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Uninsured Report

State of Kansas

MERCER
Government Human Services Consulting

MMC Marsh & McLennan Companies

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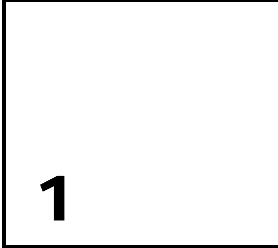

Executive Summary

Access to health care is an increasing crisis for small businesses. Less than half of small businesses (comprised of 2-49 employees) in Kansas offer health insurance to their employees. In 2000, the Kansas legislature created a Business Health Policy Committee (BHPC) to offer small businesses an alternative health insurance product that would rely on public subsidies of premiums for low-wage employees. Over 95% of uninsured Kansans live in a household in which at least one person works; the vast majority of the working uninsured is employed by a small business; and about two-thirds of all uninsured Kansans are in households with annual incomes at or below 200% of the Federal Poverty Level (FPL).[1]

A recent HRSA study revealed the prevalence of the uninsured within small firms was due to one of two factors: employers not offering health insurance to their employees or, if they offered health insurance, their employees were unable to afford the premiums. Findings of the study indicated that two-thirds of uninsured adults working in small firms were not offered health insurance. Policymakers in the State recognize that a reduction in the number of uninsured in the state will require strategies targeted at both increasing the availability and affordability of health insurance for small employers and financial assistance to low-income individuals to purchase that health insurance.

As such, this study analyzes the small group insurance marketplace in Kansas, modeling the impact of subsidies (both employee and employer tax credit), focusing on a specific benefit package and its corresponding actuarial value. From there, the study details strategies based on the modeling of subsidies that would be most effective in reducing the number of the uninsured.

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[1] Finding and Filling the Gaps: Developing a Strategic Plan to Cover All Kansans, HRSA State Planning Grant 2000, Kansas Insurance Department.

The BHPC developed the health care benefit package for this product using the following criteria:

- Comprehensiveness of coverage,
- Full coverage for preventive services, and
- Emphasis on generic drugs in the pharmacy benefit.

In order to increase the acceptance of the product to potential enrollees, the BHPC implemented these components into the product design:

- Reasonable cost sharing requirements,
- Catastrophic coverage for high cost claims, and
- Competitive benefit package with others offered in the marketplace.

The estimated per member per month (PMPM) cost for this product is $313 for an individual. Using a ratio of 3:1 for family coverage, the projected family rate for this product would be approximately $940 PMPM. These are the baseline premiums used in modeling the impact on insurance purchasing or the "take-up rate."

Similar to the policy options used in Maine's Dirigo program, there is a tax credit to employers and subsidies to employees. This is designed to achieve a given distribution of insurance costs across the State, employers and employees.

For a given state subsidy, more uninsured are covered if the remaining costs fall more heavily on employees. Existing research suggests that employers are much more price-sensitive in their decision to offer insurance than are employees in their decision to take it up once offered. Using this as a guiding principle for the target population of uninsured earning at or below 200% of the federal poverty level, the following scenarios were modeled to determine cost and insurance "take-up" by the uninsured.

Policy Percentages	10/10/80	30/10/60	40/10/50
Net Decrease in the Uninsured	16,000	12,000	10,000
Kansas Cost/Year	$44M	$25M	$18M
Kansas Annual Cost/Newly Insured	$2,750	$2,100	$1,800

Note: Policy percentages denote employee/employer/state contribution rates.

BHPC is using this information to determine the exact benefit package and subsidy structure to offer in order to help reduce the uninsured rate in the State of Kansas.

Background

Access to health care is an increasing crisis for small businesses. Less than half of small businesses in Kansas offer health insurance to their employees. In 2000, the Kansas legislature created the BHPC to offer small businesses an alternative health insurance product that would rely on public subsidies of premiums for low-wage employees (who earn up to 200% of the FPL). This quasi-public entity was to create a not-for-profit company to serve as a bridge between the public and private sector. As a result, the Business Health Partnership (BHP) was established in 2001. However, due to the state's financial plight, the vision of public subsidies through Medicaid, SCHIP or appropriated state funds was never realized.

In 2000, the Kansas Insurance Department was awarded a Health Resources and Services Administration (HRSA) grant to study the uninsured in Kansas. The study found that over 95% of uninsured Kansans live in a household in which at least one person works; the vast majority of the working uninsured is employed by a small business and about two-thirds of all uninsured Kansans are in households with annual incomes at or below 200% of the Federal Poverty Level.[2] A supplemental HRSA grant was awarded to Kansas in 2003 to gather qualitative and quantitative data from small employers. Some findings from the original HRSA study include:

- 244,800 or 10.5% of non-elderly Kansans lacked health insurance. Of that total, 56,000 are children and 188,800 are adults. The percentage of uninsured in a region varies across the state ranging from a low of 5.4% in one region to a high of 16.8% in another region.
- Statewide, 31.5% of Kansans with family incomes at or below 100% FPL are uninsured.

[2] Finding and Filling the Gaps: Developing a Strategic Plan to Cover All Kansans, HRSA State Planning Grant 2000, Kansas Insurance Department.

- The lowest rate of uninsurance (8.1%) is among those who work for an employer full-time while those who work for an employer part-time have an uninsurance rate of 15.4%.
- Among full-time employed Kansans, 18-64 years old, rates of uninsurance decline as the size of the firm increases. About 23.3% of full-time employed Kansans who work for firms with one to four employees are uninsured. By contrast, only 4.1% of full-time employees who work firms with 100 or more employees are uninsured.

The HRSA study clearly revealed that the prevalence of the uninsured within small firms was due to one of two factors: employers not offering health insurance to their employees or, if they offered health insurance, their employees were unable to afford the premiums. Findings of the study indicated that two-thirds of uninsured adults working in small firms were not offered health insurance. Policymakers in the state recognize that a reduction in the number of uninsured in the state will require strategies targeted at both increasing the availability and affordability of health insurance for small employers and financial assistance to low-income individuals to purchase that health insurance.

To supplement these statistics, US 2000 Census data detailing industry employment by size of industry were used. The data indicate the following, regarding the 67,900 establishments with employees in Kansas:

- Over 79% are in the "Under 100 Employees" size category.
- Establishments (28,144) with 1 to 4 employees comprise 41.5% of the total.
- Establishments (10,892) with 5 to 9 employees comprise 16%o f the total.
- Establishments with 10 to 19 employees (6,969) comprise 10.3% of the total.
- Businesses with 20 to 99 (7,833) employees comprise 11.5% of the total.

The fact that small employers comprise the bulk of businesses in Kansas and are much less likely to offer health insurance to their employees makes them a key component in any plan to reduce the number of uninsured Kansans.

Current Climate for Change

A September 2003 poll of Kansas residents' views of the health care system, commissioned by the Kansas Health Institute and conducted by Harvard School of Public Health, found that 78% of Kansans felt that funding programs designed to help small businesses find affordable health insurance is an "extremely important" or "very important" priority for the state's health care agenda. Additionally, 64% of Kansans favored increasing state taxes on alcohol and tobacco products and 53% favored a 0.5% increase on state sales tax to help low-income workers pay for health insurance. And when asked if cost, quality or access is the most important health care issue at the present time, 38% of Kansans felt that access to health care was the most important, compared to

48% for cost and 9% for quality.[3] Kansas business owners rank health care as the most important issue facing their business today. A poll of business owners commissioned by the Kansas Chamber of Commerce in February 2004 found that businesses ranked health care costs as the most pressing problem for their businesses, placing it in the "crisis stage" category.[4]

Given the results of these recent polls, health care is clearly a top concern for Kansans. The Governor has committed to making health care her top priority as well through a comprehensive health reform agenda.

Governor's Health Reform Agenda

In October 2003, Governor Kathleen Sebelius 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 coordinates health policy initiatives brought forth by health and human service cabinet team members and approved by the Governor. The OHPF also serves as a convener of 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.

In addition, legislation was passed and signed that expands the role of the BHPC in assisting small businesses to acquire adequate and affordable health coverage for its low-wage employees.

These beginning initiatives are critical to engaging the health care community in a larger effort to make major reforms in the health care system. In the future, we will be exploring how we can stabilize premium increases in the small group market.

Project

This project analyzes the small group insurance marketplace in Kansas, modeling the impact of subsidies (both employee and employer tax credit), focusing on a specific benefit package and its corresponding actuarial value. From there, the study details strategies based on the modeling of subsidies that would be most effective in reducing the number of the uninsured.

As noted earlier, the Business Health Partnership was established with the goal of expanding coverage through a linkage between the public and private sector to improve the affordability and quality of health insurance for low-wage workers in small

[3] Harvard School of Public Health, Kansas Health Institute and International Communications Research, September 2003.

[4] Kansas Chamber of Commerce, Cole Hargrave Snodgrass & Associates, February 2004

businesses. Any solution must address both the willingness of businesses to offer health care coverage and the ability of low-wage employees 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. Governor Sebelius, as part of a health reform package, has requested subsidy funding for small businesses that employ low-wage employees.

By statute, any health benefit plan offered through the Kansas Business Health Partnership is exempt from state mandates (K.S.A. 40-4704) except for preventive and health screenings. The benefit plan offered must be designed to encourage preventive care, reduce inappropriate emergency room use and establish a medical home for members. In addition, the benefit package for dependent children must mirror the current Medicaid and SCHIP benefits if Titles XXI and XIX monies are to be used for children's dependent coverage.

