

*Issues in Missouri Health Care 2009*

Prescription: Policy Options for Covering  
Missouri's Uninsured

## **Acknowledgement**

This is one in a series of issue papers on critical health care issues facing Missouri and the nation prepared by Health Management Associates, Inc., a national health care policy research and consulting firm and made possible by funding from the Missouri Foundation for Health and the Healthcare Foundation of Greater Kansas City. The papers are intended to provide nonpartisan expert analysis in an accessible format that will contribute to the public dialogue on the state of health care in Missouri. Questions should be directed to Thomas McAuliffe, Policy Analyst, Missouri Foundation for Health, 314.345.5574, [tmcauliffe@mffh.org](mailto:tmcauliffe@mffh.org).

## **Issue Statement**

How can Missouri substantially reduce the number of uninsured? What are the major policy options? What can Missouri learn from other states? What are the strengths and limitations of various policy reforms and the tradeoffs involved?

## **Background**

According to the new Census Bureau figures, 45.7 million Americans were uninsured in 2007. Another 25 million are estimated to be “underinsured,” a 60 percent increase since 2003.<sup>1</sup> In Missouri, the number of uninsured jumped from 668,000 in 2006 to 729,000 in 2008, or from 11.7 percent of the population to 12.4 percent.<sup>2</sup> This compares to about 15 percent uninsured nationwide. The increase in the number of uninsured in Missouri can be traced to a decline in employer-sponsored health coverage and reductions in eligibility levels for the Medicaid program. The proportion of the population enrolled in Medicare is higher in Missouri than in the country as a whole, 14 percent versus 12 percent, and roughly the same proportion is in Medicaid (12 percent in Missouri, 13 percent nationwide).<sup>3</sup>

Missouri spends about \$31 billion a year on health care, amounting to roughly 16 percent of the state's total economy. In 2006, premiums for employer-sponsored health coverage averaged \$3,958 for single coverage and \$11,171 for family coverage. These premium levels were slightly below the national averages of \$4,118 for single coverage and \$11,381 for family coverage. Missouri employers pay a slightly higher proportion of the premium for family coverage (77 percent versus 75 percent), but about the same proportion for individual coverage.<sup>4</sup>

The uninsured are mostly a working population, with many in households headed by someone working full-time or part-time for a small company. Nearly two-thirds of uninsured workers are not offered coverage from their employers. The others are about equally divided between those ineligible for their employers' plan (e.g., because they do not work enough hours per week) and those who turn down coverage because they cannot afford their contribution. Large numbers of adults living in poverty are excluded from Medicaid because they do not have dependent children. Others are excluded because of their immigrant status. Many young adults do not get health insurance. People with serious medical conditions are frequently priced out of the private insurance market or turned down when they apply. Policy reforms must address these basic facts about the uninsured.

It is important to understand that Missouri is already paying for the problem of the uninsured. Missourians pay taxes to support safety net programs for the uninsured. Employers and employees face higher premiums because of the uninsured. Of course, the most serious burden of all is borne by the uninsured themselves and their families. The uninsured get only about half the

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<sup>1</sup> C. Schoen et al. “How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007. *Health Affairs Web Exclusive*. Vol. 27, Nos. 3-4. P. w298.

<sup>2</sup> [www.covermissouri.org](http://www.covermissouri.org).

<sup>3</sup> [www.statehealthfacts.org](http://www.statehealthfacts.org).

<sup>4</sup> Ibid.

health care that they need, and they frequently receive late-stage diagnoses of cancer and other life-threatening diseases. Addressing this serious problem is in the interest of all parties involved.

## **Policy Options**

The uninsured are a heterogeneous group, with varying amounts of resources and varying reasons for being uninsured. Policymakers may benefit by trying to match policy tools with various sub-groups of the uninsured. Below is one grouping of target groups and policy measures. Of course, there is overlap among these groups.

<b>Target Groups</b>	<b>Policies</b>
Eligible for public programs or employer-sponsored Insurance (ESI) but not participating	<ul style="list-style-type: none"> <li>• Auto assignment</li> <li>• Single point of entry</li> </ul>
Uninsured young adults	<ul style="list-style-type: none"> <li>• Enforcement of existing law and outreach campaign</li> </ul>
Poor but ineligible for public programs	<ul style="list-style-type: none"> <li>• Limited Medicaid expansion</li> <li>• HSAs</li> </ul>
Eligible for public programs with access to ESI	<ul style="list-style-type: none"> <li>• Premium assistance</li> </ul>
Moderate incomes, ineligible for public programs, and cannot afford private insurance	<ul style="list-style-type: none"> <li>• Reinsurance program</li> <li>• Insurance exchange with subsidies</li> </ul>
Medically uninsurable	<ul style="list-style-type: none"> <li>• Strengthen high-risk pool</li> <li>• Health savings accounts (HSAs)</li> </ul>
Small firms	<ul style="list-style-type: none"> <li>• Premium assistance</li> <li>• Three-share programs</li> <li>• Reinsurance</li> <li>• Purchasing arrangements</li> </ul>
Upper-income uninsured	<ul style="list-style-type: none"> <li>• Individual responsibility</li> </ul>
Non-offering firms	<ul style="list-style-type: none"> <li>• Requirement for offering coverage or assessment</li> </ul>

