HEALTHCARE VALUE HUB

Health Care Affordability in Missouri: A Closer Look

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CONTENTS

INTRODUCTION 3
CURB EXCESS PRICES 4
ESTABLISH A STATE-RUN ALL-PAYER CLAIMS DATABASE 5
ESTABLISH A HEALTH SPENDING OVERSIGHT ENTITY 6
CONSIDER A HEALTH CARE COST GROWTH BENCHMARK 7
IMPLEMENT PRICE TRANSPARENCY TOOLS 9
REDUCE LOW-VALUE CARE 11
MEASURE LOW-VALUE CARE IN CLAIMS AND/OR EHR DATA 11
EXTEND COVERAGE TO ALL RESIDENTS 13
ADDITIONAL PROVISIONS WITHIN MEDICAID 15
ADDITIONAL COVERAGE OPTIONS FOR PEOPLE ABOVE THE MEDICAID ELIGIBILITY THRESHOLD 16
COVERAGE FOR IMMIGRANTS 19
RATE REVIEW 20
MAKE OUT-OF-POCKET COSTS AFFORDABLE 22
INCREASE PROTECTIONS AGAINST SHORT-TERM, LIMITED-DURATION PLANS 22
PROTECT PATIENTS FROM SURPRISE OUT-OF-NETWORK MEDICAL BILLS 23
WAIVE OR REDUCE COST-SHARING FOR HIGH-VALUE SERVICES 24
PROTECT CONSUMERS FROM MEDICAL DEBT 26
TRANSPARENT AND READILY AVAILABLE HOSPITAL FINANCIAL ASSISTANCE POLICIES 26
CURTAIL AGGRESSIVE MEDICAL DEBT COLLECTION PRACTICES 28
REPORT POPULATION DATA FOR FINANCIAL ASSISTANCE AND MEDICAL DEBT 28
CONCLUSION 30

INTRODUCTION

States play an important role in making health care more affordable for their residents. They have the power to pass and implement policies to curb excess prices, expand coverage, and limit cost-sharing for high-value care (among other interventions) and can exercise this authority to protect residents from high (and rising) health care costs in the absence of slow-moving and/or politically gridlocked federal action. In a 2022 Scorecard assembled by the Healthcare Value Hub, Missouri scored 25.3 out of 80 possible points (an F grade) on health care affordability policies and outcomes, ranking 34th out of 50 states, plus D.C.[1] While Missouri has taken a few steps to address health care affordability—such as expanding Medicaid—it generally performs poorly on a suite of measures across many health care affordability domains: curbing excess prices; reducing low-value care; expanding coverage; reducing out-of-pocket costs; protections against medical debt.[2]

A 2022 survey of Missouri adults conducted by the Healthcare Value Hub revealed that more than 3 in 5 (62% of) respondents say they or a family member have experienced a health care affordability burden in the past year, and over 4 in 5 (82%) reported worry about affording health care in the future. Furthermore, 42% report facing financial hardship due to medical bills—including being contacted by a collection agency (22%); using up all of their savings (14%); being unable to pay for basic necessities (12%); and having to borrow money or take out a loan to pay off medical debt (10%).[3]

In light of residents' grave health care affordability burdens, Missouri has much work to do to make health care more affordable for its residents. This report describes Missouri's performance in addressing high health care costs and the resulting medical debt that many residents face, and provides recommendations for actions policymakers can take to reduce these burdens.

CURB EXCESS PRICES

For many reasons, the health care prices that many Americans pay are unrelated to the cost of providing those services. These prices often exhibit unwarranted variation across geographic areas, as well as among providers within the same city, county, or state.[4] This pricing problem, in part, reflects excessive profit-taking by certain healthcare providers and particularly affects people who are uninsured and pay list prices out-of-pocket, as well as those with private health insurance who pay high negotiated prices before meeting their deductibles and face excess prices embedded in their premiums(about 9.3% and 58.3% of Missouri's population in 2021, respectively[5]).

Roughly $230.7 billion to $240.5 billion in wasteful spending is associated with excess prices each year.[6]

Healthcare spending growth in Missouri is driven primarily by increases in the *price* of services, rather than the quantity of services patients are using. Total spending per person in Missouri on medical care and prescription drugs increased 26% from 2017 to 2021, going from $5,051 per person to $6,361 per person. The total average price per service increased 28%, while utilization of services increased by 13%. Notably, price growth was highest for hospital inpatient services (29% increase from 2017 to 2021) and prescription drugs (19% increase), with less price growth for outpatient services (5% increase) and professional services (7% increase). [7]

The combined inpatient and outpatient relative price in Missouri were more than double (225% of) Medicare prices for the same services, placing them in the middle range of all states (Missouri ranked 28th out of 50 states, plus D.C. for this measure).[8] While is it debated whether Medicare prices are too low or too high for different services, private prices remain a significant driver of cost increases over time, and Medicare prices are one common measure of how much services should cost. Further analysis finds that almost all Missouri hospitals receive prices from commercial payers that exceed the commercial breakeven point—the payment level required to cover their maximum expenses with no profit.[9]

High prices can be particularly burdensome for people with disabilities as they interact with the health care system more than those without a disability. One in four Missouri adults have a disability and the state allocates 39% of its health care spending on disability

health care costs.[10] Addressing high prices may not only reduce overall health spending, but may also ensure that needed care is affordable for everyone and not limited to those with few health needs.

Missouri can reduce total spending on healthcare services and the resulting costs passed on to consumers by enacting policies that track and ultimately reduce the prices charged for healthcare services.

ESTABLISH A STATE-RUN ALL-PAYER CLAIMS DATABASE

All-payer claims databases (APCDs) are large-scale databases typically created by states that contain diverse types of health care data, including claims data from private insurance companies, state employee health benefit programs and, in some cases, Medicare and Medicaid.[11] APCDs (or their near cousin, multi-payer claims datasets) can provide useful information on payment, utilization, and disease patterns, which can be used by a wide range of stakeholders to aid in health system transformation efforts, including initiatives designed to reduce excess prices.

