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## Expanding Health Insurance Coverage in Kansas

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In October 2000, Kansas was given an opportunity to learn more about the state's uninsured population in order to develop targeted policy options to address this problem. The Kansas Insurance Department was awarded a \$1.3 million health resources and services administration state planning grant, as part of a federal initiative to provide states with resources to develop plans to insure that all citizens have access to affordable health insurance. A commissioned survey revealed that more than 244,000 Kansans lacked health insurance coverage in 2001.<sup>1</sup> Most of the uninsured were younger than 65 years of age, since virtually all of the elderly had Medicare coverage. Three-quarters of the uninsured were adults,<sup>2</sup> and most had low incomes.<sup>3</sup> A quarter of the uninsured had a household income below the federal poverty level (\$17,650 for a family of four), and half had a household income below 150% of the federal poverty level (\$26,600 for a family of four).<sup>4</sup> Increasing numbers of policy makers and health care professionals have expressed renewed interest in expanding health insurance coverage, so a careful exploration of state policy options is needed.

This paper examines the options currently under

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consideration. It begins by examining why being uninsured is a matter of public concern and what we know about the uninsured in Kansas. The paper then briefly describes the three basic policy approaches that were analyzed and discussed within the state planning grant process: intervention in the small group market, expansion of public programs, and facility-based insurance plans. The paper continues by exploring eleven specific policy initiatives, drawing on the experiences of other states to draw what lessons we can about the political, administrative, and financial implications of these initiatives. The paper concludes by assessing which of the options seem most worthy of further examination and debate.

## **I. THE PROBLEM**

We are concerned about the uninsured for two reasons. First, lack of insurance affects the uninsured and the local health care system. Uninsured adults and children often cannot afford to get the health care that they need.<sup>5</sup> Uninsured patients generally face higher out-of-pocket expenses, and are more likely to be expected to pay in full when they get care.<sup>6</sup> Especially for those with low incomes, being uninsured is likely to delay access to care. Delays in getting care can transform a minor health problem into a major, sometimes untreatable, costly health crisis. In addition, those without health care coverage may face financial disaster if they suffer illness or injury. And even if neither of these misfortunes occurs, the uninsured worry that they will.

Second, large numbers of uninsured residents also compromise local health care systems. Areas with high numbers of uninsured residents generally have fewer health care providers per capita, as the prospect of working harder to make a lower income has a limited appeal. The Kansas Health Insurance Study divided the state into ten Groups, combining twenty-five southwestern Kansas counties into Group Ten. Taken together, these twenty-five counties have the highest percentage of residents without coverage in Kansas. These counties are also next to last in the numbers of physicians, nurses, dentists, and pharmacists per thousand residents. Of these counties, the Kansas Department of Health and Environment has designated two as Underserved and eleven as Critically Underserved. Throughout the state, moreover, large numbers of uninsured residents mean low numbers of health care providers.<sup>7</sup>

Furthermore, providers in areas with large numbers of uninsured residents face added challenges because they are expected to provide services to uninsured patients who need care, but cannot pay for it. This can be a major problem for rural and inner city health care organizations that face other financial stresses. Simply staying open can be difficult, and generating the funds to acquire current technology may seem impossible.

**A. How do people get insurance?**

Most non-elderly people in the United States who have health insurance get it through their employment. Employment-based insurance covers most active workers, early retirees, and their dependents. This pattern holds in Kansas as well. In 2001, 71.5% of Kansans had employment-based insurance coverage.<sup>8</sup>

For those who are not employed or whose employers do not offer health care coverage, the primary option is individual coverage. At 11.2%, the proportion of Kansans with individual coverage is above the national average.<sup>9</sup> This is important because individual coverage is inherently riskier than group coverage. Individual coverage can become unaffordable because an individual beneficiary's medical claims have been too high or because an insurer has experienced an unanticipated surge in overall claims. Given that rapid increases in medical costs again appear to be on the horizon, this is a real concern.

This concern has special relevance to many of the state's rural counties. In the counties of north-central Kansas, 17.5% of the residents have individual insurance, and in the counties of northwest Kansas, 20.6% have individual insurance.<sup>10</sup> Any disruption in the market for individual insurance will have a major impact on these areas, and since this is a market that has experienced insurance carrier departures in Kansas and other states, further instability needs to be avoided. Relatively few adults currently qualify for public insurance programs (such as Medicaid or HealthWave), although substantial numbers of children do because income eligibility thresholds are set substantially higher, at 200% of the Federal Poverty Level versus 43% for most adults. Only 8.9% of adult Kansans have government-sponsored insurance,<sup>11</sup> compared with the 19.2% of children with such coverage.<sup>12</sup>

**B. Why does how people get insurance matter?**

How individuals get coverage significantly affects how much insurance costs them, because different ways of buying insurance change both the underlying cost of the policy and the share of the cost that the individual must pay. For example, as we will explore later, the total cost of an individual policy usually exceeds the total cost of a group policy. And the cost of a small group policy usually exceeds the cost of a comparable large group policy.

