

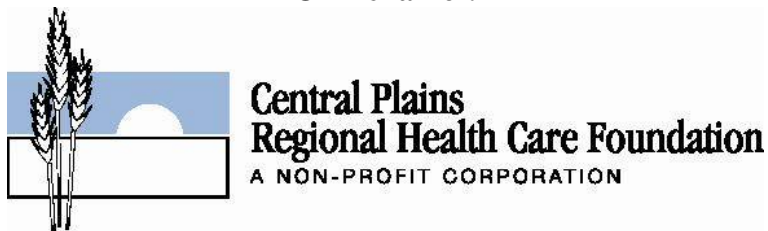


Project Overview
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ATTACHMENTS:

- A. CHAT Game Report
- B. Community Survey Results
- C. Overview of Local Access Models
- D. American Community Survey Microdata

Section 1. Executive Summary

What is the proposed Community Coverage Initiative?

The intent of the Community Coverage Initiative (CCI) is to fill an access gap in health insurance coverage for a targeted group of residents in Sedgwick County. CCI would focus on those whose income is just high enough not to qualify for existing public programs, but low enough that they must make difficult decisions daily between receiving health care and providing their family with food, housing, and appropriate child care.

Why does Sedgwick County need CCI?

This initiative aims to provide low income, uninsured residents of Sedgwick County with access to affordable health care coverage. It is estimated that in Sedgwick County 22.3% of civilian residents between 19 and 64 years of age who are not institutionalized are uninsured. CCI will be targeted at uninsured adults who are currently working, with incomes up to 250% of the Federal Poverty Level.

How does CCI fit with currently available health care options?

It cannot be emphasized enough that this initiative is not designed to compete with existing health insurance products – rather, the initiative is to focus resources on getting people into a health care delivery system that is available to, and affordable for, both individuals and providers.

How will it be financed?

The services would be reimbursed at current “Medicare reimbursement levels.” We are committed to paying all providers at the same level – i.e. payment for specific services will be the same regardless of which provider delivers the care. Revenue will be derived from participants’ premiums and co-payments, employers’ monthly contributions, government contribution, and an estimated charitable giving amount. Administrative expenses will be kept at or below 20% of revenue.

Applying expertise to urgency

This proposal is the product of a collaboration of public and private organizations with extensive experience providing health care to the uninsured and planning for the community’s needs. We believe that there is a need for this community to act quickly to implement this program and meet the needs of our friends, neighbors, and families who currently do not have access to health care.

Section 2. Making the Case

Sedgwick County takes an active approach to planning for and encouraging their residents toward establishing health goals. All facets of this unique community are engaged: consumers, health care providers, government, and business. Focused attention has been given to this issue for at least the last seven years. However, despite our best efforts, there are still gaps in appropriate services, access to needed care and affordable health insurance.

Access to health care is largely driven by access to affordable health insurance. In our community, many people do not have an option of enrolling in affordable health insurance plans. This coverage gap has been growing due to the economic realities in our community for employers as well as individuals. Without new and creative approaches to covering the uninsured, our community will suffer the burden of an unhealthy population.

This problem is not unique to our community. Nationally, the rising cost of health insurance and shrinking number of employers that provide health insurance to their employees are causing significant strain on the average family.

A recent study by the Kaiser Family Foundation¹ found that:

- i The “middle class” is now defined as having household income between 200 and 400% of the federal poverty level (FPL) - \$44,000 - \$88,000 for a family of four in 2009.
- i The large majority of uninsured persons (66%) are from low-income families (under 200% of FPL), but 11 million come from the middle class (25%). Seventy percent of the growth in the uninsured between 2004 and 2007 came from the middle class.
- i Between 2000 and 2008, the cumulative increase in health insurance premiums grew over three times as fast as wages increased – which translates into families spending 7% of their pre-tax income on health insurance.
- i Nearly three out of four middle-income families are insured through their employers. This coverage is put into jeopardy as unemployment levels have climbed upward of 10% in 2009

In our community we believe that over 13% of our adult population does not have health insurance. This statistic translates into the following problems for them and for our economy:

- i Non-elderly adults with medical debt are almost twice as likely to have an ongoing or serious health problem compared to others with private coverage.²
- i Non-elderly adults with insurance and medical debt are as likely as the uninsured population to postpone care, skip recommended tests and treatments, and not fill drug prescriptions.³
- i Our emergency rooms bear the brunt of this lack or delay of care. Because they are by law not able to turn people away regardless of payment source, emergency rooms are

¹ Focus on Health Reform: Health Care and the Middle Class: More Costs and Less Coverage; July 2009; The Henry J. Kaiser Family Foundation

² Ibid.

³ Ibid

providing growing levels of primary care to those who feel they have no other option to receive care.

- i Growing emergency and hospital utilization is causing our community's health care providers to take on more and more debt that is uncollectible – or spend significant resources trying to track down and collect from those who may not have the ability to pay.
- i Increasing uncollectible debt has the ability to threaten institutions' and practices' access to financial capital, forcing a constriction in the types of care they can provide and the hours they can provide it.
- i In our community, like many others, hospitals are the economic engines that drive the overall economy. Therefore a growing number of uninsured threatens the whole life of the community.
- i Physicians also feel the pressure to serve those who are “self-pay.” Small provider offices do not have the financial wherewithal to sustain ongoing, uncollectible debt. This financial reality may cause providers to close office locations, modify available times for appointment, or to refuse to see anyone who does not pay for services at the time of the visit.

On the reverse side, those with access to affordable health care are more likely to have better health. Being healthy frequently translates into higher education attainment, being employed and to higher earning potential for the individual. Some believe that earnings can increase by 10 to 30 percent with improved health. Both of these factors lead to an individual's greater contributions to the economy overall.⁴

Because employers are the most common vehicle for distributing health insurance in our country thus far, it is important to consider why they would or would not offer health insurance to their work force. For the most part, not offering insurance is purely a financial decision. In our community, Wichita Independent Business Association (WIBA) has done an excellent job in offering to employers options for providing coverage. However, there are a growing number of employers who face a tough dilemma: paying their employees livable wages or offering them health coverage. For many business, offering a health insurance benefit simply is not an option.

An employer who is able to offer coverage receives a substantial “pay-back”: The business is legitimized as a “real” company and becomes a desirable place of employment. The business will likely see increased employee retention and decreased sick time of the employees.

Certainly the state and our community do offer health coverage for those with low incomes. HealthWave 19 and MediKan cover some adults who are up to 150% of FPL; Project Access provides access to care for those up to 200% of poverty. However, there are a large number of people who do not qualify for these programs either because of their income or because they do not meet other specified criteria.

Based on the most recent American Community Survey, the Kansas Health Institute estimates there are approximately 40,000 uninsured, working individuals within Sedgwick County.

This initiative aims to provide low income, uninsured residents of Sedgwick County with access to affordable health care coverage. It will be targeted to those uninsured residents who are

⁴ The Kaiser Commission on Medicaid and the Uninsured [Kaiser], 2003. *Sicker and Poorer: The Consequences of Being Uninsured.*

currently working, with incomes up to 250% of the Federal Poverty Level, or approximately 15,000 individuals.⁵

Our objectives include:

1. **Increased access to affordable health coverage** through the implementation of a local access to care program – the Community Coverage Initiative.
2. **Implementation of the “medical home” concept** through required primary medical home selection and an array of supportive services to encourage relationships between primary care providers and their patients.
3. **Development of tools that clearly measure utilization and cost outcomes** resulting from this focused effort on good primary and preventive care services.

Accomplishing these objectives will (a) expand affordable coverage options and reduce the strain on the safety net providers, as all willing providers within the community can participate; (b) reduce disparities in access to health insurance coverage, through focused work with “enrollment counselors” and creative outreach approaches; and (c) moderate the increasing trajectory of costs and decreasing quality of life experienced by those who do not have access to appropriate health care providers.

This proposal is the product of a collaboration of public and private organizations with extensive experience providing health care to the uninsured and planning for the community’s needs. We believe that there is a need for this community to act quickly to implement this program and meet the needs of our friends, neighbors, and families who currently do not have access to health care.

⁵ For 2009, 250% of the Federal Poverty Level is equal to \$27,075 for a single person.

Section 3. Background/Setting the Stage

Health Planning Activities in Wichita and Sedgwick County

Wichita/Sedgwick County, Kansas is actively engaged in thinking about, planning for and moving toward health goals for their community. Consumers, health care providers, government, and business leaders of this unique community are all working toward solutions. Planning has occurred through a number of diverse efforts, and for the most part they have identified similar needs and are driving toward common outcomes.

