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HEALTH STRATEGY

Report to the Kansas Health Policy Authority Board

Kansas—Pricing the Roadmap to Health Insurance Reform Options

UNITED METHODIST HealthMINISTRYFund

Sunflower Foundation
HEALTH CARE FOR KANSANS

Health Care Foundation
OF GREATER KANSAS CITY

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November 2007

ABOUT THE FOUNDATIONS

PRIMARY FUNDING WAS PROVIDED BY:

United Methodist Health Ministry Fund

In 1986, the Kansas West Conference of the United Methodist Church established the Health Fund with a portion of the proceeds of the sale of Wesley Hospital in Wichita. The Health Fund works with all of its resources to fulfill its mission of Healthy Kansans through strategic and cooperative philanthropy guided by Christian principles.

The Health Fund's Mission

Healthy Kansans through cooperative and strategic philanthropy guided by Christian principles.

Sunflower Foundation – Health Care for Kansans

Since its inception, the Sunflower Foundation has been concerned about issues related to access to health care and disease prevention/health promotion. With a mission to serve as a catalyst, the Sunflower Foundation's program is a balance between grant-making, foundation initiatives, and special projects.

The Sunflower Foundation's Mission

To serve as a catalyst for improving the health of Kansans.

ADDITIONAL FUNDING WAS PROVIDED BY:

REACH Healthcare Foundation

The REACH Healthcare Foundation believes all people deserve access to the health care they need. As a result, the REACH Healthcare Foundation serves as a leader and community catalyst for health care change and funds change, not just need, in order to create hope and a true system of care for our communities' poor and underserved populations.

The REACH Healthcare Foundation's Mission

To inform and educate the public and facilitate access to quality health care for poor and underserved people.

Health Care Foundation of Greater Kansas City

The Health Care Foundation of Greater Kansas City (The Foundation or HCF) is dedicated to improving access and quality of health for medically indigent and underserved individuals and communities in Kansas City, Missouri and a six county service area in Kansas (Allen, Johnson, Wyandotte) and in Missouri (Cass, Jackson, Lafayette).

The Mission of the Health Care Foundation of Greater Kansas City

The Foundation or HCFstrives to improve access and quality of health for the medically indigent and underserved individuals and communities by providing financial support and leadership directed toward all aspects of health in Kansas City, Missouri, and a six-county service area.

Report to the Kansas Health Policy Authority Board

Kansas – Pricing the Roadmap To Health Insurance Reform Options

An Actuarial and Policy Analysis to Inform the Kansas Health Care Reform Debate

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This complete report can be found at the United Methodist Health Ministries Fund website (www.healthfund.org) as well as the **s**chramm▪**r**aleigh **H**ealth **S**trategy website (www.schrammraleigh.com).

Executive Summary

This report presents *Pricing the Roadmap to Health Insurance Reform Options* for the state of Kansas (State or Kansas) as prepared by **s**chramm▫**r**aleigh **H**ealth **S**trategy (**srHS**) for the Kansas Health Policy Authority (KHPA). srHS has prepared a policy driven actuarial analysis of health insurance reform options chosen by the KHPA Board. This analysis was completed in response to House Substitute for Senate Bill 11 (SB 11)[1], signed into law by Governor Sebelius in May of 2007, requiring the KHPA to develop and present to the Legislature options for comprehensive health insurance reform in Kansas. The reform options analyzed are designed to increase access to affordable health care coverage, thereby, promoting the health of Kansans. This report will be used by policymakers in further developing health insurance reform plans for the State.

Funding for this analysis was provided privately through a collaboration of Kansas Foundations:

- United Methodist Health Ministry Fund,
- Sunflower Foundation,
- REACH Healthcare Foundation, and
- Health Care Foundation of Greater Kansas City.

Health insurance reform options were identified based on the State's existing health care marketplace and Kansas-specific uninsured population characteristics. Reforms across the participation spectrum (voluntary to mandatory) as well as the access mechanism (public to private) were considered. Five separate options were preliminarily modeled for the KHPA Board using srHS's State Health Reform Projection (SHRP) model. The five options included:

1) voluntary public program expansion (Reference Option),
2) voluntary market-based reform through an insurance clearinghouse (Affordable Coverage Option),
3) mandatory coverage with individual and employer mandates (Universal Coverage Option),
4) mandatory State coverage (The Mountain or Single Payer Option), and
5) combined option using portions of the previous voluntary and mandatory options (Sequential Option).

The SHRP model produced estimated cost and coverage impacts for each of the different options. Results were then compared to a Baseline, reflecting Kansas' current insurance situation (using a non-elderly population and cost basis averaged over 2004 and 2005), adjusted to reflect the impact of the full implementation of SB 11's Premium Assistance program. It is important to bear in mind these estimates should not be considered final calculations for any one reform option's total expenditures or premium rates. The SHRP model is structured to provide guidance to policymakers as they weigh the options and chart the next steps on the road to reform. The Kansas SHRP model itself and projections from the model can be further refined as the Kansas health insurance reform plan is further debated and refined.

While each option considered would increase coverage for uninsured Kansans, there are a series of trade-offs made within each option. After feedback regarding these trade-offs from interested parties, including the public and provider communities throughout Kansas, and much careful consideration and deliberation, the KHPA Board chose to recommend and pursue modeling of a group of initiatives referred to as the Updated Sequential plan. The Updated Sequential plan is composed of three individual voluntary reform initiatives that combine to expand coverage to the poorest Kansans while employing a market-based approach to offer coverage to uninsured Kansans of all income levels. Each reform initiative within the Updated Sequential plan targets a discrete uninsured Kansan population and can, therefore, be implemented in a sequential or step-by-step manner. The initiatives are:

- voluntary public program extension through targeted outreach to extend coverage to currently eligible, but unenrolled individuals (targeted outreach);
- SB 11 expansion to extend Premium Assistance to childless adults up to 100% federal poverty level (FPL) (SB 11 expansion); and
- voluntary market-based reform through an insurance clearinghouse to expand coverage to two populations with the highest rates of uninsurance – young adults (19-24 years old) and the very small group (one to ten employ-

ees) market (voluntary implementation of insurance clearinghouse).

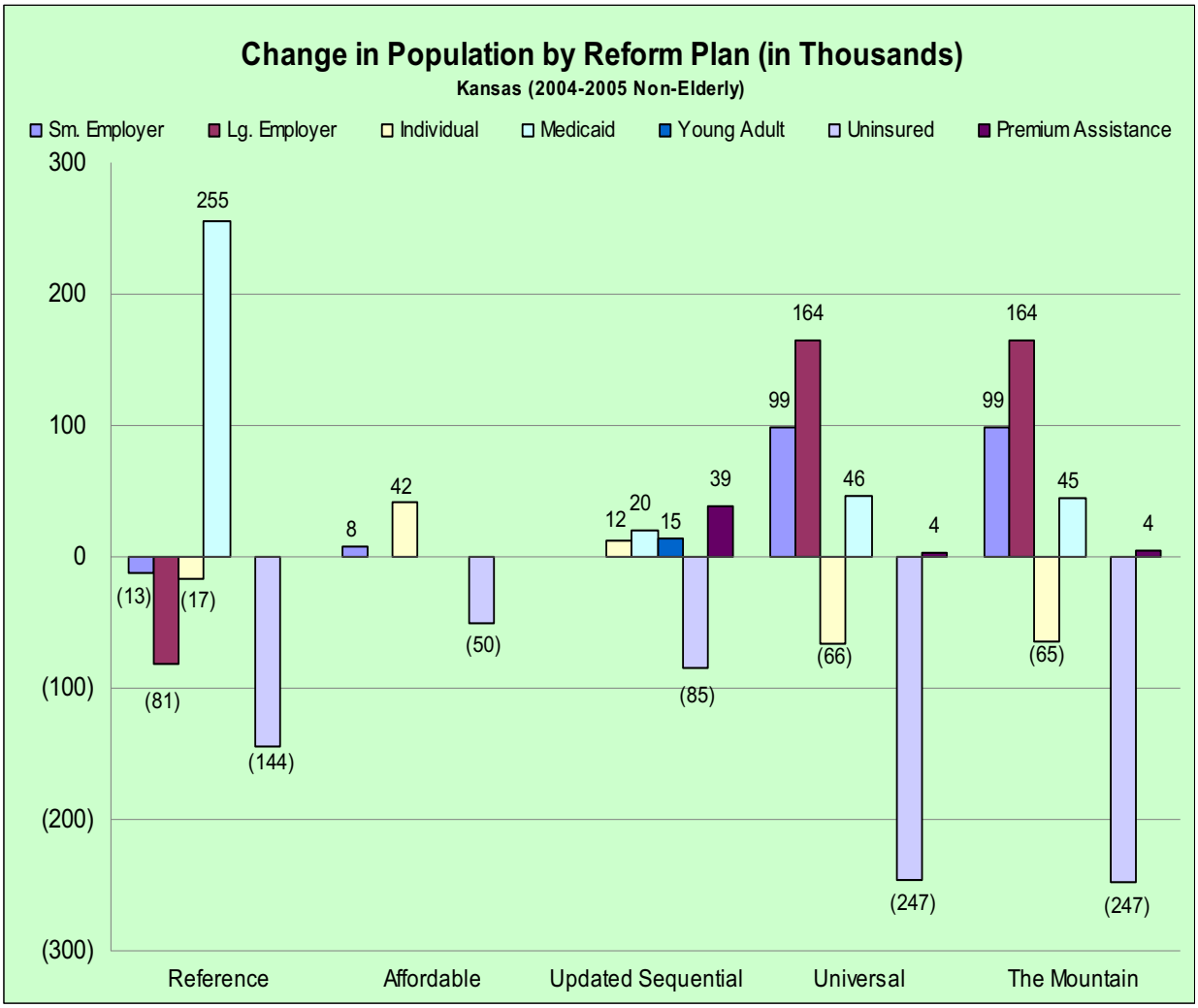
The KHPA Board recognized that given Kansas' current economic, political, and health care environment, the Updated Sequential plan places Kansas solidly on the road to insurance reform, while leaving policymakers ultimate latitude in crafting the final reform vehicle.

Summary of Findings

Through preliminary modeling it was clear that only some form of a mandate would effectively eliminate uninsurance in Kansas (Figure 1). After the authorized SB 11 expansion, there will be 260,000 uninsured non-elderly Kansans[2]. Both the Universal Coverage and The Mountain options contain mandatory insurance provisions and leave some 13,000 Kansans uninsured. We describe this as "effectively" eliminating uninsurance in Kansas because, much like the concept of "full-employment" still has upwards of 4% unemployed, so will "full-insurance" have some uninsured. Of the voluntary options, the Reference plan is the most successful at reducing the number of uninsured through a substantial expansion of Kansas' public programs. All of the original options would face major barriers to implementation, but each modeled option provided insight for the KHPA into what reform changes might best be combined to lower the number of uninsured Kansans.

The KHPA Board used that information to develop

Figure 1. Changes in Population Among Health Insurance Reform Options*



*Note: Totals may not add due to rounding

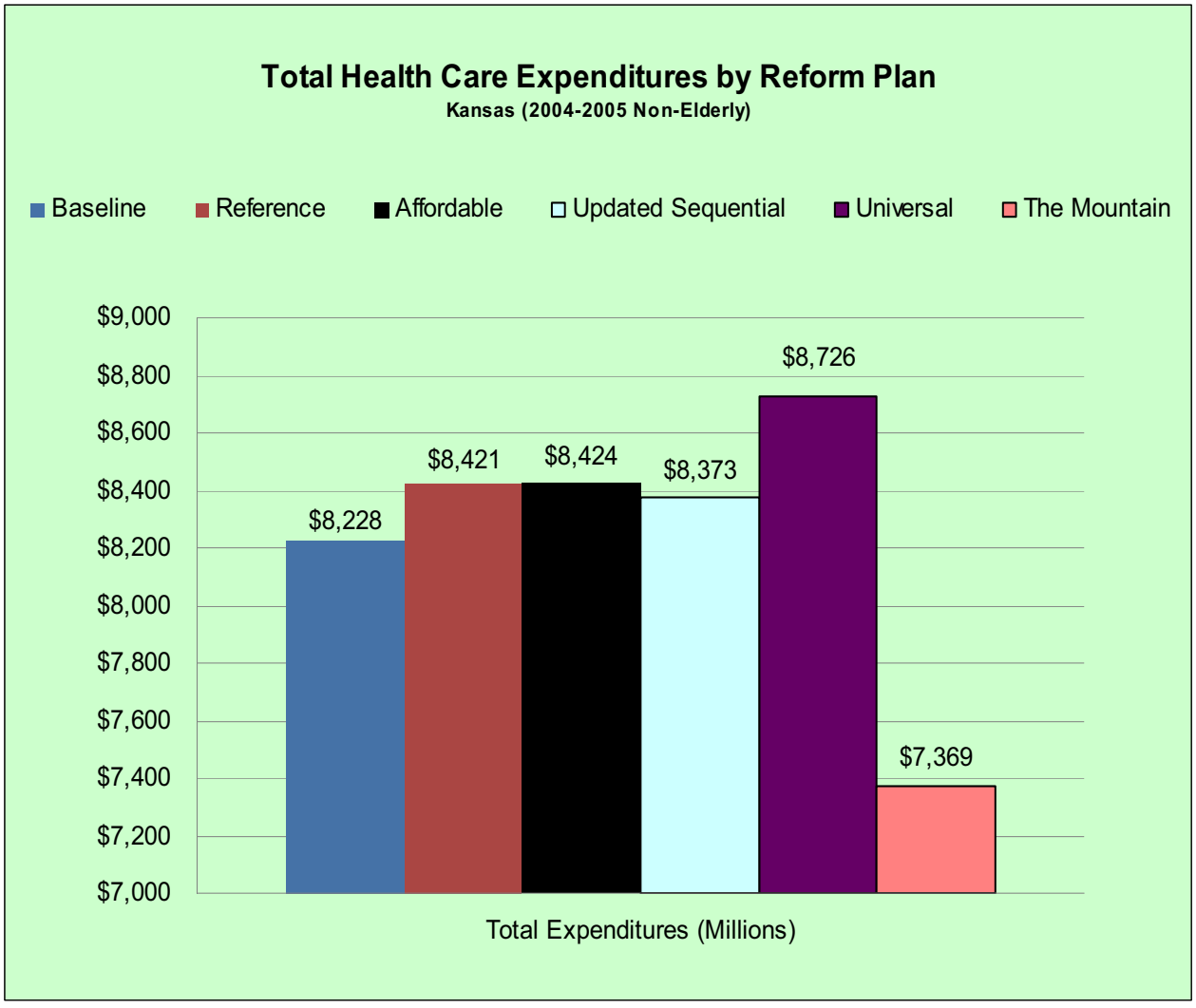
the Updated Sequential plan Option. Looking in more detail at the Updated Sequential plan, modeling results indicate that through implementation of all three initiatives within the plan, the number of uninsured (non-elderly) is cut by nearly one-third. The number of uninsured Kansans drops from 260,000 to 174,000 and lowers the percentage of uninsured to about 7%, ranking the State among the lowest nationally in terms of percent uninsured. The newly covered population of 86,000 is the additive result of each of the individual components:

- 20,000 more children becoming insured through public program outreach,
- 39,000 more childless adults becoming insured through a SB 11 expansion
- 12,000 more sole proprietors becoming insured through the market combination and reinsurance efforts, and
- 15,000 more young adults being insured due to new products being offered at the insurance clearinghouse

The total expenditures are all very similar for the reform plans considered except for the Mountain (single-payer) reform plan. Assuming the administrative savings can be realized and the legal obstacles overcome, The Mountain plan actually has lower total spending than the Baseline while effectively eliminating uninsurance in Kansas (Figure 2).

For the Updated Sequential plan, the additional cost of the reform plan, when compared to the Base-

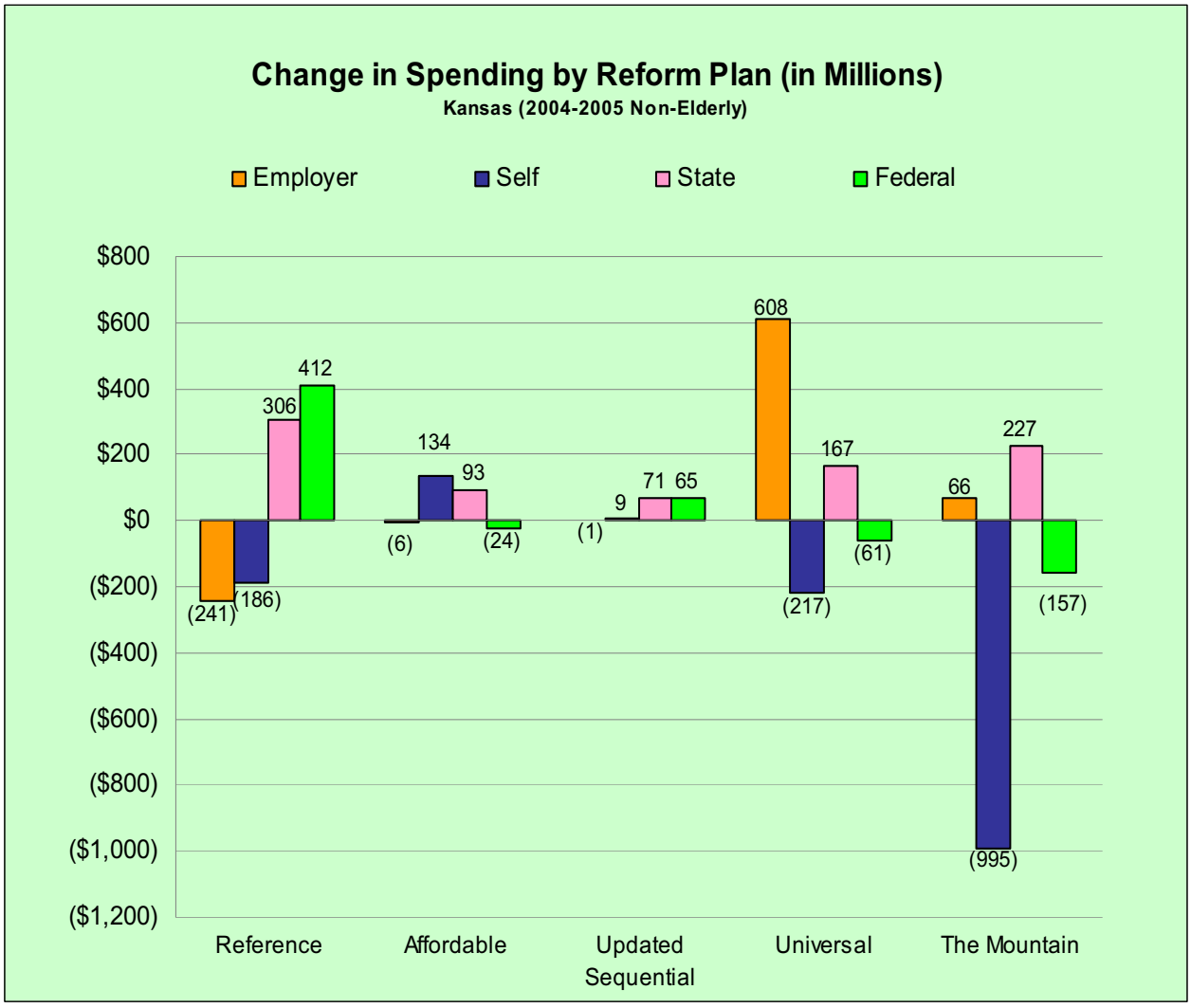
Figure 2. Changes in Total Expenditures Among Health insurance Reform Options



line, is $145 million. This cost reflects the additional costs of insuring the population, and does not include additional administrative costs that might be necessary to implement the reforms (i.e., implementing the insurance clearinghouse). The insurance reforms within the Updated Sequential plan are not without additional costs or challenges however. An effective outreach program to entice those children already eligible for Kansas' public programs to enroll could be costly compared to the cost of Kansas' existing outreach programs. For the childless adults, Kansas would need to find an acceptable vehicle for federal matching funds. Finally, with the targeted health insurance market reform for very small groups and young adults, the potential for disruption of the existing health insurance marketplace is real and should only be undertaken after careful examination and deliberations, with safeguards in place to protect those already insured and the insurers against any unintended consequences.

In terms of spending by major payers; the "net savers" and "net payers," there is a great deal of variation depending upon the reform plan being considered (Figure 3). Equally as compelling is how much variability there is among who saves and by how much and who pays and by how much by each of the reform plans. Three out of the five reform plans considered have clear net savers and net payers (Table 1). For the remaining two reform plans, clear net savers or net payers are not as obvious (Table 2).

Figure 3. Changes in Expenditures by Payer Among Health insurance Reform Options



***Definition:* Who Pays for Health Care – Employer, Self, State, and Federal**

The monies shown are total health care cost plus administrative dollars and are broken down as follows:
Employer *– Portion of employee premiums paid by an employer.*
Self *– Paid by an individual for their health care. Dollars include premium contribution, cost sharing expenses, and money paid by the uninsured to cover their own medical expenses.*
State *– Paid out of the State General Fund. State expenditures come in the form of their portion of Medicaid, SCHIP, and Premium Assistance expenditures, though there is also some subsidization in several of the options.*
Federal *– Paid by the federal government. The bulk of the money spent by the federal government is related to the public Medicaid/SCHIP, Medicare, and Premium Assistance programs, as well as the Military health care coverage. Also includes money spent on the uninsured through programs such as DSH, UPL, IME, and other federal programs.*

Table 1. Insurance Reform Plans with Clear Net Savers and Net Payers

	Net Savers			Net Payers		
		Dollars	%*		Dollars	%*
Reference	Employer	- $241 million	-5.9%	Federal	+ $412 million	39.1%
	Self	- $186 million	-6.6%	State	+ $306 million	117.2%
Universal	Self	- $217 million	-7.7%	Employer	+ $608 million	14.9%
	Federal	-$61 million	-5.8%	State	+ $167 million	64.1%
The Mountain	Self	-$995 million	-35.2%	State	+$227 million	86.9%
	Federal	-$157 million	-14.9%	Employer	+$66 million	1.6%

Table 2. Insurance Reform Plan with Less Clear Net Savers and Net Payers

	Net Savers			Net Payers		
		Dollars	%*		Dollars	%*
Affordable Coverage	Federal	- $24 million	-2.3%	Self	+ $134 million	4.7%
	Employer	- $6 million	-0.2%	State	+ $93 million	35.6%
Updated Sequential	Employer	- $1 million	0.0%	State	+ $71 million	27.1%
				Federal	+ $65 million	6.2%
				Self	+ $9 million	0.3%

* % = Percentage Change in Expenditures for that Payer

Part I. Background

Introduction

The Kansas Legislature, in House Substitute for Senate Bill 11 (SB 11), required the Kansas Health Policy Authority (KHPA) develop and present to the Legislature options for comprehensive health insurance reform in the state of Kansas (State or Kansas). The KHPA is a State agency created to develop and maintain a coordinated and data-driven health policy agenda, and it was tasked this year with reforming health care delivery in Kansas[3]. Kansas established three priorities for health reform:

1) ***Promoting Personal Responsibility*** – for healthy behaviors, informed use of health care services, and sharing financial responsibility for the cost of health care;
2) ***Promoting Medical Homes and Paying for Prevention*** – to improve the coordination of health care services, prevent diseases before it starts, and contain the rising costs of health care; and
3) ***Providing and Protecting Affordable Health Insurance*** – to help those Kansans most in need gain access to affordable health insurance.

