Department of Health & Senior Services

Report on the Missouri State Planning Grant Public Deliberation Forums

August 31, 2005

It is beyond "insurance"…it is a systemic problem that includes access, providers, infrastructure, community, state, and federal values of caring for community well-being. -comment from a participant at the MSPG Public Forum Discussion

The State Planning Grant is a federally funded grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). The amount of funding received to date is $1,030,361. More information regarding the State Planning Grant Program to help the uninsured can be found at www.hrsa.gov/osp/stateplanning

Table of Contents

Executive Summary…….. 2
Introduction…… 2
Methods…… 5
Results…… 9
Appendix…… 19

Executive Summary

The Missouri State Planning Grant (MPSG) received a Limited Continuation Competition Grant to seek feedback from citizens in communities across the state. It was decided that 21 public deliberation forums would be scheduled throughout the state and would involve two types of meetings: community meetings and regional meetings. To successfully carry out these forums, a team of individuals was recruited to assist with training, planning, and the development of an Issue Book to be used at the forum to guide discussion.

The name of the forums was "Covering the Uninsured in Your Community: Why it is Everyone's Problem. At a public deliberation, participants are allowed to explore a number of options to help solve the problem and present solutions. Deliberation allows community members to weigh the consequences of each option in order to help solve the problem. The intent is to create a tension so that solutions present themselves. The analysis for public deliberation forums is qualitative and involves reviewing individual statements from the participants and assigning them to a category. For these public deliberations, the top 10 themes were:

1. Pooling encouraged
2. Prevention needed
3. Affordability
4. Accessibility
5. Consumerism
6. Medicaid concerns
7. Personal responsibility
8. Better health insurance products
9. Over-utilization and misuse
10. State involvement is a concern.

The citizens of Missouri, through these forums, have provided valuable insight and feedback. Change and innovative thinking in the system are clearly needed and wanted. That change must involve multiple stakeholders, including the individual, families, employers, pharmaceutical and insurance industries, hospitals and providers, and the state government. Most importantly, change will most likely occur if these key players apply solutions to this challenge within a community context. Their insightful deliberation shows that all stakeholders must become better integrated and work together to provide affordable and accessible health insurance for all Missourians.

Introduction

In October 2003, Missouri was awarded a State Planning Grant from the Department of Health and Human Services, Health Resources and Services Administration (HRSA). One of the first activities of the grant was to measure and describe the uninsured in Missouri. About 7,000 households were surveyed and asked questions about insurance, accessibility, affordability and health. Focus groups were held with small business employers and consumers. In addition, a group of key stakeholders, using the data collected, developed and evaluated a wide range of policy options to increase access to affordable health insurance coverage for Missouri residents. The next step was to talk and listen to community members across the state on the issue of the uninsured to help identify solutions.[1] For a diagram of Missouri's activities since 2003, refer to Figure 1.

The public deliberation forums were an opportunity for the people of Missouri to have a voice in health care policy for the state of Missouri. These forums were designed so that people can discuss a difficult, complex issue. A moderator uses deliberation so participants can explore a number of options to help solve the problem and present solutions. As everyone shares their thoughts, deliberation allows community members to weigh the consequences of each option in order to help solve the problem. What are the pros of each option? Do the options have drawbacks? What are the likely trade-offs with each option? What are the best solutions?

The Social Costs of Uninsurance

HRSA recognizes that access to affordable and quality health care is necessary for all to attain optimal health. As the Nation's Access Agency, HRSA focuses on uninsured, underserved, and special needs populations in its goals and program activities. The understanding that lack of health insurance coverage is detrimental to individuals, families, and society is well supported.[2,3,4] The Institute of Medicine (IOM)[5] identifies several social costs of uninsurance.

With a lack of health care coverage,

- Individuals lose their health and die prematurely. Uninsured children lose the opportunity for normal development and educational achievement when preventable health conditions go untreated;
- Families lose peace of mind because they live with the uncertainty and anxiety of the medical and financial consequences of a serious illness or injury;
- Communities are at risk of losing health care capacity because high rates of uninsurance result in hospitals reducing services, health providers moving out of the community, and cuts

[1] For a more thorough description of the HRSA State Planning Grant Program (SPG) and Missouri's Experience, see Appendix A.

[2] The Commonwealth Fund, http://www.cmwf.org/publications/publications_show.htm?doc_id=274289
[3] The Kaiser Family Foundation, http://www.kff.org/.
[4] The Institute of Medicine, http://www.iom.org
[5] Institute of Medicine Report , Hidden Costs, Value Lost, Uninsurance in America, Available path: http://www.iom.edu/report.asp?id=12313

in public health programs like communicable disease surveillance. These consequences can affect everyone, not just those who are uninsured; and

