

Cover Missouri Project: Report 6

# The Missouri Health Insurance Pool: Issues for Policymakers



## About MFH

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Established in 2000, the Missouri Foundation for Health is dedicated to its mission of empowering the people of the communities we serve to achieve equal access to quality health services that promote prevention and encourage healthy behaviors. In support of its mission, the Foundation undertakes policy research to educate the public and decision makers on effective health policies that will result in long-term, positive health system change in the state of Missouri. Formulating sound health policies advances the Foundation's efforts to increase access to high quality, cost-effective preventive and curative care, especially for the uninsured, underinsured, and underserved in our service region of 84 Missouri counties and the City of St. Louis.

The Missouri Foundation for Health does not take responsibility for any analysis, errors, or omissions of fact found in this report.

# Cover Missouri Project

## Preface

In an effort to inform the discussion regarding practical policy options to expand health care coverage for the uninsured in Missouri, the Missouri Foundation for Health (MFH) has established the Cover Missouri Project. Under this project, MFH has engaged The Urban Institute to produce a series of papers which considers strengths and weaknesses of the current health care system in Missouri and explores options for decreasing the number of uninsured. MFH offers these studies as a means to further understand and ultimately improve access to health care coverage.

Missouri currently faces considerable challenges related to creating an equitable and comprehensive system of health care for all Missourians. In 2005, between 635,000 and 707,000 Missouri residents were without health insurance. In addition, eligibility cuts and cost-sharing changes to Missouri's Medicaid program made in 2005 increased the number of uninsured. Ultimately, these changes may shift Missouri from being one of the 12 states with the lowest uninsurance rates to being among the 12 states with the highest rates of uninsurance.

Research broadly documents the serious health and financial consequences associated with being uninsured. The uninsured live sicker and die younger than those with insurance. They forego preventive care and seek health care at more advanced stages of disease. Society then bears these costs through lower productivity, increased rates of communicable diseases, and higher insurance premiums. Those without health insurance often must choose between visiting a doctor and paying for other essentials.

This paper, "The Missouri Health Insurance Pool: Issues for Policymakers" represents the sixth paper in the series emerging under the Cover Missouri Project. It provides background on high-risk pools and specifically examines Missouri's high-risk pool, comparing it to those in other states. This study offers specific recommendations for Missouri policymakers to consider regarding enrollment, benefits, costs, and funding for the state's high-risk pool. Changes in the structure of this program could reduce the amount of uncompensated care provided by Missouri's health providers and also decrease the number of uninsured in our state.

Leslie Reed  
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### About the Author

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### About The Urban Institute

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The Urban Institute is a nonprofit nonpartisan policy research and educational organization established to examine the social, economic, and governance problems facing the nation. It provides information and analysis to public and private decision makers to help them address these challenges and strives to raise citizen understanding of the issues and tradeoffs in policy making. The Urban Institute works to promote sound social policy and public debate on national priorities through gathering and analyzing data, conducting policy research, evaluating programs and services, and educating all Americans. More information about The Urban Institute may be found at [www.urban.org](http://www.urban.org).

# The Missouri Health Insurance Pool: Issues for Policymakers

by Karen Pollitz, MPP

The Missouri Health Insurance Pool (MHIP) is one of 32 state high-risk pools operational in the United States today.<sup>1</sup> States establish high-risk pools as a coverage alternative for residents who, due to health status, cannot obtain individual health insurance. However, enrollment in state high-risk pools is extremely low relative to the population in need of such coverage. Various program features tend to discourage enrollment, and therefore limit the cost of

high-risk pools to states. MHIP, one of the smaller high-risk pools in the nation, has many such limiting features. The program has not maximized opportunities to cover sick, uninsured Missouri residents and has not embraced changes adopted by many other states' high-risk pool programs in recent years. This study provides background on all high-risk pools and reviews specific issues for consideration by Missouri policymakers.

## Background on High-Risk Pools

Enrollment in all state high-risk pools combined was approximately 180,000 people in 2003<sup>2</sup> (Table 1). In almost every state, high-risk pool enrollment constitutes less than 2 percent of individual market participation<sup>3</sup> (Appendix A). By contrast, insurance industry

sources acknowledge that approximately 15 percent of applicants for medically underwritten health insurance are either denied for medical reasons or offered policies that exclude particular conditions or body parts; and another 10 percent of applicants receive offers for policies at higher than standard rates. These adverse underwriting actions could qualify individuals as uninsurable, and therefore eligible for coverage under most state high-risk pools.<sup>4</sup>

On average, the per capita annual cost (claims and administrative expenses) of all high-risk pool enrollees exceeded \$7,500 in 2003. Enrollee premiums typically cover about 60 percent of these costs, while the remaining costs are publicly financed. Most states assess health insurers to cover pool losses, although

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**Table 1. Combined U.S. High-Risk Pool Costs/Participants, 1996-2003**

	2003	2002	2001	2000	1999	1998	1997	1996
<b>Number of Pools</b>	32	30	28	27	27	27	25	25
<b>Participants</b>	181,441	172,845	153,351	127,406	112,833	100,894	88,990	88,659
<b>Annual Growth</b>	5.0%	12.7%	20.4%	12.9%	11.8%	13.4%	0.4%	(2.6%)
<b>Premiums Earned</b> (in millions)	\$793.5	\$638.1	\$490.8	\$371.4	\$282.7	\$232.7	\$217.9	\$215.3
<b>Total Costs</b> (in millions)	\$1,332.0	\$1,106.7	\$892.5	\$711.7	\$571.3	\$476.0	\$417.4	\$397.7
<b>Net Loss</b>	\$538.5	\$468.5	\$401.7	\$340.3	\$288.6	\$253.8	\$199.5	\$182.5
<b>Per Capita Cost</b>	\$7,343	\$6,403	\$5,820	\$5,586	\$5,063	\$4,718	\$4,691	\$4,486
<b>Annual Growth</b>	14.7%	10%	4.2%	10.3%	7.3%	0.6%	4.6%	4.0%
<b>Per Capita Subsidy</b>	\$2,968	\$2,711	\$2,619	\$2,671	\$2,558	\$2,515	\$2,242	\$2,058
<b>Annual Growth</b>	9.5%	3.5%	(1.9%)	4.4%	1.7%	12.2%	8.9%	4.0%
<b>Avg. Annual Premium</b>	\$4,374	\$3,692	\$3,200	\$2,915	\$2,505	\$2,203	\$2,449	\$2,428
<b>Annual Growth</b>	18.5%	15.4%	9.8%	16.4%	13.7%	(10%)	0.9%	0.4%
<b>Premiums as % of Total Cost</b>	59.6%	57.7%	55.0%	52.2%	49.5%	48.8%	52.2%	54.1%

Source: Health Policy Institute, Georgetown University analysis of data from *Comprehensive Health Insurance for High-Risk Individuals, A State-by-State Analysis*, 10th-18th eds. (Fergus Falls, Minn.: Communicating for Agriculture and the Self-Employed, 2004/2005).

many indirectly finance high-risk pool losses through general revenues because industry assessments are eligible for tax credit offsets. Other states rely on hospital assessments or general revenue financing in an effort to spread program costs over a broader funding base<sup>5</sup> (Appendix B).

