maximum) or 10% of monthly take-home income with $1,000-$1,500 deductible was suggested as affordable for people with regular employment, including laborers, factory workers, and those with similar jobs, and retirees. All felt that they should be able to obtain coverage for catastrophic illness. Those who were offered COBRA complained that the cost was too high, upwards of $650 per month for a family, an option they usually rejected.

The majority of uninsured participants in the focus groups reported that 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 the uninsured participants have children who are enrolled in Medicaid programs. Parents of these children said that they could not afford health care for their children if they were not covered by Medicaid. They also said that 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 that their children received health care. The working poor who participated in the 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, are required to sell their assets in order to qualify for public programs. For these people, this is not a reasonable option, and they 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. They complain 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 that 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.

Participants do not have the opportunity to enroll as opposed to refusing 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.

They identified employer situations in which the number of hours worked is limited yet linked to opportunity to receive benefits. Coverage is not offered and/or affordable especially for small businesses or the self-employed; waiting periods are lengthy (3-6 months); part-time workers cannot receive benefits; and there are multiple exclusions 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 that 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.

Uninsured and underinsured participants reported that 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 no longer a student covered by their 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.

Access to health care and quality health care providers are particularly problematic in rural areas. People in small 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 were 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 that they suffer more with dental problems than with health care needs, simply because dental care is completely unavailable to them.

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.

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 emphasize the working poor, such as, those who have jobs but make too much to qualify for insurance. Under- and uninsured needs to take in those who have other assets, primarily land, that account for high income.

Section 2. Employer-based Coverage

Missouri is one of 30 states to be included in the Medical Expenditure Panel Survey – Insurance Coverage (MEPS-IC) for the past years, which means that Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ) fields a full sample for the MEPS-IC survey in Missouri each year. Approximately 800 establishments are selected in the sample each year. Therefore, the state elected to use the MEPS-IC data in combination with the data on industries in Missouri that offer health insurance coverage for the employer survey component of this research project. Data from Current Population Survey for industry and health care coverage were also analyzed.

Access to Employer-based Health Insurance Coverage

Based on the 2001 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) data, approximately 57.1% of Missouri's establishments offer health insurance. This is down from 58.8% in 2000, but up from 1999, which was at 52.8%. In 2001, approximately 72.0% of the full-time employees were enrolled in the employer-based health insurance. In these same establishments, 41.7% of the part-time employees were eligible for the employer-based coverage, but only 28.0% participated. It is important to note that employer offered insurance for part-time employees increased from 21.3% in 2000 to 41.7% in 2001, an increase of 20.4 points. Likewise, there was an increase in part-time employee participation from 11.1% to 28.0% for the same time period. From 1996 to 2000, 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%. 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. Table 5 details the percent of private-sector establishments that offer health insurance and self-insure at least one plan by firm size.

Table 5. Percent of private-sector establishments in Missouri that offer health insurance and self-insure at least one plan by firm size, Source: MEPS-IC 2002.

	Establishment by Number of Employees					
	Total	**Less than 50**	**50 or more**	**100-999**	**1000+**	**500 or more**
Percent	36.3%	11.4%	67.4%	11.0%	23.1%	67.4%

The 2002 MEPS-IC data was recently made available. Comparative analyses will be conducted, looking at indicator data and trends over time. This data will be comprehensively reported in the final report. Tables 6 through 10 are a brief reporting on some of the measures from 2002.

Table 6. Private-Sector Data by Firm Size for Missouri, Source: MEPS, 2002.

Variable	Less than 10 Employees	1000 or More Employees	Total
Percent of establishments	55.2	15.4	128,978
Percent of establishments that offer health insurance	33.1	100	56.4%
Percent of employees	10.9	48.3	2,276,688
Percent of employees in establishments that offer health insurance	43.5	100	89.5%
Percent of full-time employees	9	51.5	1,809,233
Percent of full-time employees at establishments that offer health insurance	50.7	100	92.8%
Percent of part-time employees	18	36	467,455
Percent part-time employees at establishments that offer health insurance	29.4	100	76.9%

Table 7. Private-Sector Establishments by Average Wage by Firm Size for Missouri, Source: MEPS, 2002.				
Variable	**Wage in Quartile 1**	**Wage in Quartile 2**	**Wage in Quartile 3**	**Wage in Quartile 4**
Percent of establishments	35.1	34	17.9	13
Percent of establishments that offer health insurance	30.4	60.7	75.9	88.6
Percent of employees	24.8	25.1	25	25.1
Percent of employees in establishments that offer health insurance	75.1	88.3	96.2	98.3
Percent of full-time employees	*	23.3	26.9	29.5
Percent of full-time employees at establishments that offer health insurance	83.2	88.9	97	98.5
Percent of part-time employees	42.5	32.1	17.6	7.8
Percent of part-time employees at establishments that offer health insurance	60	86.9	91.3	95.3

Table 8. Percent of private-sector establishments offering health insurance by plan options and insurance offerings to retirees for Missouri, Source: MEPS, 2002.	
2 or more plans	25.3%
Conventional indemnity	14.5%
Any managed care	90.6%
Exclusive provider	32%
Mixed provider	68.5%
Insurance to retirees under 65	14.1%
Insurance to retirees over 65	11%
With waiting period	73.9%

Table 9. Private-Sector Data by Industry Groupings for Missouri, Source: MEPS, 2002.

	Agri, fish, forestry and construction	Mining and Manufacturing	Retail/Other Services	Professional Services	All Others
Percent of establishments	12.4	5.1	46.4	17.2	18.9
Percent of establishments that offer health insurance	33.9	61.2	54	60.3	72.4
Percent of employees	4.5	10.9	35.7	27	21.9
Percent of employees in establishments that offer health insurance	67.2	93.2	83.6	93.4	97.1
Percent of full-time employees	5.2	12.9	28.8	28	25.2
Percent of full-time employees at establishments that offer health insurance	70.2	93.6	88.6	96.3	97.8
Percent of part-time employees	1.7	*	62.4	23	9.2
Percent of part-time employees at establishments that offer health insurance	*	87.2	74.7	79.8	89

Table 10. Private-Sector Data by Ownership Type and Age of Firm, Source: MEPS, 2002.

	For profit	Ownership For profit, Unincorp.	Nonprofit	Profit Status Unknown	Less than 5 years	Age of Firm 5 or more years	Age Unknown
Percent of establishments	63.3	23.6	10	*	13.2	78.5	8.3
Percent of establishments that offer health insurance	65.4	31	48.3	94.3	31.5	56.3	97.1
Percent of employees	70.2	10.7	8.1	*	5.2	72.4	22.4
Percent of employees in establishments that offer health insurance	91.5	69	85.3	99.9	54.5	88.8	99.9
Percent of full-time employees	70.8	*	7.4	*	4.2	71.9	23.9
Percent of full-time employees at establishments that offer health insurance	94.1	78.2	89.5	99.9	59.7	92.3	99.9
Percent of part-time employees	67.9	11.7	10.6	*	*	74.5	16.6

Geographic Location

Using data from the 2003 County Level BRFSS, Missouri is able to identify the uninsured population by county, region and across the state. This data set will be incorporated into the Multi-State Integrated Data System, which will allow the state to analyze the data to determine employment and other demographic information for the uninsured by county. However, Missouri does not have information regarding small employer or industry type of the uninsured at the county level. Additionally, the household survey will provide information that can be used to answer this question in more detail in the final report.

Qualitative Research

An equivalent of 10 employer-based focus groups and 34 key informant interviews were conducted with participants from across the state. The narrative below provides key findings from small business employers and interviews with key informants. Responses are organized according to emerging themes and notable ideas.

Small Business Employers

A total of 64 employers from around the state participated in the focus group process; 48 participated in seven face-to-face focus groups, and 16 participated in conference call phone interviews. Interviews and focus groups took place between April 14 and July 15, 2004. Fifty-three (83%) of the companies represented offered health insurance to at least some employees; 11 (17%) did not. According to the U.S. Census definition of urban and rural, 21 (33%) of the participants were from urban counties and 43 from rural counties. According to geographical distribution by city size, 44 participants were from towns with more than 10,000 people, and 20 were from towns with fewer than 10,000 residents. At the conclusion of each focus group, employers were asked to complete a short survey. (Those who were interviewed by telephone received a survey in the mail.) All 64 participants completed surveys.