Benefit Package

Benefit Design

The BHPC met over a period of months to determine the benefit package for the uninsured product using the guiding principles from K.S.A. 40-4702.

Discussions with the BHPC and Kansas stakeholders moved through a process of better defining:

- **Who the uninsured are.** Findings from the 2001 HRSA study in Kansas were invaluable in better understanding this group and their employment status, size of their employer, family size and geographic status, among other characteristics.
- **Reasons why people are uninsured.** The HRSA study pointed to the key reasons for people not having coverage: 1) insurance is not offered by employers and 2) employees cannot afford coverage.
- **What is happening nationally regarding uninsured initiatives?** Maine's Dirigo program, as well as other state programs, served as a backdrop in the decision making process. Lessons learned from Maine were considered, specifically relating to the types of benefits offered.
- **Potential benefit designs.** The BHPC identified the following criteria for the uninsured product:
  - Comprehensive benefit coverage,
  - Full coverage for preventive services, and
  - Emphasis on generic drugs in the pharmacy benefit.

- **The impact of stakeholder groups on benefit designs.** In order to increase the acceptance of the product to potential enrollees, the BHPC considered and implemented these components into the product design:
  - Reasonable cost sharing requirements – set according to the ability of the uninsured to meet these requirements.
  - Catastrophic coverage for high cost claims – without which the product lacks what the BHPC sees as a crucial component of providing "true" insurance.
  - Competitive benefit package with other plans offered in the marketplace to avoid a "crowd-out" of existing insurance purchased by the target population.
- **The price sensitivity of various benefit levels.** Cost analysis on Kansas mandated benefits for various types of service, such as preventive and pharmacy services, allowed the group to adjust the benefit package to maintain a premium level consistent with the existing Kansas market in order to promote stakeholder acceptance of the product.

With these criteria in mind, Mercer summarized potential benefit designs modeled after the State Employee Health Plan (SEHP), Kansas small group products and other state uninsured initiatives. These products were chosen as representatives of the current marketplace. Medicaid was included as a full coverage option for comparative purposes.

Appendix A-1 contains a chart summarizing the seven benefit plans' coverage for inpatient hospital, outpatient hospital, physician, prescription drugs, mental health and general member cost sharing requirements. Mercer utilized a flexible benefit pricing tool, *Benefit Pricing Modular,* to analyze the various benefit options being considered by the BHPC. The bar graph in Appendix A-2 compares the relative price of each benefit package to full coverage under Medicaid. This illustrates the percentage of overall costs funded by each plan for the average recipient.

Mercer also detailed the member and plan responsibility for the actual cost of care. The exhibit in Appendix A-3 compares the member responsibility for the initial cost of care (deductibles) through the cost of catastrophic care. Based on these discussions, the BHPC determined the insurance plan must have the responsibility for catastrophic claims.

The BHPC decided the Kansas SEHP was a good model for the benefit plan. In order to create an affordable product, the cost sharing requirements were increased from the SEHP. The BHPC included a moderate deductible ($500 for an individual or $1,000 per family) and higher coinsurance requirements for the uninsured to help keep premiums affordable. The BHPC designed the prescription drug benefit to encourage members to utilize generic drugs through higher co-payment requirements for brand name drugs.

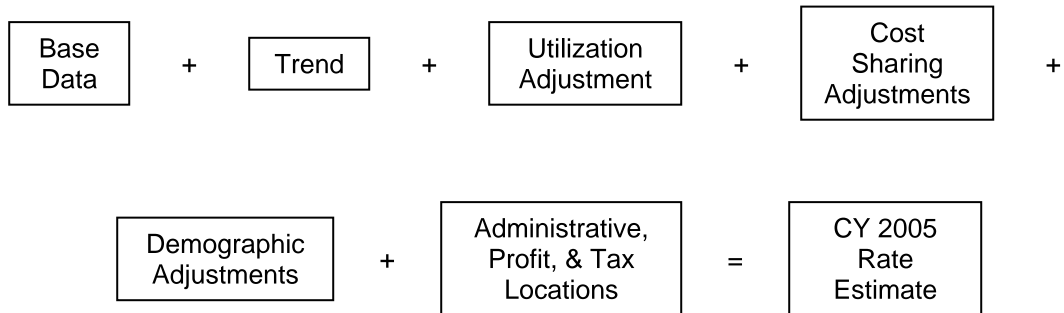
The proposed benefit design is contained in Appendix B-1 and Appendix B-2. This design is tailored to the BHPC's goals. The BHPC was able to design a product covering a full array of medical services. The final product covers preventive services at 100%,

which should help lower long-term costs resulting from delaying necessary care. The final product has higher member cost sharing requirements with the deductible and coinsurance than the SEHP, which is similar to "uninsured" products developed in other states and small group products in the Kansas marketplace. This should help the product gain acceptance among potential purchasers and insurers.

The Committee also considered alternative benefit designs primarily for pharmaceuticals. The first alternative package was identical to the proposal benefit design except prescription drugs were not covered. The second alternative package covered prescription drugs, using 50% coinsurance instead of the tiered co-payments of the proposed package. This package also increased the emergency room co-payment from $75 to $150 per visit. These designs were reviewed as lower cost options to the product in Appendix B. The pricing summary of these options is included for reference in Appendix C.

Benefit Pricing Methodology

The rate-setting methodology began with the selection of a base data set from a comparable population. These data were projected into the contract period to account for medical inflation and increases in historical utilization. Mercer adjusted the projected data for differences in utilization patterns between the base population and the uninsured as well as cost sharing differences and demographic differences. Finally, a provision for administrative and profit components was included to arrive at the base rate for the uninsured population. As will be discussed further below, the Kansas Small Group Regulations allow health plans to adjust the base rate up or down after accounting for demographic differences based on the expected health risk of the uninsured population.



Base Data

Since the current uninsured population typically finances their own health care services on a fee-for-service basis or receives charity care from hospitals or emergency rooms, historical cost and utilization data do not exist for this population. In order to estimate a premium rate for this population, alternative sources of cost and utilization data were used with the focus on the following criteria in selecting the base data.

- **Comparable Population.** The data should be representative of health care utilization for adults preferably from the State of Kansas.

- **Data Time Period.** The data must represent at least a full year of health care cost and utilization to account for any seasonality. The data must also be from a recent time period within the last three to five years to shorten the projection period and dependence on the assumptions.
- **Service Specific Data.** The data must contain separate information for the major service categories such as inpatient, outpatient, physician and pharmacy.
- **Benefit Package.** The underlying benefit package must be accessible for the comparable data set in order to facilitate comparisons to the uninsured benefit package to determine if adjustments are warranted.
- **Group Demographics.** Information must also be available on the demographics of the comparable population to facilitate comparisons and adjustments.

Mercer identified two separate data sources appropriate for this analysis: 1) the Kansas SEHP and 2) the Kansas Medicaid data.

Kansas SEHP Data

Since the benefit package was modified from the SEHP benefit package, the SEHP was a logical data source for rate-setting. The Committee provided Mercer with calendar year 2003 cost and utilization data for inpatient, outpatient, physician and pharmacy services by medical plan. The Committee also provided demographic information on the individuals enrolled in each plan option.

Mercer selected the SEHP Preferred Provider Organization (PPO) plans as the most representative for the uninsured coverage. Mercer based the calculations on the Allowed Amount, which includes patient co-payments, deductibles and coinsurance payments to reflect the full cost of care under the plan.

Kansas Medicaid Data

The State of Kansas also provided historical cost and utilization data related to their fee-for-service Medicaid program. These data contained full cost coverage for a defined set of benefits listed in the Kansas Medicaid State Plan for certain eligible individuals. Mercer determined that the comparable population to the uninsured were the individuals eligible for Medicaid on the basis of income level rather than disability status. The historical cost data for medical and pharmacy services from July 1, 2002 through June 30, 2003 were summarized for individuals ages 37+ eligible for the State's Temporary Aid to Needy Families (TANF) program. Mercer removed Medicaid-specific costs related to graduate medical education payments as well as cost settlements to certain federally qualified health centers, since these costs are not comparable to a commercial provider network.

After summarizing each of the data sets, Mercer applied the adjustments as outlined below to calculate a rate based off of each data source.

Utilization and Cost Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the utilization and cost of providing health care services in calendar year 2005. To assist in the trend development and other small group rating assumptions, Mercer requested small group rate filings from the Kansas Insurance Department for the large small group carriers in the State.

The small group filings indicated medical service trend between 8% and 14% with pharmacy trend between 14% and 18%. Mercer also relied on trend information collected during our numerous engagements with clients across the country. Based primarily on these two sources, Mercer developed a medical trend assumption of 10% with the pharmacy trend at 15%. These trends were used to project the SEHP data two years, from 2003 to 2005, and the Medicaid data two and a half years, from the time period of July 2002 through June 2003 to the January to December 2005 time period.

Please note: premium estimates for time periods other than calendar year 2005 will need to be updated for additional medical inflation.