These differences in underlying costs are further complicated by the federal tax code. If a self-employed individual buys an individual policy, he or she will usually qualify for a substantial tax credit, which effectively reduces the cost of the policy. But if an employee buys the same individual policy, he or she will not qualify for a tax credit and must pay the full cost of the policy. Similarly, if an employer pays for an employee's insurance coverage, that payment is not treated as income for the

employee. If the employee pays for insurance coverage, in contrast, he or she will first have to pay income and payroll taxes and then use the remaining after-tax dollars to buy insurance. In effect, the after-tax cost of coverage is much less if the employer pays for it than if the employee pays for it. Finally, a limited number of Kansans qualify for public insurance plans and are eligible for free insurance. But those with an income one dollar over the limit must buy insurance themselves. A seemingly innocent question like, "How much does health insurance cost?" has a very complicated answer.

One thing is clear. Employees who must buy individual policies face much higher costs than other Kansans. The total after-tax cost of an employee's individual policy can be *more than double* the after-tax cost of the same coverage bought by a large employer.<sup>13</sup> For example, John Gabel and his colleagues estimated that in 2000 the median premium for coverage purchased by an employer was \$198 per month, making the after-tax cost as little as \$100 per month.<sup>14</sup> In contrast, the premium for significantly less generous individual coverage for a healthy 55-year-old male was \$313 per month.<sup>15</sup>

This has two important policy implications. First, any expansion of coverage is apt to emphasize encouraging employers to offer and pay for health insurance coverage, as the effects of buying group policies and using pre-tax dollars to do so are so large. Second, the tax treatment of health insurance benefits is largely a federal policy question. Although changing the tax code might well be a useful step, it is not a policy that an individual state can consider.

Before moving on we will briefly explore why large group health insurance policies offer consumers more attractive values than individual or small-group policies, independent of tax effects. Buying health insurance as a member of a group has four advantages apart from the tax advantages of doing so. First, insurers' overhead costs are lower when they sell to large groups, so insurance costs less. It costs only a little more to sell a policy that covers a 500-beneficiary group than it does to sell a policy to an individual. Second, average spending per beneficiary varies less in large groups, so premiums vary less (and are apt to be lower because insurers can profitably operate with smaller margins). Third, one or two individuals with high medical bills will have little impact on average spending in a large group. In a small group, though, one very ill member can push up premiums for everyone in the group. Finally, larger groups can offer different types of coverage, so beneficiaries can choose a plan that best meets their needs. One common pattern is for young single workers, who anticipate low medical care spending, to choose much less generous plans than older married workers, who anticipate much higher levels of spending. In a large group both types of workers can be accommodated; in a small group usually only one policy can be offered. Taken together these advantages mean that larger groups will be offered a wider array of more attractively priced policies than smaller groups or individuals.

As a result, individual and small-group medical insurance policies may be difficult to purchase and can be very expensive. These policies are likely to be beyond the reach of most low-income families and many middle-income families. For families with a history of serious illness, the cost of individual or small-group policies can be enormous.

**C. Why do people lack health insurance?**

Research tells us that the main reason for not having coverage is that the cost is too high relative to an individual's income.<sup>16</sup> Expanding coverage requires making it more affordable. Most observers would argue that the steady decline in health insurance coverage during the last twenty years can be attributed to: (1) average health care costs that have risen faster than average incomes, and (2) incomes of low-skill workers that have risen more slowly than average incomes.<sup>17</sup> Both of these increase the number of households for whom health insurance is too expensive.

Because of the tax treatment of benefits, making coverage more affordable requires having an employer offer and pay for coverage or having the government offer a very substantial subsidy. Overall, 80.6% of adult Kansans are offered health insurance benefits by their employer.<sup>18</sup> Not surprisingly though, part-time employees, seasonal employees, and newly-hired employees are far less likely to be offered coverage than established full-time employees.<sup>19</sup>

The picture is less optimistic for employees in small firms. Only 17.4% of those working in firms with fewer than five employees are offered coverage.<sup>20</sup>

While most full-time workers are offered health care coverage as a benefit of employment, this does not assure that these workers and their dependents can take advantage of this coverage.<sup>21</sup> The portion of the premium that employers require employees to pay can vary dramatically. Half of the employees in Kansas pay \$152 per month or less for family coverage, but a quarter need to pay more than \$260 per month.<sup>22</sup> Some workers, particularly lower income workers, may not be able to afford the portion of the premium they are expected to pay. In addition, some employers do not offer coverage for the dependents of employees, even though it is available for employees themselves.<sup>23</sup> Among those offered coverage, 11.8% did not have the option of purchasing family coverage.<sup>24</sup>

As might be expected, most of those without coverage have low incomes.<sup>25</sup> Among those with household incomes below the Federal Poverty Level, 31.5% do not have insurance.<sup>26</sup> In contrast, among those with household incomes 250% above the Federal Poverty Level, only 4.2% do not have insurance.<sup>27</sup> The cost of insurance is a more formidable obstacle for those with low incomes.