Emerging Themes

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

Employers welcome the idea of more information about health insurance coverage so that they can make informed decisions about health care. 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.

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.

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.

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.

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 insurance consumers.

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.

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.

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."

Notable Ideas

- Add a self-insured component to insurance plans. Purchasing catastrophic coverage and paying for routine care is yielding substantial savings for some companies.

- Send email 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 that 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.

Key Informant Interviews

Thirty-four interviews were conducted between April 30 and August 19, 2004. Key informants represented all areas of the state and a variety of health care backgrounds (i.e., FQHCs, free clinics, health care providers, insurance companies, etc.).

Emerging Themes

Cost is an enormous barrier to obtaining health insurance. Even for persons who have coverage available through an employer, the cost is becoming increasingly prohibitive, causing many to drop out of the system, especially young, healthy workers.

Medicaid is in need of reform. Application procedures are overly complicated; many people are not even aware that they're eligible; doctors won't accept patients because of the low reimbursement; the system has no incentives to use it efficiently; and there is an over-emphasis on disease rather than wellness.

Businesses are doing the best they can and are not to blame for the uninsured problem. Although employers are passing more of the health insurance costs to their employees, most key informants understood that this was being done out of necessity, not choice.

The insurance and pharmaceutical industries are largely motivated by profits and play a significant role in the uninsured problem. Few key informants saw altruistic motives for either of these industries.

The most essential services in a basic health insurance package are prescription drugs, primary care, preventive services, and catastrophic care. Most key informants agreed that placing a greater emphasis on prevention would pay significant dividends in the long run.

Advanced technology, malpractice insurance, and rising drug prices are largely to blame for the large increase in health care costs in recent years. This assertion is borne out in part by a recent study that found the factors most responsible for health care costs in 2002 were drugs, medical devices and other medical advances.

Wellness and prevention need to play a more prominent role to bring health care costs under control and add people to the insurance roles. Screenings, annual physicals, and early management of chronic diseases will become more and more important, especially as the population continues to age.

Support and expansion of FQHCs is an effective way to provide a much needed safety net. According to those key informants familiar with FQHCs, the clinics are very cost effective in providing care. In fact, the National Association of Community Health Centers reported that in

2002, $36 million could have been saved in Missouri if just 10% of emergency room visits were redirected to FQHCs or other primary care facilities.

Universal coverage might (or might not) work. There was a good deal of support for universal coverage among key informants but also a good deal of skepticism about the ability of such coverage to seriously address the underlying problem of escalating health care costs.

The need for health insurance reform is clear from the many hours spent interviewing these key informants. The most persuasive argument may have come from a physician who described the different way that patients are treated depending on their insurance status: "When a resident comes out to me and they present a case and tell me what they have, I say what do you want to do and basically the question is do they have insurance or not and what can we do and what can the patient afford? Because it doesn't do a patient any good to make a diagnosis if they can't afford any of the things that are going to make them better. I really feel like I am practicing two kinds of medicine depending on whether or not the patients have insurance. You know—is that right? Is that what we want to do?"

Notable Ideas

- During the course of the interviews, key informants made several excellent suggestions about how the system could be improved. With the realization that these might have been "lost" in the information on the preceding pages, they are repeated here:

- Increase the choice of plans for employees—varying degrees of coverage, different deductibles, etc. This might allow an employee who could not afford full coverage to have some minimal coverage instead.

- Raise the deductible on plans to cover the major expenses and self-insure the smaller claims like office visits.

- Require screenings and annual physicals as a condition of employment, which would reduce health care costs by diagnosing diseases earlier rather than later.

- Design an education program that employers could use to help individuals become better health care consumers.

- Gather experts from around the state to formulate a proposal. A lot of "best practices" are undoubtedly in existence in Missouri but could be unknown outside their communities. Sharing ideas and information from a variety of health care organizations could form the foundation of an innovative and effective plan.

- Educate legislators on the impact that their decisions have in regard to public insurance.

Connected themes from small businesses and key informant interviews

Cost is the overriding issue. Employers and health professionals alike believe that cost is an overwhelming barrier, which threatens both the employers' ability to offer health insurance; an individual's ability to purchase it; and the provider's ability to appropriately diagnose and treat.

There should be more of an emphasis on wellness and prevention. From on-the-job wellness programs to preventive components in insurance plans, both groups generally agreed on the importance of prevention.

A considerable amount of animosity exists towards the insurance and pharmaceutical industries. Both groups had a surprisingly negative view of these industries, and few saw altruistic motives for either of these.

Purchasing alliances would be a good way to increase employer-based coverage. Small business owners, as well as a number of key informants, were strongly in favor of this idea.

Medicaid is held in low regard. Employers were more likely to complain about welfare dependency and abuse of the system, while key informants criticized the inefficiency and complicated application procedures.

There is a desire for tort reform. Although neither group had specific details about the costs associated with malpractice litigation, other than rising malpractice insurance costs, a number of people in both groups thought there was a need for tort reform.

According to the 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. Help 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 that 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

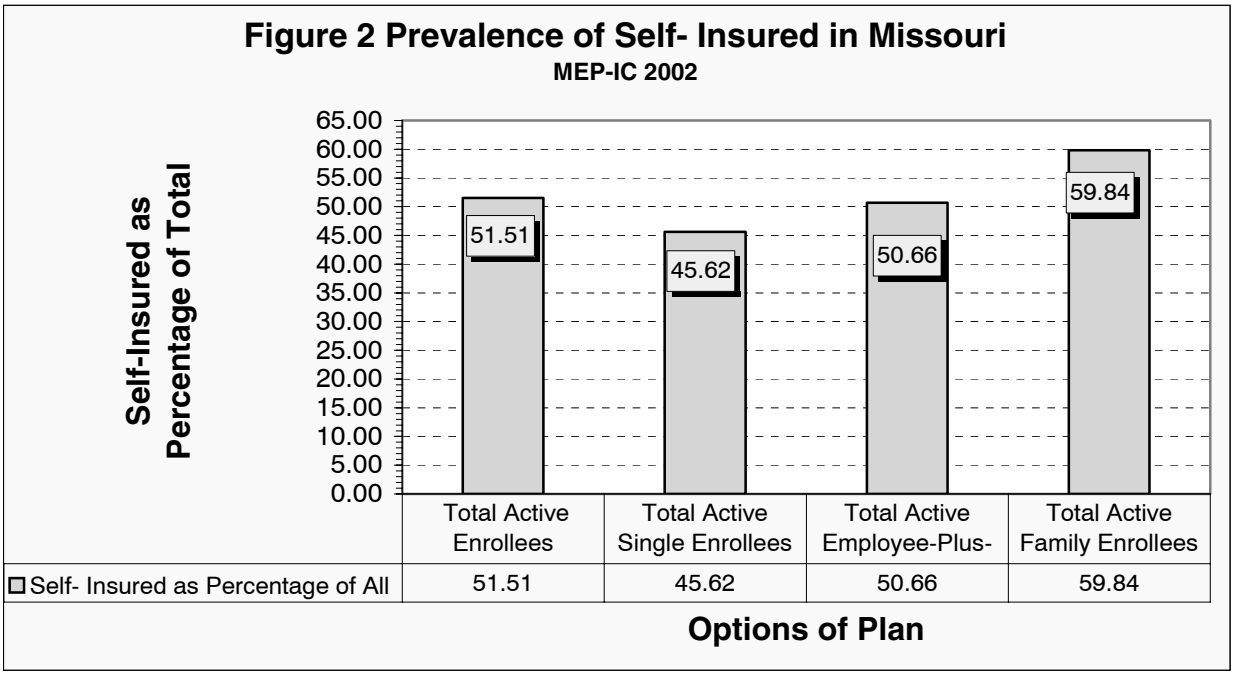
pharmaceutical companies. A similar effort will soon be undertaken in Pennsylvania. Americans pay more out of pocket for their health care than do people in any other industrialized country. Solutions will not come easy. As one focus group participant quipped when asked how insurance coverage could be 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.