Missouri is a part of the Midwest Health Initiative, a non-profit commercial claims database which includes data on Missouri, Western Illinois, and Eastern Kansas commercial payers; however, it is not a state-run initiative and does not include any public payer claims data. This data has been used to produce reports and statistics related to health care utilization, cost, and quality, but it does not appear that any claims data is immediately available to the public, only available by request. Missouri should take the following steps to improve the reliability and accessibility of the APCD:

Recommendations:

- **Establish a Regulatory or Collaborative Relationship with the Midwest Health Initiative:** Missouri does not need to reinvent a tool that is currently in place, but rather strengthen what has already been established. By establishing a relationship with the Midwest Health Initiative, the state can ensure that the data is standardized, meets certain criteria, and is easily accessible by the public.
- **Require Insurers to Submit Claims to the Database:** Without claims from all insurers, Missouri's APCD provides an incomplete view of service utilization and price variation within the state. Missouri should enact legislation to require insurers, including fully-funded employee health plans, individual, small group

plans within and outside the Marketplace, and public payers, including Medicare[12] and Medicaid, to submit all of their claims to the database for a more thorough and accurate representation of health care service usage and costs. While states cannot require self-funded employee health plans to submit claims,[13] Missouri should encourage self-insured employee health plans to voluntarily submit their claims data to the APCD.

ESTABLISH A HEALTH SPENDING OVERSIGHT ENTITY

Once an all-payer claims database is established, curbing excess prices will require a comprehensive, inter-agency, multi-payer plan to address the health care segment of the state's economy. To systematically address the health care affordability burdens of state residents (and inform health system transformation efforts more generally), states need an entity empowered to look across various types of health and social spending and to identify opportunities for improvement in terms of value for each dollar spent, quality shortcomings, and affordability problems for residents—in other words, a permanently convened, health spending oversight entity.

As of 2022, nine states have established comprehensive oversight entities that target all health care spending (Colorado, Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Vermont, and Washington) and seven states have established entities that target narrow forms of spending, such as hospital or drug spending (Maine, Maryland, New Hampshire, New York, Ohio, Pennsylvania, and Rhode Island).

Recommendation:

- **Establish a Health Spending Oversight Entity:** Missouri should establish a health spending oversight entity that targets all forms of health spending. The entity should be empowered to make legislative recommendations that improve quality of care provision and improve affordability for consumers.

POLICY IN ACTION

Maryland's Health Services Cost Review Commission monitors the efficiency and effectiveness of hospitals using financial data (revenue, expenditures, and utilization) to inform the Commission's recommendations on global hospital spending targets, uncompensated care and community benefits.[14]

Colorado's Office of Saving People Money on Health Care works in conjunction with the Department of Health Care Policy & Financing and other cabinet offices to reduce patient costs for hospital stays and expenses, improve price transparency, lower the price of prescription drugs, and make health insurance more affordable. In 2021, Colorado established a Prescription Drug Affordability Board tasked with setting upper payment limits to reduce prescription drug costs.[15]

Vermont's Green Mountain Care Board is empowered to: monitor spending and quality of care across sectors; operate the state's all-payer claims database; review health insurance rates and identify drivers of rate increases; oversee pilots and innovations; align activity across payers; and make legislative recommendations.[16]

CONSIDER A HEALTH CARE COST GROWTH BENCHMARK

Health care cost growth benchmarks seek to constrain annual health care spending growth across sectors. Benchmarks can target different types of health spending and may be accompanied by quality benchmarks (ex. Delaware) and/or spending minimums for high-value services like primary care (ex. Connecticut) to ensure that reductions in spending growth do not sacrifice health care quality. Varying degrees of enforcement exist; some states do not have an enforcement mechanism, relying on public displays of performance to incentivize cooperation, while others (like Massachusetts and Oregon) require entities that exceed the benchmark to complete a performance improvement plan to address excessive price growth and have the power to fine entities that exceed the benchmark.[17]

POLICY IN ACTION

Massachusetts boasts the longest running benchmark in the country. However, spending within the state has varied significantly over the years—cost growth has been below the benchmark for four of the eight years with data available. Prior to the coronavirus pandemic, spending was on an upward trajectory above the 3.1% benchmark, growing 3.6% in 2018 and 4.1% in 2019. Spending declined 2.3% in 2020 due to a reduction in care during the pandemic, followed by a 9% growth in spending in 2021 as people sought previously delayed care.[18] When looking closer at the data during this volatile period, the annualized rate of spending growth between 2019 and 2021 is 3.2%—closer in line to the state's 3.1% benchmark. Moreover, spending growth in Massachusetts has been lower than the spending growth rate nationally—while the benchmark is not solely responsible for this, it does factor into Massachusetts' health care landscape.

2022 was the first year that the Massachusetts Health Policy Commission—the entity that oversees the benchmark—voted to require the hospital system with the highest prices in the state to implement a Performance Improvement Plan.[19]

Connecticut's benchmarking approach is novel in that it uses the state's Healthcare Affordability Index to estimate the policy's impact on the number of Connecticut households that will have access to quality health care coverage and be able to meet their basic economic needs.[20] An initial study conducted prior to implementation found that adherence to a cost growth benchmark would grant more than 14,000 additional households access to affordable health care (a six percent increase compared to the number of households with adequate income to afford health care expenses in 2019). The impact of the cost growth benchmark is projected to be even greater among households that purchase coverage through the Marketplace, with the amount of households that do not have adequate income to afford health care halving.[21]

Notably, Connecticut's benchmark includes targets for increased primary care spending as part of its strategy.[22] The goal of this initiative is to divert more resources towards primary care and avoid the need for costly and complex care resulting from unmet needs. In 2021, the statewide primary care spending met the five percent target (spending 5.1%), but on their own, commercial payers fell short, spending less than four percent.[23]

Despite inconclusive evidence on the effectiveness of benchmarks and the significant changes to health care utilization and spending during the pandemic, states are still pursuing this policy with the hope that it will work as intended. The impacts of policy

changes are rarely seen immediately and over time, states will be able to evaluate and tailor their benchmark programs to better fit their environment. Furthermore, the continuous data collection for the benchmark will enable states to identify sectors that drive cost growth and can tailor interventions to address those factors and curtail costs.

