

FINAL REPORT:
Summary of Health Insurance
Focus Groups and Key Informant
Interviews

A PROJECT OF THE MISSOURI STATE PLANNING
GRANT ON THE UNINSURED

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INTRODUCTION

Consider this fact: the number of people without health insurance in the U.S. is equal to the combined population of Kansas, Oklahoma, Connecticut, Iowa, Arkansas, Mississippi, Utah, Nebraska, Nevada, Montana, North Dakota, South Dakota, Alaska, Vermont, Wyoming, Rhode Island, New Mexico, Oregon, West Virginia, Idaho, Maine, New Hampshire, Hawaii, and Delaware.

The U.S. Census Bureau recently reported that the number of uninsured increased to 45 million people in 2003.¹ If no reforms in health care are made, that number is projected to grow to 52 million by 2006.²

A survey conducted in 2002 by the Census found that the key demographic factors affecting health insurance coverage are age, race, nativity, and educational attainment. A typical uninsured person is more likely to be young, non-white, foreign-born, and have a low level of education. Though there is widespread belief that the uninsured are also unemployed, that is often *not* the case. The survey found that 49% of people without health insurance for the previous year were employed full-time.³

Even one uninsured person in a family can put the family's financial and health status at risk. The uninsured are less likely than the insured to have a regular source of health care, less likely to receive preventive care, and less likely to benefit from early detection of medical problems.⁴ In short, the uninsured suffer worse health and die sooner than those with insurance. In addition, uninsured persons are often charged more than their insured counterparts, whose insurance companies can negotiate discounts.

Being uninsured has both financial and health consequences, and the costs are borne by the uninsured themselves, employers, the health care system, taxpayers, and the general public. A common sentiment is that when an uninsured person visits a hospital emergency room and receives high-cost care, "we all pay." That certainly appears to be the case. Hospitals whose emergency rooms are filled with uninsured, non-emergency cases are often compelled to redirect patients requiring immediate care to other facilities. The National Center for Health Statistics reported that the number of visits to emergency rooms increased from 89.8 million in 1998 to 110.2 million in 2002 despite a 15% decrease in emergency rooms over the same period.⁵

The cost of health insurance is rising so rapidly that it is becoming more elusive for both individuals and employers. Premium costs are rising at six times the rate of inflation.⁶ In 2003, premiums increased by 13.9%, the third consecutive year of double-digit increases.⁷

Health insurance is no guarantee of health care affordability, however. A 2003 Commonwealth Fund survey found that 29% of respondents who were insured all year reported that they did not get the care they needed because of cost, up from 21% in 2001. For those with household incomes under \$35,000, the figure increased to 39%. An astounding 39% of *insured* respondents who reported medical bill problems in the last 12 months said they had to use all or most of their savings to pay off their medical debt.⁸

If the insurance picture is grim for individuals, it is equally bleak for employers. Between 1977 and 1998, the cost of employer-based insurance increased by 260%.⁹ That's the *good* news, since costs have increased even more sharply since 1998. The average annual premium for employer-based family coverage was \$7,053 in 2001. If no reforms in health care are made, that figure is projected to increase to \$14,545 by 2006, more than doubling in five years.¹⁰

Small businesses are having a particularly difficult time providing health insurance. According to a study by the Kaiser Family Foundation, health insurance premiums are, in fact, rising at a faster rate for small companies. For employers with 3-199 workers, costs rose 15.5% in 2003, versus 13.2% for businesses with 200 or more employees.¹¹ A recent survey found that uninsured workers in companies with fewer than 100 employees account for 57% of all uninsured workers. In addition, more than half the businesses surveyed with fewer than 50 workers did not even offer health insurance.¹²

A survey conducted by the National Federation of Independent Business found that health care costs were the number one rated problem by small businesses. Although the item had been ranked number one since the mid-1980s, the number of respondents citing the issue as "critical" increased significantly from 47% in 2000 to 65% in 2004. According to NFIB Research Foundation Senior Research Fellow Bruce D. Phillips, "No other single problem can touch health-care costs in terms of either the unanimity or intensity of concern it generates among small-business owners."¹³

Larger employers are not immune from health insurance struggles, however. According to a Commonwealth Fund study, the number of workers at companies with more than 500 employees who lack health coverage has increased by 50% since 1987.¹⁴

The U.S. spends more per capita on health care than any other nation, but our spending has not bought us top health status among nations, and it has failed to reduce the size of the uninsured population.¹⁵

It is no understatement to say our health care system is in a crisis. An estimated 13.2% of Missourians were uninsured in 2002.¹⁶ To address this problem, the Missouri Department of Health and Senior Services (DHSS) was awarded a State Planning Grant in late 2003. DHSS selected the Ozarks Public Health Institute (OPHI) at Southwest Missouri State University as a subcontractor. OPHI's role was to conduct key informant interviews and employer focus

groups as part of a data-gathering process intended to propose models and options for increasing health insurance coverage in Missouri. The purpose of this report is to present the findings of those efforts.

FINDINGS: FOCUS GROUPS

A total of 64 employers from around the state participated in the focus group process; 48 participated in seven face-to-face focus groups, and 16 participated in individual phone interviews. Interviews and focus groups took place between April 14 and July 15, 2004. Fifty-three of the companies represented offered health insurance to at least some employees; eleven did not.

According to the U.S. Census definition of urban and rural, 21 of the participants were from urban counties and 43 from rural counties. Looking at geographical distribution by city size, 44 participants were from towns with more than 10,000 people, and 20 were from towns with fewer than 10,000 residents.

Details about the research methodology and procedures may be found in a separate technical report.

At the conclusion of each focus group, employers were asked to complete a short survey. (Those who were interviewed by telephone received a survey in the mail.) All 64 participants completed surveys. Below is a demographic profile of the participating employers based on their responses. Note: Because of rounding, not all percentages will add up to 100.

➤ Number of full-time employees:	1-5	20.3%
	6-20	31.3%
	21-30	10.9%
	31-40	4.7%
	41-50	4.7%
	51 or more	28.1%

➤ Number of part-time employees:	None	12.5%
	1-5	56.3%
	6-20	17.2%
	21-30	4.7%
	31-40	1.6%
	41-50	1.6%
	51 or more	6.3%

➤ Percentage of employees represented by educational	No formal education	0.0%
	Grade school	0.0%

categories	Some high school	3.1%
	High school graduate/GED	53.1%
	Some college	15.1%
	College graduate	22.6%
	Postgraduate degree	6.0%

It should be noted that 23 of 64 (or 35.9%) of the respondents did not respond to this question or used checkmarks rather than numbers. The percentages listed above are based on 41 responses.

➤ Industry that most closely described business:	Retail and wholesale trade/sales	23.4%
	Other	14.1%
	Health care	10.9%
	Manufacturing	9.3%
	Education	7.8%
	Social services	6.2%
	Government/public administration	6.2%
	Professional and related services	6.2%
	Construction, mining	4.7%
	Agriculture, farming, forestry and fishing	4.7%
	Banking, finance, insurance, real estate	3.1%
	Transportation, communications and utilities	1.6%
	Entertaining	1.6%
	Business and repair services	0.0%
Personal services	0.0%	

“Other” responses include staffing/employment, mortgage, publishing, non-profit, restaurant, and auto dealer.

➤ Top three employment/labor force issues affecting business	Finding qualified workers	1 (46.9%)
	Health insurance	2 (35.9%)

Interestingly, only these two issues were ranked as significant concerns; *minimum wage* was a distant third at 11.3%. When the ‘1’ and ‘2’ rankings were combined, *finding qualified workers* was rated by 59.4% of respondents and *health insurance* by 73.4%, illustrating the grave concern employers have about this issue.

➤ Health insurance issues most affecting business (ranked 1 to 5 with 1 being most influential):	Premium cost of health insurance	1
	Availability of health insurance choices	2
	Access to health care providers	3
	Administrative costs of health insurance	4
	Insurance mandates	5

➤ Best describes company's annual contribution to health insurance per employee:	Do not offer insurance	12.9%
	Less than \$1,000	0.0%
	\$1,000-\$1,999	11.3%
	\$2,000-\$2,999	22.6%
	\$3,000-\$3,999	13.9%
	\$4,000-\$4,999	8.1%
	\$5,000-\$5,999	1.6%
Over \$6,000 contribution	12.9%	

➤ Total health insurance obligation for all employees:	Variable
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The amounts varied from \$3,250 to more than \$1 million. Unlike the previous question, this one did not specify whether it was a monthly or annual contribution, and respondents indicated both.

➤ Type of insurance offered:	Preferred Provider Organization (PPO)	73.5%
	Health Maintenance Organization (HMO)	22.5%
	Point of Service Plans (PSP)	10.2%
	Fee for service	8.2%
	Other (self-insured)	2.0%

Respondents checked more than one option. Therefore, the total responses add up to more than 100%.

➤ Deductible or co-pay?	Yes	90.4%
	No	7.7%
	Don't know	2.0%

➤ Health insurance options offered:	Hospital care	97.9%
	Emergency care	97.9%
	Surgery	97.9%
	Office visits to your doctor	95.8%
	Laboratory services	95.8%
	X-rays	95.8%
	Prescription drugs	91.7%
	Medical tests	89.5%
	Maternity care	87.5%
	Immunizations	85.4%
	Mammograms	85.4%
	Well-baby care	81.3%
	Mental health care	81.3%
	Occupational, speech, and physical therapy	47.9%
	Dental care	41.7%
	Vision care	31.3%
	Home health care	33.3%

The focus group questions were divided into four parts:

- Part 1 – background questions for those companies offering insurance
- Part 2 – background questions for those companies not offering insurance
- Part 3 – factors affecting coverage; health care services; regulations
- Part 4 – alternatives to typical employer-based coverage

A summary of responses to each question is listed below, followed by analysis and discussion.

Part 1

DO YOU HAVE EMPLOYEES WHO DECLINE TO PARTICIPATE IN YOUR HEALTH INSURANCE PLAN? IF SO, WHY?

The answer to this question was **yes** by the vast majority of employers. Employees typically did not participate in company health plans for one of two reasons: **cost** or **coverage through spouse**. The reason seemed to be somewhat dependent on the employee's age. Older workers were more likely to be covered through spouses, and younger workers were more likely to "go without." In the case of younger workers, there was also an attitude that they did not need the insurance in addition to the cost issue.

The reported participation for employees' families was particularly low. Premiums for family members were, in general, very expensive. One employer described it this way: "A lot of these people are single parents or you know lower income type families with multiple children. They just can't afford it. Even with the 50% that we pay they still can't...and I have almost no one who takes family coverage or spouse coverage because of the cost. Simply because of the cost." This expense has led some to make alternative arrangements. One employer whose family coverage was too expensive had purchased an individual plan with catastrophic coverage for his wife and child.