Section 3. Health Care Marketplace

The question of "How adequate are existing products for persons of different income levels or persons with pre-existing conditions?" is difficult to ascertain at this time. Further, information on the variation in benefits among non-group, small group, large group and self-insured plans is not available yet.

The prevalence of self-insured firms in Missouri is apparent from the enrollment in the self-insured firms. The enrollment ranges from approximately 46% to 60% depending on variation in number of enrollees. Figure 2 depicts this data with respect to total active single enrollees, plus-one enrollees, family enrollees, and total active enrollees.



Medicaid and SCHIP

Public-sponsored health insurance, such as Medicaid and SCHIP, has a significant impact and is the state's second largest source of health insurance coverage. In a report by the Kaiser Family Foundation, State Health Facts, 916,017 Missourians were enrolled in the state Medicaid Program in December 2002, compared to 847,000 Missourians in 2001 (Table 11). For 2002, 528,000 children and 403,000 adults were Medicaid enrollees, creating a 57% child to adult comparison.

Table 11. Medicaid Enrollment in Missouri 1999 to 2002, Source: Kaiser Family Foundation, 2002 (number in thousands)

Year	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Missouri	572	600	710	768	847	916
United States	30,734	30,666	31,825	33,400	36,706	39,604

This year's legislative debate regarding the Medicaid program helped many realize the important role that Medicaid plays in our state's health care system and its economy, and any future committee on Medicaid should review the Medicaid program's strengths and weaknesses - not simply the issue of cost containment.

Medicaid and SCHIP have a substantial economic impact on our state and local economies. Medicaid brings significant federal matching dollars into the state. State Medicaid funds generate federal matching funds at a 61% rate for most individuals and a 72% rate for SCHIP children. Missouri Medicaid spending generates almost $1.6 in federal matching funds for every state dollar spent while SCHIP spending generates nearly $2.7 in federal matching funds.

An analysis of economic data by economists at the St. Louis University (SLU) John Cook School of Business found that every $1 million that the state reduces in Medicaid spending will lead to the loss of over $3 million in business activity and the loss of 42 jobs. Reductions in SCHIP funding would have even larger effects. Applying this methodology, SLU economists found that the House-passed Medicaid eligibility and service cuts would have cause Missouri to lose more than 2049 jobs, $150 million in economic activity, $73 million in wages, and $5.4 million in tax revenue (based on those wages).

The St. Louis University study is consistent with 17 other studies that are reviewed in a new Kaiser Commission report. Kaiser concludes that, "[a]ll of the studies provide evidence that Medicaid spending has a positive impact on state economies. It is clear from the studies conducted thus far that, in addition to providing valuable health coverage for low-income people, state Medicaid spending also yields significant economic benefits for states. As a result of Medicaid's unique matching arrangements, these benefits may be larger than state spending alone." Clearly, the economic ramifications of making cuts ought to be a part of *any* discussion in which cuts are proposed.

Assuring continued access to health coverage through Medicaid bolsters Missouri's ongoing efforts to help people leave the welfare rolls and move into self-sustaining employment because

it helps them receive coverage for themselves and their families *and* helps them stay healthy, making them better and more productive workers.

Missouri Consolidated Health Care Plan for State Employees (MCHCP)

The MCHCP 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 and 12,000 retirees. 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 are primarily dependents (there are very few retirees in this program). Each year contracts are negotiated with various HMOs and insurance companies. Various benefits packages (HMO, POS, PPO, etc.) are developed, and organizations bid for the services. Prices are negotiated for the various products, decisions made and the contracts are awarded and offered to the membership.

The Missouri Department of Insurance does not collect data on the benefit packages offered through private health insurance; however, the benefits available to the public for Medicaid and state employees (i.e., through Missouri Consolidated Health Care Plan Benefits) are identified and will be reported on in the final report.

Analyses of the impact the current market trends and regulatory environment would have on various models for universal coverage; the changes that would be needed to the current regulations; how universal coverage would affect the financial status of health plans and providers; and how utilization would change with universal coverage will be addressed through the work of the MSPG Advisory Council. The state does not yet have this information to address these issues.

The planning process for the MSPG continues to take various stakeholders into account, not excluding safety net providers. The preliminary draft of the MSPG potential solutions for policy options included “expanding the safety net direct care services through enhancing community health centers and expanding rates to increase Medicaid provider base”. At the submission of this report, the Advisory Council is reviewing these policy options.

Also, the state is underway in its analysis of uncompensated care in Missouri - care that is not paid for by private or public insurance. The uncompensated care costs are transferred to other parts of the health system, driving up costs and straining health resources for other people. In testimony before the House Interim Committee, the Missouri Hospital Association pointed out the substantial “cost-shift” that would occur if Missouri’s rate of uninsured were higher. The St. Louis Regional Health Commission also has documented the uncompensated care burden that results when people become uninsured and the impact this cost-shift has on private insurers and the employers with whom they contract. This cost-shift ultimately affects people who have insurance and employers who provide insurance. As previously discussed, Medicaid and SCHIP are a significant reason why Missouri’s rate of uninsured has not grown more than it has over the past several years. Any proposal to cut eligibility needs to examine the impact on the safety net and the cost shifting to the financing arm of health care and analyze whether the harm from

shifting costs in this manner outweighs the "savings" to state general revenue anticipated from such cuts.

As indicated earlier in this preliminary report, the MSPG Advisory Council is currently underway in evaluating policy options that will increase access to affordable health care coverage. Learning from the experiences of other states is an essential step in the process.

In evaluating the potential support for public coverage expansion, the state must contend not only with the insurance issue, but balancing it with massive budget deficits, mounting security/public health commitments, education, and other current issues. The realization appears that the state's infrastructure for insurance (e.g., Medicaid) cannot do it alone and that other strategies must be sought. Other states are reacting to these challenges with cost containment measures, prioritizing the populations most in need, scaling back benefit packages, bolstering the safety net, and examining other options for fiscal relief. Most importantly, Missouri realizes that there are no "silver bullets," no single answer, and that the answer is not about just having insurance, but accessible and affordable insurance and accessible health care.

One of the most important principles of the MSPG is that an effort is made to create policy options that are based on sound evidence and tested approaches. Through the Policy Options Subcommittee Workgroup (made of the co-chairs, members, and MSPG staff), a review of the literature with respect to best practices and current recommendations was conducted. One invaluable resource in this process is the research by Barbara Yondorf (Table 12).

Table 12. Strategies for Health Insurance Coverage Policy Options, Reference: Yondorf

Major Increases	
• Expand Medicaid and SCHIP (most effective) • Strengthen Medicaid and SCHIP outreach and enrollment efforts • Enact an employer mandate	• Enact/broaden state continuation of coverage laws • Set up state-funded coverage program
Moderate or Small Increases	
• Medicaid premium assistance • High risk pools (especially with sliding premiums)	• Publicly-funded reinsurance for private coverage (early results look promising)
Ineffective Strategies	
• State tax incentives • Group purchasing arrangements • Small group market reforms plus guarantee issue	• Individual health reforms SCHIP premium assistance (small maybe)
Not Clear or Convincing Evidence	
• No-mandate and mandate-light policies • High deductive plans with MSAs	• Coverage expansions vs. expansion of safety net direct care services (not clear which is preferable in terms of effect on access)
No Outcome Studies	
• Expand definition of "dependent" (unmarried dependents to 22 years of age, dependent parents, grandchildren living with grandparents)	• Allow others to join state plan • Mandate college student insurance • Require state contractors to provide coverage • Universal health insurance

The *draft* policy options proposal has been presented to the Policy Options Subcommittee for comment and is listed below and in more detail in Section 4. This set of proposals has 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. Further, this may not be the exhaustive list for consideration. Group members were also encouraged to not limit themselves in thinking about what might work based on what they think will pass the legislature.