The planning efforts to date of both private and public entities have grown organically to link with each other and with the daily work that is being done throughout the county by various parties: the Sedgwick County Health Department, Project Access (a program of Central Plains Regional Health Care Foundation), the Medical Society of Sedgwick County, the Wichita Business Coalition on Health Care, the Vision Group, and many, many other for-profit and not-for-profit providers and health facilities throughout the county. What follows is a summary of this work over the last five years designed to provide insight into a community that has taken a long term, planful approach to improving the health of its residents.

Visioneering Wichita and the Health Alliance

Visioneering Wichita⁶ is a forum for obtaining citizen input into developing the desired future for the city of Wichita. The organization formally started in 2004 and by December 2004 had developed a plan for not only Wichita itself, but also for the surrounding areas of Sedgwick, Butler, Harvey, and Sumner counties. The plan sets goals, requires measurement, and engages interested residents of the region in shaping the future of south-central Kansas.

The long term (20 year) vision of the effort is to focus on the following areas: Economic Development, Education, Quality of Life, Government, Infrastructure, and Private Sector Leadership. Its mid-term vision (five to 10 year) is focused on developing the platforms that will allow growth in the areas listed above.

Specific to health care, its strategy includes increasing the accessibility and quality of health care while lowering the cost by:

- i Encouraging healthy lifestyles, wellness, fitness, and education programs.
- i Addressing tobacco, obesity, drug, alcohol, and violence issues.
- i Improving dental health for all ages.
- i Promoting and strengthening free and/or reduced cost clinics as a substitute for emergency room use for indigent health care and promoting awareness of these resources.
- i Encouraging physicians and nurses to provide services to indigent patients.
- i Dramatically increasing the use of technology in administrative functions.
- i Advocating for tort reform.

⁶ See: www.visioneering.org

- i Providing comprehensive coordinated medical care (including mental, dental, and health) to all people regardless of ability to pay and providing easy access to services.
- i Establishing a community-wide expert committee that advises the community on health care costs and quality.
- i Promoting disease prevention.
- i Ensuring the availability of qualified nurses.

These issues are generally moving forward under the direction of the Health Alliance, a subgroup established by Visioneering Wichita, which notes that its major action areas are:

- i Promoting disease prevention by encouraging healthy lifestyles, wellness, fitness, and education programs.
- i Having comprehensive coordinated health care, including mental, dental, and medical care for all people.
- i Ensuring the availability and adequate supply of qualified health care professionals.
- i Communicating about and promoting existing health services.

Specifically, the Alliance is targeting nine measurable health indicators and benchmarks for success. They are:

- i Asthma
- i Chronic Illness Prevention
- i Drug/Alcohol Abuse
- i Mental Health
- i Nutrition
- i Oral Health
- i Physical Activity
- i Tobacco Use
- i Unintentional and Intentional Injury

Wichita Business Coalition on Health Care

A spin-off of Visioneering and the Health Alliance is the Wichita Business Coalition on Health Care.⁷ Its goal is to reduce health care costs, increase quality, and improve access. The Coalition believes that progress can be made through a dedicated infrastructure and leadership within the business community to provide a consistent focus on health care issues in the region. The Coalition leverages the involvement and collaboration of diverse key stakeholders: employers, physicians, insurance companies, hospitals, and others involved in both the business and practice of medicine.

The Coalition is focused on the following priorities:

- i Framework for Common Understanding and Improvement – developing common understanding and common language among the members of the Coalition.
- i Utilization – understanding and addressing regional variations and implications for cost, quality, and value.

⁷ See: www.wbhc.com

- i Disease Management/Risk Identification – understanding and addressing specific health issues among employees, including wellness, prevention, early identification, and chronic disease management.
- i Value-Based Benefit Design and Purchasing – increasing accountability by better aligning incentives for each component of the health system (patient, employer, and provider).
- i Transparency – understanding the basis and drivers of both cost and quality.
- i Infrastructure and Participation – expanding participation and funding to support a strong and sustainable organization that can accomplish its vision and mission.

Sedgwick County

In addition to the private efforts noted above, in 2002 the Board of Sedgwick County Commissioners assumed administrative and primary financial responsibility for the Health Department of Sedgwick County (this had been a City function) while the City remained responsible for the environmental services.⁸ Due to their new responsibilities, the Board of Sedgwick County Commissioners began to examine the issue of public health with a Community Assembly in 2004.

This process included the distribution of 25,000 health-focused surveys to registered voters throughout the county. Concerns about health care coverage and access to health care providers emerged as major issues. Additional planning activities occurred under the auspices of the private sector as a result of the survey during subsequent years. Then the Sedgwick County Commissioners convened a “Summit” in June 2007 to further explore the problem of health access and look for possible solutions to decrease the barriers citizens have to health care access. Attending the Summit were approximately 90 community members representing the health care industry, nonprofit sector, business community, citizens, academia, and local and state governments.

During this Summit, three main barriers to health access were identified:

- i Coverage: lack of health access for people who are uninsured or underinsured.
- i Coordination: lack of health access due to the difficulties of coordinating services between hospitals and safety net clinics.
- i Navigation: lack of health access caused by people having a limited understanding of options.

Three work groups were initiated following the Summit. The work groups held regular meetings from September 2007 to March 2008 to develop implementation plans for addressing these issues. Commissioner Tim Norton led a steering team to oversee all work. Their final recommendations were summarized in the Milestone Report (July 2008), which identifies, in part, the next stage of implementation:

⁸ Prescription for Health Citizens; Proceedings of the Sedgwick County Assembly. 2004

i **Coverage:**

- A. Review analytical information on identifying the uninsured.
From this the following groups were targeted: Small business employers and employees; adults 19-24, children not receiving but eligible for HealthWave, and chronic Emergency Department (ED) users.
- B. Identify public and private insurance programs available.
- C. Conduct a gap analysis and define necessary programs to cover the uninsured.
Identified that coverage programs for small business, small business employees, and low-income individuals are still an obstacle. Central Plains Regional Health Care Foundation was identified to lead a group that is studying the viability of a Community Health Coverage Plan (CCI) to address this need.
- D. Serve as a link to the State of Kansas coverage programs.

i **Coordination:**

- A. Establish appropriate hours of health access; recommending standard hours for the community be 8:00 am – 8:00 pm and some weekend hours.
- B. Develop a transportation plan to assist access to health care; surveyed the community and produced a list of available transportation.⁹
- C. Analyze the current system for shared health information data on the uninsured and underinsured.
Recommended continued support of the community's current Electronic Health Record (EHR)/Wichita Health Information Exchange (WHIE) and identified the Medical Society of Sedgwick County as the lead on the issue of shared health information.

i **Navigation:**

- A. Establish a one-stop information source; enhance the information currently available through existing United Way "2-1-1" phone system and increase education on how to use the system.
- B. Create an educational campaign for health literacy, including a marketing plan for increasing awareness of available services.

Developed a "Health Access Toolkit" that was launched during Cover the Uninsured Week in April 2008.¹⁰

After the release of the July 2008 report, the Commissioners organized further efforts for the community to identify solutions to the issues identified. Under the "Coverage" component, a

⁹ See: <http://www.sedgwickcounty.org/healthdept/transportation.asp>.

¹⁰ See: http://www.sedgwickcounty.org/healthdept/fact_sheets/access%20final%20with%20page%20numbers.pdf.

Coverage Work Group established a goal to assess the feasibility of a local health coverage plan – now referred to as the Community Coverage Initiative. The results of this feasibility study ideally will lead to the implementation of a plan with the following basic components:

1. Facilitate the establishment of medical homes.
2. Work to provide access to a full continuum of care.
3. Develop a sustainable funding mechanism.
4. Support the local existing health care providers.
5. Support care coordination and patient education processes in order to achieve efficient and effective utilization.

Local Access Model

Following the report, Central Plains Regional Health Care Foundation, the nonprofit affiliate of the Medical Society of Sedgwick County, was approached to take the lead on completing the feasibility study and adding detail to the skeleton structure outlined above. United Methodist Health Ministry Fund and United Way of the Plains provided substantial contributions toward the cost of the study; the Central Plains Foundation’s Board approved a generous contribution as well.

These funds were earmarked to hire contracted consultants to assist in the feasibility study. Halleland Health Consulting, Tillit Consulting, Bothner & Bradley, Creative Assistance, and the University of Kansas School of Medicine-Wichita provided various components of support for the study.

Leadership for this feasibility study has been provided by a 25-member Advisory Committee made up of stakeholders from within the county. The group began meeting in January 2009 and established a work plan that began in earnest in March of 2009 with the hiring of Halleland Health Consulting. The group met on a routine basis from April through August 2009 and the results and recommendations presented in this document are the conclusion of many hours of the Advisory Committee’s and staff’s dedicated time.