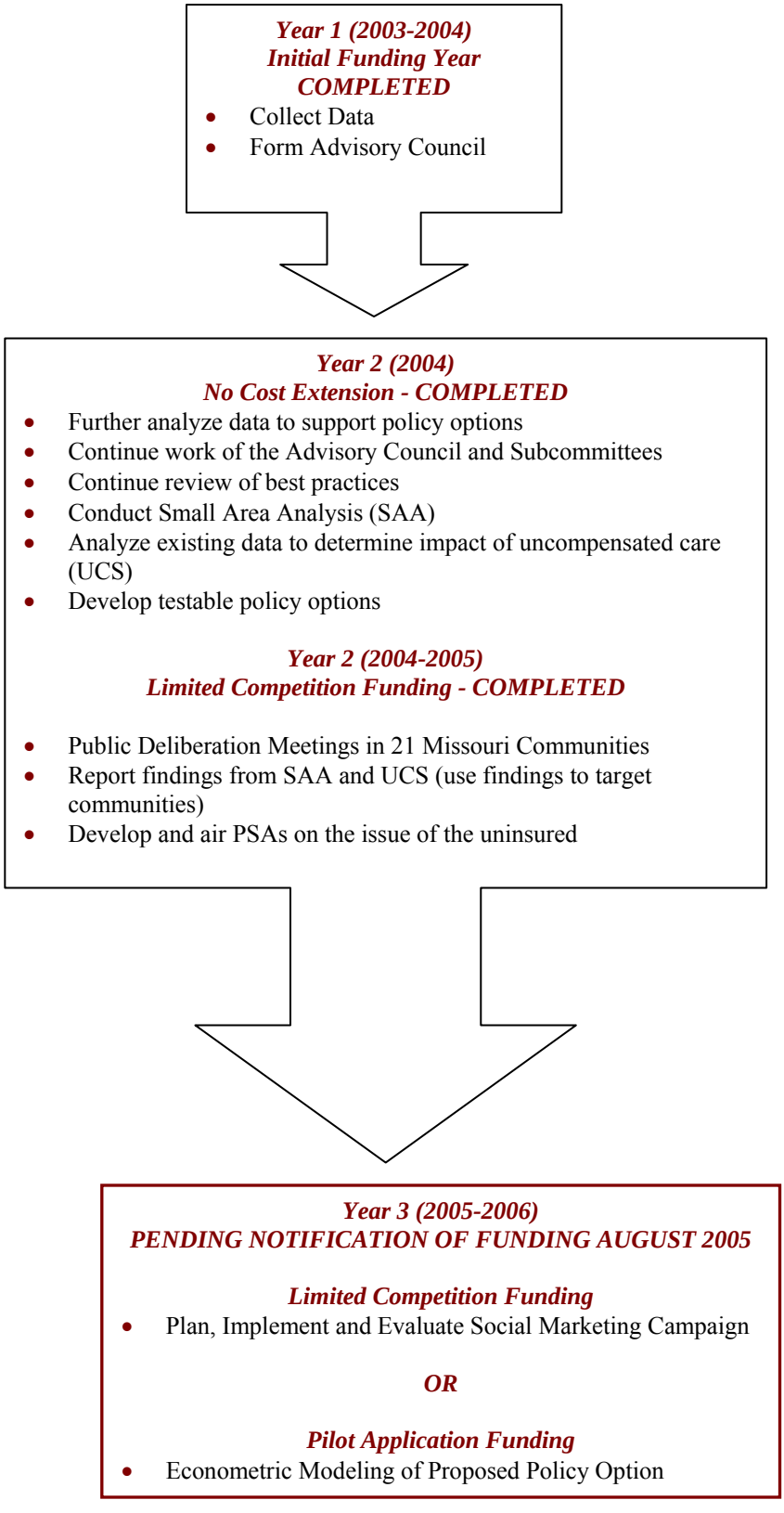
- The economic vitality of the country is diminished by productivity lost as a result of the poorer health and premature death or disability of uninsured workers.

Because of the multi-dimensional effects of uninsurance, the HRSA State Planning Grant (SPG) program has a unique role in allowing states to collect data and use that data to inform other states, stakeholders, and federal policy makers. According to the Commonwealth Fund,

"the SPG program has become more than just a funding stream for state research and planning activities; it is a mechanism for health policy stakeholders at all levels to understand the issue of uninsurance and possible solutions on a more sophisticated level. Sharing of information about data analysis and policy development, along with the kinds of experiments being developed under the pilot planning grants, are vital for creating successful models that can be expanded and replicated throughout the nation".[6]

[6] Sharon Silow-Carroll and Tanya Alteras. (April 2005). **HRSA State Planning Grant Update: A Review of Coverage Strategies and Pilot Planning Activities.** Economic and Social Research Institute, Commonwealth Fund pub. no. 813.

Figure 1. The Missouri HRSA State Planning Grant Timeline



Methods

In 2004, the MPSG received a Limited Continuation Competition Grant to seek feedback from citizens in communities across the state. It was decided that public deliberation forums would be scheduled through the state and would involve two types of meetings: community meetings and regional meetings. To successfully carry out these forums, a team of individuals was recruited to assist with training, planning, and the development of an Issue Book to be used at the forum to guide discussion. This team included a public deliberation event coordinator, a public deliberations training coordinator, conveners, moderators, recorders, and observers (Table 1).

Table 1. MSPG Public Deliberation Forum Team

Title	Purpose
Public Deliberation Event Coordinator	Works with the Training Coordinator and the Conveners throughout the state to coordinate the community public deliberation forums
Public Deliberations Training Coordinator	Designs and implements training for moderators and conveners of the public deliberative processes and provides technical assistance and training for the community public deliberation forums.
Conveners	Act as the lead in recruiting participants to the forums. Works with local organizations to publicize event, and reserve facilities.
Moderators	Leads the discussion among the participants on the day of the forum following guidelines and ensuring that the forum stays true to objectives. Understands and uses deliberation, and not debate, to help participants explore a number of options to help solve the problem and present solutions.
Recorders	Record the discussion among the group using the Issue Guide as a framework.
Observers	Observe the discussion of the group ensuring that the methodology stays true to the intended objectives.

Recruitment for the forums was carried out by the Conveners, which were staff from the Missouri Area Health Education Centers (AHEC). With the assistant of the Coordinators, 21 communities were specially selected across the state to hold forums (Table 2). For a visual representation of the various regional and community forums, see Figure 2.