HOW DO YOU DECIDE IF OR HOW MUCH THE EMPLOYEE SHOULD PAY?

There were several responses to this question. In the majority of cases, the decision was dictated by **budgetary considerations**. Many employers expressed their frustration at having to pass more of the costs to their workers, but they felt they had no choice if they wanted to continue to offer insurance. One offered this observation: "Although philosophically all the business owners would like to make sure that this is a benefit...the perception from a lot of the employees as you reduce benefits and increase costs, at some point it becomes not perceived as a benefit any longer."

Some employers said that they decided employee contributions by working with their insurance agents. Others decided via union negotiations or through a Board of Directors. One owner had an employee committee that deals with insurance: “We take bids and we have an agent, of course, who comes out and hustles our bids for us. Then we have an employee committee that reviews what the bids will be at the current level and we look at the next level down in liability coverage and we take a recommendation from them.” Still other employers did not have a clear idea of how to make these decisions and went with what they thought was fair. “What is the norm?” asked one employer. “I have no clue as to what is customary, what is average, what is accepted.”

Some of the employers did not offer coverage until the employee had been with the company for a specified period of time, such as six months or one year. For others, coverage began immediately after the employee was hired.

Premium costs varied considerably, depending on the insurance carrier. Some of the companies offered premiums that were the same for all employees. For others, the amount was dependent on age, gender, and health status. One employer told the story of a worker in his company who paid over \$900 a month for himself, his wife, and two children. The cost was high because of health problems with both the man and his wife. Another employee, meanwhile, paid \$230 a month for family coverage.

The percentage of premiums being paid by the employers varied from 50-100%. Approximately half of the employers paid 50% of the premiums and half paid more. It should be noted that few companies still paid 100%, although many had done so as recently as one or two years ago.

HAVE YOUR PLANS CHANGED RECENTLY?

Not surprisingly, the answer to this question was yes. Here was a typical response: “We had to increase our deductibles and increased our maximum out-of-pocket in each of the last three years.”

A variety of changes had occurred, including dropping dental or vision coverage, doubling premiums to retain the same coverage as the previous year, increasing the amount of maximum out-of-pocket costs, changing carriers, and increasing deductibles. Most of the deductibles reported had at least doubled. In some cases, the one-year increases were even higher; one went from \$100 to \$1,000.

Of all the participants in the focus groups, only a handful reported no recent changes in their health insurance plans.

Some of the business owners had added self-insured components to their plans. For example, one company has a \$1,000 deductible but reimburses the employees' expenses from \$500 to \$1,000. The employer said that it was "saving us a lot of money in the long run and matter of fact this coming year we are looking at increasing the deductible more to make the premiums cheaper still." Another company had implemented a self-insured component as well where it pays half of the \$2,600 deductible and 80% of prescription drug costs. This arrangement appears to be working well. As the employer said, "We had Blue Cross Blue Shield previously and total out of pocket was \$3,000 and they [the employees] paid it all, so it brings it down to \$1,300 for us. We do not carry any prescriptions. We pay 80% of that; the employees pay 20%. They still come out ahead and we do, too."

A few businesses have begun offering case management in their insurance plans and report it being successful. Case managers stay in close contact with individuals who have chronic diseases to make sure they take their medications and get the proper care. As one employer explained, "The employees feel special that a case manager calls them and says you know we are wanting to follow your care...they like it because somebody cares enough to follow up and makes sure they are getting the right care."

Business owners were certainly not happy about the cost increases they have experienced in recent years. According to one employer, "We pay more and more and more and the coverage gets worse and worse and worse. Is that not universal for everybody?" At this particular focus group, the other participants agreed enthusiastically.

"No money tree out back when you are a small business," quipped another employer.

Employers were also unhappy about the increasing amount of time they have to spend on insurance issues. One put it this way: "Ten years ago [we] didn't spend near as much time in shopping, looking, settling on a carrier for a year or what they could expend as they do now. Now it is a long process that begins months ahead of time and a lot of sweat and anguish going into it to try to figure out, can we do this or is this the best thing we can come up with? Then meeting with employees and explaining to them and then trying to let them know we are doing the best we can for you. It has turned into a major human resources problem. Very much so."

IS THERE A SITUATION WHERE YOUR COMPANY MIGHT DECIDE TO DROP COVERAGE ALTOGETHER?

The answer to this question was a **resounding no!**

- "There is no way in God's green earth that we could do something...would do something like that."

- “That would have to be a very, very, very, very last resort after you’ve trimmed the policy down and gotten rid of as many benefits as you could.”
- “As long as we have employees we will have health insurance.”
- “If I am on the verge of bankruptcy, that might be a consideration, but that would be the only thing.”
- “I don’t know if I would stay in business if I couldn’t pay for the insurance anymore.”
- “We are going to do whatever it takes. If we have to cut back somewhere else we’re not going to drop the healthcare.”
- “I don’t intend to ever drop it, unless I am absolutely bloody forced to.”

Among the companies that offered insurance, only a few said that dropping coverage was a distinct possibility, although many did qualify their answers with the old adage, “Never say never.” Employers agreed that if they did have to drop coverage, the overwhelming reason would be cost, although one said that if he dropped coverage, it would more likely be for lack of participation.

Ironically, one owner said that the only reason her company was able to offer insurance was because the participation was so low (5 of 14 workers). If participation was higher, the company would not have been able to afford it.

As an alternative to dropping coverage, one owner was exploring the possibility of an on-site medical clinic. This particular employer was part of a large, nationwide company. If such a plan was implemented, the company was considering dropping all insurance except for catastrophic care.

DO YOU THINK EMPLOYERS SHOULD MAKE HEALTH EDUCATION OR WELLNESS PROGRAMS AVAILABLE TO THEIR EMPLOYEES?

The majority of employers thought that such programs should be made available, although they did feel that, for financial reasons, their own companies would not necessarily be able to do so. Some of the programs that business owners either offered or were aware of included:

- Smoking cessation support
- Smoke-free offices
- Mental health counseling

- A wellness group that meets weekly
- 24-hour nurse line
- Walking program
- Health fair
- Presidential Fitness Challenge
- Wellness bus
- Partial to full membership in fitness clubs
- Changing the contents of snack machines from candy and soda to fruit and juice

Owners were also generally supportive of educational efforts, such as meetings held by insurance agents to explain premium increases to employees. As one employer stated: “I think education...is needed. Do you understand the bill? Do you understand the explanation of benefits? Do you understand what they are telling you? That is the biggest thing going on right now is to educate these people on the most precious thing to them, which is their health.”

Some employers’ insurance plans offered discounts to those who offered wellness programs; others did not. The issue of “motivating the unmotivated” was discussed, and the consensus was that incentives must be used, but they only work up to a point. As one owner pointed out, “When they attach an incentive to it, usually physical bonus days off or whatever, that is when you start getting attention.” A suggestion was also made to increase the insurance co-pays for those employees who smoke.

Frustration was expressed at the number of employees who do not get routine physicals, since insurance plans are now mandated to offer such services. A simple suggestion was made for companies to send out email reminders as a way of encouraging workers to get their check-ups.

Some owners were against the idea of employer-provided education or wellness programs. Some felt that the services would not be used. Others thought that these services were the responsibility of insurance companies, not businesses. Still others had a more philosophical view, such as these:

- “I don’t think the employer or the government or anyone else has any responsibility to make individuals responsible for their own health.”
- “I certainly encourage my employees to take care of themselves and remind them that they do have health insurance for a reason, but I am not their mama.”

Part 2

WHAT WOULD IT TAKE FOR YOUR COMPANY TO START OFFERING COVERAGE?

The most common response to this question was **lower cost**. All of the participating employers expressed a desire to offer insurance, and all said that the primary reason they could not was because of cost. One employer who owned a restaurant was asked about increasing her prices to offset the cost of health insurance, but that was not an option for her: “We are just a Mom and Pop organization type, country-style, home-style; you come in and you can usually get a meal for \$5 or \$6. It is just not fair. If we raise our prices, our senior citizens who we are getting in here and most of them are on fixed incomes and they just wouldn’t come back.”

Employee contributions are an issue as well. One employer spoke of another company who had decided to offer insurance but was unable to pay 100% of the premiums, and the employees were unwilling to pay any portion of the premiums. As a result, no insurance plan was implemented.

Other responses included:

- Tax incentives. Most employers were in favor of this idea, although for some tax credits would still not be enough to make insurance premiums affordable.
- Full-time employees. One employer had only part-time workers and would not seriously consider offering insurance unless she had some full-time employees.

Two employers pointed out that their current circumstances were such that they did not need to offer insurance. In one case, the company employed college students who were covered through their parents. In the other case, the employees were covered under their spouses’ insurance.

HOW MUCH WOULD YOUR COMPANY BE WILLING TO PAY PER EMPLOYEE PER MONTH?

Responses ranged from **\$0 to \$150** and were dependent on the financial health of the company. One business was in financial trouble and could not afford to pay anything, while others thought that \$100-\$150 would be a reasonable amount.

WHAT IS THE MINIMAL TYPE OF COVERAGE YOU WOULD WANT TO BE ABLE TO OFFER FOR THE AMOUNT OF MONEY YOU COULD AFFORD TO PAY?

The most common response to this question was **catastrophic coverage**. Many of the employers felt that that was all they would be able to afford and that catastrophic coverage was the most needed service. One employer wanted to offer primary care and dental coverage instead. Several were not sure of the type of coverage they would want to offer.

WHAT ARE THE BENEFITS OF NOT OFFERING HEALTH INSURANCE?

The most common response was that **there are no benefits to not offering health insurance**. Many of the companies not currently offering insurance very much wanted to do so.

Other responses included:

- Cost savings for the company.
- The employees have the extra salary that would have been paid in insurance instead.
- Easier for the employer. “You don’t have to worry. They have to go out and get it on their own.”
- No administrative or paperwork hassles.

WHAT ARE THE COSTS OF NOT OFFERING HEALTH INSURANCE?

The most common response was **the ability to recruit and retain quality employees**. The trend of potential employees seeking out insurance, even at lower pay, was mentioned. One employer said that “keeping your good health” was another cost. She recalled one or two instances where employees had health issues that might not have occurred had they had insurance. Another employer said that there were not any costs because the type of people she attracted as potential employees were not used to having insurance, vacation days, or sick leave.