## **Enrolling Children Eligible for Public Coverage**

Missouri has implemented the State Children's Health Insurance Program (SCHIP), known as MC+ for Kids, that provides insurance for children in families with income up to 300 percent of

poverty through Medicaid. Most families with incomes above 150 percent of the FPL who enroll their children pay premium contributions on a sliding scale basis related to income.

Missouri is challenged to enroll more of the children eligible for but not participating in SCHIP, as is true in most states. An estimated 67 percent of the nation's 9 million uninsured children, or about 6 million kids, are eligible for Medicaid or SCHIP but not participating, and children comprise 20 percent of the uninsured nationally.<sup>5</sup> Roughly another 4.5 million adults are Medicaid-eligible but not enrolled. Thus, close to 25 percent of the uninsured could be in a government insurance program but remain uninsured.

An option that goes beyond the efforts Missouri has already conducted to enroll eligible children involves "auto-enrollment." Under this approach, children participating in federal nutrition programs (e.g., Food Stamps, WIC, or National School Lunch Program) would be presumed eligible for SCHIP (subject to some discrepancies in definitions of eligibility and later verification of income) and would be automatically enrolled unless their parents opt out. By enhancing participation in Medicaid and SCHIP, auto-enrollment would draw new federal funds into Missouri, with that portion associated with new SCHIP enrollment matched at the enhanced federal rate (30 percent greater than the Medicaid matching rate). Missouri did expand presumptive eligibility for MO HealthNet during the 2008 legislative session.<sup>6</sup>

Missouri can also establish linkages between the schools and the health programs so that both public and private schools report information about participation in the School Lunch program to Medicaid to help identify children who might be eligible for either Medicaid or SCHIP.

## **Covering More Young Adults**

Missouri has extended the age that dependent children may remain on their parents' policies to age 25. Yet, there is some question about the extent of compliance with this policy by the insurance community. Missouri could conduct more oversight on how these family policies for young adults are working out in practice. Another step to consider would be to allow Medicaid youth to extend their participation in the program through age 21 if they do not get a job that brings employer-sponsored coverage. A third step is a statewide outreach campaign to acquaint young adults with affordable options in the private market, including limited benefit plans.

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<sup>5</sup> Genevieve Kenney. "The Role of Public Programs in Addressing the Uninsured Problem in the U.S." Health Plan Foundation Leadership Roundtable: Priorities in Children's Health: Access to Health Insurance and Services." March 25, 2008.

<sup>6</sup> The option available to states to extend limited Medicaid coverage (with federal matching payments) to certain groups of individuals from the point a qualified provider determines that the individual's income does not exceed the eligibility threshold until a formal determination of eligibility is made by the state Medicaid agency. The groups to whom states may offer Medicaid coverage during a presumptive eligibility period are pregnant women, children, and women diagnosed with breast or cervical cancer.

## **Expanding Medicaid to Cover Poor Adults**

Missouri reduced its Medicaid coverage for poor parents in 2005, and poor adults without dependent children have not ever been eligible. As a result, many of the poorest residents of the state are without an affordable health coverage option. In fact, while Missouri has among the highest eligibility standards for children, it is one of the states with the lowest eligibility thresholds for adults. Over the past three years, the number of adults enrolled in Medicaid has dropped from 185,000 to 95,000. Most of these adults losing coverage also lack access to job-based coverage and cannot afford to buy health insurance on their own.

Two options could alleviate this problem. First, the drop in adult participation in Medicaid can be traced to the changes in eligibility for parents. Raising eligibility standards to 75 percent of the poverty level for parents would put Missouri in line with the average state in the US and would make an important contribution to reducing the number of uninsured.

A second step involves extending eligibility to childless adults living in poverty. Following the lead of more than a dozen states, Missouri could apply for a waiver to obtain federal matching support to cover poor adults without a dependent child. Covered services could be made affordable through certain limits on the traditional Medicaid benefit package. A well-designed care management plan for the large number of poor childless adults with one or more chronic illnesses would help improve health outcomes and reduce costs.

