

INSURE MISSOURI: EARLY OBSERVATIONS

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On September 18, 2007, the Governor announced a new health care initiative called “Insure Missouri.” The three-phase program would expand health coverage to uninsured low-income Missourians, including many of those who lost coverage from the 2005 Medicaid cuts and previous reductions in coverage. The proposal includes several categories of coverage expansions. The State estimates that this program will cover almost 190,000 uninsured Missourians if and when it is fully implemented in 2012. More than 130,000 of these individuals would be enrolled by the end of fiscal year 2009, assuming that the program is authorized by the General Assembly and the federal government. This paper reviews some of the key aspects of the proposal based on what is known about the initiative at this point and reviews some of the key questions regarding the new plan. Additional details should emerge over the coming weeks and months.¹

In addition to offering a description of the Insure Missouri initiative and its financing mechanisms, this paper raises questions in several key areas, including the eligibility requirements for the new program, the benefits package, the out-of-pocket costs to participants, legislative and federal authority for the new initiative, federal waivers and related financing arrangements, and service delivery mechanisms. In the months ahead, the answers to these and other questions will help policymakers and the public to better understand the new program and its potential impact in covering Missouri’s low-income uninsured population.

1. Who would be covered by the “Insure Missouri” initiative?

The Governor’s plan proposes to expand access to health insurance in three distinct phases:

- **Phase One:** The first phase would expand coverage to low-income working parents and caretakers with incomes at or below 100% of the federal poverty level. This expansion is projected to cover 54,531 new individuals in this group in 2008.² As discussed below, it appears that Phase 1 would cover just over half of the low-income parents and caretakers that were previously covered by the Missouri Medicaid program.
- **Phase Two:** The second phase would expand coverage to working parents, caretakers, and childless adults up to 185% of the federal poverty level. This expansion is estimated to cover 48,836 additional low-income individuals in fiscal year 2009.³ The Department estimates that 107,192 individuals in this group will be enrolled by 2012.⁴ This group would be phased in incrementally according to their income level (e.g., 120%, 130% of poverty) but enrollment in this group could be capped if enrollment exceeds projections or available funding is insufficient.⁵
- **Phase Three:** The third phase would provide assistance to small businesses that provide health insurance for their employees. While the details of this component

are not developed, the proposal could potentially enable the State to provide either “reinsurance” or premium assistance to small businesses for coverage of their employees. The State estimates that 28,064 individuals will participate in this phase of the program, which would begin in January 2009.⁶

The total number of individuals covered is projected to be 189,787 Missourians when *all three* phases are fully implemented in 2012.⁷

Table 1: Estimated Total Enrollment in Insure Missouri (by fiscal year)⁸

Phase	2008	2009	2010	2011	2012
One	54,531	54,531	54,531	54,531	54,531
Two	0	48,836	66,497	84,157	107,192
Three	0	28,064	28,064	28,064	28,064
All Phases	54,531	131,431	149,092	166,752	189,787

2. How would the State finance the program?

The overall projected cost of the program to the state and federal governments (including all funding sources) is projected to be \$51.6 million in 2008, rising to \$980.7 million in 2012 (*including* the portion that is paid by individuals and employers).⁹ The State would use a combination of funding streams, including general revenue, provider taxes, disproportionate share hospital (DSH) payments, cost-sharing payments (e.g., premiums), and federal matching funds to fund the expansion of health coverage under Insure Missouri. In particular, the proposal takes advantage of the Missouri Medicaid/MO HealthNet program’s unique funding structure, under which a substantial portion of state matching funds (“state match”) that support Medicaid comes from provider taxes, in particular the federal reimbursement allowance (FRA) paid by Missouri hospitals.¹⁰

States draw down federal matching funds when they spend state dollars on the federal Medicaid program, now called MO HealthNet in Missouri. For many years, Missouri’s “state match” has included additional funding streams besides state general revenue dollars, and the percentage of the program that is funded by general revenue has declined significantly over time. The federal reimbursement allowance (FRA) or hospital provider tax is a key source of state matching funds for Medicaid spending in Missouri.¹¹ Funding for Insure Missouri would include the following sources:

- **Federal Reimbursement Allowance:** The bulk of the “state match” for the new program comes from the FRA or “provider tax” on hospitals. The “Insure Missouri” plan would rely on continued *growth* in hospital revenues, on which the state’s provider tax is based, to finance a substantial portion of the funding for the

program. While no FRA funding would be used to fund Phase One in FY 2008, \$71.4 million would be used in FY 2009, steadily increasing to \$189.1 million in FY 2012.¹² The FRA draws down federal matching funds.

- **DSH Transfer:** The State would also rely heavily on a transfer of “Disproportionate Share Hospital” (DSH) dollars that are now used to finance the cost of “uncompensated” care (i.e., health care that is not financed by public or private health insurance) to expenditures on direct health insurance coverage of individuals under the Insure Missouri initiative.¹³ DSH funds compensate hospitals for the costs of treating uninsured patients. The transfer of funds from spending on DSH to expenditures on health *coverage* is based on the idea that safety net providers’ costs of treating the uninsured would be reduced because more people would have insurance, and the providers would be compensated by receiving insurance payments, instead of DSH dollars, for the health care services they provide. It is important, however, that sufficient DSH dollars remain in the system to cover the costs of treating the uninsured whose health care costs are not *fully* covered by the new Insure Missouri coverage initiative. The State would initially transfer \$41.7 million in state DSH dollars in FY 2009, increasing that amount to \$60.2 million in FY 2012. These state dollars draw federal matching funds.¹⁴ While this plan represents a significant transfer of uncompensated care dollars, it appears that substantial sums will continue to be allocated to DSH funding to address the remaining uninsured and underinsured.¹⁵
- **State General Revenue:** The General Revenue commitment is approximately \$19.5 million dollars for the remaining months of the first year of the program, increasing to \$46.8 million annually by FY 2012.¹⁶ These state general revenue dollars would draw down federal matching funds.
- **Premiums paid by employers and employees:** The State proposes to charge premiums to employees in some categories of the Insure Missouri program and will also require employers in the “small business” component to pay a share of the premiums. In contrast to the other funding sources, the State cannot receive federal matching funds based on the premiums charged to Insure Missouri participants or employers. The State estimates that \$19.5 million in premiums will be paid by employees in FY 2009, increasing over time to \$98.5 million in 2012.¹⁷ Similarly, the State estimates that \$19.5 million in premiums will be paid by employers in FY 2009, increasing over time to \$98.5 million in 2012.¹⁸

