HRSA PILOT PLANNING GRANT INTERIM ANNUAL REPORT
September 30, 2005

A. Executive Summary

Kansas policymakers have focused their attention on issues of health care access throughout the state for over three decades. During the 1970s and early 1980s, several commissions and special legislative committees issued recommendations for improving access and controlling costs. Over the past decade, Kansas policymakers have continued the work to improve access to health insurance through additional health insurance market reforms, establishment of a state tax credit to encourage small employers to offer health insurance, and most recently the development of a small employer pooling mechanism.

In 2000, Kansas was awarded a State Planning Grant which allowed the collection of state specific information about the insurance status of Kansans under the age of 65. In 2001 quantitative data was obtained through a telephone survey, the Kansas Health Insurance Survey. A total of 8,004 households were surveyed. These households contained a total of 22, 690 individuals. The sampling plan was constructed to produce meaningful statewide estimates as well as estimates for ten regions on various demographic characteristics. In addition, key informant interviews were conducted with fifty-seven non-elderly uninsured individuals residing in the ten regions of the state. The information gained through these qualitative interviews coupled with the quantitative data yielded a comprehensive picture of the health insurance status of Kansans.

An analysis of the insurance status of all Kansans under the age of 65 revealed that 71.5% of all Kansans have health insurance through a current or former employer; 11.2% have health insurance coverage purchased on their own; 6.9% have health insurance coverage through Medicaid or HealthWave; 3.6% have health insurance coverage through the military, CHAMPUS, or VA; and 1.6% are insured through other government programs (e.g. Indian Health Service, Medicare for the disabled and end-stage renal disease populations). 10.5% of Kansans have no source of health insurance. Regional variation in rates of uninsured populations range from 5.4% in Region 2 to 16.8% in Region 10. Prevalence of employer-based health in Kansas at 67.9% is higher than the 2002-2003 national average of 62.6%. Kansas also has a higher percentage of citizens attaining coverage in the individual market at 7.2% with the national average being 5.3%.

That information guided the formation of a menu of policy options that adhered to six principles adopted by the Steering Committee:

- Utilization of the employer based coverage is the preferred route
- Comprehensive wellness focused benefit package
- Maximize federal dollars
- Subsidization will be needed
- Role of individual responsibility needs to be incorporated

- Health insurance should not be mandated for individual to carry or employer to provide

The policy options menu developed by the Steering Committee sought to maximize the use of current state policies that support or promote the number of Kansans who have access to health insurance through the employer-based coverage system. The target population was low-income workers employed by small firms and their dependents because this group encompasses a substantial number of all uninsured Kansans. Attention was paid to those strategies that would provide incentives for more employers to offer coverage and would assist low-income workers to purchase health insurance when it was offered.

Policy approaches the Steering Committee identified as demonstrating the most potential in Kansas for improving access to health insurance for the identified target population (low-income employees of small firms and their dependents) included expansion of an existing small employer tax credit program, implementation of a small business health purchasing pool (Kansas Business Health Partnership) and integrating a reinsurance mechanism, expanding use of the Medicaid Health Insurance Premium Payment Program, expanding enrollment in the State Employee's Health Insurance Program, extending the age of dependent coverage under family plans, improving enrollment in Medicaid and HealthWave, and expanding Medicaid eligibility. Economic modeling was applied to the various options and take-up rates and costs estimated.

In 2003, the Kansas Department of Insurance was awarded State Planning Grant supplemental funds to secure valuable information about health benefit decisions being made by small employers during the current economic times. An examination of small business' health insurance experience reveals increasing vulnerability in continued provision of health insurance to employees. Kansas employers participating in the 2004 Small Business Health Insurance Survey reported that insurance premiums had increased substantially from 2003 to 2004 with over thirty percent of firms reporting that their premiums rose by 16-25 percent and 28 percent reporting that their premiums rose over 25 percent. More than a fifth of the firms reported that they were considering dropping coverage and nearly three-fifths were planning to increase employee contributions.

The small employer data findings have provided valuable information about health benefit decisions being made by small employers during the current economic times that the Steering Committee is using to construct more detailed policies derived from the original policy menu. The intent of the small employer targeted policies is two fold; preventing erosion of current level of health insurance provision by small employers as well as creating incentives to expand access to health insurance.

The 2002 election brought new leadership to both the Governor's and the Insurance Commissioner's offices. The previous two-term governor of Kansas had little interest in health care issues and pursued other policy goals during his administration. Former Insurance Commissioner Kathleen Sebelius, a Democrat was elected governor and the former chair of the Senate Committee and Financial Institutions Sandy Praeger, a

Republican and long-time health care proponent was elected Insurance Commissioner. These individuals although from opposite political parties have both been long committed to improving the access of all Kansans to affordable health insurance, have collaborated in the past on health issues, and now that they hold leadership position are actively pursuing health initiatives in our state. The leadership's focus on health care issues coincides with growing Kansas citizen concern about access to health insurance.

Kathleen Sebelius took office in 2003 and began to act on her long-standing commitment to improving access to health care. As an initial step in initiating her health agenda, Governor Sebelius in October 2003 created the Governor's Office of Health Planning and Finance (OHPF) to address the issues of affordability, quality and accessibility of health care in Kansas. In fall 2004 the governor and the insurance commissioner introduced the bipartisan health proposal, entitled the Healthy Kansas reform initiative. Many of the policy options supported by the Steering Committee were incorporated into this comprehensive health care reform initiative. Key elements of the reform initiative include: streamlining all of the state's major health care programs into a new business division called the Kansas Health Care Authority, establishment of a Kansas Health Care Cost Containment Commission to cut unnecessary administrative costs and improve quality and use of technology, increasing the enrollment of children eligible for HealthWave, enabling small businesses to attain affordable health insurance, assisting citizens to procure less expensive prescription drugs, and reducing preventable chronic health conditions.

A key element of Governor Sebelius's health care reform agenda is a reduction in the number of uninsured workers, especially those employed by small businesses for which access to health care is an increasing crisis. In 2000 the legislature created the Business Health Partnership with the goal of expanding coverage through a linkage between the public and private sector by improving the affordability and quality of health insurance for low-wage workers in small businesses. Kansas recognized that the solution must address both the willingness of the business to offer health care coverage and the ability of the low wage employee to afford the cost of coverage. It was the intended purpose of the legislation creating the BHP that there be available subsidies and/or tax credits to encourage such participation but economic conditions prevented allocation of subsidy money. The Governor's plan for reducing the numbers of uninsured relies on the creation of public subsidy dollars for low-wage employees of small businesses through a plan offered by the Business Health Partnership and in 2005 an appropriation of $500,000 was secured to subsidize the purchase of health insurance by low wage workers employed in small firms. That same legislative session the tax credit was restructured to encourage more participation by small employers.