The health insurance reform options are designed to increase access to affordable health care coverage, thereby, promoting the health of Kansans. This report will be used by policymakers in further developing health insurance reform plans for the State and will be used in conjunction with KHPA's overall health reform efforts in Kansas.

Options were created based on the State's existing health care marketplace and Kansas-specific uninsured population characteristics. Reforms across the participation spectrum (voluntary to mandatory) as well as the access mechanism (public to private) were considered. Five separate options[4] were initially considered. Those five options included;

1) Reference – Voluntary expansion of public programs,
2) Affordable Coverage – Voluntary market-based reform through implementation of an insurance connector/exchange or insurance clearinghouse (the KHPA Board used the terms connector, exchange, and insurance clearinghouse interchangeably during its deliberations),
3) Universal Coverage – Mandatory coverage with an individual mandate and an employer mandate,
4) The Mountain – Mandatory coverage using a single payer controlled by the State, and
5) Sequential – Combines voluntary and mandatory portions from the options above in a sequential, step by step approach to health insurance reform.

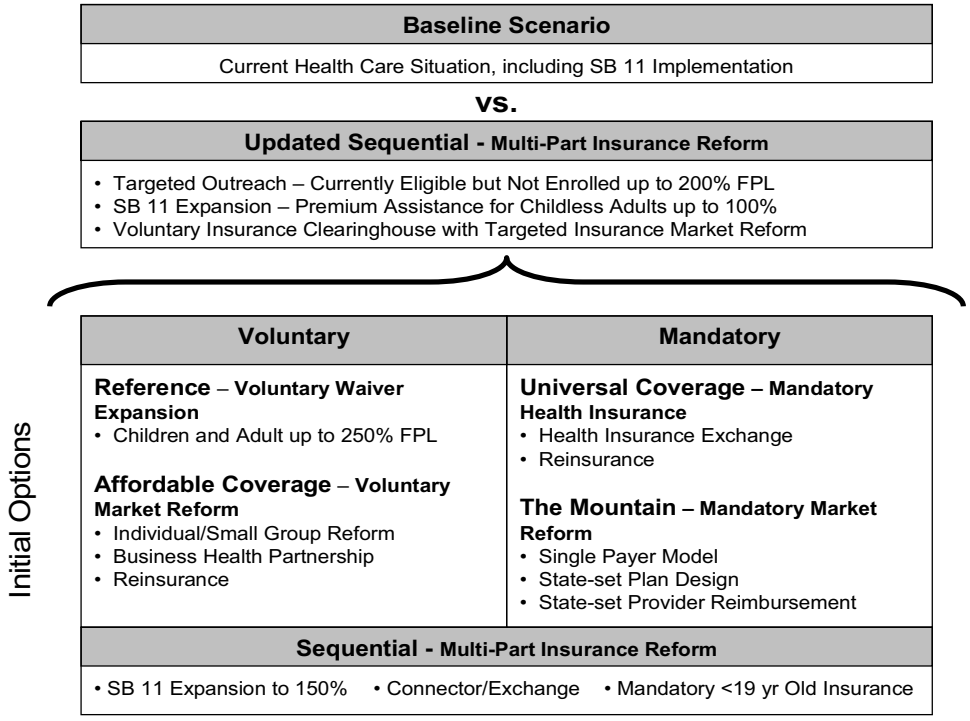
Ultimately, the KHPA Board chose to make modifications to the Sequential reform plan (the revised version is described as the Updated Sequential plan) that combined portions of each option above while avoiding a coverage mandate (Figure 4). The Updated Sequential reform plan was then compared to the Baseline (2004/2005 Kansas Health Care Market including SB 11 Premium Assistance) to determine the cost and population impacts of the proposed reform.

While each original insurance reform effort considered would increase coverage for the uninsured, the Updated Sequential plan approach, which bundled a variation of the voluntary public expansion and an insurance clearinghouse with targeted health care insurance market reform, stood out during the KHPA Board debate. Using a combination of components allows the State to expand coverage to some of the poorest Kansans while relying on a market-based approach to reach out to uninsured Kansans of all income levels.

***Definition:* SB 11 Premium Assistance**

The State of Kansas' Premium Assistance program, authorized through House Substitute for SB 11, uses federal and State Medicaid funds to subsidize the purchase of employer-sponsored health insurance or through a state procured private health insurance plan. Some states are moving toward this model to encourage low-income families' participation in private health insurance coverage, shore-up the private coverage market and prevent crowd-out, and achieve cost savings by bringing in employer contributions to help offset costs. Premium Assistance in Kansas will be phased in over four years, with a "legislative trigger" each year to evaluate the program and ensure that funding is available.

Figure 4. Evolution of the Updated Sequential Option



The KHPA Board recognized that given Kansas' current economic, political, and health care environment, the Updated Sequential Option not only placed Kansas solidly on the road to reform and historic reductions in the uninsured, but also lays the ground work for further insurance reform efforts. Even with this road map for reform developed, the KHPA Board recognizes that it remains for the Governor and Kansas Legislature to determine the ultimate reform vehicle and the speed at which insurance reform will occur.

This report presents the findings of actuarial modeling of the final Updated Sequential Option conducted by **s**chramm▪**r**aleigh **H**ealth **S**trategy (srHS) based on the KHPA Board of Directors input and recommendations. The analysis illustrates the impact of implementing the Updated Sequential Option in contrast to the current Kansas Baseline of health care (including SB 11 Premium Assistance implementation). Estimated costs and coverage impacts of the Updated Sequential plan components are presented. See Appendix A for a flowchart depicting the variables incorporated within the Kansas State Health Reform Projection (SHRP) model. See the Summary (page 13) as well as Appendix B for more information on the five original reform plan options.

Health Insurance Coverage in Kansas – Where We Are/The Baseline Scenario

Of nearly 2.35 million non-elderly Kansans[5], 65% or a little over 1.5 million access health care insurance through private employers. Currently, 8% or 186,000 individuals purchase coverage on their own and an additional 18,000 (0.8%) out of 24,000 eligible are projected to enroll in health insurance through the Premium Assistance expansion included in SB 11[6]. Of the remaining Kansans, 10.5% or 248,000 are covered through public health insurance, such as traditional Medicaid or State Children's Health Insurance Program (SCHIP)[7]. Other publicly funded programs cover roughly 4.5% of the population (81,000 covered through their military service by Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Tri-Care and the Veterans Administration, and 19,000 through Medicare). The remaining

Five Original Reform Plans Considered—Summary

Reference (Voluntary)

Major Differentiator

- Waiver Expansion: Expand Public Programs up to 250% FPL – Children/Adults & Childless Adults

STRUCTURE

1. Waiver Expansion:
   - Create SPA and/or Waiver for CMS approval and Federal $'s

POLICY DECISIONS

1. Program Design:
   - Expand Public Programs
2. Benefits:
   - Medicaid Benefit Package
3. Service Delivery Network:
   - Medicaid Managed Care Program

ISSUES

- State Match & Vehicle
- Federal Approval
- Crowd-Out

Affordable Coverage (Voluntary)

Major Differentiator

- Individual/Small Group Market Reform – Merge & Subsidize w/ Reinsurance Merged Market <250% FPL

STRUCTURE

1. Merge Individual/Small Group Markets:
   - Require Community Rating and Guaranteed Issue
   - Require access to Section 125
   - Add Subsidized Reinsurance Program to Spread Risk
2. Market Clearinghouse – Business Health Partnership (BHP) for Combined Market:
   - Provide Seal of Approval to Products
   - Provide Section 125 Assistance

POLICY DECISIONS

1. Program Design – Market Driven Reform:
   - Change Kansas Insurance Law
   - Require Section 125 for All Employers
   - Establish Reinsurance Program
   - Determine Reinsurance Funding
   - Determine State Subsidy for those with Income below 250% FPL
   - Empower Business Health Partnership as Clearinghouse

ISSUES

- KS Insurance Law
- Combined Market – Selection v. Level-Playing Field
- Role/Authority of BHP

Sequential (Mandatory & Voluntary)

Major Differentiator

- 3 Part Health Insurance Reform – Mandatory for Children, Expand SB11, and Connector/Exchange

STRUCTURE

1. Mandatory Health Insurance for Children:
   - To enroll in School, Children < 19 yrs old must show proof of insurance
2. Expand SB 11 to 150% FPL
3. Market Clearinghouse – Business Health Partnership for Small Group Market:
   - Allow Sole Prop's and Small Group
   - Require access to Section 125
   - Add Subsidized Reinsurance Program to Spread Risk for combined market
   - Provide Seal of Approval to Products
   - Maintain Go Bare Provision

POLICY DECISIONS

1. Program Design – Market Driven Reform:
   - Establish and Enforce Mandate on Children's Health Insurance
   - Expand SCHIP to 250% FPL
   - Expand SB11 to 150%
   - Affordability & Coverage Standards
   - Change Kansas Insurance Laws
   - Establish Reinsurance Program
   - Determine Reinsurance Funding
   - Subsidize Small Group/Sole Props < 250% FPL
   - Require Section 125

ISSUES

- Children's Mandate
- Combined Market – Selection v. Level-Playing Field
- State Match/Vehicle

Universal Coverage (Mandatory)

Major Differentiator

- Mandate on Individuals and Employers for Health Insurance – Pay or Play Mandate for All Kansans

STRUCTURE

1. Existing Employer/Carrier Model:
   - Mandate Individuals to Have and Employers to Offer Health Insurance
   - Require Section 125 through all Employers
   - Add Subsidized Reinsurance with Funds from Combined Carriers and State
2. Compliance/Exemption Process:
   - Affordability Set at 10% of Income
   - Enforcement for Non-Compliance
   - Establish Religious Exemptions
   - Establish Income/Age Exemptions

POLICY DECISIONS

1. Program Design – Market Driven Reform:
   - Establish and Enforce Individual and Employer Mandate
   - Change Kansas Insurance Law
   - Set Pay or Play Standards and Enforcement for Individuals and Businesses
   - Set Minimum Coverage Standards
   - Set Exemption Process
   - Establish Reinsurance
   - Determine Reinsurance Funding
   - Subsidize Individual/Small Group < 250% FPL

ISSUES

- Achieving a Mandate
- ERISA and Federal Law
- KHPA – Pay or Play Provisions

The Mountain (Mandatory) – Single Payer

Major Differentiator

- Single Payer – All Kansans must receive Health Insurance through the Kansas Health Insurance Program

STRUCTURE

1. Market Maker – Single Payer:
   - Single Combined Health Care Market for All Kansans
   - Require Community Rating
   - Require Guaranteed Issue
   - Capture Existing Funding Sources
2. Compliance/Exemption Process:
   - Affordability Set at 10% of Income
   - Enforcement for Non-Compliance
   - Establish Religious Exemptions
   - Establish Income/Age Exemptions

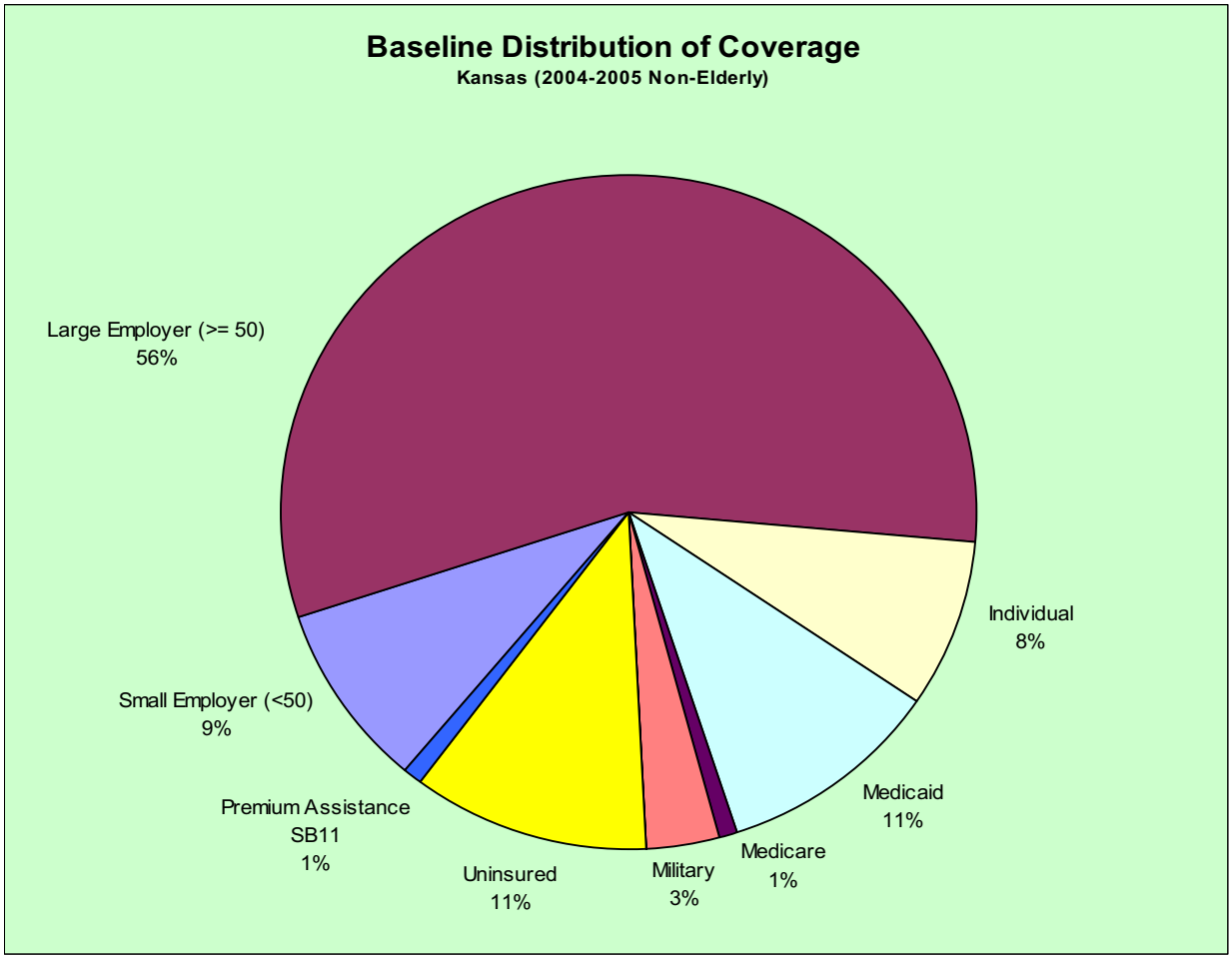
POLICY DECISIONS

1. Program Design – State Driven Reform:
   - Establish Individual Mandate
   - Change Kansas Insurance Law
   - Elimination of Carriers
   - State-Controlled Benefits
   - State-Controlled Reimbursement
   - Set Pay or Play Standards and Enforcement for Individuals
   - Set Exemption Process
   - Subsidize Individuals < 250% FPL
   - Amount of Program Administrative and Provider Administrative Savings

ISSUES

- Achieving a Mandate
- ERISA and Federal Law
- State-Controlled Health Care Market

Figure 5. Distribution of Kansans (Non-elderly) by Type of Insurance Coverage



11% of Kansans, roughly 260,000 people, are uninsured (Figure 5)[8].

Kansas policymakers have been decidedly bipartisan in their recent efforts to consider health insurance reform options. During the 2007 Kansas Legislature, SB 11, a broad-reaching health care reform bill, passed unanimously and was signed into law by the Governor. In addition to mandating the preparation of this analysis and its reform options, a main piece of SB 11 was a Premium Assistance program that makes available State and federal dollars to subsidize the purchase of private health insurance for approximately 24,000 Kansans eligible for SB 11 on a four-year phase in basis. This Premium Assistance program was included within the current situation/Baseline scenario in this analysis so the effects of additional potential reforms can be identified discretely. The approval of this wide-ranging legislation shows the willingness of the policymakers to grapple with the difficult issues surrounding health insurance reform in order to ensure wider access to affordable insurance for Kansans.

While Kansas' overall uninsured population rate of 11% is lower than the national average of 15%[9], 260,000 non-elderly Kansans will be without coverage after the implementing of Premium Assistance SB 11, and this number is unlikely to self-resolve as health care insurance premiums continue to outstrip inflation[10]. There are many circumstances that may lead to a person being uninsured. Some employers do not offer coverage to their employees. Some employees are unable to afford the coverage they are offered and/or are unable to afford individual policies, and some people are unemployed or simply choose to forgo coverage. Whatever the direct circumstance, low-income Kansans and those working in the State's smallest firms are the most likely to be uninsured. Families

living below 200% of the federal poverty level (FPL) are uninsured at rates at least three times those of families living at or above 300% FPL[11]. Reform options must identify ways to increase access to affordable health insurance for all Kansans, but to maximize their impact, options should include strategies that focus specifically on these low and moderate income Kansans.

Why Kansans Need Health Care Coverage

There has been extensive research indicating that the availability of health insurance or lack of it affects the health and quality of life of individuals and families. The Institute of Medicine of the National Academies (IOM) reports that not only are the uninsured less likely to get timely and appropriate care than their insured counterparts, but that the uninsured suffer worse health and die sooner than those who have coverage[12]. Additionally, the IOM has found that the uninsured are more likely to require crisis care for conditions that could have been treated in a less intensive setting[13]. Providing appropriate, timely health care through access to health insurance care can be less expensive in the long run than paying for emergency care for the uninsured.

Not only does a lack of insurance weaken the health and finances of individuals and families, the uninsured may financially weaken health care providers who may receive no financial recompense for services provided. The IOM reports that treating a high volume of uninsured patients can lead to destabilization of providers. All of Kansans pay for the uninsured, either through higher general medical costs or through drains on State funding for critical care and other uninsured population needs. Also known as a "hidden tax", insured Kansans pay an additional premium for their coverage to pay for the care needed and received by the uninsured. Additional research has shown the impact that the uninsured have upon a community For example, healthier children consistently achieve more in school and children without health insurance are more than one and a half times more likely to report low health status than their insured counterparts[14]. Businesses suffer from the consequences of uninsurance as well[15]. A 2004 white paper from the HR Policy Association estimated that the economic impact of uninsured Americans to be over $150 billion a year in lost productivity, turnover, and absenteeism costs[16].

Policymakers have recognized (through their unanimous support of SB 11) the need to explore options for increasing access to affordable health insurance for all Kansans as a way to benefit individuals, families, businesses, our communities, and society at large.

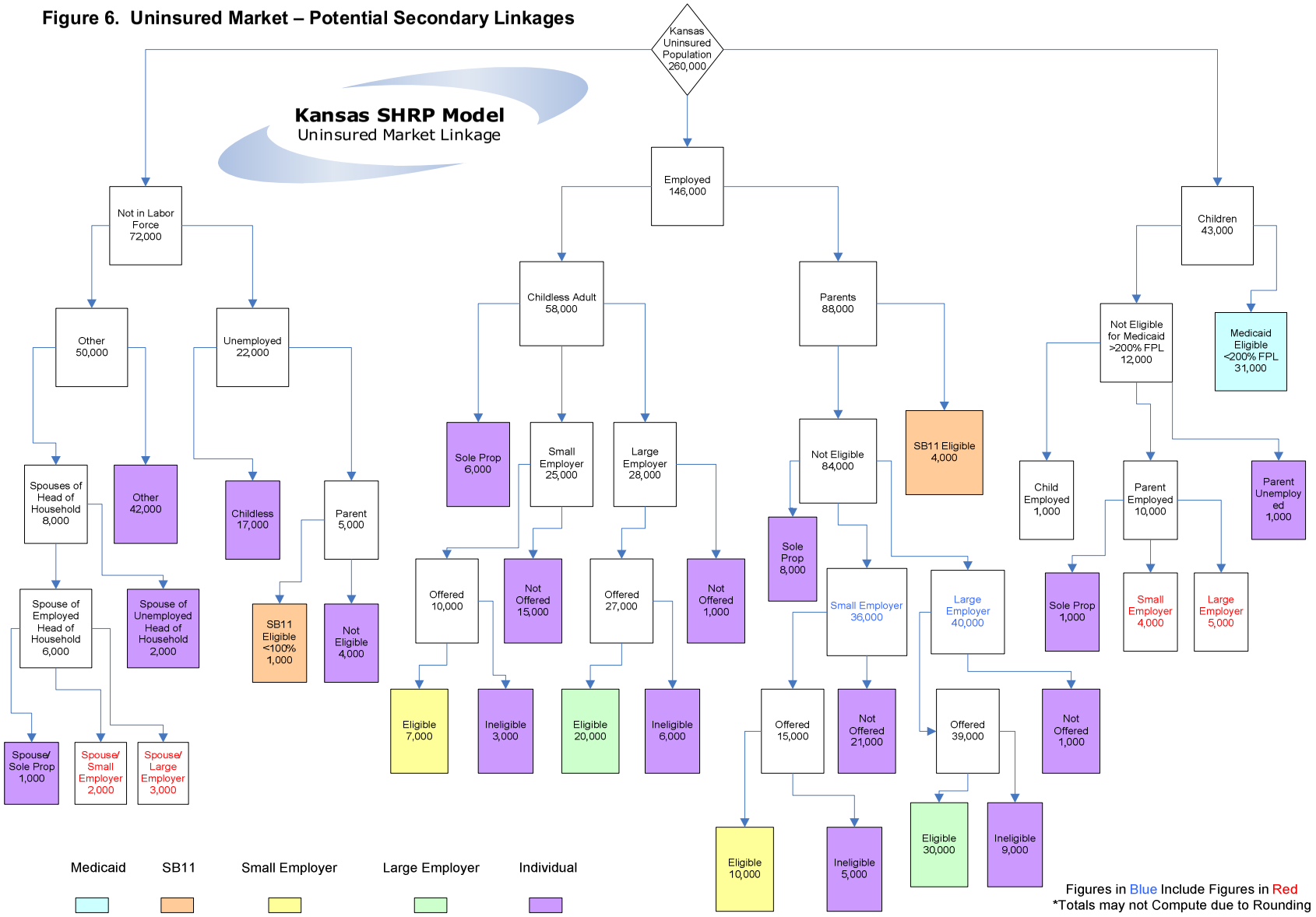
The Model

To estimate the impact of the various insurance reform options being considered on Kansas' current health insurance Baseline situation, srHS used its SHRP model (see Appendix A for a more complete listing of the variables contained within SHRP). The SHRP model develops cost and population projections for the entire Kansas health care marketplace based on an individual's primary "market link" to the health insurance market. The primary market link is how individuals currently receive their health care coverage and what entity pays for that coverage. Those without insurance are given the primary market linkage of uninsured.