Table 2: Estimated Cost Per Year for Insure Missouri¹⁹

Source of Funds	2008	2009	2010	2011	2012
General Revenue	\$19.5 million	\$43 million	\$46.8 million	\$46.8 million	\$48.6 million
Federal Matching Funds	\$32.1 million	\$257 million	\$320.1 million	\$391.6 million	\$487.6 million
Federal Reimbursement Allowance	\$0	\$71.4 million	\$100.3 million	\$138.1 million	\$189.1 million
Disproportionate Share Transfers	\$0	\$41.7 million	\$47.3 million	\$52.9 million	\$60.2 million
Employer-paid premiums	\$0	\$19.5 million	\$42.2 million	\$91.2 million	\$98.5 million
Employee-paid Premiums	\$0	\$19.5 million	\$42.2 million	\$91.2 million	\$98.5 million
All Funds Combined	\$51.6 million	\$452.1 million	\$598.9 million	\$811.8 million	\$980.7 million

3. What kind of legislative authority is needed to implement Insure Missouri?

House Bill 11, which is the budget legislation for the Missouri Department of Social Services, provides appropriations authority for Missouri to develop a program for uninsured adults initially covering individuals with incomes up to 100% of the federal poverty level.²⁰ To continue the program beyond this fiscal year, the State will need to obtain ongoing legislative authority to fund this program.

Additional legislative authority will be required to implement phases 2 and 3 of Insure Missouri, i.e., the expansion to additional working adults and the program to assist small businesses with the cost of their premiums. It is not clear whether substantive legislation (as opposed to appropriations legislation) will be proposed to authorize subsequent components of the proposal.²¹

4. How would health care services be provided under Insure Missouri?

The State is requesting bids from private insurers to provide coverage to individuals covered by Insure Missouri. These plans will receive “capitated” payments to provide the health care services required under their contracts with the State. Many of the same managed care plans that serve current MO HealthNet beneficiaries could well bid to provide care to the Insure Missouri group, along with additional private insurers. However, the potential bidders will not be limited to health maintenance organizations, but may include preferred provider organizations (PPOs) and indemnity plans. It is not clear whether there will be sufficient numbers of insurance carriers to ensure that health care is provided to individuals who reside in the many (primarily rural) Missouri counties that do not have managed care for current MO HealthNet participants.²² The State may need to ensure that there is a state-administered fee-for-service option for counties, especially in rural areas, in which there are insufficient bids from managed care plans and other insurers so that the program is actually available on a statewide basis.

5. Is Federal Approval Required?

The State must obtain federal approval to implement the new Insure Missouri program. The State can seek to obtain federal approval by amending its State Medicaid Plan, requesting a waiver, or using a combination of these two methods.

A. State Plan Amendment

Under federal law, the State must obtain federal approval to amend its State Medicaid Plan to expand coverage under the Insure Missouri program. State Plan Amendments must be approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicaid program. The fact that Missouri has changed the name of its Medicaid program to “MO HealthNet” has no bearing on the legal requirements governing the receipt of federal matching funds under Title XIX of the Social Security Act. States still must amend their State Plans to include these types of eligibility changes, subject to approval by CMS.

Missouri will need to file a State Plan Amendment to expand coverage to low-income working parents under 100% of the federal poverty level. **The State does not need a waiver to expand coverage to this group.** Federal law *allows* states to expand eligibility by using less restrictive income methodologies than are currently employed in Missouri. The State can also use options under the Deficit Reduction Act of 2005 to provide a modified or reduced benefits package to the low-income parents who would be covered under Phase I of the plan. The State also does not need to secure a federal waiver to provide coverage to low-income parents at income levels *higher* than 100% of the federal poverty level because federal rules allow states to expand coverage in this manner by changing their income-counting methodologies. The State could, however, choose to seek a waiver to cover some of these higher income parents because of other program design decisions that may deviate from current federal requirements.²³ Nevertheless, the State could achieve these expansions of parent coverage by filing a State Plan Amendment.

B. Waivers

The State would need to file a waiver to implement those provisions of the Insure Missouri plan that *deviate* from federal Medicaid law. Waivers are required to allow the State to vary program rules -- for example, to cover non-traditional Medicaid eligibility groups or to limit enrollment. The State *would* need a waiver to provide Medicaid-funded coverage to childless adults because this group is not a traditional Medicaid eligibility group under federal law.²⁴ It is also likely that the State would need additional waiver authority if it chooses to use federal Medicaid funds to provide assistance to small businesses in Phase 3. Finally, the State would need a waiver if it seeks to implement “caps” on enrollment or otherwise limit participation in the program. The current RFP indicates that there could be “enrollment caps” in Phase 2 of the program – the expansion of coverage to parents, caretakers, and childless adults up to 185% of the federal poverty level.²⁵

6. Are there any concerns with using waivers to expand coverage?

If the State seeks to vary federal Medicaid requirements (for example, to use federal Medicaid funds to cover childless adults), then it will need what is referred to as a Section 1115 Medicaid waiver. Section 1115 is the section of the federal Social Security Act that authorizes states to seek waivers of the federal laws governing the Medicaid program.

Financing under Section 1115 waivers is very different than regular Medicaid financing rules. Under regular Medicaid financing rules, the federal government is obligated to share in paying for a state’s Medicaid costs at the prescribed matching rate, whatever those costs turn out to be.²⁶ There is no cap or ceiling on the amount of federal funding that states can claim, as long as the claims are for legitimate Medicaid expenditures.²⁷ If costs rise for any reason (such as an economic downturn or increases in the costs of prescription drugs), federal funding levels automatically respond.²⁸

However, when a state obtains a Section 1115 waiver, the Centers for Medicare and Medicaid Services (CMS) does not allow the state to receive any more federal funds than it would have received in the absence of the waiver. Rather, the federal government *limits* the amount of funds it will provide as a way to protect itself from incurring additional costs as a result of the waiver.²⁹ This requirement is called “budget neutrality.”³⁰ Thus, the State of Missouri would not receive any *additional* federal funding to pay for covering the additional individuals, and if the State exceeds projected costs, it must absorb the cost of any increased expenditures beyond those agreed to under the budget neutrality agreement. In other words, the State would have to shoulder the burden of any unexpected increases in health care costs, paying 100% of these increases instead of the 38% for which Missouri is now responsible.³¹ The waiver will likely require a per capita (or per person) cap on the amount of federal funds that will be paid to Missouri over the course of the waiver.³²

Therefore, if Missouri seeks to use a waiver to implement an expansion that it could not have accomplished without a waiver (such as covering childless adults in Phase 2), it must find offsetting *federal* savings or redirect federal funds that are being used for another purpose to cover the newly eligible population.³³ It is likely that the State would attempt to meet these “budget neutrality” requirements by redirecting the DSH funds that it would normally spend *without* a waiver to fund direct health care coverage of the expanded group of low-income individuals under the Insure Missouri initiative.³⁴ In this instance, the projected federal expenditures on the Missouri Medicaid program, including the Insure Missouri component, must not exceed the projected federal expenditures *without* the expansion, including the costs of projected expenditures on DSH. If the State’s actual expenditures exceed the “budget neutrality” projections (for example, if health care expenditures rise faster than expected, as they have in the past due to unexpected increases in the costs of prescription drugs), it is possible that the State could choose to cut *existing* coverage or services to meet the requirements of its budget neutrality agreement with CMS and/or limit enrollment in the Insure Missouri expansion.