1. Strengthen Medicaid and SCHIP outreach and enrollment efforts
2. Expansion of safety net direct care services
3. Reform the High Risk Pool
4. Insurance reform – expand definition of dependent
    - Unmarried dependents to 22 years
    - Dependent parents
    - Grandchildren living with grandparents
5. Enact/broaden state continuation of coverage laws
6. Expand Medicaid Provider Base (increase rates)
7. Expand Medicaid eligibility
    - Low-hanging fruit – reinstate eligibility
    - Broad sweeping – childless adults
    - Increase flexibility
8. Let small businesses and others (if appropriate) buy in to MCHCP
9. Publicly-funded reinsurance for private coverage
10. State tax incentives – small businesses (under 10 employees)
11. Fair share tax - tax employers of a certain size who do not subsidize a set percentage of their employees and use money to cover reinsurance and premium assistance programs.
12. Set up state funded/assisted coverage program
13. Universal health insurance coverage through a network of private/public plans with subsidies for low/moderate income and small businesses/self employed
14. Expand provider tax to apply to all providers and health plans to expand eligibility
15. Implement demand-side and supply-side programs to reduce costs

Individual mandate was also briefly discussed and suggested that it should be given consideration.

Section 4. Options and Progress in Expanding Coverage

Missouri has not reached a consensus on a coverage expansion strategy and is not yet in a position to answer all of the questions included in this section.

A target eligibility group has been discussed but no final consensus reached as the state data analysis on the characteristics of the uninsured from the Coordinated State Coverage Survey is still underway. A list of potential target populations, based on data from CPS and BRFSS, were identified to be used as a starting point for discussion at one of the Advisory Council meetings. These subpopulations are the working poor (under 300% FPL), small employers/firms (50 or

less), self-employed, large employers (1,000 + employees), all of the uninsured, those who deny coverage, young adults (18-24 years), parents of children who are eligible for Medicaid and SCHIP, inner city minorities, rural residents, entire population of the uninsured. These subpopulations were used as part of the Values exercise at the June Advisory Council meeting. The Advisory Council, based on preliminary household data and an understanding of the current legislature, reduced this list to the working poor, small employers/firms (50 or less), self-employed large employers (1,000 + employees), rural residents, and parents of children who are eligible for Medicaid and SCHIP.

As previously mentioned, 13 policy options for consideration were presented before the Policy Options Subcommittee for consideration. The following describes some of the discussion and factors that worked in favor or, or against the various options. No formal recommendations have been made or consensus reached on any of these options.

Policy Options Discussed by Policy Options Subcommittee

Option 1. Strengthen Medicaid and SCHIP outreach and enrollment efforts
The major political and policy considerations that worked against this choice are the financing of an expansion given the state's budget environment. The group agreed that the state is doing fairly well compared to other states in reaching children. New Jersey's eligibility goes up to 350% FPL for children. Most of the children enrolled in SCHIP with family incomes between 200-300% FPL have special health care needs and cannot get coverage elsewhere. Given the rate of uninsured for children in Missouri, the subcommittee members were not sure that the state needed to do much more on strengthening Medicaid, SCHIP for children. Therefore, this policy option was tabled for consideration.

Option 2. Expansion of safety net direct care services[1]
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.

Option 3. Reform High Risk Pool
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 has been unable to access this tax credit since 1997. This policy option is being given strong consideration by the Department of Insurance, which is working on a proposal to reform the high-risk pool this next legislative session.

Option 4. Insurance reform – expand definition of dependent[2]
This policy option for expanding the coverage for young adults is being given strong consideration, but no consensus has been reached. Members of the subcommittee are researching this option further.

Option 5. Enact/broaden state continuation of coverage laws.
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.

Option 6. Increase Medicaid reimbursement rates for primary and specialty care
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. This policy option was given strong consideration by members of the subcommittee. This option is also being addressed by one of the advocacy groups in the state.

Option 7. Expand Medicaid eligibility[3]
As with Option 1, expansion of Medicaid, while given consideration, was tabled for consideration given the state's budget environment, with the exception of expanding coverage for children up to age 21.

Option 8. Let small business and others (if appropriate) buy in to MCHCP
This policy option is being given consideration within the parameters of the law. Missouri Consolidated Health Coverage Plan covers most of the state agencies. The Highway Patrol and the Department of Conservation are separate. MCHCP has statutory authority to provide coverage for public employer group coverage and other non-state public. MCHCP does not have statutory authority to provide coverage for private entities.

Option 9. Publicly funded re-insurance for private coverage
Missouri has something similar to this option but no one is in the pool. This option works in theory but may not apply. More research into this option is needed.

Option 10. State tax incentives – small businesses (under 10 employees)
On the surface, this option appeared appealing; however, a concern was raised that this type of option might also affect the growth of a small business. For example, if a small business expands 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. In addition, tax credits are an after the fact, whereas with premium assistance the money is upfront. More research is needed on this option.

Option 12. Set up state funded/assisted coverage program
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.

Option 13. Universal health insurance coverage through a network of private/public plans with subsidies for low/moderate income and small businesses/self-employed that assures adequate, affordable coverage for all.

While this policy option was favored strongly by the group members, it was recognized that for this option to work, everyone has to participate. In addition, 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. Committee members, including an evaluation of the options presented in the MFH report, will further research this option.

Options 11, 14, and 15 are pending discussion by the subcommittee members.

The number of uninsured persons potentially eligible for existing public assistance programs, is unknown at this time. Data analysis from the Coordinated State Coverage Survey is not yet available; therefore, the state is unable to fully respond to this question at this time. State efforts to increase enrollment of eligible children in Medicaid and SCHIP have been viewed as successful, based on the uninsured rate for children. The state's outreach efforts are administered through a Robert Wood Johnson grant and Missouri Primary Care Association is the lead agency. Activities for this funding cycle include radio spots and print media distributed to schools and local functions.

Section 5. Consensus Building Strategies

The governing structure for the Missouri State Planning Grant (MSPG) is comprised of the Advisory Council, three Subcommittees, and the Executive Workgroup.

The Advisory Council

The Advisory Council is responsible for establishing guiding principles, reviewing the study results and cited best practices literature, and recommending programs models, and policy options to the State. The membership and structure of this Advisory Council is comprised of 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. Invitation for selection to the Advisory Council was determined by the state. Table 13 depicts the various agencies, organizations, and associations serving as members of the Advisory Council.

Subcommittees

The Advisory Council maintains three subcommittees. Subcommittees were formed on a voluntary basis from the Advisory Council membership and include selected individuals from the community as needed at the subcommittee leadership and members' discretion. This grant and all activities are planned, implemented, and evaluated by the MSPG staff, but it is imperative that 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 provide logistical and

philosophical direction to their respective subcommittees, but assistance is provided from the MSPG staff as necessary. At least one representative from the MSPG attends subcommittee meetings. Therefore, co-chairs are responsible for sending initial communication to subcommittee members, making arrangements for all meetings (in-person, conference call, etc.), communicating with Project Director about meeting dates and progress, location, provide minutes of each meeting (via e-mail) to the Project Director. Table 14 identifies the subcommittee, co-chairs'affiliation, major purpose, and activities. Note that these activities were given as suggestions only and assisted the subcommittee co-chairs with a starting place and a way to educate them about the intent of the grant.

Executive Workgroup

The Executive Workgroup is comprised of approximately 10 to 12 members and includes the State Health Officer, Staff Assistant to the State Health Officer, State Social Service Director, and Assistant to the Director, Representatives from the Governor's Budget Office, DHSS Legal Staff, Project Director, and other key members of the Advisory Council.

Table 13. 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
Missouri Hospital Association	Lieutenant Governor's Office
University of Missouri-Columbia	Missouri Department of Mental Health
Missouri Physicians for a National Health Program	Missouri Consolidated Health Care Plan
Missouri Association of Health Plans	Missouri Primary Care Association
Missouri Association of Local Public Health Agencies	Missouri Chamber of Commerce
Missouri Department of Health and Senior Services	Citizens for Missouri's Children
Missouri Division of Medical Services	National Federation of Independent Business
	Missouri Department of Insurance

Table 14. 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 for 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.
Sustainability *Center for Health Policy and National Federation of Independent Business*	Define what sustainability means for the Missouri State Planning Grant. Conceptualize the angle for sustainability activities for this effort. What will Year 2, Year 3, and Year 4 look like? What about management and integration of the Program after Year 1?