As the uninsured are our main target market for insurance expansion, we go a step further for the uninsured population by identifying any secondary linkages the uninsured have to the other, more traditional market links. This secondary link is the vehicle or venue most likely for the uninsured person to access health care insurance if they desired to do so and if it was made available. In the SHRP model, the secondary link is not a static link. A key model component is that this secondary link will potentially vary depending upon the health insurance reforms being considered. This linkage analysis assists in identifying the most effective health reform options by connecting the uninsured with their most likely point of access to coverage based on the reforms being considered.

srHS establishes the primary and secondary market linkage by undertaking a multi-level analysis of the Current Population Survey (CPS)[17] data on the health insurance marketplace in Kansas. srHS created a hierarchical map of the CPS uninsurance data to the key variables within the SHRP model we developed for Kansas (Figure 6)[18]. Based on this comprehensive mapping of the characteristics of uninsured Kansans, srHS helped the KHPA Board identify key reform options that use market-based solutions to expand an

Figure 6. Uninsured Market – Potential Secondary Linkages



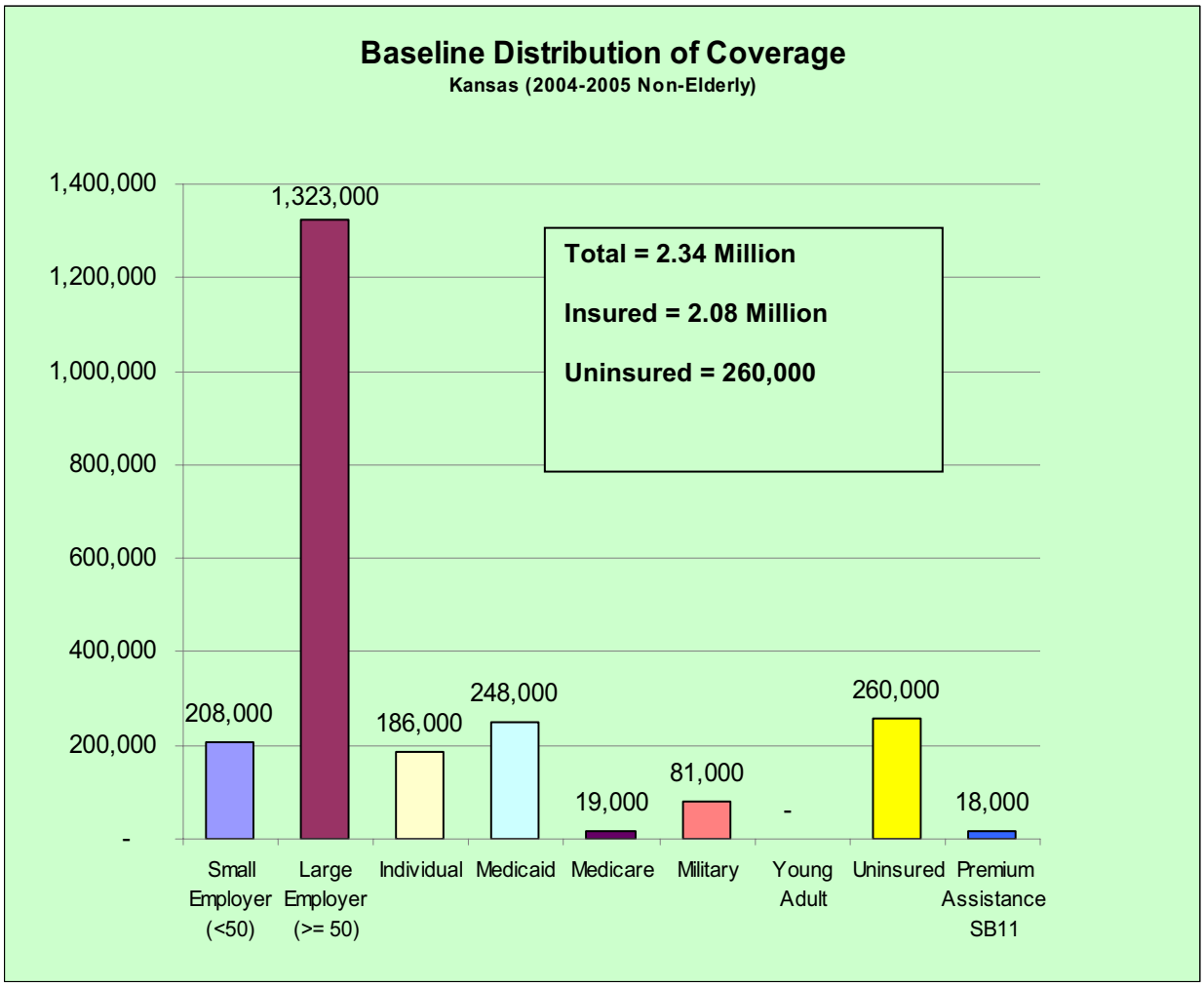
individual's access to insurance. This market link approach forms the basis of srHS's SHRP model.

The initial primary market links were:

- **Small Employer** – Defined as those that receive their insurance through employers with 2-50 employees.
- **Large Employer** – Defined as those that receive their insurance through employers with greater than 50 employees.
- **Individuals** – Defined as those individuals and sole proprietors that purchase health insurance in the non-group marketplace.
- **Medicaid** – Defined as those individuals that are enrolled in the Kansas' Medicaid and SCHIP programs.
- **Medicare** – Defined as those individuals under age 65 whose primary health insurance coverage is provided by Medicare.
- **Military** – Defined as those individuals whose primary health insurance in provided by CHAMPUS, Tri-Care, CHAMPVA, and VA.
- **Uninsured** – Defined as those individuals without a regular source of health insurance coverage for the calendar year preceding the survey.
- **Premium Assistance SB 11** – Defined as those adults that would qualify for a related-adults expansion of SB 11 with incomes up to 100% FPL

Using a weighted average from the CPS data for 2004-2005, there are 2.34 million non-elderly Kansans, of which 260,000 are uninsured (Figure 7). Another

Figure 7. Total Kansas Non-Elderly Population by Insurance Coverage



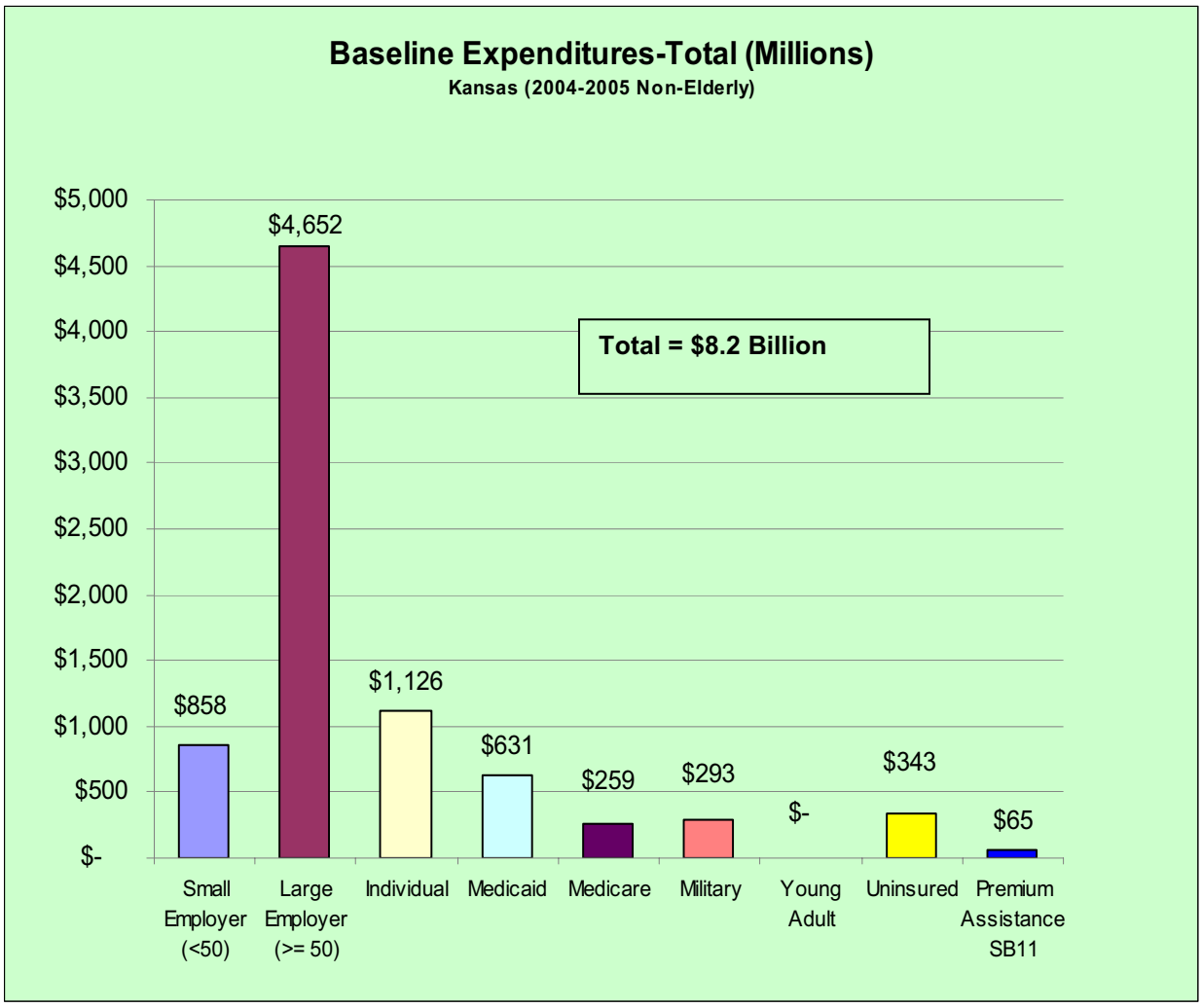
market link, the Very Small Group (VSG) – employer groups with one to ten employees – was later developed and added within the modeling of the Updated Sequential Option.

The SHRP model produces cost and population projections for the entire Kansas health care market by modeling market link evolution under different health reform scenarios. To achieve this, the individual's market link is coupled with the health care costs associated with that individual. The SHRP model used 2004-2005 as the Baseline time period for both population and costs, assuming full implementation for each option or initiative within an option. As a result, policymakers can see the cost of the options expressed in terms of figures for population and dollars that are relatively current and, therefore, understandable in practical terms. The Baseline for all acute health care non-elderly health care expenditures for Kansas is $8.2 billion (Figure 8).

To develop comprehensive cost projections, the market link is then coupled with the health care costs associated with its constituent individuals. Cost estimates for the model are:

- based on Kansas-specific premiums and out-of-pocket expenditures[19],
- 2004 and 2005 calendar year averages,
- exclusive of nursing home, home health, and long-term care expenditures, since these expenditures are untouched in the health insurance reform modeling,

Figure 8. Total Acute Health Care Expenditures for Kansas by Sub-Population



- expressed as a standardized per member per month (PMPM) basis for comparative purposes (total dollar impact is also calculated),
- variable depending on the individual's market linkage (which varies depending on health insurance reform option), and
- reflective of market linkage the person is moving to (versus the market linkage the person came from).

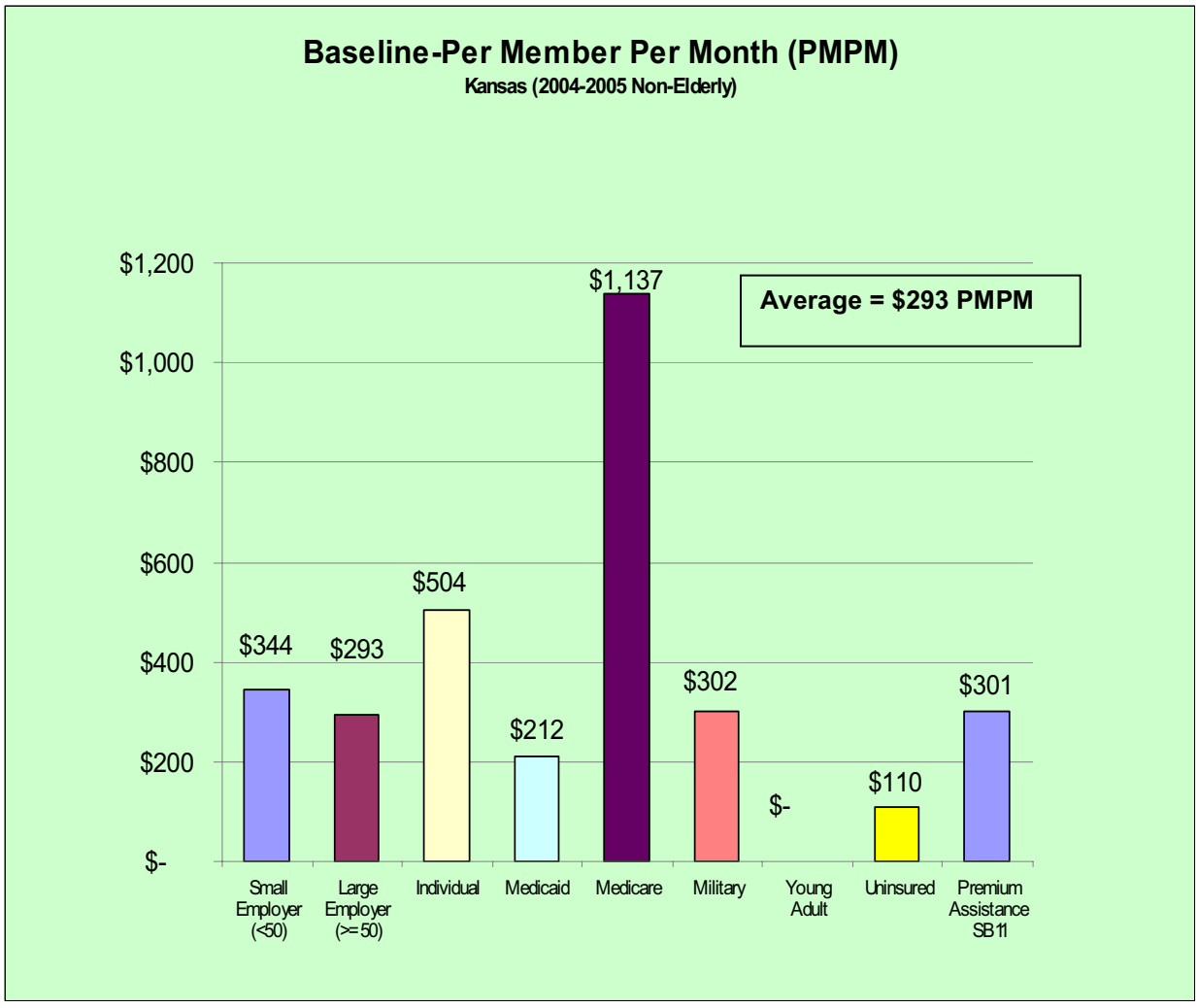
Kansas' 2004-2005 average acute care costs for the non-elderly population are $293 PMPM (Figure 9). The need for the SHRP model to separately identify the PMPM costs of each of Kansas' non-elderly sub-populations is evident in the wide range of PMPM costs that make up Kansas' health care marketplace.

As we move people between and among the various sub-populations, it is critical to track the dollars associated with those moving.

A critical distinction of the SHRP model is that it tracks PMPM costs for the uninsured according to where the individual ends up as a result of the health insurance reform. For example, as an uninsured individual moves to the Medicaid population, we use the Medicaid populations' PMPM to estimate the risk of the newly insured individual. The cost for the new category is a much more accurate indication of their risk when insured and, therefore, ultimate cost to the health care system of that previously uninsured individual than their cost when they were uninsured.

To ensure that our expenditures are accurate indi-

Figure 9. PMPM Acute Care Costs for Kansas by Sub-Population



vidually and in aggregate for Kansas, srHS performed a number of reasonableness checks on the expenditure data. First, we compared our expenditure figures on an aggregate basis to CMS' estimates for total health care expenditures[20] in Kansas, average for 2004-2005. Next, where available, we compared the data to publicly available sources for Kansas-specific health care expenditures.

The SHRP model allows each reform option to be considered in terms of its overall coverage affect on Kansans (uninsured to insured or vice-versa), market link shifts within the population, and related expenditure changes. Model results are useful in summary for informing the Kansas health insurance reform policy debate concerning the different options presented, since the options may be viewed through the consistent lens of the model parameters. Given the macro-level of data used to populate the model and the models broad parameters – results should not be considered final calculations for any one reform option's total expenditures or premium rates. The SHRP model is structured to provide guidance to policymakers as they weigh the options and chart the next steps on the road to reform. The Kansas SHRP model itself and projections from the model can be further refined as the Kansas health insurance reform plan is further debated.

Part II. Roadmap to Health Insurance Reform

Goal and Process

The KHPA Board's goal was to make a health insurance reform recommendation based on the economic, political, and health care environment in Kansas while providing the Governor and the Kansas Legislature with the multiple options considered. The insurance reform recommendations were designed to increase access to affordable health care coverage, thereby, promoting the health of Kansans. In crafting the reform recommendations, the KHPA Board employed the following iterative process:

- Solicit Input – The KHPA Board conducted a statewide "Listening Tour", held multiple advisory council and steering committee meetings, and solicited public comment on health insurance reform options at the KHPA Board meetings.
- Facilitated Deliberations – Using srHS as the facilitator, the KHPA Board identified multiple reform options by considering a variety of reforms across the participation spectrum (voluntary to mandatory) as well as the access mechanism (public to private), and worked with srHS to identify the key differences, structure, policy impacts, and major overall issues for each of the reform options.
- Modeling – srHS created for Kansas the SHRP model that projects the impact of reform on the Kansas population, overall health care expenditures and individual payers, as well as, highlighting policy decisions and major outstanding issues related to the modeled options.
- Analysis – Modeling results were then studied and a combination of strategies where chosen to present to the KHPA, Health Care For All Kansans Steering Committee, the Governor, members of the Kansas Legislature, and interested citizens.

Solicit Input

It was very important to the KHPA Board that the health insurance reform debate in Kansas be an inclusive process, soliciting input from Kansans of all backgrounds. To accomplish this goal, the KHPA Board directed the KHPA staff to develop a "Listening Tour," where KHPA would meet with Kansans in community forums all over the State. The Listening Tour was conducted over two months during the summer of 2007 and included 34 meetings in 22 communities. In addition, the KHPA Board established the Health For All Kansans Steering Committee and four advisory councils:

- Consumer Advisory Council,
- Purchaser Advisory Council,
- Provider Advisory Council, and
- At-Large Advisory Council.

The goal of the Steering Committee and the Advisory Councils was to assist the KHPA Board with the development of health reform options for Kansas. Feedback from all of these forums; the Listening Tour, the Steering Committee and the Councils, as well as public comments during the KHPA Board meetings,

was used in crafting the options to be modeled.

Facilitated Deliberations

To ensure a complete and thorough consideration of the spectrum of health insurance reform options available to Kansas, the KHPA Board requested that srHS facilitate the KHPA Board's health insurance reform deliberations. Using the KHPA Board's Health Reform Roadmap for guidance, srHS developed a series of "straw man" reform options and provided those options to the KHPA Board as a starting point for the KHPA Board's health insurance reform deliberations.

Additionally, the "straw man" options were used to probe the KHPA Board's collective tolerance for more expansive reform options being considered in other states. The result was a lively and wide-ranging discussion on the scope and structure of health insurance reform capable in the current context of Kansas' health care, political, and economic environments. Based on that feedback, srHS fine-tuned the structure and assumptions within each of the five original reform options under discussion and began modeling.

Modeling

srHS used the SHRP model to project population, expenditure, and market place changes under the five original health reform options. Modeling was also completed for the Updated Sequential Option developed after analysis and deliberation on the five original options (as discussed below).

Health Insurance Reform Options – Five Original Options

Description

The following health insurance reform options were modeled and discussed at KHPA Board meetings and were instrumental in the development of the Updated Sequential plan.

1. Reference Option

Voluntary expansion of public programs to cover children and adults, regardless of family status up to 250% FPL ($48,375 annually for a family of four in 2005) . Administration and delivery would piggyback on the current system with benefits matching current Medicaid or HealthWave levels and utilizing the same delivery network. The Reference Option would require:

- obtaining federal approval so expansion costs can be shared between the state and federal governments, and
- dealing with crowd-out: some portion of this newly enrolled individuals in this population chose to forgo private insurance and opt for public coverage.

2. Affordable Coverage Option

Voluntary individual and small group market reform. It would merge the individual and small group markets. It would require:

- community rating and guarantee issue to ensure uniform coverage access,
- access to Section 125 to open up tax benefits for offering insurance to more companies, and
- moderation of risk from any single policy or policyholder through public subsidization of a reinsurance program.

Additionally, the option creates an insurance clearinghouse for the combined market to provide review and approval of products and provide assistance to employers seeking Section 125 tax benefits.

3. Universal Coverage Option

Mandatory health insurance reform through individual and employer mandates. It would establish a "pay or play" mandate for all Kansans. It would require:

- all individuals to have, and all employers to offer, health insurance,
- access to Section 125 to open up tax benefits for offering insurance to more companies
- moderation of risk from any single policy or policyholder through public subsidization of a reinsurance program.

The option would be built on the existing employer/carrier marketplace with an added infrastructure to establish and maintain an insurance mandate and provide assistance to employers seeking Section 125 tax benefits.

4. The Mountain (Single Payer) Option

Requires all Kansans receive health insurance through the Kansas Health Insurance Program, a

newly established statewide health insurance program responsible for all health insurance in Kansas. It would create a single payer for all health insurance in Kansas. It would require:

- community rating and guarantee issue to ensure uniform coverage access,
- establishing a compliance/exemption process with affordability set at 10% of income, and
- creation of state-controlled benefit package and reimbursement schedule.

5. Sequential Option

The Sequential Option is a three-part health insurance reform option with both voluntary and mandatory components. It would require:

- mandatory insurance for children up to age 19 years old,
- expanding SB 11 premium assistance up to 150% for childless adults, and
- creation of a connector/exchange, (modeled after the Business Health Partnership) to be an insurance market clearinghouse.