Utilization Adjustments

While the SEHP and Medicaid data sets are comparable to the uninsured population, service utilization will likely be different for the uninsured population. These differences arise due to differences in health status based on income level as well as the lack of health care coverage for the uninsured. Based on State mandates for this coverage expansion, certain benefits are required to be covered by the carrier. The historical utilization of the SEHP and Medicaid populations were adjusted to be representative of the uninsured population expected to be covered by this product.

Income Related Adjustment

Research has shown a positive correlation exists between health status and income level. In general, the health status of individuals tends to increase and medical costs decrease as their income level increases. This is a result of a higher standard of living, better nutrition, increased access to preventive health care, and improved basic health care. The targeted uninsured population contains individuals with incomes between 100% and 200% of the FPL. The Medicaid program covers adults up to 37% of the FPL whereas the SEHP data represent individuals with income above 300% of the FPL. To account for the differences in income levels, Mercer developed separate adjustments for the Medicaid and SEHP data based on models developed off of data from previous coverage expansions.

An upward adjustment was applied to recognize the lower anticipated health status of the uninsured population compared to the SEHP population. Conversely, a downward adjustment was applied to recognize the higher anticipated health status of the uninsured population compared to the Medicaid population.

Service Utilization Adjustment

Typically, individuals delay necessary health care when insurance coverage is not available to them. Individuals will delay preventive office visits and also limit utilization of costly prescription drugs if insurance is not available to share the cost. Mercer developed and applied a factor to account for pent-up demand to better align expected health costs of individuals during the initial contract period.

Mercer adjusted the utilization data upward to account for the increased acuity or morbidity of the uninsured population. This adjustment was developed by service category for outpatient physician and pharmacy services based on our experience with uninsured populations.

Mandated Benefits Adjustment

The Kansas legislature mandated certain benefits be covered under the uninsured product.

- Insurance coverage for Mental Health and Substance Abuse treatment was required to cover 30 days of treatment, at a minimum.
- Preventive and Health Screening Services related to mammograms and pap smears, diabetes, preventive screenings and osteoporosis were required to be covered.
- Reconstructive Breast Surgery was required to be covered after a mastectomy was performed.

The mandates related to the mental health and substance abuse services and preventive services were covered through the SEHP and reflected in the base data. Breast reconstruction surgery was also listed as a mandate, but was not explicitly covered in the SEHP. Mercer adjusted the SEHP outpatient expenses upward to account for this additional benefit mandate.

Mental health and substance abuse services were excluded from the initial Medicaid data summarization. Mercer adjusted the Medicaid data to include commercial coverage of mental health and substance abuse treatment by increasing utilization of inpatient services and outpatient services. In addition, the Medicaid data did not reflect costs associated with breast reconstruction surgery. Mercer adjusted the outpatient data upward to account for this mandate. The preventive screening mandate was already reflected in the historical Medicaid data.

In total, the additional mandates slightly increased the overall rate when compared to a similar commercial policy.

Medicaid Specific Adjustments

The Medicaid fee-for-service data reflect utilization of services in a relatively unmanaged environment reimbursed at the Medicaid fee schedule. Typically, as a program shifts from a fee-for-service arrangement into a managed care arrangement, the utilization of health

care services shifts from more intensive inpatient and emergency room services to less intensive outpatient and preventive services. To account for this shift, Mercer applied managed care adjustments to the Medicaid fee-for-service data.

The Medicaid data also reflect services reimbursed at the Medicaid fee schedule. Typically, Medicaid fee schedules are much lower than the fees obtainable in the commercial provider networks. Based on discussions with Kansas, Mercer understands the Medicaid fee schedule for hospitals and physicians is significantly below the commercial marketplace. Mercer applied adjustments to increase the unit cost in the Medicaid data significantly (40-50%) to better reflect the commercial contracts.

These adjustments were only applied to the Medicaid data to reflect expected utilization and cost of services in a commercial marketplace. Since the SEHP data are from a commercial plan, these adjustments were not necessary.

Cost Sharing Adjustment

To ensure the uninsured product was affordable for both employers and employees, the Committee included cost sharing provisions to keep the upfront premiums at a reasonable level. The Committee incorporated a combination of deductibles, coinsurance and co-payments to share the service cost between the health plan and the individual user. The Committee's benefit package also ensures catastrophic coverage by implementing out-of-pocket maximum protection for the individual medical expenses after $2,200 and pharmacy expenses after $1,000. The adjusted SEHP data and Medicaid data reflect the full cost of providing health care services. To account for the patient cost sharing provisions, Mercer adjusted the projected total costs downward 35% to arrive at the premium rate.

Demographic Adjustment

The rate estimate includes consideration for the demographic characteristics of the uninsured population in comparison to the base data populations of the SEHP and Medicaid. The 2001 Kansas Health Insurance Study commissioned by the Kansas Insurance Department was used to determine the characteristics of the uninsured population. The data gathered in this study indicate the average uninsured adult in Kansas is a male, age 37.

The average adult covered under the SEHP is a male, age 42. As individuals age, health care costs tend to increase. To account for the differences in demographics, Mercer adjusted the SEHP rate estimate downward -12%. The Medicaid population was chosen to have a similar demographic mix as the uninsured. Therefore, no adjustment was necessary for this data source.

Administrative, Profit, and Tax Loading

The rate estimates developed represent the cost for medical services as well as administration, profit, commissions and premium tax costs. As part of the rate estimate Mercer utilized loadings consistent with commercial small group insurance offerings in the State. The total administrative loading is approximately 19%; the following components are included in the administrative loading:

- Administration (12.0%),
- Risk, contingencies and profit (2.0%),
- Commissions and broker fees (4.0%), and
- Premium tax (1.0%).

Uninsured Rate Estimate

Using the methodology outlined above, Mercer developed a rate estimate for the uninsured product separately for the SEHP and Medicaid data. Mercer blended these two rate estimates weighting the SEHP rate estimate 80% and the Medicaid estimate 20%. Mercer put the greatest emphasis on the SEHP rate estimate because the SEHP benefit package was the initial basis for the uninsured product and the SEHP data are already representative of a commercial product offering. The overall rate estimate is detailed in the following exhibit.

CY 2005 Rate Development

	CY 2005 Estimates		Credibility		Final
	(A)	(B)	(C)	(D)	(E)
Category of Service	Based on SEHP Data	Based on Medicaid Data	SEHP	Medicaid	Blended Rate
Inpatient - Acute	$ 39.56	$ 46.40	80.0%	20.0%	$ 40.93
Outpatient - Facility	$ 50.92	$ 52.06	80.0%	20.0%	$ 51.15
Outpatient - Professional	$ 96.66	$ 87.71	80.0%	20.0%	$ 94.87
Pharmacy	$ 66.17	$ 62.32	80.0%	20.0%	$ 65.40
Other Claims	$ 3.54	$ 4.44	80.0%	20.0%	$ 3.72
Total	**$ 256.85**	**$ 252.92**			$ 256.06
Administration					12%
Profit					2%
Total Admin/Profit					14%
Premium					$ 297.75
Commissions					4%
Premium Tax					1%
Total Commissions/ Premium Tax					5%
Final Base PMPM					**$ 313.42**

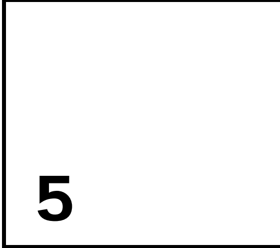
The estimated PMPM cost for this product is $313 for an individual. Using a ratio of 3:1 for family coverage, the projected family rate for this product would be approximately $940 PMPM. As mentioned earlier, the pricing for alternative benefit designs is included in Appendix C.

Kansas Small Group Rating operates under an adjusted community rating methodology. This allows insurance companies to adjust the base premium rate for differences in demographics (age, gender and regional).

Characteristics of Base Uninsured Population	
Average Demographics	37-year-old Male
Region	Shawnee, Kansas
Small Group coverage	2-50 Covered Lives
Industry Factor = 1.00	Clerical/Office Worker
Federal Poverty Level	175%

No Underwriting Risk Adjustment based on Health Status

Insurance companies can adjust the index rate for differences in a group's demographics. For example, if the average individual in the group was a 45-year-old female instead of a 37-year-old male, this could increase the rate by 10%. Similarly, if the group requesting coverage operated in Kansas City, the rate may be adjusted upward 5-10% as well. In addition to these demographic adjustments, the insurance companies can adjust for differences in expected health status of the group up to 25%.



Economic Modeling Methodology

The analysis relies on micro-simulation modeling. This model has also been used for academic research as well as for policy analysis at the national and state levels. The model has been used to analyze a wide variety of health insurance policies, ranging from tax credits for non-group insurance purchase to expansions of public health insurance. This micro-simulation model has several components, which are described below.

Data

The data base for this analysis is the Current Population Survey (CPS) of February and March, 2001. The March survey contains data on family demographic characteristics, income and health insurance coverage, while the February survey adds information on employer insurance offering. Importantly, the March survey also contains data on taxable income and marginal tax rates.

The March CPS reported insurance coverage rates that differ from Kansas' own state survey. In particular, the CPS reported an uninsurance rate for the state of 15%, while the rate in the state survey was only 10.5% (as stated in the report, "Finding and Filling the Gaps: Developing a Strategic Plan to Cover all Kansans"). The CPS data were adjusted to match the distribution of insurance coverage from this report, both overall, and by income and age group. The CPS data on insurance offering were also adjusted to match the percent of employed Kansans offered insurance by firm size.

