Issues in Missouri Health Care 2011

Uninsured Prescription:
Policy Options for Covering Missouri's Uninsured

Acknowledgement

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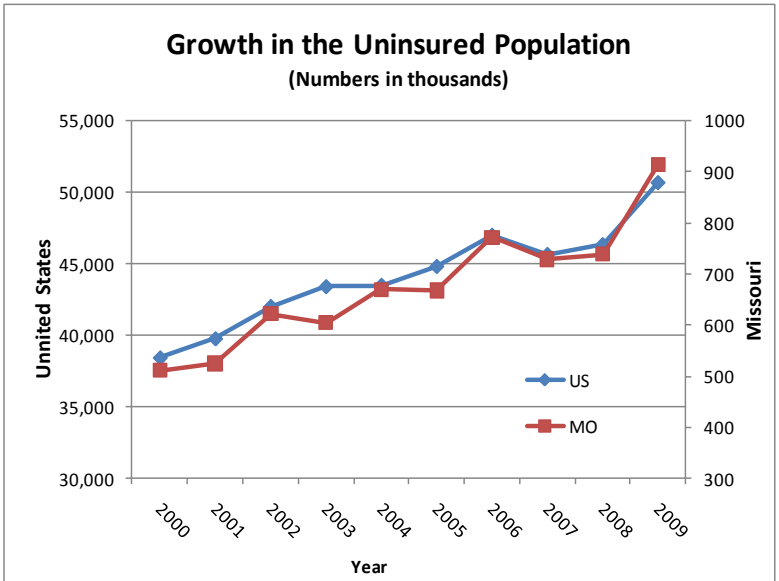
Issue Statement

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Patient Protection and Affordable Care Act (ACA) of 2010 are designed to substantially reduce the number of uninsured Americans. Both pieces of legislation offer funding, financial incentives, and a number of unprecedented policy reforms to increase access to health insurance through the nation's existing system of coverage. This paper provides an overview of ACA's impact on the uninsured and examines their strengths and limitations in the context of Missouri.

Background

The number of Americans without health insurance has continued to grow over the last decade. However, the recent recession, along with lingering high unemployment, has significantly increased the number of uninsured nationwide. According to the latest Census Bureau figures, 50.7 million Americans, or 16.7 percent of the population, were uninsured in 2009.[1] This figure represents an all-time high since the Census Bureau began tracking the statistic in 1987, and is the first year in which the number of people with health insurance actually decreased.[2] Another 25 million Americans were estimated to be "underinsured" in 2007.[3] This figure has likely grown due to the recession. Unfortunately, given the current high national unemployment rate of 9.6 percent, and the eventual loss of unemployment benefits including government funded insurance subsidies for the unemployed, the number of uninsured could remain high in the near future.[4,5]

Figure 1.



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, September 2010.

1 U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, September 2010, Table HIA-4

2 U.S. Census Bureau, "Income, Poverty and Health Insurance Coverage in the United States: 2009 Summary of Findings", September 16, 2010.

3 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. 2008.

4 www.bls.gov

In Missouri, the number of uninsured, again fueled by job losses and the weak economy, jumped from 729,000 in 2007 to 914,000 in 2009, or from 12.4 percent of the population to 15.3 percent. In fact, Missouri experienced a greater increase in the percentage of uninsured between 2008 and 2009 than the nation as a whole. At the same time, the number of Missourians covered by Medicaid, the publicly funded health insurance program for the poor and disabled, increased from 772,000 in 2007 to 891,000 in 2009, a 15 percent increase in enrollment since the recession began in 2007.[6]

Table 1.