Uninsured Kansas can be sorted into four groups: those who are unemployed but actively seeking work (17.1% of the uninsured); those who are not in the labor

force (17.0% of the uninsured); those who are self-employed (11.5% of the uninsured); and those who are employed (54.4% of the uninsured).<sup>28</sup> Among those who are employed and uninsured, only about a quarter (representing 14.4% of the uninsured) are eligible for coverage through an employer.<sup>29</sup>

This typology makes it clear that several types of policies to increase access to health insurance may have to be considered to address these distinct groups. Over half of the uninsured are employed, so increasing offers of insurance through their employers could allow many of them to get coverage. Still, roughly a third of the uninsured are not employed. Policies that might induce more employers to offer coverage will have no effect on them. In addition, subsidies will have to rise to increase enrollment among the self-employed and employees who decline coverage, as there are already significant tax subsidies in place for many of them.

## **II. OPTIONS FOR EXPANDING COVERAGE**

Three basic policy approaches for expanding coverage became the focus of State Planning Grant Steering Committee activities. These are: (1) intervention in the small group market; (2) expansion of public programs; and (3) facility-based insurance plans. Each of these basic options has a number of potential variants that can be considered. These variants can transform each of the options from tightly focused interventions that cover only a few additional people and do not cost very much to broad-based interventions that cover many additional people and cost a good deal. The details matter a great deal. For example, during its first year of operation the Wisconsin BadgerCare Health Insurance Premium Payment Program enrolled only four families.<sup>30</sup> In contrast, the Oregon Family Health Insurance Assistance Program, which looks similar to BadgerCare, had enrolled over 4,000 people and had a waiting list of 23,369.<sup>31</sup>

In the next three sections we will examine each of the three approaches for expanding coverage. To the extent possible, we will draw on the experience of other states to assess the political feasibility, administrative feasibility, coverage enhancement potential, and cost per new enrollee of programs of each type.

Eleven proposals are currently under final consideration by the State Planning Grant Steering Committee.<sup>32</sup> All represent either interventions in the small group market or expansions of public programs.<sup>33</sup> Conspicuously absent from final consideration are any facility-based plans.<sup>34</sup> Given the Kansas context, this omission is quite sensible, as we will explore in Section V.

Seven interventions in the small group market are now under consideration.<sup>35</sup> The first, called the Phase I Tax Credit, represents an existing statute that provides a tax credit for businesses with two to forty-nine employees that do not currently offer health insurance, with education and technical assistance enhancements.<sup>36</sup> The second

proposal, called the Phase II Tax Credit, is a new tax credit for all small businesses that enroll 80% of their low-income employees.<sup>37</sup> A third proposal would expand the size of the existing Phase I tax credit to \$1,000 per employee with a revised phase-out schedule, but as in the original proposal, limiting it to small employers not currently offering health insurance to their employees.<sup>38</sup> The fourth intervention in the small group market is implementation of the Kansas Business Health Partnership, an entity established under current statute but as yet non-operational.<sup>39</sup> It creates a purchasing coalition for small businesses that would incorporate subsidies for low-income enrollees.<sup>40</sup> The fifth proposed intervention in the small group market is the Phase II Kansas Business Health Partnership.<sup>41</sup> This would add state-subsidized reinsurance to the Phase I Partnership.<sup>42</sup> The sixth intervention would allow employees in selected industries to purchase coverage in the State Employee Health Plan.<sup>43</sup> The seventh proposal would allow any Kansan without access to employer-sponsored insurance to buy into the State Employee Health Plan.<sup>44</sup>

Four expansions of public programs are being considered.<sup>45</sup> The first is to improve marketing, enrollment, and retention procedures to increase enrollment of children who are eligible for Medicaid or HealthWave.<sup>46</sup> The second expansion would maximize use of existing Medicaid provisions that allow the purchase of employer-based health insurance coverage for Medicaid-eligible children and their parents.<sup>47</sup> The third would expand the eligibility of adults for Medicaid to include those with incomes up to 100 percent of the Federal Poverty Level.<sup>48</sup> The fourth public initiative would allow any Kansan to buy into Medicaid.<sup>49</sup> Those with incomes below 300% of the Federal Poverty Level would be eligible for subsidies.<sup>50</sup>

### **III. INTERVENTION IN THE SMALL GROUP MARKET**

Intervention in the small group market generally combines a mixture of four components. Some interventions, like the Kansas Small Employer Tax Credit, the Massachusetts Insurance Partnership, and the New York State Health Insurance Partnership Program, directly subsidize firms that offer coverage.<sup>51</sup> Other interventions, like Oregon's Family Health Insurance Assistance Program and Iowa's Health Insurance Premium Payment Program, subsidize low-income families to help them afford their share of the cost of employment-based insurance.<sup>52</sup> Still others, like the Healthcare Group of Arizona, the New Mexico Health Insurance Alliance, and the New York State Health Insurance Partnership Program, seek to reduce some of the problems of the small group health insurance market, typically by offering reinsurance or changing the applicable regulations.<sup>53</sup> Finally, some interventions, like the Healthcare Group of Arizona and MinnesotaCare, effectively merge many small groups into one or more larger ones.<sup>54</sup> These interventions are not mutually exclusive.