These data are matched to information on health insurance premiums and health costs. Data on the premiums for employer insurance were provided by Mercer. It can be assumed that premiums will vary across firms due to the underlying health of workers in the firms. For non-group insurance, a premium for a healthy 40-year- old male is assigned based on analyses from the Community Tracking Survey and the Medical Expenditure Panel Survey (MEPS) combined with data on premiums collected by the Commonwealth Fund, the Health Insurance Association of America and from the "e-health

insurance.com" website. This premium is then adjusted by age, sex and health status using factors provided by an actuarial consulting firm.

Finally, data on underlying medical expenditures come from the MEPS. Total medical expenditures of those with employer-provided health insurance are estimated as a function of age, sex and health status. These estimates are then reduced by 15% to account for administrative costs of private health insurance. The resulting costs are assigned both to those on public insurance and as a measure of the underlying value of insurance provision. All cost data in the model have been updated to Calendar Year (CY) 2005.

Modeling Individual Behavior

These data are used to develop a micro-simulation model that computes the effects of health insurance policies on the distribution of health care spending and private and public sector health care costs. This model takes as inputs the data sources described above and the detailed parameterization of reform options. First, the model converts these policy rules into a set of insurance price changes. For example, if the policy intervention is a tax credit for non-group insurance, then the model computes the implied percentage change in the price of non-group insurance for each individual in the model. Second, these price changes are run through a detailed set of behavioral assumptions about how changes in the absolute and relative price of various types of insurance affect individuals, families and businesses.

The key concept behind this modeling is that the impact of tax reforms on the cost of insurance continuously determines behaviors such as insurance take-up by the uninsured and insurance offering by employers. The model assiduously avoids "knife-edge" type behavior, where some critical level is necessary before individuals respond, and beyond which responses are very large. Instead, behavior is modeled as a continuous function of how policy changes (net of tax) insurance prices. In doing this type of analysis, a number of assumptions must be made about how individuals will respond to tax subsidies, through their effect on the cost of insurance. These assumptions have been developed based on the available empirical evidence.

Some Key Assumptions

- Take-up of subsidized non-group insurance among the uninsured:
  - Take-up of such subsidies by the uninsured is calculated by applying both a price elasticity and a correction for the burden of premiums relative to income. For the base price elasticity, -0.625 is used. This is then augmented with a correction factor of the form: $(1- (X/\text{income}))^2$, where, for half the population, X represents the post-subsidy non-group premium, and for the other half of the population, X represents the pre-subsidy non-group premium. This term accounts for two factors which are likely to lead to take-up that falls with income. The first is that individuals are less likely to take up subsidies that are less than 100% as income

falls, because disposable income is needed for other expenditures that may be perceived as more urgent (such as food and housing). The second is liquidity constraints: insurance expenditures are made throughout the year, but any credits or deductions are only received the following April. This is a much larger problem for lower income individuals who usually have little savings and potentially poor access to credit markets. It is assumed that, due to administrative efforts to address this "advancability" problem, it only arises for one-half of the sample.[5] The quadratic form of the expression captures the fact that both of these effects are likely to operate very strongly towards the bottom of the income distribution. On average, the take-up elasticity for the uninsured is -0.45 to -0.5.

- Switching from group to non-group policies:
  - It is assumed that individuals compare the out-of-pocket costs of group insurance with the subsidized costs of non-group insurance when evaluating their insurance options. In particular, switching from group to non-group is a function of the post-subsidy non-group premium minus the post-subsidy employee cost of health insurance, divided by the full cost of group insurance (the value of the insurance), with an elasticity of -0.33.
- Price sensitivity of employee take-up of employer-provided insurance:
  - One of the clearest lessons from health economics over the past decade is that the decision of employees to take-up insurance provided by their employers is not very sensitive to price. As a result, for those with insurance whose employers raise contributions, the ratio of changes in employee contributions to insurance relative is computed to the full price of employer-provided insurance. It is then assumed that there is only a -0.1 elasticity of take-up of employer-provided insurance with respect to this ratio. For those without insurance whose employers decrease contributions, the percentage change in employee contributions is computed while assuming an elasticity of -0.067 for changes of less than 75% and an elasticity that rises to -0.75 for changes between 75% and 100%.

Modeling Firm Behavior

A key aspect of modeling health insurance policy is appropriately reflecting the decisions of firms, since 90% of private health insurance is provided by employers. Economists tend to model a firm's decision-making as reflecting the aggregation of worker preferences within the firm. The exact aggregation function is unclear; in the micro-simulation model it is assumed that the mean incentives for the firm (e.g. the average subsidy rate for non-group insurance) is what matters for a firm's decision-making.

The fundamental problem faced by individual-based micro-simulation models is that data on individuals do not reflect the nature of their co-workers, such that it is impossible to exactly compute concepts such as the average non-group subsidy in a worker's firm. This

[5] This assumption may be generous, given that the government's only existing experience with advancability, advance claiming of the Earned Income Tax Credit, has a 1% take-up rate.

problem is addressed by building "synthetic firms" in the CPS, assigning each CPS worker a set of co-workers selected to represent the likely true set of co-workers in that firm. The core of this computation is data from the Bureau of Labor Statistics that show, for workers of any given earnings level, the earnings distribution of their co-workers, separately by firm size, region of the country and health insurance offering status. Using these data, 99 individuals in the same firm size/region/health insurance offering cell are randomly selected as a given CPS worker in order to statistically replicate the earnings distribution for that worker's earnings level. These 99 workers then become the co-workers in a worker's synthetic firm.

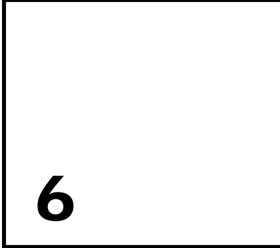
These synthetic firms then face three decisions about insurance: offering (whether to offer if not currently offering, or whether to drop if already offering), the division of costs between employer and employees and the level of insurance spending. Each of these decisions is modeled as subject to "pressures" from government interventions. In particular:

- Subsidies to outside insurance options (non-group insurance or public insurance) exert pressure on firms offering insurance to drop that insurance and raise employee contributions.
- Subsidies to employer spending on insurance cause firms not currently offering insurance to be more likely to offer. Subsidies also cause firms to pick up a larger share of the cost of insurance and they cause a rise in employer spending on insurance.
- Subsidies to employee spending on insurance also raise the odds that firms will offer insurance and raise employer spending on insurance, but they *lower* employer contributions to insurance.

Modeling the firm's reactions to these pressures once again involves making a number of assumptions about the behavior of these synthetic firms. Some of the key assumptions include:

- Firm offering/dropping:
  - Research-based estimates for insurance demand for firms are -0.69 for firms with fewer than 100 employees, -0.2 for firms with 100-999 employees and -0.1 for firms with more than 1000 employees. For firm offering in response to employer subsidies, the ratio of subsidies to existing employer spending is computed and these elasticities are applied. For firm offering in response to employee subsidies, this is reduced by 0.7, to account for the fact that only about 70% of employees take up insurance. For firm dropping in response to a non-group subsidy, the extent of the non-group subsidy is compared to the existing tax subsidy and to employer insurance. When the non-group subsidy is below the existing group tax subsidy, only a fraction of the elasticities is applied, rising from 50% to 100% to the point where non-group subsidies and existing tax subsidies are equal; from that point on, the elasticity is applied.

- Employee contributions:
  - When the government subsidizes spending on employer-provided insurance, it affects the distribution of spending across employer and employee. If the subsidy goes to the employer, it is assumed that 30 cents of each dollar of subsidy is spent on buying back employee contributions. Likewise, if the subsidy goes to the employee, it is assumed that employers raise employee contributions to offset 70 cents of each dollar of (average across the firm) subsidies to employees. When there is a subsidy to non-group insurance, it is assumed that the firm raises employee contributions by 15% of the subsidy rate in order to encourage non-group insurance take-up.
- Employer spending:
  - If the government offers an open-ended percentage credit, an elasticity of spending with respect to the credit amount of 50% is assumed. But, if there is a flat dollar credit, it is assumed that only 20 cents of each dollar goes to higher spending. For employee credits, spending reacts in the same way, but scaled down by 0.7.
- Finally, a key assumption for this type of modeling is the assumption on the wage incidence of changes in employer-insurance spending. The economics literature clearly demonstrates there is strong evidence for full shifting to wages of firm-wide changes in insurance costs, with some evidence of shifting to sub-groups within the workplace as well. There is a mixed incidence assumption for this model. Any firm-wide reaction, such as dropping insurance or lowering employee contributions, is directly reflected in wages. Yet any individual's decision, such as switching from group to non-group insurance, is not reflected in that individual's wages; rather, the savings to the firm (or the cost to the firm) is passed along on average to all workers in the firm.



Economic Modeling Results

Policy Structure

This report considers a variety of policy options within a structure consistent with Maine's "Dirigo" program. Under this structure, there is a tax credit to employers, and subsidies to employees, to achieve a given distribution of insurance costs across the government, employers and employees.