As health care costs have increased, states have steadily shifted an increasing share of program costs to enrollee premiums. Nationwide, enrollee premiums paid for about half of program costs in the late 1990s but accounted

for 60 percent of program costs in 2003. All states set high-risk pool premiums at above-market rates, usually 125 to 200 percent of prevailing individual market premiums. High-risk pools have adopted a variety of other features in order to minimize losses that must be covered by public subsidy. All but three high-risk pools temporarily exclude coverage of pre-existing conditions for at least some enrollees. Additionally, many pools impose high cost sharing for covered services, including annual deductibles of \$1,000 or more and annual coinsurance liability of \$5,000 or more,

although most state pools offer a range of cost-sharing options (Table 2). Some pools limit coverage for prescription drugs, maternity care,

and other health services.<sup>6</sup> Several states restrict eligibility or have waiting lists to access insurance through the state's high-risk pool.

**Table 2. Cost-Sharing Options in State High-Risk Pools, 2003**

State	Annual Deductible Options					Annual Cost-Sharing Liability Options (in addition to deductible)				
	Less than \$500	\$500- \$999	\$1,000- \$2,499	\$2,500- \$4,999	\$5,000 or more	Less than \$2,000	\$2,000- \$4,999	\$5,000- \$9,999	\$10,000 or more	No limit
AL			✓	✓		✓				
AK			✓	✓	✓	✓	✓	✓		
AR			✓		✓		✓		✓	
CA*							✓			
CO			✓	✓	✓					
CT		✓	✓				✓	✓		
FL			✓		✓				✓	
IL		✓	✓	✓	✓	✓				
IN		✓	✓	✓		✓	✓			
IA			✓	✓		✓				
KS		✓	✓	✓	✓	✓				✓
KY	✓	✓	✓			✓	✓	✓		
LA			✓	✓	✓		✓	✓		
MD	✓	✓	✓			✓				✓
MN	✓		✓		✓	✓	✓			
MS			✓	✓				✓		✓
MO		✓	✓	✓	✓		✓	✓		
MT			✓	✓	✓		✓			
NE		✓	✓	✓			✓			
NH		✓	✓	✓	✓		✓			
NM		✓	✓		✓		✓			
ND		✓	✓				✓			
OK		✓	✓		✓				✓	
OR		✓	✓			✓	✓			
SC		✓	✓			✓	✓			
SD			✓	✓	✓		✓			
TX		✓	✓	✓	✓		✓	✓		
UT		✓	✓	✓		✓				
WA		✓	✓			✓				
WV	✓	✓	✓							
WI			✓	✓		✓				
WY	✓	✓					✓			

\* No deductibles in California.

Source: *Comprehensive Health Insurance for High-Risk Individuals, A State-by-State Analysis*, 10th-18th eds. (Fergus Falls, Minn.: Communicating for Agriculture and the Self-Employed, 2004/2005).

Such features have the effect of limiting enrollment in state high-risk pools. A study of health insurance problems of diabetics reviewed experiences of 344 people who needed individual coverage and lived in high-risk pool states. The study found that only seven individuals were able to successfully enroll. High premiums and pre-existing condition exclusions were the leading factors that discouraged the rest from obtaining high-risk pool coverage.<sup>7</sup> Another study estimated only 8 percent of

the target uninsurable population is able to enroll in high-risk pools, due primarily to high premiums. The same study estimated federal financial assistance, in the amount of \$105 million, could subsidize premiums sufficiently to allow 11 percent of uninsurable residents to enroll in high-risk pools and noted that “while this increase may be modest, this is a population most in need of coverage and likely to rely on substantial amounts of high-cost emergency care if uninsured.”<sup>8</sup>

## Federal Law and State High-Risk Pools

Over time, states have modified high-risk pools – in some instances, to mitigate enrollment barriers. The enactment of two federal laws prompted some of these changes in states’ high-risk pools.

### **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

HIPAA governs access to non-group health coverage for “HIPAA-eligible individuals” – people with a continuous coverage history of at least 18 months who have lost job-based coverage and exhausted COBRA. Most state pools opened their doors to HIPAA-eligible individuals and adopted other changes to conform their programs to minimum federal standards under HIPAA. In particular, HIPAA-qualified pools must waive all pre-existing condition exclusion periods and enrollment caps for HIPAA-eligible individuals. HIPAA also set general standards for high-risk pool premiums and covered benefits and premiums, prompting improvements in several states.<sup>9</sup> State high-risk pool enrollment grew by more than 12 percent annually in the two years following HIPAA, having declined for several consecutive years prior to HIPAA.<sup>10</sup>

### **Health Coverage Tax Credit (HCTC)**

The Trade Act of 2002 also stimulated changes in state high-risk pools. This law created a 65 percent HCTC to subsidize qualified health insurance coverage for certain trade dislocated workers and early retirees and gave states the option to designate qualified high-risk pools as qualified coverage. As under HIPAA, qualified high-risk pools may not impose pre-existing condition exclusions or waiting lists on qualified HCTC recipients. Nineteen states have designated high-risk pools as qualified coverage options for HCTC recipients,<sup>11</sup> although nationwide, less than 10 percent of people eligible for the credit have claimed it.<sup>12</sup>

Some pools have not extended eligibility to HCTC recipients out of concern for the additional losses these new members might generate. However, preliminary data from a U.S. Department of Treasury analysis of losses from HCTC-eligible individuals in three state high-risk pools (Colorado, Illinois, and Maryland) indicate otherwise. According to the Treasury analysis, the risk profile of the HCTC population is, in fact, very similar to the commercially insured population, and

only about half as expensive as traditional high-risk pool enrollees.<sup>13</sup>

In Missouri, an estimated 6,500 residents were potentially eligible for the HCTC as of August 2005.<sup>14</sup> Between 1994 and 2004, an estimated 31,068 Missourians experienced trade-related job loss – from the garment sector, manufacturing, electronics, and other industries – and this number continues to grow.<sup>15</sup>

### **Federal Grants to State High-Risk Pools**

In addition to the HCTC, the Trade Act established a new federal grant program for HIPAA-qualified state high-risk pools. In the first two years of the program, \$40 million in federal grants were awarded to eligible high-risk pools each year. Initially, only HIPAA-qualified pools with premiums at or below 150 percent of standard market rates were eligible for federal grants. In the first two years of the grant program, 21 state pools were awarded federal grants. Federal grant assistance is modest in comparison to the cost of operating all high-risk pools

nationwide; although in the first year of the grant program, 11 states received grant awards equal to 25 percent or more of their operating costs.<sup>16</sup> Most states used grant funds to pay claims, thereby reducing high-risk pool losses that would have required state financing.<sup>17</sup> In 2005, Congress reauthorized the federal grant program for high-risk pools, increasing available funding to \$75 million annually and expanding eligibility for grants to HIPAA-qualified pools with premiums up to 200 percent of standard rates.<sup>18</sup> Pools with premiums above 150 percent of standard rates will be required to spend at least half of their grant award to reduce enrollee premiums. In addition, Congress set aside one-third of total program funding for “bonus grants” to high-risk pools that adopt changes that directly benefit enrollees (such as, disease management programs or premium subsidies) and/or expand pool enrollment (e.g., by vacating waiting lists). Missouri’s pool was not, and continues to not be, eligible for federal grant assistance because it is not a HIPAA-qualified high-risk pool.

