Issues in Missouri Health Care 2009

When Basic Benefits Are Not Enough: Caring for Missourians with Chronic Health Care Conditions

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Issue Statement

As states consider options for addressing the challenge of covering a growing number of uninsured people, adults with chronic or disabling conditions are often overlooked in the policy debate. However, this group presents significant challenges to successful reform strategies. They are more expensive to insure. Commercial insurers are reluctant to offer coverage to people at high risk of needing expensive health care and may either deny coverage to individuals or charge a higher rate (to individuals or small groups) to reflect the increased risk, making coverage unaffordable. Chronic health conditions may result in disability that prevents employment – and therefore any access to employer-sponsored coverage.

The debate over health reform to cover the uninsured can often presume that the uninsured are relatively healthy adults who are fully participating in the work force. The focus is often on identifying a low-cost (affordable) benefit package, but such a package may not contain the range or duration of services needed by those with chronic conditions. Public subsidies are typically linked to income, not health status. Failing to recognize and address the complication presented by large numbers of uninsured adults with chronic or disabling conditions can result in a failure of reform strategies, even for lower-cost uninsured individuals. This is because people in poor health may be more likely to participate in reform options than healthy people, which can drive up the cost of these products and further discourage participation by low-risk individuals. Perhaps most importantly, the long term sustainability of any reform strategies requires more effective approaches to managing the cost of care for those with chronic or disabling conditions.

Background

Chronic conditions are common, even among the non-elderly population. In 2000, there were over 33 million working age people with disabilities in the United States (ages 16 to 64).[1] Six million of these were covered by Medicare, and another 1.2 million were estimated to be in the 29 month waiting period between establishing disability and having Medicare coverage begin. Forty percent of those in the Medicare waiting period had

[1] U.S Census Bureau, Disability Status: 2000. Available at http://www.census.gov/prod/2003pubs/c2kbr-17.pdf

Medicaid coverage, but another one third was uninsured.[2] In all, 2.3 million non-aged adults with a disabling condition reported being uninsured.[3]

There were an estimated 465,000 working age adults in Missouri with a disability in 2004, or 13.3 percent of all adults age 18 to 65. Only 21 percent of Missourians with a disability in this age group were employed.[4]

There is a relationship between being uninsured and having a chronic condition. An analysis of the 2003 National Health Interview Survey (NHIS) found that, of the 15.6 million non-elderly adults who are uninsured in the United States, at least 45 percent report one or more chronic health conditions (e.g., diabetes, asthma, chronic heart failure). Uninsured adults with chronic conditions are less likely than those who are insured to receive needed medical care. Thirty-eight percent are without a usual source of care, compared with 5 percent of insured adults with chronic conditions, and almost half of uninsured adults with chronic conditions reported forgoing needed medical care due to cost. Despite this, many uninsured adults with chronic conditions report spending from 5 to 10 percent or more of their family incomes on out-of-pocket medical care.[5]

The Center on an Aging Society at Georgetown University reports that the problem of lack of insurance is particularly focused among older adults. Over half of all adults age 55 to 65 have arthritis, cancer, diabetes, heart disease or hypertension. While two-thirds of this population have private insurance and an additional 22 percent have public insurance (Medicare and/or Medicaid covers those whose chronic conditions have resulted in permanent disability), 12 percent are uninsured. Most of the uninsured group will have Medicare coverage when they turn 65, but, until then, their options for health care coverage are extremely limited. As expected, those with public insurance are the most frail (e.g., report fair or poor health status, have functional limitations or multiple chronic conditions). However, uninsured adults in this age category are significantly less healthy than those with private insurance coverage. They are also the least likely, when compared to privately and publicly insured adults age 55 to 65, to use preventive care and

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[2] Williams, B., Claypool, H., Perry, M., et. al., "Waiting for Medicare: Experiences of Uninsured People With Disabilities in the Two-Year Waiting Period for Medicare," Commonwealth Fund and Christopher Reeve Paralysis Foundation, October 2004.
[3] Ibid.
[4] Missouri Disability Data Table from the 2004 American Community Survey, Estimates for 2004, Centrel for Personal Assistance Services. Available at http://www.pascenter.org/state_based_stats/state_statistocs_2004.php?state=missouri
[5] Uninsured Americans With Chronic Health Conditions: Key Findings from the National Health Interview Survey, prepared for the Robert Wood Johnson Foundation by The Urban Institute and the University of Maryland, Baltimore County, May 2005.