MSPG Staff and Center for Health Policy (CHP) Staff

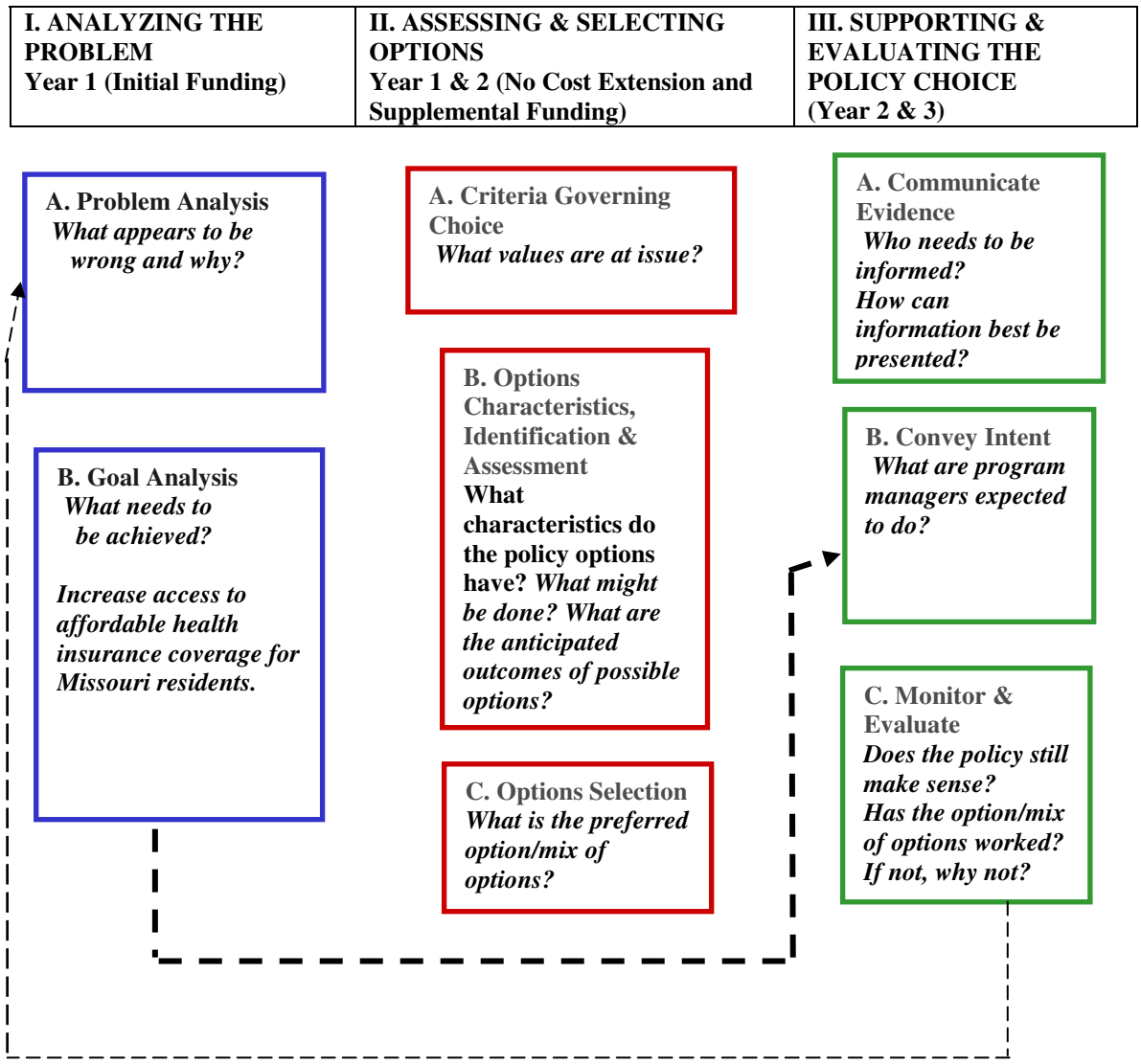
The MSPG Staff and the CHP Staff (subcontractor) jointly plan and direct all meetings and activities of the above mentioned entities. Meetings occur on a monthly or bi-monthly basis. The Advisory Council met in January, March, May, and June of 2004. These meetings served as the orientation period to the project and included the following agenda topics as presented in Table 15.

Table 15. Agenda Items for Advisory Council Meetings from January to June 2004.

January 2004	
Agenda Items • National/state environment (rising cost and uninsured) • Low-hanging fruit and short-term solutions • The State Planning Grant Opportunity • State Stories • The Small Business Challenge • Public-Private Partnerships • Open Discussion • Overview of State Planning Grant (broad goal, objectives, activities, and subcontractors)	• Purpose of the Advisory Council, Executive Workgroup, and Subcommittees • The Missouri Regions: What do we know now? • Advisory Council members assigned selected discussion topics with a staff facilitator. (Topics were: Selected Consequences of Uninsurance for Communities; Relationship between Individual, Community; and Health Effects; Factors Affecting Eligibility and Process of Obtaining Health Care)
March 2004	
Agenda Items • Developing the Guiding Principles of the Advisory Council • Data from the Missouri Hospital Association • Data from the National Federation of Independent Business • Data from the Medicaid Program, Department of Social Services	• Missouri Data Reports o Medical Expenditure Panel Survey, o Current Population Survey, o Behavioral Risk Factor Surveillance System • Advisory Council assigned discussion topics with facilitator (topics was the Institute of Medicine's 5 Principles for Guiding Health Insurance Policy) • Update of Subcontractor Activities
May 2004	
Agenda Items • Review and Adopt Guiding Principles • Update on Continued Funding for MSPG • Subcommittee Reports • Data from the Department of Insurance • Data from Federally Qualified Health Centers (MO Primary Care Assoc.) • Cost-Drivers of Health Insurance Coverage • Who are the Uninsured in Missouri?	• Preliminary Data from the Household Survey Subpopulations of the Uninsured • Co-chairs meet with Subcommittees (topics were "Are there any policy options for Missouri that could directly impact the escalating cost for health coverage? Should we place equal emphasis on all subpopulations or prioritize them?)
June 2004	
Agenda Items • Policy options – What other states are considering • Policy Analysis Framework as Method for Building Consensus • Analyzing the problem (Step 1A)	• Goal Analysis (Step 1B) • Criteria governing choice (2A) • Policy Option Characteristics (Step 2B) Group Discussion of Policy Option Characteristics (Step 2B)

The June 2004 meeting represented a departure from the orientation phase of the Advisory Council agenda into more of a policy characteristic discussion phase. The Policy Analysis Framework was chosen as the theoretical model to stimulate discussion among with the Advisory Council as shown in Figure 3.

Figure 3. Policy Analysis Framework Applied to the Missouri State Planning Grant (MSPG) in the Development of Policy Options



The guiding principles adopted by the Advisory Council, *Working for an Insured Missouri,* are as follows:

In our approach we recognize that:

- Local, state, and federal governments, employers, and individuals should not and cannot fully solve the problem of the uninsured.
- A solution should be bipartisan and serve the needs of all citizens, whether currently insured or not.
- Even under optimal circumstances, reaching 100 percent coverage in the current system is difficult, if not impossible.
- Some families and individuals will not participate in voluntary health insurance programs.
- An income threshold exists below which families have limited capacity to contribute to health insurance deductibles and co-payments.
- The current foundation of insurance coverage should be maintained building on public/private partnerships, as most employers want to provide employer-based health insurance to their employees.
- A cost threshold exists above which some employers have limited capacity to support employer-sponsored health insurance.

In researching options to address access, we are interested in ideas that:

- Integrate the concept of individual, family, community, and provider accountability to improve health status.
- Build on what works using evidence based principles.
- Integrate with the health care finance and health care delivery systems.
- Maximize available state, federal, and private resources.
- Include elements that are incremental, timely, and fiscally responsible.