In August, 2004 the state through foundation funding obtained technical assistance to model the impact of various levels of subsidies (both employee and employer tax credit), based on a specific benefit package whose actuarial value had been determined and develop a subsidization plan based on the modeling that would be most effective in reducing the numbers of uninsured. Findings from that project have been reported and the Business Health Policy Committee is using that information to guide the development

of a sliding scale subsidy schedule for low-wage workers employed by small firms attaining health insurance through the Business Health Partnership.

The Steering Committee believes that maximum reduction in the number of uninsured Kansans will be achieved by combining a variety of the policy options to capitalize on the additive effect the options have on each other. The Business Health Partnership would serve as the mechanism through which small employers could attain affordable, quality health insurance; employers would be encouraged to offer health insurance through a tax credit set at an optimal level; employees would be assisted in payment of their premiums through adequate subsidies; and the dependents of those employees could attain employer-based coverage using public monies. These multiple strategies collectively provide a much more effective approach to improving access to health insurance for small employers and low wage workers.

The goal of our pilot project is to test the cost/benefit implications of controllable claim fluctuations, pricing stability, and risk acceptance by carriers using alternative reinsurance mechanisms and risk or cost spreading methodologies. The quantified cost reductions will be applied to average premium rates in order to test the propensity for small employers to buy health insurance with reduced costs. This improved propensity to purchase health insurance will be applied to the market as a whole in order to project the resulting potential to reduce the uninsured small employer population in Kansas.

More specifically, the objectives of this project are:

1. Gather and analyze existing Kansas specific small employer health insurance data bases to select data elements required for the reinsurance modeling project and develop testable assumptions where data is insufficient.
2. Transform data into actuarially sound assumptions for integration into the Reinsurance Assessment Modeling Software.
3. Model the impact of the four alternative reinsurance mechanisms on carriers and small employers.
4. Analyze the combined impacts of reinsurance, employer tax credits, and low income employee subsidies on small employer and employee premium costs and reductions in the number of uninsured.
5. Add specificity to target policy options based upon the information gained through the reinsurance modeling project.
6. Continue the consensus building activities to garner support for targeted policymaking action to improve access to health insurance for Kansans
7. Prepare the Secretary's report summarizing the finding and policy recommendations emanating from the State Planning Grant Limited Competition Grant.

The Kansas Insurance Department contracted with Pool Administrators Inc. to model four different reinsurance pools to determine which pool design would best reduce the volatility that exists in the Kansas fully insured small employer health insurance market. Kansas Health Insurance Information System (KHIIS) data, a data set containing claims

data from the 20 largest health insurance carriers regulated providing private health insurance coverage for Kansans, has been de-identified and provided to Pool Administrators Inc... Pool Administrators Inc. has "cleaned" and compiled the raw data into a usable form and entered the data into the reinsurance modeling software. They are currently awaiting a resubmission of data from one of the carriers and will compare that data to the information that was reported prior to the resubmission by this carrier for materiality.

Pool Administrators has also identified the ceded lives for the four different types of reinsurance. For the prospective reinsurance pools that are to be modeled, the reinsurance premiums have been developed and the ceding processes have been established, based on the experience of insurers that participate in other state reinsurance pools. For the retrospective reinsurance pools being modeled, the ceding processes have been established, based on a specific corridor of coverage for one of the retrospective pools and on diagnosis codes for the second retrospective reinsurance pool.

Kansas requested and was granted a no cost extension for the pilot project to complete the remaining project tasks. Pool Administrators will run the four reinsurance models and quantify the impact of each of them on the Kansas small employer insurance market. The findings will be presented to the Steering Committee and they will use that information to determine which reinsurance mechanism will be most effective in Kansas to control premium cost volatility in the small group market, adding a specific reinsurance policy to the already selected small employer strategies.

Kansas State Planning Grant activities up to this time have been focused on data generation and using that information to refine the originally selected policies targeted to making health insurance more accessible for low wage employees in small firms. Implementation has not yet occurred, but the policies nearing implementation phase are the remodeled small employer tax credit and the subsidies for low wage workers securing health insurance through the Business Health Partnership.

Federal grants such as those proposed by Representative Johnson to fund state reinsurance pilots would provide startup funds for those states pursuing strategies to stabilize the small employer health insurance market. Also further expansion of existing federal data collection efforts such as the CPS and MEPS-IC to allow for state regional analysis would assist a state in targeted efforts to reduce the number of uninsured.

B. Background and previous HRSA SPG Accomplishments

Kansas policymakers have focused their attention on issues of health care access throughout the state for over three decades. Special legislative committees designed to deal comprehensively with health issues facing the state have been in existence for over fifteen years beginning with the Joint Committee on Health Care Decisions for the 1990s initiated in 1990, followed by the Health Care Reform Legislative Oversight Committee in 1994, and the current Joint Committee on Health Policy Oversight. In 1991 the Legislature created the Kansas Commission on the Future of Health Care, Inc. charged with developing a long-range health care policy plan incorporating the social values of Kansans. The Commission unveiled their plan in January of 1994 at a time when national health care reform efforts were failing and interest in comprehensive state reform was abandoned.

The state returned to a focus on health insurance reforms building upon earlier efforts to expand health insurance coverage that had begun in the late 1980s and early 1990s. Those iterative health insurance expansions were intended to build upon, rather than erode, the existing coverage base in the state. They focused on structuring coverage to be as seamless as possible for families, expanding private employment-based coverage approaches in ways that could provide stable coverage sources for workers and families, and developing public and private roles that complement rather than undermine each other.

In the early 1990s the Kansas legislature undertook insurance reforms requiring insurers to accept or reject entire groups that applied to them for coverage, required insurers to guarantee issuance of coverage for pre-exiting conditions, limited such exclusions to a maximum of 90 days, and required insurers to give new enrollees credit (toward the pre-existing condition exclusion period) if they had prior coverage. These reforms led insurers to reject coverage for entire groups, so additional reforms were enacted to guarantee all small employers had access to "standard and basic" plans and to establish uniform rating standards for small employer plans. Insurers were still permitted to deny small groups access to other insurance plans they offered. In 1997, Kansas implemented the federal Health Insurance Portability and Accountability Act (HIPAA), thus extending open enrollment within groups, uniform definitions for pre-existing condition exclusions and portability of coverage to self-insured as well as insured groups. In addition, small employers were guaranteed access to all insurance plans offered by carriers.

Kansas has an unusually large number of self-employed individuals, including farmers and ranchers, who obtain their insurance coverage through the individual market. Individuals with existing health problems often found that no carrier would offer them coverage. To address this problem, the 1992 legislature established the Kansas Health Insurance Association (KHIA), a "high-risk" pool. KHIA provides needed coverage at relatively affordable rates (no more than 125% of regular market rates) for high-risk individuals, while helping keep coverage as affordable as possible in the regular

individual market. As of May 31, 2004 there were 1750 individuals enrolled in any of the six major medical plans offered by KHIA (which vary primarily with respect to deductible levels). After the enactment of HIPAA, KHIA was modified to also serve as the individual-market continuation option for people who exhaust their continuation rights under group coverage (COBRA).