The children's mandate would be enforced by requiring all children to show proof of insurance prior to enrolling in school. The connector/exchange would have several components; require all employers provide access to Section 125 plans, combine the sole proprietors and small group markets into a single market that spreads the risk through a subsidized reinsurance program and a mandatory go-bare provision of at least six months (employers would have to demonstrate that they have not had health insurance for the last six months).

Analysis

As the KHPA studied the modeling results from the original five reform options, the majority of the debate focused on the Sequential Option. The Sequential Option blended reforms across both the participation spectrum (voluntary to mandatory) as well as the access mechanism (public to private) to achieve reform goals. Some of the policy decisions and issues related to the Sequential Option ultimately appeared prohibitive, so the KHPA Board further fine-tuned the Sequential Option to create the components of the Updated Sequential Option, which maintained a blended private and public focus while avoiding a coverage mandate.

The label chosen by the KHPA Board for this option—sequential was —very telling. The term sequential denotes a step-by-step approach; measured progress moving forward toward an ultimate goal. In this case, the KHPA Board believed that the Updated Sequential plan was very consistent with the concept behind the Roadmap to Reform – the plan would be a series of clearly identifiable, measurable initiatives, each of which would help move Kansas ahead on the road to reducing the number of uninsured Kansans.

The KHPA Board also clearly saw the initiatives described herein as the first milestones in Kansas's health insurance reform initiatives; implicit in the concept is that there will be additional, follow-up milestones to be added in future years. In fact, the KHPA Board described the initiatives included in our modeling as de facto "Phase I," with the success of these initial initiatives determining what initiatives would need to be considered in "Phases II and III" and so on.

Part III. Updated Sequential Plan Approach – Strategies for Voluntary Public Expansion and Market Driven Reform

Updated Sequential Plan Approach – Structure

The Updated Sequential Option is comprised of three individual voluntary reform components – two from the public access mechanism and one from the private market access mechanism – that work together to increase access to affordable health care coverage for Kansans (Figure 10).

Each component's basic structure is described below.

- **Targeted Outreach – Currently Eligible but Not Enrolled Children up to 200% FPL**
  This initiative would target the children currently eligible but not enrolled up to 200% FPL under HealthWave 19 and 21. The newly eligible individuals could be served within the current HealthWave service and

Figure 10. Summary of Updated Sequential Plan

Updated Sequential Reform Plan

Summary of Health Insurance Reform

- Multi-Part Reform – Targeted Insurance Market Reform for 3 Key Populations:
  Children and Young Adults, Low Income Kansans, and Small Businesses

STRUCTURE

1. Children and Young Adults - Targeted Outreach
   - Children: Create Targeted outreach and web-based enrollment for Medicaid/SCHIP eligible but not enrolled children
   - Young Adult: Allow young adults up to age 25 to stay in family insurance plan and develop affordable Young Adult Plans (YAPs) for adults 19-24 years old
2. Low Income Kansans - Premium Assistance SB 11 for Childless Adults
   - Expand up to 100% FPL
3. Small Businesses - Voluntary Insurance Clearinghouse with Targeted Market Reform
   - Create new Very Small Group (VSG: Sole proprietors plus 1-10 ee's) and provide subsidized reinsurance to new VSG market
   - Assist Small Groups (1-50) in Section 125
   - Other Pilot Projects to Improve Access to Insurance for Small Businesses

POLICY DECISIONS

1. Program Design – Market Driven Reform:
   - Children: Develop programs for Targeted Outreach & coordinate with web-based enrollment
   - Young Adults: Change Kansas Insurance Laws
   - Low Income Kansans : Funding and Vehicle to Expand Premium Assistance SB11 to 100% for Childless Adults
   - VSG: Develop Program and Determine Funding for Reinsurance Program
   - Choose Vehicle(s) for Educating all Small Employers about Section 125

ISSUES

- Cost of Additional Outreach
- Combined Market – Selection v. Level-Playing Field
- State Match/Vehicle

administrative structure which covers a similar population. Participation would be voluntary with costs borne by the State and federal governments.

- **SB 11 Expansion – Premium Assistance for Childless Adults up to 100% FPL** This would be a voluntary program aimed at integrating the poorest childless adults into the health care system by providing them with subsidized access to health care insurance. The structure for this initiative would be an expansion of the covered population specified in SB 11 by the Governor and Kansas Legislature. The newly eligible individuals could be served within the same administrative structure that is being developed for the current SB 11 Premium Assistance program. Costs would be borne by the State and federal governments.
- **Voluntary Implementation of Insurance Clearinghouse –** This would be a market-based, small group market reform initiative aimed at increasing coverage for uninsured individuals who are self-employed or employed by a subset of small employers – sole proprietors and employer groups with two to ten employees, respectively. We identified this new combined employer market as the very small employer group (VSG – employer groups with one to ten employees). This new VSG market would entail merging the sole proprietors and employer groups with two to ten employees in the State and subsidizing that merged market with reinsurance.

To spread the risk within the newly created VSG market, the SHRP Model used community rating and guarantee issue as well as a subsidized reinsurance program. These are important changes for this targeted population – because of their lower income, a high percentage of the VSG market has most likely lacked access to the insurance market in the

past. In addition, the initiative assumes the State provides resources for the both the VSG market as well as the entire small group market to help employers implement Section 125 plans (so the entire small group market can benefit from pre-tax payment for insurance). The insurance clearinghouse would be the only place to purchase health care insurance for this newly created VSG market.

This initiative includes the development of Young Adults Plans (YAPs) – health insurance products specifically designed for adults aged 19-24 year-old. This would be a voluntary program aimed at offering a market specific insurance product. These plans would be developed by the State in conjunction with private health insurers; however, similar to the VSG market, the only place to purchase YAPs would be through the insurance clearinghouse.

Another key component of this initiative is the development of an insurance clearinghouse for the sole proprietor, small employer, and YAP markets. The voluntary insurance clearinghouse would review, approve, and offer products for the VSG and YAP markets. The insurance clearinghouse is also tasked with providing assistance to the small employer market in accessing Section 125 benefits. This insurance clearinghouse would be a new administrative structure developed by the State in conjunction with small employer market business leaders, although these additional administrative costs have not been included in our modeling. The insurance costs would be borne by individuals, small employers, and by the State and the federal governments.

Updated Sequential Plan Approach – Policy Decisions, Model Results, and Issues

To facilitate the usefulness of this information for all concerned parties, the model results for the initiatives that comprise the Updated Sequential Option are presented individually. First, each of the three initiatives comprising the Updated Sequential Option is considered as a discrete step and then they are considered collectively. This permits each individual initiative's impact to be considered on a stand-alone basis. In fact, these initiatives were crafted to each address a unique segment of uninsured Kansans so they can be implemented independently of one another as needed or required.

For each initiative the policy considerations are identified, and then the model results (health care policy and cost impact) are presented followed by the remaining outstanding issues related to the reform.

Targeted Outreach – Children Currently Eligible but Not Enrolled in Medicaid/SCHIP up to 200% FPL

Policy Decisions

This initiative builds on an existing, authorized program, so relatively few policy decisions would be necessary. However, given the success of Kansas' current outreach campaigns, any decision to go forward would be a commitment of additional administrative resources.

Developing a successful outreach program can be split into two areas: 1) administrative changes that ease the eligibility process, and 2) operational strategies that increase the impact of outreach programs. The goal of administrative and operational changes is to positively impact the take-up rate, or the relative propensity of individuals to participate in free (or minimal cost) health insurance[21]. For administrative changes, research has shown that there are a number of potentially successful strategies to increase take-up rates, although other states have been reluctant to implement them[22]. They include presumptive eligibility, self-declaration of income, and 12-month continuous eligibility. Kansas has presumptive eligibility for children as well as 12-month continuous eligibility but is not planning to implement self-declaration of income. For operational changes, states that have been successful have extended their outreach programs operationally, by partnering with specific organizations from the communities they are targeting[23]. Successful strategies have included web-based enrollment, public-program coordination/collaboration, school-based outreach programs, and outstationing eligibility workers with culturally competent community partners. Each of these efforts entails moving the point of en-

gagement with the child or family into the family's everyday life through a known contact, local geography, or both. In addition to the administrative changes described above, we assume Kansas implements and/or increases the public-program coordination and outstationing eligibility workers to achieve the very aggressive take-up rates modeled below.

As part of this initiative, the KHPA Board recommended the Updated Sequential plan include specific enrollment targets and "trigger" additional action by the KHPA if the targeted outreach did not reach a penetration rate of at least 90% within three years. The trigger would include consideration of mandating that all children have health insurance in Kansas, subject to Legislative approval. As the model projected penetration rates above 90%, we have not included any impact for this mandatory insurance trigger.

Model Results

Successful, targeted outreach characterized by culturally competent, face-to-face eligibility and enrollment assistance is designed to enroll as many children as possible without use of financial incentives. Using targeted outreach strategies to reach those children below 200% FPL currently eligible for the public programs would add a substantial number of new enrollees to Kansas' public programs. Experience nationwide in public programs shows that take-up rates have a distinct pattern. First, initial take-up rates tend to be the highest that can be expected. Individuals who do not enroll through a first outreach connection typically ascribe less value to health care coverage and are less likely to enroll when approached again through subsequent outreach efforts. Second, take-up rates are inversely related to income; that is, as income rises, take-up rates slow. Thus, the take-up rate used in the modeling for the targeted outreach was lower than the overall take-up rate of Kansas' current public program take-up rate of 84%[24] and consistent with lower take-up rates for those with higher income, an even lower (substantially) take-up rate was used for those with higher income.

For lower income children that qualify for Medicaid, take-up at 75% was estimated to be only slightly lower than Kansas' current public program take-up rate for children of 84%. This results in approximately 15,000 additional children enrolled in Medicaid as a result of an extremely visible and effective outreach program specifically targeting lower income children eligible for public programs (Table 3). Aggressive outreach to lower income children qualifying for SCHIP was estimated to have a take-up rate of 42%, approximately half that of Kansas' current overall take-up rate for children. This results in an estimated approximately 5,000 additional children enrolling in SCHIP as a result of an extremely visible and effective outreach program targeting higher income children eligible for public programs. Practically speaking, these results will have been achieved over a multi-year period, although the model reflects a mature, fully-implemented program.

The costs associated with these currently eligible children enrolling in public programs would be borne jointly by the State and federal governments, with the relative portions dependent upon whether the children were Medicaid- or SCHIP-eligible (Table 4)[25]. For the uninsured, the research shows two primary funding sources:

- out-of-pocket expenditures from the uninsured themselves; and

Table 3. Targeted Outreach for Children Eligible but Not Enrolled up to 200% FPL

Additional Children	Newly Enrolled in Medicaid	Newly Enrolled in SCHIP	Total Newly Enrolled
Number previously uninsured	15,000	5,000	20,000

Table 4. Cost of Targeted Outreach for Children up to 200% FPL

Payer	Paid by Self	Paid by State Government	Paid by Federal Government	Net Cost of Reform
Change	($9 million)	$14 million	$17 million	$22 million

***KHPA Board Deliberations:* Original Sequential Model**

In the original Sequential model presented to the KHPA Board, there was a children's SCHIP expansion that went up to 250% of the FPL (with an insurance mandate). If we assume a voluntary environment and an 80% take up rate (which is reasonable from our perspective compared to the existing enrolled population), the State could net an additional 5,000 children more than the Updated Sequential Option. Assuming the expanded outreach already exists, it is likely that there would be only minimal additional outreach costs associated with this expansion. This expansion would come at a cost of approximately $5 million (approximately $2 million from the State and $3 million from the federal government) more than the Updated Sequential Option.

- federal programs, such as Disproportionate Share Hospital (DSH), upper payment limit (UPL), and Indirect Medical Education (IME)[26].

Thus, this additional cost for the federal government is partially offset by the reduction in payments for public programs associated with treating these previously uninsured children. As a result of the targeted outreach for public programs to cover all children currently eligible for public programs, the State would be responsible for an additional estimated $14 million and the federal government for an additional estimated $17 million.

Issues

The effective take-up rates that result from these aggressive outreach efforts are high compared to the typical range of take-up rates assumed for public programs. Typical public program take-up rates range from 60-80% of those eligible[27]. Kansas' current take-up rate of 84% is already above the upper end of that range. The resulting effective take-up rates after the aggressive outreach are 95%[28] for Medicaid children and 94% for SCHIP children[29]. Participation rates of this high are difficult to achieve for a variety of reasons, including administrative barriers to enrollment and retention and the knowledge gap among individuals eligible but not enrolled[30]. Another caution would be the return on investment of this additional outreach when measured on a cost per additional enrollee basis. The outreach costs per additional enrollee for these currently eligible but not yet enrolled children will be greater when compared to Kansas' historical outreach costs per additional enrollee. Our cost estimates do not include the additional administrative expense borne by the State and federal government for the targeted outreach.

SB 11 Expansion – Premium Assistance for Childless Adults up to 100% FPL

Policy Decisions

Similar to the targeted outreach described earlier, this initiative can build upon an existing program so, again, relatively few new policy decisions are assumed necessary to expand Premium Assistance to childless adults up to 100% FPL. The principal challenge for SB 11 expansion is finding a suitable vehicle for extending eligibility to this childless adults up to 100% FPL for which federal funds are available.

Childless adults do not fit within Medicaid's traditional eligibility categories, although the Centers for Medicare & Medicaid Services (CMS) has provided states flexibility recently through provisions within the Deficit Reduction Act (DRA). States have taken a variety of approaches to covering childless adults, typically either through State-only programs like Connecticut's State Administered General Assistance (SAGA) program or by pursuing waiver authority through the federal government and CMS waiver process. If the Governor and the Kansas Legislature made the policy decision to implement a State-only program, Kansas could implement a State-only program fairly quickly by building upon the existing Kansas public program infrastructure.

However, if the Governor and the Kansas Legislature made the policy decision to pursue federal matching funds for childless adults, significant challenges may exist depending upon whether the State could pursue approval using flexibility through the DRA or whether the State would be required to pursue a waiver. If required to pursue a waiver, Kansas would

need to determine the appropriate waiver vehicle to use. Regardless of the waiver vehicle and strategy selected, the second and perhaps the more vexing challenge would be meeting budget neutrality. Kansas would struggle to meet the budget neutrality requirements inherent within the CMS waiver process. Broadly stated, CMS requires that new initiatives like this spend no more money than the State would have in the absence of the waiver. Some states have unspent federal dollars in other health care areas that they have exchanged for the additional spending on childless adults to meet budget neutrality. Other states have attempted to meet their budget neutrality requirement by bundling their additional spending for childless adults with other pieces of health insurance reform designed to save federal dollars. At this time, neither strategy appears promising for Kansas to meet its budget neutrality requirement. On top of those issues, the waiver approval process in and of itself can be a challenge. Waivers are fairly time-consuming, first at the State-level to get authorization to submit a waiver, and second, at the federal-level to successfully negotiate a waiver.

Model Results

Childless adults make up approximately 22% of the uninsured adult population in Kansas[31]. Assuming Kansas chose to expand its SB 11 Premium Assistance to childless adults, the number of uninsured adults would drop by 39,000 from 217,000 to 178,000 (Table 5). Again, take-up rates play a part in determining how many childless adults opt for coverage. As this is the initial expansion into childless adult coverage and the eligibility is for the lowest income childless adults, the model used a take-up rate of 80%, comparable to that of the upper-end of most states' general Medicaid take-up rate (80%) and Kansas' current take-up rate.

The costs associated with expanding SB 11 to childless adults would be borne jointly by the State and federal governments (Table 6). For the federal government, this additional cost is somewhat offset by the reduction in their portion of public programs associated with these previously uninsured adults. Individuals' costs also go down as these previously uninsured adults had substantial out-of-pocket expenses while uninsured that will be replaced by State and federal expenditures. As a result of expanding SB 11 to childless adults, the State would be responsible for an additional $56 million and the federal government for an additional $63 million. Individual spending will be reduced by $34 million as a result of individuals having little or no out-of-pocket costs in the Premium Assistance program.

Issues

The primary issues facing Kansas relative to expanding SB 11 coverage to childless adults are funding and federal approval. By definition, State-only programs do not receive any federal funding and are relatively costly when compared to waiver programs where

Table 5. Expansion of SB 11 to Childless Adults up to 100% FPL

Additional Adults	Newly Enrolled in Medicaid
Number previously uninsured	39,000

Table 6. Costs of SB 11 Expansion to Childless Adults up to 100% FPL

Payer	Paid by Self	Paid by State Government	Paid by Federal Government	Net Cost of Reform
Change	($34 million)	$56 million	$63 million	$85 million

***KHPA Board Deliberations:* Original Sequential Model**

In the original Sequential model, we modeled the SB 11 program to increase to 150% of FPL for both caretakers and childless adults. In this scenario, an additional 31,000 adults would have been insured (beyond the 39,000 described above) and would have cost an additional $67 million (an increase of $46 million in State funds and $50 million in federal funds, offset by a $29 million decrease in individual expenditures more than the Updated Sequential Option.

funding is borne jointly by the State and federal governments. If Kansas chose to pursue a State-only program for childless adults, the price tag would be $140 million for a fully implemented program (at the current take-up rates). Alternatively, if the State had to achieve CMS budget neutrality, the State would need to find reductions in federal spending on the order of approximately $63 million annually[32] (once the childless adults hit full enrollment). Absent federal participation, the State could consider a less expensive, modified benefit package.

Voluntary Implementation of Insurance Clearinghouse

Policy Decisions

This is the most complex of the initiatives being considered as part of the Updated Sequential plan. This initiative requires the development of an insurance clearinghouse structure which, while there is some precedent with Kansas' Business Health Partnership (BHP), the ultimate role of the insurance clearinghouse has not yet been finalized. As a result, this initiative requires the most policy decisions for enactment.

The principal policy decisions to be made center around Kansas insurance law, as the major focal point of this initiative is targeted insurance market reform. The KHPA Board's goal was to develop "micro-markets" – small, efficient markets where the risk of the market is more evenly spread across the entire market. The research has shown that the key is developing a set of reforms which deal with the problems of availability and accessibility in these markets[33].

These reforms are typically achieved by changing the rating laws governing the newly created micro-market. As described previously, a micro-market was defined and targeted to work to increase insurance coverage for uninsured individuals self-employed or employed by a subset of very small employers. For that newly created VSG market (one to ten employees), reform could necessitate several strategies to help level the playing field, including requiring community rating and guarantee issue. The State could further consider market reforms, such as standardized waiting periods, standardized benefits, and limiting permissible rating factors and rate variation[34]. All these would work together to make the VSG market more efficient by standardizing the offerings and more evenly distributing the health care risk associated with the newly covered population.

This VSG market would also benefit from a reinsurance program by sharing in the risk of this merged market. There are a variety of reinsurance approaches available to Kansas. The State, led by the Kansas Insurance Department, has been examining the pros and cons of various reinsurance options. As a result of the Insurance Department's Pilot Grant analysis[35], the State is considering retrospective reinsurance based on high cost conditions. For purposes of this policy analysis, we have used a similar retrospec-

***Definition:* Business Health Partnership (BHP)**

In 2001, Kansas implemented a small employer pooling mechanism called the Kansas BHP. The pool, a non-profit organization, purchases coverage via the private market with the goals of employee choice, minimized administrative costs, and benefits that meet standards of State and federal law. The original BHP has been dissolved and will be reorganized under the leadership of the Kansas Business Health Policy Committee (BHPC). Efforts are now being weighed to pursue alternative sources of additional funding.

tive high-cost reinsurance program that removes the upper 5% of claims risk. This program would be funded by the State and carriers. The premiums for this group would drop by an assumed 5%, which due to the elasticity of demand (elasticity of demand is explained further below), causes additional insured individuals to enroll.

This initiative's targeted insurance market reform also includes the development of YAPs – health insurance products specifically designed for adults aged 19-24 years old. This again would require changes to Kansas insurance law. Massachusetts, as part of its landmark health care reform legislation, established a new set of regulations governing their newly created YAPs (In Massachusetts, YAPs were originally defined as adults aged 19-26 years old. This has since been adjusted to include 18 year olds.). The Massachusetts regulations included who could sell the product, minimum coverage standards, and rating requirements. Kansas would need to develop similar regulations. As research has shown affordability to be among the key drivers of take-up for this market[36], the policy challenge for Kansas health policymakers is to develop the regulations so that they balance affordability with comprehensive coverage. In a further effort to address the issue of uninsurance in young adults, the Updated Sequential plan includes a provision to alter Kansas insurance law and allow parents to keep young adults (through age 25 years) on their family insurance plan. This was intended as a bridge for young adults' health insurance coverage as they transition to employer-sponsored coverage when they enter the ranks of the employed.

Kansas will need to determine what role the newly created voluntary insurance clearinghouse will play in assisting small employers to access benefits under Section 125 (favorable tax treatment of health insurance premiums paid on a pre-tax basis). Consistent with an insurance clearinghouse role – helping small employers with the challenges associated with providing health insurance, the KHPA Board envisioned the insurance clearinghouse as a reference source for small employers on Section 125. The insurance clearinghouse would be responsible for disseminating information about the benefits and how to take advantage of Section 125, but would not be involved in Section 125 administration. The KHPA Board envisioned Section 125 administration remaining in the private market.

***Definition:* Section 125 and Tax-Preferred Insurance Premiums**

Section 125 of the Internal Revenue Code provides companies a vehicle to allow their employees to pay for certain qualified benefits on a pre-tax basis. Pre-tax, or tax-preferred benefits lower payroll-related taxes for both the employer and employees. With a Section 125, employers can establish tax-preferred benefit programs that can make health insurance more affordable. Section 125 qualified plans allow employees to pay for certain qualified expenses before taxes are deducted from their paycheck, thus maximizing an employee's take-home pay and minimizing an employer's payroll-related taxes. These qualified expenses can include health insurance premiums and certain out-of-pocket health care expenses.

Model Results

Elasticity of demand is an economic concept that attempts to measure the response of individuals to a given change in price. Elasticity of demand has not previously been factored into the model results because the Updated Sequential plan reforms modeled to this point have not included significant health care consumer price alterations. The first two reform options deal with public programs which have no market price, so the focus has been on take-up rates – the relative propensity of individuals to participate in free (or minimal cost) health insurance.

Conversely, in the voluntary market reform option, the individuals in the VSG market and the YAPs will have to pay for their health insurance. Instead of take-up rates, the SHRP modeling is based on the elasticity of demand for the VSG market and young adult population groups. Research by health economists has traditionally used a base elasticity of demand figure of negative .625 (-.625) for all insured adults and negative .50 (-.50) for the uninsured[37]. What this means is that for every 1% reduction in health insurance costs, demand in that market will increase by .625% (or .50%

when looking at the uninsured). This base elasticity of demand number is then impacted by two factors. First, how much income a person has; and second, how much the cost of insurance changes. Essentially, a change in cost has more impact on someone making less money, all else being equal.