States can and do choose the policy combinations that best address their concerns about cost, coverage, political feasibility, and administrative complexity.

In principle, merging small groups into a virtual large group could dramatically expand coverage, especially if individuals were allowed to join the virtual group and if insurers viewed the group as a standard risk group. As we noted earlier, coverage provided through a large, standard risk group usually has substantially lower premiums than comparable small group or individual policies. The initial experiences of the Healthcare Group of Arizona makes it clear that, unless the virtual group is well defined or heavily subsidized, adverse selection may turn it into a high risk group. By adverse selection we mean the process by which standard risk customers will seek coverage with commercial insurers, and high-risk customers will seek coverage with the virtual group. This will result in a virtual group that either charges very high premiums or requires very large public subsidies.

It should be stressed that, without significant subsidies, such a plan is unlikely to provide coverage for many of the unemployed, who constitute just over a third of the uninsured. Individual coverage will remain unaffordable for most of them because they generally have low incomes and because they have to buy insurance with after-tax dollars. As a result, relatively few of those who are not employed will be able to afford unsubsidized insurance.

Still, two-fifths of the uninsured are employed, but not able to secure coverage at work.<sup>55</sup> Because of the substantial tax subsidies associated with employment-related insurance, purchasing coalitions have considerable potential. In addition, a significant portion of those who are self-employed might well seek coverage in such a group.

Unless care is taken though, three problems can limit the impact of virtual large groups. One is that adverse selection (in which low-risk small groups buy commercial insurance, leaving behind high-risk small groups) may gradually convert the virtual group into a high-risk pool. This appears to have happened to the Healthcare Group of Arizona. Another is that, to keep costs down, the resulting plan offers coverage that is unattractive to employees or employers. There is very little evidence that there is considerable unmet demand for bare bones health insurance, and plans with high deductibles or co-payments are likely to be unacceptable to low-income beneficiaries (who represent a large share of the uninsured).

There are two main financial challenges to the enhancement of the small-group market. One is that substantial subsidies are apt to be needed for large numbers of employers to add coverage as a benefit. Small employers often lack the management resources needed to navigate the complexities of buying health insurance or setting up tax-advantaged benefit plans. Furthermore, many small employers will have trouble in reducing wages or raising prices to cover the cost of insurance. As either employer purchases of insurance or tax-advantaged employee purchases are needed to take advantage of tax subsidies, these are real issues. The other challenge is that substantial

employee subsidies may be needed for widespread acceptance of the offer. Many of the uninsured have low family incomes, and an out-of-pocket premium of even \$100 per month is likely to discourage a high proportion of them.

Taken together, subsidies for employers and employees means that the cost of small-group enhancement will be high if coverage is to expand very much. This is likely to pose a substantial political obstacle. Passing and sustaining this sort of health insurance enhancement will quickly begin to compete for scarce budget allocations.

Thus far, interventions in the small group market have expanded coverage less than advocates hoped.<sup>56</sup> In California, Connecticut, and Florida, three states in which the effects of interventions in the small group market have been examined carefully, the performance has been somewhat disappointing.<sup>57</sup> The fundamental problem appears to be that, because the purchasing pools were relatively small, administrative costs and premiums were relatively high.<sup>58</sup> Because premiums were high, the purchasing pools remained relatively small.<sup>59</sup> Some mechanism, probably substantial state subsidies, is needed to end this stalemate.

A core fact is that many employers need not provide health insurance benefits to attract and retain workers.<sup>60</sup> This is especially true for small firms that rely on low-wage, low-skill workers.<sup>61</sup> Even with substantial subsidies, the business case for adding health insurance benefits is tenuous for these employers. The implication is that improvements in the small group market can increase employment-based insurance somewhat, but significant numbers of low-wage, low-skill employees will remain uncovered. At most, it appears to us that improvements in the small group market will be a part of the solution, not the entire strategy for expanding health insurance coverage.