TO WHAT DEGREE WOULD YOUR COMPANY BE INFLUENCED BY PURCHASING ALLIANCES OR ADDITIONAL TAX INCENTIVES?

There was **unanimous support** for this idea, although the employers realized that such alliances or tax credits might not be cost-effective enough to offer insurance. Still, they were all very much interested in the idea.

Part 3

WHAT IS THE MOST IMPORTANT FACTOR THAT HAS INFLUENCED YOUR DECISION TO OFFER OR NOT OFFER HEALTH INSURANCE?

The majority of employers that offered insurance said they did so because it was a **recruiting and retention tool**. “The main reason would be to hire and retain employees,” noted one owner. “That is the only reason.” Another employer said that “at the end of the day it comes down to money and you know they are not here because they like me and so I have to have a competitive package and for what I am asking them to do, the level of professionalism that I require.”

Several employers noted that health insurance has become so important that it is often the first thing a prospective employee asks about during interviews.

Employers did not see insurance as strictly a business decision, however. Other reasons cited were employee need and because “it’s the right thing to do.” One employer put it this way: “Luckily our Board of Directors, as well as our Executive Director, we all see, we all read off the same page and we all think it is not an option. A person has to have insurance to survive in the real world.” Another told a story about an employee who had heart surgery a number of years ago: “I said, you owe me \$75. He couldn’t believe it. That is all of his out-of-pocket there was. It is not that way now. Now that is something that you feel good about from an employer’s standpoint.”

One employer mentioned a trend that is occurring with greater frequency: “We seem to have a significant population that comes in that is in the middle-age to older bracket and it is because they cannot afford healthcare and so they actually are working for the insurance.”

For those companies that did not offer insurance, the overwhelming factor was **cost**.

DO YOUR COMPETITORS OFFER HEALTH INSURANCE?

The majority of companies that offered insurance had **competitors that did the same**; a few did not or weren’t sure. For companies that did not offer insurance, **their competitors didn’t, either**.

DO YOU THINK CURRENT INSURANCE REGULATIONS DETER SOME COMPANIES FROM PARTICIPATING?

The majority of employers said that they thought **regulations did deter companies from offering insurance**. A surprising number seemed to be unaware of existing regulations or said that their insurance agents “took care of it.”

Some of the regulations specifically mentioned included HIPAA and COBRA. One employer said that billing through COBRA should go directly to the ex-employee rather than the former employer. As he put it, “We have to include them with our insurance and if they skip town or decide not to pay us, then we are caught with the cost.”

HIPAA was roundly criticized for increased paperwork and administrative hassles. Employers complained that their personnel in charge of benefits are now restricted in trying to help employees with insurance questions. “The regulations have really tightened our strings as far as helping,” said one business owner. Another called HIPAA “classic government overkill.” Still another described his frustration in having to hire a Third Party Administrator because of HIPAA: “I as an employer paying for the plan am not allowed to even see the bills that I am paying for by federal regulations on privacy issues. So in effect we lost all we gained almost in having to hire a TPA to do all that. It is just a frustrating exercise in futility.”

Some owners, especially those struggling to offer even basic coverage, were not appreciative of the mandates requiring insurance policies to include things such as a minimum number of chiropractic visits, child immunizations, mammograms, prostate testing, and psychiatric services.

Finally, employers did not like the restrictions placed on them by the insurance companies themselves, such as limited physician choice or pre-approval requirements. According to one employer, “If you have a life or death situation, you are not thinking about calling to see if you can get a referral to get it pre-approved, and I think that it is to the point where it is so controlling that there is no humanity involved.”

WHAT ARE THE MOST NEEDED HEALTH CARE SERVICES BY YOUR EMPLOYEES?

Employers interpreted this question in one of two ways: services most *needed* or services most *used*. They said that **prescription drugs** were the most used health service by their employees. According to two insurance brokers who were present at different focus groups, that is actually the case: approximately 30% of benefits are paid for drugs, making them the single largest expense, followed by office visits.

One owner reported that her company had begun using a mail order prescription program which had saved money and was popular with the employees.

Office visits were mentioned as the second most used service. One employer said that dental services were most often used in his company.

The most needed service was **catastrophic care**. One owner explained it this way: “Most of our employees would be able to afford the doctor’s visits and the pharmacy and all of that, especially with what they are having to pay for insurance. It is the catastrophic coverage that really gives them peace of mind.”

The need for management of pharmacy benefits was discussed. For example, in some instances, two compounds may be mixed together that result in an identical—but much cheaper—drug. In other instances, pills may be prescribed at double the milligrams for little or no additional cost. The pharmacist then splits the pills, and the patient saves money. Finally, larger supplies of drugs are often cheaper. One employer talked about using 30-day supplies of insulin for diabetes until she found out that a 90-day supply was substantially cheaper. Neither her doctor nor her pharmacist had told her of the potential savings. She discovered it on a television commercial.

The mention of prescription drugs often led to broad (and spirited) discussions about the pharmaceutical industry. Employers were not at all pleased with the amount of advertising for prescription drugs or the amount of money spent to entice health care workers to promote certain drugs. One mentioned that her two young children knew all the drug names and loved the “Zoloft ball.” “If you watch a NASCAR race, how many male enhancements ads do you see?” asked another. One employer put it this way: “You know used to, you went to the doctor and they told you what you needed. Now you go to the doctor and tell them what you want because you saw it on TV last night.”

One participating employer, who was representing a pharmacy, spoke of the money being spent by pharmaceutical sales representatives: “We just opened a deli in our store in [the clinic] and I sold \$100 worth of smoothies to a drug rep this afternoon that was taking them to the nurses...Honest to God, they will go to Pasta Express, McAllister’s, and bring in carts full of food. They will take orders from the nurses for the next day. \$1,000 in food go through those doors everyday.”

Another employer, who was representing a grocery store chain, mentioned that the cost for a pharmacist has also added to the price of drugs in recent years.

WHAT KIND OF INFORMATION WOULD YOU FIND USEFUL IN MAKING DECISIONS ABOUT HEALTH INSURANCE?

There was unanimous support for information about health insurance plans that would help employers make more informed decisions. As one business owner admitted, “I am kind of

flying by the seat of my pants and relying on my agent to keep me in line with the various regulations...Yeah, it would be very beneficial.”

The consensus was that a **rating or report card of insurance companies would be very beneficial**. This could include basic information about a sample plan so that “apples could be compared to apples,” with specific information on premium prices, deductibles, and what is covered. In addition, employers said that ratings of the companies by customer satisfaction or complaints would be helpful so that they would not necessarily be tempted to go with a company offering the lowest price. A suggestion was made to add a feature on the state government or other appropriate website where employers could lodge complaints about insurance companies.

Some employers expressed a desire to learn more about medical savings accounts as well.

Employers had a number of complaints about the way they are treated by insurance companies, not the least of which was the tendency to give no explanation when premiums are increased. One employer suggested that it would be helpful if insurance companies reported to its customers where the money goes: “How much would actually go to insurance companies, as far as profit for them? How much of it goes to providers? Just where does all that premium money go to?” Another pointed out that the same problem did not exist with property and casualty insurance and that health insurance was unique in *not* giving explanations for cost increases.

Others felt slighted as well: “I think insurance companies should fight for our business to give us the best quote...They don’t do that. They just wait until your policy is over in August and on July 15, they say okay we’re raising your premiums \$2000 and then they know that you need insurance so you are basically stuck.”

Some employers even questioned the legality of the policies of some insurance companies. One told this story about BeneCorp (sic): “What they do is that they go back and underwrite every claim from your enrollment sheet and if you don’t mention one little tiny thing, they’ll use that as an excuse to deny you coverage, to block you as the individual employee on this group from the plan...Why doesn’t the state help get rid of these criminal organizations that are out there to just take your money and run.”

“Low-balling” was mentioned several times (where insurance companies give initial low rates and then raise prices dramatically within the first year). This had happened to several employers and they were understandably bitter about the experience. One described his experience with United Healthcare: “They low-balled us to get the coverage and then 30 days later they hit us...We had several employees with procedures on-going and we were basically forced to go back and our company picked up and it cost us close to \$40,000 just for the 30

days interim period to get the people with procedures their coverage and they were basically without insurance until the 9th.”

The need to be an informed consumer of insurance was pointed out. As one employer said, “There are so many insurance companies out there. You see their sign hanging off a telephone pole and you usually get what you pay for.”

Nearly three-fourths of the employers who participated in the focus groups had fewer than 50 employees. Many of them felt that, although they are the backbone of American business, insurance companies are turning their backs on them in favor of large corporations.

The dissatisfaction of focus group participants with insurance companies was confirmed by several employers and key informants who reported that the average stay with the same carrier is only 2.5 – 3 years. As one business owner said, “Our philosophy always was if we possibly can we will stay with the carrier we have. We don’t want to put our employees through that every year. Nevertheless, we have probably done it five times in the last ten years out of necessity.”

IS THE SYSTEM BECOMING BETTER OR WORSE FOR EMPLOYERS? WHY?

The majority of participants said the system was becoming worse, primarily because of increasing costs. One employer summed it up this way: “Remarkably worse. Every year we have more mandates that we have to comply with and the costs continue to go up dramatically and you know if you had something in your life that tripled in cost, what would you do?” Two employers pointed out that while the system is worse from a cost standpoint, it is better as far as the quality of health care received. A few business owners said that the system was unchanged.

Employers seemed bewildered by the differential charges made by hospitals for cash versus insurance. One recalled the story of her daughter having to go to the hospital. The charge was \$5,000. Her family had insurance but the deductible was \$2,500, and they would have been required to pay 20% of the other \$2,500. The hospital said that if they paid \$1,500 in cash, the rest of the charges would be dropped. They got a loan for the \$1,500 and saved money in the process, leading this employer to say of insurance, “Sometimes it’s not even worth having.”

The demand for high-tech, immediate health care was discussed, as was the cost of advanced technology. One employer pointed out that years ago when someone had a joint that was going bad, he got a cane, but now he would get his joint replaced.

Service was an issue as well as cost. Employers complained of problems with claims and of hospital statements that are no longer itemized as they were in the past. One employer even mentioned the fact that some doctors and dentists now require full payment from their patients, who they reimburse if and when payment is received from the insurance companies.

Increasing regulations, such as HIPAA, were also cited as a reason for the system becoming worse for employers.

The increasing role of health insurance in the workplace was lamented by the employers. Not only are business owners spending more time shopping for insurance and explaining it to their employees, there are adjustments for the employees as well. As one owner said, “Anytime that there is an increase in their contribution, you know it is like you just hit them over the head with a hammer.” Another worried about the possibility of having to give up insurance for her employees: “My people are hard-working, good people, most of them with families, mostly rural communities, and if we don’t provide it for them, those people are not going to have it—simple as that—and they are going to show up on [the hospital’s] doorstep...and there they’ll be.”