Table 2. Locations for Regional and Community Public Deliberation Meetings

Region	Regional Forum	First Community Forum	Second Community Forum
Northwest	St. Joseph	Gallatin	St. Joseph
Kansas City	Kansas City	Independence	Kansas City
Southwest	Springfield	Joplin	Bolivar
Mid-Missouri	Jefferson City	Rolla	Osage Beach
Northeast	Kirksville	Hannibal	Moberly
Southeast	Cape Girardeau	Caruthersville	Poplar Bluff
East Central	St. Louis	Crystal City	St. Louis

About Public Deliberation Forums

The name of the forums was "Covering the Uninsured in Your Community: Why it is Everyone's Problem". The public deliberation forum, unlike a debate, was an opportunity for citizens from various backgrounds to have a voice in health care policy for the state of Missouri. Because the problem of the uninsured is such a complex issue, this format was chosen. According to Adler, there are three broad categories of problems. These problems can be diagnosed according to two factors: agreement on problem definition and agreement on possible solutions. Type I problems tend to be technical in nature (e.g., how to fix a broken arm), whereas Type II problems are closely tied to values and must be solved by those whom the problem affects. (e.g., how to effectively educate our children). Type III problems are more complex and intractable because of multiple stakeholders, overlapping jurisdictions, multiple viewpoints with varying moral dimensions.[7,8] Health insurance could be described as a Type III problem.

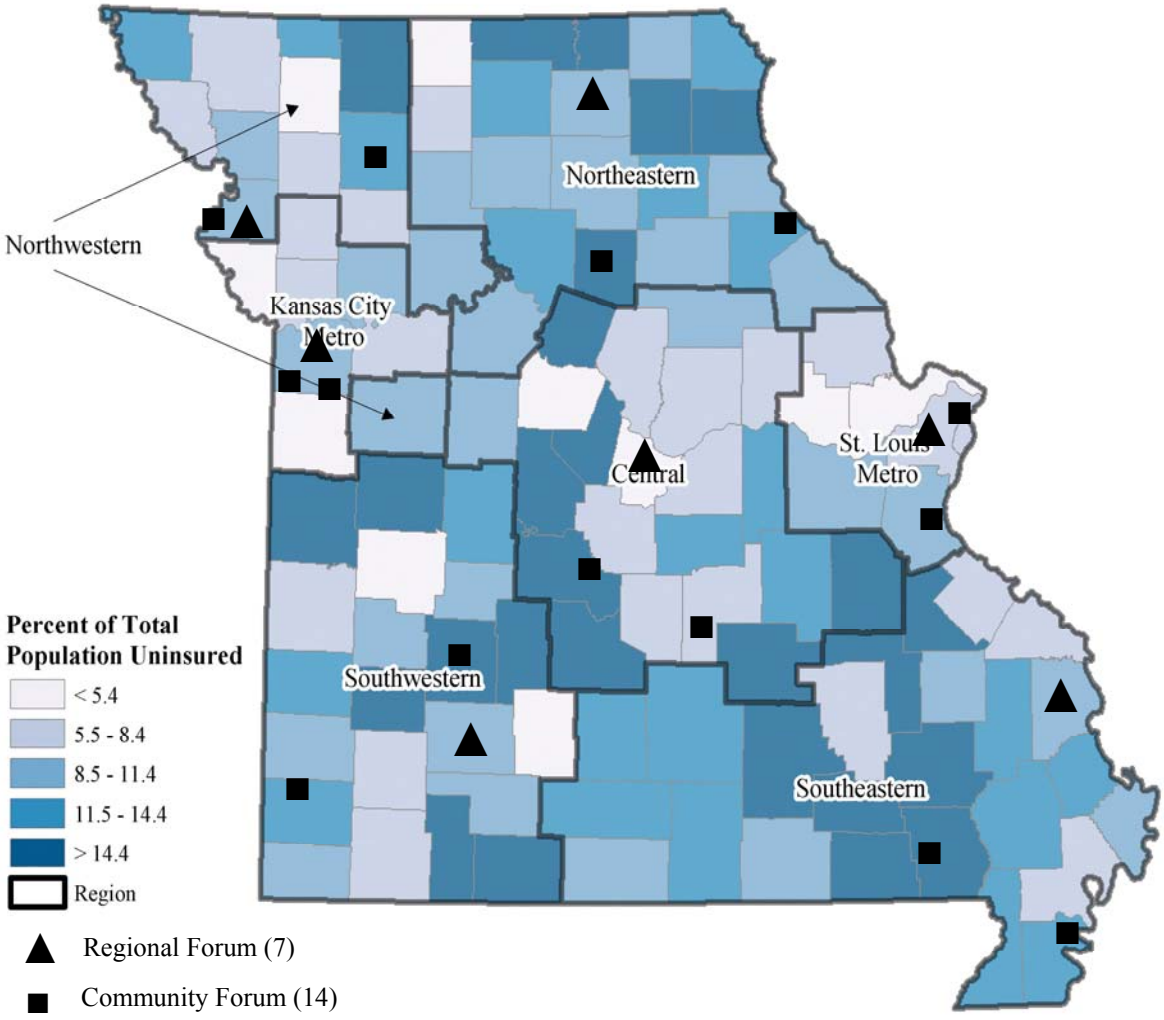
There are many stakeholders involved from consumers, families, insurance companies, providers, employers, legislators, all of whom struggle to answer the basic question: is health insurance a privilege or a right? There's no one right way to do it. Should employers offer health insurance? Should the government be responsible for providing insurance? Should a policy cover preventive or catastrophic care or both?