Average Premium per Enrolled Employee for Employer Sponsored Health Insurance, 2009		
	MO	**US**
Single Coverage	$4,393	$4,669
Family Coverage	$12,353	$13,027
Employer Share of Premium Cost, 2009		
Single Coverage	77%	80%
Family Coverage	71%	73%
Average Annual Percent Growth in Average Premiums for Employer Sponsored Health Insurance, 2006-2009		
Single Coverage	2.8%	3.3%
Family Coverage	2.6%	3.6%
Source: www.statehealthfacts.org		

While the majority of Missourians with health insurance are covered through their employers, since 2007, both nationally and in Missouri, this number has actually decreased. In Missouri, individuals with employer- sponsored coverage decreased 3 percent, by 93,000, since 2007.[7] While Missouri's average premiums for employer-sponsored coverage are lower than the national average and have grown at a slower rate, Missouri's employers pay a lower proportion of the premium for both family and single coverage when compared to the national average. This means that in a weak economy, employed and insured Missourians pay proportionately more of their wages to purchase health insurance than the national average.

The uninsured population in Missouri consists mostly of working adults, 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 by their employers. The others are about equally divided between those ineligible for their employers' plans (e.g., because they work part-time) and those who turn down coverage because they cannot afford the employee contribution. Large numbers of adults living in poverty are ineligible for Medicaid because they do not have dependent children, and even low-income parents are only covered up to 25 percent of the federal poverty level (FPL).[8] Others are

5 The American Recovery and Reinvestment Act of 2009 established an employer-provided health insurance continuation subsidy for workers who involuntarily lost their jobs between Sept. 1, 2008, and May 31, 2010. A 65% subsidy for COBRA continuation premiums is available for up to 15 months.

6 http://www.census.gov/hhes/www/hlthins/hlthins.html

7 Ibid.

8 www.statehealthfacts.org

excluded because of their immigration status. In terms of young adults, since most are relatively healthy, many choose not to purchase health insurance. In contrast, people with serious medical conditions are frequently priced out of the private insurance market or turned down when they apply for coverage.

The primary barrier to covering the uninsured is cost. However, careful consideration should be given to the fact that Missouri is already paying for the uninsured, both directly and indirectly. Missourians pay taxes to support publicly funded programs such as Medicaid and Medicare. Employers and employees face higher premiums because of the cost the state and communities absorb as a result of providing charity and indigent care. Ultimately, the most serious cost is borne by the uninsured themselves. The uninsured get about half the health care they need, and they frequently receive late-stage diagnoses of cancer and other life-threatening diseases. Delayed treatment can lead to worse outcomes, and adds to the medical bills that burden the uninsured and their families, frequently leaving them in debt. So, increasing coverage of the uninsured offers Missourians the opportunity to better manage health insurance costs and health outcomes on the front end and across the population.

Recently enacted federal legislation, CHIPRA and ACA, offer a number of policy options and tools, along with funding, to help states substantially reduce the number of uninsured and provide individuals and their families with greater security in terms of access to affordable health care and improved quality of life.

Children's Health Insurance Program Reauthorization Act of 2009

Missouri is one of a dozen states with fairly generous income eligibility criteria for low-income children. Through the MO HealthNet program, which includes the state's Medicaid and Children's Health Insurance Program (CHIP), Missouri covers low-income children up to 300 percent of FPL. For enrolled children in families with incomes above 150 percent of FPL, a premium based on a sliding fee scale related to income is required for participation.

Currently, more than 530,000 children are covered by MO HealthNet. A recent study indicates that the program participation rate is close to the national average of 81.8 percent of Medicaid- and CHIP-eligible children.[9,10] The Census Bureau's latest data for Missouri show that in 2009, more than 123,000 children were eligible but not enrolled in MO HealthNet. CHIPRA is designed to help the state enroll these children. CHIPRA provides enhanced federal funding and incentives, new tools to simplify enrollment and member retention, increased outreach efforts, and expanded coverage options.

9 Mo HealthNet Oversight Committee, February 2010 Meeting Presentation http://www.dss.mo.gov/mhd/oversight/pdf/handout2010feb04.pdf

10 G. Kenney et al. "Who and Where are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program". Health Affairs, Vol. 29, No. 10, p. 1925. 2010.

CHIPRA has substantially increased the federal contribution to state CHIP programs. Missouri's federal allotment increased by 58 percent, from $81.9 million to $129.3 million for fiscal year 2009. Additional funding mechanisms to support the program include a contingency fund to provide states with additional money if there is a CHIP funding shortfall; enhanced funding for interpreter and translation services; and a federal bonus payment to those states that implement five of eight enrollment simplification and member retention strategies.