Especially with regard to tax credits, administration of enhancements to the small group market has proven to be a major challenge. The difficulty is that it asks the three players to do things that they are ill equipped to do. Governments are asked to engage in a sustained and sophisticated marketing effort that gives employers and employees the information that they want, in the form that they need it, without antagonizing small employers, insurance brokers, or insurance plans. Small businesses are asked to make fairly complex changes in their wage, benefit, and tax strategies without (in many cases) a clear economic rationale for doing so. Employees are asked to set aside funds now to reduce their tax and medical bills later, even though many already face severe cash flow problems. What sounds simple at a conceptual level turns out to be quite complex for the participants.

That said, the political attractions of improving the small group market are significant. Doing so is consistent with the general preference for market-oriented strategies that many Kansans appear to share. Doing so also extends a generally accepted mechanism to new groups. At a minimum, policy makers need to carefully explore options for expanding coverage by improving the small group market. It may

be feasible to turn to other approaches after enhancements of the small group market have been thoroughly assessed; it will almost certainly not be feasible to turn to other approaches before doing so.

Our projections of the number of those eligible for each of the seven small-group interventions, the number accepting the offers, the total cost, and the cost per newly covered beneficiary vary a good deal.<sup>62</sup> (Table 1 summarizes this data.) We forecast that 52,000 uninsured Kansans will be eligible for the Phase I Tax Credit. The proposed subsidies are quite modest, so we forecast that only 4,000 of the uninsured will accept the offer of insurance. We project that just over half of the \$2,100,000 in total costs will be spent on Kansans who previously had insurance, making the cost per newly insured person \$525. Because it is less sharply focused on the uninsured, we estimate that the Phase II Tax Credit will have a cost per new insured more than five times as large. We forecast that 43,000 uninsured Kansans will be eligible for it and that 2,000 will gain coverage as a result. As a result, we estimate that the Phase II Tax Credit will have a total cost of \$5,600,000.

We project that the third tax credit proposal, which would give a \$1,000 tax credit per employee to small businesses that add health insurance coverage, would increase coverage by 5,000, somewhat more than the Phase I or Phase II tax credits. We forecast that 52,000 uninsured Kansans will be eligible for it. We anticipate that the total cost of such a program would be \$7,700,000, making the cost per new insured \$1,540.

Phases I and II of the Kansas Business Health Partnership would both target 73,000 uninsured people. We forecast that Phase I would increase coverage by 6,000 at a cost of \$300 each and that Phase II would increase coverage by 8,000 at a cost of \$1,488 each. The added cost of the Phase II program arises because it entails publicly subsidized reinsurance of the purchasing coalition.

We project that neither of the two proposals to expand access to the State Employee Health Plan would entail any cost to taxpayers. Employers and newly insured employees would bear all of the costs. This might not be correct, in that some reinsurance of the State Employee Health Plan might be needed to address the concerns of state employees that these initiatives would increase their costs. We have no way of projecting these costs, so we simply note the possibility. We forecast that allowing employees in selected industries to purchase coverage in the State Employee Health Plan could cover up to 15,000 Kansans, but anticipate that 3,000 would actually gain coverage as a result. Allowing any Kansan without access to employer-sponsored insurance to buy into the State Employee Health Plan could cover up to 167,000 Kansans. We project that 17,000 uninsured Kansans would actually gain coverage if this program were initiated.

#### **IV. EXPANSION OF PUBLIC PROGRAMS**

Medicaid and HealthWave are related state-federal programs.<sup>63</sup> Medicaid is an entitlement program established in the 1960s that provides health care for various target populations,<sup>64</sup> and HealthWave was created in the late 1990s to cover additional low-income children.<sup>65</sup> For both programs the federal government matches state spending. The Kansas Medicaid federal matching rate is 59.7%; the HealthWave federal matching rate is 71.8%.<sup>66</sup> HealthWave matching money can be used to expand Medicaid coverage, create or expand a state insurance program, or a combination of both. Medicaid funds can be used to expand Medicaid. Because the HealthWave matching rate is higher and because the HealthWave benefits package is more flexible, expansion of HealthWave seems to be a much more attractive option than expansion of Medicaid.

HealthWave can be expanded in three ways. One entails enhanced marketing to those who are now eligible. This enhanced marketing can take the form of more aggressive outreach, simplified enrollment mechanisms, or more flexible retention policies. The second entails opening enrollment to higher-income children. This might include using income disregards (making eligibility determinations without counting portions of the family income) to enroll children in families with incomes above 200% of the Federal Poverty Level. The third, and perhaps the most important, mechanism involves expanding coverage to parents. This is important because doing so appears to increase enrollment of eligible children and increase use of appropriate medical services. Some states have expanded eligibility parameters for low-income parents or allowed higher-income families to purchase Medicaid, and recently a few states have been granting Medicaid waivers to expand coverage to additional low-income adult populations utilizing a modified benefits package.

Connecticut, New Jersey, and New Hampshire have used income disregards to expand eligibility for coverage.<sup>67</sup> An income disregard involves ignoring some income in determining eligibility, increasing the number of those who can be covered with federal and state funds.