The MSPG staff also used a list of questions, as listed below, to stimulate discussion among Advisory Council members in order to begin the discussion of what policy options will work in Missouri.

Questions and Characteristics/Values for Advisory Council on Policy Options Decision Making (Step 2B)

1. What should be the level of benefits for the target population?

- Prevention
- Prevention and Catastrophic
- Catastrophic only
- Equal to state employee health plan
- Equal to federal employee health plan
- Other

2. What is the employer's role and responsibility in health insurance coverage?

- ☐ No role
- ☐ Voluntary offer
- ☐ Mandatory Offer
- ☐ Should Offer insurance
  - For employee
  - For employee and family
- ☐ Should contribute to cost of premium
  - Something
  - Minimum%
  - Capped amount
  - Other

3. What is the employee's role and responsibility in health insurance coverage?

- ☐ None
- ☐ Voluntary offer
- ☐ Mandatory offer
- ☐ Should participate if employer offer, unless private coverage elsewhere
- ☐ Should cover family if employer offer unless private coverage elsewhere
- ☐ Should contribute toward cost of premium.
- ☐ Minimum % based on income
- ☐ Other

4. What form of public programs should the option have?

- ☐ Refundable, advanceable, income related tax credits
- ☐ Vouchers
- ☐ Premiums reduced on a graduated basis for those choosing the new public plan
- ☐ No family pays more than [xxx%] of income.
- ☐ Continue or expand Medicaid
- ☐ Continue or expand SCHIP
- ☐ Premium assistance
- ☐ Better funded high-risk pools
- ☐ Other
- ☐ State subsidies cover 100% of employee premium share for workers below xxx% FPL Example: 100% if 100% FPL; 80% if 100-200% FPL

5. What would be the source(s) of funding?

- ☐ Charge a xx [6.5]% payroll tax for employers not offering
- ☐ Charge Employee tax penalties on persons not buying coverage
- ☐ Use savings from reductions in uncompensated care
- ☐ Use state savings from program reductions
- ☐ Use employee, state and federal combined funding
- ☐ "Sin" tax
- ☐ Use general revenue
- ☐ No tax change
- ☐ Develop Flex MSA/IRA
- ☐ Develop advanceable tax credits
- ☐ Use reductions on non-health spending
- ☐ Use earmarked value added tax
- ☐ Other

6. What should be the role of state government?

- ☐ None
- ☐ Establish purchasing insurance pools
- ☐ Subsidies for Medicaid/SCHIP
- ☐ Use federal grants to supplement tax credits
- ☐ Reinsurance
- ☐ Adopt attractive insurance regulations
- ☐ Single Payer System

7. Do your decisions and discussions support the values and criteria for decision-making in the guiding principles of the MSPG Advisory Council? If no, what values and or criteria need to be changed?

The governance structure used in the planning process for the MSPG is very effective, as it has allowed for "checks and balances" in the process. The Advisory Council in the beginning took the lead in developing the agenda and dialoging. Since the last meeting in June, the policy subcommittee has forged ahead. Since the purpose of the Advisory Council is to respond to policy option proposals by the Policy Options Subcommittee, this was an important transition in leadership. Therefore, the Advisory Council laid the groundwork for the respective subcommittees.

State agencies, key constituencies (e.g., providers, employers, and advocacy groups), and state officials are incorporated into the governance design through service on the Advisory Council and the Subcommittees.

Methods used to obtain input from the public and key constituencies have varied. Activities included the following:

- A citizen, who is self-employed and uninsured, serves on the Advisory Council.
- The MSPG website (www.insuremissouri.org) was one of the first public activities associated with the grant. Published in November 2003, the development of the website allowed the staff to publish, through an *Issue Brief*, the scope, goals, and activities of the project. This was one mechanism to build public awareness about the issue of the uninsured.

The site includes information about the MSPG award, staff and subcontractor biographical information and roles on project, descriptions of the governing structure of the MSPG (i.e., Advisory Council and Subcommittee members), and information about HRSA. In addition, visitors to the site are provided a form where they may "tell a story" about how health insurance, or lack thereof, has affected their lives. These stories are then shared with the Advisory Council to give real meaning and a "face" to this issue. Other important features of the site include issue briefs on various aspects of the uninsurance issue; Advisory Council and Subcommittee calendar, agendas, and minutes; links to Missouri legislative activity on health insurance; State Coverage Initiative Website; Resources on Health Insurance; and an opportunity to join a list serve.

- The MSPG staff seeks appropriate opportunities to provide information about the grant and inform the public. A proposal for a roundtable was submitted to the Missouri Public Health Association (MPHA) to be held in October 2004. The audience for this conference consists of local public health administrators of county health departments, state and local health officials involved in the public health field in Missouri. The purpose of this presentation is two fold: to provide information about the issue of health insurance in Missouri and to garner feedback on this issue from those on the "front lines" of public health care.

- In November 2004, the Center for Health Policy (University of Missouri - Columbia) requested that MSPG staff speak at the annual Health Care Summit. Those interested in moving the health policy discussion forward in Missouri attend this conference. The main objective of our presentation is dissemination of the Household Survey data finalized in September.

- In addition to the Household Survey data, two other data collection activities were conducted. The Sinclair School of Nursing (SSN) of the University Missouri - Columbia and the Ozarks Public Health Institute (OPHI) of Southwest Missouri State University each conducted focus groups and/or key informant interviews. SSN focused on individual or consumer focus groups and OPHI conducted key informant interviews via telephone with people such as health insurance company representatives, local public health agency administrators, federal qualified health center officials, and emergency room physicians. OPHI also completed focus groups with small business employers in Missouri.

The eventual goal of this planning effort is to invoke legislation of a policy proposal with regard to increasing access to affordable health insurance. However, with the MSPG in its early stages of data collection and planning, influence may not be readily evident to those outside the planning efforts. The MSPG has provided a platform for discussion about health insurance coverage, an issue already on the national agenda. To move this discussion forward, the following challenges must be considered to facilitate change in Missouri:

- In 2003 the House Interim Committee on Health Care Access and Affordability was convened to examine health care access and affordability issues confronting Missouri residents; to identify salient problems and feasible solutions concerning health care access and affordability for inclusion in the interim report; and to consider legislation. From the work of this committee, 11 recommendations were made. During this past legislative

session, some of the recommendations appeared in specific pieces of legislation, but none passed. Unfortunately, several of the key legislators that served on this committee will be term limited off, creating an environment of inexperience on issues of health insurance coverage.

- During the past legislative session a serious attempt was made to solve the state's fiscal problem at the cost of health coverage for Missourians. State legislators, in an attempt to balance the budget, proposed a bill to reduce the number of insured through a public program by tightening the eligibility guidelines. Instead of looking for ways to reduce health care expenditures, a reduction in access to coverage for the vulnerable population was chosen. It is important to note that the legislators did support additional funding ($5 million) to expand the safety-net infrastructure.

- The social infrastructure barriers to expansion efforts are often more difficult to address. The ability of institutions, agencies, governmental entities, and the people, all working together to improve the system for providing and financing health care, is incredibly challenging and overwhelming. Some of these challenges include not only dealing with the perceptions and attitude about health care and health insurance coverage, but also a willingness to change the way we have been providing and paying for health care for the past decades. Some of the barriers that may impact expansion efforts include the many cost drivers contributing to the rising costs for premiums. In the state's review of the literature on cost drivers, four main themes were identified and include:
    - Health care industry (insurer's overhead, pressure for profitability, underwriting strategies, benefit design, and one-time savings effect);
    - Providers (physicians, pharmaceuticals, hospitals, research and community, and ranges from payment and operating costs, quality, availability, technology, cost shifting and uncompensated care);
    - Users (patient and consumer, and includes behavior choices, health literacy, utilization and misuse of the health system, demographic changes and consumer expectations); and
    - Policy, economic, law and regulations (general price inflation, mandates, litigation, economic variables, and health insurance industry).

Missouri already outspends the nation in per capita health care expenditures. Unless the state identifies ways to curb the rising costs associated with health care, it will be challenging to identify the funding streams to pay for expansion efforts.