The CHIPRA provisions that provide opportunities to reduce the number of uninsured children in Missouri are described below.

Enrollment Simplification and Member Retention

CHIPRA encourages states to enroll children through an Express Lane Option that takes advantage of the fact that many eligible but unenrolled Medicaid and CHIP children currently participate in other means-tested public programs, such as the Women, Infant and Children's Program (WIC), School Lunch, and Food Stamps. This option permits states to use current income information from these programs to identify and then automatically enroll eligible children, subject to the parents' consent and citizenship verification by the state. These two new options help parents by eliminating time required on multiple program applications and providing quicker access to coverage for their children. To assist in this process, CHIPRA gives states the ability to access relevant federal and state databases, including the National Directory of New Hires to assess income status.[11] States can also verify citizenship by submitting names and social security numbers of individuals declaring citizenship to the Social Security Administration.

Building on the Express Lane and Auto-Enrollment options, CHIPRA makes a bonus payment available to states implementing five of eight simplified enrollment and member retention strategies:

1. Twelve months of continuous coverage before a member must renew eligibility;
2. Elimination or simplification of asset tests;
3. Elimination of the face-to-face interview requirement to initially enroll and at renewal;
4. Use of Medicaid-CHIP joint application and renewal forms and a joint information verification process;
5. Administrative verification at renewal through the use of completed forms or ex parte determinations (i.e., assessment of whether children who are no longer eligible under their current Medicaid categories may be eligible in other Medicaid categories before termination of benefits);
6. Use of presumptive eligibility (i.e., a state option to make a preliminary determination that a child is Medicaid eligible based on the parent's declaration that family income is below the state's income eligibility guidelines. The family has 30 days to submit income verification to the state. During this time, a child can receive medical services through Medicaid);

11 The National Directory of New Hires is a nationwide database of information on all newly hired employees, quarterly wage reports, and unemployment insurance claims.

7. Implementation of CHIPRA's new Express Lane Eligibility Option described above; and
8. Implementation of CHIPRA's new options for Premium Assistance (described in Coverage Options below).

Missouri currently incorporates two of the eight options: the elimination of the face-to-face interview and the use of the joint Medicaid-CHIP application. Missouri partially complies with the elimination or simplification of asset tests, the use of presumptive eligibility, and the option to provide premium assistance.[12]

Outreach Efforts to Enroll More Children

CHIPRA provides $100 million in federal funds, with no state match requirement, for outreach and enrollment in fiscal year 2009 through fiscal year 2013. Approximately $90 million in grant funds is available to state and local governments, Indian Health Services providers and other eligible entities including community-based organizations. Another $10 million is allocated for a national enrollment campaign. This is significant as many states, given tight budgets due to the recession, have drastically reduced or even curtailed funding for outreach and enrollment.

Coverage Options

Under CHIPRA, states have the option to eliminate the five-year waiting period for lawfully residing immigrant children and pregnant women in Medicaid and CHIP. States may also continue coverage of children up to 300 percent of FPL and receive the enhanced CHIP federal match. States have the flexibility to expand income eligibility over 300 percent of FPL, but the federal matching rate drops to the Medicaid level. In Missouri, the federal matching rate is 74 percent for CHIP and 62 percent for Medicaid.[13]

The new law helps states provide premium assistance to Medicaid- and CHIP-eligible children who could be covered through their parents' employer-sponsored insurance. This coverage may be subsidized by Medicaid/CHIP funds if the employer contributes at least 40 percent of the costs and the benefit package is actuarially equivalent to the Medicaid/CHIP benefit package. CHIPRA amends the Employee Retirement Income Security Act so that losing or gaining Medicaid or CHIP coverage is a qualifying event for immediate ESI enrollment. This means that a child may enroll in a parent's employer-based plan without waiting for the annual open enrollment period. In addition, CHIPRA includes a new buy-in option whereby states can establish a purchasing pool for employers with fewer than 250 employees and at least one employee with a CHIP eligible child. The purchasing pool must offer at least two CHIP benchmark products.