At a public deliberation, participants are allowed to explore a number of options to help solve the problem and present solutions. Deliberation allows community members to weigh the consequences of each option in order to help solve the problem. What are the pros of each option? Do the options have drawbacks? What are the likely trade-offs with each option? What are the best solutions? The intent is to create a tension so that solutions present themselves.

[7] Cited in John W. Cooley (ed.), 2004. The creative problem solver's handbook for negotiators and mediators: A pracademic approach. American Bar Association. Chapter by Peter S. Adler, Leadership, mediation, and the naming, framing, and taming of type II and Type III problems.

[8] Simon Buckingham Shum, Representing Hard to formalise, contextualised, multidisciplinary, organizational knowledge at http//kmi.open.ac.uk/people/sbs/org-knowledge/aikm97/sbs-paper2.html.

Figure 2. Locations of Community and Regional Public Deliberation Forums in Missouri



The typical public deliberation forum begins with an introduction of the moderator, observers, recorders, and the participants. Participants are seated in a circle or "U" shape in order to encourage interaction. The moderator states the purpose of the meeting and provides the guidelines for the discussion. The moderator will guide the discussion yet remain neutral. Participants are asked that:

- Everyone is encouraged to participate.
- No one or two individuals dominate
- The discussion will focus on the choices

- All the major choices or positions on the issue are considered
- An atmosphere for discussion and analysis of alternatives is maintained.
- We are tough on the issue, but easy on each other.

At the beginning of the deliberation, participants were given a Discussion Guide[9] to use during the deliberation. For this deliberation, the moderator opened with asking the group about how health insurance has affected them personally. The moderator asked the participants to focus on the Discussion Guide, specifically on the two approaches: make private insurance more accessible and expand government-sponsored insurance. For each, a list of "what people might say about this approach" and "what can be done" were provided and discussed (see Appendix B). The moderator probed the group with various questions, such as, What is good about this approach? What are the values of this approach? What would someone say who supported or was against this approach? After Approach Two was discussed, the group was asked to create an alternative approach to the uninsurance problem in our state. The questions used to probe the participants were:

- What are the best ideas from both that we can weave together?
- What key principles and values should serve as the foundation to this other approach?
- What trade-offs can you live with?
- What would this plan look like?

Participants continue the discussion until the moderator determined that the forum had reached a conclusion. Participants were asked to reflect on their experience and to identify common themes. The following questions were used to close the discussion:

Individual Reflections

- How has your thinking about the issue changed?
- How has your thinking about other people's views changed?

Group Reflections

- Can we detect any shared sense of direction or any common ground for action?
- What did you hear the group saying about tensions in the issue?
- What were the trade-offs the groups was willing or not willing to make?

Next-Step Reflections

- What do we still need to talk about?
- How can we use what we now know?
- What are you going to do to help with this issue?

[9] The Discussion Guide was developed using the materials from the National Issues Forum (http://www.nifi.org/).

Results

Demographic Survey Data

The Conveners were responsible for providing to the MSPG Project Director an electronic copy of the transcripts, demographic surveys, and sign-in sheets. Data analysis of the surveys revealed that 279 individuals attended the public forums representing over 56 counties and various stakeholder groups (e.g., providers, insurance industry, community development organizations, community health centers, small business, free clinics, legislators, local politicians, economic development, and the uninsured). Characteristics of the participants are presented in Table 3. On the survey, participants were asked if they had any important comments not shared in the discussion. Relevant themes from these comments, posed as statements or questions, are as follows:

1. Missourians need quality, well-rounded care that includes prevention.
2. Many Missourians do not have access to health care.
3. A profit-focused system exists.
4. The cost of health care and health care insurance forces people out of the market.
5. People need to take more responsibility for their health.
6. Is health care a privilege or a right?
7. Do we need a public and/or private solution?
8. Caring for our neighbor as a society has been lost.
9. Political will is needed to make any systemic change.
10. Universal health care is an option to consider.

Table 3. Characteristics of the Public Forum Participants (n = 240)					
Age		**Family Income**		**Provides Insurance**	
19 - 24	1%	$10,000 to 20,000	6%	Through employer	70%
25 - 34	10%	$20,000 to 30,000	11%	Publicly provided	7%
35 - 54	55%	$30,000 to $40,000	15%	Private market	8%
55 - 64	24%	$40,000 to $50,000	17%	Other	3%
65 and older	10%	Over $50,000	52%	Multiple sources	12%
Gender		**Level of Education**		**Region**	
Male	67%	Less than high school	1%	Northwest	8%
Female	33%	High school graduate	5%	Kansas City	25%
Race/Ethnicity		Some college	19%	Southwest	19%
White	80%	College graduate	31%	Mid Missouri	7%
Black	16%	Postgraduate	43%	Northeast	13%
Asian	.42%	**Insurance Status**		Southeast	15%
Hispanic	3%	Family – no insurance	3%	East Central	13%
American-Indian	.5%	I have it; family none	33%		
Other	1%	Family has it; I do not	10%		
		Whole family insured	44%		
		I have insurance	10%		

