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Health Policy for Low-Income People in Missouri

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Missouri has a robust economy and an advanced health care market compared to many other states. Its employment rate is notably higher than average and its poverty rate is lower than average, but its major health indicators are generally less favorable than those for the United States as a whole. In Missouri, managed care has significantly penetrated both the private and public markets. The state has developed an innovative children's health insurance program and has implemented one of the nation's first state-run health care purchasing coalitions for state and other public employees. Missouri's Medicaid spending per enrollee is quite low relative to that of most other states. However, the percentage of Medicaid spending dedicated to the state's disproportionate share hospital (DSH) program is one of the highest in the country.

Missouri is now one of the few states that allows children with incomes this high (300 percent of the FPL) to participate in the Medicaid program.

State Characteristics

Sociodemographic Profile

In 1994–95, Missouri's population was 5.1 million (table 1). Roughly 72 percent of the state's population is concentrated in metropolitan areas, including St. Louis, Kansas City, and Jefferson City, the state's capital. Although the population in Missouri continues to grow, the rate of expansion slowed during the 1970s and 1980s. It picked up during the first half of this decade, expanding at an average annual rate of 0.8 percent.

Missouri's population is older than that of the United States overall. Children under age 18 comprise less of the population in Missouri than they do in the country as a whole (23.9 percent versus 26.8 percent), while individuals 65 and older make up slightly more of Missouri's population than the national average (13.9 percent compared with 12.1 percent) (table 1).

Missouri's population is less ethnically and racially diverse than the U.S. population as a whole. Non-Hispanic whites comprise 86.5 percent of Missouri's population, versus 72.6 percent nationwide. Only 1.8 percent of Missouri's population classify themselves as Hispanic, compared with 10.7 percent nationally. In addition, the state's percentages of non-Hispanic blacks (10.0 percent) and other non-Hispanic residents (1.7 percent), such as Asians and Native Americans, are slightly lower than the corresponding U.S. percentages (12.5 percent and 4.2 percent, respectively) (table 1).

Economic Indicators

The average per capita income for Missouri residents in 1996 was $23,022, about 6 percent below the U.S. average of $24,426 (table 1). However, there was a 4.9 percent increase in per capita income in Missouri from 1995 to 1996, slightly above the national increase of 4.6 per-

Table 1
State Characteristics

	Missouri	United States
Sociodemographic		
Population (1994–95)[a] (in thousands)	5,106	260,202
Percent under 18 (1994–95)[a]	23.9%	26.8%
Percent 65+ (1994–95)[a]	13.9%	12.1%
Percent Hispanic (1994–95)[a]	1.8%	10.7%
Percent Non-Hispanic Black (1994–95)[a]	10.0%	12.5%
Percent Non-Hispanic White (1994–95)[a]	86.5%	72.6%
Percent Non-Hispanic Other (1994–95)[a]	1.7%	4.2%
Percent Noncitizen Immigrant (1996)[b]	1.3%	6.4%
Percent Nonmetropolitan (1994–95)[a]	28.4%	21.8%
Population Growth (1995–96)[c]	0.7%	0.9%
Economic		
Per Capita Income (1996)[d]	$23,022	$24,426
Percent Change in Per Capita Personal Income (1995–96)[d]	4.9%	4.6%
Percent Change in Personal Income (1995–96)[d]	5.7%	5.6%
Employment Rate (1997)[e, f]	67.9%	63.8%
Unemployment Rate (1997)[e]	4.2%	4.9%
Percent below Poverty (1994)[g]	13.8%	14.3%
Percent Children below Poverty (1994)[g]	19.8%	21.7%
Health		
Vaccination Coverage of Children Ages 19–35 Months (1996)[h,i]	74.0%	77.0%
Low Birth-Weight Births (<2,500 g) (1995)[j]	7.6%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1996)[k]	8.1	7.2
Premature Death Rate (Years Lost per 1,000) (1995)[l]	46.9	46.7
Violent Crimes per 100,000 (1996)[m]	590.9	634.1
AIDS Cases Reported per 100,000 (1996)[n]	16.0	25.2
Political		
Governor's Affiliation (1998)[o]	D	
Party Control of Senate (Upper) (1998)[p]	17D-16R	
Party Control of House (Lower) (1998)[p]	86D-76R-1I	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. CPS three-year average (March 1995–March 1997, where 1996 is the center year) edited by the Urban Institute to correct for misreporting of citizenship.
c. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1997* (117th edition). Washington, DC, 1997. 1995 population as of April 1. 1996 population as of July 1.
d. Bureau of Economic Analysis, U.S. Department of Commerce, January 1998.
e. U.S. Department of Labor. *State and Regional Unemployment, 1997 Annual Averages.* USDL 98-78. Washington, DC, February 27, 1998.
f. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.
g. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.
h. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. "National Immunization Survey, 1996." *Morbidity and Mortality Weekly Report* 46(29). Hyattsville, MD, July 25, 1997.
i. 4:3:1:3 series: four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of any MCV, and three or more doses of *Haemophilus influenzae* type b vaccine.
j. S.J. Ventura, J.A. Martin, S.C. Curtin, and T.J. Mathews. "Advance Report of Final Natality Statistics, 1995." *Monthly Vital Statistics Report* 45(11), supp. Hyattsville, MD: National Center for Health Statistics, 1997.
k. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for June 1996." *Monthly Vital Statistics Report* 45(12). Hyattsville, MD: Public Health Service, 1997.
l. Rate was calculated using years of potential life lost from age 65 (National Center for Health Statistics. Multiple Cause of Death Mortality Tapes, 1995) as the numerator and population estimates (U.S. Bureau of the Census. ST-96-1. Estimates of the Population of States: Annual Time Series, July 1, 1990, to July 1, 1996) as the denominator.
m. U.S. Department of Justice, FBI. *Crime in the United States, 1996.* September 28, 1997.
n. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 8(2), 1996.
o. National Governors' Association. *The Governors, Political Affiliations, and Terms of Office, 1998.* January 15, 1997.
p. National Conference of State Legislatures Web site: www.ncsl.org. D indicates Democrat, R indicates Republican, and I indicates Independent.