The recommendation of the Advisory Committee:

After much study and engagement of the community, the Advisory Committee is recommending the creation of a local access model for Sedgwick County, “Community Coverage Initiative: Exploring affordable health coverage for Sedgwick County” (CCI).

Our mission is:

“To address the needs of residents of our community who do not have health coverage by creating a coordinated approach to access to health care.”

The following sections of the report describe the CCI model, its place in the array of options currently available for receiving care in the County, and recommendations for its implementation.

Section 4. Community Coverage Initiative

A. Overview

The intent of the Community Coverage Initiative (CCI) is to try to fill a gap in access to health insurance coverage – which leads to gaps in health care access – for a targeted group of residents in Sedgwick County: those whose income is just high enough not to qualify for existing public programs, but low enough that they must make difficult decisions daily between receiving health care and providing their family with food, housing, and appropriate child care.

It cannot be emphasized enough that this initiative is not designed to compete with existing health insurance products – rather, the initiative is to focus resources on getting people into a health care delivery system that is available to, and affordable for, both individuals and providers. In addition, the initiative described here is not designed to encourage employers currently offering health insurance to their employees to cancel their existing offerings – this would be an unintended consequence that would undermine the cornerstone of health insurance coverage and lead to instability within the market overall.

B. Guiding Principles

The CCI Advisory Committee established ten guiding principles for the initiative:¹¹

1. Our common goal is to make our community healthier, particularly for the uninsured.
2. We will aspire to design a financially viable coverage model that supports the following key components, which are anticipated to improve outcomes:
 - i Medical home concept
 - i Care coordination/Case management
 - i Health education
 - i Personal accountability of patients
3. We will endeavor to develop a coverage model that is business friendly.
4. We will not include incentives that would allow currently insured persons or persons currently eligible for other coverage to participate in this program.
5. We will seek to balance administrative requirements and a desire to provide a continuum of care with the financial impact they represent.
6. We will include a community benefit analysis with the cost analysis developed in conjunction with a coverage model.
7. We will incorporate observable and measurable health, financial, and satisfaction outcomes.

¹¹ Accepted by Advisory Committee in May, 2009

8. We will strive to start small with efforts that are achievable and can be grown and expanded.
9. We will study other efforts underway in our community, be sensitive to their actions, and incorporate compatible components into any coverage model developed.
10. We will manage our community's expectations and understand that any coverage model developed cannot be all things to all people.

C. Local Access Models

A broader discussion of local access models follows in Appendix A of this report. However, it is helpful for the reader to have a short introduction to the concept as a precursor to the following description of the initiative.

Local access models are community initiatives that bring together multiple community organizations – providers as well as businesses, government, individuals, and other financing sources – to share the burden of the delivery of care, associated costs, and governance responsibilities in order to improve access to health services for those who currently do not have affordable access to health insurance.

The defining characteristic of a local access model is that the care provided, the related costs for service and administration, and the entity's governance design are spread out amongst different community organizations, public and private health care delivery organizations, state, county and/or city government, and philanthropic donations.

D. Targeted Participants

Participants in CCI will voluntarily engage in the program. While the intent of the program is to engage both the working and non-working uninsured residents of the county, the initial focus will be on those who are working. This is consistent with Guiding Principle #8 above. It is hoped that targeted enrollees can be expanded to those who have recently been laid off and cannot afford COBRA premiums. The focus will then broaden to encompass all unemployed, uninsured residents of the county.

Participants must meet and provide written verification of the following requirements:

1. be a legal resident of the U.S.;
2. be a resident of Sedgwick County;
3. be between 19 and 64 years of age;
4. have household income at or below 250% of the federal poverty level¹²;
5. not be current residents of an institution (hospital, nursing home, other group residential facilities, prisons);
6. not be eligible for any other public or private coverage; and
7. work at least part-time for an employer or prove they are self-employed.

¹² Note: the Advisory Committee expressed an interest in moving the income limit to 350% of poverty if the enrollment levels and resulting financial impacts would be manageable because there is a perceived need for access to health care for this group.

Spouses and domestic partners of those who are eligible because of their employer are also eligible to engage with the program if they also meet the above criteria.

Kansas Health Institute (KHI) has assisted our project in developing population assumptions specific to this effort. Their work is based on the recently released 2008 American Community Survey (ACS) Microdata sample and the Public Use Microdata Area analysis¹³. Based on this survey data, the total civilian, non-institutionalized people within our area of interest for the adult population ages 19 through 64 is 203,273. KHI estimates that 22% of those in this group are uninsured:

TABLE I: Civilian, Non-Institutionalized, Adult Population without Insurance by Income

Income to Poverty	Total	Percent of Total	Total Without Insurance	Percent Without Insurance
<100%	26,031	12.8%	12,304	47.3%
100 – 149%	15,896	7.8%	5,733	36.1%
150 – 199%	20,579	10.1%	9,507	46.3%
200 – 249%	21,021	10.3%	5,793	27.6%
250 – 299%	17,404	8.6%	3,028	17.4%
300 – 349%	13,137	6.5%	2,244	17.1%
350 – 399%	16,029	7.9%	2,788	17.4%
400%+	73,176	36.0%	3,936	5.4%
Total	203,273	100%	45,333	22.3%

The Microdata used for these projections reflect only a portion of Sedgwick County. Because this effort is focused on the entire County, not just the area covered by the Microdata, the information presented below has been adjusted in order to represent the population in the full County¹⁴:

¹³ See information in Attachment D for further information about PUMAs and ACD.

¹⁴ The Microdata analysis noted above accounts for approximately 71% of total residents in the county.

TABLE II: Adjusted Civilian, Non-Institutionalized,
Adult Population without Insurance by Income

Income to Poverty	Total	Percent of Total	Total Without Insurance	Percent Without Insurance
<100%	33,564	12.8%	15,876	47.3%
100 – 149%	20,453	7.8%	7,384	36.1%
150 – 199%	26,484	10.1%	12,236	46.3%
200 – 249%	27,009	10.3%	7,454	27.6%
250 – 299%	22,551	8.6%	3,901	17.4%
300 – 349%	17,044	6.5%	2,915	17.1%
350 – 399%	20,716	7.9%	3,605	17.4%
400%+	94,400	36.0%	5,098	5.4%
Total	248,603	100%	58,469	22.3%

Employers

Employers will play an important role in the first stage of development of the CCI. It is anticipated that employers will voluntarily participate in the Initiative and thereby allow employees access to CCI’s services.

Self-employed individuals will be able to participate as well if they are financially able to contribute the equivalent of the employee and employer share.

Still to be determined is the participation of individuals whose employer does not want to participate in CCI. We hope to be able to allow them to access the services through additional revenue contribution by the employee to match what an employer would have paid.

According to the Wichita Chamber of Commerce, in 2006 (the last census) Sedgwick County contained 12,126 business establishments (this is based on location not company, so each location of a franchise such as Wendy’s, Quik Trip, etc. was reflected in the count). At that time, the total estimated number of employees was 225,210.

Of these establishments, 97% (11,788) employed fewer than 100 people. The number of employees of these establishments is estimated at 134,800. Of these establishments with less than 100 employees, 48% have 1-4 employees, 20% have 5-9, 14.5% have 10-19, 13.5% have 20–49, and 4% have 50 -99.

In the United States, as of July 2009, minimum wage is \$7.25 per hour. A full-time worker paid at minimum wage earns \$15,080 per year or about 140% of FPL. For a family of four, 150% of FPL is \$33,075 per year or \$2,760 per month. Because there will be cost sharing and monthly financial contribution requirements in the program, it may be unlikely that those earning less than 150% of FPL will be financially able to participate. Therefore the target market more likely may be those making above 150% of the federal poverty level.¹⁵

¹⁵ Note: Kansas Medicaid and General Assistance programs’ income limits range from 31% of FPL to 200% for SCHIP enrollment depending on the structure and size of the family.