screening services. In this age category, uninsured adults are seven times more likely to go without care than adults with private insurance.[6]

Commercial Insurance: Barriers and Reforms

Nationally, people with disabilities are the least likely to be privately insured. Even people who are not disabled find that having chronic health conditions can impact availability or affordability of health insurance. Medical underwriting, the process by which commercial insurers determine the level of risk associated with an applicant for coverage in the non-group (individual) and small-group markets, is a major reason.

Without specific state regulations to the contrary, commercial insurers in the non-group market (which serves people buying as individuals rather than through their employers) may decide to:

- Deny a policy to someone with unacceptable medical risk.
- Grant coverage but with an exclusionary rider, which temporarily or permanently denies coverage for a specific condition.
- Grant coverage but with a pre-existing condition exclusion (i.e., excluding coverage for any medical condition in existence when the policy takes effect).
- Grant coverage with a higher premium.

In the small-employer market (2 to 50 employees), federal law prohibits insurers from denying coverage to a group or excluding an individual with high risk. But federal law does not prohibit insurers from varying the premium for the entire group based on the risk of the group. The limitations on insurers' ability to risk rate groups are determined by state regulation.

Other strategies employed by commercial insurers also discourage health coverage for people with chronic or disabling conditions. Specifically, insurers can design a benefit package that does not include sufficient coverage of treatment needed for certain conditions; that applies higher cost sharing requirements for certain treatments or services; or that limits access to providers with specialties in certain diseases. As a result of such practices, even those with health coverage may find themselves "under-insured" for needed services.

These underwriting and benefit design practices might represent logical behavior from the perspective of a commercial health insurer that wishes to prevent adverse selection (attracting a disproportionate share of high-risk people) or one that seeks to hold down

[6] The Decade Preceding Medicare Coverage, Center on an Aging Society, Georgetown University, Data Profile Number 11, September 2003.

premiums to attract lower-risk small groups to gain a competitive advantage. However, such practices make it difficult, if not impossible, for those who have the greatest need for coverage to obtain it. Underwriting practices that result in high premiums may cause some employers to not offer coverage, which denies affordable coverage not only to those with chronic conditions but to group members who are not at high risk. These underwriting practices may have even reduced employment opportunities for those with chronic health care conditions because employers know that their premiums will rise if they hire them.

A survey of 11 non-group health insurers conducted by the industry group America's Health Insurance Plans (AHIP) found that in 30 percent of the cases in which people applied as individuals, coverage was denied, offered with exclusions, or offered with higher rates.[7] In 2002, a study by the U.S. General Accounting Office found that people with physical health conditions of "generally moderate severity" were rejected for coverage 30 percent of the time and that people with mental health conditions of "generally moderate severity" were rejected for coverage 52 percent of the time.[8] As a result, public insurance programs like Medicaid and Medicare, and public health programs like those offered through community mental health centers, become the default payer for many people with chronic or disabling health problems.

As noted, federal and state regulatory reforms have limited some underwriting and rating practices. Most states have adopted state-level reforms for both small group and non-group markets to improve the availability and affordability of coverage. For small groups, the focus is often to restrict how rates are set or to limit the rate at which premiums can be increased at renewal. Some states allow small employers to join forces to negotiate for coverage as part of larger groups (e.g., "association plans"). For non-group policies, states have limited when and for how long exclusion riders or pre-existing condition exclusions can be applied and to what extent insurers can adjust rates to reflect health status or medical history of individuals. In a few instances states have required individual-market insurers to offer coverage on a guaranteed issue basis (meaning that coverage cannot be denied based on health status or any other personal characteristic).

Missouri, like other states, has adopted a range of small-group and non-group insurance reforms to address problems of access to affordable coverage. Group health insurers cannot charge more to an individual in the group because of the individual's health conditions, but polices can have waiting periods for new hires before coverage takes effect. For a newly insured group, the insurer can impose up to a 12-month exclusion for

[7] Merlis, M., "Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform," National Health Policy Forum Background Paper, April 13, 2005.
[8] Ibid.

pre-existing conditions, based upon a "look-back" period of no more than six months prior to coverage. The insurer must give credit toward the exclusionary period on pre-existing conditions if the group has had continuous coverage (no break of more than 63 days). Individuals who had group coverage for more than three months are eligible for a conversion policy if they leave the group and do not have access to a new group policy.