Tax credits and subsidies are available only for firms with fewer than 50 employees, and only for employees below some income cutoff. Three income cutoffs are considered: 100% of the poverty level; 150% of the poverty level; and 200% of the poverty level. A large number of alternative subsidy/tax credit structures were considered, but for the purposes of this report the focus is on three alternatives (described in terms of net costs paid by each party, after tax credits and subsidies):

- 10/10/80: employees pay 10% of the cost of insurance; employers pay 10% and the state pays 80%.
- 30/10/60: employees pay 30% of the cost of insurance; employers pay 10% and the state pays 60%.
- 40/10/50: employees pay 40% of the cost of insurance; employers pay 10% and the state pays 50%.

As the generosity of the state's contribution was reduced, the cost to employees (through lower subsidies) rather than to employers was increased. Existing research suggests that this is because employers are much more price sensitive in their decision to offer insurance than are employees in their decision to take it up once offered. As a result, for a given state subsidy, more uninsured are covered if the remaining costs fall more heavily on employees.

Results

Table 1 shows the results from these nine runs. The first column shows the net cost of each policy to the state, in millions of dollars, while the second shows the reduction in the uninsured, in thousands of persons. Each panel shows the findings for a different low income definition. Each row within the panel shows a different subsidy structure. It is clear that as either tax credits/subsidies get more generous (higher rows within panel) or the definition of low income becomes more expansive (lower panels), costs rise and the number of uninsured covers rises - but that the rise in the latter is not as rapid as the rise in the former. That is, more expansive policies spend more per person covered.

Table 1: Summary of Results

Policy	Cost to State (Millions)	Reduction in Uninsured (1000s of Persons)
Low Income = Less than 100% of Federal Poverty Level		
10% Employee / 10% Employer / 80% State	$12	12
30% Employee / 10% Employer / 60% State	$7	9
40% Employee / 10% Employer / 50% State	$5	8
Low Income = Less than 150% of Federal Poverty Level		
10% Employee / 10% Employer / 80% State	$31	15
30% Employee / 10% Employer / 60% State	$18	11
40% Employee / 10% Employer / 50% State	$13	9
Low Income = Less than 200% of Federal Poverty Level		
10% Employee / 10% Employer / 80% State	$44	16
30% Employee / 10% Employer / 60% State	$25	12
40% Employee / 10% Employer / 50% State	$18	10

These results presume a base premium of $313/month for single enrollees. Consideration was also given to the impact on coverage and costs as the premium varies. For illustration purposes, a poverty cutoff of 150%, and a subsidy structure of 30% employee, 10% employer and 60% state is shown.

Table 2: Results of Varying Premium (for 150% of poverty, 30/10/60 plan)

Premium for Single Enrollee	Cost to State (Millions)	Reduction in Uninsured (1000s of Persons)
$313	$18	11
$233	$14	12
$275	$16	11
$302	$17	11
$330	$18	11

Estimates for Tax Credit

The effects of the type of tax credit suggested by Senate Bill 257 were also considered. This bill increased an existing tax credit available to small businesses. Effectively, that increase amounted to $35 PMPM.

One difficulty in modeling this alternative is that the credit is only temporary. Past evidence suggests that small firms are less likely to respond to temporary subsidies than to permanent ones. Thus, two runs were considered: one in which the credit is temporary and one in which it is made permanent. In the latter, the credit has a much larger effect.

Table 3: Tax Credit Analysis

Type of Credit	Cost to State (Millions)	Reduction in Uninsured (1000s of Persons)
Temporary Credit(as in S357)	$34	6
Permanent Credit	$98	15

It is interesting to note that these policies are much less cost effective than are the employer/employee policies described above. This is because those policies are targeted to only the lowest income employees in small firms, while this tax credit is available to all employees in small firms, most of whom already have health insurance. Thus, most of the dollars for these tax credits flow to those who already have insurance.

Other State Initiatives

The State of Kansas' approach of having employers, employees and the State share in the cost of the health care premium is similar to Maine's Dirigo program. Other possible enhancements to the existing approach have been discussed; these include:

- State sponsored reinsurance pool.
- Health Savings Account.
- Exclusion of certain mandated benefits.

Kansas is not alone in their approach nor in their view regarding this initiative. Some of the key issues addressed by Kansas as well as other states attempting to move closer to universal coverage include:

- What role will the government play?
- What benefits should be covered?
- Should there be a drastic or incremental change in policy?

The following contains a snapshot of some of these issues and how states are reacting to them.

Maine

The Dirigo Health Reform Act

Maine’s Governor John Baldacci signed The Dirigo Health Reform Act, Public Law 469, into law on June 18, 2003. The purpose of the Reform Act is to make quality, affordable health care available to every Maine citizen within five years and to initiate new processes for containing costs and improving health care quality.

The Dirigo Health Reform Act seeks to address health care costs, quality, and access. In order to address access, the Act authorizes the creations of the Dirigo Health Agency to design and administer a voluntary market-based health plan to help small businesses, the self-employed and individuals afford health coverage. Individuals who meet income guidelines would receive financial assistance to participate in the program.

DirigoChoice™

DirigoChoice™ is designed to provide an affordable, high-quality option of health coverage for Maine businesses with 50 or fewer eligible employees, the self-employed and individuals. DirigoChoice™ is designed like many health insurance products and competes with private insurers in the small group and individual markets. However, because DirigoChoice™ is part of a broader initiative to lower health care costs, increase access to health care and ensure high quality care, it has some unique features:

- DirigoChoice™ is a public-private collaboration between Maine's Dirigo Health Agency and Anthem Blue Cross and Blue Shield (Anthem) and is coordinated with MaineCare (Maine's Medicaid program, administered by Maine's Department of Health and Human Services), to create a seamless program of health care coverage.
- In addition to emphasizing primary care, DirigoChoice™ includes additional wellness and prevention benefits to improve health and prevent disease and illness.
- State dollars are used to reduce costs for low income enrollees and to cover public administrative and oversight functions.
- Qualified employers and employees share the costs of insurance coverage with the state through monthly payments, annual deductibles and financial discounts.

Massachusetts

On April 6, 2005, Massachusetts' Governor Mitt Romney (R) introduced a proposal that would expand health care coverage by lowering private insurance premiums. Romney said that about 168,000 of Massachusetts' approximately 500,000 uninsured residents could afford private insurance if monthly premiums were lower. Under his proposal, health plans would offer less-comprehensive coverage for about $200 per month, compared with the current average of $350 to $500 monthly for private health plan premiums. The state has also received permission from the federal Department of Labor to allow residents to pay their premiums pre-tax, meaning they could save an additional $40 to $66. The new insurance plans would include coverage for preventive and primary care, emergency services, surgery, hospitalization, ambulatory care, mental health benefits and prescription drugs. A new state office, called the Commonwealth Care Exchange, would oversee pre-tax payments of premiums. The plans would be available to all uninsured individuals, and companies that employ 50 or fewer workers would be able to purchase the insurance for their employees.

New York

Healthy New York is a four-year-old campaign to provide health care coverage to uninsured workers in the State. Founded in 2001, Healthy New York helps small businesses and their employees purchase health insurance at discounted rates. Participating HMOs keep their premiums low by limiting benefits, and the state government assumes the cost of the most expensive cases. The New York program has been "widely praised among health care think tanks for its creativity," but its lackluster success so far "reflects the challenge of using a market-driven approach." For example, many businesses with small profit margins have trouble paying their portion – generally at least 50% – of premiums, and some low-income employees still find low-premium health care unaffordable. As a result, few employers and employees have enrolled in Healthy New York. However, response rates improved in 2003, after New York agreed to cover 90% of medical bills higher than $5,000 – down from the previous $30,000 limit – and launched a more aggressive advertising campaign.

Minnesota

The State is considering the implementation of various options which will facilitate an increase in the number of people covered in a cost-effective manner. One of the options being studied is to allow insurers to offer mandate-free or limited benefit plans to reduce premiums, encouraging employers who do not currently offer coverage to start. Another approach is to provide a public buy-out or reinsurance of high cost claims in order to reduce premiums for small employers who do not currently offer coverage. This coverage option could be offered as either a state-run plan with a standard benefit set or as an add-on to a private purchasing pool.

Health Savings Accounts

A number of states, including Florida, Iowa and Indiana have either signed legislation or are considering signing legislation that would make contributions to health savings accounts (HSAs) by both individuals and employers deductible under state tax rules.

Florida is also encouraging state health insurers to offer high-deductible policies in conjunction with HSAs. The intent of the law is to increase coverage for the State's uninsured residents. The legislation will also allow insurers to offer "stripped down coverage" that does not include some of the more than 50 benefits the State typically requires of health plans.

Two main issues need to be addressed as a part of this policy decision:

- How large of an impact will HSAs have among the uninsured as most of them have a relatively low marginal tax rate? This will dampen the benefit of tax deductibility as compared to a high marginal tax rate.
- What is the impact on the stability of the small-group marketplace? Will well compensated, healthy workers abandon job-based coverage?

