

The Medicaid Coverage Gap in Missouri: Implications for Healthcare Access Due to Increasing Out-of-Pocket Burden

by Abigail R. Barker, PhD; Leah M. Kemper, MPH; Lindsey M. Nienstedt, MPH, MSW; Karen E. Joynt Maddox, MD, MPH; and Timothy D. McBride, PhD

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Purpose

Low-income individuals and families in Missouri face rising healthcare costs in a policy environment that offers uneven levels of assistance. This brief compares estimated healthcare utilization that would be sought – if out-of-pocket cost were not an issue – to the percent of annual income that would be required to meet that need. In addition, we provide historical context by comparing out-of-pocket burden in 1996 to current burden.

Background

Medicaid is a health insurance program administered at the state level. Created by Title XIX of the Social Security Act in 1965 and adopted by Missouri in 1967, it provides insurance coverage to about 64 million low-income Americans. As of 1996, when the Personal Responsibility and Work Opportunity Act significantly changed the safety net system, Missouri’s eligibility levels were set at annual incomes of \$3,720 for a family of two, \$4,656 for a family of three, and \$5,496 for a family of four, meaning that anyone earning more than these amounts would not qualify for coverage. Non-custodial parents were not (and are not) eligible. These values represented 35-36% of the Federal Poverty Level (FPL) in 1996. In the interim, Missouri raised eligibility levels but retained the right to return to the 1996 criteria. In 2005, the Missouri legislature passed House Bill 11, and the exact dollar values set forth in 1996 were adopted again.¹ As of 2020, based upon current dollar FPL standards, these criteria represent about 19% of the current FPL (**Appendix Table 1**).

In 2010, with the passage of the Affordable Care Act (ACA), states gained the ability to expand Medicaid to all individuals with incomes less than 138% FPL (\$23,791 for a family of two in 2020). Further, in all states, regardless of expansion status, all individuals and families with household incomes between 100% and 400% FPL became eligible for subsidized coverage through the ACA Marketplaces. Those with incomes 100% to 150% FPL are eligible for very low-premium, reduced cost sharing plans: these individuals pay from 2.1%-4.2% of income on premiums (and may pay less). In 2020, out-of-pocket limits for this income group are typically about \$500-1500 per year.²

These circumstances have created a coverage gap in Missouri and other non-expansion states, under which extremely low-income families (less than 19% FPL) qualify for Medicaid, while low- and middle-income individuals and families (100%-400% FPL) qualify for assistance that varies by income, and all other low-income Missourians without employer-sponsored insurance or Medicare must rely on charity care, pay out-of-pocket, or forgo medical care. In states that have not expanded Medicaid, nearly all able-bodied childless adults with incomes below 100% FPL, as well as a large number of parents with incomes below 100% FPL, are not eligible for any financial assistance for health insurance.

Data and Methods

We analyzed the Medical Expenditure Panel Survey (MEPS) in 1996 and 2017 (the most recent data available) to identify typical healthcare service expenditures by age group. To better reflect Missouri, we calculated these averages for the Midwest region only. While averages include individuals who require very expensive utilization, and may therefore seem high, from an insurance perspective the average reflects the “expected costs” of an individual of a given age. (The figures also include some

KEY FINDINGS

- **Healthcare costs are rising faster than wages, making it harder for low-income people to afford healthcare services.**
- **A lack of Medicaid expansion in Missouri has left a gap in available health insurance coverage for some of the poorest Missourians. Custodial parents with incomes between 20% and 99% FPL are not eligible for Medicaid and do not receive subsidies to purchase Marketplace coverage because their income is too high. Childless adults are not eligible for Medicaid at all.**
- **Low-income individuals unable to qualify for Medicaid or afford to purchase health insurance must pay out-of-pocket, seek charity care, or forgo care. Over time, as higher costs lead to more forgone care, this likely contributes to Missouri’s declining population health.**

POLICY BRIEF

Data and Methods (cont'd)

less essential utilization by higher income individuals due to more generous insurance coverage and/or willingness to pay out of pocket for “elective” procedures.) We then performed a hypothetical exercise: assuming that each person’s medical need is reflected, on average, by the computed averages from MEPS, we estimated the expected costs for a low-income individual, given the available insurance assistance (Medicaid or ACA Marketplace). We highlight these results at various income levels under the current-day policies and compare how they have changed since 1996.