Section 6. Lessons Learned and Recommendations to States

Identifying the lessons learned and recommendations to states is not answerable yet. The state was able to complete all types of data collection activities originally proposed; however, the analysis of the household data from the Coordinated State Coverage Survey is currently underway. Therefore, the state's ability to describe how important this data was in the decision-making process may be a bit premature. The data overall may be very important, but the state is

not able to ascertain whether more detailed information on uninsurance within specific subgroups will be needed. Further, the state is still early in its process and not yet able to respond to the question of how important the qualitative research was in facilitating program design. This question will be fully addressed in the final report.

The state does have a plan for how it will carry out the next steps to this effort. The data collected in year one will be instrumental in enabling the Advisory Council and the Policy Options Subcommittee to formulate a plan for increasing access to health insurance coverage for Missouri residents. The state plan will consist of models and options that are not only supported by data, but also supported by the consumers and stakeholders of the state. Strategic efforts will be made to enhance enrollment in existing public and private health insurance programs for those eligible for coverage and to develop new initiatives and partnerships between public and private entities around financing to assure increased access to coverage. These efforts and overarching goals are consistent with, and supportive of the MSPG Program goal - "encouraging States to provide access to affordable health insurance coverage to all citizens."

Although these activities are separate events, they are integrated with past and future activities of the grant (Figure 4).

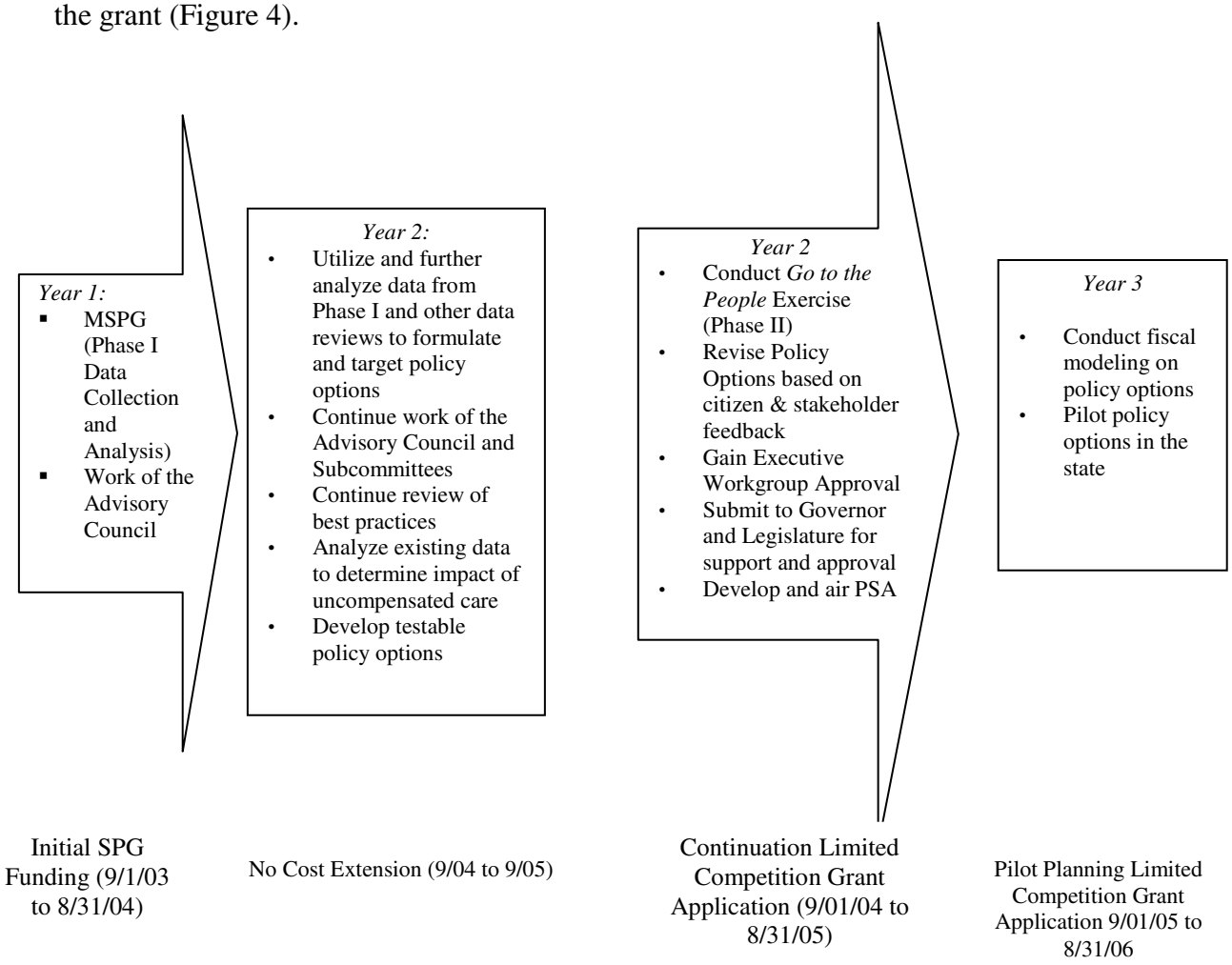


Figure 4. Progression and Continuation of the Missouri State Planning Grant

Figure 4 shows the continuity and intended progress of the MSPG from the first funding cycle (2003-2004), the No Cost Extension (2004-2005), the Continuous Limited Competition Grant (2004-2005), through to the Pilot Planning Limited Competition Grant Application (2005-2006). All prior and current activities help set the foundation to comprehensively study the uninsured population, study best practices, and the design of policy options. The Continuation Limited Competition Grant will provide the mechanism to actually take what has been learned and identify policy options that are feasible and acceptable for Missouri to implement.

Section 7. Recommendations to the Federal Government

Missouri has not yet analyzed all the research, survey and policy option development activities under the State Planning Grant project; therefore, the information requested in Section 7 is not available. Though Missouri has some preliminary thoughts and suggestions, it would be premature for the state to respond to this question at this stage in the project. This question will be addressed in the final report.

APPENDIX I: BASELINE INFORMATION

Population:

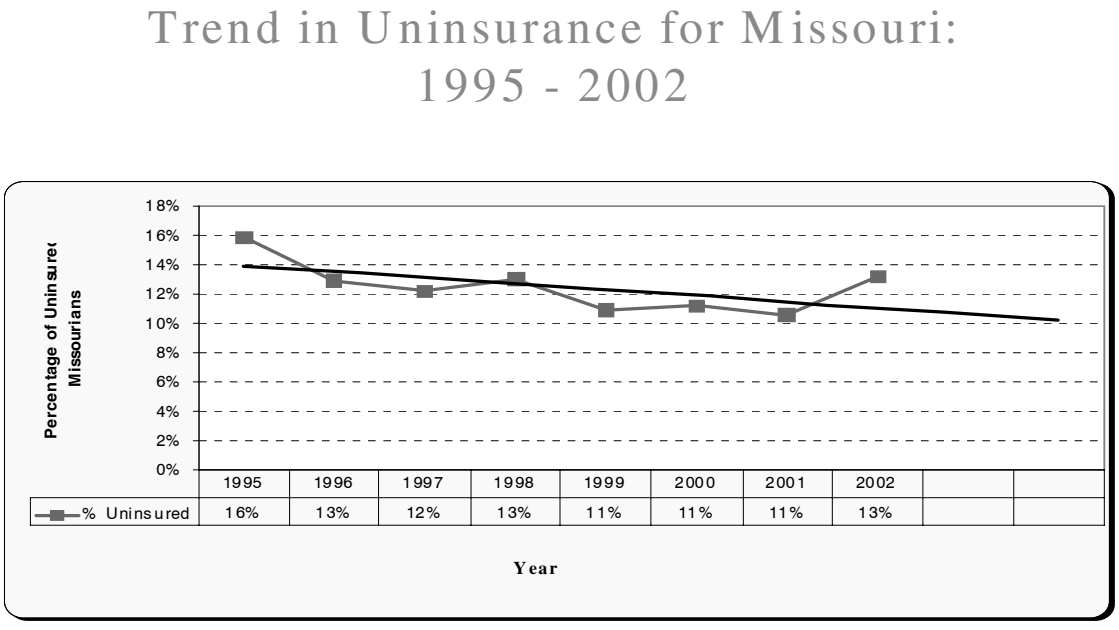
Missouri's statewide population (estimated July 1, 2003) is 5,704,484.