Because of the significant fiscal impact waivers can have on existing beneficiaries, providers and the state budget, **these “financing” arrangements should be addressed clearly and publicly in order for policymakers and the public to ascertain the full impact of the proposal.**³⁵ Again, the expansion of coverage to low-income parents through a State Plan Amendment does *not* require a waiver and would therefore *not* be subject to budget neutrality requirements.

In addition to the financial arrangements, negotiations with CMS will likely also address the program design of the Insure Missouri initiative. Because the federal government must approve any waivers to implement the program, CMS has some leverage to advocate for its own policy priorities, which could potentially have an impact on the type of program ultimately adopted. Like the financing arrangements, these program design issues should also be subject to full public disclosure before the program is implemented.

7. What is the Benefits Package?

The State has indicated that it will provide a reduced benefits package under Insure Missouri, as compared to the regular MO HealthNet benefits package. The Request-for-Proposals (RFP) to provide services under Phase 1 (released on October 5, 2007) indicates the covered services that private insurers will be expected to provide to the first group of low-income working parents covered by Insure Missouri.

It appears that Phase 1 of the program will provide a majority of the current MO HealthNet-covered services, including: prescription drugs; emergency services; physician and advanced practice nurse services; in-patient and outpatient hospital services; laboratory, radiology and other diagnostic services; emergency transportation; home health services; durable medical equipment; mental health and substance abuse services; family planning services; personal care services; hospice services; federal qualified health center (FQHC) services; services provided by local public health agencies; and transplant services.³⁶

It does not appear that the program will cover maternity care, home and community-based services, Comprehensive Substance Abuse Treatment (C-Star), podiatry services, community psychiatric rehabilitation services, non-emergency medical transportation, or EPSDT services (for parents under age 21).³⁷ Individuals enrolled in Insure Missouri who need maternity care would be transferred to the Medicaid for Pregnant Women category of MO HealthNet, which covers pregnant women up to 185% of the federal poverty level.³⁸ Because pregnant women would be disenrolled from the Insure Missouri program, the State will need to ensure a seamless transition to MO HealthNet so as not to interrupt the continuity of care.³⁹

The program also will not include dental care, vision services and hearing aids which were provided under the Missouri Medicaid program before the 2005 legislative changes.⁴⁰ It also appears that the program will not cover the limited amount of vision and dental services that the MO HealthNet program *now* provides (such as one eye exam and one pair of eyeglasses every two years and dental services related to trauma and disease).

Insurance carriers may offer additional health care services besides the ones that are required by the State. However, the cost of these additional services will not be included in the payments that the State will pay the health plans and other insurers.⁴¹

*It is not known whether Insure Missouri participants in the later phases will receive the same benefits package as low-income parents covered in Phase 1, although the Department of Social Services appears to envision that the same package will be provided to all participants.*⁴² The benefits package could be an issue that the legislature examines, especially with regard to the subsequent phases of the program. It will be important to maintain a comprehensive benefits package for all of the low-income Missourians who qualify for Insure Missouri because these individuals simply will not have sufficient incomes to pay for non-covered services “out-of-pocket” and would be likely to forgo treatment for services that are not covered.

In addition, it will be important for the program to provide comprehensive coverage to uninsured Missourians, rather than leaving critical health services uncovered, because of the proposed reduction in DSH funds *now* used to fund hospitals that provide uncompensated care. If there are major gaps in coverage, then the program will not be as effective in reducing the amount of uncompensated care, and there may be insufficient DSH funds to pay for the costs of care for people who are under-insured as well as those who are still uninsured.

8. Would Insure Missouri Restore the 2005 Medicaid cuts?

A. Low-Income Parents and Caretakers

The Insure Missouri plan would cover some of the same categories of individuals who lost coverage in 2005 and prior years. As indicated above, the program would initially

provide coverage to approximately 54,500 working parents and caretakers with incomes up to 100% of the federal poverty level. These individuals would receive a more limited benefits package than they received under the Missouri Medicaid program prior to July 2005.

Until July 2002, Missouri provided Medicaid coverage to working parents and caretakers with incomes up to 100% of the federal poverty level. This coverage was substantially reduced from 2002 through 2005.⁴³ In the 2005 legislative session, Missouri reduced eligibility from 75% of the federal poverty level to the income limits of the current Temporary Assistance (formerly AFDC) program, which currently range from 16% to 21% of the federal poverty level and are not adjusted for inflation. For example, the income limit for a family of three is \$292 per month each year, *regardless* of any increases in the federal poverty level. The 2005 eligibility reductions alone caused more than 70,000 low-income parents and caretakers to lose health coverage, while about 100,000 parents lost coverage since 2002. See Table 3.

It appears that not all parents, or even all *working* parents, who lost coverage in previous legislative sessions would have their health coverage restored by Insure Missouri. While the precise income eligibility requirements for Insure Missouri are not yet available, the Department's enrollment estimates and preliminary discussions suggest that Phase 1 of the program will not cover all working families under the poverty level and would reach just over half of the low-income parents who lost coverage in the last four years. See Table 3.

It does not appear that Phase 1 of the program will raise the income limit from current levels to 100% of the federal poverty level. Rather, the program will likely expand coverage by "disregarding" a certain amount of earnings in determining the family's eligibility. It appears, however, that this program will not *necessarily* apply that same disregard to other sources of income such as child support or Social Security Disability benefits, even though that unearned income can also cause a family to exceed the very low income eligibility limits of the current MO HealthNet program.⁴⁴ Therefore, families with some earnings but enough child support or Social Security benefits to take them over the *current* program's low-income eligibility limits may not be eligible for the Insure Missouri program. See Appendix, Example 2. This method of expanding coverage is very different from simply raising the income eligibility limits to 100% of the federal poverty level, an approach that would treat families with all types of income in the same way.

Given that there are working families with child support and other income sources who are *just as poor as those families who have only earnings*, it will be important for the State to use eligibility criteria that allow families with these other income sources to be eligible for the program if their total income is under the federal poverty level.