Another way that the system is getting worse, according to some focus group participants, is the amount of control the insurance companies have over the people who participate in their plans. In some cases, the companies approve what doctors can be seen, how long a person can stay in the hospital, and what medications can be taken.

Finally, some business owners complained about the “one-upsmanship” between health care systems, such as the hiding of profits through excessive construction. One employer mentioned a recent article in the newspaper about a new diagnostic facility that charges a substantial “facility fee” for each visit. Whether or not the patients use any of the advanced equipment at the facility, they are assessed with this fee. As he pointed out, “It would be like asking my clients to pay the services that I could provide with my copy machine just because it is there. Even if they never made a copy or needed a copy.”

Part 4

ONE WAY OF MAKING HEALTH INSURANCE MORE AFFORDABLE FOR EMPLOYERS IS KNOWN AS THE 1/3 MODEL. EMPLOYERS THAT CHOOSE TO PARTICIPATE PAY 1/3 OF THE MONTHLY PREMIUM, EMPLOYEES PAY 1/3, AND SOME OTHER SOURCE PAYS THE REMAINING 1/3. WOULD YOUR COMPANY BE INTERESTED IN SUCH AN ARRANGEMENT? IF SO, WHO SHOULD PAY THE REMAINING 1/3?

For the most part **employers were against this idea**, which they viewed with suspicion because the obvious party to pay the remaining 1/3 would be the government:

- “The State cannot do it without bringing bureaucracy into it.”
- “We will all have signs out in our yard—vote no.”
- “That third would be paid by the actual individuals in higher taxes or in businesses who would pay higher taxes. No subsidy, I don’t agree with that at all.”
- “You’ve got two things there. You’ve either got State or Local. Either case, you’ve got trouble.”

It was surprising how quickly and often the discussions turned from possible government involvement to socialized medicine. This comment from an employer was not unusual: “They [the doctors] shouldn’t make a hundred grand sitting next to another surgeon that is terrible just because the government is chipping in.”

The idea was not completely without support, however. Those employers who did not offer insurance or were struggling to maintain their insurance were more receptive to the idea. They saw the 1/3 model as at least an option. For some, it was the only option. Without a subsidy of some kind, they would be unable to offer any kind of health coverage. Nonetheless, even those employers who did express some interest in the idea did not come to the defense of the government.

One employer had a novel suggestion: limit insurance companies in Missouri to a certain percentage profit and require that any excess money go into a pool to fund the “other 1/3.”

WHAT INCENTIVES DO YOU THINK WOULD BE EFFECTIVE IN ENCOURAGING EMPLOYERS TO OFFER HEALTH INSURANCE?

The most common response to this question was **tax credits**. None of the owners provided any specifics, except for one who suggested reduction of payments to Social Security and

Medicare. For at least one business owner who does not offer insurance, tax credits would not be an incentive: “Of the last ten years, I’ve had to pay taxes about two years because our bottom line is so bad...If you’re not paying taxes, how is that going to help me?”

Several other suggestions were provided as well:

- Purchasing pools for small businesses.
- Promoting the benefits of offering insurance—better employee recruitment and retention, reduced absenteeism, etc.
- Government subsidies, such as the “1/3 model.”
- Enacting tort reforms to help bring down insurance cost. One woman who participated in a focus group had a daughter in the delivery room while the focus group was going on. The doctor who was delivering the baby was planning to stop all obstetric services in his practice by November 2004 because of malpractice insurance costs.
- Accepting all business equally into the insurance system so the playing field is level and rates will be more affordable for all.
- Providing education to make sure small businesses can make good decisions about insurance, i.e., providing information on medical savings accounts which many businesses are interested in but few know much about.
- “Get the government out.”

DO YOU THINK EMPLOYERS HAVE AN OBLIGATION TO PROVIDE HEALTH INSURANCE TO THEIR EMPLOYEES? IF NOT, WHO SHOULD?

Employers were **evenly divided** over this question. Some owners thought that companies had an obligation to provide insurance for moral and business reasons. As one owner said, “People give so much of their life and time to their companies that especially when they are working full-time and I think for Americans it is really hard to get that covered on your own. So I do think that businesses do have an obligation.” Another made the distinction between a moral and a business obligation: “I don’t see it as my responsibility to manage the healthcare of my employees. I don’t think I have a moral obligation to do that. Clearly I have a competitive obligation to do it. In that I can’t find employees if I don’t do it, so it is market driven rather than morality driven.”

Some employers spoke of the attachment they have to their employees. One summed up her feelings this way: “I’ve got a bunch of people where I’ve watched their kids be born and grow up and graduate and get married and go to their weddings and they’re like part of my family...so yeah, I’ve got an obligation to try to keep them with coverage at a reasonable cost.”

Of those employers who thought insurance was not an obligation, a variety of reasons was given:

- It is a “privilege, not a right.”
- “Absolutely not. The responsibility rests with the individual to get their healthcare.”
- If businesses were required to provide insurance, many would not be able to stay in business.
- It depends on the size and type of business. “If you are operating and employing skilled people who require higher wages, then your obligation increases...it has to be commiserate with that support that you give them the bottom line.”
- Health insurance tends to get pushed to the bottom of the list. “I know with everybody paying liability insurance, insurance on this and insurance on that, it’s insurance on everything else before you get to the health insurance part. It’s like how much percent of profit goes to other insurance and you know that’s the last one on your plate because it’s not something you have to have.”

When asked who should be responsible for providing health care if employers are not, the majority thought that the responsibility should fall to the individual.

WHAT WOULD BE SOME POSITIVES AND NEGATIVES ABOUT GOVERNMENT INVOLVEMENT IN EMPLOYER-BASED HEALTH INSURANCE?

Of those who mentioned positives about government involvement in health insurance, the most common response was that it would **help with the cost**, thereby allowing more people to be covered. As one employer remarked, “I have a lot of single moms that work for me and I think that that would give them a break and if they needed to go buy tennis shoes for two kids then they wouldn’t have to do without something. I just think that they need some relief.”

Other responses included:

- The government could enable purchasing alliances.
- Administering funds through a third party might be an effective way for the government to be involved.
- Medical savings accounts could be facilitated through the government.
- It would be beneficial if the government could regulate “closed shops” where insurance companies would not be able to contract with only a single health care system in a community. For example, in Springfield insurance companies can only contract with either Cox Health System or St. Johns Health System, not both.
- A watchdog group could be developed to oversee the activities of insurance companies.
- Legislation could be passed to level the playing field but the government should not get involved in the delivery of insurance.

On the negative side, employers said that government involvement would be too **bureaucratic**. “The government hasn’t proven to me that they can run anything efficiently,” said one employer. “The government has not been noted to do anything that is economically feasible,” noted another.

Other responses included:

- Too much control.
- Government involvement would be seen by some as welfare.
- Fewer choices.
- Too regulatory.
- Wasteful.
- The government is not answerable to the people.

It should be noted that a number of employers had only negative things to say about government involvement in health insurance. “I have no positives” was a common response to this question.

WHAT DO YOU THINK SHOULD BE DONE TO REDUCE THE NUMBER OF UNINSURED IN THE STATE?

The most common response to this question was **reduce the cost!** Some employers' responses were very straightforward, such as this one: "Cheaper insurance. Offer cheaper insurance."

There was a good deal of discussion about poor people and health care costs. For example, according to some of the participating employers, there is an urgent need to restructure Medicaid. There is no incentive for people to be prudent about their medical care because they can go to the emergency room anytime. In addition, the co-pays for prescription medicine are very low. These employers felt that if people on Medicaid had to pay a little more, they would be more accountable. Problems with MC+ were mentioned as well. One employer who worked at a community health center noted the abuse she had witnessed.

There were discussions of the impact of the uninsured incurring large hospital bills and having no assets that the hospital could take. Some people routinely use the emergency room for primary care, knowing that if something catastrophic happens, they have no personal assets that the hospital can take from them.

There was an attitude among some employers that the uninsured are well taken care of because many have access to free clinics and there is always the "emergency room" option. "Why work when you can just go on welfare or whatever or go down to the free clinic?" was not an uncommon sentiment.

The need to regulate insurance companies was discussed. One employer pointed out that Blue Cross Blue Shield, the insurance company that recently went for-profit, contributed \$45 million in 2003 to the Missouri Foundation for Health, its research organization. Many employers question why their premiums continue to skyrocket if the company has that kind of "extra" money available. One employer reported increases of 15% and 30% with Blue Cross Blue Shield in the last two years and a projected increase of 20% for the upcoming year. Another reported increases of 63%, 71%, and 58% with United Healthcare before dropping that particular carrier. The percentage increases that are allowed in a given year were noted. According to several employers, the limit is 200-300%, which they thought was not very helpful. They felt that the percentage increases should be much more limited.

Other responses included:

- Continue to fund and expand Federally Qualified Health Centers, which serve as an important safety net.
- Implement health insurance co-ops, similar to electric co-ops.

- Enact tort reform.
- Implement education programs so that people are made aware from a young age the importance of health and health care.
- Allow small businesses to band together and self-insure.
- Get the government out of healthcare.
- Make payment for health insurance on a sliding scale according to the individual's ability to pay.
- For the uninsured, offer catastrophic coverage. Even this limited coverage would help significantly with costs.
- Reform government insurance programs. For example, it was noted that as long as government programs like Medicare continue to pay exorbitant prices for hospital charges, then the hospitals will continue to charge those rates.
- Do away with employer-based health insurance altogether and give the responsibility back to the individual.

The focus group participants acknowledged the complexity of the problem. As one employer put it, "Unfortunately, there is no silver bullet and that is what everybody is looking for. Everything we have talked about here is not a short-term solution. It is not even a solution most of us will see in our lifetime."

OF ALL THE THINGS WE TALKED ABOUT TONIGHT CONCERNING HEALTH INSURANCE, WHAT IS THE FIRST THING THAT COMES TO YOUR MIND AS BEING IMPORTANT OR SIGNIFICANT?

Not surprisingly, the most common response was overwhelmingly cost. Other responses included:

- Provide educational materials so that individuals and employers can be better health care consumers.
- Regulate the insurance companies, which a number of employers felt were instrumental in driving up costs.