Number and percentage of uninsured (current and trend):

Data analysis from the state's Coordinated State Coverage Survey is underway and is not yet available. For the purpose of this preliminary report, data from BRFSS and CPS are presented in Table 16.

Table 16. 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



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 5.

Table 17. Characteristics of the Uninsured (Sources cited within table.)			
Federal Poverty Level (CPS, 1999-2001)	**Uninsured (%)**	**Employment Status** (BRFSS, 1999-2001)	**Uninsured (%)**
Less than 100% FPL	17	Employed	51
100% to 199% FPL	26	Self-employed	15
200% to 299% FPL	23	Out-of-work <1 year	8
300% to 399% FPL	13	Unable to work	5
400% to 499% FPL	9	Student	5
500% FPL or More	12	Retired	4
Marital Status (BRFSS, 1999-2001)	**Uninsured (%)**	**Income (dollars)** (BRFSS 2002)	**Uninsured (%)**
Married	40	<15,000	22.7
Never Been Married	31	15,000-24,000	23.2
Divorced	19	25,000-34,999	16.2
Unmarried Couple	4	35,000-49,999	10.5
Widow	3	50,000	4.4
Separated	2		
Age in years (BRFSS, 2002)	**Uninsured (%)**	**Race** (BRFSS, 2002)	**Uninsured (%)**
18-24 years	27.8	Hispanic	18.7
25-34 years	14.9	Black, non-Hispanic	24.6
35-44 years	15.3	White, non-Hispanic	12.0
45-54 years	11.7	Others	15.2
55-64 years	11.4	Multi Racial	12.1
65+ years	1.9	**Education** (BRFSS, 2002)	**Uninsured (%)**
Gender (BRFSS, 2002)	**Uninsured (%)**	No high school degree	26.0
Male	15.3	High school graduate	16.4
Female	11.3	Some college or Associate Degree 2 yr	11.8
		College Graduate 4 yr	4.6

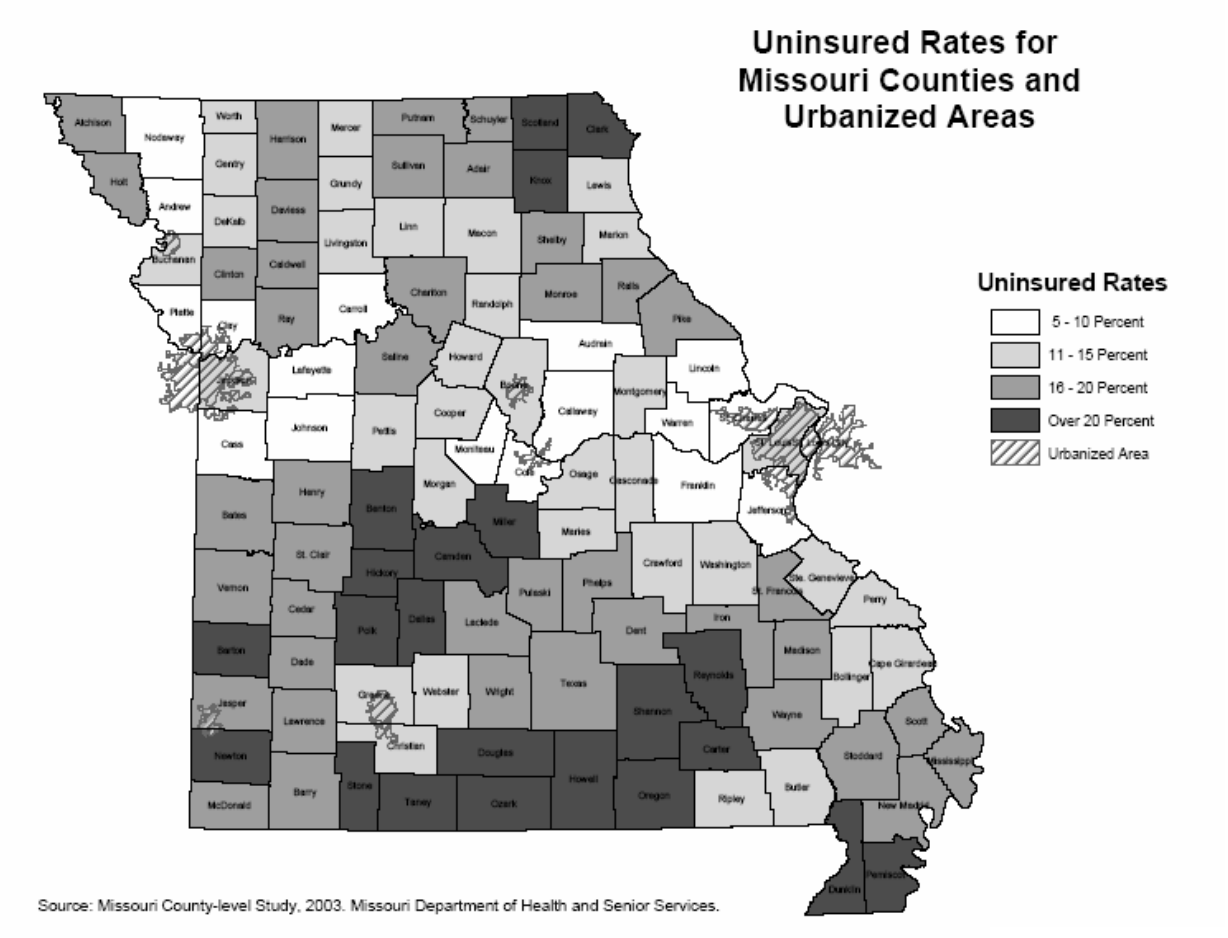

Uninsured Rates for Missouri Counties and Urbanized Areas
Uninsured Rates
5 - 10 Percent
11 - 15 Percent
16 - 20 Percent
Over 20 Percent
Urbanized Area
Source: Missouri County-level Study, 2003. Missouri Department of Health and Senior Services.

Figure 6.

Average Age of Population:

The average age in Missouri is 37 years.

Percent of population living in poverty:

Approximately 10% of all Missourians live in poverty (< 100% FPL) and 17% of all uninsured Missourians live in poverty.

Primary Industries

Table 18. 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 19. 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%

Table 19, continued	Number of Employees						
	<10	**10-24**	**25-99**	**100-999**	**1000 +**	**< 50**	**50 +**
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%
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%

Table 19, continued	**Number of Employees**						
	<10	**10-24**	**25-99**	**100-999**	**1000 +**	**< 50**	**50 +**
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 20. Missouri Insurance Market Reforms, Source: National Association of Health Underwriters, 2001	
Individual Market Reforms	
Guaranteed Issue	
Pre-Existing Conditions	None
Rating Structure	NRS
Small Group Market Reforms	
Guaranteed Issue	X
Pre-Existing 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 21. 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 22. Federal Poverty Guidelines for Missouri by Program, Source: Missouri Department of Social Services		
Medical Assistance for Families		75%
Medicaid for Pregnant Women		185%
MC+ for Kids (non CHIP)		
	Up to age 1	185%
	Age 1 to 5	133%
	Age 6 to 18	100%
MC+ for Kids (CHIP) Uninsured Child up to age 19		
	No Cost	185%
	$ 5 Co-pay	225%
	$62 to $252 monthly premium, plus $10 co-pay and $9 prescription co-pay	300%
Note. Average TANF Grant = 236/Month Minimum Wage= $5.15/Hour = $893/Month = $10,716/Year		

Table 23. 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, Primary and Secondary, 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.

Endnotes

[1]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.

[2] Unmarried dependents to 23 (or 26); Require that all colleges and universities required full-time and part-time students to have health insurance; Dependent parents (primarily disabled); Grandchildren living with grandparents

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