If Phase 2 of the proposal is fully implemented, it will go well beyond the 2005 Medicaid eligibility levels and cover parents and childless adults who have not been covered previously by the Missouri Medicaid program. Without further details, it is not clear

whether Phase 2 would cover any of the very low-income parents who are ineligible for Phase 1 because of child support or other unearned income. As indicated earlier, the State may in fact cap enrollment in Phase 2 if there is insufficient funding or if enrollment exceeds the State's projections.

B. Other Groups

The Insure Missouri plan would not restore coverage for *seniors and people with disabilities* who lost coverage under 2005 legislation or reduce the out-of-pocket health care costs of seniors and people with disabilities who were affected by the 2005 cuts. While eligibility for working parents could climb as high as 185% of the poverty level, the eligibility limit for seniors and people with disabilities would remain at 85% of the federal poverty level.

The proposal does not make any changes to *children's* eligibility for MO HealthNet coverage, although some modifications were enacted this year to address restrictions that caused children to lose coverage as a result of the 2005 cuts. However, based on the prior experiences in Missouri and other states, it is very likely that additional *eligible* children would come onto the program as their parents' coverage is reinstated.⁴⁵ A number of studies have demonstrated that "one of the most effective ways to improve participation in publicly funded health programs by *eligible* low-income children is to provide health coverage to their parents as well."⁴⁶ Indeed, covering more parents is one of the more effective ways that Missouri can reach those uninsured children who are already eligible for Medicaid or SCHIP.

The Insure Missouri plan also does not address cuts in Medicaid services to persons who meet the MO HealthNet eligibility requirements, although durable medical equipment coverage was restored in 2007 as part of Senate Bill 577.

Table 3: Changes to Medicaid Coverage of Working Parents and Caretakers in Missouri: 2002 to 2008 ⁴⁷

DATE	ELIGIBILITY CHANGE	PERSONS AFFECTED (from DSS data)
July 2002	Income eligibility Revised from 100% of poverty to 77% of Poverty	24,987 lose coverage
July 2004	Income Eligibility Lowered to 75% of Federal Poverty Level	1,511 lose coverage
July 2005	Income Eligibility Lowered to 1996 AFDC limits (\$292 per month for a family of three, no adjustment for inflation)	74,138 lose coverage
February 2008 (Insure Missouri: Phase 1)	Income Eligibility Limits unchanged but working parents would be eligible up to 100% of the poverty level, most likely through an “earned income” disregard.	54,531 would gain coverage

9. What will participants have to pay “out-of-pocket?”

It appears that the low-income parents who are covered in the first phase of the program would only be subject to the nominal cost-sharing allowed under federal Medicaid law (\$.50 to \$3.00 per service) and will not be charged a premium for their participation.⁴⁸ State officials indicate that premiums of up to 5% of family income will be imposed on higher-income families in Phase 2 of the program.⁴⁹

The State’s determinations regarding premiums will have a significant impact on whether projected enrollment is realized. Research examining the impact of premiums in public health insurance programs has found that participation falls off sharply as the premium amount increases.⁵⁰ Low-income people who are struggling to pay for housing, utilities, food, transportation, child care, and other expenses have very limited financial ability to pay for health insurance premiums and other “out-of-pocket” costs for their health care.⁵¹

To maximize the participation in the program, it is important that no premiums be charged to individuals under the poverty level, including the low-income childless adults that would be covered under Phase 2. Even if the State chooses to charge up to 5% for the highest income groups, any premiums for individuals at or near the poverty level should be very minimal so as to ensure that individuals sign up for the program. The State should also be mindful of the administrative costs involved in collecting premiums

and terminating assistance for people who fail to make their premium payments in a timely manner. Indeed, some states have abandoned policies that imposed premiums because the administrative costs of collection outweighed the benefits of imposing premiums, and because of the adverse impact of premiums on participation in the program.⁵²

Similarly, it is important that co-payments and other out-of-pocket expenses be limited because they would cause low-income participants to forego necessary health care services for which they cannot afford to pay. Research shows that increasing co-payments on Medicaid beneficiaries reduces their access to health care.⁵³ This effect on access is especially true for individuals with chronic health problems who need more health treatment and could be subject to a co-payment for each visit or service needed.⁵⁴ Therefore, it will be important for the State to maintain the initial plan to limit co-payments to the nominal amounts that are allowed under federal Medicaid law.

10. How would people apply for Insure Missouri coverage?

Thus far, state officials have indicated that applicants will be able to apply on the internet, at Family Support Division offices, and possibly at hospitals and federally qualified health clinics.⁵⁵ Parents with children already receiving MO HealthNet coverage would receive letters informing them about the Insure Missouri program and will be informed about how to apply. It is not clear whether these individuals will be able to file an application in the mail or by fax. However, the more avenues that are available to apply, the more likely it is that enrollment projections will be achieved. Because many low-income people simply do not have access to the internet, it will be crucial for potential applicants to have additional ways to apply for the program.

11. How would the program for small businesses work?

The Governor has proposed to cover a portion of the uninsured by providing financial assistance to small businesses with 25 or fewer employees that choose to provide coverage for their employees. While this proposal is still being developed, it is possible that the State would seek to use Medicaid funds to provide “reinsurance” or to otherwise help subsidize the cost of health insurance premiums for employees of small businesses.⁵⁶ A “reinsurance” program would provide state-funded “catastrophic coverage” that lowers the cost of premiums for small employers providing health insurance to their employees.⁵⁷ In this model, the State could subsidize the small employer’s purchase of insurance by reinsuring their insurers’ high-cost claims with public funds.⁵⁸

In contrast, a premium assistance program would use state and federal Medicaid funds to subsidize part of the cost of employer-sponsored coverage for employees of small employers, with employers and employees paying part of the costs of these insurance premiums. Researchers have found that subsidies to employers have not proven to be efficient in increasing coverage, even if targeted to small employers.⁵⁹ Such subsidies “are difficult to target efficiently and they provide subsidies to employers who are often not well equipped to efficiently purchase insurance products.”⁶⁰ Moreover, the evidence

suggests that even generous employer subsidies directed at small firms will not have much effect on employers' decisions about whether to offer health insurance coverage.⁶¹ In fact, states that have implemented premium assistance programs for small business have not had the large impact that was anticipated.⁶²

Depending on the details, a program that provides assistance to small businesses could potentially have a positive impact in increasing access to health insurance for the employees working for businesses that take advantage of the proposal. While the bulk of the projected impact on the uninsured is from the full implementation of Phases 1 and 2 of the Insure Missouri Initiative, the Department projects that 28,064 uninsured individuals would receive health coverage through the "small business" component of Insure Missouri.⁶³ The benefits of such a program depend entirely on the details, including the cost-sharing and benefits package for low-income employees, and the financing arrangements of any waivers that are used to divert federal Medicaid funds to a reinsurance or premium assistance program.