cent. In 1997, Missouri's employment rate, at 67.9 percent, was higher than the national employment rate of 63.8 percent. In addition, 23,500 more state residents had jobs in May 1998 than did in May 1997.[1]

Missouri also is doing somewhat better than the national average with respect to the percentage of the population living in poverty. In 1994, 13.8 percent of Missouri's population had incomes below the federal poverty level (FPL), compared with 14.3 percent of the U.S. population. Further, 19.8 percent of children lived below the FPL in Missouri, compared with 21.7 percent of children nationwide.

Missouri's economy was primarily based on agriculture until World War II, when the state began to build up its service sector (particularly in St. Louis) and manufacturing sector, building aircraft and automobiles for the war effort. These industries continue to thrive; most notably, McDonnell Douglas (now a subsidiary of Boeing) is headquartered in St. Louis. In addition, U.S. automobile manufacturers, while headquartered in Detroit, have major facilities in the St. Louis area. Missouri is also an important manufacturer of food and chemical products.

Even today, however, Missouri is second only to Texas in its number of farms, which produce dairy products, beef cattle, and crops. The state also is known for its tourist attractions (it is the home state of Harry Truman and Mark Twain), outdoor recreation opportunities (the Ozark Mountains), and river commerce (the Mississippi and Missouri rivers join within its borders). St. Louis and Kansas City are major railway hubs.

Health Indicators

Missouri has not fared as well as the United States overall on a number of health status indicators, particularly those related to maternal and child health. Missouri's infant mortality rate, at 8.1 deaths per 1,000 live births, and percentage of low birth-weight births, at 7.6 percent, are both higher than the corresponding U.S. figures (7.2 deaths and 7.3 percent, respectively). The state's vaccination rate for infants ages 19 to 35 months is lower than the national average (74.0 percent compared with 77.0 percent for the United States) (table 1). Missouri fares better than the nation

overall on indicators of violent crimes and reported AIDS cases. In 1996, Missouri had 590.9 violent criminal offenses per 100,000 population, compared with 634.1 nationwide, and the state had 16.0 reported AIDS cases per 100,000 population, while the country as a whole had 25.2 per 100,000.

The state's premature death rate (number of years of potential life lost before age 65 per 1,000 population) suggests that, on balance, the health of Missouri's population is about average (table 1). However, the state ranked 32nd on a composite measure of health indicators in 1997. This relatively low ranking was attributed in large part to the state's very high rates of heart disease and cancer.[2]

Politics and Budgetary Policy

Although political races in Missouri often are closely contested between Democratic and Republican candidates, the General Assembly, the governor's seat, and the state's delegation in the U.S. Congress are typically dominated by Democrats. Missouri's current governor, Democrat Mel Carnahan, was elected to his second four-year term in 1996. Missouri's state senate of 34 members consists of 17 Democrats, 16 Republicans, and 1 vacancy, and the house (163 members) has 86 Democrats, 76 Republicans, and 1 Independent.