## **Missouri Health Insurance Pool (MHIP)**

Legislation creating the MHIP was enacted in 1991, and the program began offering coverage in January 1992. Key features of MHIP are described below.

### **Eligibility**

MHIP offers coverage for Missourians who are unable to obtain standard health coverage because of high-risk health conditions. People who apply for medically underwritten health insurance and are turned down or offered a policy with a “rider” limiting coverage for their health condition are eligible to apply for MHIP. Traditionally, public awareness of MHIP

has been low. Since 2002, insurers are required to include notice about MHIP in denial letters to applicants for individual health insurance. HIPAA-eligible residents may apply to MHIP, although the program is not formally designated as a qualified HIPAA coverage option (discussed later). MHIP also is not a qualified coverage option for HCTC-eligible residents. MHIP coverage is issued only on an individual basis; a dependent of an MHIP enrollee who seeks coverage must be eligible in his or her own right and pay a separate premium.

### Premiums

MHIP premiums are set to approximately 175 percent of standard rate premiums in the individual market; only four other state pools have premiums higher than 150 percent of standard market rates. MHIP premiums vary based on the annual deductible option, and are adjusted for age and gender. A 60-year-old man pays roughly four times the premium of a 20-year-old man, while a 60-year-old woman pays roughly twice the premium of a 20-year-old woman (Table 3). The vast majority of MHIP enrollees are age 45 or older: 45 percent are 55-64 years old and 23 percent are 45-54 years old.<sup>19</sup> One of the largest complaints from MHIP enrollees is that premiums are too high.<sup>20</sup> For enrollees over the age of 50 with incomes at the state median (approximately \$3,500/month in 2004),<sup>21</sup> MHIP premiums constitute 10-30 percent of gross income.

### Covered Benefits

MHIP covered benefits are generally comprehensive and include hospitalization, inpatient and outpatient physician care, prescription drugs, maternity, diagnostic tests, and medical equipment. Prescription drugs are subject to a separate annual

deductible of \$100 and co-pays of \$10, \$25, or \$40 per prescription, up to an annual pharmaceutical out-of-pocket maximum of \$1,100 per year. Mental health care is covered like other medical benefits except that inpatient psychiatric care is limited to 90 calendar days per year. Enrollees can seek care from MHIP preferred providers or from those outside of the plan network. However, except in limited circumstances, non-emergency care rendered outside of the state of Missouri is not covered under MHIP. There is a lifetime maximum of \$1 million on all covered benefits.

Of note, hospital benefits under MHIP are limited to 180 inpatient days annually, a cap not found in most other state high-risk pools. A small number of enrollees (less than 3 percent) exceed this coverage limit each year.<sup>22</sup> However, the impact of this limitation is likely greater than the number of individuals might suggest. According to MHIP data, the sickest 1 percent of enrollees account for 20 percent of expenses from claims, or \$1.8 million in 2001.<sup>23</sup> The cap on inpatient days likely saves MHIP money by shifting costs onto the sickest enrollees and/or generating uncompensated care costs for hospitals.

**Table 3. MHIP Monthly Premiums, 2005**

Age	\$500 Deductible		\$1,000 Deductible		\$2,500 Deductible		\$5,000 Deductible	
	M	F	M	F	M	F	M	F
20-29	\$272	\$505	\$210	\$395	\$164	\$314	\$127	\$226
30-39	\$345	\$595	\$270	\$461	\$210	\$358	\$166	\$272
40-44	\$458	\$651	\$364	\$526	\$287	\$412	\$226	\$314
45-49	\$571	\$717	\$454	\$578	\$360	\$448	\$287	\$362
50-54	\$717	\$791	\$573	\$651	\$450	\$517	\$355	\$417
55-59	\$901	\$887	\$726	\$735	\$568	\$588	\$446	\$482
60-64	\$1,136	\$1,014	\$909	\$836	\$698	\$654	\$559	\$537

Source: MHIP, [www.mhip.org](http://www.mhip.org)

### Cost Sharing

An annual deductible applies to covered medical care. Certain preventive services are exempt from the deductible and a separate deductible applies to pharmacy benefits. Four annual deductible options are offered: \$500; \$1,000; \$2,500; and \$5,000. Once the annual deductible is satisfied, enrollees pay 20 percent of covered charges from in-network providers, up to an annual out-of-pocket maximum. The out-of-pocket coinsurance liability is an additional \$2,500 per year for the \$500 deductible plan option and \$5,000 per year for the other plan options. Coinsurance for out-of-network care is 50 percent and does not apply toward the annual out-of-pocket maximum.

MHIP introduced higher cost-sharing options in 2001, following double-digit premium increases in late 1990s, in an effort to make more affordable coverage options available. However, the tradeoff between lower premiums and higher cost sharing may be less meaningful for enrollees with very high medical expenses. Approximately 40 percent of MHIP enrollees meet their annual deductible each year and about 35 percent reach their annual out-of-pocket maximum.<sup>24</sup> For these enrollees, premium savings from joining a higher-deductible plan are offset by increased cost sharing. For example, a 55-year-old male with catastrophic medical expenses (sufficient to cause him to reach the annual out-of-pocket cap on coinsurance) would pay a total of \$15,352 in premiums and cost sharing under the “affordable” \$5,000 deductible option, compared to \$14,356 under the “expensive” \$500 deductible option (Figure 1). Catastrophically ill enrollees at the state median income would have to spend more than one-third of total income to pay for

combined premiums and cost sharing under any MHIP plan option.