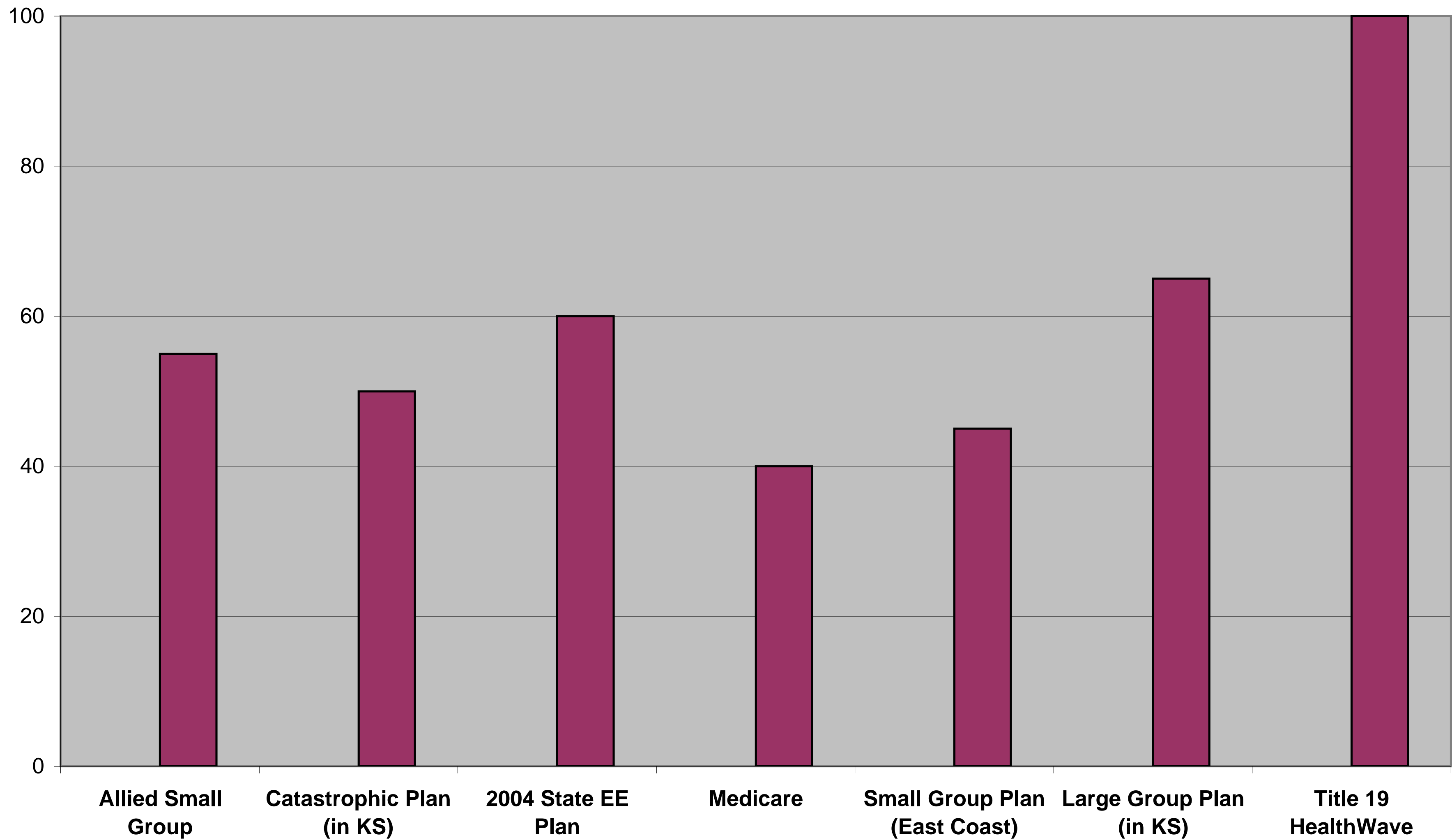
Appendix A

Kansas Health Plan Benefit Comparison
Individual Coverage

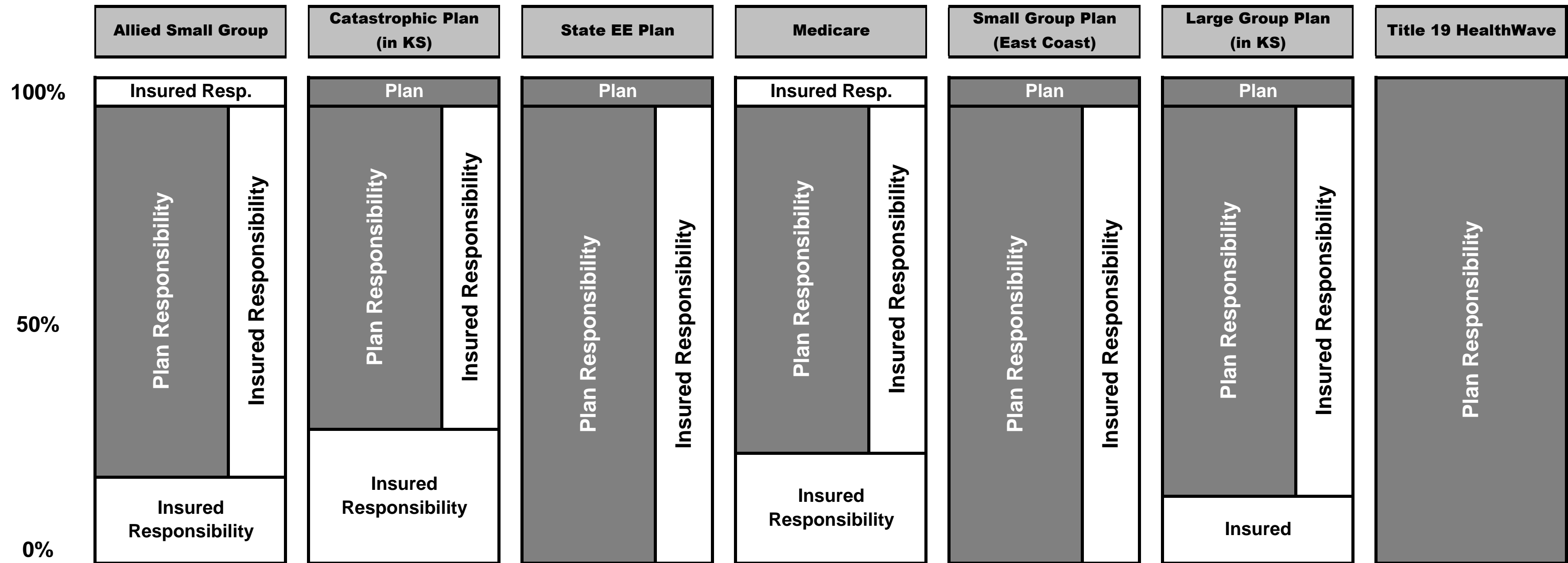
	Allied Small Group	Medicare	Catastrophic Plan (in KS)	State EE Plan	Small Group Plan (East Coast)	Large Group Plan (in KS)	Title 19 HealthWave
Inpatient	$250 copay per admission & a max benefit ranging from $1,000-$1,500 per day; up to $100,000 annual max	Days 1-60: total deductible of $876 Days 61-90: $219 per day Beyond 150 days: not covered	20% coinsurance subject to deductible	$300 copay per admit, then subject to coinsurance	$250 deductible per stay; 20% coinsurance	$250 deductible; 10% coinsurance	Covered 100%
Outpatient	**Non-surgery:** $50 copay, max benefit of $500 per visit & no annual limit on visits, combined $2,000 benefit per calendar year; Surgery: $250 copay & $1,000 max benefit per outpatient surgery, no limit on quantity of outpatient surgeries	20% coinsurance	20% coinsurance subject to deductible	50% coinsurance	20% coinsurance	$250 deductible; 10% coinsurance	Covered 100%
Physician	$20-$50 copay, combined $3,000 benefit per calendar year	20% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	PCP copay: $15 Specialist copay: $30	Covered 100%
Pharmacy	$15-$20 copay per Rx; no Rx quantity limit; brand name drugs provided at discount; $2,500 limit per calendar year	Limited, covers some specific OP drugs at 20% coinsurance	30% coinsurance and 3-Tier copay	**3-Tiers:** 20% coinsurance 35% coinsurance $75 copay	No benefit	30% coinsurance & 3-Tier copay	Covered 100%
Mental Health	31 days in any 12 month period	**Inpatient:** same as Physical Health **Outpatient:** user pays copay for the facility; 50% coinsurance	**Inpatient:** $250 copay, 20% coinsurance & 40 days/yr max **Outpatient:** visits 1-20: $15 copay; visits 21-30: $25 copay	**Inpatient:** 60-day annual limit **Outpatient:** visits 1-3: 100%; visits 4-25: $25 copay; additional visits: 50% coinsurance	20% coinsurance; limited to 15 visits	**Inpatient:** $250 copay, 10% coinsurance & 40 days/yr max **Outpatient:** visits 1-20: $15 copay; visits 21-30: $25 copay	Covered 100%
In-Network Deductible	$750	Part A: $875 Part B: $100	$1,500	N/A	Varies	$250	None
Co-insurance	20%	20%	20%	50%	Varies	10%	N/A
OOP Max	Unlimited	Unlimited	$2,500	$2,200*	10% of family income	$1,500	N/A