Using the standard elasticity of demand figure and comparing it to the change in rates due to establishing a VSG market makes insurance more affordable for 8,400 previously uninsured sole proprietors (this number includes their entire families). However, that same elasticity of demand figure also says that due to the increased costs associated with the combined market, 2,500 insured small employees (employers with two to ten employees) drop coverage and become uninsured (including families). Overall, the new VSG market results in a net increase in the insured of 5,900 prior to the impact of the reinsurance program (Table 7). The introduction of the reinsurance program allows for an additional 6,000 insured (Table 7).

Costs increase due to the VSG market for self-pay and the State by $46 million and $1 million, respectively (Table 8). While the net cost of establishing the VSG market is an increase of $40 million, costs paid by employers and the federal government decrease $1 million and $6 million, respectively. The costs of the reinsurance component of the VSG market are borne jointly by those health insurance carriers participating in the VSG market, all health insurance carriers in the State of Kansas, and the State. It should be noted that while the health insurance carriers are assessed the cost of the reinsurance, the ultimate costs are borne by policy-holders, as those costs are appropriately passed through as part of the premium development process.

The elasticity of demand for health insurance for young adults is not well known. It is known that younger adults value health care substantially less than older adults. Therefore, we assumed the elasticity of demand for uninsured young adults would be substantially less than that of uninsured older adults. As mentioned, research by health economists has used an elasticity of demand figure of negative .50 (-.50) for uninsured adults. Other research, attempting to build a composite elasticity of demand for private insurance, estimated that the elasticity of demand for private insurance is negative .11 (-.11)[38]. Reviewing this range, negative .50 (-.50) to negative .11 (-.11), our model rounded the lower end of the range and used an elasticity of demand for young adults of negative .10 (-.10). By creating YAPs, the model projects 15,000 previously uninsured adults aged 19 – 24 years old to become insured (Table 9). While it is likely that allowing parents to keep adults through age 25 years on their family insurance plan will result in more young adults staying insured through their parents policies, it was not possible to project the number of these young adults that were previously uninsured or would have been uninsured in the absence of the extension up

Table 7. Targeted Insurance Market Reform for Very Small Groups (VSGs)

Additional People	VSG Net Impact	Reinsurance Impact	Total Newly Insured
Number previously uninsured	5,900 insured	6,000 insured	Approximately 11,000 adults and 1,000 kids

Table 8. Costs of Targeted Insurance Market Reform for Very Small Groups

Payer	Paid by Employer	Paid by Self	Paid by State Government	Paid by Federal Government	Net Cost of Reform
Change	($1 million)	$46 million	$1 million	($6 million)	$40 million

through age 25.

When enrolling these young adults, the federal government ends up paying substantially less than when they were uninsured (Table 10). The net impact of the YAPs is a decrease in costs of $2 million, based on an increase in costs paid by self of $7 million and a decrease in costs to the federal government of $9 million. The new cost is borne by the individual from purchasing the insurance and paying for it without any State subsidy or employer assistance.

As the newly established voluntary insurance clearinghouse is expected to act only as a resource for encouraging small employers to offer health insurance and Section 125 plans, we have not included any population or costs impacts due to the insurance clearinghouse.

Issues

During the numerous discussions with the KHPA Board surrounding potential insurance market reforms, the concept of "Do No Harm" was introduced. In the context of health insurance market reform, "Do No Harm" conveyed the KHPA Board's desire to ensure that the market reforms being considered would only improve the workings of the admittedly complex health insurance market. The KHPA Board was very cognizant of the potential to unintentionally skew this incredibly complex market for or against a particular population or product, thereby, causing an unintended exodus of covered lives or insurers. This is not an idle concern, as borne out by the experience in several states, most clearly in Kentucky, and its brief but unsuccessful foray into individual insurance market reform[39]. To ensure the reforms "Do No Harm," substantial review of Kansas insurance law will need to take place to ensure a level playing field exists in the context of the new markets proposed here for VSGs and YAPs. Due to the complex and inter-related nature of the health insurance market, equally as important is the need to consider the proposed reforms in the context of the larger health insurance market in Kansas.

In addition, while we include a retrospective high-cost reinsurance program in our model, as mentioned earlier, a wide range of options exist. Policy and funding for the reinsurance program will need to be developed.

While beyond the scope of this analysis, there is a growing body of evidence supporting the concept of a positive economic impact associated with insurance market reform. Health economists employing micro-simulation models to examine the impact of statewide health care reform initiatives in several states, including Missouri[40] and Connecticut[41], have found making insurance more affordable has a positive impact on the economy in terms of additional dollars available from employers for wages and from employees and individuals for discretionary spending. The concept of health insurance market reform as a positive economic engine, such as the insurance market reform targeting the small employer market in the Updated Sequential plan, should be included in further deliberations and analysis on health insurance reform in Kansas.

Table 9. Target Insurance Market Reform for Young Adults

Additional Young Adults	Newly Insured
Number previously uninsured	15,000

Table 10. Costs of Targeted Insurance Market Reform for Young Adults

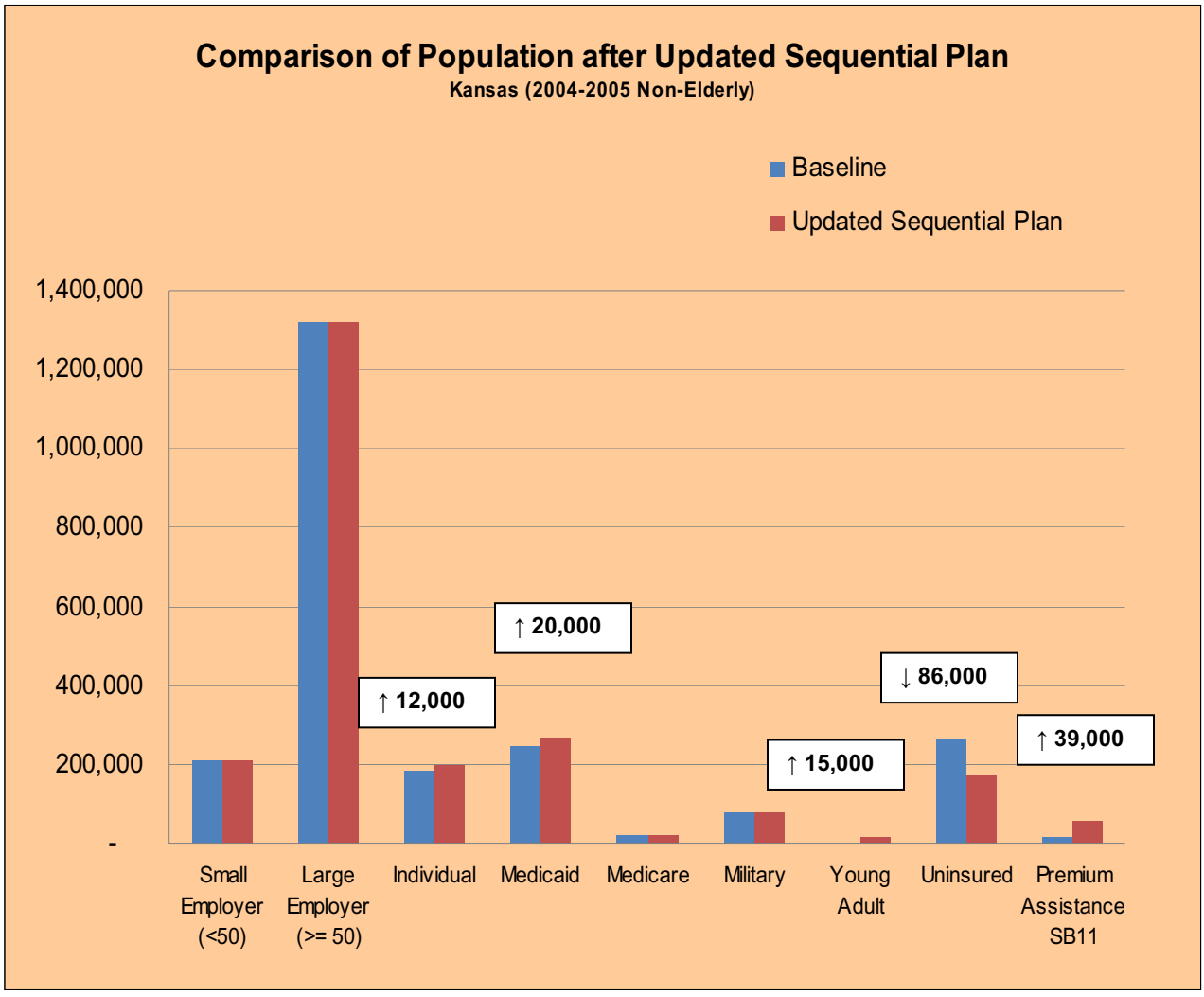
Payer	Paid by Self	Paid by Federal Government	Net Cost of Reform
Change	$7 million	($9 million)	($2 million)

Summary of Coverage and Funding Changes

The individual components of the Updated Sequential Option, as fully implemented, each decrease the number of Kansans without health care insurance. Modeling results indicate the total effect of the Updated Sequential plan is a 33% decrease in the number of uninsured Kansans (non-elderly). The number of uninsured Kansans drops from 260,000 to 174,000 (Figure 11). Because the Updated Sequential initiatives target different segments of the uninsured population through different market links, the results of the three components are essentially additive. The 86,000 newly covered Kansans are the result of each of the individual components:

- 20,000 more children becoming insured through public program outreach,
- 39,000 more childless adults becoming insured through a SB 11 expansion,
- 12,000 more sole proprietors becoming insured through the market combination and reinsurance efforts, end
- 15,000 more young adults being insured due to new products being offered at the Insurance Clearinghouse.

Figure 11. Changes in Population under the Updated Sequential Plan



The cumulative additional cost of the insurance for the newly covered population is $145 million (Table 11 and Figure 12). Again, this is the additive result of implementing the individual Updated Sequential plan reform components. The cost per initiative breakdown is shown in Table 11.

These costs reflect the additional costs of insuring the population and do not include additional administrative costs that might be necessary to implement the reforms (i.e., getting the insurance clearinghouse up and running). The cost for this additional insurance is projected to be borne by individuals (7%), the State (49%), and federal governments (45%), with a small decrease in costs to employers negative 1% (-1%).

Conclusions

Statewide health insurance reform is a complex and ambitious undertaking. Kansas is no exception, and any health insurance reform enacted will inevitably result in a series of trade-offs that balance the practical realities of the current health care, political, and economic environments in Kansas with reform goals. The KHPA Board was charged with making a recommendation on a health insurance reform option that thoughtfully considered this balance, and ultimately increased Kansans access to affordable health care coverage. After substantial discussion, debate, deliberation, and

Figure 12. Changes in Expenditures under the Updated Sequential Plan

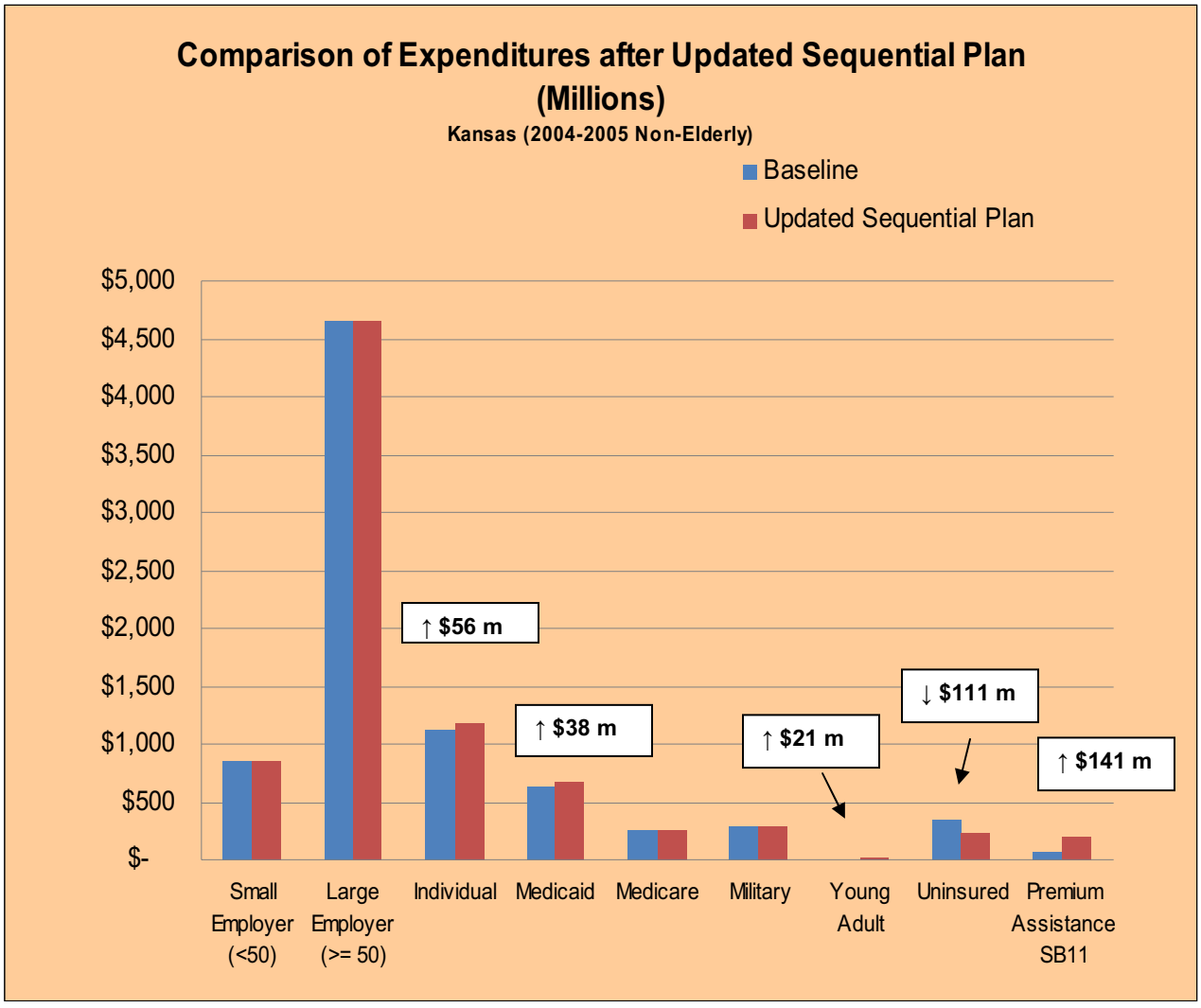


Table 11. Summary of Net Cost by Payer of Updated Sequential Option by Initiative

	Paid by Employer	Paid by Self	Paid by State Government	Paid by Federal Government*	Net Cost of Reform
Targeted Outreach	-.-	- $9 million	+ $14 million	+ $17 million	+ $22 million
SB 11 Expansion	-.-	- $34 million	+ $56 million	+ $63 million	+ $85 million
Clearing House – VSG	- $1 million	$46 million	+ $1 million	- $6 million	+ $40 million
Clearing House – YAP	-.-	$7 million	-.-	- $9 million	- $2 million
Total Costs for Updated Sequential	- $1 million	$10 million	+ $71 million	+ $65 million	+ $145 million

**Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in federal expenditures. Practically, however, at the program level, the State will not change the State's Disproportionate Share Hospital reimbursement methodology.*

modeling, the KHPA Board endorses a reform option that is a combination of the original five options considered. Known as the Updated Sequential Option, the KHPA Board believes this option represents the most feasible first step to get Kansas on the road to health insurance reform.

From a practical perspective, the Proposed Reforms:

- Are Voluntary and Targeted – The feedback from the Listening Tour, the Steering Committee, the Advisory Councils, and public comment was that Kansas was not ready for mandatory health insurance, but instead needs reforms targeted at populations that have struggled accessing affordable health insurance. The Updated Sequential Option delivers targeted assistance.
- Have a Positive Impact Now – The individual initiatives with the Updated Sequential model represent a strong first step on the road to reform, covering one-third of Kansans previously uninsured.
- Have Relatively Few Implementation Barriers/ Issues – Without attempting to minimize the barriers or issues, the Updated Sequential plan had relatively fewer issues than more ambitious reforms originally considered but ultimately dismissed. Given this, barriers that remain include:
  - Funding for additional $71 million in State funds required;
  - Federal approval for changes;
  - State approval for changes, although unanimous passage of SB 11 is a good sign of the legislative will for reform; and
  - Administrative costs that have yet to be determined.

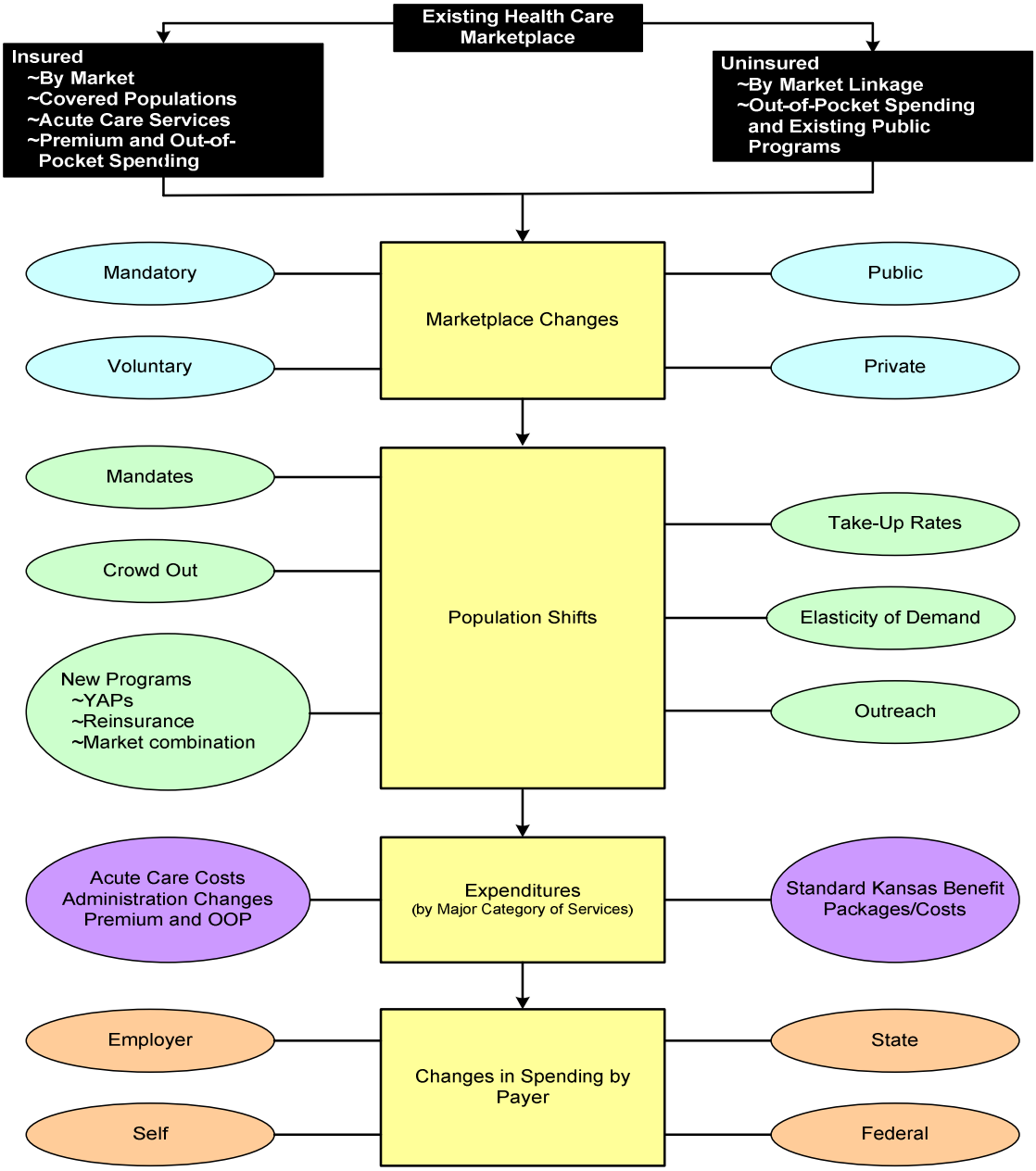
The KHPA Board recognizes and anticipates that additional reform efforts will be necessary to more completely address the issue of access to affordable health care coverage for all Kansans.

Appendix A

State Health Reform Projection (SHRP) Model – The flowchart below lays out the variables included in our model to price out health insurance reform options.

Kansas SHRP Model
Flow Chart of Variables

Flow Chart of the srHS State Health Reform Projection (SHRP) Model



Appendix B
Five Original Health Insurance Reform Plan Options

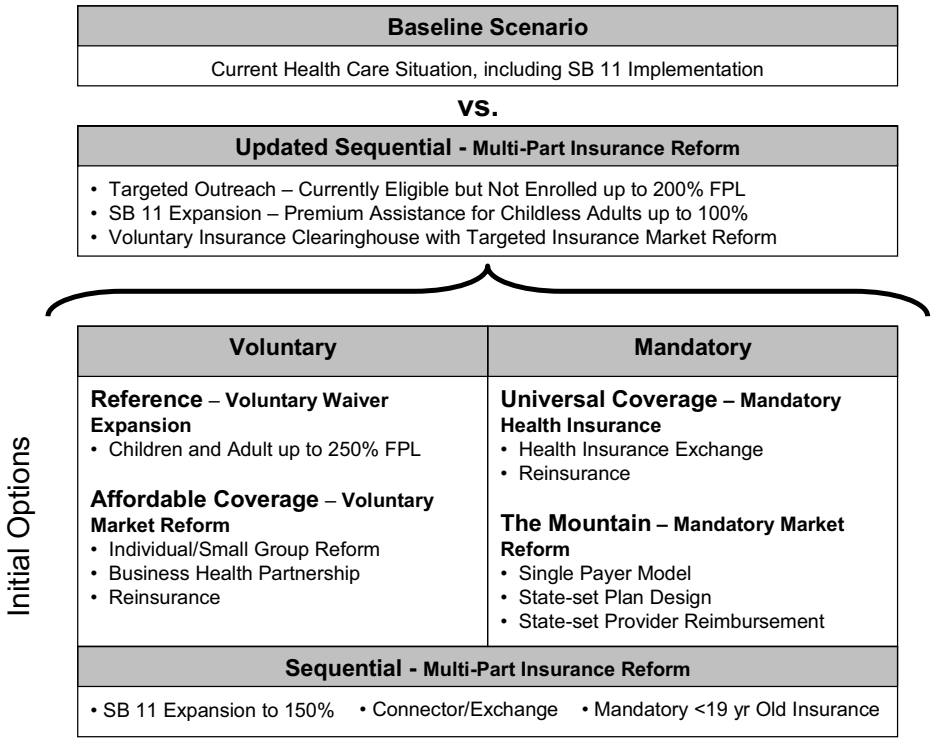
B1 Descriptions and Results of Five Original Health Insurance Reform Plan Options

During the process of developing the Updated Sequential Option presented in the main body of this report, five separate options were preliminarily modeled for the KHPA Board using srHS's State Health Reform Projection (SHRP) model. The five reforms cut across the participation spectrum (voluntary to mandatory) as well as the access mechanism (public to private) to allow for maximum consideration, debate and deliberation in reform option development. Those five original options included:

1) Reference Option – voluntary public program expansion,
2) Affordable Coverage Option – market-based reform through an insurance clearinghouse,
3) Universal Coverage Option – mandatory insurance with individual and employer mandates,
4) The Mountain (single-payer) Option – mandatory insurance coverage, and
5) Sequential Option – combined option using portions of the previous voluntary and mandatory options.