In MHIP, as in other state pools, a significant proportion of enrollees have limited, even no, claims experience. Program officials cite more stringent medical underwriting standards by insurance carriers as an explanation. Some MHIP enrollees were rejected by individual market carriers because they were overweight or had past medical conditions that were since resolved or stabilized. For these enrollees, high cost sharing may be less problematic because they do not expect to make many claims. By 2003, 56 percent of enrollees were enrolled in the \$2,500 or \$5,000 deductible plan

**Fig. 1. Premiums and Cost Sharing for a 55-Year-Old Male MHIP Enrollee with Catastrophic Medical Claims**

<u>Deductible</u>	<u>+</u>	<u>Annual Premium</u>	<u>+</u>	<u>Coinsurance</u>	<u>=</u>	<u>Total</u>
\$ 500		\$11,356		\$2,500		\$14,356
\$1,000		\$ 8,712		\$5,000		\$14,712
\$2,500		\$ 6,816		\$5,000		\$14,316
\$5,000		\$ 5,352		\$5,000		\$15,352

options, compared to 19 percent in 2001 when the high-deductible options were first offered. According to the program’s executive director, healthier and younger enrollees are more likely to select the highest cost-sharing options.<sup>25</sup>

### Pre-Existing Conditions

Under MHIP, a 12-month pre-existing condition exclusion period generally applies to new enrollees. The pre-existing condition exclusion applies to medical benefits, but not pharmaceutical benefits. MHIP acknowledges that this exclusion has discouraged enrollment because few persons can afford to pay 12 months of premiums without receiving benefits.<sup>26</sup> Unlike many other high-risk pools and private health

plans, the MHIP exclusion cannot be reduced by crediting prior health insurance coverage. However, MHIP will waive the exclusion under two circumstances. First, it is waived when a person's prior health coverage was involuntarily terminated. This can happen, for example, if an employer ceases to offer health benefits or if an insurer exits the market.

Second, the exclusion is waived for people who are offered private individual health insurance for a premium at or above 300 percent of standard market rates. This constitutes a proxy waiver for HIPAA-eligible individuals. In Missouri, all private carriers in the individual health insurance market must offer HIPAA-eligible individuals coverage on a "guaranteed issue" basis, but there is no limit on what insurers can charge for HIPAA coverage. Premiums for HIPAA-eligible individuals can typically be as high as 600 percent of standard rates in states where no rate limits apply.<sup>27</sup> By contrast, premium surcharges in excess of 100 percent are rare for underwritten

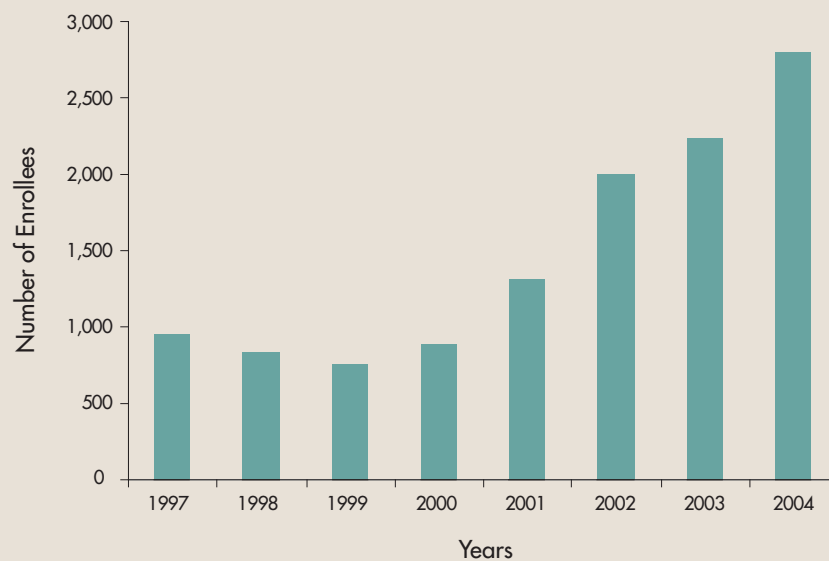
policies; applicants with higher risk profiles are typically denied.<sup>28</sup>

### Enrollment

MHIP is one of the smaller high-risk pools, both in absolute numbers (MHIP ranks 19 among 31 states) and as a share of individual market participants (ranks 23 among 31 states), even though Missouri is the seventh most populous state with a high-risk pool.

Enrollment in MHIP has grown recently, however. At the end of 2004 there were 2,800 participants in MHIP, compared to the 1,000 people enrolled at the end of 2000 (Figure 2). Program officials cite four factors contributing to recent enrollment growth: 1) exit of several carriers from the individual market, including Kaiser Permanente and Conseco; 2) stricter underwriting practices by individual market carriers; 3) substantial increase in premiums charged by private insurers for guaranteed issue HIPAA policies; and 4) new rules requiring insurers to notify denied applicants of MHIP.<sup>29</sup>

Fig. 2. MHIP Enrollment, 1997-2004



Source: MHIP, [www.mhip.org](http://www.mhip.org)

### **Program Costs and Revenue**

MHIP net claims expenses (after PPO provider discounts) for 2003 were \$16.4 million. This total represented a 41 percent increase from 2002. Growth in prescription drug claims costs accounted for 70 percent of total growth in MHIP claims costs that year. Overall, 29 percent of claims costs were for inpatient hospital care, 17 percent for outpatient hospital care, 23 percent for physician and other professional services, and 31 percent for prescription drugs.<sup>30</sup> MHIP uses two primary approaches to containing claims expenses. Provider discounts reduce gross claims by

roughly 45 percent. The introduction of high deductible plan options also has significantly reduced the program's claims exposure.<sup>31</sup>

Total program revenue in 2003 was \$15.8 million. Of this, \$12.2 million came from enrollee premiums and \$3.6 million from assessments on insurers. A small amount of revenue (less than \$20,000) was derived from earned interest.<sup>32</sup> No other revenue sources are available to MHIP at this time. Because insurers receive a tax credit offset for the high-risk pool assessment, MHIP revenue from insurers directly reduces general revenue to the state.

## **Options for the MHIP Program**

Policymakers in state government and on the MHIP governing board could consider various program changes to increase the availability, affordability, and adequacy of program coverage for Missourians. Even modest expansions in MHIP could extend coverage to more of the sickest uninsured in the state and help reduce uncompensated care. Because enrollment growth will also increase program costs, this section reviews some options for increasing program revenues.

### **Expanding Availability of Coverage Under MHIP**

MHIP coverage could be more readily available to people in Missouri with program changes that expand eligibility and outreach, and simplify the application and enrollment process.

#### **ELIGIBILITY**

MHIP could seek to formalize its status as the HIPAA coverage mechanism for Missouri – a role it fulfills informally today for at least some residents. Currently,

HIPAA-eligible individuals in Missouri are only guaranteed HIPAA protections in the commercial individual health insurance market, where no rating protections apply. Missouri is one of only 10 states with no rating protections for HIPAA-eligible individuals. The state would have to enact legislation to formally designate MHIP as a HIPAA alternative mechanism. MHIP officials have recommended this change in each of the last three annual reports (2002-2004).