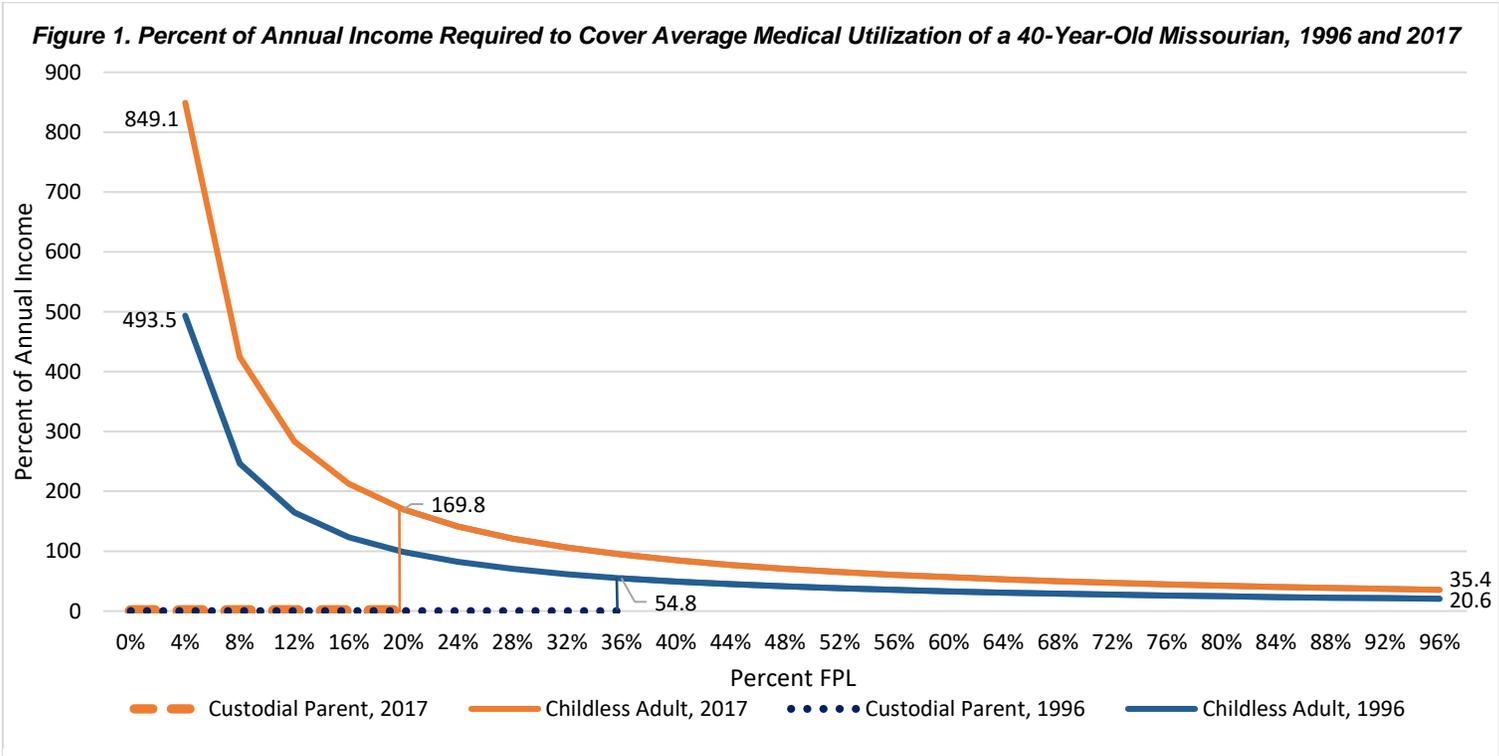
Results

Comparing spending among Midwestern adults ages 18-64 by age subgroup, and adjusting for inflation using the Consumer Price Index (CPI-U),³ we find that medical spending has outpaced average price inflation by 48-72% over the time period 1996 to 2017 (**Table 1**). In other words, medical inflation was typically 2-3% higher per year over this 21-year period than the general inflation rate. This is one reason that affordable healthcare is becoming more challenging for low-income individuals and families, as wages typically rise at or below the general inflation rate. These data represent typical utilization of all members of the age cohort and are therefore an estimate of the average healthcare need for an individual of a given age.