Over the past decade, Kansas policymakers have continued the work to improve access to health insurance through additional health insurance market reforms, establishment of a state tax credit to encourage small employers to offer health insurance, and most recently the development of a small employer pooling mechanism. The State Planning Grant Steering Committee utilized these existing policy vehicles in creating their recommended policy approaches to reducing the number of uninsured Kansans.

Until the 2005 legislative session the state tax credit incentive made refundable, per-employee tax credits available to small employers who had not contributed to any health insurance premium on behalf of their employees in the past two years. The tax benefit was available to any one employer for 5 years. For the first two years, the credit equaled $35 per employee per month, or 50% of the total amount paid by the employer, whichever was less. Decreasing amounts were paid in years 3 through 5. Since January 1, 2000 when the tax credit incentive program became operational only a modest number of eligibility certificates had been issued by the Kansas Insurance Department.

Legislation was enacted in 2005 that modified the existing health insurance tax credit incentive program. The prior tax credit legislation was amended to change the schedule of tax credits, add health savings accounts to the employer contributions that quality for a tax credit, and change the processing procedure to involve only the Department of Revenue. The tax credit was increased to $70 per month per eligible employee for the first year, $50 for the second year, and $35 for the third year. No credit would be allowed after 36 months of participation.

In 2000 the Kansas Legislature enacted legislation to assist small employers in accessing health insurance. Under this legislation, a new cabinet-level Kansas Business Health Policy Committee was created in 2000. The Business Health Policy Committee membership is statutorily defined by K.S.A. 40-4702. Members include:

1) the secretary of the department of commerce and housing or the secretary's designee;
2) the secretary of the department of social and rehabilitation services or the secretary's designee;
3) the commissioner of insurance or the commissioner's designee;
4) one member appointed by the president of the senate;
5) one member appointed by the speaker of the house of representatives;
6) one member appointed by the minority leader of the senate;
7) one member appointed by the minority leader of the house of representatives; and
8) three members at large from the private sector appointed by the governor.

In 2001 the Business Health Policy Committee selected a private non-profit employer organization to serve as the Kansas Business Health Partnership. The Partnership is an organization, neither created by nor run by the state, which purchases coverage through the private market with the stipulation that it offer employee choice of competing plans, have the capacity to minimize the administration burden for participating employees, and offer benefit plans that meet federal and state coverage requirements for SCHIP eligible children. It was intended in the original legislation to make state subsidies of premiums for low-wage employees and their dependents available to those acquiring health insurance through the Kansas Business Health Partnership. However, due to the state's financial plight, the vision of public subsidies through Medicaid, SCHIP or appropriated state funds was never realized.

In addition to small group health insurance reform, Kansas policymakers have focused upon improving access to public health insurance among low-income children. HealthWave (Kansas SCHIP) provides comprehensive health insurance coverage paralleling Medicaid benefits to children under age 19 whose family income is at or below 200 percent of the federal poverty level. A simplified, joint Medicaid/HealthWave application is used to enroll families, who may complete the process through the mail. A toll-free phone number is available for extended hours and on weekends to request applications or ask questions. HealthWave and Medicaid operate a seamless system so that families with children of different ages eligible for different programs, or families whose incomes change, will not be faced with having to change health plans and other unnecessary complications. The state has implemented numerous outreach initiatives to improve enrollment and participated in the Robert Wood Johnson Foundation's Covering Kids Initiative which piloted various outreach approaches. Irregardless, there are 55,000 uninsured Kansas children most of whom live in families with incomes in the public programs eligibility range. Data indicates that two-thirds of the public health insurance eligible uninsured children have never been enrolled in Medicaid.

In 2000, Kansas was awarded a State Planning Grant to develop detailed information about the uninsured in our state and create a menu of policy options to expand health insurance coverage to all Kansans. The lead agency for the Kansas State Planning Grant was the Kansas Insurance Department. The project was guided by a Steering Committee chaired by Insurance Commissioner Kathleen Sebelius and consisted of 20 leaders from the executive and legislative branches of government, and from the business, provider, and consumer communities. The Steering Committee met monthly for the two year tenure of the grant and participated actively in all phases of the grant from initial research design to the final production of the policy options menu.

The Kansas State Planning Grant had four specific objectives:

1. To gather policy-relevant demographic and socio-economic data about the characteristics of insured and uninsured Kansans with a particular emphasis on data that will permit an assessment of which subgroups of the uninsured can

realistically be reached through work-based coverage arrangements and which subgroups might most sensibly be reached through other arrangements.

2. To identify what alternative structures and conditions would motivate Kansas employers who do not now provide or contribute toward health insurance for their workers to participate in purchasing pools or other arrangements that would allow their workers to enroll in health coverage through the workplace and contribute through payroll deduction.

3. Based on this information, to develop several alternative approaches to subsidizing coverage for uninsured Kansans and otherwise creating more favorable conditions for obtaining health insurance, and to estimate the cost and likely effectiveness of each of these approaches for presentation to the Governor and legislature of the State of Kansas and to the Secretary of Health and Human Services.

4. To provide enhanced technical analysis and support to facilitate the development of program rules, policies, and structures necessary to effectively reach uninsured workers in small firms participating in the Kansas Business Health Partnership.

Three separate, but complementary, data collection activities formed the core tasks requisite to the achievement of those objectives. Quantitative data about the uninsured was collected through the use of a telephone survey, the Kansas Health Insurance Survey (KHIS). Development and implementation of the survey was the product of collaboration by researchers from the University of Kansas Medical Center (KUMC) and the Department of Health Services Administration at the University of Florida. Researchers at KUMC directed the survey efforts and the University of Florida researchers provided technical consultation and analysis and administered the survey. Insurance Commission staff and Steering Committee members provided input and oversight for the survey and all other research components.

The survey instrument was based on one previously used in similar studies in Florida and Indiana, modified for unique circumstances in Kansas. Fieldwork for the survey was completed between March 2001 and June 2001. Telephone interviews were conducted with 8,004 Kansas households (households composed of individuals over age 65 were not included in the survey). These households were comprised of 22,691 individuals. Interviews averaged fifteen minutes in length. Bilingual (English-Spanish) surveyors were part of the University of Florida team and 180 interviews were conducted in Spanish.

The household survey was intended to gather broad-based information that would enable estimation of differing rates of health insurance coverage among various geographic, demographic, socio-economic and occupational categories in Kansas. While previous national and Kansas-specific surveys have provided a general overview of the extent of insurance coverage in Kansas and a rough sense of whom the state's uninsured are, none of the previous surveys allowed accurate statistical estimates for sub-areas of the state or

for various sub-groups. This sort of estimation was important in crafting policy options, since no one solution is likely to work equally well for all parts of the state or all groups within the state. This very large household survey included an adequate number of respondents to make these estimates.