If MHIP were designated as a HIPAA-qualified pool, it would also become eligible for federal high-risk pool grants (discussed later). In addition, MHIP would be able to designate itself as a qualified coverage option under HCTC. Extending eligibility to the HCTC population would not necessarily require additional state legislation. (Under federal law, qualified state coverage options can be designated under state “arrangements.” A letter from the Insurance Commissioner or Governor satisfies federal requirements.) Designation as an HCTC coverage

mechanism could expand the number of Missourians able to claim this federal income tax credit. Currently, only 2 percent of HCTC-eligible Missourians claim the tax credit, compared to a national rate of 7 percent.<sup>33</sup> The absence of a qualified state-coverage option may help explain this low rate. Enrollment of HCTC-eligible individuals might also marginally improve MHIP's claims experience if the risk profile of this population is lower than other pool enrollees, as preliminary research in other states has found.

#### OUTREACH

MHIP has already taken steps to improve public awareness of the program by convincing state insurance regulators to require notice about the program in their denial letters. MHIP could build on this progress by adopting an initiative similar to the one undertaken by the Maryland high-risk pool in conjunction with the state Blue Cross Blue Shield plan, CareFirst. In Maryland, regulators require individual market carriers to report quarterly the number of applications received and the number of denials and other adverse underwriting actions taken. From these data, the Maryland high-risk pool found that less than 10 percent of denied applicants applied to the high-risk pool since its start in 2003.

Beginning this year, CareFirst encloses a streamlined application for the high-risk pool with its denial letters. Since this initiative began, almost 40 percent of Marylanders who receive the "mini-app" apply for the high-risk program. The streamlined application (stripped of questions that would be relevant only to HIPAA- or HCTC-eligible individuals) requests only information essential to document an applicant's Maryland residency and ineligibility for other coverage. By simply attaching their denial letter to the

mini-app, the applicants can prove medical eligibility. From the high-risk pool's perspective, mini-apps also are easier to process. If Missouri required insurers to report summary data on applications and underwriting actions, MHIP might gain other insights into options for improving outreach and public notice about the high-risk pool.

Several state pools also engage in direct outreach to patient organizations (such as, the American Cancer Society, American Diabetes Association). These groups serve the target audience of high-risk pools; they are positioned to distribute program brochures and applications, write newsletter articles about the high-risk pool, etc. At least two states have entered into formal partnerships with Ryan White CARE Act programs (which provide prescription drugs and other care assistance to persons with HIV) to identify patients eligible for high-risk pool coverage. Ryan White grant funds also can be used to pay high-risk pool premiums to secure comprehensive coverage for patients.

#### *Expanding Affordability of Coverage Under MHIP*

MHIP officials acknowledge that affordability of coverage is a burden on current enrollees and discourages others from enrolling. The Missouri pool premium cap of 175 percent of standard rates is the fifth highest in the nation. Several approaches could be pursued to improve the affordability of coverage.

#### LOW-INCOME PREMIUM SUBSIDY

Eight high-risk pools currently offer subsidized premiums for low-income enrollees (i.e., Connecticut, Colorado, Maryland, Montana, New Mexico, Oregon, Washington, and Wisconsin). Connecticut, Maryland, and Wisconsin also subsidize cost

sharing for low-income enrollees. Montana reduces the pre-existing condition exclusion period for subsidized enrollees, as well. Minnesota recently announced it will develop a low-income subsidy program, and New Hampshire officials are considering the same option.

Five of the pools subsidize premiums down to standard rates; this leaves low-income people still facing significant costs. In Missouri, for example, subsidizing premiums to standard rates would reduce the monthly premium for a 55-year-old man from \$901 per month to \$515 per month. A person with poverty-level wages would still have to spend 66 percent of their income for coverage. Three state high-risk pools offer below-market premiums for low-income individuals.

#### ACROSS-THE-BOARD REDUCTIONS

In recent years, numerous states have lowered high-risk pool premiums for all enrollees. Some took this action in order to qualify for new federal grants (when grant eligibility required premiums could not exceed 150 percent of standard rates). Others (e.g., Wisconsin and Maryland) reduced rates prior to the grant program in order to make coverage more affordable.

#### PREMIUM HOLIDAY

Three states (Illinois, Kansas, and Oklahoma) used federal grant funds to provide temporary premium relief to enrollees. These pools were also concerned about unaffordable coverage, but because the federal grant program had not yet been reauthorized, hesitated to adopt permanent premium reductions. Kansas and Oklahoma provided enrollees a one-month premium holiday, and Illinois temporarily deferred a scheduled premium increase for the coming plan year.

#### REDUCE AGE CLIMB

In MHIP, where older people comprise the majority of enrollees, affordability is especially problematic due to age rating. The premium age climb is 4:1 for men, and 2:1 for women. Some other state pools have moderated this climb. In Montana and Minnesota, for example, the oldest adults pay about three times the premiums charged young adults. In Maryland, the ratio is 2:1; and in Kansas it is 1.6:1.

#### *Expanding Adequacy of Coverage Under MHIP*

Coverage adequacy is especially important for high-risk populations. Studies have found underinsured individuals are more likely than the uninsured to be bankrupted by unpaid medical bills.<sup>34</sup> Financial burdens on chronically ill individuals can also delay or deter access to care.<sup>35</sup> Key challenges to the adequacy of coverage under MHIP include the following:

#### PRE-EXISTING CONDITION EXCLUSION PERIOD

In MHIP, as in most states, the very condition that renders a person medically eligible for the high-risk pool is subject to a pre-existing condition exclusion. MHIP annual reports acknowledge this exclusion period deters enrollment. Other research confirms this finding as well.<sup>36</sup> High-risk pools in other states have taken steps to moderate or eliminate pre-existing condition exclusions.

MHIP's 12-month exclusion period is one of the longest in the U.S. Only six other state pools impose a 12-month pre-existing exclusion period. Most pools apply a six-month exclusion period. In California, Indiana, and Kansas, the exclusion is 90 days. One state, Maryland, experimented with waiving pre-existing condition exclusions for all new members as of June 2004. Analysis of claims data found costs

increased roughly \$700 per member (above overall claims inflation) in the first six months of coverage when the pre-existing condition exclusion would otherwise have been in effect<sup>37</sup> (Figure 3). Because the Missouri pool does not currently apply the pre-existing condition exclusion to pharmaceutical claims – which account for 31 percent of total claims – the cost impact of completely waiving the exclusion period might be further moderated.

Almost all state high-risk pools that impose pre-existing condition exclusions will credit a new enrollee’s prior coverage to reduce the exclusion. Missouri and Illinois are the only two states that do not follow this practice. Most other states use the broad federal law definition of “creditable coverage” (which includes job-based health plans, COBRA, individual health insurance, other risk pool coverage, Medicare, Medicaid, etc.) and credit prior continuous coverage with no gap of 63 or more consecutive days. Texas is the only state that allows new enrollees to credit any prior coverage held within the

past 12 months against the pool’s pre-existing condition exclusion.