One of the main limitations of HealthWave is that, with a few limited exceptions, it does not provide federal funds for coverage of adults.<sup>68</sup> Since 1996 another section of the Medicaid law (Section 1931) has allowed states to expand coverage of low-income adults by amending their state Medicaid plan to increase income disregards, asset disregards, or income or asset limits.<sup>69</sup> Kansas now uses income disregards to ensure that Medicaid beneficiaries do not become ineligible too quickly, but has not increased income disregards for applicants. A few other states have aggressively taken advantage of this opportunity. For example, Rhode Island disregards all assets and disregards so much income that the parents in a family of four can be eligible for RIte Care with an income of up to \$31,542.50.<sup>70</sup> In addition to

being able to use federal funds for nearly three-fifths of the program's cost, Section 1931 programs allow states to change income and asset disregards slowly so that enrollment does not surge, to restrict the program at any time, to treat applicants and beneficiaries differently (as Kansas does), to require beneficiary cost sharing, and to alter what is covered.

In short, Medicaid under Section 1931 is no longer an entitlement program with federally mandated benefits. A state has considerable flexibility if the program's costs exceed forecasts or if the budget picture turns sour. As such, it is a viable, if expensive strategy for expanding coverage for adults.

A commonly voiced concern is that the stigma of "welfare" rules out expansion of Medicaid as a way of increasing insurance coverage. A recent study points out that, while welfare stigma is an issue for some potential applicants, more mundane concerns appear to be more salient.<sup>71</sup> In many states applying for Medicaid is difficult, unpleasant, and inconvenient.<sup>72</sup>

Expansion of public insurance is likely to encounter two sorts of political problems. The first is the general preference of Kansans for private sector rather than public sector solutions. The second is that expansion of public insurance will increase the competition among worthy programs for scarce state funds. Especially in periods of economic contraction or slow growth, growing requests for public health insurance funding will conflict with requests for education, road, and other funds.

Indeed, expense represents a major barrier to expanding public funding. The least expensive public program subsidizes employer-based coverage for Medicaid-eligible children and their parents. We estimate that 37,000 Kansans would be eligible for this program, that 7,000 would take advantage of it, and that the total cost would be \$9,600,000. As a result, the cost per new insured would be \$1,371.

A proposal to allow any Kansan to buy into Medicaid, with subsidies for those with incomes below 300% of the Federal Poverty Level, would cost nearly twice as much per new insured. We estimate that 245,000 Kansans would be eligible for this program and that 98,000 would participate. The combined federal-state subsidies would cost \$247,900,000, making the cost per new insured \$2,529.

The two proposals to directly enroll Kansans in public programs cost substantially more per new insured. Improving marketing, enrollment, and retention procedures to expand enrollment of eligible children in HealthWave and Medicaid have the potential to affect 37,000 children. We project that 23,000 would gain coverage and that the total cost of the program would be \$78,200,000. As a result, the cost per new insured would be \$3,400. The state, however, has already committed to these expenditures. Enrolling adults with incomes below 100% of the Federal Poverty Level in Medicaid could cover 43,000 Kansans, and we estimate that 25,000 would gain coverage. The total cost of the program would be \$88,500,000, making the cost per new insured \$3,540.

Total costs for these expansions of public programs could be limited by limiting the number of persons covered. Because means tests<sup>73</sup> are integral parts of most public programs, these expansion strategies could be focused on the poorest uninsured. But, because expansions of public programs do not take advantage of the subsidies built into the tax code (with the exception of subsidies for employment-based coverage), the cost per newly covered Kansan is generally high.

## V. FACILITY-BASED INSURANCE PLANS

Facility-based insurance plans cover beneficiaries by directly providing services at one or more sites. An example of such a plan can be found in Kansas City, Missouri, where Swope Parkway Health Center launched an insurance plan to ensure that it remained able to serve its clients after Missouri initiated Medicaid managed care. The insurance plan, now known as First Guard, now covers a variety of beneficiaries in Kansas and Missouri.

Facility-based plans have two main advantages. First, they can build on the existing network of safety net organizations. Low-income consumers often already have established links with these organizations; the organizations have adapted to meet the needs of their clients; and they are usually sited in areas with large low-income, uninsured populations. Second, facility-based plans can mix multiple funding sources to meet the needs of underserved populations. These sources include private insurance payments for services, public insurance payments for services, public subsidies, donations, and insurance premiums. In short, facility-based plans can focus health care resources on areas with large numbers of low-income, uninsured residents.

This very focus is also a shortcoming of facility-based plans. Almost by definition, such plans only offer coverage in relatively small areas (After securing contracts to provide Medicaid coverage in Kansas and Missouri, First Guard no longer really functions as a facility-based plan.). Facility-based plans, almost by definition, do not offer broad solutions to expansion of health insurance. This limitation can also be a political liability. A program that serves only part of the population is likely to be difficult to enact and difficult to sustain in the face of competing needs.