State general fund revenues for fiscal year (FY) 1998 (including refunds) totaled $6.2 billion.[3] Total state revenues, which include general-fund revenues, other state funds, and federal aid, were roughly $14 billion. General-fund revenue collections were up 5.7 percent from FY 1997, reflecting the strong economy.[4]

Spending from the general fund has also been increasing steadily. For example, from 1990 to 1995, the average annual growth rate of expenditures was 4.8 percent. General-fund spending on Medicaid as a proportion of total general-fund outlays declined during this period, from 7.1 percent in 1990 to 6.5 percent in 1995. In contrast, because of the large growth in DSH payments, total spending on Medicaid (including federal dollars) as a share of total state expenditures almost doubled between 1990 and 1995, from 11.2 percent to 21.8 percent. The state slightly increased the proportion of the general fund it spent on primary and secondary education between 1990 (41.5 percent) and 1995 (42.7 percent). Higher education's share declined from 12.7 percent to 10.6 percent, while corrections and Aid to Families with Dependent Children (AFDC) held steady (3.7 percent and 1.9 percent of spending, respectively).

More recently, spending increases from the state general fund have been budgeted for 1998 and 1999.[5] In 1998, increases in spending total $295 million, including $79 million for criminal justice and $66 million for Medicaid. Of the total $376 million in spending increases authorized for 1999, $76 million is for criminal justice, $111 million is for Medicaid, and $46 million is for education.

The Health Care Market

Insurance

Managed care penetration in Missouri is slightly higher than the national average. As of 1996, 25.2 percent of Missouri's total population was enrolled in health maintenance organizations (HMOs), compared with 24.0 percent of the entire U.S. population. Missouri lags a little behind the United States as a whole in moving its Medicare and Medicaid enrollees into HMOs. In 1997, 11.1 percent of Medicare beneficiaries in Missouri were enrolled in capitated health plans, compared with 12.5 percent of the total U.S. Medicare population. In 1996, managed care (HMO and primary care case management) enrollees were 34.8 percent of Missouri's Medicaid population, compared with 40.1 percent of the overall U.S. Medicaid population.

As of May 1998, there were 32 licensed HMOs operating in Missouri, including national firms such as Blue Cross and Blue Shield; CIGNA Healthcare; Humana Health Plan, Inc.; Kaiser Foundation Health Plan; Prudential Health Care Plan, Inc.; and United Healthcare of the Midwest, Inc. United Healthcare has the largest enrollment in the state—roughly 493,000 enrollees.[6] In April 1998, Blue Cross and Blue Shield of Missouri converted from nonprofit to for-profit status when it transferred all of its "profitable" businesses into a newly created for-profit subsidiary called RightChoice Managed Care, Inc.[7] This action followed a four-year dispute with Missouri's attorney general over the disposition of the former nonprofit entity's substantial assets of between $200 million and $400 million. These assets will fund the state's largest health care foundation.

In early 1997, Missouri passed managed care consumer protection legislation (House Bill 335) that holds health plans in the state to specific standards.[8] The legislation bans gag clauses, mandates coverage for emergency care, and establishes grievance procedures for managed care enrollees. The state is in the process of developing regulations to carry out the legislation.

Hospitals

Since 1993, the state of Missouri, and the city of St. Louis in particular, have experienced substantial hospital merger activity. Prior to 1993, there were 38 independent hospitals in the St. Louis area. Most of these hospitals survived the merger activity without closing and are now partners or affiliates of one of the four major hospital systems—Barnes Jewish Christian, Deaconess Incarnate Word Health System, Sisters of St. Mary Health Care System, and Unity Health—in St. Louis. In addition, Tenet Healthcare, the nation's second-largest for-profit hospital system, recently tried to enhance its foothold in the St. Louis area, attempting to purchase Doctors Regional Medical Center and merge it with the Tenet-controlled Lucy Lee Hospital. These two facilities are the only hospitals in Poplar Bluff, a small town in suburban St. Louis.[9] The Federal Trade Commission and Missouri's attorney general have filed suit to block the merger based on alleged antitrust violations. Several months prior to this, Tenet successfully purchased St. Louis University Hospital.[10]

A recent study of the St. Louis health care market concluded that the wave of hospital mergers had not yet resulted in any significant reduction in excess bed capacity or duplication of services. Rather, merged hospital systems were propping up some community hospitals that might otherwise have closed, in an effort to form community-wide networks that could limit managed care companies' ability to negotiate