- Determine exactly what is driving up health care costs and deal with the issue from that perspective.
- Address the administrative problems in processing claims.
- Allow purchasing alliances for small businesses.
- Enact tort reform.
- Provide a better safety net for those who do not qualify for government insurance. “People on Medicaid and Medicare are taken care of and that’s great but what about the rest of us?”
- Let the market take care of itself without a lot of undue intrusion.
- Make health insurance more wellness-oriented.
- “Health insurance can prevent financial disaster for the individual.”
- “The thing I would like to leave with you is that the system has to be changed. If not, the economy is going to go nowhere but down.”

Analysis and Discussion

A number of themes emerged from the focus groups:

- **Cost is an overwhelming issue for employers.** Cost is the “elephant in the living room.” During the focus group discussions, it was so overpowering for some employers that it was difficult for them to get beyond it to discuss other issues surrounding health insurance.
- **Employers are welcome to the idea of more information so that they can make informed decisions about healthcare.** Employers are frustrated and even resentful of the way they have been treated by insurance companies. They are receptive to information which would empower them.
- **One of the hidden costs of health insurance is the amount of time employers must spend dealing with it.** For both business owners and their employees, the amount of time spent on insurance is increasing, particularly for those businesses that change carriers frequently.
- **Those employers that offer insurance very much want to continue doing so.** They realize its importance to the success of their businesses and are not ready to give it up without a fight. Those employers that do not offer insurance have a strong desire to do so.
- **Employers are much more interested in tax credits than subsidies.** To them, subsidies imply government involvement, which they oppose. When government involvement in health care was discussed during the focus groups, not a single business owner defended the government.
- **Employees need to be educated on how to use their insurance plans effectively.** From using the emergency room only for emergencies to buying prescription drugs at a discount where possible, employees need to become better health insurance consumers.
- **Low-balling is a serious issue which has hurt many small businesses in Missouri.** The practice of giving initially low insurance rates, only to increase prices dramatically, needs to be dealt with by State insurance regulators.
- **Purchasing alliances are badly needed.** Owners of very small businesses are desperate to find a more cost-effective way of providing insurance to their employees. They see large purchasing alliances as at least a step in the right direction.

Employers, particularly those in very small businesses, were frustrated and distressed about the health insurance predicament in which they have found themselves. The degree of concern seen on the faces and heard in the voices of these small business owners cannot be overstated. Perhaps this employer said it best: “I hope that all of us go and tell three and four other business-owner friends about it and we all go on the [SPG] website and print it [the report] off and send it to all of our legislators and let them know that, hey, the small business person out there is struggling, they are really upset about this insurance problem because I, for one, am.”

Notable Ideas

During the course of the focus groups, employers made several excellent suggestions about how the system could be improved. With the realization that these might have been “lost” in the information on the preceding pages, they are repeated here:

- Add a self-insured component to insurance plans. Purchasing catastrophic coverage and paying for routine care is yielding substantial savings for some companies.
- Send email reminders to increase the number of employees who get physicals and routine screenings.
- Include case management in insurance plans. Providing ongoing management of chronic illnesses may yield significant long-term cost savings.
- Implement health insurance co-ops, similar to electric co-ops.
- Limit insurance companies in Missouri to a certain percentage profit and require that any excess money go into a pool so that employer-based coverage may be expanded.
- Develop a government watchdog group to oversee the activities of insurance companies.
- For the uninsured, offer catastrophic coverage only. Even this limited coverage would help significantly with costs.

FINDINGS: KEY INFORMANT INTERVIEWS

Thirty-four interviews were conducted between April 30 and August 19, 2004. Key informants represented all areas of the state and a variety of health care backgrounds. With assistance from MDHHS, seven areas of emphasis were developed:

- Federally Qualified Health Centers
- Free clinics
- Group purchasers of insurance
- Health care providers
- Insurance companies
- Local public health agencies
- Special individuals

Details about the methodology and procedures may be found in a separate technical report.

Each key informant was asked a series of questions. Summaries of responses are listed on the following pages, followed by analysis and discussion. The numbers in parentheses indicate the number of key informants who gave that particular response.

WHY DO SOME PEOPLE IN MISSOURI NOT HAVE HEALTH INSURANCE?

The most common response was cost. In fact, 32 of 34 key informants cited cost as a reason why people are uninsured. Whether a worker is required to pay a portion of the premium of employer-based insurance or is attempting to get individual insurance because none is available through employment, cost is a major issue. One key informant summed it up this way: “If it costs me more and I have lower income, what it will do is just force me out of insurance. I will just say the hell with it, then you are going to have to deal with that on the backside. There are not easy solutions to any of this, but I think that is the direction that the industry is going.”

Other responses included:

- Their employers don’t offer insurance. (17)
- Health insurance is offered but some people refuse because they have other priorities for their money. (7)
- They don’t think they need it because they’ll never get sick. (7)
- People do not know about MC+ that is available to them. (4)
- They have some type of pre-existing condition making it difficult or impossible to get insurance. (4)
- They don’t meet income guidelines to qualify for government assistance. (4)
- They lost their jobs. (3)
- Not U.S. citizens. (3)
- It is complicated to select or get insurance. (1)
- Access to insurance is not readily available to the individual. (1)
- Lack of knowledge of the importance of having insurance. (1)
- Many workers are underinsured. Their deductibles are so high that they are unable to afford even that expense. (1)

WHAT KEEPS PEOPLE FROM USING PUBLIC INSURANCE THAT THEY'RE ELIGIBLE FOR?

Sixteen respondents said public insurance wasn't used more because **people are not aware of its existence or not aware that they might be eligible**. As one key informant noted, "The CHIPs program? We've jokingly called it the best kept secret in Missouri."

It was noted that government assistance should not be free because that leads to abuse of the system. One key informant said that women come in on a regular basis to her clinic to replace lost antibiotics for their children. Because the cost to them is so low, there's no incentive to be responsible for the medication. The same key informant also pointed out the need to have some penalties associated with public assistance. For example, there should be some sort of cost or penalty for a woman who continues to have children while on Medicaid.

Other responses included:

- The bureaucracy involved in the application process—too many "hoops" to jump through. (14)
- Pride. Many people see public insurance as a form of welfare and won't accept it. (13)
- Social stigma. (7)
- Young people don't think they need it. (2)
- Accessibility—unable to find a doctor who will accept Medicaid patients. "There are very few doctors who would turn away a patient due to their inability to pay; but increasingly as doctors become more and more responsible for their payer status it becomes a necessity to see people are insured and unfortunately the public insurance you speak of has very low reimbursement and so this deters many health care providers from making those physicians accessible." (2)
- Religious reasons. (1)
- Unable to afford with the graduated premiums in the MC+ program. (1)
- Temporary cards are issued, but the person does not go to the Department of Family Services (DFS) in time to get registered for a permanent card. "We do a lot of temp cards and it is so hard to get them to go to DFS within 30 days to actually sign up. It is ridiculous. I don't know if they are just too lazy or they think since they've got the temp card they are okay." (1)

- Immigrants who don't have citizenship yet are unable to get government assistance. (1)
- Transportation. People who are eligible for public assistance or even enrolled in such programs often lack the means to get to their doctors' appointments. "Everyday we get calls from somebody to cancel their appointment—their old car broke down or their neighbor can't make it."
- The individual might have a very low income, but because they own property (e.g., a house) they are not eligible for Medicaid. "Having property counts against you. And we have a lot of people in a rural area that have very minimal income, but through inheritance, have some property, and they don't want to get rid of that property...We can have people that have a chronic disease like diabetes, and have only \$700 a month income, but because they own their home they don't qualify, and they cannot afford their medication." (1)

AS WE KNOW, THE UNINSURED PROBLEM IS VERY COMPLEX. WHAT ROLE DO YOU THINK EACH OF THE FOLLOWING PLAYS IN THE PROBLEM?

BUSINESSES

A majority of the responses to this question involved cost:

- Dropping coverage altogether because it is too expensive for them to purchase. (11)
- It hasn't been a priority of businesses to come up with creative ways to either subsidize insurance or minimize the cost. (4)
- Holding employee hours below full-time so they won't have to provide insurance. (3)
- Raising the deductibles until they are "out of reach" of the employees. (3)
- Not being able to cover as much of the cost for employees as they have in the past. (2)
- Making adjustments because of cost. (1)
- Being concerned with the bottom line and not offering insurance because of the cost. (1)

Businesses were not necessarily blamed for the high cost of insurance. As one key informant said, "They do have a role in the problem and that is they are cutting out retiree benefits, they are cutting out pharmaceutical benefits, they are cutting out all kinds of optional benefits, but at the same time they are doing it for a reason."

Though the key informants realized that employers "backs are against the wall" because of costs, many still felt that more could still be done on businesses' part to make sure that the maximum number of employees could be covered by health insurance. Some saw businesses as part of the solution rather than part of the problem.

Other responses included:

- It is more of a small-business issue rather than a large-business issue. For example, a mechanism isn't available for small businesses to collectively purchase insurance and have more bargaining power when dealing with insurance companies. This

option, or at least some sort of tax break, should be available to small businesses. (6)

- It is not businesses' duty to provide insurance. One informant noted: "I do not think they really are the root cause of the uninsured problem, I will say that I sincerely believe that they could be the solution to the uninsured problem if government would give them incentives or possibly have a national insurance plan where businesses would not have to worry about the paperwork and the costs and those kinds of things." (3)
- The uninsured is not a business problem. (3)
- Companies are unaware of government insurance that is available for some of their employees. (1)
- Businesses need to find a way to provide coverage that is more cost effective. (1)
- The ability of businesses to react to the marketplace has been hindered by state insurance regulations. (1)
- Businesses have a significant responsibility for benefits. (1)
- Businesses that provide health plan coverage do so to be able to take advantage of tax advantages for employers. (1)
- There have been more layoffs recently, so there are more uninsured as a result. (1)
- Employers need to provide some level of coverage for employees. (1)

THE GOVERNMENT

When it came to the government's role in the uninsured problem, there was no shortage of responses. There was clearly no consensus, either. Six key informants said that the government plays a role **by not offering universal coverage**. However, as one pointed out, "The government has a key role to play given the fact that we have a divided country in terms of politics and we have a strong libertarian tradition. I do not think it would be possible politically or feasible or maybe even wise to have government play the solitary role in fixing the problem of the uninsured, but without a doubt they will be a key member of that eventual solution."

Six key informants also said **the government needs to find the right balance—a cost-effective way to cover the greatest number of people**.

Several key informants pointed out that a solution to the uninsured really needs to be developed at the federal, rather than state, level. Otherwise, people will move from a state with no universal coverage to one with universal coverage. The need to address the insurance gap between persons aged 55-65 was also noted. Many people retire at age 55 and aren't eligible for Medicare for another 10 years. If the company they worked for continues to cover them, they are a liability because of their age and help to drive up costs for the current employees.