Estimates were developed for ten regions of the state. These regions were selected so that each contained a population large enough to insure valid statistical results and so that each exhibited a population with logical demographic, employment, and marketplace similarities. The study revealed that 10.5 percent of Kansans under age 65 were without health insurance and that rates of uninsurance varied substantially across the state, ranging from over 16 percent in two regions to five percent in another region. The data collected in the KHIS were invaluable both in the development of the policy options menu for health insurance coverage to all Kansans and in engaging policymakers from various regions of the state in recognition of both the existence and magnitude of the problem.

The quantitative data on the uninsured were enhanced by qualitative data gained through key informant interviews with uninsured individuals in all ten regions of the state. KUMC researchers conducted the interview component of the research. In-depth, in-person semi-structured interviews were conducted with fifty-seven non-elderly individuals representing fifty households in which at least one person lacked health insurance coverage. In addition, eighteen health care professionals who work with the uninsured were interviewed. These interviews were completed in early 2001. Most interviews were conducted in the interviewees' homes or workplaces. Each interview was audiotaped, with the interviewee's permission, and the transcripts were analyzed using accepted qualitative analysis techniques. Spanish language interpreters were available when the interviewee was not fluent in English.

Through the interviews, the research team sought to discover the reason why Kansans are uninsured, to explore individuals' experiences in trying to obtain health insurance and health care services, and to describe the impact that lack of insurance has for individuals and families. Interviewees were also questioned about their ideas for addressing the problem of the uninsured and for assuring access to affordable health insurance for all Kansas citizens. While the results of the household survey gave us broad-based information about rates of uninsurance and its effects in Kansas, the interviews gave in-depth information about the personal experiences of the uninsured, therefore providing a complementary view of the uninsured.

This triangulation methodology provided essential information previously unavailable to Kansas policymakers and resulted in an in-depth understanding of the dimensions of the uninsurance issue in Kansas. The resultant data provided clear evidence that more than 95 percent of uninsured Kansans live in a household in which at least one person has a job. The majority of these uninsured individuals are linked to small businesses. It also revealed that almost two-thirds of all uninsured Kansans (158,900) are in low-income families (household income at or below $35,300 for a family of four). The existence of this strong linkage of the uninsured to the workforce and their low economic status,

coupled with Kansas's policy preference for using private sector insurance vehicles for expansion initiatives, strongly influenced the nature of the policy options menu developed to improve access to health insurance developed by the Steering Committee.

Information regarding insurance offerings from employers was obtained through eight focus groups and twenty personal interviews with small business (less than fifty employees) owners, insurers, and brokers conducted around the state by staff from Bailit Health Purchasing. Those in the focus groups and those interviewed represented a total of sixty-six small businesses in Kansas. These informants were primarily small employers who were either currently offering health insurance to their employees or who expressed a strong desire to do so. The focus groups and interviews explored the challenges small business owners face in offering health insurance coverage as a benefit to workers and their dependents. The data collected from these individuals were helpful in delineating the barriers small business owners encounter in offering health care coverage to their workers. First among these is cost, but also cited is the need for clear and understandable information about health insurance options so they could make good choices and avoid potential marketing abuses. These focus groups also allowed exploration of small employer perceptions regarding the usefulness of various policy approaches such as the small employer tax credit and pooling strategies.

An integral part of the Kansas State Planning Grant project was gaining input from the public and key constituents and working to build consensus on the scope of the problem and feasible solutions. Expert input was sought through a series of three meetings where insurance industry leaders shared their perceptions about the difficulties faced by uninsured Kansans, identified contributing factors, discussed potential remedies, and provided feedback about policy options. The Kansas Insurance Department worked with the media to issue periodic press releases on the project so that the public would be aware of the grant activities, research findings, and policy options being discussed. The Department established a dedicated web site on their home page so the public could access meeting minutes, Power Point presentations, and documents used in Steering Committee deliberations. The Kansas Insurance Department also conducted eight public "town hall" meetings across the state to share the results of the research conducted through the State Planning Grant and to solicit responses to a variety of policy approaches.

That information guided the formation of a menu of policy options that adhered to six principles adopted by the Steering Committee:

- Utilization of the employer based coverage is the preferred route
- Comprehensive wellness focused benefit package
- Maximize federal dollars
- Subsidization will be needed
- Role of individual responsibility needs to be incorporated
- Health insurance should not be mandated for individual to carry or employer to provide

The policy options menu developed by the Steering Committee sought to maximize the use of current state policies that support or promote the number of Kansans who have access to health insurance through the employer-based coverage system. The target population was low-income workers employed by small firms and their dependents because this group encompasses a substantial number of all uninsured Kansans. Attention was paid to those strategies that would provide incentives for more employers to offer coverage and would assist low-income workers to purchase health insurance when it was offered.

Policy approaches the Steering Committee identified as demonstrating the most potential in Kansas for improving access to health insurance for the identified target population (low-income employees of small firms and their dependents) included expansion of an existing small employer tax credit program, implementation of a small business health purchasing pool (Kansas Business Health Partnership) and integrating a reinsurance mechanism, expanding use of the Medicaid Health Insurance Premium Payment Program, expanding enrollment in the State Employee's Health Insurance Program, extending the age of dependent coverage under family plans, improving enrollment in Medicaid and HealthWave, and expanding Medicaid eligibility.

Economic modeling was applied to the various options and take-up rates and costs estimated. For the private sector policy options the estimated take-up rates among the uninsured ranged from 204 to 8,002 for the private sector policy options and from 23,109 to 98,108 for the public program expansion options. The costs per newly insured person for the various options ranged from $0 to $3,499 depending upon the amount of crowd-out and other unintended effects.

An examination of the impact analysis highlighted the need for further refinement of those options before policy adoption could be pursued. Although the employer focus groups provided information helpful in the creation of policy options to improve health insurance access in the state, it did not yield data representative of the population of employers nor did it include the level of specificity needed to develop targeted policy strategies for the various subpopulations of employers. Much more detailed data about the small employers' provision of health insurance was needed than currently existed in the state. Kansas was subsequently awarded a SPG supplement to collect comprehensive information about the current structure of employment benefit plans, total cost, and the division of costs between employers and employees.