## **Premium Assistance**

Premium assistance involves state contributions toward health coverage for low-income workers with access to ESI, whereby the state, the employer, and in some cases the employee contribute to the cost. Most states are obtaining federal participation—“Health Insurance Flexibility and Accountability (HIFA) waivers” are the primary vehicle because they provide more flexibility to states on covered services and the cost-effectiveness standard than SCHIP and Medicaid.

State premium assistance programs can be thought of as falling into two categories: (1) “traditional” premium assistance whereby the state pays most or all of the employee’s share of the premium for low-income workers enrolled in public programs who have access to private ESI; and (2) newer initiatives in which the state defines and creates a public-private coverage plan for low-income workers in small businesses without health insurance, and the premium/cost is shared by the state, the employer, and the employee. Rhode Island and New Mexico typify the former model, while Oklahoma and Tennessee illustrate the latter approach.

Missouri may want to pay special attention to the program in Oklahoma—a “three-share” form of premium assistance not limited to people in government programs. Oklahoma developed the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) for firms located in the state with 50 or fewer employees. The firms must contribute at least 25 percent of the

premium and offer one of the plans qualified by the state. Enrollment is not limited to those enrolled in public programs, but employees must have incomes less than 185 percent of the FPL. Employees must be enrolled in an employer's qualified health plan and contribute 15 percent of the premium. When an employer offers coverage and contributes 25 percent of the premium, the state pays the remaining 60 percent for the worker. The state also pays 85 percent of the premium for the worker's spouse, with the worker contributing 15 percent of the cost of this dependent coverage.

## **Reinsurance**

Another option is state-funded reinsurance. The goal of reinsurance is to lower premiums in the private market by having the state subsidize insurers by absorbing a substantial portion of the costs of their highest-cost cases.

Unlike the direct subsidies in premium assistance models, *reinsurance* involves indirect public subsidies. Under the reinsurance model, a state pays insurance claims incurred by a private health plan when they exceed a certain amount or fall within a designated corridor, thereby protecting the private insurer and helping to keep premiums more affordable. One approach, the "Healthy NY" model, has been underway in New York State for several years.

Healthy NY provides an example of how reinsurance can be used to create a new infrastructure for coverage expansion that supports the existing private insurance system. The scope of the program is limited to uninsured, "low-income" small businesses, self-employed, and individuals, which helps to keep the cost down for the state.

New York requires all licensed HMOs to offer a standard, basic insurance package.<sup>7</sup> The state then pays 90 percent of claims that are between \$5,000 and \$75,000 – thereby reducing the HMOs' financial risk. This, along with the waiving of certain state mandated benefits,<sup>8</sup> optional prescription drug coverage, and a closed provider network, enables the HMOs to offer Healthy NY premiums that are lower than typical commercial plans – about half the price for individuals and one-third to half for families. Healthy New York now has nearly 150,000 active members.

## **Strengthening the High-Risk Pool**

Missouri has a high-risk pool called the Missouri Health Insurance Pool, or MHIP, with limited enrollment (about 3,000-4,000). Like many state high-risk pools, MHIP serves only a small fraction of the people who are "medically uninsurable" and cannot find affordable coverage, or any insurance at all, in the individual insurance market. Minnesota and Maryland have been

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<sup>7</sup> Benefits include hospital & physician services, maternity care, preventive services, diabetes management, x-ray & lab, ER services, others; limited prescription drug benefit is optional.

<sup>8</sup> The benefit plan does not include mental health or substance abuse treatment, home health or hospice care, physical therapy, dental or vision care, or chiropractic services.

notable exceptions. The main reasons for disappointing results in other states are: high premiums and deductibles, particularly in relation to median income; limitations on benefits, whether annual or lifetime; limitations on coverage of pre-existing conditions; overall waiting lists to enroll in high-risk pools in some states, likely related to an effort to limit costs to the state; and certain high-risk pools being closed to new applicants at times.

To counter these problems, Missouri could take the following steps, which would require some additional state funds: The premium could be limited to no more than 125 percent of the standard risk-rated coverage. More extensive subsidies could be offered to lower-income individuals. The pool would need to be adequately funded (a problem in many states) to ensure that coverage is sufficiently comprehensive, an adequate number of plans participate, and subsidies are large enough to make coverage affordable. The state could limit required coverage denials to one, and consider limiting pre-existing condition exclusions to six months.