Table 2
Health Insurance Coverage

Health Insurance, 1994–95	Missouri	United States
Nonelderly Population		
Percent Uninsured[a]	13.4 %	15.5 %
Percent Medicaid[a]	10.7	12.2
Percent Employer-Sponsored[a]	70.0	66.1
Percent Other Health Insurance[a, b]	5.9	6.2
19–64 Population		
Percent Uninsured[a]	16.4	17.9
Percent Medicaid[a]	5.2	7.1
Percent Employer-Sponsored[a]	71.4	67.8
Percent Other Health Insurance[a, b]	7.1	7.2
0–18 Population		
Percent Uninsured[a]	6.2	10.4
Percent Medicaid[a]	24.1	23.1
Percent Employer-Sponsored[a]	66.7	62.5
Percent Other Health Insurance[a, b]	3.0	4.0
<200 Percent of the Federal Poverty Level, Nonelderly Population		
Percent Uninsured[a]	22.7	25.3
Percent Medicaid[a]	31.0	34.1
Percent Employer-Sponsored[a]	39.0	33.9
Percent Other Health Insurance[a, b]	7.3	6.7

a. Two-year concatenated March Current Population Survey files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

lower hospital charges.[11] In fact, the desire to negotiate more effectively with managed care organizations was a major impetus for the wave of merger activity.

Missouri Consolidated Health Care Plan

Missouri is one of the first—and one of the few—states in the country to have a state-sponsored purchasing alliance, the Missouri Consolidated Health Care Plan (MCHCP).[12] MCHCP is a stand-alone state entity with its own board of trustees. As of February 1998, MCHCP negotiated coverage for more than 137,000 state and other public employees, retirees, and their dependents.

MCHCP was created by state legislation in May 1992 to increase access to health care coverage for public employees and their dependents in a cost-effective manner. The purchasing coalition, which began operating in January 1994, was initially intended to benefit only state employees and retirees. By January 1995, other public entities, including cities, counties, and school districts, were allowed to participate. In February 1998, a bill was introduced in the state's General Assembly to expand the program to farm and other small businesses that have difficulty affording health insurance.[13] This bill is still pending in the state legislature.

The MCHCP system divides the state into eight health care purchasing regions. HMOs and point-of-service plans are available in each of the regions. Indemnity plans are available in only a few of the regions. Contracts under MCHCP were awarded to virtually all of the managed care plans that responded to the request for proposals, enabling many public employees to maintain access to their preferred physicians.

Prior to the implementation of MCHCP, the state of Missouri paid 100 percent of the state employee's portion of the premium (for any health plan) and nothing for dependent coverage. Under MCHCP, the state pays 100 percent of the premium of the lowest-cost plan for employee coverage (the employee pays the difference if enrolled in a higher-cost plan) and a fixed portion of the premium for dependent coverage. These incentives have contributed to a fourfold increase in HMO enrollment for public employees in Missouri, from 24 percent in 1994 to an estimated 96 percent in 1998.[14]

MCHCP is working closely with Gateway Purchasers for Health (GPH), a coalition of 30 large corporations in St. Louis, to use quality indicators to support comparable assessments of health plans. MCHCP and GPH jointly contracted with vendors to collect quality and patient satisfaction information through the Health Plan Employer Data and Information Set (HEDIS).

Health Insurance Coverage

In 1994–95, 70.0 percent of Missouri's nonelderly population had employer-sponsored health insurance; approximately two-thirds (66.1 percent) of the U.S. population had employer-sponsored coverage for the same period (table 2). Above-average coverage in Missouri may reflect the strong presence of the state's manufacturing sector, where employee health benefits are more prevalent than in the service sector.

Roughly 588,000—or 13.4 percent—of Missouri's 4.4 million nonelderly residents were uninsured in 1994–95, lower than the national rate of 15.5 percent. Of the state's 1.5 million nonelderly low-income individuals (defined as having incomes below 200 percent of the FPL), 336,000—or 22.7 percent—were uninsured, compared with 25.3 percent nationwide.

Medicaid enrollment in Missouri is just below the national average, with 10.7 percent of the state's nonelderly population enrolled in Medicaid, compared with 12.2 percent of the U.S. population. Of the state's nonelderly low-income population, 31.0 percent is enrolled in Medicaid, compared with the national figure of 34.1 percent.

State-sponsored health insurance programs also include a statewide high-risk insurance pool, started in 1992, with roughly 1,000 enrollees. The state also supports a general assistance medical program for low-income residents that is more limited in its eligibility stan-

dards than Medicaid. The program had an average monthly caseload of about 5,000 enrollees in 1996.