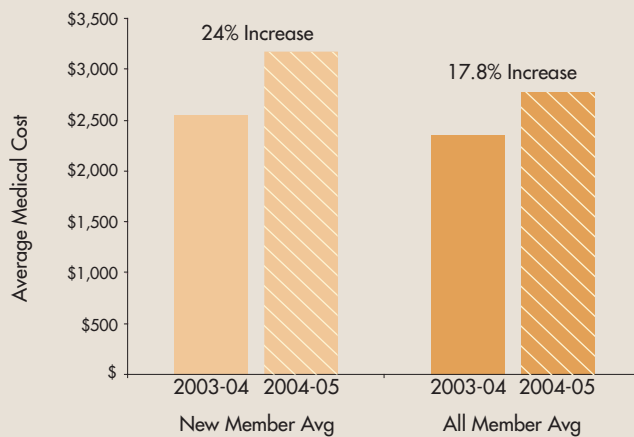
#### HOSPITAL BENEFIT LIMIT

Only two other state high-risk pools (Indiana and Washington) limit covered hospital care to 180 days per year. A third state, Iowa, eliminated the 180-day cap effective in 2005. In Missouri, the hospital benefit limit affects a small number of MHIP’s sickest enrollees. Although conventional wisdom assumes people manage to find needed care even when they cannot pay, research shows hospitals provide limited amounts of charity care and are likely to engage in aggressive collection practices against uninsured patients.<sup>38</sup> Full hospitalization coverage would enhance MHIP protection for enrollees against the cost of catastrophic medical conditions.

#### COST SHARING

A substantial number of MHIP enrollees reach their annual deductible and out-of-pocket limit each year. Out-of-pocket costs can compound annually for enrollees with

**Fig. 3. Maryland High-Risk Pool Claims Cost of New Enrollees Before and After Elimination of Six-Month Pre-Existing Condition Exclusion Period**



Source: Maryland Health Insurance Plan, [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us).

extended or chronic health conditions. MHIP has offered plan options with higher cost sharing and correspondingly lower premiums. However, for seriously ill individuals premiums and cost sharing are more likely to be additive, not alternatives. In other areas, MHIP has taken steps to limit cost-sharing liability – especially in the pharmaceutical benefit where enrollee co-payments are limited to a maximum of \$1,100 per year. MHIP might consider reducing the out-of-pocket limit on other medical benefits to this level.

### **Avoiding “Crowd Out”**

A common, constant concern of state high-risk pools is that private insurance carriers and health plans might divert expensive enrollees to the high-risk pool. Such “crowd out” or anti-selection runs counter to a high-risk pool’s function as the coverage of last resort. States can and do take steps to prevent or stop other health insurers from steering risk to the high-risk pool. All states can call on insurance regulators to investigate suspected instances of dumping risk into the high-risk pool. Periodic market-conduct examinations can also focus on marketing, enrollment, and renewal practices of carriers that may result in discouraging high-cost individuals from enrolling or continuing in private coverage or steering such individuals to the high-risk pool.

Two additional state strategies are noteworthy. The state of Washington regulates and standardizes the practice of medical underwriting by health insurers. All individual market carriers must use a standard questionnaire to evaluate the health status of applicants. A common scoring tool assigns points to health conditions and history to identify the most costly 8 percent of new applicants. Only these applicants are medically eligible for high-risk pool

coverage. In a somewhat different approach, Utah’s high-risk pool underwrites all applicants. Some of these applicants are found to not be sufficiently high-risk by the pool underwriters and are given a certificate of insurability, entitling them to request coverage on a guaranteed issue basis from private insurers.

### **Enhancing MHIP Revenue**

Improving the availability, affordability, and adequacy of MHIP coverage will likely increase program costs. Currently, MHIP’s two main sources of revenue are enrollee premiums and assessments on insurers. Insurer assessments are offset by other tax credits, however, decreasing state general revenues. MHIP and state policymakers might consider other options for funding pool losses and promoting coverage expansion.

#### **FEDERAL MATCHING GRANTS**

Under the recently reauthorized federal high-risk pool grant program, \$75 million in annual federal financial assistance is available to qualified pools. Missouri could join the list of qualified pools by becoming a HIPAA-qualified pool.

The \$75 million grant fund is allocated as follows: \$25 million is initially set aside in a bonus pool (discussed below). Of the remaining \$50 million:

- 40 percent (\$20 million) is divided equally between eligible pools. Assuming all 30 HIPAA-eligible pools apply, Missouri would receive \$667,000 under this allocation.
- 30 percent (\$15 million) is allocated based on each grantee pool’s share of total high-risk pool enrollment in all grantee pools. Because MHIP is a small pool, Missouri would likely receive about 1.6 percent of this allocation, or another \$245,000. However, the state’s share of these funds could increase if

MHIP adopted changes to increase enrollment.

- 30 percent (\$15 million) is allocated based on each grantee pool's share of the total uninsured population residing in the states of all grantee pools. Large population states such as Texas would receive the lion's share of this allocation; Missouri would likely receive only 3-4 percent of this pool, or roughly \$500,000.

Based on these estimates, Missouri might receive approximately \$1.4 million from basic grant funds.<sup>39</sup> Assuming MHIP does not reduce premiums to 150 percent of standard rates, at least half of this amount would have to be spent on premium relief to enrollees in one form or another.

Missouri also could apply for funds under the \$25 million bonus pool that is available to programs which reduce or subsidize enrollee premiums, expand covered benefits, expand eligibility, reduce pre-existing condition exclusion periods, or offer disease management programs for enrollees. Federal legislation does not specify a formula for allocating the \$25 million bonus grant pool, other than to limit any one pool from receiving more than 10 percent of those funds in a year. In theory, therefore, Missouri could qualify for bonus grants of up to \$2.5 million annually to help offset the cost of other program improvements.

#### HCTC PREMIUM SUBSIDY

As noted earlier, MHIP could also be designated as a qualified coverage option under the HCTC. The federal government would then pay 65 percent of MHIP premiums for Missourians eligible for the tax credit. The HCTC tax subsidy can be claimed on the end-of-year return, or individuals can elect to have it paid on a monthly basis directly to MHIP.

#### THIRD-PARTY PREMIUM ASSISTANCE

Several pools accept premium payments on behalf of enrollees from third parties. Payments might come from charitable organizations, such as churches. Several nonprofit organizations, sponsored mostly by pharmaceutical manufacturers, will also pay premiums for available coverage on behalf of patients who would otherwise be uninsured.

#### OTHER FEDERAL FINANCIAL ASSISTANCE

At least one state, Montana, has been able to secure special federal appropriations to support the cost of its high-risk pool. The Montana pool initially financed its low-income subsidy program with a \$1 million grant secured by the Montana Congressional Delegation in 2004.