Recommendations:

- **Commission a Report on Health Spending:** Policymakers should consider commissioning a report specifically within Missouri's health care market to identify cost drivers in order to develop targeted policy interventions.[24] As more evidence becomes available about the impact of benchmarks in other states, Missouri policymakers may determine that a cost growth benchmark aligns with Missouri's health care affordability needs and priorities and can pursue this policy.
- **Establish an Affordability Index:** Policymakers should consider establishing an affordability index for Missouri households, as Connecticut has.[25] Doing so will enable policymakers to evaluate the effects of various health care policies and reforms (including, but not limited to, a cost growth benchmark) on Missouri households' ability to maintain quality health care coverage along with their basic economic needs.

IMPLEMENT PRICE TRANSPARENCY TOOLS

It is well established that prices for the same health care service can differ significantly across providers—even within the same geographic area.[26] Yet, it is extremely difficult for consumers and policymakers to get reliable information about this pricing landscape. Contrary to popular belief, transparency tools have generally not been successful when it comes to incentivizing consumers to compare services and shop for the best price.[27] This failure stems from tools that don't contain the types of actionable information consumers need and from the fact that some consumers don't view health care as a "shoppable" commodity. Moreover, many health care services are not "shoppable," such as those provided in emergency situations and settings that lack a selection of treatments or providers.[28]

While "shopping" by patients is unlikely to drive down excess prices,[29] transparent pricing data can be used by researchers, payers, regulators, and legislators to identify outliers and embrace targeted solutions such as reference pricing, strategic network construction, and

rate setting, though success will depend on the level of provider competition in the market. For maximum impact, health care price transparency tools should be: free; publicly available; reflect negotiated rates; display prices that are treatment- and provider-specific; and pair pricing information with reliable quality metrics.[30]

The Missouri Hospital Association (MHA) produces a price transparency tool—Focus on Hospitals—with pricing, quality, and community data from participating hospitals. However, the state has no affiliation or regulation over the tool, and the pricing data only shows chargemaster rates, not negotiated rates.

POLICY IN ACTION

New Hampshire's price transparency tool—NHHealthCost—was instrumental in driving down prices charged by a major hospital within the state. Prior to 2010, payments to the state's most expensive hospital exceeded those of its competitors by nearly 50%. The state's largest insurer had been unable to decrease prices due to the hospital's prominent reputation and loyal patient base, however, evidence of excessive prices—made public on the state's price transparency website—enabled the insurer to brand the hospital as a pricing outlier, garner public support, and negotiate lower prices. Market observers testified that, despite limited public awareness of the price transparency tool, publicly identifying high-priced providers shifted the balance of power towards the state's insurers and narrowed price variation over time.[31]

Recommendation:

- **Establish a State-Run Price Transparency Tool:** Missouri should establish a state-run and regulated price transparency tool. By creating its own tool, the state can ensure that it is free, easily accessible by the public, and includes negotiated prices for specific procedures and hospitals.

REDUCE LOW-VALUE CARE

Low-value care is defined as patient care that does not provide a net health benefit in clinical scenarios. Low-value care can be further parsed into services that are clinically inappropriate for particular clinical cases, services that provide little to no clinical benefit and are against patient preferences, and services that are done out of habit rather than scientific evidence.[32]

Approximately one-quarter of total health care spending is wasted. [33] Researchers estimated that one category of health care waste—overtreatment/low-value care—drives $75.7 billion to $101.2 billion in health expenditures each year. The estimated annual savings from the implementation of measures to eliminate overtreatment/low-value care ranges from $12.8 billion to $28.6 billion. Failure to curtail this "waste" raises premiums and causes patients to endure unnecessary cost-sharing for services, inconvenience, and, occasionally, medical harm.[34]

Researchers have found geographic variation in low-value care provision, with high rates of care overuse localized to certain regions, suggesting that payer or state strategies to identify where low-value care is being provided is a key initial strategy to ensure subsequent efforts are well targeted.[35]

MEASURE LOW-VALUE CARE IN CLAIMS AND/OR EHR DATA

The delivery of high-quality and cost-effective health care is critical for achieving better health outcomes and increasing access to care. However, a growing concern among policymakers and health care providers is the prevalence of low- and no-value care, which can lead to patient harm, increased health care costs, and waste of health care resources. Measuring low- and no-value care allows a state to identify provision and frequency of low-value care and inform strategies to reduce it.

POLICY IN ACTION

The **Virginia** Center for Health Innovation (VCHI) and Virginia Health Information, Virginia's APCD administrator, began analyzing claims and electronic health records (EHR) data to identify overuse and wasteful services in 2014. Researchers found that, of the 5.4 million services measured, over 1.6 million services were considered low-value, resulting in over $586 million in wasteful spending.[36]

The VCHI subsequently received a $2.2 million grant from Arnold Ventures to create a statewide pilot aimed at reducing the provision of low-value care by creating a largescale health system learning community and employer task force, in addition to developing a set of consumer-driven low-value care measures. In 2022, VCHI launched the Virginia Health Value Dashboard, which reports data related to reducing low-value care, increasing high-value care, and improving the infrastructure for value-based care across the state.[37]

Recommendations:

- **Measure Low-Value Care:** Missouri should review claims and/or EHR data to identify the prevalence low-value care across the state. The services studied can be identified from medical specialty societies and from other states' efforts.[38,39,40]
- **Enact a Multi-Stakeholder Campaign to Reduce Low-Value Care**: Measuring and identifying low-value care is an important first step for states to take and should be dovetailed with efforts to reduce its provision. Stakeholders should convene to develop actionable steps to eliminate low-value care.