Small businesses cannot be turned down or canceled because of health conditions (under federal law). For very small businesses (2 to 25 employees), the state imposes limits on how premiums can be varied to reflect health-related risks, but there are no rating limits imposed for groups larger than 25. Self-employed individuals are not considered "small employer groups" and must buy in the non-group market.

In Missouri, individuals seeking non-group health insurance can still be denied coverage because of their health status, unless the individual is protected by Health Insurance Portability and Accountability Act (HIPAA) status.[9] Exclusion riders can be applied for up to 24 months, and when a claim is filed within the first 24 months of coverage, the insurer is permitted to review the individual's medical history to check for pre-existing conditions. Non-group coverage cannot be cancelled if a person becomes ill after coverage is issued, but there are no limitations on health-related rating.

Missouri operates a high-risk pool, the Missouri Health Insurance Program, which offers subsidized premiums for high-risk people. The program offers a range of coverage options (varying in terms of co-payments and deductibles) and even offers a health savings account option. The pool coverage includes a 12-month pre-existing condition exclusion that is waived for those who involuntarily lost coverage or for those whose premiums were in excess of 300 percent of the standard rate. Rates in the pool are capped at 175 percent of standard rate premiums.[10] Even with these subsidies, pool premiums can easily exceed 10-30 percent of a typical applicant's income (assuming state median income).[11] The Missouri pool remains fairly small, containing between 3,000 and 4,000 individuals.

[9] The federal Health Insurance Portability and Accountability Act (HIPAA) limits restrictions that a group health plan can place on benefits for preexisting conditions. Group health plans may refuse to provide benefits relating to preexisting conditions for a period of 12 months after enrollment in the plan or 18 months in the case of late enrollment. However, individuals may reduce this exclusion period if they had group health plan coverage or health insurance prior to enrolling in the plan. The Act allows individuals to reduce the exclusion period by the amount of time that they had "creditable coverage" prior to enrolling in the plan and after any "significant breaks" in coverage. "Creditable coverage" is defined quite broadly and includes nearly all group and individual health plans.

[10] "The Missouri Health Insurance Pool: Issues for Policymakers," Missouri Foundation for Health, Cover Missouri Project, Report 6, March 2006.

[11] Ibid.

Medicaid's Role in Covering Chronically Ill or Disabled Adults:

In state fiscal year 2007, MO Health Net provided coverage to approximately 77,000 elderly and over 141,000 non-elderly disabled individuals in Missouri, at a total (state and federal) cost of almost $3.3 billion. The average monthly cost of the elderly population was $1,156 per person, while the average monthly cost for the non-elderly disabled population was $1,299 per person. This compares to an average monthly cost of only $342 for an adult with dependent children.[12]

In Missouri, the Aged, Blind or Disabled (ABD) population makes up 26 percent of total enrollment in MO Health Net but accounts for 65 percent of total program spending.[13] MO Health Net experience underscores the reality that a relatively small number of people with chronic and disabling conditions among the uninsured will present significant challenges in terms of offering viable strategies that are affordable, sustainable and meet the complex medical needs of a medically involved group.

As in all states, Missouri's Medicaid program has become the primary insurer of people whose medical conditions result in disability and the inability to work. However, not everyone with chronic health conditions is disabled, and not everyone with a disability lives in a family whose income qualifies under basic Medicaid income standards.

Over time, federal Medicaid policy has evolved to allow states considerable flexibility to expand Medicaid coverage to additional, optional groups with chronic or disabling conditions. For example, states can adopt Medically Needy programs that allow individuals who would qualify for Medicaid except for their income to "spend down" to Medicaid eligibility by subtracting incurred medical expenses from countable income to reach the Medicaid standard. In addition, Congress has enacted specific optional programs to allow states to reach targeted groups, including:

- Breast and Cervical Cancer Program: allow states to extend coverage to women with higher incomes who have been diagnosed with breast or cervical cancer through a federally-funded screening program.
- *Ticket to Work*: allow states to establish a subsidized premium program that allows people with disabling conditions to return to work and "buy-in" to Medicaid coverage.
- *Family Opportunity*: allow states to offer a subsidized premium program that allows higher income families to "buy-in" to Medicaid to obtain coverage for children with high cost medical conditions.