In addition to the small employer data gap, other impediments to implementation of the policy options developed initially by the Steering Committee included timing and economic conditions in the state. The Steering Committee released their policy recommendations for improving the access of all Kansans to health insurance in August 2002 at the peak of an election cycle where a new leadership team was to be chosen, including a new governor and insurance commissioner. All representatives in the Kansas House faced elections as well. As policymakers convened for the 2003 legislative session, there was a new insurance commissioner, a new administration, governor and cabinet, as well as one-third of the House members being newly elected. For all of these

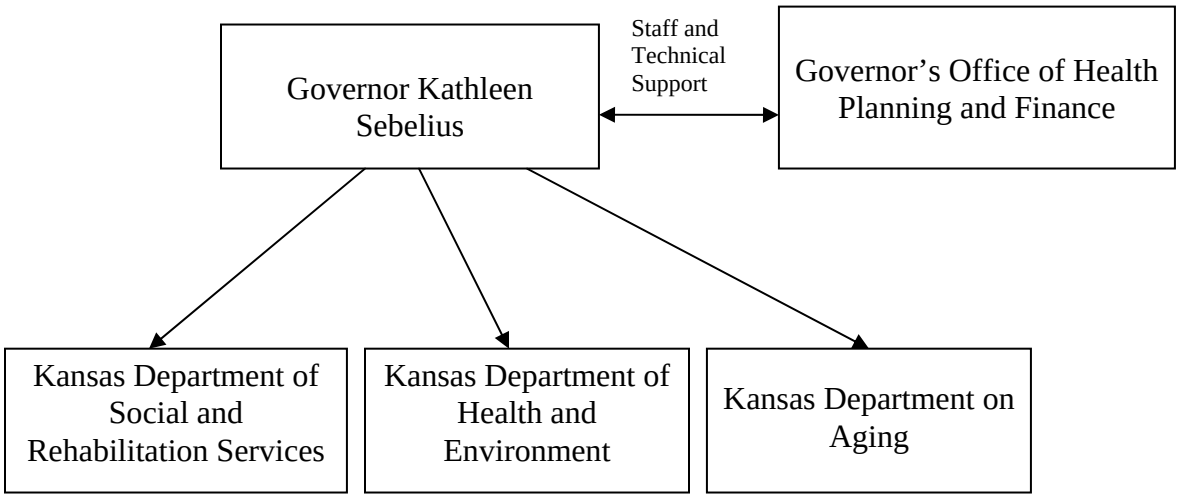
newly elected individuals, it took time to become oriented to the job. In 2003 when policies to expand access to health insurance potentially could have been considered, Kansas also faced a serious economic downturn resulting in sizable reductions in revenue across the state. This economic climate dictated that the primary policy focus of the governor and legislature be on budget reductions and maintenance of current programs rather than expansion and new program creation.

The budget shortfalls made it impossible to fully implement components of previous legislation that would have improved access to health insurance for Kansans. As noted earlier, the Business Health Partnership was established with the goal of expanding coverage through a linkage between the public and private sector by improving the affordability and quality of health insurance for low wage workers in small businesses. The statute establishing this entity stipulated that subsidies be available through Medicaid, SCHIP, or appropriated state funds. However, due to the state's financial plight, the vision of public subsidies was never realized.

In 2003 the political climate in Kansas changed dramatically with health care reform emerging as a high priority issue. The previous two-term governor of Kansas had little interest in health care issues and pursued other policy goals during his administration. The 2002 election brought new leadership to both the Governor's and the Insurance Commissioner's offices. Former Insurance Commissioner Kathleen Sebelius, a Democrat was elected governor and the former chair of the Senate Committee and Financial Institutions Sandy Praeger, a Republican and long-time health care proponent was elected Insurance Commissioner. These individuals although from opposite political parties have both been long committed to improving the access of all Kansans to affordable health insurance, have collaborated in the past on health issues, and now that they hold leadership position are actively pursuing health initiatives in our state.

Kathleen Sebelius took office in 2003 and began to act on her long-standing commitment to improving access to health care. As an initial step in initiating her health agenda, Governor Sebelius in October 2003 created the Governor's Office of Health Planning and Finance (OHPF) to address the issues of affordability, quality and accessibility of health care in Kansas. This office was established to coordinate health policy initiatives brought forth by health and human service cabinet team members and approved by the Governor. It also serves as a catalyst for such initiatives to assure coherent and collaborative cross agency policy development and has convened a group of providers, advocates, key Cabinet officials, elected officials, and business leaders to begin dialogue on a comprehensive, multi-year approach to address the issues of cost, quality and accessibility. The OHPF was established with grant funding provided by three major health foundations in Kansas: Sunflower Foundation, United Methodist Health Ministry Fund, and Kansas Health Foundation. The fiscal support provided by these private health philanthropies occurred because of their strong belief in the need for a comprehensive approach in addressing health issues in Kansas. The figure below illustrates the relationship between the Governor, the Office of Health Planning and Finance, and the cabinet level agencies with authority over health issues.

Figure 1



The creation of this office established a focal point for health care reform and the processes for pursuing comprehensive strategies to improve health care access, affordability and quality throughout the state. The Director of the office was a member of the original State Planning Grant Steering Committee and is co-chair of the reconfigured Steering Committee.

In 2003 Kansas was awarded a SPG supplement to collect comprehensive information about the current structure of employment benefit plans, total cost, and the division of costs between employers and employees.

The specific objectives of this project were:

1. To gather uniform comprehensive demographic, experiential, and attitudinal data from small employers about health insurance benefits.

2. To gather in-depth qualitative data from small employers in select locales experiencing different types of economic impacts as to the effect on the provision and dimension of health benefits offered.

3. To refine the policy options menu to provide access to health insurance for all Kansans using the triangulated quantitative and qualitative data from small employers

4. To continue the consensus building activities to garner support for policymaking activity to improve access to health insurance for Kansans.

5. To prepare the Secretary's report summarizing the findings and policy recommendations achieved through the State Planning Grant supplemental funding

The overall goal all Kansas State Planning Grant projects is access to affordable health insurance coverage for all Kansas citizens. Successful completion of the activities outlined in our original grant provided much needed information about the uninsured population in our state which guided the creation of a menu of policy options designed to improve access to health insurance. That data indicated that by concentrating upon low wage workers in small firms we had the potential to significantly reduce the number of uninsured in our state. The insights gained through the small employer study allowed for the refinement of the policy options constructed during the original State Planning Grant period. The small employer data collection endeavor provided valuable information about health benefit decisions being made by small employers during current economic times. That information is being used to design detailed policies intended to both prevent the erosion of current health insurance provision by employers as well as create incentives to expand access to health insurance.

Findings from the Small Business Health Insurance Survey indicated increasing vulnerability among small employers in their continuing ability to offer health insurance to their employees. More than a fifth of the firms reported that they were considering dropping coverage and nearly three-fifths were planning to increase employee contributions. Among Kansas small businesses that did not offer health insurance benefits, cost was the most important reason. When asked about policy approaches that they believed would be helpful, a majority of small businesses supported insurance purchasing pools, joining the State Employees' health plan, health savings accounts, tax credits, Medicaid buy-ins for children, and subsidies for low income workers.