EXTEND COVERAGE TO ALL RESIDENTS

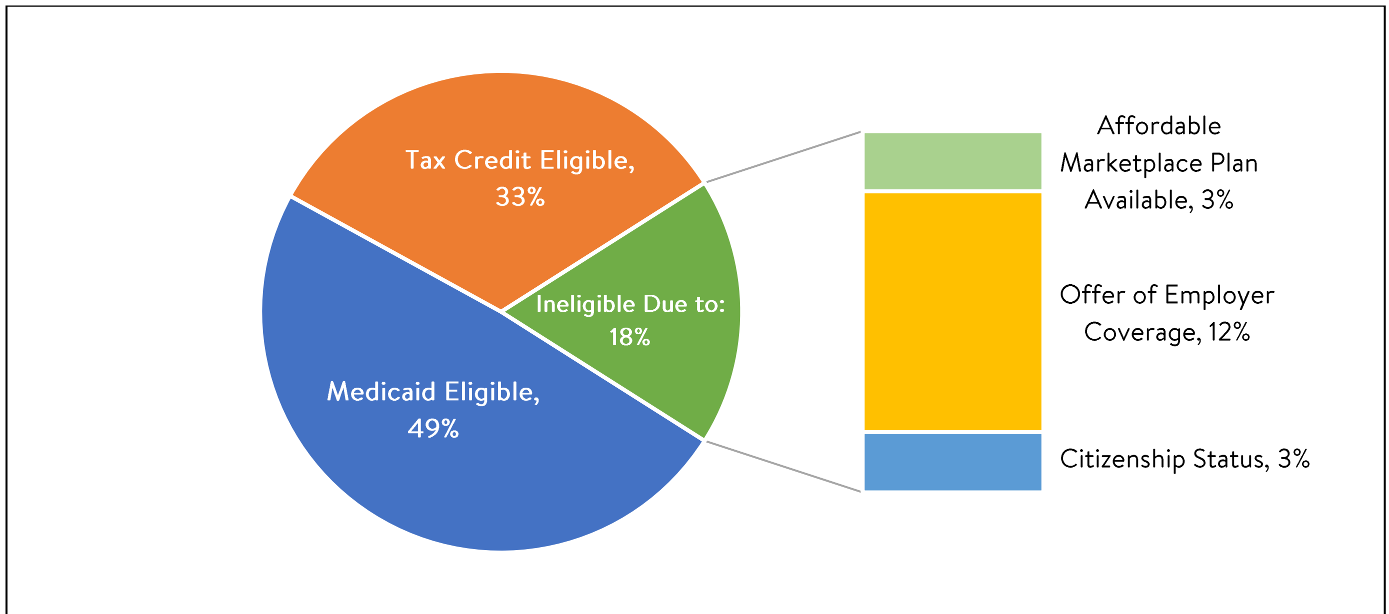
Uninsured people face significant barriers to accessing health care, and the high cost of paying out-of-pocket often prevents people from getting needed preventive care and treatment for chronic conditions. This in turn generates uncompensated care costs for hospitals when uninsured residents use costly emergency services as a last resort but cannot afford to pay the resulting medical bills. In 2021, nine percent of Missouri's population was uninsured—roughly 557,000 people.

It is important to understand the composition of the state's uninsured population to inform efforts that increase the share of those with insurance and reduce disparities. Over four in five of Missouri's uninsured residents are eligible for Medicaid coverage or Marketplace premium tax credits, but remain uninsured (see Figure 1)[41]—suggesting that the coverage is undesireable or unknown to eligible residents. Missouri can reduce its uninsured population by determining why these individuals are not enrolled in Medicaid or a subsidized Marketplace plan and enact policies that make these programs more attractive and/or affordable.

The remaining 18% of uninsured are ineligible for Medicaid or premium tax credits either because of their citizenship status or because they have an offer of coverage that is deemed "affordable" by federal standards[42]—but may not be affordable for individuals in reality. In 2023, the federal government amended a rule, fixing the so-called "family glitch," and expanding access to affordable coverage for many families.[43]

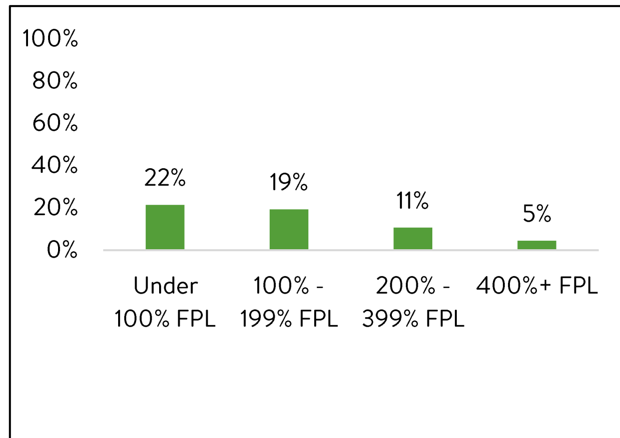
In addition to reducing the overall uninsured population, reducing *disparities* in uninsurance rates requires looking at which populations have the highest uninsurance rates.[44] By income, Missouri's nonelderly residents earning under 200% of the federal poverty level have the highest uninsurance rates (see Figure 2). By race/ethnicity, the state's non-white populations have higher uninsured rates than the white population, particularly residents who are American Indian or Alaska Native, Hispanic or Latino, or Native Hawaiian or other Pacific Islander (see Figure 3).[45] Missouri can reduce disparities in uninsurance by focusing Medicaid and Marketplace plan outreach in these communities to increase enrollment among eligible residents.

FIGURE 1: DISTRIBUTION OF ELIGIBILITY FOR STATE-SPONSORED COVERAGE AMONG MISSOURI'S UNINSURED POPULATION (2021)



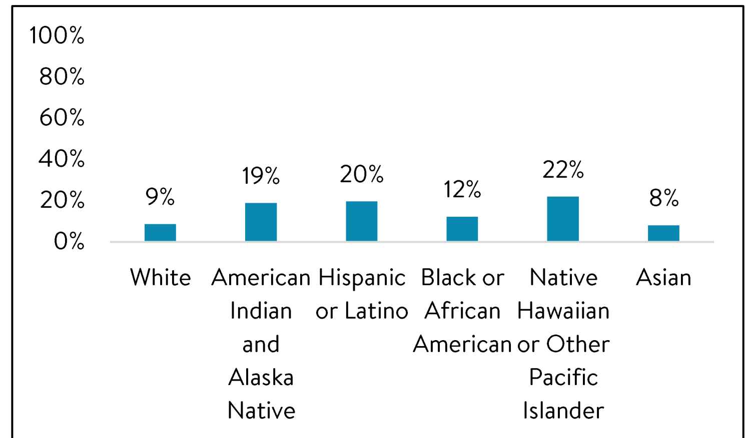
Source: Kaiser Family Foundation, Distribution of Eligibility for ACA Health Coverage Among the Remaining Uninsured (2021), (accessed May 10, 2023).