Other responses included:

- Creating a dependent class of people who expect to be taken care of by the government and not helping them to get off Medicaid or Welfare. (3)
- Under-funding of their own programs. As one key informant remarked, "If they're able to cover a larger percentage of their population, their uninsured or unfunded hospital and medical costs would drop drastically." (2)
- The legislature does not realize the impact they have when they make changes to Medicaid. As one respondent said: "Our state legislators really don't have a clue as to the day-to-day impact the changes they make on Medicaid have. It is very hard to educate them and unless they have a very vocal person in their constituency, I am not sure they even care to try and learn more about it." (2)
- The government is trying to help by funding Federally Qualified Health Centers (FQHCs). Continuing support of these clinics is essential since they provide an important safety net for those without insurance. (2)
- The government needs to protect society's most vulnerable. (2)

- Financial debt for Medicaid and Medicare continues to grow. (1)
- There is no “uniformness” between state insurance plans which makes it hard for people when they move from one state to another. (1)
- The government lays the burden of insurance on private industry. (1)
- The government hasn’t done its job in providing availability of insurance. (1)
- The government does not offer an economical program for people who can’t afford insurance. (1)
- Too much information is given by the government, so much so that it becomes overwhelming. (1)
- The government has allowed insurance companies to do what they want, which has made it very difficult for businesses. (1)
- Health insurance is not the government’s responsibility. (1)

Key informants had a number of ways in which they thought the government could improve regarding health insurance:

- Help small businesses so they can provide coverage. Businesses need more options, such as tax breaks. (3)
- Provide better education, then the problem would be smaller. (1)
- Take a broader role in insurance regulation. (1)
- Put caps on premiums and utilization. (1)
- Align personal responsibility with behavior and the cost of insurance. (1)
- Improve efficiency. (1)

THE INSURANCE INDUSTRY

Thirteen key informants said that **the insurance industry wants to make a profit and does not care about the long-term effects.** As one noted, “They are in the business of making money, when they look for those instances where they will collect more premiums than they will pay out in benefits.”

Other responses included:

- The industry is a funding mechanism and not part of the problem. (3)
- The insurance companies are lobbying to protect their interests. “Truman tried to enact a plan...Richard Nixon tried to enact a national plan...Bill Clinton tried to enact a national plan and who won? The insurance companies won every time. Under Clinton, the insurance companies spent \$60 million on television advertising telling everyone that this is a communistic overthrow threat to our nation. Who can compete with \$60 million in TV advertising?”(2)
- Traditional managed care is no longer effective. (2)
- The industry keeps raising their rates. (1)
- The industry does not want to offer programs that will cost them money. (1)
- The industry “cherry picks” so it is difficult to get insurance if you have a pre-existing condition. (1)
- The insurance companies want to insure large groups so that they can spread the risks over a large number of individuals. (1)
- The industry needs to be more active in finding creative ways to help cover people with lower incomes. (1)
- The industry still has tiered payments. The specialist gets more money than the general practitioner does for the same service. (1)
- There are too many restrictions. (1)
- The industry is doing too much cost shifting. For example, different prices are paid for the same services, depending on the type of coverage (no insurance/Medicaid/private insurance).

- Claims are denied until someone puts in a formal grievance or appeal. (1)
- The industry does not want to provide certain coverage, like mental health. (1)
- Insurance is used as a restrictive product rather than an access product. (1)
- The insurance companies underbid to get a contract and then raise prices the next year to make up the losses. (1)
- Getting individual insurance is too expensive relative to group plans. (1)
- The insurance companies only want to insure healthy people. (1)
- The insurance companies look at the larger picture and do not court smaller employers. It is the same amount of work for 50 employees as for 5,000 so the insurance agencies tend to ignore smaller businesses. (1)
- More emphasis needs to be put on wellness and prevention. (1)
- Insurance companies need more competition. One key informant had this to say: "I think insurance companies need competition and I think that the only entity that is powerful enough or large enough to compete with major insurance companies in today's world is government." (1)

THE MEDICAL COMMUNITY

Although there were a variety of responses, the most common was that **doctors are not providing access to Medicaid patients**, cited by six key informants as the primary role played in the uninsured problem. As one observed: “They contribute to the problem by not as a united whole being willing to take their share, and if everyone took a little bit then it wouldn’t be a problem for the whole.” According to one respondent, this is more of a problem in rural areas of the state. Along the I-70 corridor, where there are managed care providers for Medicaid, patients do not have a problem getting in to see doctors. There is also a problem with dental care for Medicaid patients. According to this key informant, Missouri is “losing dentists at an alarming rate.”

Other responses included:

- Advanced technology contributes to high medical costs. (6)
- The medical community is doing the best it can and could be seen as the victim. (5)
- They set the prices and are responsible for cost shifting. (3)
- Overuse of tests by physicians to protect themselves against malpractice. One key informant from the Kansas City area noted the trend of doctors moving practices to the Kansas side of the city because of malpractice issues. (3)
- The medical community is not at fault for the insurance problems. (3)
- Problems in the safety of health care delivery: “There are way too many post-surgical infections, too many accidents and errors of omission and commission and I think the industry needs in part to have some of its payments tied to sustained quality performance and obviously joint commission is moving that direction.” (2)
- They just want to make money. (2)
- Doctors are sympathetic to those who don’t have insurance. (2)
- They oppose any national health care plan because it would intrude on their prerogatives. (2)
- The medical community is very supportive with the services they provide. (2)
- Doctors prescribe medication without regard to its cost. One key informant, who is a clinic director, spoke of the high learning curve with doctors who volunteer at

her clinic when it comes to the financial side of medication management. Because they're not used to dealing with indigent patients, they have a tendency to prescribe the latest drugs promoted by the pharmaceutical representatives without regard to the patient's ability to pay. (1)

- The medical community enables insurance companies to set up an artificial reality. (1)
- Keeping up with the Joneses. "If one [hospital] gets an MRI, the other gets one. If one gets a helicopter, the other gets two." (1)
- They need to place a greater emphasis on wellness and prevention. (1)
- The medical community needs to be involved in every level of the process for things to work. (1)
- The not-for-profit organizations are not helping. (1)
- They need to continue to communicate with their patients. (1)
- They need to provide more services for low-income individuals. (1)
- There is a possibility of socialized medicine, but there would be no freedom to dictate terms and no ability to exercise the marketplace freedoms that we have now. (1)

THE PHARMACEUTICAL INDUSTRY

According to 19 key informants, the pharmaceutical industry's role in the uninsured problem involves profit. Phrases such as "**profit-driven**," "**vast profit margins**," "**huge mark-ups**," and "**looking to make money**" were frequently used.

Various components of the profit issue were discussed. Although the respondents understood the need for research and development, the other aspects of the industry did not go unnoticed. One key informant asked, "Are the increases because of research and development or because of price gauging?" Another said, "I think they hide behind the research racket."

The incentives used to get health care workers to promote drugs were pointed out by several respondents. Here was a typical story of "wining and dining" by the pharmaceutical representatives: "I see drug companies where I work bring in a catered lunch every single work day of the year for about 60 people in this building, and when I think of all the drugs that could be bought and distributed to the folks that need them for the money they spend on lunch for my staff, who could go out and buy their own lunch—their values are very misplaced."

The pervasive advertising of drugs on television was also mentioned several times, prompting one key informant to ponder how many patient requests are generated due to these ads that might not otherwise occur.

Five respondents spoke in defense of the pharmaceutical industry. One said that it "is pretty well caught. You know they have research and development and they have profit margins that they have to make to keep their stockholders happy and they have a public to serve." Another made this observation: "I think the pharmaceutical industry does have an awful lot of cost and I don't think the general public wants to hear that or acknowledges that. Yes, they make a lot of money, they waste a lot of money...and buy doctors with a lot of money; but they are also developing drugs that are making things better and it sometimes takes two decades to get that drug. The whole time they are paying high costs to develop it."

Other responses included:

- The pharmaceutical companies offer medications to low-income persons at low or no cost, but it is such a cumbersome process that many people do not participate. For example, one key informant reported having to fill out extensive paperwork every three months to get Paxil for a patient. (5)

- Undue influence as a lobbying group is a significant problem. One key informant asserted that upwards of \$7 million a year is spent on lobbying and that the pharmaceutical industry has two lobbyists for every representative in Washington. (3)
- The pharmaceutical industry sells drugs at different prices to different countries. (2)
- People are not allowed to “shop the world” for their prescriptions. (1)
- The escalating cost of drugs causes some patients to choose between purchasing medications or food. (1)
- The pharmaceutical industry has “very little” to do with the problem. (1)

INDIVIDUALS

The most common response to this question was **not taking personal accountability for their health**, which was cited by 12 respondents as being the prime contributor to the uninsured problem. As one respondent noted, “I think that eventually...they are going to force everybody to take a health risk assessment survey, so that the personal—not only the historical and genetic risks that we have—but our health behavior risks are clearly identified and we start taking some personal accountability.”

Other responses included:

- Not having a good understanding of medical costs. “It’s probably one of the best unknown consumer facts. We’ve always thought of ourselves as excellent consumers but when it comes to health care we are very poor consumers.” (11)
- Not taking better care of themselves. “I don’t think anybody is going to do anything about it unless it affects their pocketbook. There has got to be some sort of penalty.” (4)
- Thinking that health insurance is not needed. (3)
- Cost-ineffective choices such as habitual use of the emergency room for non-emergencies. “It is really their money and so I think there is a lot of cost unconsciousness among individuals about what things cost and in a sense it doesn’t matter because somebody else is paying for it.” (3)
- Lack of knowledge about the benefits available to them. (3)
- Not taking the responsibility of getting insured. (2)
- Not doing a better job of prevention and wellness. (2)
- Abuse of insurance plans. Too many people follow their doctor’s orders blindly and do not question treatment. However, it was pointed out that no incentives exist to be more responsible with insurance plans. As one key informant observed, “If they’ve got a \$10 co-pay, there’s absolutely no incentive for them to consider cost and quality.” (2)
- Poor nutrition. (2)
- Not accepting insurance that is offered to them. (1)

- Noncompliance with instructions from physicians. (1)
- Inability to afford insurance. (1)
- Drug use. (1)
- Individuals are victims of the system. (1)
- Some people are despondent about health care because of waiting periods and then because of the cost. (1)
- Lifestyle choices. (1)
- Individuals don't realize the cost of insurance to their employers. (1)
- Scamming – people who could afford health insurance/care but instead take advantage of public health services. (1)
- Elective procedures drive up the cost of insurance. (1)
- Not accepting government insurance because they're too proud to take the help. (1)
- Some people will never be insured; they simply choose not to. (1)

WHAT CONSTITUTES ESSENTIAL SERVICES IN A HEALTH INSURANCE BENEFIT PACKAGE?