	Allied Small Group	Medicare	Catastrophic Plan (in KS)	State EE Plan	Small Group Plan (East Coast)	Large Group Plan (in KS)	Title 19 HealthWave
Rate Based on PPO Model	$101.20	$75.01	$94.41	$106.39	$85.80	$114.17	$176.04
Rate Relative to Medicaid	0.57	0.43	0.54	0.60	0.49	0.65	1.00

	Allied Small Group	Medicare	Catastrophic Plan (in KS)	State EE Plan	Small Group Plan (East Coast)	Large Group Plan (in KS)	Title 19 HealthWave
Medical Rate Only (No Rx)	$68.03	$75.01	$69.95	$71.47	$85.80	$89.72	$120.85
Rate Relative to Medicaid	0.56	0.62	0.58	0.59	0.71	0.74	1.00


Relative Value of Benefit Plans
100
80
60
40
20
0
Allied Small Group
Catastrophic Plan (in KS)
2004 State EE Plan
Medicare
Small Group Plan (East Coast)
Large Group Plan (in KS)
Title 19 HealthWave

Patient vs. Plan Funding



Appendix B

Comparison of KS Uninsured Benefit Package with 2004 KS SEHP and Maine's Dirigo Plan
In-Network Benefits

Plan Benefit	Dirigo (PPO) In-Network	KS SEHP 2004 (PPO) In-Network	KS Uninsured (PPO) In-Network
Deductible			
Individual	$1,250 (INN and OON combined)	N/A	$500 (INN only)
Family	$2,500 (INN and OON combined)	N/A	$1,000 (INN only)
Out-of-Pocket Maximum (Includes deductible)			
Individual	$4,000	$2,200	$2,200
Family	$8,000	$4,400	$4,400
Coinsurance	80% / 20%	50% / 50% (Tiered Coinsurance after $1100/$2200 = 30%)	70%/30%
Lifetime Maximum	Unlimited	$2,000,000	$2,000,000
Emergency Room Care	Subject to deductible and coinsurance	$100 copayment (waived if admitted) then coinsurance.	$75 copayment (waived if admitted) then deductible and coinsurance.
Hospital Services			
Inpatient	Subject to deductible and coinsurance	$300 copay per admit then coinsurance	$300 copay per admit then deductible and coinsurance.
Outpatient	Subject to deductible and coinsurance	Subject to coinsurance	Subject to deductible and coinsurance
Physician Office Services			
PCP Office Visit	**$15 Copayment;** Included but not limited to: Sick Care, Family Planning, Diagnostic Testing, Allergy Testing & Injections.	Subject to coinsurance	$15 copayment
Specialist Office Visit	$25 copayment	Subject to coinsurance	$25 copayment
Preventive Care	**100%** Included but not limited to: Office Visit, Immunizations, Well Child Care, Standard Screening tests performed as a part of the physical exam, Lab/X-Rays associated with preventive visits.	1st $300 covered in full through preventive care allowance, then subject to coinsurance	**100%** Included but not limited to: Preventive PCP Office Visit, Immunizations, Well Child Care, Standard Screening tests performed as a part of the physical exam, Lab/X-Rays associated with preventive visits.
Physician Hospital Visits	100%	Subject to coinsurance	Subject to deductible and coinsurance
Surgery & Asst. Surgeon Fees	100%	Subject to coinsurance	Subject to deductible and coinsurance
Laboratory/X-Ray	Subject to deductible and coinsurance. Unless ordered as part of a routine physical, then it is covered at 100%	Subject to coinsurance	Subject to deductible and coinsurance

Comparison of KS Uninsured Benefit Package with 2004 KS SEHP and Maine's Dirigo Plan
In-Network Benefits

Plan Benefit	Dirigo (PPO) In-Network	KS SEHP 2004 (PPO) In-Network	KS Uninsured (PPO) In-Network
Mammography **Pap Smear** **Routine Preventive Test**	100%	Applies towards $300 preventive care allowance, then subject to coinsurance	100%
Prescription Drug – Retail Program (30-day supply)			
Generic	$10	20% coinsurance, subject to $2580 Max Drug OOP	$10 copay, $1000/$3000 Drug OOP Max
Preferred Brand	$25	35% coinsurance, subject to $2580 Max Drug OOP	$25 copay, $1000/$3000 Drug OOP Max
Non-Preferred Brand	$40	60% coinsurance, no max	$50 copay, $1000/$3000 Drug OOP Max
Prescription Drug - Mail Order Program (90-day supply & oral contraceptives are covered)			
Generic Preferred Brand Non-preferred Brand	$30 $75 $120	Same as retail	Same as retail
Maternity Expenses			
Pre/Post Natal Office Visits	100% after $25 copayment	Subject to coinsurance	Subject to deductible and coinsurance
Delivery Charges	Subject to deductible and coinsurance	Subject to $300 copay, then coinsurance	Subject to $300 copay, then coinsurance
Newborn Hospital Bill	Subject to deductible and coinsurance	Subject to coinsurance	Subject to deductible and coinsurance
Newborn Pediatrician	100%	Applies towards $300 preventive care allowance, then subject to coinsurance	100%
Rehabilitation Therapies	Rehabilitation Therapies are covered up to a combined limit both in and out of network of $3,000 per calendar year.	Subject to prior approval. Outpatient is limited to 180 consecutive days, with documented approval	Subject to prior approval. Outpatient is limited to 180 consecutive days, with documented approval
Physical Therapy Occupational Therapy Cardiac Rehabilitation Speech Therapy	Subject to deductible and coinsurance	Subject to coinsurance	Subject to deductible and coinsurance
Home Health Care	Subject to deductible and coinsurance	Subject to coinsurance, limit of $5000 per year	Subject to deductible and coinsurance, limit of $5000 per year
Skilled Nursing Facility	Subject to deductible and coinsurance 100 days per calendar year combined in- and out-of-network.	Subject to coinsurance	Subject to deductible and coinsurance
Hospice Care	100%	Subject to coinsurance, lifetime limit of $7500	Subject to deductible and coinsurance, lifetime limit of $7500
Mental Health Care			
Inpatient (Non-listed illnesses)	Coin after $150 Mental Health deductible is met Maximum of 30 days per calendar year	Inpatient Copay, then coinsurance. 60 limit per year	Inpatient Copay, then coinsurance. 30 limit per year
Outpatient (Non-listed illnesses)	Coin after $150 Mental Health deductible is met Maximum of $1,500 per calendar year	First 3 visits 100%, next 22 have $25 copay. Additional visits 50% coinsurance.	First 3 visits 100%, next 22 have $25 copay. Additional visits 50% coinsurance.

Comparison of KS Uninsured Benefit Package with 2004 KS SEHP and Maine's Dirigo Plan
In-Network Benefits

Plan Benefit	Dirigo (PPO) In-Network	KS SEHP 2004 (PPO) In-Network	KS Uninsured (PPO) In-Network
Substance Abuse			
Inpatient	Coinsurance after $150 Substance Abuse deductible is met Maximum of 31 days per calendar year Two days of day treatment equal one day of inpatient services.	Same as Mental Health	Same as Mental Health
Outpatient	Coinsurance after $150 Substance Abuse deductible is met Maximum of $1,500 per calendar year	Same as Mental Health	Same as Mental Health
Ambulance	Subject to deductible and coinsurance	Subject to coinsurance	Subject to deductible and coinsurance
Acute Chiropractic Treatment	Deductible/Coinsurance 40 visits per calendar year	Not covered	Not covered
Allergy Care	Subject to deductible and coinsurance	Subject to coinsurance	Subject to deductible and coinsurance
Allergy Injections	Subject to deductible and coinsurance	Subject to coinsurance	Subject to deductible and coinsurance
Durable Medical Equipment (DME)	Subject to deductible and coinsurance Limited to $3,500 / calendar year	Subject to coinsurance, limit of $4500 per year	Subject to deductible and coinsurance, limit of $4500 per year
Prosthetic Appliances and Orthotics	Subject to deductible and coinsurance	Not covered	Subject to deductible and coinsurance
Smoking Cessation	100%	Not covered	100%
Chemotherapy and Radiation Therapy	Subject to deductible and coinsurance	Subject to coinsurance	Subject to deductible and coinsurance
Second Surgical Opinions	Office visit with specialist $25 copayment	Subject to coinsurance	Subject to deductible and coinsurance
Refractive Eye Exam one every 2 years	100% after $25 copay	Applies towards $300 preventive care allowance, then subject to coinsurance	Subject to deductible and coinsurance
Lenses, Frames, and Contacts Lenses	Not covered	Not covered	Not covered
Refractive Vision Surgery	Not covered	Not covered	Not covered
Elective Abortion	Subject to deductible and coinsurance	Not covered	Not covered
Artificial Insemination	Not covered	Limited to testing & 3 attempts at artificial insemination per year. Subject to coinsurance	Not covered
IVF GIFT ZIFT	Not covered		
Fertility Medication	Not covered		
Surgical Treatment of Underlying Medical Condition Causing Infertility	Not covered		
Reversals of Sterilization	Subject to deductible and coinsurance. Vasectomies and tubal legations are only covered under the plan in network only and only once per lifetime.		
Dental Services	Not listed as covered	Provided by Delta Dental	Not covered

Comparison of KS Uninsured Benefit Package with 2004 KS SEHP and Maine's Dirigo Plan
Out-of-Network Benefits