CHIPRA also assists families whose income level requires them to pay a monthly premium for their children's participation in MO HealthNet. The law establishes a 30-day premium payment grace period before terminating a child's coverage, and states must provide families with a seven-day notice of termination and their right to appeal.

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12 www.covermissouri.org

13 www.statehealethfacts.org

The Patient Protection and Affordable Care Act of 2010

ACA became law in March 2010, and builds upon many CHIPRA efforts to cover the uninsured. While CHIPRA's focus is health insurance coverage for children, ACA's focus is coverage for most U.S. citizens and legal residents regardless of age or income. Beginning in 2014, ACA mandates that most U.S. citizens and legal residents obtain health insurance, and expands Medicaid coverage to non-Medicare individuals under age 65 up to 133 percent of FPL. ACA is estimated to provide coverage for 32 million more Americans by 2019, and reduce the number of uninsured to 7.3 percent of the population.[14,15]

The primary ACA provisions that impact the uninsured are described below, in order of their effective dates.

Maintenance of Current State Medicaid and CHIP Eligibility Levels, Effective March 2010
In order for states to continue to receive federal Medicaid and CHIP funding, they must maintain their current eligibility levels until 2014 for adults and 2019 for children. This means that states that expanded their eligibility levels above the mandatory federal requirement cannot reduce the levels. For example, Missouri, which currently covers CHIP eligible children up to 300 percent of FPL, cannot reduce the coverage to 200 percent of FPL. This provision protects current Medicaid and CHIP enrollees from losing coverage as states struggle to balance their budgets as a result of the recession.

- *Outreach Efforts to Enroll More Children:* ACA increases the CHIPRA funds for outreach and enrollment of eligible but unenrolled Medicaid and CHIP children from $100 million to $140 million, with no state match requirement. ACA also extends the period in which these funds are available through 2015.
- *Reinsurance, Effective June 2010:* Reinsurance is a temporary federal program that reimburses employers whose group health plan covers retired individuals who do not yet qualify for Medicare. In Missouri, an estimated 82,600 early retirees fall into this category.[16] The Reinsurance Program reimburses employers 80 percent of the individual's annual coverage cost between $15,000 and $90,000.[17] The reimbursement must be used to lower the cost of the employer's overall group health plan and cannot be used as general revenues to the employer. As of September 2010, 32 Missouri employers have received assistance from the program. The Reinsurance Program ends on January 1, 2014, when early retirees and their families will be able to choose from a range of coverage options that will be available in new Health Insurance Exchanges.

14 www.whitehouse.gov/healthcarereform.
15 Sisko, Andrea M., et al. "National Health Spending Projections: the Estimated Impact of reform through 2019." Health Affairs, Vol. 29, No. 10, p. 5. 2010.
16 www.whitehouse.gov/healthcarereform.
17 Ibid.

- *Temporary Federal High-Risk Pool, Effective July 2010*: The Temporary Federal High-Risk Pools provide subsidized premiums for individuals with pre-existing medical conditions who have been uninsured for at least six months. This program expires in January 2014 when insurers are required to cover all individuals with pre-existing conditions.

  Missouri already operates a state high risk pool funded by premiums paid by enrollees and assessments paid by health insurers. In 2008, the state high-risk pool covered about 3,000 individuals at a cost of $27.5 million.[18] Missouri will run the new Temporary Federal High-Risk Pool as a separate program. The state has received $81 million for the new High-Risk Pool Program.

- *Health Plan Benefit Changes, Effective September 2010:*
  - No annual or lifetime limits on essential health benefits;
  - No rescission of coverage after a policyholder becomes sick or injured (except for fraud/ intentional misrepresentation);
  - Coverage of certain preventive health services and immunizations without cost to covered individuals (for non-grandfathered health plans);
  - No discrimination in favor of higher-wage employees (self-insured plans continue to be subject to prior nondiscrimination rules);
  - No pre-existing condition exclusions for enrollees under 19 years of age; and
  - Extension of plan coverage to adult children up to 26 years of age (Missouri already covers adult children through 25 years of age).