Analysis of Themes

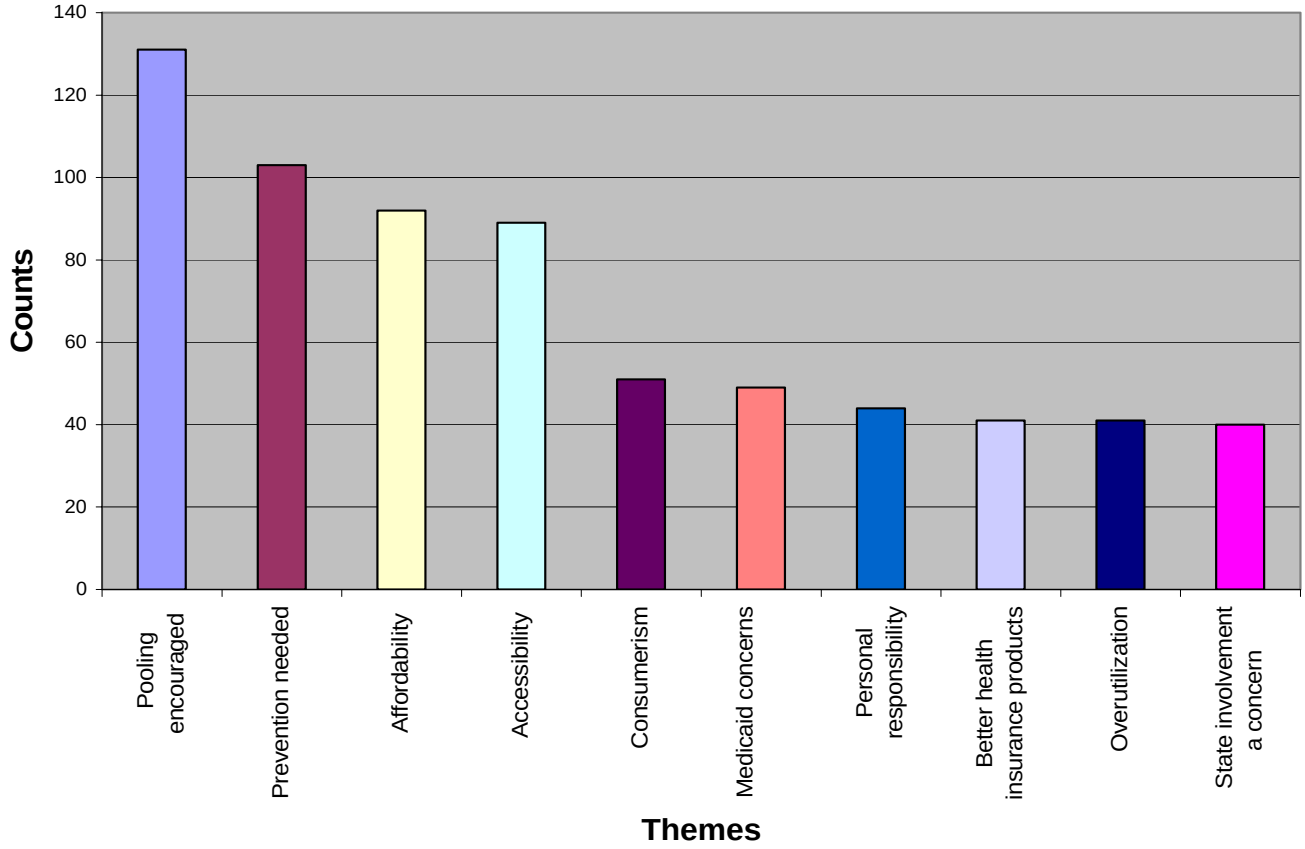
The public deliberations were centered on three approaches discussed by the participants.

Approach One: Improve access to employer-based (private) health insurance
Approach Two: Expand government-sponsored health insurance
Approach Three: Is there an alternative approach?

The data from these forums were analyzed through qualitative analysis. A cross-approach theme tally was conducted, where all comments were reviewed and a master list of themes created. From this data analysis, 10 top themes were identified. Table 4 provides the listing of the top 10 themes in addition to "all other themes" receiving at least one tally count. Figure 4 shows the top 10 themes presented in a bar graph.

Table 4. Theme Counts of Public Deliberation Forums			
Theme	**Count**	**Theme**	**Count**
Pooling encouraged (small business, not-for-profits, low and high risk individuals)	131	Medicaid is a benefit	11
Prevention needed/More primary care/Lifestyle/Wellness	103	Basic health insurance coverage needs defined	11
Affordability (fair and equitable, premiums/deduct)	92	Medical malpractice needs a cap	10
Accessibility (supply of physicians, reimbursement rates, geographic imbalance)	89	Regulation of pharmaceutical industry	8
Consumerism/Early education/Financial management	51	Values determine perceived solution	8
Medicaid concerns (stigma, over-reliance, system)	49	Medication is too expensive	7
Personal responsibility	44	Physicians vs. health insurance companies	7
Better health insurance products	41	Regulate health care costs	7
Over-utilization/Misuse (provider, patient, insurance, ethics)	41	Tax break deduction (small business, individual)	7
State involvement is a concern (bureaucracy, taxes)	40	Need legislative changes	6
System is difficult to navigate (inefficient, wasteful)	38	Socialized medicine is a concern	6
Partnership is solution (state, business, physicians, schools)	32	Choose no health insurance	5
Employer model supported	29	Health determines risk	5
Universal coverage supported	29	Physicians need to make a living	4
Legislative concerns/Informed of issue/Need buy-in	26	Mandate insurance for everyone	3
Regulation of insurance companies	26	Premium assistance needed	2
State/Federal involvement supported/needed	23	Public health infrastructure needs to be strengthened	2
Cost-shifting is part of the problem	20	Balance patient and insurance rights	1
Funding source	20	COBRA rules are difficult	1
Universal coverage negative	27	Cut from other programs	1
Quality care/Evidenced based medicine	19	Gap in the retirement and Medicare	1
Humanism/compassion/victim blame	17	Low-cost healthcare is an incentive	1
Profit-centered system	17	Medical debt	1
High risk pool needed	14	Multi-faceted solution needed	1
Is healthcare a right or privilege	14	National level effort is supported	1
Free Clinics needed	13	Dependents do not need to be included	1
Dependents need coverage	12	Too many overuse/too many underuse	1
Employer model questioned	11		

Figure 4. Top 10 Themes from the Public Deliberation Forums



Supporting Statements for Top 10 Themes

The public forum discussions yielded approximately 100 pages of dialogue. To illustrate the top 10 themes, statements were selected and are presented below:

1. *Pooling encouraged (small business, not-for-profits, low and high risk individuals)*

- Small businesses are reprimanded for using insurance in relation to the number of claims submitted.
- Is it possible for families to get together to buy group coverage?
- Turn over is cheaper for business than paying for long-term insurance and aging employees with typically greater health issues.
- Very positive approach. Individuals are treated better as part of a plan.
- A state pool would be cheaper by covering health insurance premiums rather than high medical bills through Medicaid.