The five original reform options can be considered the building blocks for the Updated Sequential Option. This appendix will provide detail on the five original options.

Figure B1 – Evolution of the Updated Sequential Option (Reproduced from Part I. Introduction)



1. Reference Option – Voluntary Public Program Expansion

The Reference Option is a voluntary expansion of public programs to cover children and adults, regardless of family status up to 250% FPL ($48,375 annually for a family of four in 2005) (Figure B1-1.1). Expansion would be achieved through creation of a State plan amendment and/or a federal waiver. Administration and delivery would piggyback on the current system with benefits matching current Medicaid or HealthWave levels and utilizing the same delivery network. Issues for the Reference Option include:

- obtaining a federal waiver so expansion costs can be shared between the State and federal governments, and
- crowd-out among some portion of this population – that is having a portion of the population choose to forgo private insurance and opt for public coverage.

After full implementation (as compared to the Baseline), the Reference Option would cover an additional 255,000 individuals through Medicaid (Figure B1-1.2) – 144,000 of those would be previously uninsured individuals, while there would be a crowd-out of 81,000 from large employer health coverage, 13,000 from small employer coverage and 17,000 from individual policies.

Costs for the Reference Option would be borne by the federal government at $412 million, and the State at $306 million, while large and small employers and self-paid expenditures would experience a decrease in expenditures of $241 million and $186 million, respectively (Figure B1-1.3 and Table B1-1.4).

Figure B1-1.1 Summary of the Reference Option

Reference (Voluntary)

Major Differentiator

- Waiver Expansion: Expand Public Programs up to 250% FPL – Children/Adults & Childless Adults

STRUCTURE

1. Waiver Expansion:
   - Create SPA and/or Waiver for CMS approval and Federal $'s

POLICY DECISIONS

1. Program Design:
   - Expand Public Programs
2. Benefits:
   - Medicaid Benefit Package
3. Service Delivery Network:
   - Medicaid Managed Care Program

ISSUES

- State Match & Vehicle
- Federal Approval
- Crowd-Out

Figure B1-1.2 Population Changes in Reference Option

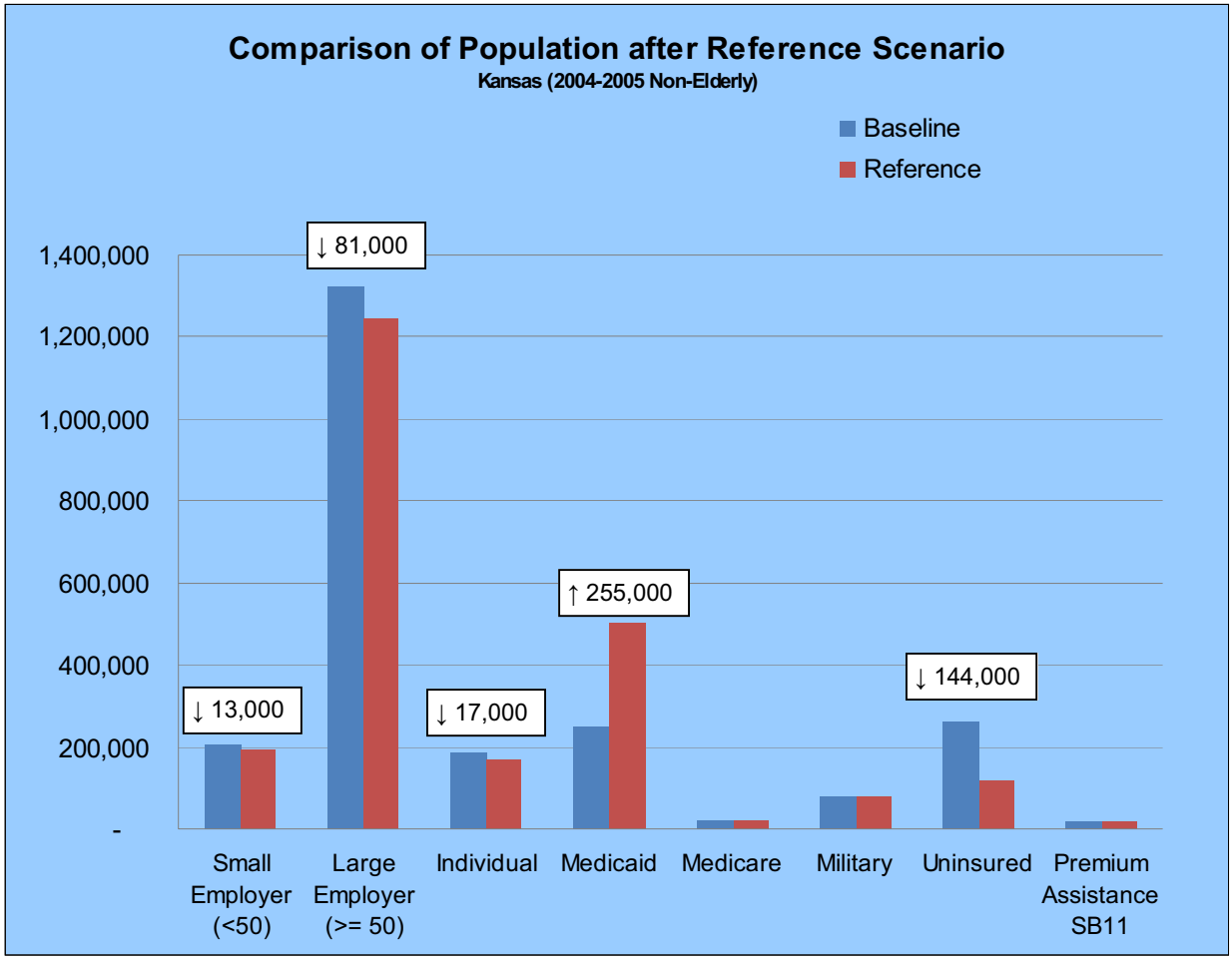


Figure B1-1.3 Expenditures Changes in Reference Option

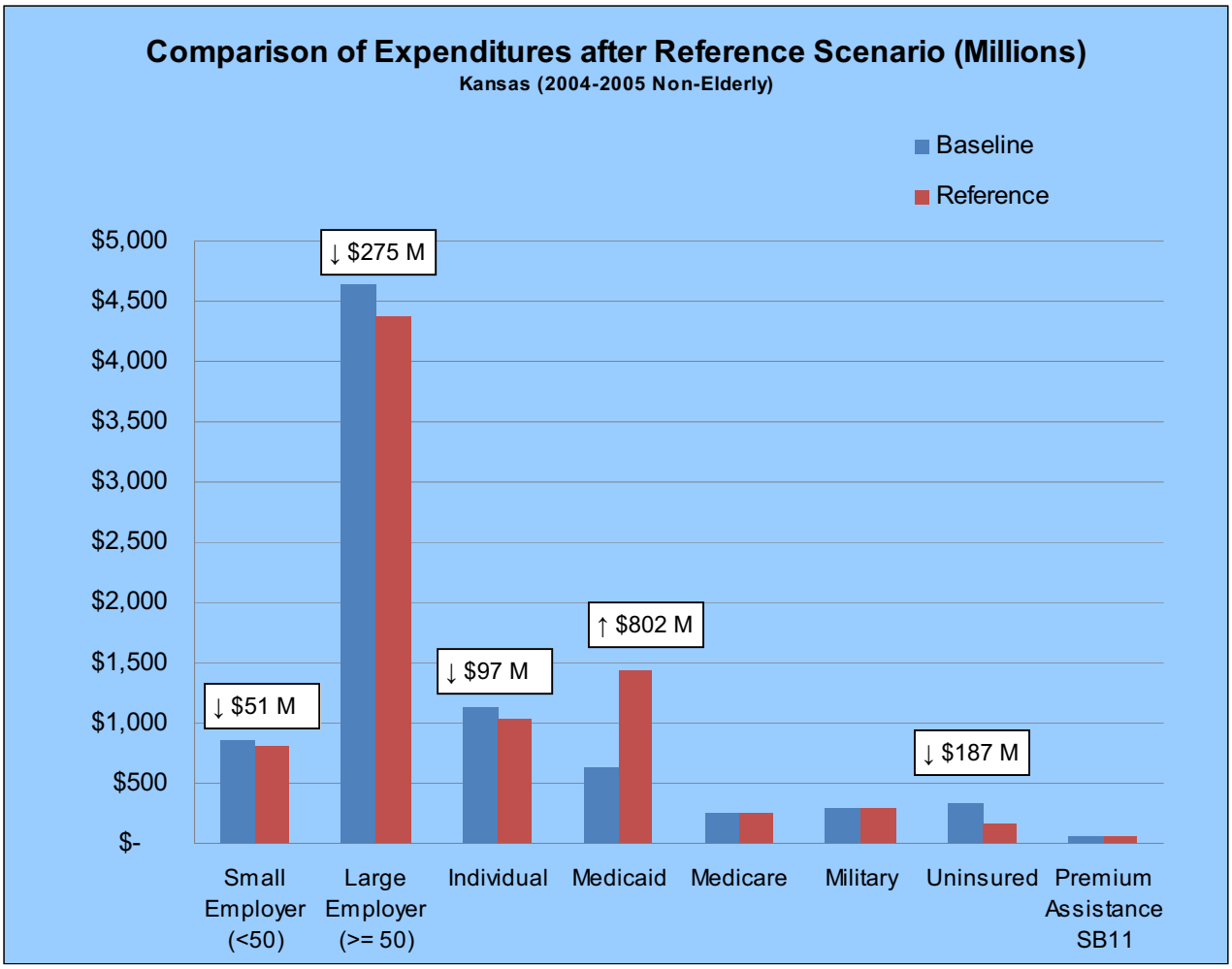


Table B1-1.4 Reference Reform Plan Net Savers and Net Payers

	Net Savers		Net Payers	
Reference	Employer	- $241 million	Federal	+ $412 million
	Self	- $186 million	State	+ $306 million

2. Affordable Coverage Option – Voluntary Market-Based Reform through an Insurance Clearinghouse

The Affordable Coverage option is a voluntary individual and small group market reform (Figure B1-2.1). It would merge the individual and small group markets. It would require:

- community rating and guarantee issue to ensure uniform coverage access,
- access to Section 125 to open up tax benefits for offering insurance to more companies, and
- moderation of risk from any single policy or policyholder through public subsidization of a reinsurance program.

Additionally, the option creates an insurance clearinghouse for the combined market to provide review and approval of products and provide assistance to employers seeking Section 125 tax benefits.

This reform would require several changes to law, new administrative structures, and financing mechanisms. Kansas law would need to be changed to accommodate the merge of the markets, the rating changes, and access to tax benefits. Health insurance carriers would need to offer desirable products for this market. The insurance clearinghouse would need to be created and empowered working with small business market leadership in the State. Not only would the new insurance clearinghouse need ongoing funding, but a reinsurance program would need to be developed.

The issues facing this option match to the reform requirements:

- changing Kansas insurance law;
- combining the market will lead to issues of product variation/selection versus providing a level playing field by mandating/controlling coverage;
- establishing the insurance clearinghouse, including the role and authority; and
- funding both the reinsurance program and the insurance clearinghouse.

After full implementation (as compared to the Baseline), the Affordable Coverage option would cover an additional 50,000 individuals through coverage offered by small employers and purchased individually by sole proprietors (Figure B1-2.2). All of the 50,000 individuals would have previously been uninsured.

Insurance costs for the Affordable Coverage option would be borne by self-paid expenditures at $134 million and the State at $93 million. The federal government and large and small expenditures would see decreases in their expenditures as a result of implementing the Affordable Coverage option of $24 million and $6 million, respectively (Figure B1-2.3 and Table B1-2.4).

Figure B1-2.1 Summary of Affordable Coverage Option

Affordable Coverage (Voluntary)

Major Differentiator

- Individual/Small Group Market Reform – Merge & Subsidize w/ Reinsurance Merged Market <250% FPL

STRUCTURE

1. Merge Individual/Small Group Markets:
   - Require Community Rating and Guaranteed Issue
   - Require access to Section 125
   - Add Subsidized Reinsurance Program to Spread Risk
2. Market Clearinghouse – Business Health Partnership (BHP) for Combined Market:
   - Provide Seal of Approval to Products
   - Provide Section 125 Assistance

POLICY DECISIONS

1. Program Design – Market Driven Reform:
   - Change Kansas Insurance Law
   - Require Section 125 for All Employers
   - Establish Reinsurance Program
   - Determine Reinsurance Funding
   - Determine State Subsidy for those with Income below 250% FPL
   - Empower Business Health Partnership as Clearinghouse

ISSUES

- KS Insurance Law
- Combined Market – Selection v. Level-Playing Field
- Role/Authority of BHP

Figure B1-2.2 Population Changes in Affordable Coverage Option

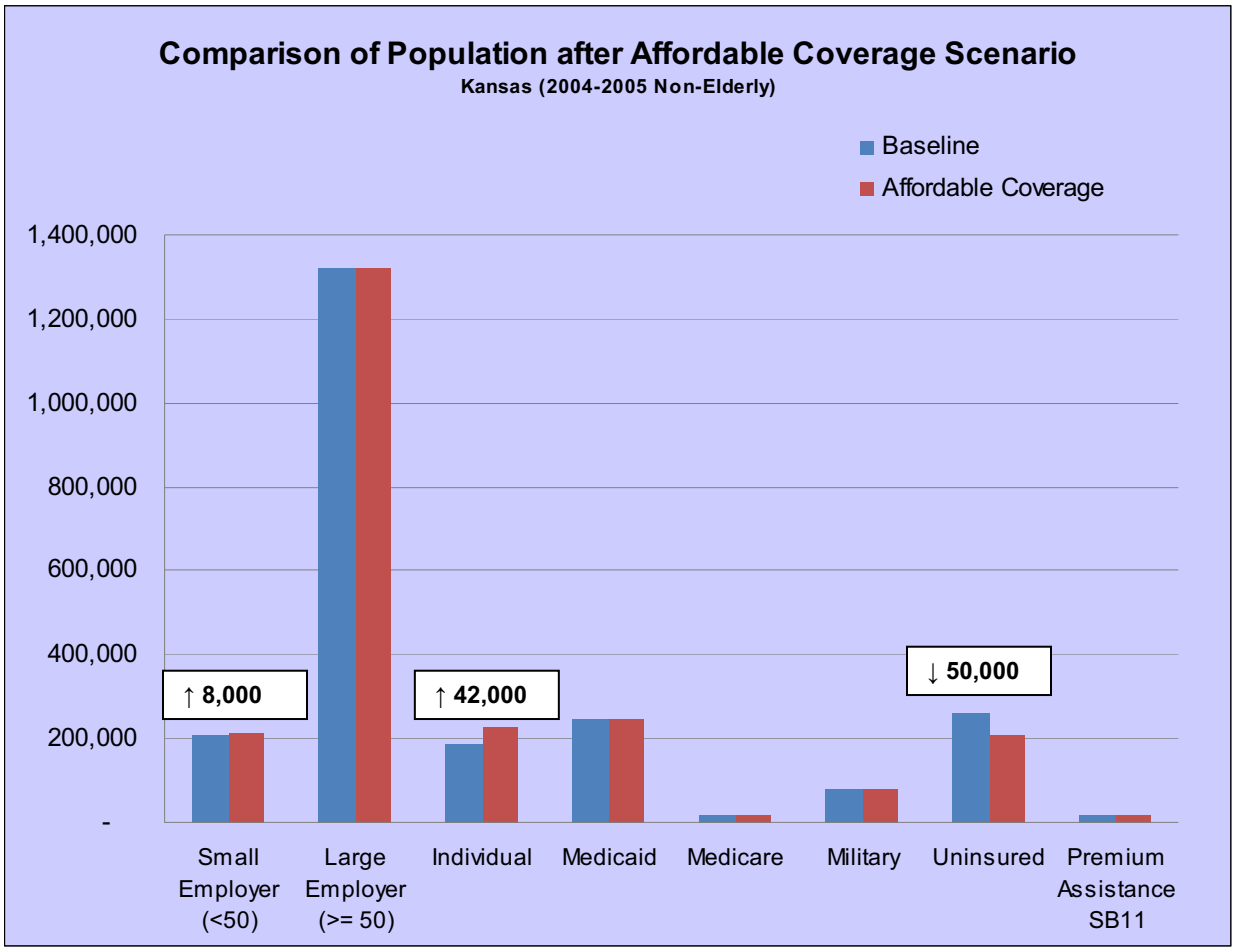


Figure B1-2.3 Expenditure Changes in Affordable Coverage Option

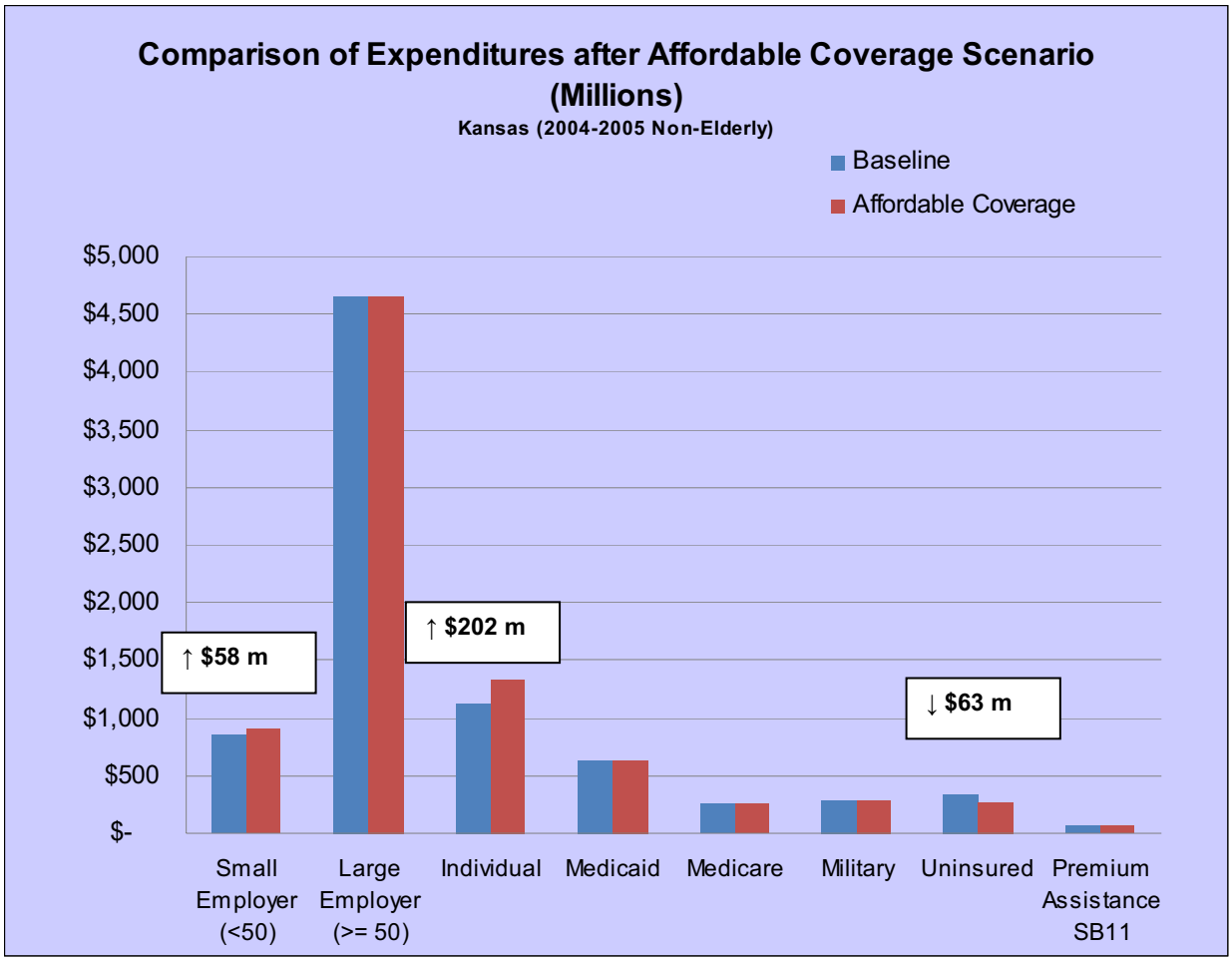


Table B1-2.4 Affordable Coverage Reform Plan Net Savers and Net Payers

	Net Savers		Net Payers	
Affordable Coverage	Federal	- $24 million	Self	+ $134 million
	Employer	- $6 million	State	+ $93 million

3. Universal Coverage Option – Mandatory Coverage with Individual and Employer Mandates

The Universal Coverage Option is a mandatory health insurance reform through individual and employer mandates (Figure B1-3.1). It would establish a pay-or-play mandate for all Kansans. It would require:

- all individuals to have, and all employers to offer, health insurance;
- access to Section 125 to open up tax benefits for offering insurance to more companies; and
- moderation of risk from any single policy or policyholder through public subsidization of a reinsurance program.

The option would be built on the existing employer/carrier marketplace with an added infrastructure to establish and maintain an insurance mandate provide assistance to employers seeking Section 125 tax benefits.

This reform would require several changes to law. Kansas law would need to be changed to accommodate the individual and employer insurance mandate, set pay-or-play standards, establish affordability and minimum coverage standards, and an exemption process. A reinsurance program would need to be developed and the amount of subsidization of the low-income for the individual and small group markets established.

The issues facing this option match to the reform requirements:

- establishing and enforcing an individual and employer mandate;
- addressing any concerns from federal law and ERISA; and
- KHPA setting the various enforcement provisions, such as pay-or-play amounts, minimum creditable coverage, and affordability standards.