Plan Benefit	Dirigo (PPO) Out-of-Network*	KS SEHP 2004 (PPO) Out-of-Network*	KS Uninsured (PPO) Out-of-Network
Deductible			
Individual	$1,250 (INN and OON combined)	$500	$1000 (separate from INN)
Family	$2,500 (INN and OON combined)	$1,500	$2,000 (separate from INN)
Out-of-Pocket Maximum (Includes deductible)			
Individual	No Limit	$3,650	No Limit
Family	No Limit	$7,300	No Limit
Coinsurance	50% / 50%	50% / 50% (Tiered Coinsurance after $1450/$2900 = 30%)	50% / 50%
Lifetime Maximum	Unlimited	$2,000,000	$2,000,000
Emergency Room Care	Subject to deductible and coinsurance	$200 copayment (waived if admitted) then coinsurance. Copayment does not apply towards coinsurance maximum.	$200 copayment (waived if admitted) then deductible and coinsurance. Copayment does not apply towards OOP maximum.
Hospital Services			
Inpatient	Subject to deductible and coinsurance	$600 copay per admit then coinsurance. Deductible does not apply. Copayment does not apply towards coinsurance maximum.	$600 copay per admit then deductible and coinsurance. Copayment does not apply towards OOP maximum.
Outpatient	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Physician Office Services			
PCP Office Visit	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Specialist Office Visit	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Preventive Care	**Not covered**	Not covered	**Not covered**
Physician Hospital Visits	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Surgery & Asst. Surgeon Fees	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Laboratory/X-Ray	Subject to deductible and coinsurance. Unless ordered as part of a routine physical, then it is covered at 100%	Subject to deductible and coinsurance	Subject to deductible and coinsurance

Note: Out-of-Network benefits account for approximately 20% of gross medical costs (before cost sharing). The SEHP plan covers approx 40-50% of gross OON costs.

* Benefits are based on reasonable and customary charges for covered services. Members will be responsible for charges billed beyond R&C.

Comparison of KS Uninsured Benefit Package with 2004 KS SEHP and Maine's Dirigo Plan
Out-of-Network Benefits

Plan Benefit	Dirigo (PPO) Out-of-Network*	KS SEHP 2004 (PPO) Out-of-Network*	KS Uninsured (PPO) Out-of-Network
Mammography	100% if ordered as part of a routine physical, otherwise subject to deductible and coinsurance	Not Covered	Not covered
Pap Smear	Routine pap test not covered. Non-routine pap test is subject to deductible and coinsurance		
Routine Preventive Test	Not covered		
Prescription Drug – Retail Program (30-day supply)			
Generic	Not covered	20% coinsurance, subject to $2580 Max Drug OOP	$10 copay, $1000/$3000 Drug OOP Max
Preferred Brand	Not covered	35% coinsurance, subject to $2580 Max Drug OOP	$25 copay, $1000/$3000 Drug OOP Max
Non-Preferred Brand	Not covered	60% coinsurance, no max	$50 copay, $1000/$3000 Drug OOP Max
Prescription Drug - Mail Order Program (90-day supply & oral contraceptives are covered)			
Generic	Not covered	Same as retail	Same as retail
Preferred Brand	Not covered		
Non-preferred Brand	Not covered		
Maternity Expenses			
Pre/Post Natal Office Visits	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Delivery Charges	Subject to deductible and coinsurance	Subject to $600 copay, then deductible and coinsurance	Subject to $600 copay, then deductible and coinsurance
Newborn Hospital Bill	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Newborn Pediatrician	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Rehabilitation Therapies	Subject to deductible and coinsurance	Subject to prior approval. Outpatient is limited to 180 consecutive days, with documented approval	Subject to prior approval. Outpatient is limited to 180 consecutive days, with documented approval
Physical Therapy Occupational Therapy Cardiac Rehabilitation Speech Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Home Health Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance, limit of $5000 per year	Subject to deductible and coinsurance, limit of $5000 per year
Skilled Nursing Facility	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Hospice Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance, lifetime limit of $7500	Subject to deductible and coinsurance, lifetime limit of $7500
Mental Health Care			
Inpatient (Non-listed Illnesses)	Coin. after $150 Mental Health deductible is met Maximum of 30 days per calendar year	Inpatient Copay, then deductible and coinsurance. 30-day limit per year	Inpatient Copay, then deductible and coinsurance. 30 limit per year
Outpatient (Non-listed Illnesses)	Coin. after $150 Mental Health deductible is met Maximum of $1,500 per calendar year	First 3 visits 100%, next 22 have 50% coinsurance. 25 visits maximum	First 3 visits 100%, next 22 have 50% coinsurance. 25 visit max.

Note: Out-of-Network benefits account for approximately 20% of gross medical costs (before cost sharing). The SEHP plan covers approx 40-50% of gross OON costs.

* Benefits are based on reasonable and customary charges for covered services. Members will be responsible for charges billed beyond R&C.

Comparison of KS Uninsured Benefit Package with 2004 KS SEHP and Maine's Dirigo Plan
Out-of-Network Benefits

Plan Benefit	Dirigo (PPO) Out-of-Network*	KS SEHP 2004 (PPO) Out-of-Network*	KS Uninsured (PPO) Out-of-Network
Substance Abuse			
Inpatient	Coinsurance after $150 Substance Abuse deductible is met Maximum of 31 days per calendar year Two days of day treatment equal one day of inpatient services	Same as Mental Health	Same as Mental Health
Outpatient	Coinsurance after $150 Substance Abuse deductible is met Maximum of $1,500 per calendar year	Same as Mental Health	Same as Mental Health
Ambulance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Acute Chiropractic Treatment	Subject to deductible and coinsurance 40 visits per calendar year	Not covered	Not covered
Allergy Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Allergy Injections	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Durable Medical Equipment (DME)	Subject to deductible and coinsurance Limited to $3,500 / calendar year	Subject to deductible and coinsurance, limit of $4500 per year	Subject to deductible and coinsurance, limit of $4500 per year
Prosthetic Appliances & Orthotics	Subject to deductible and coinsurance	Not covered	Subject to deductible and coinsurance
Smoking Cessation	Not covered	Not covered	Not covered
Chemotherapy & Radiation Therapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Second Surgical Opinions	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Refractive Eye Exam (One every 2 years)	Not covered	Not covered	Not covered
Lenses, Frames & Contacts Lenses	Not covered	Not covered	Not covered
Refractive Vision Surgery	Not covered	Not covered	Not covered
Elective Abortion	Subject to deductible and coinsurance	Not covered	Not covered
Artificial Insemination	Not covered	Limited to testing & 3 attempts at artificial insemination per year. Subject to deductible and coinsurance	Not covered
IVF GIFT ZIFT	Not covered		
Fertility Medication	Not covered		
Surgical Treatment of Underlying Medical Condition Causing Infertility	Not covered		
Reversals of Sterilization	Not covered		
Dental Services	Not listed as covered	Provided by Delta Dental	Not covered

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Appendix C

Uninsured Rate Development
Analysis of Potential Benefit Changes

CY 2005 Rate Development

	Current Benefit Package			Modification #1: Current Benefits without Rx			Modification #2: Rates with Rx 50/50, $1000 Drug OOP Max & $150 ER Copay		
Category of Service	(A) Total PMPM	(B) Member Cost Sharing	(C) Net Premium	(A) Total PMPM	(B) Member Cost Sharing	(C) Net Premium	(A) Total PMPM	(B) Member Cost Sharing	(C) Net Premium
Inpatient - Acute	$ 81.85	50.0%	$ 40.93	$ 81.85	50.0%	$ 40.93	$ 81.85	50.0%	$ 40.93
Outpatient - Facility	$ 85.25	40.0%	$ 51.15	$ 85.25	40.0%	$ 51.15	$ 85.25	45.0%	$ 46.89
Outpatient - Professional	$ 126.49	25.0%	$ 94.87	$ 126.49	25.0%	$ 94.87	$ 126.49	25.0%	$ 94.87
Pharmacy	$ 93.43	30.0%	$ 65.40	$ 93.43	100.0%	$ -	$ 93.43	35.0%	$ 60.73
Other Claims	$ 7.44	50.0%	$ 3.72	$ 7.44	50.0%	$ 3.72	$ 7.44	50.0%	$ 3.72
Total	$ 394.46	35.1%	$ 256.06	$ 394.46	51.7%	$ 190.66	$ 394.46	37.3%	$ 247.13
Administration			12%			12%			12%
Profit			2%			2%			2%
Total Admin/Profit			14%			14%			14%
Premium			$ 297.75			$ 221.70			$ 287.36
Commissions			4%			4%			4%
Premium Tax			1%			1%			1%
Total Commissions/ Premium Tax			5%			5%			5%
Final Base PMPM			**$ 313.42**			**$ 233.37**			**$ 302.48**

Current Package includes drug coverage with variable copays for generic and brand name drugs as well as a separate drug out-of-pocket maximum. The current package also includes a $75 ER copay.

Modification #1 removes drugs from the covered benefit package.

Modification #2 covers drug expenses 50/50 with a $1000 drug out-of-pocket maximum and increases ER copay to $150 per visit.

MERCER
Government Human Services Consulting

Mercer Government Human Services Consulting
800 LaSalle Avenue, Suite 2100
Minneapolis, MN 55402-2012
612 642 8600