During the 2004 legislative session, recognizing the need to strengthen the financial relationship between the provider community and the State of Kansas, the Governor and leaders in the Senate and House crafted a bipartisan proposal that resulted in an increase in Medicaid reimbursements of over $100 million dollars. In addition legislation was passed and signed which expanded the role of the Business Health Policy Committee in assisting small businesses in acquiring adequate and affordable health coverage for its low wage employees. Those beginning initiatives were believed to be critical to engaging the health care community in a larger effort to make major reforms in the health care system. In addition, state agencies engaged in health care purchasing began collaborating with Kansas physicians to produce a common set of evidence-based guidelines that could form the core of a pay-for-performance reimbursement model.

In fall 2004 the governor and the insurance commissioner introduced the bipartisan health proposal, entitled the Healthy Kansas reform initiative. Many of the policy options

supported by the Steering Committee were incorporated into this comprehensive health care reform initiative. Key elements of the reform initiative include: streamlining all of the state's major health care programs into a new business division called the Kansas Health Care Authority, establishment of a Kansas Health Care Cost Containment Commission to cut unnecessary administrative costs and improve quality and use of technology, increasing the enrollment of children eligible for Health Wave, enabling small businesses to attain affordable health insurance, assisting citizens to procure less expensive prescription drugs, and reducing preventable chronic health conditions.

A key element of Governor Siberia's health care reform agenda was a reduction in the number of uninsured workers, especially those employed by small businesses for which access to health care is an increasing crisis. The existing Business Health Partnership would provide the mechanism to accomplish this improvement in access. The Governor's plan for reducing the numbers of uninsured relied on the creation of public subsidy dollars for low-wage employees of small businesses through a plan offered by the Business Health Partnership. The legislature appropriated $500,000 in 2005 to provide subsidies to low wage workers securing health insurance through the Business Health Partnership.

As noted earlier, the Business Health Partnership was established with the goal of expanding coverage through a linkage between the public and private sector by improving the affordability and quality of health insurance for low-wage workers in small businesses. Kansas recognized that the solution must address both the willingness of the business to offer health care coverage and the ability of the low wage employee to afford the cost of coverage. It was the intended purpose of the legislation creating the BHP that there be available subsidies and/or tax credits to encourage such participation. While previously those subsidies have not been available due to budget constraints, Governor Rebellious proposed them and the legislature funded them, thus allowing the BHP to operate according to original legislative intent.

In August, 2004 the state secured foundation funding to obtain technical assistance to model the impact of various levels of subsidies (both employee and employer tax credit), based on a specific benefit package whose actuarial value has been determined and then develop strategies based on the modeling that would be most effective in reducing the numbers of uninsured. The information gained through this project is being utilized by the Business Health Policy Committee as they develop a sliding scale subsidy schedule for low-wage workers employed by small firms attaining health insurance through the BHP.

Kansas is also currently exploring the impact of four reinsurance mechanisms on health insurance take-up by small employers. The state was awarded a SPG Pilot grant in 2004 that funded the modeling of two prospective and two retrospective reinsurance methods and the information derived from this feasibility study will be used to select the most effective reinsurance mechanism for use in Kansas to control premium cost volatility in the small group market. Once that is determined reinsurance will be added to the

collective small employer policy strategies employed by the BHP to make health insurance more accessible and affordable to small employers.

A product of the initial Kansas State Planning Grant was a policy options menu containing a number of different mechanisms intended to reduce the number of uninsured Kansans. In 2005 the Kansas Legislature passed two bills from that menu, an authorizing bill which enhances the effectiveness of the tax credit for small employers and an appropriations bill which provides subsidies for low wage workers attaining health insurance through the Business Health Partnership. The feasibility of using of reinsurance for the small employer market is being modeled and mechanisms for increasing enrollment of children eligible for public programs is included in the Governor's initiative, will be facilitated by the Business Health Policy Committee and enhanced agency outreach strategies.

The policy options menu also included some approaches which have not progressed including expansion of the Medicaid Health Insurance Premium Payment Program, allowing select industry groups to enroll in the State Employee's Health Insurance Program, continuation of employer-based coverage for dependents up to age 25, and State Employee Program and Medicaid buy-ins. Policy movement has concentrated on those incremental policy approaches targeted to low wage workers of small employers using existing vehicles. A Medicaid expansion proposal to adults with household incomes below the federal poverty level was included in the Governor's original health proposal but did not garner legislative support in 2005.

C. Pilot grant activities

In 2004 the Kansas Department of Insurance was awarded a SPG Pilot Planning Limited Competition grant. The Kansas pilot project is designed to model the impact of four distinct reinsurance mechanisms on premium price stability and take-up among small employers in offering health insurance to their employees. The first mechanism to be tested is prospective reinsurance with a $ 5,000 attachment point, 10% retention, and reinsurance premium paid by the ceding carrier. This will test the NAIC Model. The second mechanism is prospective reinsurance with first dollar coverage, but with reinsurance premium paid by the ceding carrier. This was the original design for the Connecticut mechanism. The third mechanism is retrospective reinsurance for all paid claims applicable to a set of selected diagnosis codes. The fourth mechanism is retrospective reinsurance for all paid claims in excess of a specific attachment point on all small employer business and it will produce the highest losses of the mechanisms being considered.

The Steering Committee believes that maximum reduction in the number of uninsured Kansans will be achieved by combining a variety of the policy options to capitalize on the additive effect the options have on each other. The Business Health Partnership would serve as the mechanism through which small employers could attain affordable, quality health insurance; employers would be encouraged to offer health insurance through a tax credit set at an optimal level; employees would be assisted in payment of

their premiums through adequate subsidies; and the dependents of those employees could attain employer-based coverage using public monies. These multiple strategies collectively provide a much more effective approach to improving access to health insurance for small employers and low wage workers. The findings of the pilot project will provide information about which reinsurance mechanism will be most effective in Kansas to control premium cost volatility in the small group market.

The goal of the pilot project is to test the cost/benefit implications of controllable claim fluctuations, pricing stability, and risk acceptance by carriers using alternative reinsurance mechanisms and risk or cost spreading methodologies. The quantified cost reductions will be applied to average premium rates in order to test the propensity for small employers to buy health insurance with reduced costs. This improved propensity to purchase health insurance will be applied to the market as a whole in order to project the resulting potential to reduce the uninsured small employer population in Kansas.

More specifically, the objectives of this project are:

1. Gather and analyze existing Kansas specific small employer health insurance data bases to select data elements required for the reinsurance modeling project and develop testable assumptions where data is insufficient.

2. Transform data into actuarially sound assumptions for integration into the Reinsurance Assessment Modeling Software.

3. Model the impact of the four alternative reinsurance mechanisms on carriers and small employers.

4. Analyze the combined impacts of reinsurance, employer tax credits, and low income employee subsidies on small employer and employee premium costs and reductions in the number of uninsured.

5. Add specificity to target policy options based upon the information gained through the reinsurance modeling project.

6. Continue the consensus building activities to garner support for targeted policymaking action to improve access to health insurance for Kansans

7. Prepare the Secretary's report summarizing the finding and policy recommendations emanating from the State Planning Grant Limited Competition Grant.