Medicaid

Eligibility

Before the enactment of the federal Balanced Budget Act of 1997, which contains the Children's Health Insurance Program (CHIP) that led many states to expand Medicaid eligibility, Missouri was operating its Medicaid program essentially at minimum federal eligibility guidelines. The main exception was that pregnant women and infants (children under age one) in families with incomes up to 185 percent of the FPL were eligible for Medicaid, exceeding the 133 percent mandatory minimum. For all other children, coverage was at federally mandated levels: Children ages 1 through 5 in families with incomes up to 133 percent of the FPL and children ages 6 to 14 in families with incomes up to 100 percent of the FPL were eligible for Medicaid. The Omnibus Budget Reconciliation Act of 1991 requires states to expand Medicaid eligibility by one year of age annually until all children under age 19 up to 100 percent of the FPL are eligible for Medicaid by the year 2002. States are permitted to expand Medicaid eligibility further through the federal waiver process. Missouri submitted a research and demonstration waiver in 1994 that included an eligibility expansion; although the waiver was not approved by the time that the Balanced Budget Act was enacted, it was approved soon after.

Recipients of Temporary Assistance for Needy Families (TANF, previously Aid to Families with Dependent Children (AFDC)) also are eligible for Medicaid. To be eligible for Medicaid under this category, families must meet the state-established need standard, which in 1994 was an annual income of $3,504 for a family of three in Missouri, compared with the mean level of $5,231 for the United States as a whole. Missouri also has an optional medically needy category within its Medicaid program, allowing individuals with high health care expenses to "spend down" to Medicaid income eligibility levels.

Enrollment

In 1996, 786,000 individuals were enrolled in Missouri's Medicaid program, down from 790,000 in 1995. This absolute drop in enrollment marked the end of a steady expansion trend in Missouri's program: Between 1990 and 1992, the average annual growth in enrollment was 10.4 percent, and between 1992 and 1995, it was 6.9 percent. These trends paralleled national Medicaid enrollment figures, which edged downward from 41.7 million in 1995 to 41.2 million in 1996, after average annual growth of 11.3 percent between 1990 and 1992 and 5.3 percent between 1992 and 1995. Just under half (47 percent) of Missouri's enrollees were cash assistance recipients in 1996, down from 60 percent in 1990. The nation overall experienced a similar decline in the number of Medicaid enrollees receiving cash assistance (54 percent in 1996, compared with 67 percent in 1990).

More than half of Missouri's Medicaid enrollees are children, while 21 percent are nonelderly adults, 13 percent are blind and disabled, and 12 percent are elderly. Children made up more of the Medicaid population in 1996 (53 percent of total enrollees) than they did in 1990 (48 percent), while the adult segment of enrollees has declined (21 percent in 1996, compared with 25 percent in 1990). The proportions of the Medicaid population that are elderly and blind and disabled have remained relatively steady since 1990.

Expenditures

In 1996, Medicaid expenditures in Missouri reached $3 billion, over three times as much as the $992 million spent in 1990 (table 3). About 60 percent of this amount was the federal government's match. The overall increase in Medicaid spending during the 1990–96 period masks a dramatic deceleration in outlay increases for the program. The annual increase was only 5.1 percent from 1995 to 1996, down slightly from 6.0 percent average annual growth in the 1992–95 period and down sharply from 55.6 percent average annual growth in the 1990–92 period.

The significant growth in expenditures from 1990 to 1992 can be attributed to double-digit increases in expenditures per enrollee (on services) and a dramatic increase in the state's DSH program. DSH payments are directed to hospitals that serve a large share of the Medicaid and uninsured populations. In 1990, DSH payments represented 4.4 percent of the state's total Medicaid spending; by 1995, DSH payments were $732 million, representing 26.4 percent of total Medicaid spending.[15] Only Louisiana and New Hampshire had higher DSH spending levels as a share of total Medicaid spending. The deceleration of state Medicaid spending in the mid-1990s primarily reflects changes in federal law restricting states' DSH programs.

To a lesser extent, the state's expenditure trends reflect enrollment trends, as enrollment surged between 1990 and 1992, then continued to grow, albeit more slowly, between 1992 and 1995. As noted earlier, total enrollment actually decreased from 1995 to 1996.

In 1996, Missouri spent $2,776 per Medicaid enrollee. This average is a composite of very different spending levels for different groups of eligible people. For example, Missouri's average Medicaid spending per child was $862 in 1996. In contrast, spending per nonelderly adult averaged $1,139; per blind and disabled beneficiary, $6,876; and per elderly beneficiary, $9,399 (table 4). As noted earlier, elderly beneficiaries comprise only 12 percent of total enrollment, yet Missouri spends 31 percent of its Medicaid budget on these beneficiaries, reflecting their use of costly long-term care services and higher incidence of acute care needs.