12. How does Insure Missouri relate to MO HealthNet?

"MO HealthNet" is the new name for the State program that receives funding under the federal Medicaid program, pursuant to Senate Bill 577. "Insure Missouri" would cover additional categories of individuals and would rely on federal Medicaid matching funds to provide coverage to these individuals. The State would provide a reduced benefits package to the individuals in "Insure Missouri," as compared to the coverage provided under regular MO HealthNet coverage. Insure Missouri focuses on "working parents" and assistance to small businesses, whereas the regular MO HealthNet program covers a much wider range of eligibility groups, including children, seniors, and people with disabilities. While MO HealthNet covers long-term care services (including nursing home and home and community-based care), Insure Missouri focuses only on acute care services.

13. What must happen in order for Insure Missouri to be fully implemented?

Because the State has budgetary authority to begin Phase 1, this expansion for working parents should be implemented; in fact the State has already sent out an RFP for health plans to provide services under this program. However, subsequent phases of the Insure Missouri plan will depend on actions of the General Assembly in its appropriations legislation and any substantive legislation to expand coverage or provide assistance to small businesses. The federal government (i.e., the Centers for Medicare and Medicaid Services) will also have a role in determining whether the program is fully implemented, because federal waivers will be needed for subsequent phases of the program. CMS will have a lot to say about the financing arrangements that are imposed as terms and conditions of any such waivers, and these arrangements will help determine whether the expansion is viable from a budgetary perspective for the State.

14. Would coverage through Insure Missouri make a difference in low-income Missourians' access to health care?

It is well established that *having health insurance* improves access to health care and health outcomes.⁶⁴ The uninsured receive less preventative care, are diagnosed at more advanced disease states, and, once diagnosed, tend to receive less therapeutic care (such as drugs and surgical interventions) than people who have health insurance.⁶⁵ Moreover, a wide array of studies demonstrate that Medicaid and SCHIP coverage improves access to health care and health outcomes.⁶⁶ Such coverage can decrease emergency room usage, reduce preventable hospitalizations, and increase the use of primary health care.⁶⁷ In fact, *Missouri's* Medicaid and SCHIP programs have had a similar, positive impact on access to health care.⁶⁸ Therefore, if Insure Missouri provides meaningful health insurance to tens of thousands of Missourians who are currently uninsured, it would have a substantial positive impact on their access to health care. Whether this potential is realized will depend on decisions that are made in the coming months and years.

15. When will the program start?

The State sent out RFPs for insurance carriers to bid to provide services to parents under 100% of the poverty level on October 5, 2007.⁶⁹ Insurers must submit their bids no later than January 2, 2008. Insurance carriers will likely be selected by the State sometime in January 2008. Enrollment is expected to start on or about February 1, 2008, and services are scheduled to begin on March 1, 2008. While the second and third phases are slated to begin later in 2008, these components will depend upon further actions by the Missouri General Assembly and the federal government.

Conclusion

Insure Missouri is estimated to provide expanded health coverage to approximately 190,000 uninsured Missourians if it is fully implemented. The Department of Social Services appears to have the legislative authority to expand coverage to 54,500 low-income working parents under the federal poverty level in February 2008 -- the first phase of the Governor's plan. Implementation of the other phases of Insure Missouri and continuation of the first-year expansion will depend upon legislative approval, negotiations with the federal government, and ultimately federal approval of the proposal. Although there are important details to flesh out, the expansion of coverage through this program could well make a substantial difference in improving access to health care for low-income Missourians who are currently uninsured. It is especially striking that such a significant expansion of coverage could be achieved with so few general revenue dollars in comparison to the overall funding of the program.

APPENDIX

HOW MIGHT THE EXPANSION FOR LOW-INCOME PARENTS AND CARETAKERS (PHASE ONE) WORK?

Here are two very simplified examples of how families with different types of income *could* be treated under Insure Missouri, in comparison to the current MO HealthNet program. These examples assume that the state adopts a methodology that disregards all earnings under the current federal poverty level (\$1431 per month for a family of three). The state may well choose to adopt a *different* budgeting methodology that disregards some unearned income as well as earnings.

EXAMPLE 1 (FAMILY OF THREE)

Monthly Earnings \$700

Other Income: \$0

Child Care Expenses: \$0

Income Determination Under MO HealthNet:

Countable Income Under Current Program: \$610 (\$700 - \$90 work expense deduction)

Net Income Standard: \$292 per month

Parent not eligible for MO HealthNet because net income exceeds \$292 per month.

Possible Income Determination Under Insure Missouri:

Under Insure Missouri, assume that the state disregards all Earnings under 100% of the Federal Poverty Level (\$1431 per month)

Net Income Standard: \$292 per month

Countable Income under Insure Missouri: \$0 (Disregarding all earnings under 100% of the poverty level)

Parent is *eligible* for Insure Missouri coverage because it has zero net income.

EXAMPLE 2: (FAMILY OF THREE)

Monthly Earnings: \$200 per Month

Child Support: \$500 per month

Child care expenses: \$0

Income Determination Under MO HealthNet:

Net Income Standard: \$292 per month

Net Income Under Current Program: \$560 (\$700 minus \$90 work expense deduction and \$50 child support disregard).

Parent is not eligible because net income exceeds \$292 per month

Possible Income Determination Under Insure Missouri:

Under Insure Missouri, assume that the state disregards all earnings under 100% of the Federal Poverty Level (\$1431 per month)

Net Income Standard: \$292 per month

Countable Income: \$450 (Disregarding all earnings under 100% of the federal poverty level and the \$50 child support disregard required by federal law)

Parent is *not eligible* for Insure Missouri coverage because the family's net income still exceeds \$292 per month.

These examples demonstrate just *one* way in which the State may choose to determine eligibility for Insure Missouri. If the State chooses to disregard some portion of unearned income or certain types of unearned income, than the results will be different and more low-income parents would be eligible for the program.

Endnotes

¹ The State maintains a website for Insure Missouri at www.insuremissouri.org. It is likely that additional information on the Insure Missouri initiative will be available on this website.

² Department of Social Services, *Insure Missouri: Estimated Enrollment and Cost*, September 27, 2007 (hereinafter “Insure Missouri Estimated Costs Fact Sheet”) (available at <http://www.insuremissouri.org/news/pdf/092707cost.pdf>).