According KHI’s analysis, of those employed, 78% of individuals have health insurance. This leaves 45,333 (22%) without health insurance. Their income levels are as follows:

TABLE III: Civilian, Non-institutionalized, Adult Population without Health Insurance
Employed, Unemployed or Not in Labor Force

Income to Poverty	Employed	Unemployed	Not in Labor Force	Total
<100%	4,875	3,098	4,331	12,304
100 – 149%	4,514	564	655	5,733
150 – 199%	7,610	771	1,126	9,507
200 – 249%	4,504	547	742	5,793
250 – 299%	2,936	92	0	3,028
300 – 349%	1,946	0	298	2,244
350 – 399%	1,900	204	684	2,788
400%+	2,969	745	322	3,936
Total	31,154	6,021	8,158	45,333

After adjusting the estimates to approximate the full Sedgwick County service area, the civilian non-institutionalized people ages 19-64, without health insurance are:

TABLE IV: Adjusted Civilian, Non-institutionalized, Adult Population without Health Insurance
Employed, Unemployed or Not in Labor Force

Income to Poverty	Employed	Unemployed	Not in Labor Force	Total
<100%	6,274	3,987	5,574	15,834
100 – 149%	5,809	726	843	7,378
150 – 199%	9,793	992	1,449	12,235
200 – 249%	5,796	704	955	7,455
250 – 299%	3,778	118	0	3,897
300 – 349%	2,504	0	383	2,888
350 – 399%	2,445	263	880	3,588
400%+	3,821	959	416	5,196
Total	40,221	7,748	10,500	58,469

Therefore, our initial target group for engagement of Sedgwick County residents, who are working, do not have current health insurance and have an income above 150% of federal poverty is:

TABLE V: Initial Target Enrollment Group
Civilian, Non-institutionalized, Adult Population. Working without Health Insurance

Income to Poverty	Employed without Insurance
<100%	6,274
100 – 149%	5,809
150 – 199%	9,793
200 – 249%	5,796
250 – 299%	3,778
300 – 349%	2,504
350 – 399%	2,445
400%+	3,821
Total	40,221

The intent of the program is to focus on low income populations, initially defined as less than 250% of FPL, which would suggest a total target enrollment group of 27,972. However, the planning group did indicate that it would be desirable to move the upper limit of income up to 350% if possible. If this was done, the targeted enrollment group would be approximately 33,954 individuals.

E. Engagement & Intake Process

There will be a thorough pre-screening process of individuals whereby those applying for CCI participation will be screened for eligibility with existing programs; or have significant concerns that lead them not to enroll. If they are eligible for existing public or private options, individuals would be encouraged to apply for the other options and support will be provided to assure this process is completed.

If they truly are not eligible for other options, they will be encouraged to join CCI and be provided with information about the program. There will be staff included in the administration budget called “Insurance Navigators” who will perform this activity. These staff will be closely aligned with those currently providing this service for existing government-sponsored programs.

A recent study (December 2008) by Mathematica Policy Research, Inc.¹⁶ reviewed many programs across the U.S. that are attempting to expand coverage to the uninsured. The study findings focus on the nonprice design features that influence nonelderly adults’ engagement in these programs.

The study identified these key components of success:

- i Outreach is critical. Generally, targeted, decentralized, community-based, in-person outreach approaches are most effective.
- i A broad spectrum of partnerships is key. Many trusted community partners that support the program lead to higher engagement rates.

¹⁶ Designing Subsidized Health Coverage Programs to Attract Enrollment: A Review of the Literature and a Synthesis of Stakeholder Views; Mathematica Policy Research, Inc. December 31, 2008. Contract No 233-02-0086. See <http://aspe.hhs.gov/health/reports/08/subenroll/report.pdf>. Accessed August 10, 2009.

- i Applicants need a high level of insurance counseling and application assistance. Applicants are confused about insurance concepts, income eligibility criteria and required documentation
- i Manage expectations and avoid negative perceptions. Properly managing expectations ensures accurate information is presented first and tailors outreach for audiences.
- i Target individuals directly rather than work through employers. Benefits, enrollment processes, eligibility criteria that must appeal to both employers and employees are difficult to simplify enough to engage participants.

These results will need to be incorporated into a plan for outreach and marketing. Initial thoughts on the approach have focused on employers as being the entrée to their employee base; however, the findings of this study suggest that a balanced approach of outreach to employees with one message and employers with another may be more appropriate. As our development of CCI continues, a focused group of marketing and outreach experts will be convened to flesh out the outreach and engagement plan.

Documents that verify the information required for eligibility on the application will be required. However, the intent is to make this process as easy as possible, while also assuring that the targeted residents of our community get enrolled as soon as possible.

There will not be a waiting period of residency in the County required prior to enrollment; however the person must prove their residency at the time of enrollment and annually thereafter.

Estimated year end enrollment into the coverage model is as follows. This does not assume any change in the national approach to assuring all Americans have insurance coverage.

TABLE VI. Enrollment Projections

	<u>Conservative Estimates</u>	<u>Likely Enrollment</u>	<u>Aggressive Enrollment</u>
Year 1	5% (1,384)	10% (2,767)	15% (4,151)
Year 2	8% (2,214)	15% (4,151)	25% (6,918)
Year 3	12% (3,321)	20% (5,534)	40% (11,068)

F. Service Packages

CCI will have a strong bias toward supporting a primary care/medical home concept. It is believed that the most effective way to “bend the curve” in terms of improving quality, improving individuals’ functional lives, and impacting costs is to support a strong relationship between a patient and primary care physician.

During the developmental phase, the Advisory Committee directed the exploration of community feedback sessions to understand the community’s wants and needs, as well as their preferences for benefits. Small focus groups were held to solicit individual feedback using the Choosing Healthplans All Together (CHAT) game. A full report of the results is included as Attachment A.

Six focused groups provided feedback to our process through participating in the CHAT game process. Most were women between 19 and 40 years old and all were not insured at the time of the game. During the process, people try to come to consensus about what type of health care service they think is important to be covered by health insurance. The services most frequently identified were (in no particular order):

- Primary Care
- Hospitalizations
- Pharmacy

In addition, a web-based survey was established in June and was open for responses through mid-August 2009.¹⁷ A full report of the results is included as Attachment B. This community survey gathered a wide range of responses from residents of the county. It was publicized on a variety of web sites, in newspaper articles, and on TV news websites. In addition, hard copies of the survey in English and Spanish were distributed in the FQHC and health department clinics.

In the end, 447 respondents initiated the survey and 434 completed it. Of these respondents, 196 (43%) did not have health insurance – which was the group of most interest. Analysis of those who responded via the web versus on paper survey was very similar except in their race, education, and size of household. The two groups, however, did have different preferences when it came to the types of coverage they wanted.

The preference of those responding via the web ranked preferred benefits as:

- | | |
|----------------------|--------------------|
| 1). Primary Care | 5). Testing |
| 2). Pharmacy | 6). Specialty Care |
| 3). Hospitalizations | 7). Other |
| 4). Emergency Room | 8). Mental Health |

When considering both those responding via web AND via hard copy, the ranking is:

- | | |
|----------------------|--------------------|
| 1). Primary Care | 5). Emergency Room |
| 2). Hospitalizations | 6). Specialty Care |
| 3). Testing | 7). Other |
| 4). Pharmacy | 8). Mental Health |

Based on the community’s feedback and the Advisory Committee’s understanding of wants versus affordability, the services of CCI are anticipated to be structured in two parts. First, the Primary Care Service Package with a rich array of services to support a medical home concept, health education, promotion of wellness, and preventive care. Second, the Referral Service Package that includes specialists, hospital care, mental health, and other services that would be used to meet the unique needs of the participant and would be capped at a set amount per year.

More specifically, the services included in the Initiative are anticipated to be:

¹⁷ See: http://www.surveymonkey.com/sedwick_county_community_coverage_initiative

- 1. Primary Care Services:** This coverage initiative will be focused around the services of primary care physicians and a medical home concept that is being developed within the Wichita Business Coalition on Health Care.¹⁸ This model of care incorporates the following characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

CCI will include coverage for as many primary care visits as necessary to meet the needs of the individual participant. It will allow for a range of providers (physicians, nurse practitioners, physician assistants, registered nurses, etc.) to deliver care using the skill level most appropriate to the individual's needs. It will cover extended office visits if the provider feels it is necessary to spend more time with the patient. In addition, CCI will provide reimbursement to providers to consult with hospitalists/emergency department/nursing home staff if their patients require care in those settings. Home visits will be reimbursed in cases where the person is not able to come to a clinic.

Patient co-pays will be required for visits/services, set at levels "affordable" to those whom we are targeting for engagement.