FIGURE 2: MISSOURI NONELDERLY UNINSURANCE RATES BY FEDERAL POVERTY LEVEL (2021)



Source: Kaiser Family Foundation, Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL) (2021), (accessed May 10, 2023).

FIGURE 3: MISSOURI NONELDERLY UNINSURANCE RATES BY RACE AND ETHNICITY (2021)



Source: U.S. Census Bureau, 2021 American Community Survey 5-Year Estimates, Table S2701: Missouri, (accessed May 10, 2023).

Additionally, people who receive disability benefits face unique coverage challenges that impact their ability to afford needed care, such as the possibility of losing coverage if their household income or assets increase over a certain amount (as of 2023, the income limit is $1,470 per month or $2,460 per month if the beneficiary is blind). In Missouri, residents who receive Supplemental Security are automatically eligible for Medicaid; thus, if they lose their disability benefits, they may also lose their Medicaid coverage.[46,47]

Missouri's Ticket to Work Health Assurance (TWHA) program allows residents with disabilities whose incomes are above the Medicaid limit to pay premiums for Medicaid coverage.[48] Enrollment data for TWHA is limited, but national data suggests a notably low take-up of this option by the target population and only modest success in making eligible individuals with disabilities aware of this program.[49] Missouri should increase outreach and provide clear, consistent, and accessible consumer information and educational resources about TWHA, along with additional policies to expand affordable coverage options, described below.

Recommendation:

- **Fund a Medicaid Education and Enrollment Campaign:** One way Missouri can increase Medicaid enrollment among eligible residents is funding a public education and enrollment campaign focused on geographic areas and demographic groups with the highest uninsurance rates. This would include distributing materials that explain Medicaid, eligibility rules, and providing funding to pay health insurance navigators to do community outreach and enroll residents.

ADDITIONAL PROVISIONS WITHIN MEDICAID

Missouri voters approved a ballot measure expanding Medicaid in 2020, with coverage beginning on July 1, 2021.[50] While Medicaid expansion has certainly benefited Missourians, there may still be people struggling to maintain their coverage. Many states have reported issues with churn (the process of enrollees repeatedly losing and regaining Medicaid coverage during a short period of time), which can disrupt care, resulting in unnecessary administrative costs for states and delays in care for beneficiaries, which may increase health costs in the long run.[51] It can also indirectly make Medicaid expansion less effective at providing stable coverage if low-income beneficiaries are churning in and out of the program and delaying or foregoing care during coverage disruptions. Continuous

eligibility is one method that can reduce churn by allowing people to verify their income once a year rather than once a month. In July 2023, the state extended Medicaid coverage for pregnant women to twelve months postpartum, up from 60 days.[52]

Recommendation:

- **Enact 12-Month Continuous Eligibility:** Missouri should enact continuous Medicaid eligibility for all children through a state plan amendment and for all adults through an 1115 waiver.[53] Although adopting continuous eligibility does come with increased costs from additional coverage months and initial implementation, reductions in health care costs over time and administrative savings can help offset these costs.[54]

ADDITIONAL COVERAGE OPTIONS FOR PEOPLE ABOVE THE MEDICAID ELIGIBILITY THRESHOLD

Residents who have incomes above the Medicaid eligibility threshold—in Missouri, 138% of the federal poverty level—still face affordability burdens for needed care. States can take additional steps to ensure residents can afford care, including: premium subsidies for Marketplace plans; reinsurance programs through a 1332 waiver; Medicaid Buy-In program; Public Option plan; Basic Health Plan. Missouri has one such program—Show-Me Healthy Babies—which provides pregnancy-related coverage for pregnant women who make too much to qualify for the state's Medicaid for Pregnant Women program (196% FPL) and have incomes up to 300% of the federal poverty level.

- **Additional Subsidies:** States can offer Marketplace subsidies in addition to federal subsidies, however, this typically requires operating a state-based Marketplace (SBM) such that the state can determine eligibility and make payments to the insurers. Of the five states that offer additional state subsidies, all operate an SBM.[55]

- **Reinsurance:** Seventeen states have established a reinsurance program through a 1332 State Innovation waiver as of January 1, 2023.[56] However, the federal government temporarily increased Marketplace subsidies during the COVID-19 pandemic, rendering reinsurance programs less effective than in the past. A state

reinsurance program should be reevaluated if the federal government lets the additional subsidies expire.[57]

- **Medicaid Buy-In:** Several states and stakeholders have proposed Medicaid Buy-In programs as another option to extend affordable coverage to residents. Specific rules and regulations vary by proposal, but the overall policy enables families with incomes above the Medicaid limit to purchase Medicaid coverage. **Vermont** is the only state that has implemented a Buy-In program through an 1115 waiver, allowing families with children whose household income is below 312% of the federal poverty level to purchase Medicaid coverage for $15-$60 per month.[58] Models of a Medicaid Buy-In proposal in **New Mexico** found that premiums would be reduced by 15-28% and would enroll between 7,000-16,000 individuals.[59] However, Medicaid Buy-In programs for people with disabilities has low take-up across the country; addressing enrollment barriers, along with education and outreach should be integrated with any Medicaid Buy-In policies.

- **Public Option:** This strategy is another avenue in which states run or regulate—to ensure affordability—a form of health insurance that residents can purchase. A "public option" policy may allow states more freedom to pursue tailored subsidies and payment rate limits for commercial plans available to residents ineligible for Medicaid, especially if the state allows employers to offer public insurance instead of private plans. States have flexibility in how they approach and structure a "public option"—some are similar to a Medicaid Buy-In, while others direct the private sector to administer the plan.