³ *Id.*

⁴ *Id.*

⁵ See State of Missouri, Office of Administration, RFP No. B3Z08082, October 5, 2007 (“Insure Missouri RFP”) at 5-6.

⁶ Insure Missouri Estimated Costs Fact Sheet, *supra*.

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ The National Associations of State Budget Officers reports that in fiscal year 2006, Missouri was projected to fund approximately 20.5% of its Medicaid program with general revenue while funding 17.7% of the Medicaid program with other state funds, which includes Missouri’s provider tax. National Association of State Budget Officers, *Fiscal Year 2005: State Expenditure Report*, Fall 2006, at 49, Table 28. (available at: <http://www.nasbo.org/Publications/PDFs/2005%20State%20Expenditure%20Report.pdf>).

¹¹ The FRA already funds a variety of Medicaid expenditures in Missouri and is not limited to expenditures for in-patient or outpatient hospital care. For example, the FRA funds a significant portion of managed care spending in the MO HealthNet program and has been used to fund prior expansions of health care coverage under a Section 1115 Medicaid waiver. For further discussion of the Federal Reimbursement Allowance (FRA), see Stephen Zuckerman et al., *The Cost of Care for Missouri’s Uninsured*, Missouri Foundation for Health, Cover Missouri Project, Data Book 2, at 12-13; 34-35 (available at <http://www.mffh.org/CoverMoDataBook2.pdf>); Missouri Hospital Association, Missouri’s Federal Reimbursement Allowance Program, October 2006 (available at http://web.mhanet.com/asp/Governmental_Relations/pdf/FRA.pdf).

¹² Insure Missouri Estimated Costs Fact Sheet, *supra*.

¹³ The Medicaid DSH program was established in the early 1980s to provide financial support to hospitals that serve a large or “disproportionate” number of Medicaid and other low-income patients. The Health Policy Center, The Urban Institute, *The Medicaid DSH Program and Providing Health Care services to the Uninsured: A Look at Five Programs*, March 2001, at 1. The rationale behind the DSH program was that by helping to offset hospitals’ losses resulting from caring for Medicaid patient and the uninsured, hospitals could survive and access for the low-income population could be maintained. *Id.*

¹⁴ The DSH figures included herein represent the state share of Disproportionate Share Hospital payments. This state share generates additional federal matching funds. With federal matching funds, the *total* DSH transfer is \$110.2 million for SFY -2009, \$125.1 million for SFY-2010, \$140 million for SFY 2011, and \$159.3 million for SFY-2012. Insure Missouri Estimated Costs Fact Sheet, note 2. To give some perspective, Missouri spent nearly \$740 million on DSH payments in FY 2006. Kaiser Family Foundation *Missouri: Distribution of Medicaid Spending by Service, FY2006*, (available at <http://www.statehealthfacts.kff.org/profileind.jsp?ind=178&cat=4&rgn=27>) Missouri’s federal DSH allotment for state fiscal year 2007 was over \$446.2 million. Kaiser Family Foundation, *Missouri: Federal Medicaid DSH Allotments, FY 2007*, available at <http://www.statehealthfacts.kff.org/profileind.jsp?ind=185&cat=4&rgn=27>. See also 71 Fed. Reg. 58411 (October 3, 2006).

¹⁵See Note 14. “While increasing health coverage for the uninsured should reduce the need for uncompensated care payments over time, the need for these payments will not be entirely eliminated as long as some people remain uninsured or underinsured.” Judy Solomon, *President’s Affordable Choices Initiative Provides Little Support for State Efforts to Expand Health Coverage*, Center on Budget and Policy Priorities, April 3, 2007, at 5.

¹⁶ Insure Missouri Estimated Costs Fact Sheet, *supra*.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.* The State estimates an annual cost of \$3,784 per enrollee for custodial parents and childless adults at or below 100% of the federal poverty level, \$3,316 per enrollee for custodial parents and childless adults above the poverty level, and \$2,580 per enrollee for persons enrolled in the “small business” component (Phase 3). *Id.*

²⁰ House Bill 11, Missouri General Assembly, 1st Reg. Sess., Section 11.525. That section states:

Section 11.525: To the Department of Social Services

For the Division of Medical Services

For the purpose of funding the insurance premium offset program or a program that will promote private health insurance coverage for certain low-income employees.

The Department of Social Services is authorized to pursue either a federal Medicaid waiver or a State Plan Amendment to obtain federal funds necessary to provide funds for a premium offset program or similar effort that would assist lower-income Missourians in obtaining health care coverage. Allowable uses of these funds may include but not necessarily limited to providing assistance to small employers who provide health coverage to their employees and/or providing reinsurance, risk mitigation, risk pooling, or other strategies that reduce the costs of insurers to provide coverage for lower income workers. Such waiver or plan amendment may include changes in benefit design as authorized by the Federal Deficit Reduction Act in order to reduce program costs. Such benefit design shall include elements to promote individual responsibility and accountability for health care decisions, such as consumer-driven health care financing models. Initially, the department may pursue coverage for adults with incomes at or below 100 percent FPL. Such eligibility standard may be adjusted annually by appropriation

HB 11 authorizes the expenditure of \$5 million in general revenue for such a program. The State also intends to redirect \$14 million already appropriated for payments to compensate hospitals for possible losses in funding caused by changes in the federal rules governing provider taxes. However, because hospital revenues have grown in the last year, the state would use those dollars to help fund the initial phase of Insure Missouri -- the coverage of low-income working parents.

²¹ SB 577 authorizes pilot programs for premium assistance but the broad program to expand coverage that is included in “Insure Missouri” is not a component of SB 577.

²² Even with the expansion of MO HealthNet Managed Care slated to begin in January 2008, the State will have managed care in only 58 of Missouri’s 115 counties. Therefore, it could be very challenging to find insurance carriers to serve the expansion groups in every county in the State.

²³ While the details can be quite complicated, there are ramifications to the State’s decisions on whether to provide full Medicaid coverage to parents up to 185% through the State Plan Amendment process or use the waiver process to provide more limited coverage. For example, a decision to raise the Medicaid eligibility limits for family coverage up to 185% of the program would bring more children into the program who are not eligible under Missouri’s current SCHIP program, which require children to be uninsured and without access to coverage for six months, subject to limited exceptions. These two restrictions are not requirements of the federal Medicaid program. If the state wants to require that higher income parents be uninsured for six months, it will have to

apply for a federal waiver, and subject these populations to budget neutrality requirements.

²⁴ Some states (e.g., Massachusetts, Maine, and Oregon) have received waivers to cover childless adults. See Stan Dorn and Sharon Silow-Carroll, et al., *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States*, Henry J Kaiser Family Foundation, August 2004, (available at <http://www.statecoverage.net/statereports/multi34.pdf>)

²⁵ Insure Missouri RFP at 5-6.