#### END TAX CREDIT OFFSET FOR HIGH-RISK POOL INSURER ASSESSMENTS

Finally, Missouri policymakers might consider ending the tax credit offset for insurer assessments. Most states that assess insurers do not provide tax credit offsets. The ability to medically underwrite coverage is financially advantageous to insurers and disadvantageous to consumers whose access to private insurance is curtailed. An assessment is one way to equitably balance such wins and losses. Advocates for a tax offset may argue that general revenue funding provides a broader, more equitable funding base than an assessment on commercial insurers that cannot reach other Employee Retirement Income Security Act (ERISA) exempted health coverage. However, some or all of the increase in state general revenue from ending the tax offset could also be used to support MHIP. Other more broad-based funding sources could also be considered. Several states assess hospitals and stop loss carriers, instead of or in addition to health insurance carriers in the individual market.

## Conclusion

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Missouri has been slow to adopt changes that other states have implemented to enhance the protection that high-risk pools can offer “uninsurable” residents. Eligibility standards for high-risk pool coverage in Missouri are narrower than under most other state high-risk pools, and MHIP premiums are set at a higher level than in most other states. Additionally, Missouri does not offer relief for low-income enrollees, and the state does not take advantage of premium assistance that may be available from the federal government or other third parties. Cost sharing for covered benefits under the MHIP program is high; and while lower cost-sharing options are available, they have correspondingly higher premiums. This makes the total cost of participation in the program very high for individuals with expensive health conditions. In addition, for medically uninsurable applicants, MHIP imposes a lengthy pre-existing condition exclusion period that generally is not waived or reduced for prior coverage. These features limit the protection MHIP offers sick residents in Missouri who are in need of non-group health insurance because they do not qualify for job-based coverage or Medicaid. As a result, MHIP helps far fewer such individuals than it could. Program enrollment constitutes only 0.8 percent of individual health insurance market participation. This percentage falls well below the average enrollment rate of other

high-risk pools and far below the likely number of Missourians who might be considered “uninsurable.”

A new federal grant program for state high-risk pools presents an opportunity for MHIP to enhance the protection it offers residents with serious and chronic health conditions who need individual health insurance and who have no other coverage options. MHIP would need to become a HIPAA-qualified pool in order to qualify for federal grants. The amount of federal funds MHIP might receive would depend, in part, on the extent to which the program increases enrollment and adopts other changes to promote enrollment growth (e.g., premium relief, benefit coverage enhancement, and reduction or elimination of pre-existing condition exclusions). In addition, the state would likely need to explore other financing sources to cover the costs of significant enrollment growth. Missouri might also coordinate changes in MHIP with changes in the regulation of private health insurance so that program expansion covers uninsured residents instead of displacing other coverage. Any increase in MHIP enrollment, however modest, will provide significant relief to seriously ill, uninsured individuals who are able to enroll in the program. Additionally, an expansion will help reduce uncompensated care for the broader health care system.

## Appendix A. High Risk Pool Enrollment as a Percentage of Individual Market Participants

State	Pool Enrollment in 2003*	State Individual Market Participants Under Age 65 in 2003**	Pool as % of Individual Market
AL	3,464	207,000	1.7
AK	484	29,000	1.7
AR	3,296	134,000	2.5
CA	8,570	2,601,000	0.3
CO	4,801	325,000	1.5
CT	2,290	143,000	1.6
FL	520	1,173,000	0.04
ID	1,330	106,000	1.3
IL	16,055	741,000	2.2
IN	9,309	362,000	2.6
IA	130	214,000	0.1
KS	1,703	197,000	0.9
KY	2,457	213,000	1.2
LA	1,368	259,000	0.5
MD	6,137	251,000	2.4
MN	33,705	424,000	7.9
MS	4,240	138,000	3.1
MO	2,440	294,000	0.8
MT	3,556	70,000	5.1
NE	6,087	176,000	3.5
NH	158	48,000	0.3
NM	1,200	62,000	1.9
ND	1,806	61,000	3.0
OK	2,845	167,000	1.7
OR	9,885	232,000	4.3
SC	1,798	247,000	0.7
SD	386	67,000	0.6
TX	24,675	879,000	2.8
UT	3,000	181,000	1.7
WA	2,652	485,000	0.5
WI	17,447	304,000	5.7
WY	657	40,000	1.6
<b>Total</b>	<b>178,451</b>	<b>10,830,000</b>	<b>1.6</b>

\* *Comprehensive Health Insurance for High-Risk Individuals*, 18th ed. (Fergus Falls, Minn.: Communicating for Agriculture and the Self-Employed, 2004/2005).

\*\* U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2003, available at [http://pubdb3.census.gov/macro/032004/health/h05\\_000.htm](http://pubdb3.census.gov/macro/032004/health/h05_000.htm).

## Appendix B. High Risk Pool Financing Arrangements

State	Source(s) for Financing Pool Losses*
AL	Assessment on insurers, with tax credit offset
AK	Assessment on insurers, no tax offset
AR	Assessment on insurers, tax credit offset
CA	Tobacco tax
CO	Assessment on insurers, no tax offset; plus other state funds
CT	Assessment on insurers, no tax offset
FL	Assessment on insurers, no tax offset
IL	Assessment on insurers, tax credit offset
IN	Assessment on insurers, tax credit offset
IA	Assessment on insurers, tax credit offset
KS	Assessment on insurers, no tax offset; plus other state funds
KY	Assessment on insurers, no tax offset (HIPAA enrollees only); plus other state funds (non-HIPAA enrollees only)
LA	Assessment on insurers, no tax offset; plus other state funds
MD	Hospital assessment
MN	Assessment on insurers, no tax offset
MS	Assessment on insurers, tax credit offset
MO	Assessment on insurers, tax credit offset
MT	Assessment on insurers, tax credit offset
NE	Assessment on insurers, no tax offset
NH	Assessment on insurers, tax credit offset
NM	Assessment on insurers, tax credit offset
ND	Assessment on insurers, no tax offset
OK	Assessment on insurers, no tax offset
OR	Assessment on insurers, tax credit offset
SC	Assessment on insurers, no tax offset; plus other state funds; provider payment reductions
SD	Assessment on insurers, no tax offset
TX	Assessment on insurers, no tax offset
UT	Assessment on insurers, no tax offset; plus carriers whose loss ratio falls below 72% must remit the excess to pool
WA	Assessment on insurers, no tax offset; plus excess loss ratio remittances from carriers with loss ratios below 72 percent
WV	Hospital assessment
WI	Assessment on insurers with tax offset, provider payment reductions, general revenue appropriations
WY	Assessment on insurers, tax credit offset

\* In many states, health insurers are assessed, or taxed, to finance high-risk pool losses, but the assessment is offset by credits to reduce other insurer taxes. In these states, pool losses are funded indirectly by general revenue.

Source: *Comprehensive Health Insurance for High-Risk Individuals, A State-by-State Analysis*, 18th ed. (Fergus Falls, Minn.: Communicating for Agriculture and the Self-Employed, 2004/2005).