After full implementation (as compared to the Baseline), the Universal Coverage Option would cover an additional 247,000 previously uninsured individuals and 66,000 individuals previously insured in the individual market would shift to large and small employer-sponsored coverage. Small employer coverage would increase 99,000, large employer coverage would increase 164,000, Medicaid coverage would increase 46,000, and Premium Assistance SB 11 would increase 4,000 (Figure B1-3.2). The Universal Coverage Option would effectively eliminate uninsurance in Kansas.

Insurance costs for the Universal Coverage Option would be borne primarily by large and small employers, which would experience an increase of $608 million, with the State experiencing an increase of $167 million in health care expenditures. Self-paid expenditures and the federal government would see a decrease in expenditures if the Universal Coverage Option were implemented of $217 million and $61 million, respectively (Figure B1-3.3 and Table B1-3.4).

Figure B1-3.1 Summary of Universal Coverage Option

Universal Coverage (Mandatory)

Major Differentiator

- Mandate on Individuals and Employers for Health Insurance – Pay or Play Mandate for All Kansans

STRUCTURE

1. Existing Employer/Carrier Model:
   - Mandate Individuals to Have and Employers to Offer Health Insurance
   - Require Section 125 through all Employers
   - Add Subsidized Reinsurance with Funds from Combined Carriers and State
2. Compliance/Exemption Process:
   - Affordability Set at 10% of Income
   - Enforcement for Non-Compliance
   - Establish Religious Exemptions
   - Establish Income/Age Exemptions

POLICY DECISIONS

1. Program Design – Market Driven Reform:
   - Establish and Enforce Individual and Employer Mandate
   - Change Kansas Insurance Law
   - Set Pay or Play Standards and Enforcement for Individuals and Businesses
   - Set Minimum Coverage Standards
   - Set Exemption Process
   - Establish Reinsurance
   - Determine Reinsurance Funding
   - Subsidize Individual/Small Group < 250% FPL

ISSUES

- Achieving a Mandate
- ERISA and Federal Law
- KHPA – Pay or Play Provisions

Figure B1-3.2 Population Changes in Universal Coverage Option

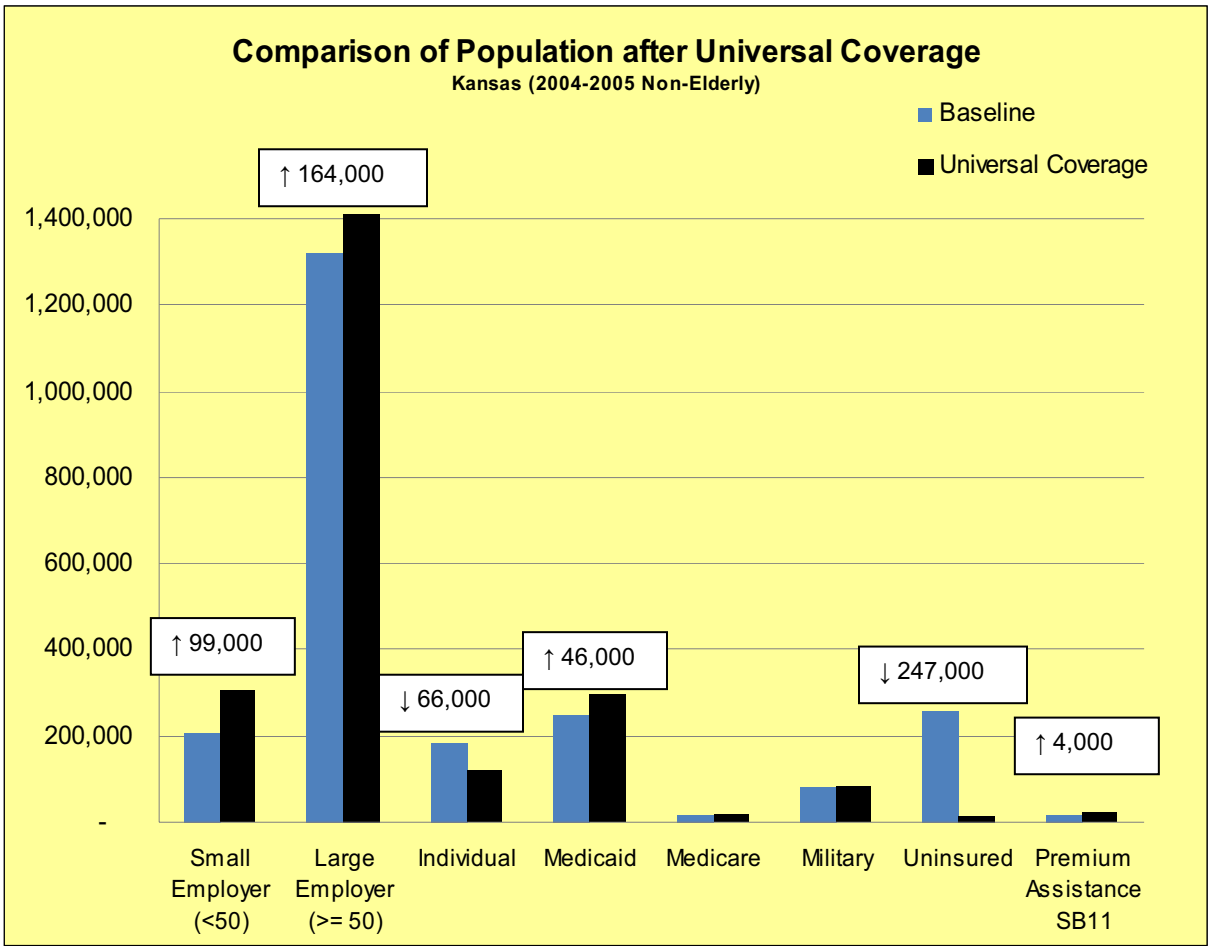


Figure B1-3.3 Expenditure Changes in Universal Coverage Option

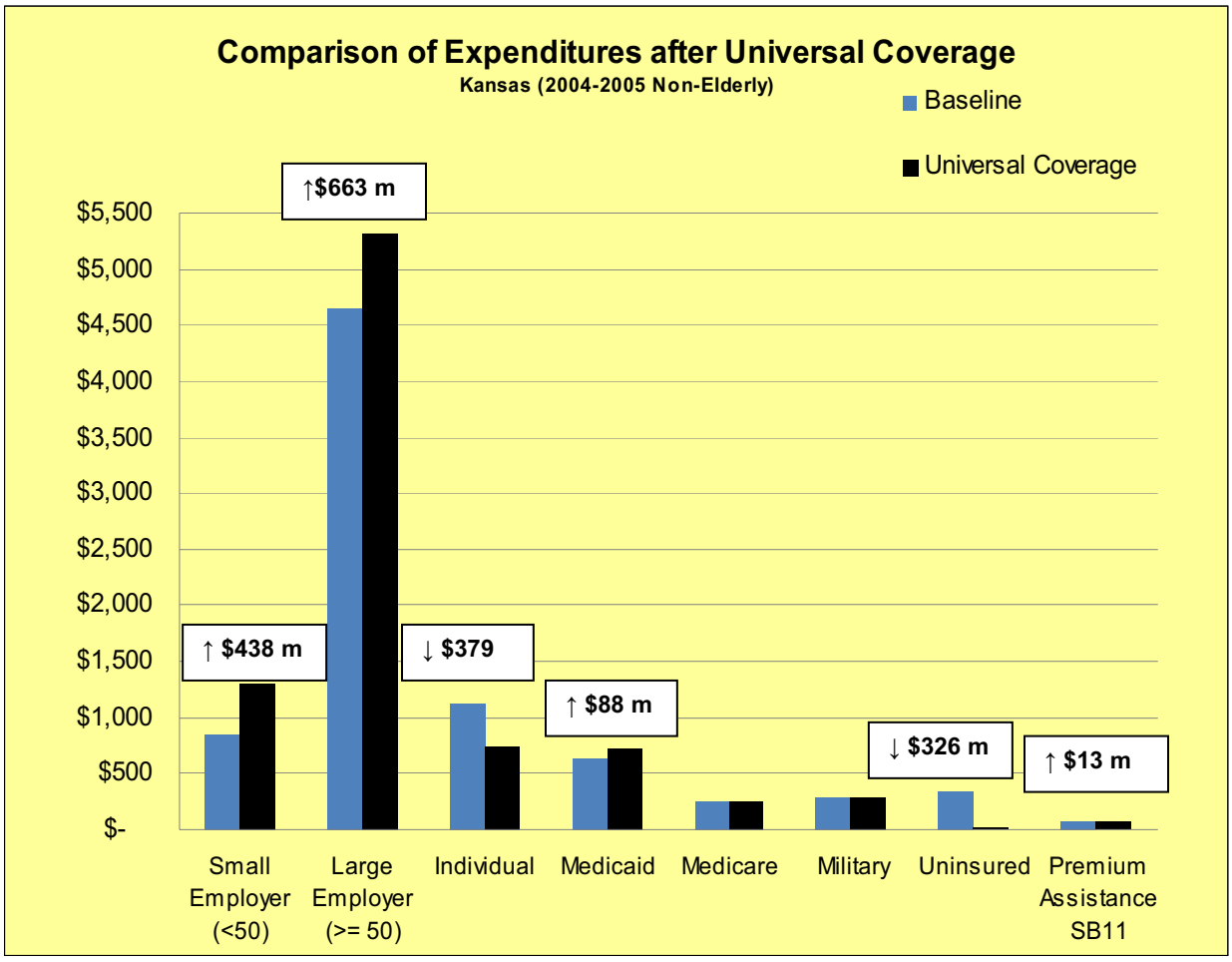


Table B1-3.4. Universal Coverage Reform Plan Net Savers and Net Payers

	Net Savers		Net Payers	
Universal	Self	- $217 million	Employer	+ $608 million
	Federal	- $61 million	State	+ $167 million

4. The Mountain (Single Payer Option) – Mandatory Health Insurance Coverage

The Mountain (Single Payer) Option requires all Kansans receive health insurance through the Kansas Health Insurance Program, a newly established statewide health insurance program responsible for all health insurance in Kansas (Figure B1-4.1). It would create a single payer for all health insurance in Kansas. It would require:

- community rating and guarantee issue to ensure uniform coverage access;
- establishing a compliance/exemption process with affordability set at 10% of income; and
- creation of State-controlled benefit package and reimbursement schedule.

This reform would require a sweeping overhaul to Kansas insurance law, an entirely new health care infrastructure and a new financing mechanism. Kansas law would need to be changed to accommodate the single payer market, the rating changes, and access to tax benefits. The single payer infrastructure would need to be created and empowered to redesign the entire health care marketplace in Kansas. As the single payer would contract directly with providers to achieve administrative savings, insurance carriers would be eliminated. Not only would the new insurance infrastructure need ongoing funding, but it would also need to capture any existing funding sources.

The issues facing this option match to the reform requirements:

- establishing an individual mandate;
- overcoming potential challenges to the single payer programs under ERISA and federal law; and
- State control of the benefits package and reimbursement schedule.

After full implementation (as compared to the Baseline), The Mountain Option would cover an additional 247,000 previously uninsured individuals, and 65,000 individuals previously insured in the individual market would shift to large and small employer-sponsored coverage. Small employer coverage would increase 99,000, large employer coverage would increase 164,000, Medicaid coverage would increase 45,000, and Premium Assistance SB 11 would increase 4,000 (Figure B1-4.2). The Mountain would effectively eliminate uninsurance in Kansas.

Overall insurance costs for the State actually go down as a result of implementing The Mountain Option's single payer reform plan. The State would experience an increase in insurance costs for The Mountain of $227 million, with large and small employers experiencing a slight increase of $66 million in health care expenditures. The primary benefactor of The Mountain is self-paid expenditures, which experience a decrease of $995 million. The federal government also would see a decrease in expenditures if The Mountain option were implemented of $157 million (Figure B1-4.3 and Table B1-4.4).

Figure B1-4.1 Summary of The Mountain

The Mountain (Mandatory) – Single Payer

Major Differentiator

- Single Payer – All Kansans must receive Health Insurance through the Kansas Health Insurance Program

STRUCTURE

1. Market Maker – Single Payer:
   - Single Combined Health Care Market for All Kansans
   - Require Community Rating
   - Require Guaranteed Issue
   - Capture Existing Funding Sources
2. Compliance/Exemption Process:
   - Affordability Set at 10% of Income
   - Enforcement for Non-Compliance
   - Establish Religious Exemptions
   - Establish Income/Age Exemptions

POLICY DECISIONS

1. Program Design – State Driven Reform:
   - Establish Individual Mandate
   - Change Kansas Insurance Law
   - Elimination of Carriers
   - State-Controlled Benefits
   - State-Controlled Reimbursement
   - Set Pay or Play Standards and Enforcement for Individuals
   - Set Exemption Process
   - Subsidize Individuals < 250% FPL
   - Amount of Program Administrative and Provider Administrative Savings

ISSUES

- Achieving a Mandate
- ERISA and Federal Law
- State-Controlled Health Care Market

Figure B1-4.2 Population Changes in The Mountain Option

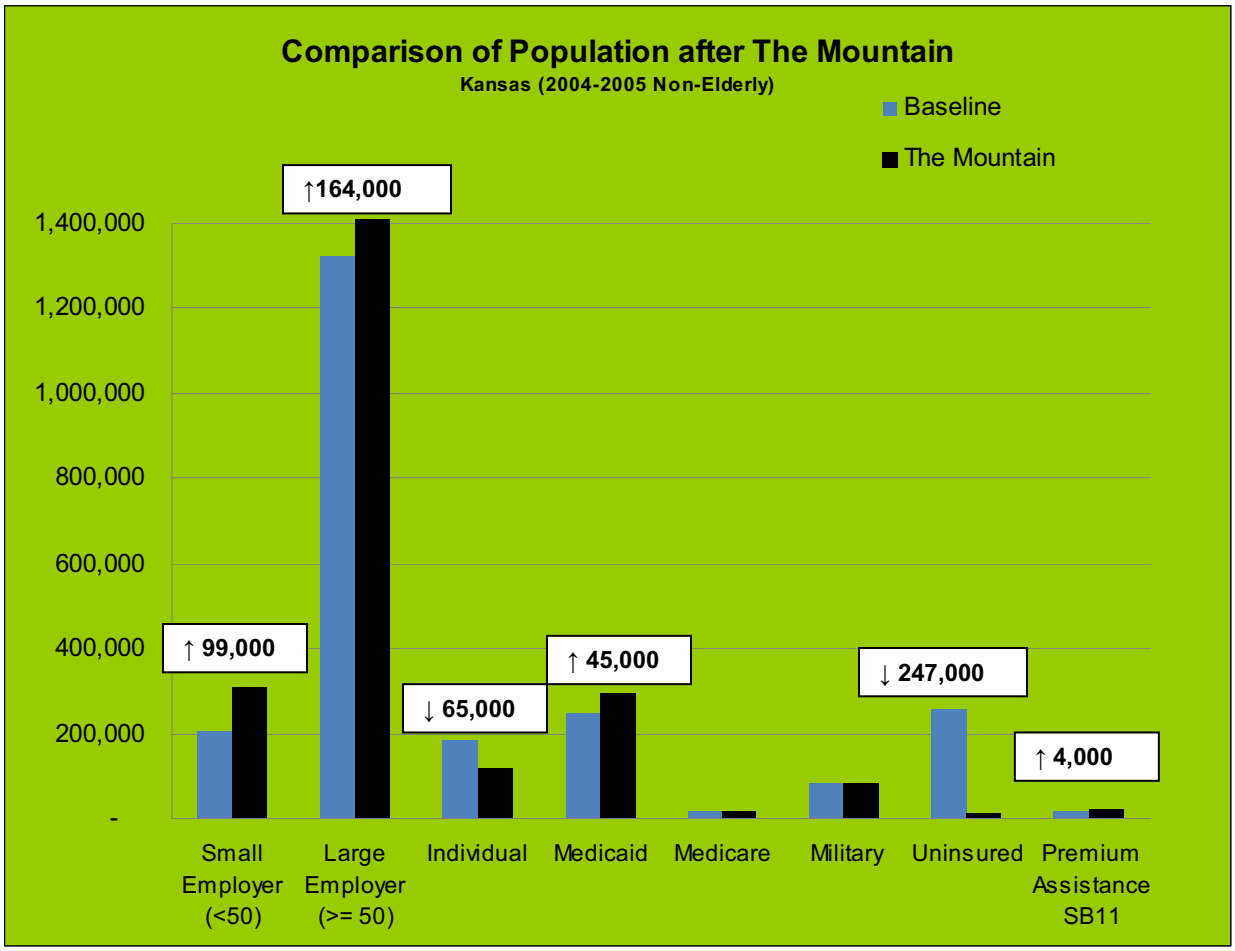


Figure B1-4.3 Expenditure Changes in The Mountain Option

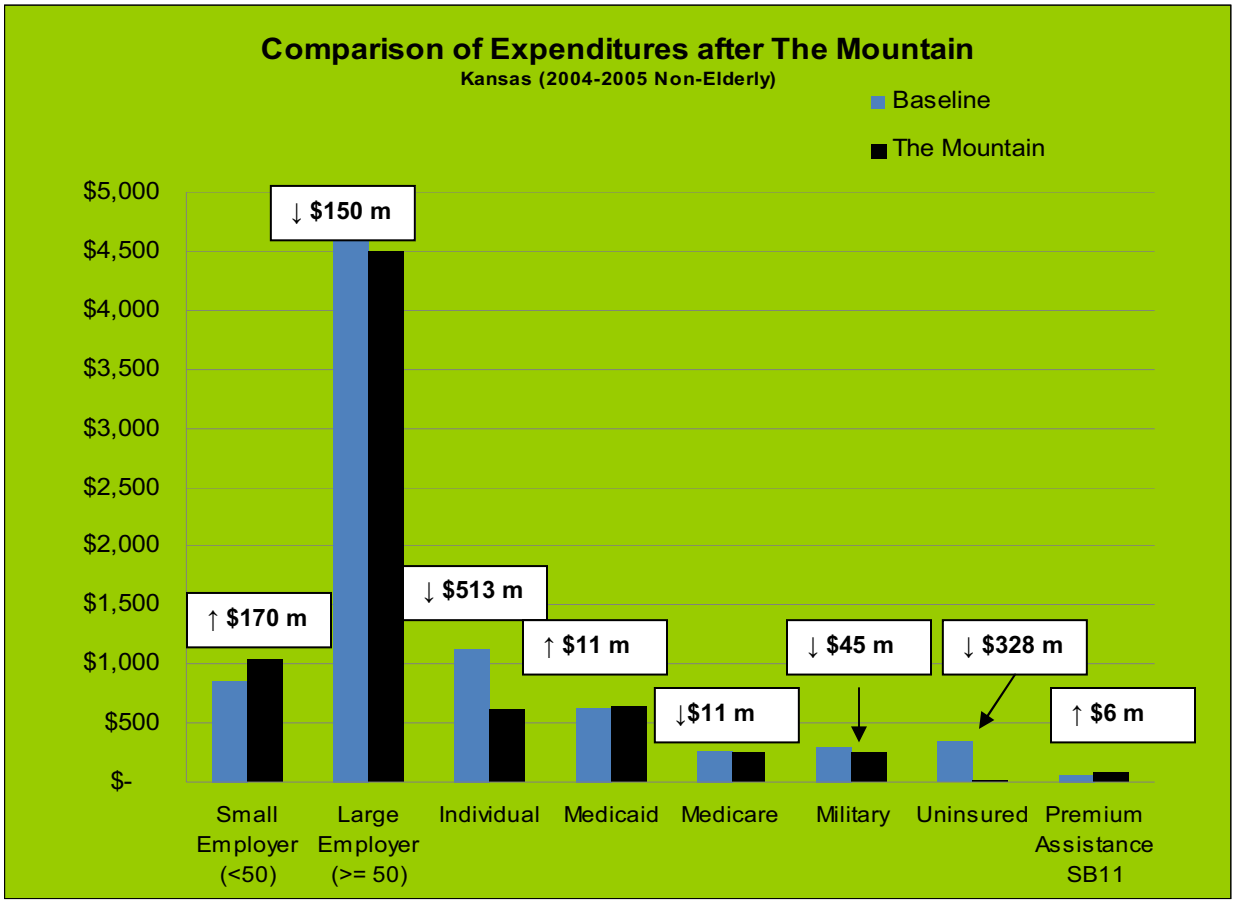


Table B1-4.4 The Mountain Reform Plan Net Savers and Net Payers

	Net Savers		Net Payers	
Mountain	Self	- $995 million	State	+ $227 million
	Federal	- $157 million	Employer	+ $66 million

5. Sequential Option – Combine Voluntary and Mandatory Coverage

The Sequential Option is a three-part health insurance reform option with both voluntary and mandatory components (Figure B1-5.1). It would require:

- mandatory insurance for children up to age 19 years old;
- expanding SB 11 Premium Assistance up to 150% for childless adults; and
- creation of a connector/exchange, modeled after the Business Health Partnership to be an insurance clearinghouse.

The children's mandate would be enforced by requiring all children to show proof of insurance prior to enrolling in school. The connector/exchange would have several components; require all employers provide access to Section 125 plans, and combine the sole proprietors and small group markets into a single market that spreads the risk through a subsidized reinsurance program. The connector/exchange would be given the authority to provide a seal of approval for products and negotiate for competitive rates for those products. To ensure the products offered by the connector/exchange would not compete with or cannibalize existing insurance products, the products would have a mandatory go-bare provision of at least six months (employers would have to demonstrate that they have not had health insurance for the last six months).

This reform would require several changes to law, new administrative structures and financing mechanisms. Kansas law would need to be changed to create an insurance mandate for children, accommodate the merger of the sole proprietor and small employer markets, the rating changes, and access to tax benefits. Health insurance carriers would need to design products that meet the connector/exchange's seal of approval. The insurance clearinghouse would need to be created and empowered working with small business market leadership in the State. Not only would the new connector/exchange insurance clearinghouse need ongoing funding, but a reinsurance program would need to be developed and funded.

The issues facing this option match to the reform requirements:

- creating and enforcing a children's health insurance mandate, including affordability and coverage standards;
- combining the sole proprietor and small employer markets will lead to issues of product variation/ selection versus providing a level playing field by mandating/controlling coverage;
- establishing the insurance clearinghouse, including the role and authority;
- funding both the reinsurance program and the insurance clearinghouse; and
- finding an appropriate vehicle to expand the SB 11 Premium Assistance program.

After full implementation (as compared to the Baseline), the Sequential Option would cover an additional 49,000 children, an additional 70,000 individuals through the SB 11 expansion, and 37,000 individuals through coverage offered by small employers and purchased individually by sole proprietors (Figure B1-5.2). The uninsured would drop by 156,000.