²⁶ Cindy Mann, *Financing under Federal Medicaid Section 1115 Waiver: Federal Policy and Implications for New Hampshire*, Georgetown University Health Policy Institute, September 9, 2004 (available at <http://www.endowmentforhealth.org/docs/42.pdf>), at 8.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.* at 10.

³⁰ See Kaiser Commission on Medicaid and the Uninsured, *Medicaid Section 1115 Waivers: Current Issues*, January 2005 (“Current Issues”). Cindy Mann, *supra*, Judy Waxman, Medicaid Reform Commission, Testimony of Judy Waxman, September 12, 2005 (“Waxman Testimony”); Leighton Ku, *Medicaid in Missouri: The Possible Role of Waivers*, Power Point Presentation to the Missouri Medicaid Commission, September 2005 (hereinafter “Ku Commission Presentation”).

³¹ Mann, *supra*, at 10.

³² Mann, *supra*, at 9-10.

³³ See Kaiser Commission, *Current Issues*; Mann *supra*, Waxman Testimony; Ku Commission Presentation.

³⁴ In fact, DSH transfers have commonly been used to help states achieve budget neutrality for Section 1115 waivers. Cindy Mann and Joan Alker, *Federal Medicaid Waiver Financing: Issues for California*, Kaiser Commission on Medicaid and the Uninsured, July 2004, at 8.

³⁵ These financing arrangements can be quite complicated. For example, even though the policy changes in Florida’s Section 1115 Medicaid waiver program are initially limited to just two counties, the program’s per capita caps apply to the State’s entire Medicaid program. Joan Alker, *What Will Florida’s “Medicaid Choice” Waiver Mean for Children?*, Georgetown University Health Policy Institute, Center for Children and

Families, updated January 4, 2006 (available at: <http://ccf.georgetown.edu/pdfs/florida1105.pdf>).

³⁶ Insure Missouri RFP at 33-37 and Attachment 2. Contracting private insurance carriers would be responsible for pre-transplant and post-transplant follow-up care while the MO HealthNet agency would pay for covering the other costs of transplant services, including the costs of surgery, in-patient hospital stays, and other charges incurred during a transplant stay. Insure Missouri RFP at 36-37 and Attachment 2.

³⁷ EPSDT stands for Early Periodic Screening and Treatment Services. EPSDT provides comprehensive coverage of health care screenings and medically necessary services for children under age 21. Missouri is required to cover this service for individuals in its regular Medicaid/MO HealthNet program but would seek to provide a less comprehensive benefits package under Insure Missouri. That benefits package would not include EPSDT services for young parents. Children ages 18 and below will still receive EPSDT services under the regular MO HealthNet program.

³⁸ Insure Missouri RFP at 6.

³⁹ For example, it is possible that an Insured Missouri participant who becomes pregnant will no longer be covered by her current health carrier, and will be transferred to fee-for-service coverage under MO HealthNet. She would then have to choose a new health plan, with different provider networks, if the Insure Missouri plan does not participate in Mo HealthNet. This could create an additional layer of complexity and disrupt access to health care.

⁴⁰ The MO HealthNet program covers services that are not specifically listed on the Insure Missouri Website, such as family planning services, Hospice Services, EPSDT for individuals under age 21, transplant services, and personal care services.

⁴¹ Insure Missouri RFP at 37.

⁴²As indicated earlier, the projected cost per enrollee is the same for low-income beneficiaries under the federal poverty level but the cost is slightly lower for the group with incomes exceeding the poverty level. See note 19. That group would pay premiums to fund part of the cost of their coverage.

⁴³ In 2002, the State reduced eligibility from 100% to 77% of the federal poverty level, Family Support Division, Income Maintenance Memorandum #65, June 4, 2002 (available at http://www.dss.mo.gov/fsd/iman/memos/memos_02/im65_02.html). In 2004, the State cut eligibility to 75% of the federal poverty level. Family Support Division, IM-54, June 3, 2004 (available at http://www.dss.mo.gov/fsd/iman/memos/memos_04/im54_04.html).

⁴⁴ See Virginia Young, “Whatever His Reason, People Like Blunt’s Plan; Some Debate Why the Governor Wants It, But Other Just Say Thanks,” *St. Louis Post-Dispatch*,

September 23, 2007 (regarding the proposed plan's differential treatment of earned and unearned income).

⁴⁵ Gary Stangler, the Missouri Department of Social Services Director under Governors Ashcroft and Carnahan, noted that after his state expanded parents' eligibility, "With no outreach, no advertising, no partnerships to spread the word, **enrollment soared....Helping adults greatly contributed to the enrollment of children.**" Comment by Gary Stangler on "Supporting Work Through Medicaid and Food Stamps," by Bob Greenstein and Jocelyn Guyer in Rebecca Blank and Ron Haskins, editors, *The New World of Welfare*, Washington, DC, Brookings Institution (emphasis added).

⁴⁶ Leighton Ku et al., *Improving Children's Health, A Chartbook about the roles of Medicaid and SCHIP*, Center on Budget and Policy Priorities, January 2007, at 16 (available at <http://www.cbpp.org/schip-chartbook.htm>); Leighton Ku and Mathew Broaddus, *Coverage of Parents helps Children Too*, Center on Budget and Policy Priorities, October 20, 2006, (available at <http://www.cbpp.org/10-20-06health.pdf>). See also Sara Rosenbaum and Ramona Perez Trevino Whittington, *Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature*, George Washington University Medical Center, June 2007 (available at: http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/Parental_Health_Insurance_Report.pdf).

⁴⁷ Department of Social Services (DSS), *Chart on MAF (Section 1931)/1115 Waiver Parent closings*, July 11, 2002; DSS data on 2005 Medicaid reductions. The figures provided in Table 3 only include the loss of coverage for *custodial* parents covered in the Medical Assistance for Families (MAF) component of the Missouri Medicaid program. In 2002, the State also eliminated programs that covered non-custodial parents (1,617), and reducing eligibility for programs that provided "Extended" Transitional Medical Assistance to low-income parents (1,125) and Extended Women's Health Services to women who losing their full Medicaid coverage 60 days after giving birth (4,810). *Id.* For additional information regarding the 2002 cuts, see Joel Ferber, *Economic and Health Benefits of Missouri Medicaid*, Missouri Foundation for Health, Show Me Series: Report 5, at 9 (and citations therein) (available at: <http://www.mffh.org/ShowMe5Final.pdf>). In 2005, the State *eliminated* the Extended Transitional Medical Assistance program, causing 1,560 more working parents to lose coverage.