In all of these Medicaid spending areas, Missouri spends significantly less per enrollee than the national averages (table 4). In 1996, spending for the United States as a whole was $1,143 per child, $1,838 per nonelderly adult, $8,450 per blind and disabled beneficiary, and $10,338 per elderly beneficiary.

Current State Health Policy Issues

Medicaid Managed Care

Missouri has operated a Medicaid managed care program, Missouri Managed Care Plus (MC+), since 1995.[16] Participation in MC+ is mandatory for certain Medicaid eligibility groups,

including pregnant women and children eligible for Medicaid based on family income, families eligible for Medicaid based on AFDC (now TANF) status, children in state custody, and refugees.

MC+ was implemented in a limited number of counties under the operating authority of a Section 1915(b) freedom-of-choice waiver from the federal Health Care Financing Administration (HCFA). The state awarded contracts to plans in the St. Louis metropolitan area in 1995, the Kansas City area in 1996, and other parts of the state in 1997. Although the state plans to implement the program statewide eventually, as of August 1997 the program operated in only 46 of Missouri's 115 counties, including many rural counties in the northwestern part of the state. By August 1997, the state had contracted with 14 managed health care plans to provide a comprehensive set of services to enrollees.

Missouri submitted a Section 1115 research and demonstration waiver proposal to HCFA in June 1994. The initial objective was to expand MC+ eligibility to uninsured adults and children with family incomes up to 200 percent of the FPL. The proposal was revised in 1995 to limit the expansion in the MC+ program to children under age 19 with family incomes up to 200 percent of the FPL. This expansion was to have begun in St. Louis and then expanded statewide.

Because of questions regarding the amount of federal funding that would have been involved in implementing the expansion, HCFA's approval for the waiver was still pending when the Balanced Budget Act was passed in August 1997. The waiver proposal has since been revised again and integrated with Missouri's CHIP proposal, although both were submitted separately. Both proposals were approved by HCFA on April 28, 1998.

Children's Health Insurance Program

To take advantage of the new federal CHIP funds, Missouri amended its Section 1115 waiver, which was pending with HCFA, to conform it to CHIP requirements. This amendment was submitted in August 1997, just after the enactment of the Balanced Budget Act. Missouri then submitted a corresponding CHIP plan to HCFA in September 1997. Both the waiver and the CHIP plan proposed expanding eligibility for Missouri's existing Medicaid managed care program (MC+) to all children under age 19 in families with incomes up to 300 percent of the FPL. HCFA approved both the waiver and the plan. It permitted Missouri to waive CHIP's income eligibility threshold (200 percent of the FPL) based on Section 1902(r)(2) of the Social Security Act, which effectively allows states to set income eligibility for CHIP at any level. Missouri's objective was to integrate CHIP coverage into its Medicaid waiver to make these higher-income children eligible for CHIP's enhanced federal match. Missouri's CHIP plan was submitted to HCFA as a Medicaid expansion rather than a separate state-run program.

In February 1998, Missouri submitted a revised CHIP plan to include copayments and income-based premiums as part of the program. Under the revised plan, families earning between 185 percent and 225 percent of the FPL will pay $5 per physician visit, and those earning 226 percent to 300 percent of the FPL will pay a $65 premium, $10 per physician visit, and $5 per prescription.

Table 3
Medicaid Expenditures by Eligibility Group and Type of Service, Missouri and United States
(Expenditures in Millions)

	Missouri				United States			
	Expenditures	Average Annual Growth			Expenditures	Average Annual Growth		
	1996	1990–92	1992–95	1995–96	1996	1990–92	1992–95	1995–96
Total	**$3,003.0**	**55.6%**	**6.0%**	**5.1%**	**$160,968.6**	**27.1%**	**9.7%**	**2.3%**
Benefits								
Benefits by Service	2,181.6	33.5	8.1	7.2	140,290.1	18.8	10.9	5.4
Acute Care	1,211.6	33.8	10.7	4.7	84,666.5	22.3	12.8	6.6
Long-Term Care	969.9	33.1	4.9	10.3	55,623.6	14.6	8.2	3.5
Benefits by Group	2,181.6	33.5	8.1	7.2	140,290.1	18.8	10.9	5.4
Elderly	904.9	37.8	5.3	11.7	42,418.5	16.7	8.4	3.7
Acute Care	247.3	22.7	15.6	4.9	11,229.3	18.9	12.7	8.6
Long-Term Care	657.7	43.2	2.0	14.5	31,189.2	16.0	7.1	2.1
Blind and Disabled	728.1	24.6	12.5	3.9	56,601.3	17.6	13.3	8.6
Acute Care	420.9	33.6	13.0	4.5	33,880.1	22.9	15.8	10.7
Long-Term Care	307.2	15.2	11.9	3.2	22,721.2	11.9	10.1	5.7
Adults	186.4	36.7	3.9	–1.3	16,956.6	21.4	9.1	0.7
Children	362.1	39.2	9.1	7.6	24,313.8	23.8	11.4	4.4
Disproportionate Share Hospital	724.6	317.6	–0.1	–0.6	15,102.6	263.4	2.0	–19.6
Administration	96.9	12.4	18.5	5.3	5,575.9	9.8	12.8	2.3