POLICY IN ACTION

Washington's Cascade Select is a hybrid public-private plan whereby the state contracts with private insurers to provide the plans, rather than creating a state-run insurance company. While this method saves on costs, it limits the state's control. Legislation originally capped provider reimbursement at 100% of Medicare rates in an effort to keep premiums lower than other private coverage options, but pushback from industry stakeholders on rate setting caused legislators to increase the cap to 160%.[60]

Initially, Washington's public option plans were not as affordable as expected and were not available in several counties. State policymakers passed additional legislation and the state has adapted to many of the early challenges. In 2023—the third year it has been available to consumers—Cascade Select plans: saw lower rate increases than other plans; were the lowest cost Silver plans in 25 counties; were available in 34 out of 39 counties, reaching 98% of those finding coverage on the exchange; and enrollment tripled from the previous year, with data suggesting few enrollees moving out of Cascade Select plans.[61]

- **Basic Health Plans (BHP):** This program is implemented through Section 1331 of the ACA to provide affordable coverage for residents making between 133-200% of the federal poverty level and who would otherwise be eligible to purchase coverage through the Marketplace. The federal government provides 95% of the premium tax credits and cost-sharing reductions that would have gone towards an individual's Marketplace plan to the state to fund the BHP. This program enables states to provide more affordable coverage for residents—including lawfully present non-citizens who do not qualify for other coverage types—and improve continuity of care by reducing rates of churn.[62]

POLICY IN ACTION

New York and **Minnesota** have had success with their Basic Health Plans. In these states, low-income consumers have had greater access to affordable coverage: premiums and cost-sharing for BHP enrollees have, on average, been lower than they are for individuals enrolled in Marketplace plans in other states. Furthermore, the BHP can reduce administrative burdens and complexity when a single entity handles eligibility for Medicaid, the BHP, and Marketplace coverage—typically, a state-based Marketplace.[63]

Recommendation:

- **Pursue a Medicaid Buy-In Program:** To provide additional coverage options for those above the Medicaid eligibility threshold, Missouri should establish a Medicaid Buy-In program. This builds on existing infrastructure—easing feasibility burdens—and can provide sliding scale costs for residents across the income ladder. Additionally, it can be targeted for certain populations—such as children, as Vermont has done—or other groups who have difficulty accessing affordable coverage, such as individuals who may not be eligible for Medicaid or CHIP. However, Missouri should increase outreach and provide clear, consistent, and accessible consumer information and educational resources to ensure success of this policy.

COVERAGE FOR IMMIGRANTS

Approximately three percent of Missouri's uninsured population is ineligible for state-based coverage due to immigration status. Missouri offers comprehensive benefits similar in scope to pregnancy-related Medicaid/CHIP through the CHIP "unborn child" option for undocumented pregnant women with incomes up to 305% of the federal poverty level. In addition, Missouri's Show-Me Healthy Babies program provides limited, pregnancy-related health coverage for pregnant women who are undocumented or do not meet qualifying immigration criteria and have incomes less than or equal to 300% of the federal poverty level. Coverage includes pregnancy-related care for up to 60 days after giving birth.

Missouri does not offer Medicaid coverage to lawfully residing children without a five-year wait or for undocumented children and non-pregnant adults outside of coverage for refugees, asylees, and other immigrant populations exempt from the five-year bar on Medicaid. The state would benefit from expanding coverage to these currently ineligible populations.

Recommendations:

- **Remove the 5-Year Bar for Lawfully Residing Children and Adults:** The five-year bar prevents immigrants who do not have access to health insurance through an employer from accessing health insurance—making it more likely that individuals will delay or go without care and can result in costlier care in the future. Missouri should remove the five-year bar and enable all lawfully residing, low-income residents to access needed support services.

- **Offer Coverage for Undocumented Children:** Offering comprehensive coverage for undocumented children would extend coverage and reduce long-term health care costs incurred from emergency care for untreated chronic conditions among undocumented children. This could be achieved in several ways, including by allowing undocumented children to access Missouri Medicaid/CHIP coverage.
- **Offer Coverage Options for Undocumented Adults:** Offering comprehensive coverage options for undocumented adults will help Missouri achieve universal insurance coverage among its residents. Because undocumented adults are not eligible for Medicaid and are not allowed to purchase plans on the Marketplace, Missouri would need to pursue strategies to provide affordable, off-Marketplace coverage for undocumented adults. Missouri could expand coverage incrementally by age group, similar to Illinois' process.[64,65]

RATE REVIEW

Rate review is the process by which insurance regulators review health insurers' proposed insurance premiums to ensure they are based on accurate, verifiable data and realistic projections of health care costs and utilization. Using a rigorous review process with input from the public and consumer advocates has been shown to lower rates for consumers.

Missouri has an "effective" rate review process—as deemed by the federal government—in which state regulators are able to review and make public rate proposals and determine if the rates are reasonable. However, the state does not have the power to deny rate changes that they deem unreasonable, and regulators do not take affordability into their rate review process.[66]

POLICY IN ACTION

Rhode Island's affordability standards include four criteria that insurers must meet in order to have their rates approved: increased spending on primary care; adoption of the patient-centered medical home model; supporting the state's health information exchange; and working towards comprehensive payment reform, which include a cap of inflation, plus 1%, in insurers' negotiated prices with hospitals. This rate review process applies to large group market plans as well as the individual and small group markets. A 2019 study found a net reduction in spending by an average of $55 per enrollee.[67]

Recommendations:

- **Empower State Regulators:** Missouri should pass legislation enabling state regulators to approve or deny insurers' rate changes that it deems unreasonable. Without veto power, regulators cannot stop insurers from excessively increasing premium rates and burdening consumers.
- **Incorporate Affordability Criteria into the State's Rate Review Process:** Missouri should develop affordability criteria into its rate review process to inform and guide whether rate change proposals are reasonable and affordable for consumers. Doing so could ultimately reduce the number of uninsured residents and amount of medical debt in Missouri by making health insurance more accessible and affordable.