- Small businesses incur extraordinary costs to purchase health care insurance, but even then it is often offered to employees on a cost-share basis…but some employees still can't afford it, even on a cost-share basis.
- Reduce the high cost of medications through collective bargaining; large groups can pool together to purchase meds through state formularies.
- You should not penalize small businesses for not offering health insurance…small businesses have trouble surviving.
- Our company has used grant money for insurance for staff.
- Lower wage people in large corporations cannot get insurance. For example in a large hotel chain the maids, kitchen help do not make enough to afford insurance.

2. *Prevention focused (primary care, lifestyle, wellness)*

- …we need early prevention in schools and to increase funding to health departments.
- Federally Qualified Health Clinics (FQHC) are the best example of public/private partnerships. Use this example and other states to shape solutions for Missouri.
- …document accurately the savings of treating diabetic/hypertensive patient vs. hospitalization, including value of social security after parent's death.
- Free clinics can and do provide better healthcare than private clinics. Doctors have to meet the group's goals. Clinics can treat as needed and can take more time with patients. Doctors have to see so many patients to make money, labs to order, tests….
- People wait too long to seek care for mental health; need to increase prevention…
- Preventive should be covered at 100% when paired with a high deductible for other claims.
- Provision of healthcare coverage is currently after-the-fact…we need to create a culture of health and wellness to ultimately reduce costs.
- Nobody is currently paying for preventive health and wellness programs, although we all agree it should be done. There is no federal or state support to do it.
- The public health infrastructure should be strengthened, rather than dismantled.

3. *Affordability (fair and equitable, premiums/deductibles)*

- The cost structure is out of whack. An uninsured person's emergency room visit costs four times more than someone with insurance coverage.
- Top level employees receive excellent health insurance packets vs. employees at the lower end of the pay scale who have to struggle to make ends meet. There is a huge inequity that needs to be addressed.
- What can be done to look at the company and make it more equitable? Premiums should be based on income level of each employee vs. everyone from the CEO to the secretary paying the same premium amount.
- There is a level where there is no service at all …people unable to find a provider and so sick when they go to a free clinic, but waited because of pride…working and poor.
- …$150.00 in medical bills for some you might as well ask for $150,000 for the procedure.
- Livable wages or non-livable wages keep people from saving for medical bills.

- …you have no clear understanding of the working class struggle…
- Are we willing to give up advances in medicine and quality of life? We want the best we can possibly get for ourselves and our children.
- Don't understand how we got to this place in time with so much disparity, salaries of ballplayers vs. salaries of teachers-and discussing how to cover those who aren't.
- A person under age 65 indicates they are uninsured and afraid they will lose their property over health care costs.
- Public is already picking up the slack for those who cannot afford to pay. We are already paying the bill, just don't realize it!
- What about single parents who can't afford medical savings or to put any money aside. They don't have any extra money to pay anything.
- A Sedalia clinic has 78% of their patients who are uninsured. Most cannot pay for medication for high blood pressure or diabetes. Cost of medications so low vs. hospital stay for stroke, heart attack or diabetes complications.
- Wife's medicine cost over $100 a month and difficult to cover. I do not know what I will do if they say the medicine will not be covered.
- I heard that the sheriff's department is releasing inmates early because the county can not afford the health care costs.

4. *Accessibility (supply of physicians, reimbursement rates, geographic imbalance)*

- Consequences of people not having insurance can be more costly than having insurance (e.g., Newborn baby having problems due to no early intervention during pregnancy).
- Legislators need to see what the low access issue is truly doing to the people in their districts.
- Need to consider people who can't access healthcare due to legal status. McDonald County has had 2000% growth. Noel, Missouri has 60% population of Hispanics in the schools.
- Providers can't offer services if the state reimbursement numbers keep dropping. When there are no providers to treat you, there's no access to care…except through the emergency room. Reimbursement is the key to making sure local systems of care work right.
- Missouri has six medical schools, but keeps losing doctors to other states; we need to educate doctors in training on the costs of care, treatment, medicines and help them help their patients better.
- The lack of practitioners in Missouri is critically under-supplied…we need to legislate expectations to meet current and future demand for trained practitioners.
- Start school based health clinics…Missouri has had some funding in the past to something similar, but had problems getting providers.
- Use HPSA model to offer physicians funds to write off their school loans if they would practice in any rural area, not just shortage sites.
- Many of the physicians coming into the area will not accept Medicare. You must have cash or they will not see you.
- MC+ provider community consists of 800 primary care physicians…only 500 of those physicians agree to participate in MC+ due to low reimbursement rates and massive amounts of paperwork.