Source: The Urban Institute, 1998. Based on HCFA 2082 and HCFA 64 data.

There are no cost-sharing requirements for children in families with incomes below 185 percent of the FPL. These cost-sharing requirements were mandated by the General Assembly through legislation and have been implemented in Missouri's CHIP program. State officials acknowledged that the Medicaid program typically does not permit such high levels of cost-sharing and that they may be in a bind. Nevertheless, Missouri's amended CHIP plan was approved by HCFA in September 1998. As of November 1998, program administrators were uncertain about how the issue of cost-sharing would ultimately be resolved.

State legislation was needed to expand the state's Medicaid income eligibility level to 300 percent of the FPL for all children under age 19. This state legislation (Conference Committee Substitute for Senate Bill 632) passed in June 1998. Missouri is now one of the few states that allow children with incomes this high to participate in the Medicaid program. Other such states include Tennessee (400 percent of the FPL), Rhode Island (250 percent of the FPL), and Connecticut (235 percent of the FPL, but with income disregards effectively 300 percent of the FPL).

Under CHIP's state allotment formula, Missouri was scheduled to receive roughly $52 million from the federal government for FY 1998. At CHIP's enhanced federal matching rate, the state was expected to cover 28 percent of costs, for a total budget of $72 million. However, the state estimated FY 1998 program costs at roughly $87.5 million. If the state were actually to exceed its federal allotment, it could receive additional federal money, but at its regular Medicaid matching rate rather than the enhanced rate. Missouri's contribution to program costs comes from general revenues and provider tax revenues.

By June 1999, Missouri anticipates providing health insurance to an additional 90,000 children, or roughly 45 percent of uninsured children in the state. This is a much higher percentage than that achieved by many other states.

Missouri's Section 1115 Waiver

Missouri's Section 1115 waiver, which was implemented simultaneously with its CHIP program, makes certain categories of adults eligible for Medicaid. These individuals include adults up to 300 percent of the FPL who are moving off of TANF (extended coverage is expanded from 12 months to two years); uninsured noncustodial parents with family incomes up to 125 percent of the FPL who are current in paying child support;[17] uninsured custodial parents with incomes up to 100 percent of the FPL; and uninsured women losing Medicaid 60 days after they give birth (for two years, women's health services only), among others. Through these provisions, the state anticipates expanding Medicaid eligibility to an additional 94,000 adults.

Insurance Market Reform

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), primarily to make it easier for smaller work establishments (firms with 2 to 50 employees) to purchase health insurance products for their workers. Prior to HIPAA, insurers could make it very difficult for employers with high-risk workers (or their family members) to purchase insurance products. The legislation removed or minimized some of these barriers, particularly with respect to the issuance and portability of insurance products. HIPAA also gives specific pro-

Table 4
Medicaid Enrollment and Expenditures per Enrollee: Contributions to Total Expenditure Growth

	Missouri				United States			
		Average Annual Growth				Average Annual Growth		
	1996	1990–92	1992–95	1995–96	1996	1990–92	1992–95	1995–96
Elderly								
Total expenditures on benefits (millions)	$904.9	37.8%	5.3%	11.7%	$42,418.5	16.7%	8.4%	3.7%
Enrollment (thousands)	96.3	9.4	5.4	1.6	4,103.2	5.1	2.9	0.0
Expenditures per enrollee	$9,399	26.0	–0.1	10.0	$10,338	11.0	5.4	3.7
Blind and Disabled								
Total expenditures on benefits (millions)	$728.1	24.6	12.5	3.9	$56,601.3	17.6	13.3	8.6
Enrollment (thousands)	105.9	3.5	7.3	3.9	6,698.2	9.8	9.3	5.2
Expenditures per enrollee	$6,876	20.4	4.9	0.0	$8,450	7.1	3.7	3.2
Adults								
Total expenditures on benefits (millions)	$186.4	36.7	3.9	–1.3	$16,956.6	21.4	9.1	0.7
Enrollment (thousands)	163.7	9.8	3.2	–6.5	9,225.0	11.4	5.0	–4.1
Expenditures per enrollee	$1,139	24.5	0.7	5.6	$1,838	8.9	4.0	5.0
Children								
Total expenditures on benefits (millions)	$362.1	39.2	9.1	7.6	$24,313.8	23.8	11.4	4.4
Enrollment (thousands)	420.1	13.1	8.9	0.3	21,270.5	13.1	4.8	–1.6
Expenditures per enrollee	$862	23.1	0.2	7.3	$1,143	9.5	6.3	6.3