- *Small Business Health Insurance Tax Credit, Effective for 2010:* ACA includes provisions to make health insurance more affordable for small businesses. Employers with fewer than 25 full-time employees and average annual salaries of no more than $50,000 are eligible for a federal tax credit to offset as much as 35 percent of the health insurance cost (25% for nonprofits). In Missouri, an estimated 94,300 small businesses could qualify for this tax credit.[19] Additionally, this tax credit increases in 2014 to 50 percent of the health insurance cost (35% for nonprofits).

- *Health Insurance Exchanges, January 2014:* A key component of ACA is the establishment of Health Insurance Exchanges ("Exchanges") to facilitate the selection and purchase of affordable health insurance for the individual and small group markets. The Exchanges serve as a portal to prospective enrollees and members where they can access and compare detailed, consumer–based information on private health insurance options. This is meant to foster competition between plans and ultimately contain or reduce coverage cost. Also, tax credits will be available for individuals and families with incomes between 133 percent and

18 www.statehealthfacts.org
19 www.whitehouse.gov/healthcarereform

400 percent of FPL who purchase coverage through the Exchange, thereby making health insurance more affordable.

ACA establishes two types of insurance exchanges, one for the individual market (American Health Benefit Exchanges) and one for the small-group market (Small Business Health Options Program or SHOP Exchanges). Exchanges can be administered by either the state or federal government or a nonprofit organization designated by the governmental entity. States can also decide to join a regional or interstate Exchange, or establish subsidiary exchanges that serve distinct geographic areas. Beginning in 2017, states can decide to open their Exchanges to large employers (those with more than 100 employees).

ACA also requires the Exchanges to certify that their products comply with federal standards of essential health benefits.

- *Employer Requirements, Effective January 2014:* While ACA does not require employers to offer health insurance coverage to their employees, there are still a number of ACA provisions that impact employers and go into effect in January 2014:
  - Employers who have 50 or more full-time employees and do not offer coverage must pay a penalty of $2,000 per full-time equivalent employee for all full-time employees in excess of 30, even if only one employee receives a government subsidy or purchases coverage through a Health Insurance Exchange.
  - Employers must pay a $3,000 penalty for each employee who opts out of the employer's health insurance coverage because it is unaffordable, meaning the premium exceeds 9.5 percent of family income.
  - Employers must offer plans in which they pay at least 60 percent of the total health insurance plan cost (also referred to as an actuarial value of 60%). Penalties will be assessed if the employer pays less than 60 percent of the plan costs.
  - Employers who do offer coverage must provide a "free choice voucher" to employees who choose to enroll in a Health Insurance Exchange and whose income is less than 400 percent of FPL, and the share of their premium exceeds 8 percent but is less than 9.8 percent of income. The voucher amount must be equal to what the employer would have paid if the employee had chosen the employer's plan. In this instance, employers will not be subject to penalties for their employees' participation in the Exchange.
  - Employers cannot impose insurance waiting periods of more than 90 days.
  - Employers with more than 200 employees must automatically enroll employees in their health plans, although the employee may choose to opt out.
  - Employers must report to the IRS whether they offer employees minimum essential coverage; the length of any waiting period; monthly premium amounts; and the employer's share of cost.

- *Medicaid Expansion, Effective January 2014:* The Medicaid Program will be expanded to cover all non-Medicare individuals under age 65 up to 133 percent of FPL. Currently, states are not required to cover childless adults in Medicaid, so the ACA expansion is a significant step toward covering the uninsured. In Missouri, according to the Kaiser Family Foundation, an estimated 307,872 residents could be covered by 2019 at a cost of $8.4 billion.[20] States are required to share in the cost of the Medicaid expansion; however, for 2014 through 2016, states will receive 100 percent federal funding to pay for the expansion, with the federal share gradually dropping to a 90 percent match by 2020. States also receive a 23 percentage point increase in their CHIP match rate, up to 100 percent, beginning in 2016. Missouri's CHIP match rate will increase to 97 percent. Additionally, states have the option to expand Medicaid eligibility to childless adults before January 2014, but will not receive enhanced funding for this early expansion.
- *Individual Mandate, Effective January 2014:* ACA requires that nearly all individuals and their families obtain health insurance either through an employer, a government program, the new Exchanges, or the individual insurance market. Those individuals who fail to secure coverage must pay a penalty, with exemptions available for people with financial hardship or religious objections, American Indians, those without coverage for three months or less, and those who are Medicaid eligible.