[12] *Medicaid Reform Commission Report*, 2006.
[13] *Missouri Medicaid Basics*, Missouri Foundation for Health, Winter 2008.

Missouri offers coverage through MO Health Net to optional groups of people with chronic or disabling conditions. For example, MO Health Net allows individuals who meet the federal Supplemental Security Income (SSI) disability definition to qualify by spending down their incomes on medical expenses to meet the state's income standard. Also, in 2007, the Missouri Health Improvement Act created a new Ticket to Work program (formerly known as Medicaid Assistance for the Working Disabled) to restore Medicaid eligibility to some persons who would otherwise exceed the state's income standards.

Managing the Cost of Chronic Care

State Medicaid programs understand the impact that providing services to people with chronic and disabling conditions has on program costs and are generally concerned that the growth in enrollment as the nation's population ages will present significant challenges to the ability of states to sustain even current program commitments. States are actively engaged in efforts to adopt more cost effective strategies for managing care for people with chronic and disabling conditions. Some states (including Arizona, Pennsylvania, Ohio, and Washington) now require some or all ABD consumers to enroll in managed care organizations or primary care case management arrangements to receive Medicaid services. Some states (including Florida, Massachusetts, Wisconsin and New Mexico) have begun to provide long term care coverage through managed care arrangements, often pursuing full integration of acute and long term care services in a single managed care arrangement. These states generally are contracting with Medicare Special Needs Plans (SNPs) to encourage integration between Medicaid and Medicare funded services for individuals who are dually eligible.

Many states have turned to disease management strategies to control costs and improve outcomes. Some strategies target managing specific diseases or conditions (e.g., asthma, diabetes, chronic obstructive pulmonary disease or COPD), while others are implementing strategies that provide care coordination for targeted, high-cost individuals across all co-morbid conditions (including mental illness). Both disease management and full-risk managed care strategies can include elements of consumer education and coaching to encourage individuals to take a more informed and active role in self-management of their medical conditions.

Throughout the 1990s, states became actively engaged in managing the cost of the Medicaid pharmaceutical benefit, introducing preferred drug lists, making more effective use of prior authorization, and negotiating supplemental rebates directly with manufacturers. Some states even introduced efforts at counter-detailing to educate prescribing providers regarding more effective drugs.

Most states have pursued reform and rebalancing in the delivery and financing of long term care services and supports, both to better support community integration for people with disabilities but also to achieve a more cost effective delivery system for Medicaid. States have implemented home and community based waiver options that enable people with long term care needs to receive in-home supports rather than moving into higher cost institutional settings. Federal grant funds have been made available to states through programs like Money Follows People to assist states in the development of rebalanced systems.

Several states are actively engaged in exploring ways in which information technology can be used to improve the outcomes and cost of health care. Some states are involved in the development and use of electronic medical records. Other states have introduced electronic prescribing technology to improve information exchange and reduce costs associated with drug errors or drug interactions. States are experimenting with information exchange and with the use of internet-enabled consumer education and self-management support. And several states are introducing automated information and resource systems to assist people seeking long term care services to find appropriate assessment, counseling, and referrals to the full range of services available.

MO Health Net currently requires some populations to enroll in full-risk managed care health plans in 58 counties, with approximately 345,000 enrollees as of June 2007. However, people covered by Medical Assistance (ABD population) are excluded from these arrangements. The Missouri Health Improvement Act of 2007 strongly supported health prevention and promotion as a strategy for overall cost management, providing funding for all Medicaid participants to be enrolled in health improvement plans, have health care homes and receive health risk assessments.

Missouri policy strongly supports prevention of institutional care both to maximize quality of life and program cost containment. MO Health Net offers seven home and community based services waivers to targeted populations to enable individuals to receive long-term care services and supports in their own homes, rather than enter an institutional setting.[14] In addition, the Missouri Health Improvement Act of 2007 provided for development of a long term care partnership program, which encourages individuals to purchase private long term care insurance by offering a level of asset protection if Medicaid coverage eventually becomes necessary.