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

tections to individuals purchasing health insurance coverage.

To facilitate the application of HIPAA's provisions in state insurance markets, the federal government encouraged states to enact HIPAA implementation legislation. Some state legislatures have yet to do so; Missouri's proposed HIPAA implementation legislation failed to pass in the summer of 1998. Even so, HIPAA regulations will supersede existing state laws that do not conform to HIPAA requirements, and the new requirements are enforceable by HCFA.

Following are the relevant provisions of HIPAA and how Missouri has addressed the issues. Insurers for the small-group market must

Limit the exclusion period for preexisting conditions to 12 months for any condition diagnosed or treated up to six months before the policy was issued. Prior to HIPAA, *Missouri had a similar law.*

Credit prior exclusion periods that have elapsed under a previous policy if the gap between new and previous coverage is less than 63 days. Prior to HIPAA, *the maximum gap in coverage in Missouri was set at less than 30 days.*

Guarantee renewal of insurance policies to groups of all sizes, regardless of past claims experience. Prior to HIPAA, *Missouri had a similar law.*

Guarantee issue of all small-group health insurance products (for firms with 2 to 50 workers), regardless of past claims experience or group health status. Prior to HIPAA, *Missouri guaranteed issue only for selected products.*

Convert a group enrollee's coverage to a nongroup (individual) policy if the individual meets HIPAA eligibility requirements. Prior to HIPAA, *Missouri had a similar law.*

Insurers in the individual market must guarantee renewal of insurance policies to individuals, regardless of past claims experience. Prior to HIPAA, *Missouri did not have a similar law.*

HIPAA also authorizes medical savings account (MSA) demonstrations. *Missouri has permitted MSAs for individuals and employers and a state tax exemption since 1993.* The state also planned an MSA pilot program for Medicaid in January 1999. However, because Missouri did not pass HIPAA legislation, MSAs in Missouri do not have federal tax exemptions.

Conclusions

Missouri is currently enjoying a strong and stable economy, reflective of the national economy. A combination of state-specific economic factors, including a large manufacturing sector and a high employment rate, has led to an above-average rate of employer-sponsored health insurance and a lower rate of uninsurance.

Missouri has experienced a large amount of activity in health care policymaking and marketplace initiatives compared with many states. HMOs have significantly penetrated both the private and public health care markets, and the state, particularly the city of St. Louis, has experienced a great deal of hospital merger activity and many nonprofit conversions since the early part of the 1990s. Missouri is one of only a few states that operate a statewide health care purchasing alliance for public employees.

Compared with the nation as a whole, Missouri spends significantly less per enrollee on Medicaid benefits for each beneficiary category. In contrast, Missouri dedicates a larger proportion of its total Medicaid funds to the DSH program than do all but two other states. The state was the first to coordinate its CHIP plan with a Medicaid research and demonstration waiver. The combined reforms will expand Medicaid coverage (either through the CHIP program or the Section 1115 waiver) to children in families with incomes up to 300 percent of the FPL, as well as to certain categories of adults.

Notes

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15. Teresa Coughlin and David Liska. *The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues.* Washington, DC: The Urban Institute, *Assessing the New Federalism.* October 1997.
16. Health Care Financing Administration Web site: http://www.hcfa.gov, 1998.
17. One reason for the discrepancy in eligibility criteria between noncustodial and custodial parents is to encourage the payment of child support. With health insurance subsidized, money that these parents might otherwise use for health insurance is available for child support. The provision acknowledges the financial contraints on noncustodial parents, while continuing to encourage the payment of child support.

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Stephanie E. Anthony is a senior research associate at the Economic and Social Research Institute. Ms. Anthony has conducted policy research and analysis on federal and state programs that improve the health of women, children, and families. Her writing has focused on health issues concerning uninsured children, Medicaid managed care for persons with disabilities, public hospital conversions, and youth violence.

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