  The Individual Mandate is controversial, and 20 states have filed lawsuits challenging the constitutionality of the provision. Moreover, in August 2010, 71 percent of Missouri voters approved a ballot initiative banning the government from requiring individuals to purchase health insurance. However, the outcome of the lawsuit is uncertain, and appeals are likely; in the meantime, ACA is the law of the land and Missouri needs to prepare for its implementation. Failure to do so would result in the federal government implementing and enforcing ACA provisions.

CHIPRA and ACA – Hurdles to Implementation

CHIPRA and ACA provide generous funding, financial incentives, and unprecedented policy reforms to substantially reduce the number of uninsured. But there are several hurdles associated with their successful implementation. First and foremost is the cost to states and employers.

Missouri, like most states, is faced with huge budget shortfalls and is struggling to come up with the necessary funds to cover current enrollment increases in Medicaid and CHIP. The cost of ACA is of particular concern. ACA requires states to share in the costs of the Medicaid expansion and to contribute to the costs of establishing and operating Health Insurance Exchanges. The Kaiser Family Foundation estimates that the cost for the Missouri Medicaid expansion will range from $8.8 billion to $11 billion between 2014 and 2019. However, the

20 Holahan, J and Headen, I. "Medicaid Coverage and Spending in Health Care Reform: National and State-by-State results for Adults at or Below 133% FPL." Prepared by the Urban Institute for the Kaiser Family Foundation, May 2010.

federal government covers most of the cost, with Missouri's share estimated to be between $431 million and $773 million, or 4 percent to 7 percent of the total between 2014 and 2019.[21]

ACA also provides federal grants to assist states in planning and implementing the Health Insurance Exchanges and Medicaid Expansion. On September 30th, 2010, the federal Department of Health and Human Services announced $49 million in grants to help states plan for the establishment of the Health Insurance Exchanges. Missouri, like most states, received a grant of $1 million to conduct the research and planning necessary to establish the Exchange. Future funding will be available to support development and implementation activities that states will undertake through 2014.

Employers are concerned that ACA will increase their health insurance premiums, especially in the short-term, as health plans remove lifetime limits, eliminate coverage rescissions, eliminate pre-existing condition exclusions for children under age 19, and extend coverage to adult children up to age 26. In Missouri, employers cover children through age 25, so the latter provision will not significantly affect premiums. Employers contend that they will have to pass increased premium costs onto their employees, offset increased costs with benefit reductions, or pass on the cost to consumers. But effective in 2010, the ACA provides tax credits to small businesses to offset as much as 35 percent of health insurance costs. In Missouri, an estimated 94,300 small businesses could benefit from this tax credit.[22]

Conclusion

Overall, CHIPRA and ACA offer unprecedented opportunities to cover the uninsured. In the case of CHIPRA, more than 4 million children nationwide and 123,000 in Missouri could gain coverage.[23] In the case of ACA, about 32 million Americans and more than 500,000 Missourians could gain coverage.[24,25] This substantial increase in insurance coverage benefits individuals and families by providing greater economic security. Affordable health care will be available when Americans need it without concern about pre-existing conditions, coverage rescissions, lifetime limits, or waiting periods that all could result in huge medical debt.

21 http://oa.mo.gov/bp/pdffiles/aug2010budupdate.pdf
22 www.whiltehouse.gov/healthcarereform
23 www.census.gov/hhes/www/hlthins/hlthins.html
24 www.cbo.gov
25 The estimate of the number of uninsured Missourians covered by ACA was not available, so the CBO estimate of the percent of uninsured gaining coverage due to ACA was applied to the 2009 Census Bureau estimate of the uninsured in Missouri.