Currently the following Pilot Planning grant tasks have been completed. Pool Administrators Inc. has compiled and reviewed various sets of public information. Sources information included, but were not limited to, the Kansas Small Employer Health Insurance Survey, Kansas census data, and information available from the Kansas Commerce Department and Kansas Chamber of Commerce. Pool Administrators Inc.

also collected information collected related to Kansas health insurance premiums in the small group market, including base rates, the allowable Kansas rating factors, and the state's premium and unemployment tax rates.

Pool Administrators Inc. attained the Kansas Health Insurance Information System (KHIIS) data, a data set containing claims data from the 20 largest health insurance carriers regulated providing private health insurance coverage for Kansans, small groups sample. The data, membership and claims, were loaded onto the dedicated server of Pool Administrators Inc. After the data was successfully loaded, the membership data was analyzed for completeness and accuracy. This was a three step process which involved cleaning the data, identifying carriers and groups, and consolidating the individual data elements to form one record per unique member.

The data then was subjected to an extensive cleaning process. The first step of the cleaning process started with 7,057,858 data elements which needed to be reviewed for completeness, consistency and relevance. Of the 7,057,858 data elements received, 523 exact duplicates existed which were removed leaving 7,057,335 data records. Next, all non medical products were removed as well as disease specific health plans. The data elements removed during this stage of the process totaled 1,243,171 leaving 5,814,614 records for further analysis. Next invalid birth dates among the remaining health plans were removed. The invalid birth dates totaled 29,487 leaving 5,785,127 data elements for still further analysis. This data cleanup process resulted in the removal of all incomplete and irrelevant data.

Pool Administrators Inc. then combined the data elements to form one record for every unique member. The resultant data set was contained 18 unique carriers, 940 unique small groups, and a membership count of 913,388. From the membership all relationships that were identified as invalid were removed which resulted in a "cleaned" membership of 873,098 unique members for the entire five year period KHIIS data was collected.

During the process of cleaning the data, it was determined that for some of the individuals in the data set discrepancies existed between the membership and claims data... For example, in month June insured X was in the membership file and had claims in the claims file. In month July, insured X had claims in the claim file but was not present in the membership file. Finally, in month August insured X appeared in both the membership and claims files. Based on the information contained in the claims file, that information being that Insured X had claims paid by the same carrier in months June, July and August, and yet only appeared in the membership file for the months of June and August, it was assumed that insured X was covered for the month of June. Any gaps in coverage for any individuals that met this criterion were corrected.

After the membership count was established for all years of KHIIS data, the data was compared to previously published information from the Medical Expenditure Panel Survey for reasonableness. This data source was chosen because it is one of the few data

sources that report groups and employees by the size of the group and it has well established validity and reliability.

In order to test for the reasonableness of the number of small groups contained in the cleaned data, the group count that was derived from the KHIIS data was compared to the number of private sector establishments with less than 50 employees offering health insurance as reported by the Medical Expenditure Panel Survey (MEPS). It was expected that the derived groups would be somewhat smaller than what was reported in the MEPS because the MEPS data appeared to contain groups of one and the KHIIS data does not contain information from all of the carriers which insure small groups in the state of Kansas. For the years 2000 and 2002, the derived KHIIS group counts were approximately 55% and 78% of what was reported in the MEPS data.

Reconciliation of derived groups to MEPS Groups	**2000**	**2002**
Number of establishments in the state	53,766	52,382
% of establishments offering health insurance	47.8%	39.7%
Number of establishments offering health insurance	25,700	20,796
Group Counts Derived from KHIIS Data	14,046	16,310
Derived Data as a Percentage of the MEPS Data	54.65%	78.43%

After the group count comparison between the KHIIS and MEPS data were completed, comparisons between the KHIIS and MEPS data were undertaken for employee counts. As with the group counts, this comparison was done for the years 2000 and 2002 and the reasonableness test results were similar to the group results.

Once the data set was cleaned and inspected for reasonableness, members who would be ceded to each of the four pool types were identified. The two retrospective reinsurance models include: (1) the full retrospective reinsurance pool, which assumes that all insured members with claims will be reinsured through the pool for a certain corridor of coverage, (2) the retrospective reinsurance pool based on diagnosis code, which assumes that any insured member who had a claim or claims bearing specific diagnosis codes for a given year would be ceded to the pool for reinsurance. For both of these retrospective models decisions to cede will be based upon claims history recorded in the KHIIS data set. The two prospective reinsurance models are (3) the NAIC model pool and (4) the Connecticut Small Employer Health Reinsurance Pool. In a prospective reinsurance situation insuring carriers must decide which insured members to cede to the pools. Simulation of this carrier decision making process using criteria developed by the carriers participating in the actual reinsurance pools were applied uniformly to all carriers included in the KHIIS data set. The ceding simulation assumes, as is observed in actual reinsurance pools, that none of the carriers would be able to accurately cede all high risk members. To simulate this inherent level of inaccuracy, it was assumed that the insurers would be effective at levels of 50% and 75%, resulting in only 50% or 75% of the high

cost claimants insured by the carrier being ceded to the Pool. It also assumed that there would be risks ceded to the pool that do not generate claims in excess of the reinsurance premium paid. Simulation of this phenomenon was performed at the 50% and 75% accuracy level.

Pool Administrators Inc. is currently awaiting the delivery of a resubmission of data from one of the carriers that previously submitted incomplete data to the KHIIS data set. When this data is received it will be compared to the existing data from this carrier for materiality. If differences between the two files are material the resubmitted data will be cleaned and added to the data set being utilized for the modeling runs.

In order to model the two prospective reinsurance mechanisms a reinsurance premium must be entered into the modeling software field. This reinsurance premium has been calculated by the consulting actuary utilizing Kansas insurance data. Once the missing KHIIS data is resubmitted the four reinsurance mechanisms will be modeled.

The State Planning Grant Steering Committee has been reconvened with a majority of the original members continuing to serve. The Committee has received briefings about the reinsurance modeling project as well as the small employer study and the subsidy modeling. At the next meeting of the Steering Committee Pool Administrators Inc. will present preliminary findings from the reinsurance modeling runs.

D. Implementation status

Kansas requested and was granted a no cost extension for the pilot project to complete the remaining project tasks. Pool Administrators will run the four reinsurance models and quantify the impact of each of them on the Kansas small employer insurance market. The findings will be presented to the Steering Committee and they will use that information to determine which reinsurance mechanism will be most effective in Kansas to control premium cost volatility in the small group market, adding a specific reinsurance policy to the already selected small employer strategies.

Kansas State Planning Grant activities up to this time have been focused on data generation and using that information to refine the originally selected policies targeted to making health insurance more accessible for low wage employees in small firms. Implementation has not yet occurred but the policies nearing implementation are the remodeled small employer tax credit and the subsidies for low wage workers securing health insurance through the Business Health Partnership.