Also included in the Primary Care Service Package are:

- a. Diagnostic Testing/Screening:** These services must be ordered by a primary care physician. Certain diagnostic services will require some type of pre-certification or pre-determined criteria to assure the efficient use of our resources. The ideal process will be designed for ease of use and does not assume overutilization will occur. Instead, it assures that appropriate care is being provided.
 - b. Care Navigation/Case Management/Education Services:** While not yet well defined, it is anticipated that each participant will have access to the support services appropriate to his or her needs. Navigation assistance, health education, coordination of medical appointments, and transportation planning would be provided in a tailored approach.
 - c. Pharmacy:** Recognizing that access to affordable and appropriate medications is critical to maintain health, medications will be covered by the program in two ways: First, a limited program to cover generic medications at \$4 per prescription will be built into the Primary Care Service Package. Second, additional medications will be covered under the Referral Service Package described below. Physicians, as part of their participation agreement, will be asked to prescribe generics whenever possible.
- 2. Referral Services:** A fixed annual limit currently estimated at \$7,000 of additional services is available to participants. The package would cover a wide range of services that could be used as needed to meet the enrollee's specific needs. A participant's primary care provider would be required to make the referral. An appropriate "justification process" would be put into place to assure proper usage of services. Data

¹⁸ The Wichita Business Coalition on Health Care is basing its work around the *Joint Principles of the Patient Centered Medical Home*, a document that was released in 2007 and supported by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association.

mining at the aggregate level would identify those participants who could be better served through more focused primary care medical management or partnered with a care navigator.

- a. Pharmacy: Brand name medications to treat illness and for chronic disease management are also an important part of patient care. Brand medications will be included in the Referral Service Package with a \$20 copayment when appropriately authorized for medical appropriateness. In addition, certain supplies/equipment (i.e. diabetic supplies, EpiPens, etc.) will be eligible, again with medical appropriateness requirements.

Specific services included in CCI are:

Services	Member Contribution	Limitations
Primary Care Service Package		
Initial Primary Care Visit	No Copayment	One within 2 months of joining
Primary Care Office Visit	\$15 Office Copayment	None
Maternity Care – prenatal visits	\$10 Office Copayment	Limited to 12 visits per pregnancy
Maternity Care – postpartum visits	\$10 Office Copayment	Limited to 2 visits post pregnancy
Specialist Office Visit:	\$15 Office Copayment	Must be referred by PCP; 2 visit maximum (then covered by Referral Service Package)
MH/Substance Abuse Counselors – Level 1 Care	\$15 Office Copayment	Must be referred by PCP; 2 visit maximum (then covered by Referral Service Package)
Level I Outpatient Lab, X-Ray, and Diagnostic Testing	\$20 per service	Must be medically necessary
Urgent/After Hours Care	\$40 Copayment	Limited to 6 visits/year
Prescription Drugs – Generic ¹⁹	\$4 Copayment	Benefit will have an annual limit that has not yet been determined.
Referral Service Package Limited to \$7,000 Annually		
Coverage for specific supplies/equipment	\$__ to be determined; will vary by specific item.	Examples: insulin & diabetic supplies, EpiPens, etc. Must be justified by physician
Specialist Office Visit	\$20 Office Copayment	Must be referred by PCP
Prescription Medications	\$20 Copayment	Must be medically appropriate for specific participant.
Level II: Outpatient Lab, X-Ray, and Diagnostic Testing	\$20 per service MRI/PET Scans \$75 per	Must be medically necessary

¹⁹ As part of their participation agreement, physicians will be asked to prescribe generics whenever possible.

Services	Member Contribution	Limitations
MH/Substance Abuse Counselors – Level 2 Care	\$15 Office Copayment	Must be referred by Level 1 Counselor
Maternity Care – Delivery	\$200 per day	
Maternity Care – complications post delivery	\$15 Office Copayment	Must be medically necessary
Outpatient Surgery	\$100 per surgery	Must be medically necessary
Allergy Testing or Treatment	\$25 per test or treatment	Must be medically necessary
Inpatient Behavioral Health & Substance Abuse	\$200 per day	Must be medically necessary
Inpatient Hospital	\$200 per day	Must be medically necessary
Emergency Room Services	\$80 per visit	Must be medically necessary; limited to 3 visits per year w/o hospitalization
Ambulance Services	\$200 per trip	Must be medically necessary; limited to 2 trips per year
Durable Medical Equipment	\$50/\$100 per piece of equipment depending on price.	Must be medically necessary
Home Health Care	\$40 per visit	Must be medically necessary
Therapies (OT, PT, ST)	\$40 per visit	Must be medically necessary
Inpatient Rehabilitation	\$150 per day	Must be medically necessary
Outpatient Rehabilitation	\$20 per visit	Must be medically necessary
Orthotics and Prosthetics	\$50/\$100 per piece depending on price	Must be medically necessary
Medical Transportation	\$10 per trip	Coordinated through member's Care Navigator
Not Covered (Note: Not a Complete Listing)		
Eye Exams		
Eye Glasses		
Infertility Treatment		
Cosmetic Surgery		

Special Case: Dental Services

We believe that good oral health is essential to maintain physical health as well as an overall sense of wellbeing. Our initial efforts included dental cleanings and x-rays as part of the Primary Care Service Package and dental fillings/extractions in the Referral Service Package.

Once included, we began to talk with the dental society and others regarding the availability of dentists in Sedgwick County and our ability to develop a provider network that would meet the needs of those participating in our plan. The results of community discussion highlighted a

problem: There are only approximately 150 general dentists practicing in Wichita,²⁰ nowhere near enough to serve the general population. In fact, Kansas as a state has .6 dentists per 1,000 residents compared to .8 per 1,000 in the rest of the U.S. A recent study by the Kansas Health Institute shows that ten counties in Kansas have no dentists at all.

While improvements to access are underway through Wichita State University's new dental residency program and existing dental hygienist program, as well as expanding access in the safety net clinics, there continues to be a lack of available capacity in the community.

Because of this reality, and in an effort to adhere to Guiding Principle #8 (start with small efforts that are achievable), the program will not initially offer dental coverage. That said, there is a desire to reach out to dental providers to further understand capacity availability and attempt to find ways to creatively meet this important need for the program's participants.

G. Participant Accountability

In keeping with Guiding Principle #2, we will build into CCI approaches that encourage education and active participation of enrollees. Studies have shown that patient non-compliance results in poor outcomes and increased spending. Investments by CCI toward education about diseases and chronic conditions, healthy lifestyle options, and the proper use of components of the care system are hoped to influence quality of life as well as costs. As a community initiative, we have the ability to put social pressure on all of our members to make healthy choices and encourage responsibility in using the resources the community provides through CCI.

H. Provider Network

The network for the Initiative would include any provider/facility that desires to participate in the program. Safety net providers in the area would certainly be a core component of the network, but private physicians are equally important to include. Medical Society of Sedgwick County would encourage broad participation in this program for primary care physicians as well as specialists. Engagement with the Wichita District Dental Society is also anticipated to be critical. Local hospitals, both for profit and nonprofit, would also be encouraged to participate. As start-up of the project nears, communication with providers would begin and analysis would be completed to assure reasonable access (both geographic and timeliness) to providers.

Involvement in this program is not intended to dis-incent providers from participating in Project Access. This program is not designed to be a "funnel" for patients into the existing Project Access. We see this Initiative as being one of an array of options for this targeted group of people to receive needed health care.

Emphasis will be placed on making this program user friendly for both the patient and the health care professional.

I. Outcome Measurement

As stated in the goals of the Initiative, the intent is to incorporate observable and measurable health, financial and satisfaction outcomes into the initial and ongoing operations of the CCI.

²⁰ Source: Wichita District Dental Society's web site: www.wichitadds.net accessed August 24, 2009.

While definitive decisions have not yet been made on these outcomes, it is anticipated that they will parallel work existing in the community.

As the project becomes more refined, a stakeholder group will begin meeting to identify the most appropriate outcomes and assure that systems are in place to measure them.

J. Organizational Structure

It is anticipated that CCI will operate as a non-profit 501(c) 3 organization, using either an existing or newly formed entity. Staff would be hired to perform certain functions while other functions would be provided by contracted vendors. It is anticipated that the contracted vendors would be identified through a competitive bidding process.

Below are baseline assumptions on the staff that may be necessary to operate CCI successfully. Note that the financial model presented in the next section assumes a percentage of revenue for administration and that amount has yet to be aligned with the staffing and contracting approaches listed below.

Employed Staff:

- i Project Director
- i Insurance Navigator/Engagement Coordinator: 5 initially
Will provide counseling to potential participants on insurance options available to them, information about CCI, and assistance with the completion of the application form.
- i Care Navigator: 1:400 participants
Will provide assistance with identifying medical home physician, completion of an initial health assessment, facilitation of initial appointments, education about specific diseases, etc. A Care Navigator will be assigned to each participant but, through risk stratification, only those with specific needs will have ongoing contact with a Care Navigator. It is anticipated that these will be either nurses or social workers.
- i Case Aids: 1:1,200 participants
Will provide assistance to participants with a variety of issues – identification of physicians in the network, help arranging for transportation to appointments, referrals to other community programs or services (e.g., I need help buying food for my family), etc. Also will assist providers who have questions about the “medical review” process of CCI.
- i Provider Relations: 2 initially
Will assist the provider community initially with contracting, but also ongoing servicing and fielding questions.
- i Financial/Utilization Reporting: .5 FTE
Although claims processing will be a vended service, the position will analyze and report on data provided by the vendor.