MAKE OUT-OF-POCKET COSTS AFFORDABLE

High out-of-pocket costs are a principal driver of affordability burdens. Median family out-of-pocket spending on medical costs in Missouri was $1,900—above the national average of $1,725—in 2021.[68] While there are many reasons why an individual may go without needed care, high costs are a significant deterrent. A recent survey in Missouri found 55% of respondents delayed or went without care due to cost during the past 12 months. Even for those who got the care they needed, 42% have struggled to pay the resulting bill. Moreover, four in five respondents reported being "worried" or "very worried" about affording health care in the future.[69]

High prices are especially burdensome for residents with disabilities, as they interact with the health care system more often than those without disabilities and, as a result, tend to face more out-of-pocket costs.[70] Eighty percent of respondents with a disability in a survey of Missouri adults reported experiencing a health care affordability burden in the past twelve months—compared to 53% of respondents without a disability.[71] Forty-five percent of respondents in a household with a disability rationed medication due to cost, 73% delayed or went without care due to cost, and 60% went into debt, depleted savings, and/or sacrificed basic needs due to medical bills (compared to 23%, 47%, and 33% of those in a household without a disability, respectively). Those with disabilities also face healthcare affordability burdens unique to their disabilities—26% of respondents reporting a disability in their household delayed getting a medical assistive device such as a wheelchair, cane/walker, hearing aid or prosthetic limb due to cost.[72]

While Missouri has taken some steps to make out-of-pocket more affordable for its residents—such as some surprise medical bill protections—the state has several areas for improvement.

INCREASE PROTECTIONS AGAINST SHORT-TERM, LIMITED-DURATION PLANS

In response to rising insurance costs, some people turn to Short-Term, Limited-Duration (STLD) health plans, which offer lower monthly premiums compared to ACA-compliant plans. These plans are not required to provide the standard ACA protections for non-

group coverage, and therefore, typically offer poor coverage, can reject claims based on a wide variety of criteria, can charge higher rates for women and people with pre-existing conditions, and pose significant financial risks for consumers. Though the term limit of these plans was capped at three months in 2016 under the Obama administration, the Trump administration extended the limit to 364 days with an option to extend the policy to 36 months in 2018.[73] In July 2023, the Biden Administration proposed rules to limit STLD plans,[74] however, federal rules regulating these types of plans have changed with different administrations. State action can ensure STLD plan regulations are consistent and include consumer protections.

Missouri, like many states, has no protections against STLD plans beyond the federal minimum, leaving residents vulnerable to the financial harms these plans can cause. Many states have established a variety of protections to reduce consumer harm from STLD plans, including: prohibiting gender rating; prohibiting pre-existing condition exclusions or waiting periods; requiring coverage for essential health benefits; limiting the term limit; and banning the sale of STLD plans in the state altogether.

Recommendation:

- **Enact Protections Against STLD Plans:** Missouri should pass legislation banning or heavily regulating STLD plans in the state in order to protect consumers from many of the risks of STLD plans.

PROTECT PATIENTS FROM SURPRISE OUT-OF-NETWORK MEDICAL BILLS

Surprise medical bills (SMBs)—any medical bill for which a health insurer paid less than the patient expected—are alarmingly common within the American health care system. SMBs, also known as balance bills, can create significant financial burdens for patients, leading to debt and financial insecurity.

The federal No Surprises Act (NSA), which prohibits balance billing in most insurance plans, went into effect January 2022. The NSA protects consumers from cost-sharing beyond the normal in-network amount when a patient receives emergency services by an out-of-network facility or provider or when out-of-network providers at in-network facilities provide nonemergency services.[75] However, the NSA does not wholly protect

consumers from balance billing, leaving some services, like ground ambulance rides, susceptible to a balance bill.

Missouri has partial SMB protections (as defined by The Commonwealth Fund),[76] but residents are still vulnerable to some surprise bills for services that are not covered by state and federal law. For example, in 2021, 59% of ground ambulance rides in Missouri charged to commercial insurance plans had the potential for a surprise medical bill.[77]

Recommendation:

- **Broaden Surprise Medical Bill Protections to Cover NSA Loopholes:** Missouri should pass legislation expanding its SMB protections to include ground ambulance services, additional non-emergency services provided by out-of-network professionals at in-network facilities (such as lab work), and services provided at facilities that are not covered by the NSA (such as urgent care centers, hospice facilities, and addiction treatment facilities).

WAIVE OR REDUCE COST-SHARING FOR HIGH-VALUE SERVICES

Failure to receive high-value care like flu vaccines and cancer screenings and rationing prescription drugs for chronic conditions can worsen health outcomes and result in higher spending on medical care in the future.[78,79] Reducing financial barriers by waiving or reducing cost-sharing for specific high-value services is one strategy states can use to encourage the utilization of high-value care. A 2022 survey in Missouri found that 30% of respondents either did not fill a prescription, cut pills in half, or skipped a dose of medicine due to cost concerns.[80]

Across the country, a common area of action among states was capping the cost for high-value prescription drugs, particularly insulin. Additionally, states with standardized benefit plans can include high-value services pre-deductible, or with low to moderate copay amounts. Services frequently include non-preventive primary care, specialty care, laboratory and diagnostic testing, mental health, and substance use treatment. Some states also require separate deductibles for prescription drugs to lower financial barriers to needed medication.

POLICY IN ACTION

Utah's Insulin Savings Program allows any resident—not limited to residents with state-regulated plans—to purchase insulin at wholesale prices through the state and public employee plan.[81,82]

New Mexico passed legislation to cap copays and out-of-pocket expenses for insulin at $25 for a 30-day supply, and established an advisory group to study the cost of prescription drugs for New Mexico consumers and make recommendations on increasing accessibility.[83] In 2022, New Mexico established a Healthcare Affordability Fund that will invest in health care affordability initiatives for lower- and middle-income residents, such as reducing premiums and out-of-pocket costs.[84]

Texas passed a law in 2021 that caps the cost-sharing of a 30-day supply of insulin to $25, regardless of the amount or type of insulin needed for an enrollee of a state-regulated health plan.[85] Another Texas law instructs state officials to develop a drug savings program that would give uninsured individuals a discounted rate on insulin purchases.[86]

Recommendation:

- **Reduce Financial Barriers to High-Value Prescription Drugs:** Missouri should cap the cost of high-value prescription drugs, including insulin and other specialty drugs, such as those used to treat HIV and hepatitis, which will apply to state-regulated plans. Missouri might also consider establishing a program similar to Utah's to broaden residents' access to affordable prescription drugs.

PROTECT CONSUMERS FROM MEDICAL DEBT

While many look to the federal government for a solution to the medical debt crisis, there are concrete steps that state policymakers can take to ease consumer burden. One of the most effective ways to reduce and prevent medical debt is to increase health care affordability by promoting policies that expand access to affordable coverage and directly lower consumer out-of-pocket costs—including many of the policies recommended above.