E. Recommendations to the Federal Government and HRSA

The Kansas Pilot Planning Grant project work is not yet completed so we have limited suggestions for Federal or HRSA support at this time. Kansas anticipates that federal grants such as those proposed by Representative Johnson to fund state reinsurance pilots would be very helpful as these grants could provide startup funds to put in place a mechanism to help stabilize the small employer health insurance market. Also having a

reliable data source to monitor insurance status of Kansans at a sub-state level would assist in creating targeted policy strategies to reduce the number of uninsured. This would be facilitated with further expansion of existing federal data collection efforts such as the CPS and MEPS-IC.

F. Appendix 1: Summary of Policy Options

Option considered	Target Population	Estimated Number of People Served	Status of approval (for example waivers submitted or legislation proposed)	Status of implementation (please include date program or initiative began)	If implemented, most recent estimate of number people served. (date and point in time estimate)
1.Increase Tax Credit in Current Program	51,722	4,764	Legislation enacted	Department of Revenue is drafting regulations New tax credit awarded to businesses with eligible covered employees first covered after December 31, 2004	
2. Implement Kansas Business Health Partnership	73,200	6,084	Subsidy Funds Appropriated	Business Health Policy Committee is drafting subsidy schedule	
3. Reinsurance for Small Employers	73,200	8,002	Feasibility being modeled		
4. Improve Enrollment Rates for HealthWave Eligible Children	36,975	23,109	Governor's Health Proposal initiative	Business Health Policy Committee plan to enroll children of adults receiving subsidies Agency reviewing outreach activities	

5. Expand Use of Medicaid HIPP Program	37,078	7,404	No action		
6. Select Industry Enrollment in State Employee Program	15,145	3,090	No action		
7. Continue Employer Based Coverage of Dependents	1,092	204	No action		
8. Expand Medicaid Eligibility	43,054	25,291	Governor's Health Proposal initiative		
9. Medicaid Buy-in Program	244,696	57,464	No action		
10. State Employee Plan Buy-in	244,696	16,533	No action		

G. Appendix 2: Project Management Matrix

PROJECT MATRIX

Objective	Action Steps	When	Responsible Party	Outcome
Gather and analyze existing Kansas specific small employer health insurance data bases to select data elements required for the reinsurance modeling project and develop testable assumptions where data is insufficient	Compile data profiling Kansas small employer population using Kansas Small Employer Survey data, Kansas Census data, Kansas Department of Commerce data, and Kansas Chamber of Commerce data	11/04 – 3/05	Project Director and Co-Director in collaboration with Pool Administrators	Populate the data fields of the Reinsurance Modeling Software
	Compile data profiling Kansas health insurance premiums including base rates, rating factors, premium tax rates, and unemployment tax rates	12/04 – 3/05	Kansas Department of Insurance, Project Director and Co-Director in collaboration with Pool	Populate the data fields of the Reinsurance Modeling Software
	Data cleanup of the Kansas Health Insurance Information System database and transmittal to Pool	1/05 – 10/05	Kansas Department of Insurance, Project Director and Co-Director, and consultant in collaboration with Pool	Populate the data fields of the Reinsurance Modeling Software
	Identify any missing data elements required by the Reinsurance Modeling Software and select a alternative	3/05 – 10/05	Kansas Department of Insurance, Project Director and Co-Director in collaboration with Pool	Populate the data fields of the Reinsurance Modeling Software
Transform the data into actuarially sound assumptions for integration into the Reinsurance Assessment Modeling Software	Actuarial determination of average small employer rates for median health insurance plan	3/05 – 6/05	Pool Administrators and actuary consultant	Populate the data fields of the Reinsurance Modeling Software
	Actuarial determination of reinsurance premium rates employing NAIC Model Act guidelines	3/05 – 6/05	Pool Administrators and actuary consultant	Populate the data fields of the Reinsurance Modeling Software
	Determine reinsurance ceding assumptions to be used by carriers for the two prospective reinsurance mechanisms	3/05 – 6/05	Pool Administrators and actuary consultant	Populate the data fields of the Reinsurance Modeling Software
	Determine the assumed reinsurance loss ration for each of the four reinsurance mechanisms	3/05 – 6/05	Pool Administrators and actuary consultant	Populate the data fields of the Reinsurance Modeling Software
Model the impact of the four alternative reinsurance mechanisms on carriers and	Using the Reinsurance Modeling Software and the Reinsurance Assessment Software actuarially	9/05 – 11/05	Pool Administrators and actuary consultant	Quantified impact analysis of variation between

small employers	estimate the expected change in carrier pricing and risk acceptance under the four reinsurance mechanisms			reinsurance models and design alternatives
	Model alternative pricing and benefits structures using the four reinsurance mechanisms	9/05 – 11/05	Pool Administrators and actuary consultant	Quantified impact analysis of variation between reinsurance models and design alternatives
	Allocate net losses for each mechanism	9/05 – 11/05	Pool Administrators and actuary consultant	Quantified impact analysis of variation between reinsurance models and design alternatives
	Determine financial impact of each reinsurance mechanism on carrier pricing and risk acceptance and explore impact with modifications in premium pricing and benefit structures	9/05 – 11/05	Pool Administrators and actuary consultant	Quantified impact analysis of variation between reinsurance models and design alternatives
	Use the Assessment Modeling Software to examine the impact of several cost allocation methodologies	9/05 – 11/05	Pool Administrators and actuary consultant	Quantified impact analysis of variation between reinsurance models and design alternatives
Analyze the combined impacts of reinsurance, employer tax credits, and low income employee subsidies on small employer and employee premium costs and reductions in the number of uninsured	Use the economic modeling to estimate the costs and take-up using a combination of policies	1/06 - 3/06	Sherry Glied in consultation with Pool Administration	Estimated costs and take-up rates of uninsured
Add specificity to target policy options based upon the information gained through the reinsurance modeling project	Review the findings of the reinsurance modeling project	11/05	Steering Committee in consultation with Pool	Identification of most appropriate reinsurance mechanism for Kansas
	Review the findings of the combined impacts modeling	4/06	Steering Committee in consultation with S. Glied	Select the combination of policy options for the targeted strategy and delineate the detail specifications
	Publish targeted policy strategy for small employer and low income employees	5/06	Steering Committee with staff support of Project Director , Co-Director, and KID program manager	Targeted small employer and low income employee policy strategy
Continue the consensus building activities to garner support for targeted policymaking action to improve access to health insurance for Kansans	Seek public and stakeholder input	8/05 – 8/06	Steering Committee, Project Director and Co-Director, and Insurance Commissioner	Presentations to various stakeholder and public audiences

Prepare the Secretary's report summarizing the findings and policy recommendations emanating from the State Planning Grant Limited Competition Grant	Submit final report adhering to specified format	9/06	Steering Committee with staff support of Project Director, Co-Director, and KID Project manager	Final Secretary's report

H. Appendix 3

No reports or products have been generated at this time.