- i Marketing/Employer Relations: 2 initially

Will provide outreach to the employer community to engage them in the opportunity of participating with CCI and facilitate the introduction of the Insurance Navigators to the employer/employees.

- i Administrative Support: 2 FTE

Contracted Services:

- i Claims processing
- i Utilization management (pre-authorization)
- i Data mining for targeted follow-up
- i Medical Director
- i Insurance Agent/Brokers

K. Financial Model

Medical Expense:

The services would be reimbursed at current “Medicare reimbursement levels.” While paying exactly at Medicare levels is a complex task, we believe that we can approximate this level through creative approaches. Also, we are committed to paying all providers at the same level – i.e., payment for specific services will be the same regardless of which provider delivers the care.

Administrative Expense:

The administrative expense will be developed based on the staffing ratios above and on market pricing for commonly vended services. CCI is committed to maximizing the amount of revenue that is available to provide services; therefore it is focused on limiting administrative expenses to those necessary and producing value to the Initiative. It is anticipated that the total administrative expense will account for no more than 20% of revenue.²¹

Revenue:

Revenue will be estimated based on the participants' monthly contributions and co-payments, employers' monthly contributions, government contributions, and an estimated charitable giving amount. Most local access models do operate with up to 30% of needed revenue coming from philanthropic donations during start-up periods.

Financial Model Projections

For purposes of developing an initial financial model, Tillit Consulting made the following assumptions:

²¹ Source: Industry publications: Medicaid Plans: 9.3%, Independent/Provider-Sponsored Plans: 9.4%, Blues Plans: 10.4%.

- The service array contemplated is that which was presented at the August 19, 2009 Advisory Committee meeting. This is slightly different than what is outlined in our section outlying services above. Most notably is the inclusion of dental services in the primary care services line item. During the Advisory Committee meeting, a determination was made not to include dental. This results in \$8.64 pmpm being taken out of the expense model. In its place would be generic medication services that are described above. While the actuarial value of ‘switching’ the two services is not calculated in the numbers below, it is assumed that the annual limit for the generic drugs would be set at a limit that would cost approximately the same as the dental services.
- Offering will be made through the employer-employee structure
- Provider reimbursement will be equivalent to 2009 Medicare allowable fees
- Enrollees are limited to adults age 19 – 64
- Sound underwriting principles will be applied such as: minimum participation requirements, employment verification, and appropriate handling of late enrollees
- Because monthly contributions by participants and employers will be at fixed amounts, it will be important to market the program to a variety of groups to best manage risk.
- Financial projections will need to be tightened once more is known about administrative staffing, contractual services, start date, expected enrollment, etc.

Per Member Per Month (PMPM) Revenue

Employer Contribution	\$ 50.00
Employee Contribution	50.00
Third Party Contribution	<u>50.00</u>
Total PMPM Revenue	\$150.00

Per Member Per Month (PMPM) Expenses

Administration [Reflects 20% of total revenue]	\$ 30.00
Primary Care Services Grouping	26.13
Referral Package Services Grouping	88.87
Contingency Fund	<u>5.00</u>
Total PMPM Expenses	\$150.00

Not yet quantified are the amount of start-up expenses CCI may incur during its ramp up phase and the amount of risk reserve that may be required. The above calculation assumes a reserve of 25% of annual claims, but this may or may not meet the level of expectation held by the State, participating employers who are contributing to CCI or other sponsors of the initiative.

While the level of risk reserves may be a significant factor related to the early stages of the initiative, the critical nature (both initially and ongoing) of the third party revenue share needs to be highlighted.

To illustrate, if the initiative is able to achieve and maintain a first year membership enrollment as projected through year two, the annual third party revenue obligation will be \$936,000. Although the first year enrollment may require a lower obligation, we believe it is fundamentally important for the initiative to understand and address the on-going need and magnitude of this obligation. Failure to adequately secure the third party revenue stream could jeopardize the effort as early as year two or three as membership grows.

Section 5. Legal/Regulatory Considerations

Initial discussions with the Insurance Commissioner began in July 2009 with a preliminary discussion among Anne Nelson, Jon Rosell and Commissioner Sandy Praeger. Initial discussions focused on the intent of CCI and explored ways in which necessary oversight can be provided to the initiative without impeding its ability to offer needed access to health providers. This communication has led to a working relationship between CCI and Linda Sheppard, Director of Accident and Health Division within the Department.

As the program becomes more refined and actuarial projections can be fine tuned, further discussion with Ms. Sheppard will occur to assure that CCI can be operated within the legal parameters established by the Commissioner.

An overview of how local access models are defined and regulated is included in Attachment C.

Section 6. Initiative Timeframe

There will be numerous operational details to be addressed if the CCI program is to be implemented.

At this stage, the below graphic characterizes the major work efforts and their timing throughout the development cycle:

Activity	1 st Qtr	2 nd Qtr	3 rd Qtr	4 th Qtr	5 th Qtr	6 th Qtr
Finalize initial plan for CCI						
Advisory Committee Approval Gained						
Sedgwick County Commissioner Approval Gained						
First Round of Funding Obtained for Development						
Operational Planning						
PR/Marketing Campaign Implementation						
Engagement with Employers						
Staffing/Hiring/Operations Implementation						
Operational – Go Live!						
First Enrollment Effective Date						

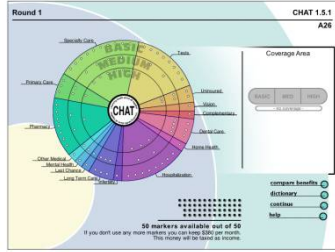


Attachments





Attachment A
CHAT Game Results



Community Coverage Initiative

CHAT Focus Group Report

Provided by: Amy Chesser, PhD
University of Kansas School of Medicine – Wichita
September 18, 2009

09

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Workforce Alliance

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Project Access

Anne Nelson

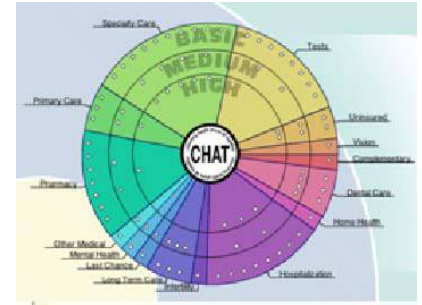
Monica Flask

Traci Hart, PhD(C)

The team also extends thanks
to the people
who participated in
the focus group sessions

2 Executive Summary

The CHAT Game



CHAT is a game which was created as a tool to begin discussions about health insurance. During six, two-hour meetings of 4-9 people, uninsured community member participants used a computer game to design healthcare benefits packages:

ROUND 1: For themselves and their families

ROUND 2: For all people living in their neighborhood

ROUND 3: For all people living in the city of Wichita, and

ROUND 4: Again for themselves (with a possibility for changes from Round 1).

CHAT Game Specifics

- CHAT participants had only 50 "markers" representing dollars, to spend among 16 categories of healthcare services, but there were 99 possible places to put them.
- Participants had to weigh limitations (i.e. increased cost-sharing and reduced services) while making the coverage choices.
- A Health Event Lottery presented participants with medical scenarios, depicting common and uncommon illnesses and accidents to test their newly designed benefit packages.
- Each CHAT group had to reach consensus in designing a common benefits package, a process requiring negotiation and compromise (in Rounds 2 & 3).

3 Introduction

With support from Anne Nelson, Central Plains Regional Healthcare Foundation, and consultant Jeanne Ripley, Halleland Health Consulting, the University of Kansas School of Medicine – Wichita, Department of Preventive Medicine and Public Health convened a series of six (6) focus groups with uninsured members from the Wichita community to discuss health-related services and benefit package design. This report includes the results of:

- A quantitative survey (pre and post) from participants who attended focus group sessions,
- Qualitative discussion sessions that were conducted to assess and better understand decision-making influences surrounding how these participants prioritize health care needs and services
- Recommendations provided by the focus group participants

3.1 Purpose

The purpose of the CHAT focus group sessions was to provide the Community Coverage Initiative information regarding the knowledge and opinions of uninsured Wichita-area community members concerning health-related service. The project was designed to better understand decision-making influences surrounding how the participants prioritize health care needs and services.