⁴⁸ See Insure Missouri RFP at 14.

⁴⁹ The RFP for Phase 1 states that cost-sharing requirements for Insure Missouri Participants above one-hundred (100) percent of the federal poverty level shall not exceed five percent (5%) of the individual's income and shall be set by the state agency in accordance with state and federal law. Insure Missouri RFP at 14.

⁵⁰ Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-income Population*, Kaiser Commission on Medicaid and the Uninsured, March 2003, at 5; Leighton Ku and Victoria Wachino, *The Effect of*

Increased Cost-Sharing in Medicaid: A Summary of Research Findings, Revised July 7, 2005, at 7-9. For example, one multi-state study found that participation in three states' publicly funded health insurance programs declined from 57% to 18% as premiums rose from 1% to 5% of family income. Hudman and O'Malley at 5. The same study showed that even premiums set as low as 1 percent of a family's income were estimated to lead to a 15 percent reduction in enrollment. Ku and Wachino at 7-8. And a study of Oregon's premium policies showed that one-half of those enrolled lost coverage due to new premium policies, and *about three-quarters of those who were dropped became uninsured*. Id. at 8.

⁵¹ See Ku and Waccino, *supra* at 6-7; Linda Blumberg et al., Lowering Financial Burdens and Increasing Health Insurances Coverage of those with High Medical Costs, Urban Institute, December 2005, at 3-4, (available at http://www.urban.org/UploadedPDF/311261_financial_burdens.pdf)

⁵² Ku and Waccino, *supra*, at 9.

⁵³ Joseph Newhouse, "Free for All: Lessons from the Rand Health Insurance Experiment," Cambridge: Harvard University Press, 1996 (hereinafter, "Lessons"), discussed in Leighton Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 7, 2003 (hereinafter "Cost-Sharing"); Ferber, *Economic and Health Benefits of Missouri Medicaid*, *supra*; Robyn Tamblyn, et al. "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons," *Journal of the American Medical Association*: 285(4): 421-429, January 2001. Other studies demonstrate similar negative consequences from the imposition of cost-sharing on low-income people. See Ku, Cost-Sharing, *supra*, for an excellent overview of the research in this area.

⁵⁴ See Ku and Waccino, *supra*, at 6-7.

⁵⁵ The RFP states that applications may be accessed through the Insure Missouri internet website, and specified health care provider sites, or at local DSS Family Support Division (FSD) offices. An Insure Missouri Call Center will provide support for the website and additional information for applicants. Trained staff will be stationed full-time at the call center and at field offices located throughout the State and on a periodic basis at certain health care provider sites. See Insure Missouri RFP at 18.

⁵⁶ The Governor's press release and slide presentation refer to the program as "reinsurance" program. *Blunt Unveils New Plan to Health Nearly 200,000 Missourians Buy Health Issuance*, News Release, September 18, 2007. <http://www.insuremissouri.org/news/pdf/091807b.pdf> Governor Matt Blunt, September 19, 2007, *Insure Missouri Coverage Initiative*, September 19, 2007, (available at <http://www.insuremissouri.org/news/pdf/091907pres.pdf>);Gov.

⁵⁷ Reinsurance is essentially "insurance for insurers." Another insurance carrier, or sometimes the state, shares the risk for high-cost claims. For example, Arizona and New

York have programs that provide subsidized reinsurance to encourage coverage among small employers and individuals. These states sponsor a primary insurance program that operates as a purchasing pool, contracting with insurers to provide coverage. The reinsurance component assumes some or all of the risk of the high cost care for qualifying small groups or self-employed individuals, but does not subsidize premiums directly. Deborah Challet, *The Role of Reinsurance in State Efforts to Expand coverage, State Coverage Initiatives*, October 2004, at 3.

⁵⁸ Randall Bovbjerg, *Implementing Reinsurance Reform: Health Insurance Reform in Missouri*, Missouri Foundation for Health, Cover Missouri Project: Report 11, at 6.

⁵⁹ Linda Blumberg and John Holohan, *Expanding Insurance Coverage for Workers in Small Business: Lessons from Massachusetts and California*, Missouri Foundation for Health, Show Me Series: Report 10, at 4, 15. (available at <http://www.mffh.org/Showme10.pdf>).

⁶⁰ *Id.* The Urban Institute noted that: (1) most firms, including small ones, have a mix of high-and low-income workers, meaning that subsidies would benefit all income levels and those poorly target those in need; (2) firms know wages but do not know the household incomes of their workers. Thus, while subsidies could be well targeted to workers based upon their wages, they could actually benefit higher-income families; and (3) while some of the subsidies targeted to small firms would be worthwhile, doing so would not address the needs of low-income workers in larger firms. *Id.*

⁶¹ *Id.* at 4.

⁶² For example, when O-EPIC, the Oklahoma program for small businesses with less than 50 employees (which subsidizes the premiums for individuals at or below 185% of poverty at varying levels) was established in 2005, the State anticipated that the program would enroll 50,000-70,000 people. Insure Oklahoma through O-EPIC, *O-EPIC Program Update*, October 2005. However, as of September 2007, there were only 1218 businesses and 2,654 employees enrolled in the program. O-EPIC Premium Assistance, *Fast Facts: April 2007*, April 6, 2007 (available at: http://www.okhca.org/reports/pdflib/O_EPIC_PA_FF_4_2007.pdf). The Oklahoma program started with employers with less than 25 employees but expanded the program to include employer with less than 50 employees.

⁶³ Insure Missouri Estimated Costs Fact Sheet, *supra*. This assumes a 25% take-up rate by eligible individuals.

⁶⁴ Kaiser Commission on the Future of Medicaid and the Uninsured, *The Uninsured and their Access to Health*, January 2003.

⁶⁵ See Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured: Executive Summary*, The Kaiser Commission on Medicaid and the Uninsured, February 2003. www.kff.org/uninsured/20020510-index.cfm,1.

⁶⁶ Ellen O'Brien and Cindy Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*, Covering Kids and Families, June 2003.

⁶⁷ Id. (and citations therein). See also Katie Plax and Joel Ferber, *Medicaid and SCHIP Improve the Health of Missourians*, Washington University School of Medicine, April 20, 2004, for a more detailed review of the medical literature on Medicaid and SCHIP's impact on health.

⁶⁸ Medicaid and SCHIP have had a number of positive effects on the health care of Missouri children, including reduced emergency room visits, reduced emergency room visits for asthma, a decline in preventable hospitalizations, and improved school attendance. Department of Social Services, State of Missouri, *Since MC+ Began*, February 10, 2003; Plax and Ferber, *supra*.

⁶⁹ See Insure Missouri RFP at 1.