Table 1: Change in Average Medical Spending by Age, 1996-2017

Age Group	1996 Average Utilization, 1996\$	1996 Average Utilization, 2017\$	2017 Average Utilization, 2017\$	Real % Change, 1996-2017
18-34	\$ 1,323	\$ 2,067	\$ 3,060	148%
35-44	\$ 1,528	\$ 2,387	\$ 4,096	172%
45-54	\$ 2,325	\$ 3,632	\$ 5,983	165%
55-64	\$ 3,499	\$ 5,467	\$ 9,398	172%

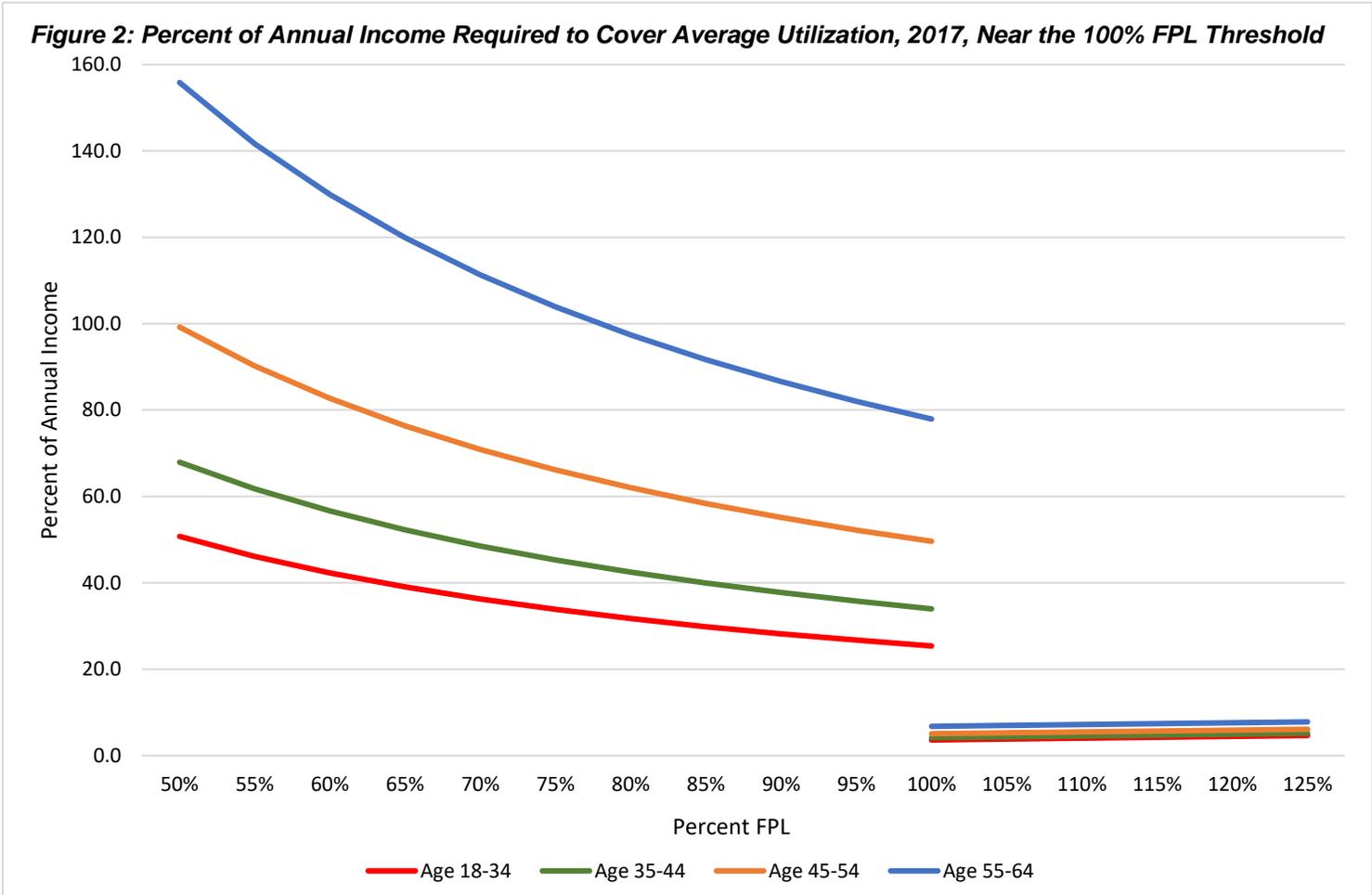
Next, as we compare these typical utilization levels to what low-income individuals might afford, we find that, over time, the estimated health care need represents an increasing share of a household’s income. Using 1996 and 2017 federal poverty levels, **Figure 1** shows that the burden of obtaining the average or expected amount of medical care for a low-income 40-year-old individual has increased substantially. In 1996, for a parent with income just above the Medicaid eligibility cutoff, expected utilization represented 54.8% of annual income; in 2017, an income just above the same dollar amount corresponded to expected utilization representing 169.8% of income. And while very low income parents have access to coverage, childless adults with very low incomes face the potential for healthcare needs amounting to 2 to 10 times their annual incomes.