4 Methods

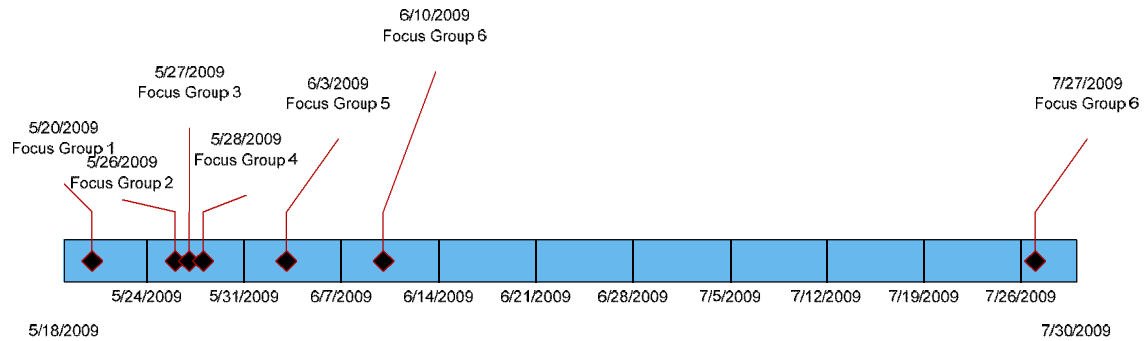
4.1 Project implementation

Six (6) focus group sessions were conducted with **uninsured adults between the ages of 18 and 64** who were willing to participate in a two hour session. One (1) focus group session was conducted with Vision Group members, who served as representatives of their professional population. Focus group participants were recruited by Central Plains Regional Healthcare Foundation staff. Participants received a \$20.00 *Dillons Food Market* gift certificate and a light meal at evening sessions at the completion of the session. **Focus group sessions were conducted at various locations throughout Wichita, Kansas.** A trained facilitator led the sessions and a technical assistant was available to help participants with questions and computer operations. The facilitator probed for common themes as well as outliers to better understand concepts and responses which would be important for community leaders.

Each session included:

- (1) Participant introductions to the facilitator and selection of computer stations,
- (2) an electronic pre-survey (Appendix 1),
- (3) the CHAT game sessions,
- (4) an electronic post-survey (Appendix 2), and
- (5) an audio-recorded focus group discussion of the CHAT game and group decisions regarding health care coverage.

Figure 4.1 Uninsured Focus Group Time Line



Qualitative data were collected via a focus group guide developed collaboratively by KUSM-W and Anne Nelson. **Groups were held May 18 through July 30, 2009 (Figure 4.1).** The focus group debriefing sessions followed a standardized script to evaluate perceptions, knowledge and beliefs of the participants regarding health care needs and services. Discussions were transcribed verbatim and compiled into reports.

Participants were asked questions such as, *“If you were going to buy your own health insurance right now, what would you be willing to pay?”* *“What, if anything, did you learn from playing the CHAT game?”* and *“If a community leader was standing here (like the mayor or a decision-maker for health insurance) what would you want to tell them about creating coverage for the uninsured in the community?”*

In addition, demographic information for race, age, income, etc. was collected.

Quantitative data were analyzed using Excel (Microsoft v2003) and SPSS 14.0 (SPSS Inc., Chicago, 2006).

Participant Demographics

Of the thirty-seven participants, most were between 19 and 40 years old (59%), 60% were female with the majority classifying themselves as White (57%), 43% has some high school education, and currently holding a marital status of “separated” (38%) (Table 4.2).

Table 4.2. Demographic Characteristics of Focus Group Participants

Characteristic	Frequency	Percentage (%)
Age (n=37)		
0-18 years	-	-
19-30 years	13	35
31-40	9	24
41-50	5	14
51-64	10	27
>65	-	-
Gender (n=37)		
Male	15	40
Female	22	60
Race/Ethnicity (n=37)		
White	9	57
Black or African American	7	24
Other	37	19
Education (n=36*)		
8 th grade or less	2	5
Some high school/did not graduate	16	43
High school diploma/GED	13	35
Some college	4	11
4 year college graduate	1	3
Marital Status (n=23*)		
Single	5	14
Married	2	5
Partnered	1	3
Separated	14	38
Divorced	1	3

* Note: Incomplete data; data reporting from clients was voluntary. Focus group 7 data not included.

Table 4.3. Socio-demographic Characteristics and Health Status of Focus Group Participants

Characteristic	Frequency	Percentage
Out of Pocket Expenses for Health Care w/in Last Year (n=36*)		
\$0	-	-
Less than \$500	6	16
\$500 to less than \$2,000	11	30
\$2,000 to less than \$5,000	13	35
\$5,000 or more	3	8
>65	3	8
Household Income (n=35*)		
\$0 to less than \$7,500	5	14
\$7,500 to less than \$15,000	9	24
\$15,000 to less than \$35,000	18	49
\$35,000 to less than \$60,000	2	5
\$60,000 or more	1	3
Self-Perceived Health Status (n=30*)		
Excellent	-	-
Very Good	5	14
Good	4	11
Fair	11	30
Poor	10	27
Missing	-	-

5 Focus Group Results

5.1 Theme One: CHAT Game

Focus Group Response: All participants were uninsured. Participants were asked how they liked playing CHAT and if they were presented with a choice of delivery method (paper or computer) which they would prefer. All participants responded positively regarding playing the game indicating it was “fun.” They would prefer to play the interactive computer-based version, rather than on paper and they would recommend the game to others.

When asked, none of the participants could think of any coverage options that were missing from the CHAT wheel. An overwhelming majority of participants said they learned something new while playing the game, such as types of coverage, how much specific categories might cost in comparison to other categories, etc.

As stated by a participant,

“As far as the game itself, I thought it was easy, made sense. I have had health care coverage in the past, but I don’t now. If the goal is to tell our leaders in our community or whatever to tell them what the uninsured people need, it is a real good way to do it.”

Post survey results indicate the participants found playing the CHAT game “very enjoyable” (35.15) (Table 5.1).

However, only 11% of the participants were willing to accept the group’s choice of health plan. The majority of the participants did not trust a group of consumers using CHAT to design a health insurance plan.

Table 5.1. Participants Reaction to Playing CHAT

Playing CHAT game was “..”	Strongly			Strongly
	Disagree	Disagree	Agree	
Enjoyable	-	-	2.7	35.1
Easy to Understand	-	2.7	-	3.51
Easy to do	-	-	-	27.0
Informative	-	-	-	13.5

Table 5.2. Participants Feelings Regarding the CHAT Session

Opinions about CHAT	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean	Std deviation
Feel angry	27.0	5.4	8.1	-	0.66	0.94
Feel frustrated	24.3	8.1	8.1	-	0.69	0.96
Learned a lot	-	35.1	54.0	-	2.53	0.66
CHAT information clarity	-	51.4	43.2	-	2.46	0.51
Group decision fairness	13.5	43.2	37.8	-	2.26	0.70
Information given is believable	2.7	54.0	35.1	-	2.29	0.67
Satisfied with group decision	8.1	51.4	32.4	-	2.26	0.62
Shared my views	2.7	51.4	37.8	-	2.38	0.55
Enough info to make decisions	-	56.8	35.1	-	2.31	0.63
Fair group decision making	10.8	48.5	35.1	-	2.26	0.66
Health care choices realistic	2.7	56.8	35.1	-	2.34	0.54
Respectfully treated	-	43.2	51.3	-	2.54	0.51
Group decision less favorable to me	37.8	24.3	8.1	-	1.17	0.92
Game choices included choices I wanted	10.8	73.0	10.8	-	2.00	0.49
My choice not considered by group	46.0	16.2	8.1	-	1.12	0.88
Had enough time to decide	-	62.2	32.4	-	2.34	0.48
Group's decision favorable	10.8	62.2	21.6	-	2.11	0.58
Group tried to be fair	-	54.02	37.8	-	2.41	0.50
Discussion during game was open and honest	-	56.8	46.0	-	2.45	0.50

5.2 Theme Two: Coverage Choice

Focus Group Response: The third round of the CHAT game session included the entire focus group creating an insurance plan together for the Wichita community. During this session, numerous discussions occurred between participants as they decided which services and benefit levels to include for each of the CHAT Wheel coverage choices (i.e. primary care, dental, specialty, etc.)

Each group spent time discussing the decisions for the community health insurance coverage. When asked, most participants said the most important coverage categories included “doctor” or primary care, dental, and vision. Some participants were interested in hospital and specialty coverage, dependent upon personal chronic care issues (Table 5.3).