Part of the debate surrounding health insurance is its scope. The responses to this question illustrated the divide that exists about the role of insurance. Some key informants felt that essential services should be just that. As one said, “Insurance is there to take care of people. It's there to keep you from losing your house or your car and it's not there to pay your 40 or 50 or 60-dollar doctor visits.” Others thought that benefit packages should be comprehensive in nature.

Several essential services were mentioned frequently by key informants, but the most common response was prescription drugs, cited by 15 key informants as the most crucial service in a health insurance plan.

Other responses included:

- Primary care. (13)
- Preventive care. (12)
- Catastrophic care. (12)
- Mental health. (9)
- Dental. (7)
- Vision. (3)
- Education and support for people with chronic diseases. (2)
- Individuals should have a choice of doctors. “I think it is crazy not to let you have the doctor you feel comfortable with...If a doctor does the same things for the same price as any other doctor that an insurance company tells you to go to, then why not?” (2)
- Family planning. (2)
- A stipulation that emergency rooms can only be used for emergencies. (1)
- There should be an across-the-board percentage co-pay. (1)
- Patients should use in-network providers to keep costs down. (1)

- Smoking cessation. (1)
- Obesity issues. (1)
- Access to specialists. (1)
- Higher lifetime maximum ceiling. (1)
- Long-term care. (1)
- Separate plans from politics. “I would also say that the most important thing about a basic benefit package that the State would put together or anybody else would put together is it would have an absolute firewall between the management of that package and politicians because that is how they break down.” (1)

HOW COULD EMPLOYER-BASED INSURANCE PLANS BE IMPROVED?

A wide variety of responses was given with no consensus on the best way to improve employer-based health insurance plans. The most common response was **more emphasis on prevention**, which was cited by nine key informants.

Other responses included:

- Find ways to reduce the costs. As one respondent said, “The only thing that lowers the cost of the health insurance is lower costs of care and a healthier group because you are receiving less care. That’s it.” (7)
- Reward individuals and companies for good health practices. (4)
- Allow small employers to pool their resources to get health insurance coverage at a more competitive price. While most key informants were generally supportive of this idea, one asserted that the arrangement usually does not work because as soon as one of the businesses has a catastrophic case, “the other companies want out.” In addition, businesses with less than 50 employees are already “community rated,” which means they are included in a pool of all small businesses in a particular community. (4)
- Provide incentives to use plans more efficiently and make employees more responsible for their benefits. (4)
- Require employers to provide education to the employees on how to use the plan. For example, the difference between a person who visits a doctor’s office and pays \$60 versus a visit to the emergency room for \$600 is enormous. Employees need to be aware of the consequences of their choices. (3)
- Provide tax incentives to help increase coverage. (3)
- Require a mandatory minimum contribution from the employer. (2)
- Dental, vision, and mental health should be added. (2)
- Raise the deductible on plans to cover the major expenses and self-insure the smaller claims like office visits. (1)
- Offer case management for chronic diseases. (1)
- Increase the choice of plans for employees. (1)

- Employers should require screenings and annual physicals as a condition of employment, which would reduce health care costs by diagnosing diseases earlier rather than later. Since a lot of employers already require drug testing, this should not be difficult to accomplish. (1)
- Change the structure of tax-deductibility of health care premiums and expenses. One key informant discusses the American Medical Association (AMA) Plan in which lower-income persons could deduct more of their medical expenses. The current system allows two-thirds of the money that is reimbursed to go to the top one-third of taxpayers. The AMA would reverse this trend. (1)
- Require a mandatory increase in public assistance tax funding using employers as the basis for the delivery of the product. (1)
- Enable employees to opt out of plans in exchange for the money that would have been spent on the plan. (1)
- Limit plan to catastrophic, thereby freeing money that could then be spent in the local economy. (1)
- Move to a more defined contribution vs. defined benefit. “Instead of a defined benefit, you go to defined contribution where the employer says the monies I would have spent on your behalf on subsidized premiums for insurance plans, I am going to bank into an account because now IRS says that I can do and it is pretax dollars. They are either health savings accounts—there are several different models under IRS rules.” (1)
- Adjust the plans to address the primary concerns of the employees. (1)
- Government should increase availability and affordability of their higher risk insurance pools. (1)
- The government should have a universal plan to which employers could contribute. (1)
- Do not mandate coverage from businesses. “How can you tell small businesses that you’ve got to spend \$30,000 a year on health insurance for people when you are not making money anywhere?” (1)
- It is not the businesses’ responsibility. (1)
- No changes are needed. (1)

WHY HAVE HEALTH INSURANCE COSTS INCREASED SO MUCH IN RECENT YEARS?

A variety of responses was given to this question, but the most common was **advanced technology**, which was cited by 18 key informants as being responsible for health insurance costs. An example given was the cost of an MRI (Magnetic Resonance Imaging), which, according to one key informant, is “\$1,500 minimum anymore and I think some of them are as much as \$4,000.” It is not uncommon for a new piece of medical equipment to cost one million dollars or more. These machines must be used many, many times to recover the money invested.

Other responses included:

- Malpractice. Doctors are practicing defensively to keep from being sued. They order a lot of tests, even if they are not really necessary. (10)
- Cost of prescription drugs. (9)
- Greed. Respondents blamed all parties involved—insurance companies, pharmaceutical companies, hospitals, managed care, physicians, and consumers—but were particularly critical of insurance companies. One respondent noted, “Insurance companies know they are making money, so they just keep jacking the rates up as long as people continue to pay those premiums they are going to charge...There is a lot of greed in the industry.” (6)
- Increasing number of uninsured individuals. “Health care for the uninsured is a hidden tax on those that are paying insurance premiums, because the hospitals and doctors cannot provide that service 100% free...It becomes a hidden tax through the increase of the insurance premium and there is a part of the escalation problem.”(5)
- Regulations such as HIPAA. (3)
- Healthy people dropping out of the system. This trend is one way to explain the commonly-heard phrase that health care costs are “spiraling out of control.” As health insurance becomes more expensive, employers are passing more of the costs to their employees. In turn, more of those employees—particularly young, healthy workers—are declining to participate, leaving the pool of participants left in insurance plans sicker and more likely to use the plans. As a result, the premiums continue to increase rapidly. (2)
- Over-utilization. (2)

- No incentive for prevention. One respondent noted, “Instead of doing the preventative stuff, most people are showing up when they are in a catastrophic state or problem state requiring additional therapy.” (2)
- General inflation in health care costs. (2)
- Catastrophic claims. (2)
- The pricing structure of health insurance. “I am just frustrated after doing this for many years that again, that health insurance creates a whole other reality for people without insurance; you are not paying fair market values for services. It is much more difficult to fix a 2003 Chevy pickup than it is to diagnosis a sinus infection, but the costs there do not equal out. A nurse practitioner is making \$50 an hour and a mechanic is making \$15. That ain’t right and the only reason why that can happen is because of health insurance.” (1)
- Government programs shifting costs. (1)
- Costs are provider driven. (1)
- Insurance administration, which was described as “40% of the cost.” (1)
- Health is not a free market industry. “When I am in the ambulance, I cannot negotiate which hospital is going to charge me less money.” (1)
- The insurance industry went through a cycle of under-pricing the service for the purpose of capturing market share, and the tolerance for those losses ran their course. Now they are pricing the service for purposes of generating profit margins. (1)
- Insurance companies did not invest their money wisely and lost a lot in the stock market decline several years ago. (1)
- Large amount of money spent on catastrophic care because there is no preventive care. (1)
- Bureaucracy. (1)
- Managed care. “I think that any time you have a middle man put into the equation, the price goes up.” (1)

- Providers are unwilling to take such low rates. “I think providers are saying you either increase my rates 25-30% or I’m dropping out of your network. They either drop out of the network or the insurance company raises the rates.” (1)
- Obesity. (1)
- New drugs. (1)
- Drug advertising. (1)
- Society is sicker than ever before. (1)
- High costs for a small percentage of the population. “We have found that that old rule applies that 20% of the people make up 80% of the costs.” (1)
- An increasing population. (1)
- An aging population. (1)
- End-of-life costs for the elderly. One key informant said that employers “are absolutely going to have to demand that we as a medical community and we as a policy-making community take a hard look at end of life care. If you look at where the dollars are spent, it is just a terrible waste at the end of life.” (1)

WHAT KINDS OF POLICY RECOMMENDATIONS OR CHANGES ARE NEEDED FOR CLOSING THE HEALTH INSURANCE GAP?

Although a large number of variable responses were given to this question, there was no consensus on the best way to close the insurance gap. The most common responses, cited by five key informants each, were an **emphasis on prevention**, which will increase health and reduce long-term costs, and **increased support and expansion of FQHCs**, which reportedly save \$9 in emergency room costs for every \$1 spent.

One key informant warned that any proposal at the State level must be bipartisan: “I think that whatever the policy changes will have to be, will have to be bipartisan, they will have to have solutions from both sides of the ideological debate; both Republican and Democratic solutions and I think that will include expansion of public programs.”

Not only were there a range of responses, the philosophies surrounding health insurance in general were diverse as well. One key informant noted that a change in mindset was needed: “We as Americans believe it is our God-given right to have access to insurance, to health care,

when we want it, how we want it, no matter what the cost.” One key informant advocated putting health care on the free market, while another saw the issue differently: “We have treated health care as a commodity and we have been trying to provide it in a free market system and I am not sure we can do that anymore. Health care, food, shelter, clothing—those basic things that you need to exist—they need to be available to the people who need them regardless.”