5. *Consumerism/Early education/Financial management*

- Need to teach people how to use the insurance system responsibly and wisely.
- There is a division of beliefs on what is important. Are people going to take care of each other or are all people to be on their own. Compared to education, private education vs. public education, private health care vs. public healthcare.
- Young employees with no job skills who job hop aren't interested in healthcare plans. Portability is not of interest to current young workers who do not stay in one job for any length of time.
- Find a way to do more school-based health and wellness and share the costs between healthcare agencies and schools.
- Use schools…kids are there all the time and there would be no transportation issues for accessing care; teach kids to value good healthcare.

6. *Medicaid and the public health infrastructure (stigma, over-reliance, delivery, system)*

- One attendee explains a client was unable to afford/reach Medicaid spend down. The client was able to get samples from a physician. Otherwise, the client would have gone without medications.
- An attendee says her client was told they should not work so they could get Medicaid benefits though the client actually wanted to work.
- Medicaid payments involve so much paper work, but the paper work is need for accountability to tax payer.
- Government rules don't fit health care.
- Government spends funds, not concerned with efficiency, are Medicaid recipients being heard on Capitol Hill, are they voting, would this affect policy?
- Medicaid is a disincentive to work. Example is a working man, whose wife has advanced diabetes with complications, lost his job, and his insurance. No insurance company will cover them now. And now, if he works, they will lose Medicaid for her (and their four children), and his wife will not be able to receive the medical care she needs, and she may die.
- There is an unfair sense of entitlement from long-term unemployed people (3rd generation Medicaid recipients) that will require community education to change their way of thinking.
- The current impressions that politicians have about the welfare system is not the original intent of the system no the way it was originally designed…it has been altered extensively since it was first instituted/implemented.
- Medicaid and MC+ just does not work for us in the Bootheel…we cannot access services now so we can't support more coming into the system. The people who are advocating for this are not speaking from a personal perspective…they are not touched by it.
- Missouri should have core public health policies that should become a standard part of every county. Public health is too disjointed…with counties making independent decisions about what services to provide. Public health should be consolidated or a mandated direction on core public health issues should be consistent in all counties.
- Paperwork could be lowered with technology, so providers do not have to spend so much time on paper work.

7. *Personal responsibility*

- The problem with America is that people are not taking personal responsibility. Smokers, drinkers, obese individuals are causing cost to go up…people have an idea that care is not costing anything so they are more likely to take risk.
- We need to provide more individual tools so that they can be more accountable-but not punish for circumstances out of their control.
- There is a population that won't value health insurance, ever.
- Frustrated by clients who insist on specific health care treatment, despite ignoring doctors instructions for prevention and changing lifestyle choices. People want the quick fix instead of taking personal responsibility.
- Should people with poor lifestyles have equal access to healthcare?
- What is the motivation to use prevention care vs. high cost care?
- Promote the theme "personal choices/personal consequences"…if you choose to smoke you will pay more for care.

8. *Better health insurance products*

- There was also general consensus that health insurance is not the same as access to health care.
- Not all insurance is necessarily good insurance!
- Dental care should also be covered in healthcare plans; poor dental care affects overall health and wellness.
- Consumers should be able to choose their own providers.
- It looks good on paper…more access/more people covered…but in reality, would access be improved? I have insurance, but what does it get me with a $2,000 deductible.
- Government meetings are held to promote chronic care management, but education needs to be done for the public to accept it. Appropriate education is a very labor intensive job to do it right and thus control costs.
- With a small business there are limited options for providers. Now every one to two years you have to change carriers and pre-existing conditions are a factor in finding a provider.
- Most insurance does not include dental or mental health…why are some services included, but others are not?
- Plans are confusing even with a PhD. I had difficulty understanding them and trying to assist employees in making choices between them.

9. *Overutilization/Misuse (provider, patient, insurance, ethics)*

- …a lot of money is at stake-everyone has to give up something.
- There is a sense of entitlement for healthcare and the perception has shifted to healthcare as a back-up to emergent care instead of the other way around.
- The high cost of brilliant technology has put the cost of healthcare beyond our means to pay.
- Health care businesses still need to make their money. Years ago people were not as sick. Now there are more diseases. You want to go to the doctor because you are being told prevention is better.

10. *State involvement is a concern (bureaucracy, taxes)*

- With current financial conditions and how it operates the state is not in a position to participate in a publicly funded health care program at any level.
- There is a fear of government involvement.
- In state budgets, it's a matter of priorities. What's more important…education? Healthcare? Things are always going to be weighed against each other.

Appendix A

The State Planning Grant Program and Missouri's Experience

The U.S. Department of Health and Human Services (HHS) is committed to assisting States as they examine their options for expanding health insurance benefits. In the past 4 years, HHS, through the Health Resources and Services Administration (HRSA), has funded 40 states, 1 territory and the District of Columbia to study the uninsured and to develop initiatives for providing access to health insurance coverage to all citizens of the State.

States were expected to use these funds to:

- collect and analyze data to describe the characteristics of their uninsured population;
- develop a plan to provide all uninsured citizens access to insurance meeting quality benchmarks such as the Federal Employees Health Benefit Plan, Medicaid, or state employee benefits through an expanded state, federal and private partnership; and
- report to the Secretary of Health and Human Services on their findings and coverage expansion proposals.

These grantee States have been engaged in designing approaches that provide affordable health insurance benefits similar in scope to the Federal Employees Health Benefit Plan, Medicaid, coverage offered to State employees, or other similar quality benchmarks. They are pursuing a multitude of approaches to this task, developing a wealth of information on their populations, and are producing unique designs appropriate to their State environment.

The State Planning Grant program has three types of funding available for states: the initial Planning Grant, the Limited Continuation Competition Grant, and the Pilot Planning Grant.