Insurance costs for the Sequential Option increase for all the payers. The costs are borne by the State, federal government, employers, and self-paid at $176 million, $121 million, $46 million, and $2 million, respectively (Figure B1-5.3 and Table B1-5.4).

Figure B1-5.1 Summary of Sequential Option

Sequential (Mandatory & Voluntary)

Major Differentiator

- 3 Part Health Insurance Reform – Mandatory for Children, Expand SB11, and Connector/Exchange

STRUCTURE

1. Mandatory Health Insurance for Children:
   - To enroll in School, Children < 19 yrs old must show proof of insurance
2. Expand SB 11 to 150% FPL
3. Market Clearinghouse – Business Health Partnership for Small Group Market:
   - Allow Sole Prop's and Small Group
   - Require access to Section 125
   - Add Subsidized Reinsurance Program to Spread Risk for combined market
   - Provide Seal of Approval to Products
   - Maintain Go Bare Provision

POLICY DECISIONS

1. Program Design – Market Driven Reform:
   - Establish and Enforce Mandate on Children's Health Insurance
   - Expand SCHIP to 250% FPL
   - Expand SB11 to 150%
   - Affordability & Coverage Standards
   - Change Kansas Insurance Laws
   - Establish Reinsurance Program
   - Determine Reinsurance Funding
   - Subsidize Small Group/Sole Props < 250% FPL
   - Require Section 125

ISSUES

- Children's Mandate
- Combined Market – Selection v. Level-Playing Field
- State Match/Vehicle

Figure B1-5.2 Population Changes in Sequential Option

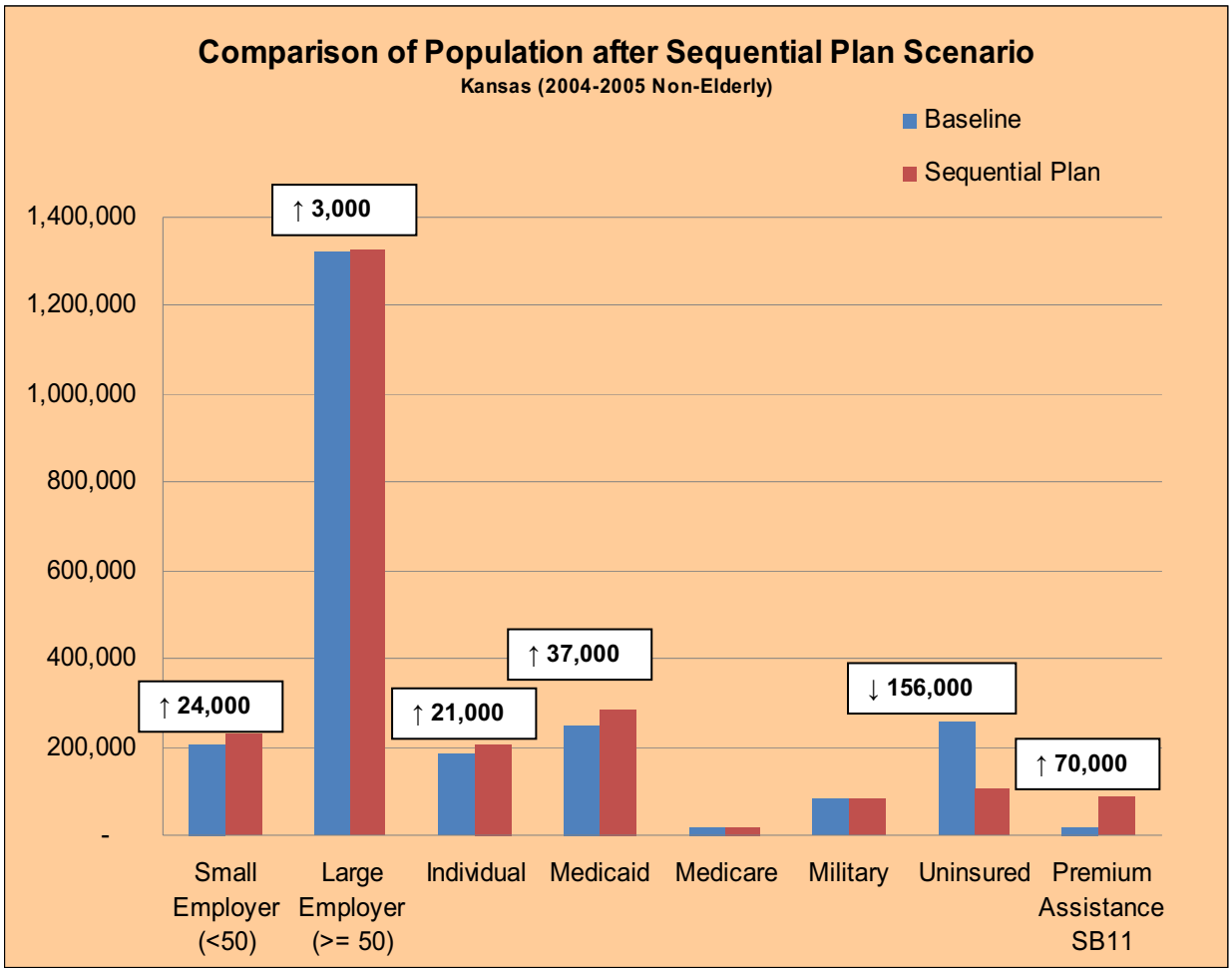


Figure B1-5.3 Expenditure Changes in Sequential Option

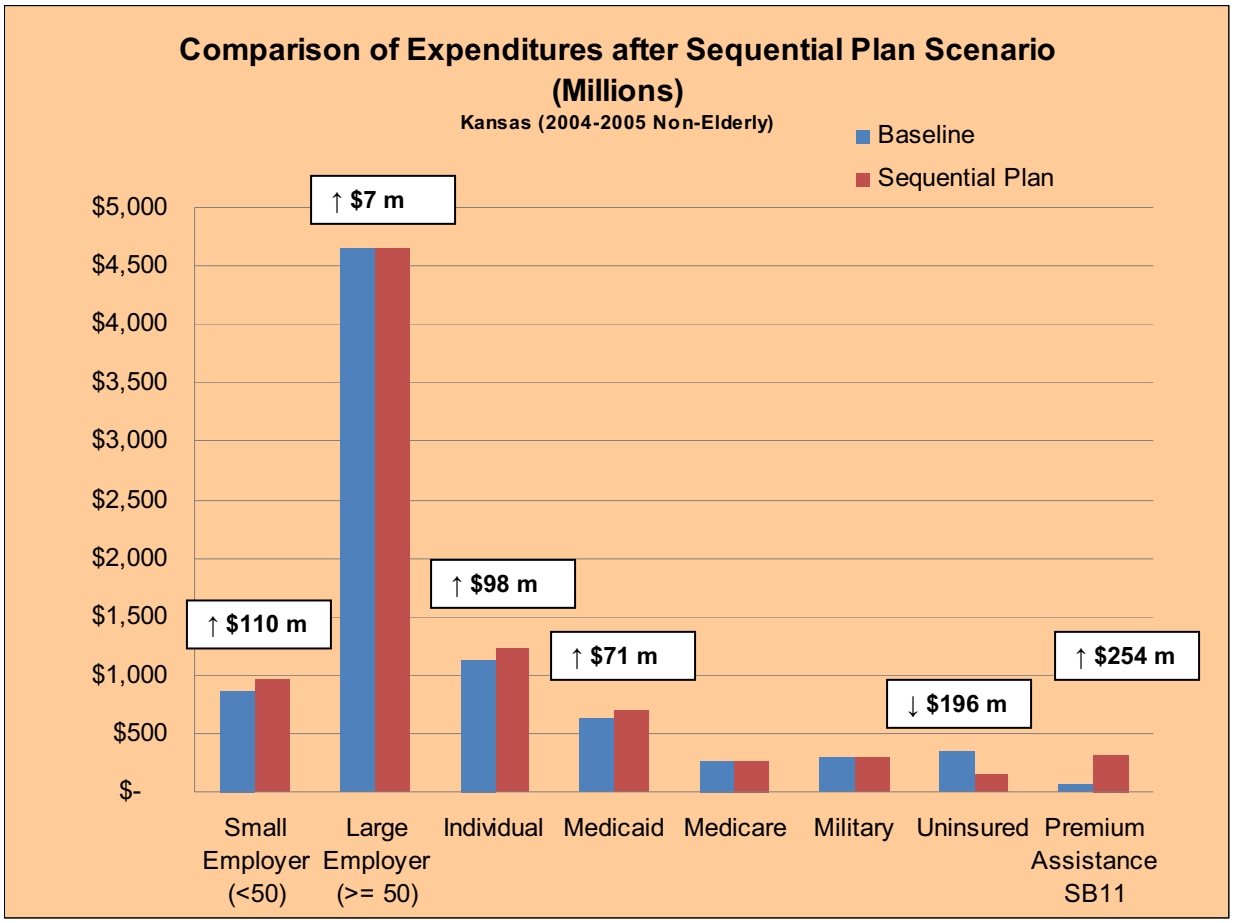


Table B1-5.4 Sequential Reform Plan Net Savers and Net Payers

	Net Savers	Net Payers	
Sequential		State	+ $176 million
		Federal	+ $121 million
		Employer	+ $46 million
		Self	+ $2 million

Appendix B2. Summary Table of Major Differentiators Among Original Five Reform Plans

	Baseline	Reference	Affordable Coverage (Voluntary)	Sequential Plan (Voluntary+ Mandatory)			Universal Coverage (Mandatory)	Mountain (Mandatory)
				Part A Mandatory Kids	**Part B** Expand Premium Assistance	**Part C** Insurance Reform		
Major Differentiator	***Status Quo***	***Medicaid Expansion***	***Individual/Small Group Market Reform***	***Insurance Mandatory for <19 years old, all income levels***	***SB11 Expansion***	***Individual/Small Group Market Reform***	***Mandate on Individuals and Businesses***	***Single Payer Model***
Description	Current situation with SB 11 (families at 100%) fully implemented Children covered through Medicaid, SCHIP, or SB 11 to 200% Caretakers/Parents covered through Medicaid or SB 11 to 100% Childless Adults not covered	Expand Medicaid up to 250% FPL Children and related Adults Childless Adults	Sect 125 – to provide e options, costs, and support Reinsurance options with premium partially subsidized by State Business Health Partnership (BHP) to Connector	Expand SCHIP from 200% up to 250% (HealthWave mandatory expansion), subsidized premiums (like current SCHIP) – auto enroll into current SCHIP plans 250%+ not Medicaid mandate (no federal match) – not Medicaid pkg, no subsidies	Expand PA SB 11 to 150% FPL for Parents and Childless Adults (match on parents, no match on childless adults)	Sect 125 – to provide options and costs Reinsurance options with premium partially subsidized covered by State BHP as Connector	All Kansans must have health insurance coverage through their existing health care marketplace connection	State-administered health care system Reduce administrative costs ("carrier" level and provider level) Reduce inefficiency in market State-controlled reimbursement State-controlled covered services
Connector/ Exchange - Market Clearinghouse vs. Market Maker	N/A	N/A	Insurance Clearinghouse – BHP	N/A	N/A	Market Clearinghouse - BHP	Market Maker – Existing Carrier Model	Market Maker - Single Payer Agency
Mandatory Insurance (individuals, businesses)	N/A	N/A	No	Yes – Children < 19	No	No	Yes – Individuals and Employer Mandate with hardship exemption process	Yes – Individual with hardship exemption process
Penalty for no insurance (amount, type)	N/A	N/A	No	Can't enroll in school/ daycare without proving you have health insurance – deduction on State tax removed or use it to buy health care	No	No	Yes – Lose State Tax Exemption	Yes – Lose State Tax Exemption
Statewide Insurance Reform (Individual, Small Group, Large Group rating – age, health, etc.)	N/A	N/A	Individual/Small Group Market combination	No	No	Individual/Small Group Market Combination	No	Complete Health Insurance Market Redesign
Reinsurance	N/A	N/A	Yes	No	No	Yes	Yes	N/A

Appendix B2. Summary Table of Major Differentiators Among Original Five Reform Plans

	Baseline	Reference	Affordable Coverage (Voluntary)	Sequential Plan (Voluntary+ Mandatory)			Universal Coverage (Mandatory)	Mountain (Mandatory)
				Part A Mandatory Kids	**Part B** Expand Premium Assistance	**Part C** Insurance Reform		
Waiver/State Plan Amendment (SPA) - cover higher FPL - reimburse more for current services	N/A	Yes	No	Yes – to get federal match (SCHIP match for up to 250% FPL), how close are they to SCHIP cap?	SPA or waiver Federal match on parents and childless adults	No	No	No
State Subsidy - vouchers - partial premium - tax credits	N/A	N/A	BHP subsidy 0%-200% FPL State Reinsurance Subsidy	Yes – sliding scale share of premium up to 250% FPL	Yes	BHP subsidy 150%-200% FPL State Reinsurance Subsidy	Yes, up to 250% for Individuals and Small Groups	Yes, up to 250% FPL for Individuals
Affordability standard (X% of income)	N/A	N/A	No	Yes – assumed standards are met with the following premiums (extension of SCHIP premiums): 200%-225% FPL: $40 monthly premium 226%-250% FPL:$50 monthly premium	No	No	Yes, 10% of income for premium, up to 250% FPL	Yes, 10% of income for premium, up to 250% FPL
Minimum credible coverage (benefit sets)	N/A	N/A	No	Yes – for kids, SCHIP benefits to 250%, different benefit package above 250%	N/A	No	Yes	Determined by State

Notes and References

[1] House Substitute for SB 11 (SB 11) was signed into law by Governor Sebelius in May 2007. Among its requirements, SB 11 includes enabling legislation that directs the KHPA to develop broader health reform options with the assistance of Kansas stakeholders and independent economic impact analysis. Kansas Health Policy Authority Website: http://www.khpa.ks.gov/AuthorityBoard/PreviousMeetingInformation/Handouts/4-17-07SUMMARY%20FINAL%20-%20House%20Substitute%20for%20SB%2011.pdf

[2] Using the two-year 2005/2004 Current Population Survey (CPS) survey data, Kansas has 278,000 non-elderly uninsured. This figure is reduced by 18,000 individuals who are eligible for and will be covered by the Premium Assistance program authorized as part of SB 11. Other figures that have been used for Kansas' uninsured cover slightly different time periods or populations. The 290,000 figure for all uninsured in Kansas is rounded from 286,000 and is based on one year of CPS data, 2005. The 335,000 figure for all uninsured in Kansas comes from the 2007 CPS.

[3] Kansas Health Policy Authority Website: http://www.khpa.ks.gov/HealthReformHome.htm

[4] See page 13 and Appendix B for a more complete description of each of the original five options considered by the KHPA Board.

[5] The majority of individuals over age 65 are covered by Medicare, which will not be impacted by the health insurance reform options being considered here. CMS Medicare Enrollment Report: http://www.cms.hhs.gov/MedicareEnRpts/Downloads/Sageall04.pdf

[6] As SB 11 has been signed into law, expansion of the Premium Assistance program authorized by SB 11 has been included within the Baseline with which all of the reform options are compared. Kansas Health Policy Authority Website: http://www.khpa.ks.gov/AuthorityBoard/PremiumAssistance.htm

[7] 2004-2005 Current Population Survey's Annual Social and Economic Supplement Website: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

[8] Ibid

[9] Ibid

[10] National Coalition on Health Care Website: http://www.nchc.org/facts/cost.shtml

[11] Health Division, Children's Defense Fund for the Kaiser Family Foundation. 2006. *Outreach Strategies for Medicaid and SCHIP*: *An Overview of Effective Strategies and Activities*. April 2006.

[12] Institute of Medicine of the National Academes Website: http://www.iom.edu/Object.File/Master/17/748/Fact%20sheet%205%20Quality.pdf

[13] Ibid

[14] *No* Health *Insurance? It's Enough to Make You Sick - Scientific Research Linking the Lack of Health Coverage to Poor Health*. American College of Physicians Website: http://www.acponline.org/uninsured/lack-contents.htm

[15] Gould, Elise. *California Kids Lose Employment-Based Coverage. The Impact On The Community, Business, And The Public Insurance System*. Economic Policy Institute Website: http://www.epi.org/content.cfm/bp199

[16] Purdum, Traci. 2004. Uninsured *Impact*. Industry Week. August 2004. Industry Week Website: http://www.industryweek.com/readarticle.aspx?articleid=1485

[17] The Current Population Survey (CPS) is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The survey has been conducted for more than 50 years. It includes an Annual Social and Economic Supplement (ASEC), with health insurance questions that have been revised to improve the consistency of estimates for the insured and uninsured as part of ongoing efforts to improve the quality of Census Bureau data. A great deal has been written about the strengths and weaknesses of the CPS data in estimating the uninsured at the state level; however, it still represents the best data source available. Using this approach, the SHRP model can account for the "potential" secondary links any given population might have depending upon where within the hierarchy the particular reform falls. For example, absent any changes to the

health care market, there are 43,000 uninsured children (approximately 17% of Kansas' 260,000 uninsured). Depending upon the level and type of reform considered, some of these children may have a secondary market link to the Medicaid program. Absent any change to Kansas HealthWave 19 and 21 eligibility, 31,000 uninsured have a secondary market linkage to Medicaid. If Kansas were to focus their reform efforts on increasing public programs' eligibility above 200% of the FPL, some portion of an additional 12,000 children could also have a secondary market linkage to Medicaid and become insured under a public program. http://www.census.gov/cps/

[18] srHS Uninsured Market Linkage: Manipulation of CPS Survey Data.

[19] Data Sources by Major Sub-Population:

Small Employer – Medical Expenditure Panel Survey for Kansas (MEPS)
Large Employer – MEPS
Individual – Kansas Insurance Commission Study (2007)
Medicaid – Kansas Medicaid Rates (1/1/07-6/30/08)
Medicare – MEPS
Military – Based on Large Employer number
Young Adult – Young Adult Rates for Massachusetts adjusted for Kansas Cost of Living
Uninsured – MEPS
SB 11 – Based on Kansas Medicaid

[20] Centers for Medicare and Medicaid, Office of the Actuary, Health Statistics Group. http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nhestatespecific2004.pdf

[21] To simplify the use of terms, srHS is using take-up rate when describing consumer responses to free (or minimal cost) health care and elasticity of demand when describing consumers responses to change in the premiums paid for health care. For an excellent summarization of the factors that affect individuals reactions to changes in premium, please see the California Health Benefits Review Program publication entitled *Criteria and Methods for Estimating the Impact of Mandates on the Number of Individuals Who Become Uninsured in Response to Premium Increases,* published by the University of California, Office of the President, California Health Benefits Review Program in February 2007.

[22] Kronebusch, Karl and Brian Elbel. May/June 2004. *Simplifying Children's Medicaid and SCHIP, What helps? What hurts? What's next for the states?* Health Affairs, Volume 23, Number 3: 233-246.

[23] Health Division, Children's Defense Fund for the Kaiser Family Foundation. April 2006. *Outreach Strategies for Medicaid and SCHIP: An Overview of Effective Strategies and Activities*.

[24] srHS calculations from CPS Survey data show that 157,000 out of 188,000 Medicaid/SCHIP eligible children enrolled in either program (91,000 Medicaid Enrolled + 66,000 SCHIP Enrolled) / (111,000 Medicaid Eligible +77,000 SCHIP Eligible) = Total 157,000/188,000=84%.

[25] For 2004/2005, Kansas' Medicaid Federal Medical Assistance Percentage (FMAP) is 60% for Medicaid and 72% for SCHIP.

[26] Hadley, Jack and John Holohan. 2003. *Covering The Uninsured: How Much Would It Cost?* Health Affairs, Web Exclusive, June 4.

[27] Hudson, J. L., and T.M. Selden. 2007. *Children's Eligibility and Coverage: Recent Trends and a Look Ahead*" *Health Affairs*, Web Exclusive, August 16.

[28] srHS calculations from CPS Survey data show that 106,000 out of 111,000 Medicaid eligible children enrolled in the program: (91,000 Medicaid Enrolled + 15,000 Medicaid presenting to be enrolled) / (91,000 Medicaid Enrolled + 20,000 Medicaid Eligible but not Enrolled) = Total 106,000/111,000 = 95%.

[29] srHS calculations from CPS Survey data show that 72,000 out of 77,000 SCHIP eligible children enrolled in the program: (66,000 SCHIP Enrolled + 6,000 SCHIP presenting to be enrolled) / (66,000 SCHIP Enrolled + 11,000 SCHIP Eligible but not Enrolled) = Total 72,000/77,000 = 94%.

[30] Haley, Jennifer and Genevieve Kenny. 2007. *Low-Income Uninsured Children with Special Health Care Needs: Why Aren't They Enrolled in Public Health Insurance Programs?* Pediatrics 119(1): 60-68.

[31] srHS calculations from CPS Survey data.

[32] Waiver budget neutrality calculations are an extremely complex under-taking. The figure provided here is for illustrative purposes only and should not be used for any other purposes.

[33] Turnbull, Nancy and Nancy Kane. 2005. *Insuring The Healthy Or Insuring The Sick? The Dilemma Of Regulating The Individual Health Insurance Market. Findings from a Study of Seven States.* The Commonwealth Fund. February 2005.

[34] Ibid.

[35] Kansas Insurance Department. Draft/Unpublished Study on Kansas Reinsurance Options. Funded by the Health Resources (HRSA) State Planning Grant (SPG) Pilot Grant program.

[36] Connecticut Office of Health Care Access. 2007. *Overview of OHCA's 2006 Young Adults Survey*. Connecticut OHCA Website: March 2007.
http://www.ct.gov/ohca/lib/ohca/publications/2007/young_adults_survey_handout.pdf

[37] Gruber, Jonathan. 2004. *Tax Policy for Health Insurance.* December 2004: p. 10. See also, Gorman et al. 2006. *Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets.* Massachusetts Division of Insurance and Market Merger Special Commission. December 26, 2006: 103-104.

[38] California Health Benefits Review Program. 2007. *Criteria and Methods for Estimating the Impact of Mandates on the Number of Individuals Who Become Uninsured in Response to Premium Increases.* University of California, Office of the President, California Health Benefits Review Program. February 2007.

[39] Clark, Michael and Ginny Wilson. 1999. *Market Responses to Kentucky's Health Insurance Reforms.* Center for Business and Economic Research, University of Kentucky. 1999.

[40] Thorpe, Kenneth. 2003. *A Universal Health Care Plan for Missouri*. Missouri Foundation for Health, 2003. See also Thorpe, Kenneth. November, 2003. *Health Care Expenditures and Insurance in Missouri*. Missouri Foundation for Health, October 2003.

[41] Dorn, Stan. 2007. *Health Coverage in Connecticut: The Costs and Benefits of Major Reform*. United Health Care Foundation of Connecticut. May, 2007.

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