Other responses included:

- Purchasing alliances for small businesses. (4)
- Tax credits to businesses. (4)
- Universal coverage. (4)
- Tort reform. (3)
- Increase public programs or mandates at the employer level. (2)
- Make guidelines to get into Medicaid as lenient as possible and simplify the process of applying. (2)
- Educate the public on the accessibility of public health insurance. (2)
- Classify the uninsured into the causes of the problem. “Are they temporarily out of coverage or has this been a persistent problem? Do they have availability at work? Why are they electing not to have coverage? When you have them classified you can move to address each class with solutions to the specific problem.” (1)
- Gather experts around the state to formulate a proposal. “Get them in a room and bounce ideas off of each other...because what you are going to find out is that each of us have pieces of it but we do not have the whole equation all by ourselves. To me that would be a very smart way of putting a plan together.” (1)
- Develop a Good Samaritan law for free clinics and government-supported clinics. “Locally that would make a big difference if we could go to a doctor and say he is not going to lose his life savings.” (1)
- Develop SNOPAC, which would be a Safety Net Oversight committee in congress, similar to MEDPAC, which advises congress on Medicare policy. (1)

- Assign tax ID numbers to people without social security numbers and then provide them with some sort of basic health care services. (1)
- Have more flexibility for employers, especially small employers. (1)
- Educate individuals to be better health care consumers. (1)
- Review benefits that Medicaid recipients receive. (1)
- Require that providers take a certain percentage of Medicare/Medicaid patients. “I hate to say that the government might have to control it or there might have to be a law passed, but maybe legislation is needed to force them (doctors) to see a certain percentage of the indigents.” (1)
- Be more lenient for physicians in who they take as patients so they do not have to worry about the number of Medicaid patients. (1)
- Educate legislators on the impact that their decisions have in regard to public insurance. (1)
- Expand outreach. Health care workers could be designated to do outreach programs and on-site health screenings. (1)
- Make everyone responsible for having and maintaining health insurance. “Insurance has to be available on an affordable basis to everyone...which means some expenses in the social system and some accountability for personal responsibility and some change in the regulatory structure.” (1)
- Keep the focus on insuring children. “I think Missouri has done a good job of that. They are insuring elderly people and the kids.” (1)
- Monitor the uninsured to try and keep them out of the hospital ER. (1)
- Increase competition in managed care. (1)
- Realize that there will never be 100% coverage because people still have a choice. (1)
- Develop a consensus on essential preventive services and catastrophic care that should be included in every benefit package. (1)

- Simplify the paperwork. An increasing number of doctors are in favor of the old “pay as you go” system to eliminate the copious amount of paperwork required by insurance. (1)
- Allow individuals to buy drugs from other countries. (1)
- Allow employee to choose the type of plan he or she wants with either minimal or comprehensive coverage. (1)
- Give choices in the amount of the plan’s deductible. (1)
- Eliminate employer-based health insurance altogether and give the responsibility back to the individual. (1)

IF GOVERNMENTAL ASSISTANCE WERE AVAILABLE FOR LOW-INCOME PERSONS, WOULD YOU BE IN FAVOR OF MANDATING THAT ALL INDIVIDUALS HAVE HEALTH INSURANCE AND THAT INSURANCE COMPANIES PROVIDE COVERAGE FOR EVERYONE?

Key informants were split over this question; approximately **half were in favor and half were opposed**. Those who were in favor of such an idea were supportive of universal health care in general. As one key informant noted, “I do believe in a national health care plan of some kind. I think we are the only industrialized nation in the world that does not have it...I think we are Americans and we can have a solution to this health care problem.” Another said that “mandatory health insurance coverage in some form through some delivery model is the right approach to take.” Still another said, “If we can spend billions of dollars in Iraq, then we can spend it on our own people for health insurance.”

However, even those who were supportive of the idea had some reservations. One said, “If you do this, you need to give the insurance companies and the employers the tools to do it right.” Another asked, “If everybody had health insurance, would that decrease our insurance costs? Would it give us better health? Would it improve the health status of people in this state? I don’t know that it would...it is the preventative and the education that has to happen.” Still another asked, “Who would have the resources financially to take care of something like that?”

Other respondents thought the idea was not feasible. One said that “policymakers won’t embrace this because of all the powerful lobbying groups.” Another asked, “Is it appropriate to mandate...coverage? I am not so sure that it is, as long as there is a means for those people to access affordable coverage; whether it is through an expansion of the Medicaid system, the use of other mechanisms like the Missouri Health Insurance pool or government employee health plans.” Still another respondent said, “It is not a good idea. This would be a tax and the individuals that are in the higher tax brackets would be stuck with the bill.”

Most respondents, although cautious about agreeing with a “mandate,” thought it was an interesting idea and had some merit. However, as one key informant pointed out, “You mandate that everybody has to have it and the government will subsidize it, but that still does not address the issue of cost.”

Analysis and Discussion

A number of themes emerged from the key informant interviews:

- **Cost is an enormous barrier to obtaining health insurance.** Even for persons who have coverage available through an employer, the cost is becoming increasingly prohibitive, causing many to drop out of the system, especially young, healthy workers.
- **Medicaid is in need of reform.** Application procedures are overly-complicated; many people are not even aware that they're eligible; doctors won't accept patients because of the low reimbursement; the system has no incentives to use it efficiently; and there is an over-emphasis on disease rather than wellness.
- **Businesses are doing the best they can and are not to blame for the uninsured problem.** Although employers are passing more of the health insurance costs to their employees, most key informants understood that this was being done out of necessity, not choice.
- **The insurance and pharmaceutical industries are largely motivated by profits and play a significant role in the uninsured problem.** Few key informants saw altruistic motives for either of these industries.
- **The most essential services in a basic health insurance package are prescription drugs, primary care, preventive services, and catastrophic care.** Most key informants agreed that placing a greater emphasis on prevention would pay significant dividends in the long run.
- **Advanced technology, malpractice insurance, and rising drug prices are largely to blame for the large increase in health care costs in recent years.** This assertion is borne out in part by a recent study which found that the factors most responsible for health care costs in 2002 were drugs, medical devices and other medical advances.
- **Wellness and prevention need to play a more prominent role to bring health care costs under control and add people to the insurance roles.** Screenings, annual physicals, and early management of chronic diseases will become more and more important, especially as the population continues to age.
- **Support and expansion of FQHCs is an effective way to provide a much needed safety net.** According to those key informants familiar with FQHCs, the clinics are very cost effective in providing care. In fact, the National Association of Community Health Centers reported that in 2002, \$36 million could have been saved in Missouri if

just 10% of emergency room visits were redirected to FQHCs or other primary care facilities.¹⁷

- **Universal coverage might (or might not) work.** There was a good deal of support for universal coverage among key informants but also a good deal of skepticism about the ability of such coverage to seriously address the underlying problem of escalating health care costs.

The need for health insurance reform is clear from the many hours spent interviewing these key informants. The most persuasive argument may have come from a physician who described the different way that patients are treated depending on their insurance status: “When a resident comes out to me and they present a case and tell me what they have, I say what do you want to do and basically the question is do they have insurance or not and what can we do and what can the patient afford? Because it doesn’t do a patient any good to make a fancy diagnosis if they can’t afford any of the things that are going to make them better. I really feel like I am practicing two kinds of medicine depending on whether or not the patients have insurance. You know—is that right? Is that what we want to do?”

Notable Ideas

During the course of the interviews, key informants made several excellent suggestions about how the system could be improved. With the realization that these might have been “lost” in the information on the preceding pages, they are repeated here:

- Increase the choice of plans for employees—varying degrees of coverage, different deductibles, etc. This might allow an employee who could not afford full coverage to have some minimal coverage instead.
- Raise the deductible on plans to cover the major expenses and self-insure the smaller claims like office visits.
- Require screenings and annual physicals as a condition of employment, which would reduce health care costs by diagnosing diseases earlier rather than later.
- Design an education program that employers could use to help individuals become better health care consumers.
- Gather experts from around the state to formulate a proposal. A lot of “best practices” are undoubtedly in existence in Missouri but could be unknown outside their

communities. Sharing ideas and information from a variety of health care organizations could form the foundation of an innovative and effective plan.

- Educate legislators on the impact that their decisions have in regard to public insurance.

CONCLUSIONS

Though the topics discussed with focus group participants and key informants were somewhat different, the responses of the two groups had much in common:

- **Cost is the overriding issue.** Employers and health professionals alike believe that cost is an overwhelming barrier which threatens both the employers' ability to offer health insurance and an individual's ability to purchase it.
- **There should be more of an emphasis on wellness and prevention.** From on-the-job wellness programs to preventive components in insurance plans, both groups generally agreed on the importance of prevention.
- **A considerable amount of animosity exists towards the insurance and pharmaceutical industries.** Both groups had a surprisingly negative view of these industries. Perhaps this attitude was best expressed by the key informant who said, "I think the insurance industry is inherently evil...I think the pharmaceutical industry is more evil than the insurance industry."
- **Purchasing alliances would be a good way to increase employer-based coverage.** Small business owners, as well as a number of key informants, were strongly in favor of this idea.
- **Medicaid is held in low regard.** Employers were more likely to complain about welfare dependency and abuse of the system, while key informants criticized the inefficiency and complicated application procedures.
- **There is a desire for tort reform.** Although neither group had specific details about the costs associated with malpractice litigation, other than rising malpractice insurance costs, a number of people in both groups thought there was a need for tort reform.

The following would seem logical next steps that could be taken by the State to help address the uninsured problem:

- Provide businesses with a rating or "report card" of insurance companies that operate in Missouri.
- Offer training to businesses on how to incorporate self-insured components in their insurance plans. This may become an increasingly common method to rein in costs.

- Investigate the feasibility of State-supported purchasing alliances for small businesses. Help may be available at the federal level as well. In May 2004, the U.S. House of Representatives passed legislation allowing creation of Association Health Plans which allows companies to band together across state lines to increase buying power for health insurance.¹⁸ As of this writing, the bill is pending in the U.S. Senate.
- Maintain an ongoing review of the latest health care literature. New and innovative ideas are being developed all the time. For example, pharmacists in Australia travel door-to-door to physician's offices in much the same manner as pharmaceutical representatives. Instead of selling drugs, they sell information, giving physicians objective data so that the most cost-effective drugs may be prescribed, not just those being marketed by the pharmaceutical companies. A similar effort will soon be undertaken in the state of Pennsylvania.¹⁹

Americans pay more out of pocket for their health care than do people in any other industrialized country. Solutions will not come easy. As one focus group participant quipped when asked how insurance coverage could be increased in Missouri, "You guys figure it out and let us know."

A final note: efforts to simply increase insurance coverage do not address the underlying question of why health care costs are rising so rapidly. Until efforts are made to address *that* question, simply increasing the number of those insured, whether through tax credits or some other means, will be treating the symptoms rather than the cause.

A recent study listed the following as being responsible for the increase in 2002 health care costs:

- Drugs, medical devices and other medical advances
- Rising provider expenses
- General inflation
- Increased demand
- Government mandates
- Impact of litigation
- Fraud, abuse and other cost drivers²⁰

Several of these factors could be addressed by the State.

¹ U.S. Census Bureau. "Income stable, poverty up, numbers of Americans with and without health insurance rise, Census Bureau reports."

<http://www.census.gov/Press-Release/www/releases/index.html>

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