The Missouri Department of Health and Senior Services (DHSS) submitted its Planning Grant application in the summer of 2003 and received notification on October 6, 2003 of its award. The award amount was $880,361 over a one-year period. The MDHSS has lead authority in this study and is responsible for filing a written report to the Secretary of HHS office regarding the details of the findings and the state's plan, based on recommendations from the Advisory Council and a decision of the Governor's Office, to increase access to affordable health insurance for Missouri residents.

With this funding, the MPSG completed its first activities of the grant. The aim was to measure and describe the uninsured in Missouri. About 7,000 households were surveyed and asked questions about insurance, accessibility, affordability and health. Focus groups were held with small business employers and consumers. [10] In addition, during this year, a group of key stakeholders, using the data collected, examined a wide range of policy options to increase access to affordable health insurance coverage for Missouri residents. These policy options were used as the basis for discussion during the forums.

[10] Copies of these reports may be found at www.insuremissouri.org.

The Limited Continuation Competition Grant is a mechanism for states that need additional resources to expand upon the activities already initiated with their grant funds (e.g., the original SPG). For example, grantee States could propose activities to gather additional data, update existing data, further analyze data, develop further options, or develop consensus on new options. These grants average approximately $150,000. Missouri received this award in September 2004. With this funding, the MSPG sought the feedback of community members across the state on the issue of the uninsured to help identify solutions and help shape policy. These activities will play an important role in garnering the interest of policy makers to assure success in plan implementation.

The third type is a Pilot Planning Limited Competition Grant to provide funds ($400,000) to support the design and planning for a pilot project to expand health insurance coverage to a significant uninsured population within the State. These grants will also have the potential to be broadly applicable to other states working on expansion options for their uninsured. These grants will support States that have developed consensus on an option or options and wish to plan for a pilot test of such an option. The full commitment of the Executive and Legislative Branch of that State government to such a pilot project will be required for funding. An application for pilot funding was submitted in March 2005.

Appendix B

Approaches One, Two, and Three presented in the Discussion Guide for the Public Deliberation Forums

Approach One: Improve access to employer-based (private) health insurance

Employer-based health insurance is the primary means of coverage for most Missourians. In 2004, nearly 70% of all adults in Missouri had health insurance through their employer. More than 12% of adults were uninsured.

A national poll, conducted in November 2004, found that:

- 75% of the workforce preferred to get health insurance from where they work.
- Employees thought it would be more difficult to get a good price for insurance, find or keep insurance if they got sick, handle administrative issues and find a plan that matched their needs if they had to buy it on their own.

Employers want to offer health insurance because it helps recruit qualified staff, and they see the value in keeping a healthy workforce. However, with the rising cost of health insurance premiums, many are making hard choices – between continuing to offer the benefit and eliminating positions. Decline of employer-sponsored coverage not only affects individual employees, but it also affects the overall health and productivity of the marketplace, the capacity of the health care system and society at large.

What can be done?	What People Might Say
Let small businesses (< 50 employees) purchase an insurance policy through the state health insurance pool.	• More people covered would reduce premiums for everyone. • Partnership between the government and small business is good. • Leverages employer contributions to cover more people. • Increases purchasing power. • May take state resources.
Lower the risk for insurance companies to cover employees in small businesses by using public funds for high cost individuals.	• Lowers premium costs. • Builds on the current system. • State only pays high cost claims.
Expand the definition of dependent to include young adults (18-25) and dependent grandchildren.	• Builds on current system. • Increases the period of health insurance. • Requires no state funds.
Help low-wage workers pay their cost for health insurance (premium assistance).	• Builds on current employer-based system. • Would require use of state funds.
Require businesses to pay a penalty tax if they do not provide health insurance for their employees (pay or play).	• Builds on the current system of employer coverage. • Levels the playing field for business offering and not offering health insurance. • Adds to labor costs for employers who previously did not offer health insurance coverage. Employers may need to reduce staff to cover costs.

Appendix B, continued

Approaches One, Two, and Three presented in the Discussion Guide for the Public Deliberation Forums

Approach Two: Expand government-sponsored health insurance programs

Some people say the state needs to help those with the least means and ability to access affordable health care coverage; find resources within the state to make health insurance affordable for individuals and families with low- and lower-middle incomes; and find resources within the state to make health insurance accessible for those who do not qualify for private or group health coverage and cannot afford to participate in the Missouri High-Risk Pool.

What can be Done?	What People Might Say
Make more people eligible for Medicaid and MC+.	• Raising eligibility for Medicaid would be effective for low-income individuals without coverage. • Would share the cost of coverage with the federal government. • Builds on an existing system. • Requires state funding. • Budget constraints do not support an expansion of public programs. • Those insured through their employer may change to this program. • A stigma exists with Medicaid services.
Sponsor a state-only health insurance program that lower-income and lower-middle income people without health insurance can buy-in to.	• Funding could be through changing how much money is given to hospitals for caring for the uninsured; the more people who are insured, the less charity care/bad debt. • State can design the program the way it wants to. • State could limit enrollment and benefits since there is no federal regulation. • Premium cost for a state-only program is not known. • Not a "right", so funding could be cut at any time. • No federal funding received.
State single payer universal health plan.	• Universal coverage could eliminate cost shifting. • All state residents would be covered. • Lowers administrative costs. • Difficult to implement. • Requires new taxes to replace what employers and employees now pay. • This is an untested approach. • May cause a disruption in the existing health care and insurance system. • May cause the state to have to do without something else.

Appendix B, continued

Approaches One, Two, and Three presented in the Discussion Guide for the Public Deliberation Forum

Approach Three: Is There An Alternative Approach?

What are the best ideas from both that we can weave together?

What key principles and values should serve as the foundation to this other approach?

What trade-offs can you live with?

What would you do?