## ENDNOTES

- <sup>1</sup> This total includes the Florida pool, which has been closed to new enrollment since 1991. Some tally the number of high-risk pool states by also including Idaho and Tennessee. Idaho requires licensed insurers to sell guaranteed issue products, which are called “high-risk pool products,” but which are not financed or governed like other state high-risk pools. Tennessee also has been considered a high-risk pool state, although its program was merged with Medicaid (TennCare) in 1994. TennCare since closed to new “uninsurable” enrollment and, as of July 2005, has begun disenrolling these individuals.
- <sup>2</sup> Communicating for Agriculture and the Self-Employed, *Comprehensive Health Insurance for High-Risk Individuals*, 18th ed. (Fergus Falls, Minn: Communicating for Agriculture and the Self-Employed, 2004).
- <sup>3</sup> L Achman and D Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (New York, New York: The Commonwealth Fund, 2001).
- <sup>4</sup> L Tooman, “Real People, Real Coverage” (Issues and Answers No. 103), Council for Affordable Health Insurance, 2002. Available at [www.cahi.org/cahi\\_contents/resources/pdf/realpeople.pdf](http://www.cahi.org/cahi_contents/resources/pdf/realpeople.pdf)
- <sup>5</sup> Many states offset insurer assessments with a tax credit so that general revenues indirectly fund high-risk pool costs.
- <sup>6</sup> Achman and Chollet, 2001.
- <sup>7</sup> K Pollitz et al, *Falling Through the Cracks: Stories of How Health Insurance Can Fail People With Diabetes* (Washington, DC: American Diabetes Association and Georgetown University, 2005). Available at [web.diabetes.org/Advocacy/healthresearchreport0505.pdf](http://web.diabetes.org/Advocacy/healthresearchreport0505.pdf)
- <sup>8</sup> A Frakat et al, “Insuring the Uninsurable: The Growth in High-Risk Pools” (HSRE Working Paper 12), Abt Associates, 2002.
- <sup>9</sup> K Pollitz et al, “Early Experience With ‘New Federalism’ In Health Insurance Regulation,” *Health Aff* 19.4 (2000):7-22.
- <sup>10</sup> Communicating for Agriculture and the Self-Employed, *Comprehensive Health Insurance for High-Risk Individuals*, 14th ed. (Fergus Falls, Minn: Communicating for Agriculture and the Self-Employed, 2000).
- <sup>11</sup> Internal Revenue Service (IRS), “State Plan Enrollment as of April 30, 2005” (Internal document), IRS, 2005.
- <sup>12</sup> United States Government Accountability Office (GAO), *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation*, GAO-04-1029 (Washington, DC: GAO, 2004).
- <sup>13</sup> S Finan, “Risk Analysis of the TAA Population, HCTC” (presentation at NASCHIP Annual Conference), 19 October 2005.
- <sup>14</sup> Finan, 2005.
- <sup>15</sup> J Ancel, *Offshoring the Missouri Economy: Free Trade Job Losses and Their Impact on Missouri Workers* (Kansas City, MO: The Institute for Labor Studies, UMKC Department of Economics, 2004). Available at [www.umkc.edu/labor-ed/documents/OffshoringMissouri.pdf](http://www.umkc.edu/labor-ed/documents/OffshoringMissouri.pdf).
- <sup>16</sup> K Pollitz and E Bangit, “Federal Aid to State High-Risk Pools: Promoting Health Insurance Coverage or Providing Fiscal Relief?” (Issue Brief), The Commonwealth Fund, 2005.

- <sup>17</sup> Pollitz and Bangit, 2005.
- <sup>18</sup> United States Cong. House, *HR 3204, State High Risk Pool Funding Extension Act of 2005* (Washington, DC: Government Printing Office (GPO), 2005). Available at [thomas.loc.gov/cgi-bin/thomas](http://thomas.loc.gov/cgi-bin/thomas).
- <sup>19</sup> Missouri Health Insurance Pool (MHIP), *2002 Annual Report*, p. 3 (Kansas City, MO: MHIP, 2002). Available at [www.mhip.org](http://www.mhip.org).
- <sup>20</sup> Missouri Health Insurance Pool (MHIP), *2001 Annual Report*, p. 10 (Kansas City, MO: MHIP, 2001). Available at [www.mhip.org](http://www.mhip.org).
- <sup>21</sup> U.S. Census Bureau, “Median Household Income by State: 1984-2004,” U.S. Census Bureau, 2004. Available at [www.census.gov/hhes/www/income/histinc/h08.html](http://www.census.gov/hhes/www/income/histinc/h08.html).
- <sup>22</sup> Interview with Vernita Bridges, Missouri Health Insurance Pool (MHIP) Executive Director, 25 October 2005.
- <sup>23</sup> MHIP, 2001, p. 16.
- <sup>24</sup> Bridges interview.
- <sup>25</sup> Bridges interview.
- <sup>26</sup> MHIP, 2002, p. 1.
- <sup>27</sup> United States Government Accountability Office (GAO), *Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators*, GAO/HEHS-98-67 (Washington, DC: GAO, 1998).
- <sup>28</sup> K Pollitz, R Sorian, and K Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington, DC: Henry J. Kaiser Family Foundation, 2001). Available at [www.kff.org](http://www.kff.org).
- <sup>29</sup> Missouri Health Insurance Pool (MHIP), *2003 Annual Report*, p. 4 (Kansas City, MO: MHIP, 2003). Available at [www.mhip.org](http://www.mhip.org).
- <sup>30</sup> MHIP, 2003, p. 6.
- <sup>31</sup> MHIP, 2002, p. 11.
- <sup>32</sup> MHIP, 2003, p. 6.
- <sup>33</sup> Finan, 2005.
- <sup>34</sup> M Jacoby, T Sullivan and E Warren, “Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts,” *New York University Law Review*, 76.2 (2001): 375-415.
- <sup>35</sup> J May and P Cunningham, “Tough Trade-offs: Medical Bills, Family Finances and Access to Care,” *Center for Studying Health System Change*, 85 (June):1-4.
- <sup>36</sup> K Pollitz, 2005.
- <sup>37</sup> This cost impact may be overstated because Maryland also introduced a new lower deductible option (\$500 vs. \$1,000) in July of 2004.
- <sup>38</sup> Community Catalyst, Inc. *Not There When You Need It: The Search for Free Hospital Care* (Boston, MA: Community Catalyst, Inc., 2003). Available at [www.communitycatalyst.org](http://www.communitycatalyst.org).
- <sup>39</sup> Author’s estimate based on census data ([www.census.gov](http://www.census.gov)) and high-risk pool enrollment data from *Comprehensive Health Insurance for High-Risk Individuals*, 19th ed. (Fergus Falls, Minn.: Communicating for Agriculture and the Self-Employed, 2005/2006).



### Cover Missouri Project Publications

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The Cover Missouri Project includes a series of reports and fact sheets produced in early 2006. All materials are available online at [www.mffh.org](http://www.mffh.org). Printed fact sheets and reports are available while supplies last. For more information about the Cover Missouri Project, contact the MFH Health Policy staff at [info@mffh.org](mailto:info@mffh.org) or toll-free at 1-800-655-5560.



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