[14] Section 1915(c) waivers include: Aged and Disabled Waiver, AIDS Waiver, Independent Living Waiver, Physical Disabilities Waiver, MR/DD Community Support Waiver, Missouri Children with Developmental Disabilities Waiver, and Mental Retardation and Developmental Disabilities Comprehensive Waiver.

Missouri has several community-level health information technology initiatives that have the potential to improve chronic disease care management through the use of electronic health records (EHRs) and electronic health information exchange (HIE). Examples include the Kansas City Regional Electronic Exchange, a data broker for sharing EHRs, and the St. Louis Integrated Health Network for safety net providers. Also, the Missouri Department of Health and Senior Services is sponsoring a statewide telemedicine initiative, and the Critical Access Hospital Network is providing statewide technical support for critical access hospitals that want to adopt EHRs and develop electronic HIE.[15]

Policy Options

People with chronic conditions require greater-than-average amounts of care and are thus more expensive to insure. Their inclusion in the risk pool of insured persons raises the average cost, so insurers charge them more or exclude them from coverage when regulations permit such practices. There are a variety of ways to address this problem:

- Limit insurers' ability to deny coverage to high-risk people (already the case for the small-group market) or to charge higher rates based on risk. The disadvantage of these policies is that they raise the cost of coverage for others in the risk pool, which could cause some to drop coverage. Experience shows, in addition, that requiring insurers to provide coverage on a guaranteed-issue basis in the individual market (in the absence of a mandate) is likely to cause that market to deteriorate because it will gain high-risk people and lose low-risk people, causing rates to rise to unsustainable levels. The challenge is to balance the need to make coverage available and affordable for high-risk people with the need to not discourage lower-risk people from buying coverage. A number of states have tried to achieve this balance by prohibiting insurers from using health status as a rating factor, frequently allowing the use of only age and geographic location as a basis for setting premiums.
- Provide special subsidies for high-risk people (i.e., those with chronic conditions) outside of the regular insurance system. A high-risk pool is one example of this approach. The problem in many states has been that the subsidies have been insufficient, so that the coverage is still unaffordable for many high-risk people, or states have capped enrollment in order to stay within their budget for such subsidies thereby excluding people who would otherwise qualify on the basis of need.

[15] *State Solutions Map*, Center for Health Transformation Missouri Project.

- *Expand eligibility for coverage under public programs.* Ultimately, the only way to make coverage affordable for higher-risk people is to provide them with subsidies. One way to do this is through the insurance system, which by its very nature involves having temporarily low-risk people subsidize temporarily high-risk people. The two previous options were examples of this approach. The other approach is to explicitly subsidize care for such people by making them eligible for public coverage programs. This approach is already widely used, but it could be expanded to include more individuals.

Implications for Missouri

Adults with chronic and disabling conditions make up a small but significant share of the uninsured population. It is important for state health reform strategies to recognize the challenges presented by this population. These can include:

- Need for access to more extensive services than contained in some low-cost or "basic" benefit plans.
- Subsidies that may need to reflect higher out-of-pocket costs that create barriers to access for even higher-income individuals with chronic or disabling conditions (i.e., subsidies may need to be tied to health care costs as a percent of income rather than just family income as compared to the poverty level).
- The likelihood that, in voluntary coverage strategies, those with greater health care needs may participate in new coverage offerings in higher percentages than healthier populations, which may result in higher average cost.

It is critical for Missouri to initiate and expand efforts to manage the cost of providing services to MO Health Net consumers with chronic and disabling conditions, first to improve sustainability of the current program and potentially to enable new coverage options that Missouri policymakers might undertake to address the uninsured. Strategies to be considered include:

- Managed care arrangements.
- Disease management strategies that include consumer education and improved self-management.
- Further efforts to enroll people with chronic or disabling conditions in health improvement plans and medical homes.
- Alignment of reimbursement and other financial incentives to encourage more efficient utilization of services and improved health outcomes.
- Adoption of evidence-based practices to improve quality and efficiency of care delivery.
- Accelerating the adoption of electronic health records and electronic health information exchange.