The financial viability of facility-based plans is also uncertain. For most, their financial viability rests on their political viability, as few can aspire to break even on their own. For example, the Boston HealthNet Pilot Plan provides services through the facilities of Boston Medical Center to over 60,000 uninsured residents.<sup>74</sup> Even though a statewide Uncompensated Care Pool funds it, the Plan has experienced some financial stress in recent years.<sup>75</sup> The financial performance of existing safety net facilities has not been good, and public hospitals have been contracting even faster than other hospitals (even though the number of the uninsured has been rising).<sup>76</sup>

Furthermore, the performance of provider-sponsored health insurance plans has generally not been good. Many are too small to pool risk effectively, and corporate

cultures that can operate both provider and insurer organizations appear to be rare. Especially in Kansas, where many communities are small, few facilities have the depth and breadth of administrative talent to expand from health care delivery to health insurance.

## V. CONCLUSION

It is likely that 2001 represented the golden age of the current insurance system. Health care costs had been rising fairly slowly for a decade, the unemployment rate was low, and wages had been rising briskly. The willingness of employers to offer coverage was high, and the ability of employees to take up the offer was also high. These trends, combined with expanded public coverage of low-income children via Medicaid and HealthWave, meant that only one Kansan in ten lacked health insurance coverage.

None of these trends looks as favorable today. Health care inflation has accelerated, unemployment has increased, and wage gains have slowed. The state budget deficit means that contraction of public coverage seems more likely than expansion. In this environment the options for expanding coverage are more limited, even as the need for coverage grows.

Our analysis suggests that expanding coverage will represent a test of political skill. The options that significantly expand coverage generally have high costs and expand the role of the state in the health care system. A Medicaid Buy-in,<sup>77</sup> which promises the largest increase in coverage of any of the options considered, would more than double the size of the program and would entail public spending of more than \$247,900,000. The proposals to expand enrollment of children in HealthWave and adults in Medicaid would cost in excess of \$75,000,000 per year and would sharply increase the size of these public programs. In addition, up to 60% of those accepting these opportunities would come from various forms of private insurance coverage. The state's health insurance industry will, when they understand the issue, almost surely express their opposition to this shift from private sector coverage to public sector coverage. The only option that costs very little, a Buy-in to the State Employee Health Plan, will also significantly expand the state's role in the health insurance market.

In contrast, the options that have low costs and do not expand the role of the state in the health care system simply do not expand coverage very much. We cannot forecast that any of the Tax Credit or Business Health Partnership proposals will increase health insurance coverage by more than 8,000. Although these sorts of expansion are worth considering, they would leave more than 230,000 Kansans without coverage.

**Notes**

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1. The population of Kansas aged 65 years and younger was estimated to be 2,332,189 in April of 2000. See U.S. Census Bureau, *Census 2000 Data for the State of Kansas* (2001), available at <http://www.census.gov/census2000/states/ks.html>. In this group 10.5% were uninsured. See also KANSAS INSURANCE DEPARTMENT, *Finding and Filling the Gaps: Developing a Strategic Plan to Cover All Kansans*, THE KANSAS HEALTH INSURANCE STUDY 11-12 (2001), available at [http://www.ksinsurance.org/other/hrsa/KHIS\\_2001.pdf](http://www.ksinsurance.org/other/hrsa/KHIS_2001.pdf).
2. Kansas Insurance Department, *Finding and Filling the Gaps: Developing a Strategic Plan to Cover All Kansans*, THE KANSAS HEALTH INSURANCE STUDY 21, Fig. 1-6 (2001), available at [http://www.ksinsurance.org/other/hrsa/KHIS\\_2001.pdf](http://www.ksinsurance.org/other/hrsa/KHIS_2001.pdf).
3. See, e.g., *id.* at 34, Table 1-11.
4. See *id.* at 15, Fig. 1-3.
5. See generally, John Z. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 J. AM. MED. ASS'N 2061, 2061-69 (2000).
6. See Thomas P. O'Toole, et al., *Primary Care Office Policies Regarding Care of Uninsured Adult Patients*, 16 J. OF GEN. INTERNAL MED. 693, 695 (2001).
7. This is based on the correlation between the percentage of residents without coverage and the number of health care providers per 1,000 in nine of the ten regions in the Kansas Health Insurance Study. For regional uninsurance rates, see KANSAS INSURANCE DEPARTMENT, *supra* note 1, at 11-12. Unpublished estimates of health care providers per 1,000 came from the Kansas Department of Health and Environment. The presence of the University of Kansas Medical Center skews the results for physicians, so Region 1 was omitted from this analysis.
8. *Id.* at 48, Fig. 2.1.
9. *Id.*
10. *Id.* at 51, Table 2-2.
11. *Id.*
12. *Id.* at 52, Fig. 2.3.
13. See Robert H. Lee, *State Tax Reform and State Health Insurance Reform*, 1995 ADVANCES IN HEALTH ECONOMICS AND HEALTH SERVICES RESEARCH 209-224 (1995).
14. Jon Gabel et al., *Individual Insurance: How Much Financial Protection Does It Provide?*, 21 HEALTH AFFAIRS: MARKETWATCH WEB EXCLUSIVE 3, ¶ 28 (2002), available at [http://www.healthaffairs.org/WebExclusives/Gabel\\_Web\\_Excl\\_041702.htm](http://www.healthaffairs.org/WebExclusives/Gabel_Web_Excl_041702.htm).
15. *Id.*
16. Kenneth E. Thorpe & Curtis S. Florence, *Why are Workers Uninsured? Employer-Sponsored Health Insurance in 1997*, 18 HEALTH AFFAIRS 213, 217 (1999).
17. *Id.*
18. See KANSAS INSURANCE DEPARTMENT, *supra* note 1, at 57.
19. *Id.* at 59, 66-67.
20. *Id.* at 60.
21. *Id.* at 55.
22. *Id.* at 74.