Note: Custodial parents above the cutoffs are identical to childless adults.

Results (cont'd)

The increasing difficulty in affording healthcare that is suggested by the above figure is complicated by the coverage gap that has existed since 2014. Focusing now on 2017 utilization and expenditure data only, **Figure 2** depicts the affordability gap. Low-income, non-disabled adults earning up to 99% FPL have no access to coverage in this gap, but those earning above the poverty line qualify for reduced-cost sharing silver plans costing 2.1-4.2% of income (by law) with cost-sharing of about 6% of expected expenditures. Therefore, there is a discontinuity in the figure at 100% FPL. Above 100% FPL, the expected out-of-pocket burden rises gradually according to the specifications of the ACA.



Discussion

Low-income families in Missouri face high costs of care and a lack of coverage options. The average medical expenditures used for this analysis represent average/expected utilization, in the sense of what care would be needed and sought if cost to the patient were not an issue. When that care is unaffordable, people must seek charity care or do without. In Missouri in 2017, hospitals reported \$1.4 billion in uncompensated care.⁴ Safety net clinics in Missouri receive federal funding to provide primary care, obstetric care, and mental health services to uninsured populations, but demand for these services frequently exceeds capacity. When people delay or forgo care, they enjoy lesser quality of life, are less productive, and may even die prematurely. Missouri currently ranks 39th among the 50 states in overall health, including a rank of 38th in premature deaths.⁵

Missouri ranked 24th in overall health in 1990.⁵ Given the pervasive challenges that social determinants of health bring to the goal of improving population health, reimagining Medicaid as a program that can help reverse the trends of the past 30 years requires that the low-income population be able to access basic health care. It is important to direct efforts both to keeping individuals healthy as well as to preventing chronic conditions when possible to keep people from becoming disabled, which currently is the main avenue for adults to obtain Medicaid services in Missouri.

In a more equitable society – in which economic growth is distributed across the workforce and incomes for low-wage workers keep pace with medical inflation – more people would be able to afford health insurance in the private market. In the meantime, healthcare access at the population level depends upon having a system that does not contain eligibility “cliffs” which are difficult to navigate and which may actually disincentivize upward mobility. Expanding access to Medicaid coverage in Missouri according to the ACA is the only policy option available at this time to address these systemic access barriers. This policy choice would likely mitigate the health consequences of rising health care costs in the setting of increasingly unequal income and wealth distribution in the United States.

Appendix: Glossary/Terms

Table 1. 2020 Federal Poverty Level by Family Size

Family Size*	Federal Poverty Level (FPL)		
	100%	138%	400%
1	\$12,760	\$17,609	\$51,040
2	\$17,240	\$23,791	\$68,960
3	\$21,720	\$29,974	\$86,880
4	\$26,200	\$36,156	\$104,800
*For families/households with more than 4 persons, add \$4,480 for each additional person			

Federal Poverty Level (FPL): A measure of income issued annually by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and Children's Health Insurance Program (CHIP) coverage. The 2020 federal poverty level income numbers shown are the upper limits for eligibility (**Appendix Table 1**). 2019 numbers are slightly lower and are used to calculate savings on Marketplace insurance plans for 2020.

Charity Care: Free or discounted medical care and especially hospital care provided to patients who do not have health insurance or are unable to pay for all or part of medical costs due to limited income or financial hardship.⁶

Cost-Sharing: The share of medical costs that consumers pay out of pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

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