### **Connector Model with Sliding-Scale Subsidies**

A stronger step that goes beyond premium assistance, reinsurance, and high-risk pools is to establish a statewide insurance exchange that offers subsidized coverage—often referred to as a “Connector.” People who are ineligible for public programs could get a choice of plans through the Connector, which would negotiate premiums with health plans. Following the lead of Massachusetts, the Connector could enable people to obtain coverage with pre-tax dollars through Section 125 plans. (Under federal law, when an employer establishes a Section 125 plan, employees can reduce their wages by the amount of their health insurance premium, and that amount is not counted as taxable income for federal or state income taxes or FICA taxes. The entire premium amount is not taxable even if the employer contributes nothing to the premium.)

A sliding scale subsidy would be key to an affordability standard, designed to assure that lower-income people would have cost sharing that they can manage. Individuals without access to ESI, sole proprietors, and employees of small firms could get their coverage through the Connector. (Small companies could opt to take all of their workers into the exchange or continue to provide coverage on their own).

### **Individual Responsibility**

An option that could accompany, or follow, the types of reforms outlined above is a requirement that everyone obtain at least basic insurance coverage. A strong case can be made to delay this “individual responsibility” mandate until eligibility for public programs has been extended to all very low-income people and mechanisms have been put in place to assure affordability for near-poor and moderate-income people. It is unreasonable to require people to obtain insurance if they cannot buy an affordable product. Yet, without such a requirement, younger and healthier people may stay out of insurance markets until they are sick. As a group, they thus incur claims that

exceed the amount they contribute in premiums. This shifts a part of their “fair share” of the insurance costs to others in the insurance pool and keeps premiums higher than they would be if the insurance pool included the full spectrum of risk/health status.

A sequencing or staging of individual responsibility could involve beginning with a requirement that all parents arrange for coverage of their children, with adult mandatory participation deferred for possible later implementation.

## **Employer Responsibility**

Some states are considering adding an employer responsibility component to their insurance reforms. Massachusetts and Vermont have implemented modest requirements on firms not offering health insurance (\$295 and \$365 per worker per year respectively). In Massachusetts there is an additional contribution required of firms whose uninsured workers use safety net services. California came close to enacting a plan with a more substantial requirement in the range of 5 to 6 percent of payroll. Oregon and Wisconsin are reviewing comprehensive reform blueprints that have a mandatory payroll assessment.

Critics contend that an employer requirement would lead to hardship for small firms and to job losses. While the assessment on small firms implemented in Massachusetts in 2006 is modest, it is noteworthy that the proportion of employers offering health coverage rather than paying the small penalty has remained steady, if not edged up slightly, since the new law was put into effect.

## **Implications**

Policy reforms such as premium assistance, reinsurance, and strengthening high-risk pools can help lower-income and medically uninsurable people afford private health insurance. These reforms either help people afford employer-based health coverage or catch them as they fall out of the private health system and provide a place to go for the medically uninsurable. To date, most of these programs have not substantially reduced the number of uninsured. But they have likely arrested or moderated the decline in job-based coverage and helped a small number of people rejected or priced out of the individual market get a kind of “coverage of last resort.”

Missouri could get many more people covered through some combination of qualifying more poor adults for Medicaid, experimenting with automatic enrollment techniques to include more eligible children in SCHIP, and establishing some form of insurance exchange with sliding scale subsidies. This would require new state funds and the establishment of a new purchasing arrangement that links people without access to either public programs or ESI to a choice of health plans meeting minimum benefit requirements.

The political appeal of this set of policies is as follows: (1) they maximize participation among those already eligible for coverage prior to a significant expansion of the role of government; (2) the expansion of Medicaid would be limited to the poor, many of whom are being excluded from coverage today; and (3) for near-poor and moderate income people, the establishment of an exchange coupled with subsidies sized to financial need would help support the private insurance market for people who are not in poverty but need some assistance in making coverage affordable.

Adding individual and employer responsibility components to a reform plan would make it possible to approach or achieve at least near-universal coverage. Yet these requirements would engender more controversy and opposition, as they move the system from purely voluntary participation toward mandatory participation.

In a paper of this scope, it is not possible to spell out in detail the relative advantages and disadvantages of each of these reform possibilities. But it is important to realize that virtually all of the options involve complex details that would have to be carefully thought through before adopting them as policy. For example, many would require changes in the way insurers set premiums in the individual and small-group markets. Moreover, each of these policy options involves difficult tradeoffs related to cost, coverage, equity, compulsion, and level of disruption of the status quo.

At the end of the day, some combination of a strong push on enrollment, new subsidies, and some degree of compulsory participation will be required to substantially reduce the number of uninsured. As a starting point, however, Missouri could consider a few reforms that at least get things moving in the right direction.