States can also directly target parts of the health care system that cause medical debt and those that negatively impact consumers with medical debt. Such policies include: requiring transparent and readily available hospital financial assistance policies; curtailing aggressive medical debt collection practices; and requiring reporting of population data for financial assistance and medical debt.

Missouri has weak protections against medical debt and has ample opportunities to improve.[87] One-third of respondents in a survey of Missouri adults reported they or a family member living with them had medical bills overdue. Medical debt disproportionately affects residents with low-incomes, residents of color, residents with a disability, and residents who are uninsured or buy their health insurance on their own.[88] Research from The Urban Institute found that 16% of Missouri residents have medical debt in collections, with 15% among white communities and 31% among communities of color—above the national average (13%, 11%, and 15%, respectively).[89]

TRANSPARENT AND READILY AVAILABLE HOSPITAL FINANCIAL ASSISTANCE POLICIES

Patients who are eligible for charity care are frequently unaware of such programs and can end up paying bills that should have otherwise been free or reduced. In 2017, the St. Louis-based BJC HealthCare estimated $77 million of its $134 million in bad debt was owed by patients who probably would have qualified for free or discounted care.[90]

The IRS requires nonprofit hospitals to translate their financial assistance policy documents into the languages spoken by every limited English proficiency group that

constitutes the lesser of 1,000 individuals or five percent of the community served by the hospital.[91] However, hospitals may not always follow these requirements in every communication with patients.[92,93,94]

Several states require hospitals to screen uninsured patients to see if they are eligible for public assistance programs, such as Medicaid.[95] The ACA has limited rules that only apply to non-profit hospitals—states can expand regulations to all hospitals, other care facilities (such as urgent care centers), as well as debt collectors.[96] Additionally, states can require hospitals to provide free or reduced-cost care to uninsured patients on a sliding scale, based on the patient's income level.[97] Some states have gone even further, mandating that hospital financial assistance policies and charity care be easier to understand and presented to patients at the time of service, making it clear how patients can receive assistance or file complaints about the process.

POLICY IN ACTION

In addition to requiring health care facilities to screen uninsured patients for public health insurance and financial assistance programs, **Colorado** also requires health care facilities to use a single uniform application that the Colorado Department of Health Care Policy and Financing developed, as well as a standardized notification of patients' rights.[98] This notification must include a written explanation at a sixth-grade reading level and be translated into any language that 10% of the county or state population speaks, in addition to being posted on the Department of Health Care Policy and Financing's website.

Recommendation:

- **Enact Transparency Requirements:** Missouri should require large health care facilities to screen uninsured patients for financial assistance programs and to place information on their financial assistance programs in conspicuous locations throughout the facility in common spoken languages.

CURTAIL AGGRESSIVE MEDICAL DEBT COLLECTION PRACTICES

Many reports have revealed the aggressive nature of hospitals' debt collection practices across the country, often at the detriment of patients. While Missouri has restricted the use of garnishing wages or initiating home foreclosure, it does not prohibit providers from selling medical debt, seizing bank accounts, and other legal proceedings.[99]

Several states have additional consumer protections against medical debt collection, including limiting interest rates on medical debt, obligating hospitals to provide payment plans, and requirements on how and when medical debt can be sent to a collection agency. Moreover, states can strengthen the enforcement of these protections through a private right of action for victims of unlawful practices and through enforcement by the health department or state Attorney General.[100]

Recommendation:

- **Expand Debt Collection Practice Regulations:** Missouri should strengthen its current regulations to protect consumers, including: applying to all large health care facilities; free care for those with incomes under 200% of the federal poverty level and sliding scale fees for those with incomes above 200%; limits on interest rates on debt; time regulations on when hospitals can sell debt to collectors; requiring hospitals to offer payment plans, preventing denial of care or requiring upfront payment for care; and preventing legal action against patients, including arrest.

REPORT POPULATION DATA FOR FINANCIAL ASSISTANCE AND MEDICAL DEBT

As more states pass hospital financial assistance laws, many are also incorporating population reporting requirements. Such metrics help policymakers understand the impact of medical debt on their residents and view trends across populations. Implementing these reporting requirements is a step towards understanding the equity concerns surrounding medical debt.

POLICY IN ACTION

Colorado requires health care facilities to report annually on patient demographic data (race, ethnicity, age, and primary language spoken) to evaluate their compliance with required screening, discounted care, payment plan, and collections practices.[101]
Illinois includes reporting on hospital financial assistance within their community benefits requirements. Each nonprofit hospital is required to prepare an annual report of their community benefits plan, which must include a disclosure of the amount and type of community benefits actually provided, including charity care and details about financial assistance applications received and processed by the hospital. Hospitals must also make the plan reports public on their website and include: the number of applications submitted to the hospital, complete and incomplete; the number of applications approved; the number of applications denied, with the five most frequent reasons for denial. To the extent that race, ethnicity, sex, or preferred language is collected and available for financial assistance applications, these data must be reported alongside those categories.[102]

Recommendation:

- **Require Public Reporting of Financial Assistance and Medical Debt:** Missouri should include reporting requirements in its medical debt protections to monitor compliance and its impact on disproportionately affected groups.

CONCLUSION

Missouri has taken a few steps to improve health care affordability for its residents, but has ample opportunity to improve. Health care affordability is a multi-faceted issue, and interventions will ultimately be needed across multiple affordability domains—including curbing excess prices, reducing the provision of low-value care, expanding coverage, reducing out-of-pocket costs, and curtailing medical debt—in order to eliminate health care affordability problems for all its residents. Not only is health care affordability a concern for many Missouri residents, but it is also a health equity issue, disproportionately impacting residents of color and residents with disabilities. Policymakers should consider the recommended strategies in light of this growing burden.

ABOUT THE ALTARUM HEALTHCARE VALUE HUB

With support from the Robert Wood Johnson Foundation, the Healthcare Value Hub provides free, timely information about the policies and practices that address high health care costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all Americans by applying research-based and field-tested solutions that transform our systems of health and healthcare.

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