23. *Id.* at 71.
24. *Id.*
25. *Id.* at 14.
26. *Id.* at 16.
27. *Id.*
28. *See id.* These percentages are based on the authors' analyses of the survey data from the Kansas Health Insurance Study.
29. *See id.* These percentages are based on authors' analyses of the survey data from the Kansas Health Insurance Study.
30. SHARON SILOW-CARROLL ET AL., STATE AND LOCAL INITIATIVES TO ENHANCE HEALTH COVERAGE FOR THE WORKING UNINSURED 50 (2000) *available at* [http://www.cmwf.org/programs/insurance/silow-carroll\\_initiatives\\_424.pdf](http://www.cmwf.org/programs/insurance/silow-carroll_initiatives_424.pdf).
31. *Id.*
32. *Id.*
33. *Id.*
34. *Id.*
35. *Id.*
36. *Id.*
37. *Id.*
38. *Id.*
39. *Id.*
40. *Id.*
41. *Id.*
42. *Id.*
43. *Id.*
44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.* at 6-7.
52. *Id.*
53. *Id.*
54. *Id.*
55. *See* KANSAS INSURANCE DEPARTMENT, *supra* note 1, at 11-12.
56. M. Susan Marquis & Steven H. Long, *Effects of "Second Generation" Small Group Health Insurance Market Reforms, 1993 to 1997*, 38 INQUIRY 365, 365 (2001-02).
57. *Id.* at 373
58. Jon Gabel et al., *Job-Based Health Insurance in 2000: Premiums Rise Sharply while Coverage Grows*, 19 HEALTH AFFAIRS 144, 145 (2000).
59. *Id.*
60. *Id.* at 150.
61. *Id.*

62. See, e.g., Sherry Glied & Mark Stabile, *Explaining The Decline In Health Insurance Coverage Among Young Men*, 37 INQUIRY 295-303 (2000) (using calculations to analyze Kansas data and national estimates of price elasticity of demand).
63. HealthWave is the name that Kansas has given to its State Children's Health Insurance Program, known to policy enthusiasts as SCHIP.
64. American Academy of Pediatrics, *State Allocations and Federal Matching Rate Under SCHIP* (using data from Health Care Financing Administration, General Accounting Office and the Center on Budget and Policy Priorities), available at <http://www.aap.org/advocacy/schipall.htm>.
65. *Id.*
66. *Id.*
67. Vickie S. Gates, Department of Health and Human Services, *Setting the Stage: States Reaching Out to the Uninsured*, available at <http://www.hrsa.gov/osp/stateplanning/Statesreachinguninsured.htm>.
68. Birnbaum, Michael, State Coverage Initiatives, *Expanding Coverage to Parents through Medicaid Section 1931*, available at <http://www.statecoverage.net>.
69. *Id.*
70. Rhode Island Department of Human Services, *RItE Care Health Insurance*, available at <http://www.dhs.state.ri.us/dhs/famchild/mrtcare.htm>.
71. Jennifer P. Stuber et al, George Washington University Medical Center, Center for Health Services Research and Policy, *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?*, available at <http://www.gwu.edu/~chsrp/pdf/stig.pdf>.
72. *Id.*
73. Means tests restrict eligibility to those with incomes or assets below the limit. For example, in Kansas infants in families with incomes below a certain amount are eligible for Medicaid.
74. SILOW-CARROLL, *supra* note 30, at 48.
75. *Id.*
76. Randall R. Bovbjerg et al., Urban Institute Occasional Paper OP-39, *Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion*, available at <http://www.urban.org/authors/bovbjerg.html>.
77. A Buy-in allows individuals to pay a premium to get Medicaid coverage. Usually a Buy-in covers those with incomes or assets that are too high to qualify otherwise.