Table 5.3. Coverage Selection for Round 3 of CHAT game by Focus Groups

Coverage Area	FG 1	FG2	FG3	FG4	FG5	FG6	FG7
Hospitalization	Low	Med.	Med.	Low	Med.	Med.	Med.
Tests	Low	Med.	Low	Low	Low	Low	Low
Specialty care	Low	Med.	Low	Low	Med.	Low	Low
Primary Care	Low	High	Med.	Low	High	Low	High
Pharmacy	Low	Med.	Low	Low	Med.	Med.	Low
Long Term Care	Med.	Med.	Low	Low	N.C.	Low	Low
Last Chance	Med.	Low	Low	Low	N.C.	N.C.	Low
Dental Care	Low	Low	Low	Low	Low	Low	Low
Infertility	N.C.	N.C.	N.C.	N.C.	N.C.	N.C.	N.C.
Complementary	N.C.	N.C.	N.C.	Low	N.C.	N.C.	Low
Mental Health	N.C.	Low	Low	Low	N.C.	Low	Low
Uninsured	N.C.	N.C.	Med.	Low	Low	N.C.	N.C.
Home Health	Med.	Low	N.C.	Low	N.C.	Low	N.C.
Other Medical	Med.	Low	Low	Low	N.C.	Low	N.C.

Key: NC = No Coverage, Low = Low Coverage, Med. = Medium Coverage, High = High Coverage

All groups selected “no coverage” for “infertility.” Other groups included several additional categories for “no coverage” (i.e. complementary, mental health, uninsured, and home health) in order to provide some coverage in the more costly areas (Table 5.4). All other categories received some level of coverage from each group.

Table 5.4. “No Coverage” Selection for Round 3 of CHAT game by Focus Groups

Coverage Area	# of Groups Opting for “no coverage”	FG 1	FG2	FG3	FG4	FG5	FG6	FG7
Infertility	7	∅	∅	∅	∅	∅	∅	∅
Complementary	5	∅	∅	∅	-	∅	∅	∅
Mental Health	2	∅	-	-	-	∅	-	-
Uninsured	4	∅	∅	∅	-	-	∅	-
Home Health	3	-	-	∅	-	∅	-	∅

“It was interesting and I don’t know if you guys felt this way but once I learned the choices were then it wouldn’t allow me to I felt pressured. I think it is realistic you bid these categories you want to choose the highest in each category, but to have coverage you have to be more realistic and compromises and sacrifice. I like the fact that you can’t just pick high on every one. As much as I would like to pick that - the reality is that you can’t.”

All groups indicated the struggle of not being able to choose as much coverage as they would have liked. Many participants discussed how difficult it would be to select coverage for a large group, due to differing opinions and needs. Participants responded with a statement during the discussion which demonstrated the difficulty in choosing plan coverage, as shown below:

“It forces you to pick what is essential and what is extra stuff that would be nice but these things are more important. It is frustrating because you would like to get everything you can, but it makes you decide what is important and what is an extra.”

5.3 Theme Three: Insurance Cost

Focus Group Response: The Facilitator sought comments regarding how much the participant was “willing to pay for insurance today.” It should be noted that there were divergent opinions regarding participant’s desire for health coverage. Several participants in one session had access to health care insurance, but indicated they were not interested – at any cost. Other participants desperately wanted health insurance, but simply could not afford coverage.

Participants voiced numerous opinions regarding affordable costs for health insurance coverage. Comments ranged from “I can’t afford to pay anything,” to “\$6 a day or \$180 a month”. Other participants discussed a wide range of cost and coverage options.

Facilitator: What would you be willing to pay for insurance right now?

Participant 1: \$380.

Facilitator: Would you personally buy insurance for that amount? What would you personally pay for insurance right now?

Participant 2: No. Most people can’t afford insurance why would they worry about it? A lot of people who are involved in insurance delegate to the general public. That person is more concerned about making a dollar. The insurance may not cover everything.

Facilitator: If you were going to get the minimum, what would you be willing to pay?

Participant 3: I don’t know it has to be worth every dollar I spend. I am not going to cover \$500 for coverage if it will only cover 20% of hospital and 10% for everything else.

Participant 4: \$200 per month. But you are not going to find that? I want to be able to choose what I want. Like I was saying most people would not be able to afford it so they wouldn't opt for it.

Facilitator: Is there an amount you could afford?

Participant 1: Right now, no.

Participant 2: That is like I got a phone call Monday, says I prequalify for insurance for \$3 a day or \$90 a month, my question is what company is calling and what kind of scam is this.

However, participants also said they would “take whatever was offered” or “I want to be able to choose for myself.” The differing comments were succinctly captured by one participant who said,

“If we were actually getting insurance, I don't like the idea of someone else choosing my coverage, we are not all the same, and our needs are very different. Since I don't have any right now I would be grateful for whatever I get.”

The overall consensus was that participants did not know an exact cost they would be willing and able to pay for health insurance coverage. One participant repeatedly asked the group, “What do people normally pay?” While other participants were able to estimate current costs for family health insurance coverage with accuracy, but knew they were unable to afford insurance at this time. One participant discussed that she was more interested in paying for automobile insurance than health insurance at this time.

Additionally, participants discussed why the cost of health care is currently so high. As posed by one participant,

“I don’t understand how they get away with charging as much as they do. We don’t have insurance and they wanted \$400 dollars to pull his tooth - that is ridiculous. They charged us \$65 for him to go in there for ten minutes and they told us the tooth had to be pulled. That is very frustrating. “

5.3 Theme Four: Tell Community Leaders

Focus Group Response: The Facilitator sought comments regarding “What, if anything, would you want to tell community leaders regarding health insurance if they were here today.” Most of the participants expressed a desire to tell leaders that they are interested in “affordable insurance with good coverage.”

A summary of participant comments was succinctly captured by one participant who said,

“They need to make it where it is more affordable, it shouldn’t be for just unemployed people it should be for everybody, not one specific category that is why we are the United States of America.”

Many of the group discussions included comments regarding the working people not able to afford coverage and the “gap” participants fell in between Medicaid and employees who are able to afford health care coverage. The self-employed and “working poor” participants discussed the lack of insurance coverage due to inability to “get in with a group.” As stated by one participant,

“I was thinking about a family plan, where our income sits right now, let me start over. If you work with the way the Medicaid program goes, you don’t get anything; if you don’t work you get everything. But you work enough but you can’t afford anything extra because your money goes toward groceries, gas, regular bills. There needs to be something for those of us who just don’t want to sit at home and pull off the government. We are in worse shape because we work but don’t qualify for anything.”

6 Discussion of Findings

Overall, participants saw value in the CHAT game, and were able to provide insights to their understanding of health insurance coverage options. It should be no surprise that group consensus was an overall desire for the most coverage possible at the lowest price. Uninsured participants for these focus group sessions expressed an interest in playing the game and discussing health care coverage options for the city of Wichita. However, it was difficult for most groups to agree on the type of coverage which could be offered for the entire community. Only one group was able to immediately decide to choose basic coverage for all major categories without much debate or discussion.

Cost issues and chronic care conditions were of concern for all groups. Although no group was able to build consensus around a monthly cost they were willing and able to pay for coverage, the game enlightened the participants in several areas. First, participants expressed a better understanding of the types of coverage offered. Second, several group members were willing to disclose their inability to pay anything for health care coverage right now. Third, several discussions included information regarding the struggle of the working class as they try to pay their bills and are not able to afford health insurance.

In conclusion, these people demonstrated an overall willingness to share their knowledge, opinions and recommendations to community leaders and decision makers for the benefit of the city of Wichita.

Appendix 1: Pre-game survey questions

If you select the pre-game survey questions, these are the questions your game participants will be asked to answer.

1. Do you consider yourself of Hispanic or Latino origin?
 - Yes
 - No
2. What race do you consider yourself to be? (Choose all that apply)
 - White
 - Black or African American
 - Asian
 - Native Hawaiian or Pacific Islander
 - Other (specify)
3. Are you: (Choose one choice only)
 - Single or never married
 - Married
 - Partnered
 - Separated
 - Divorced
 - Widowed
4. How many people live with you (not counting yourself)
 - 0
 - 1
 - 2
 - 3
 - 4
 - 5
 - 6 or more
5. What is the highest grade or level of school that you have completed? (Choose one choice only)
 - 8th grade or less
 - Some high school, but did not graduate
 - High school graduate or GED
 - Some college or 2-year degree
 - 4-year college graduate
 - Some graduate/professional school or graduate/professional degree
6. What is the source of your health insurance? (Choose all that apply)
 - I have no health insurance
 - My employer, spouse/partner's employer or parents' employer
 - Medicare
 - Medicaid
 - VA/military
 - Student insurance

- Other (specify)
7. I trust my (my family's) health insurance company's decisions.
- A great deal
 - Somewhat
 - A little
 - Not at all
8. Generally, would you say your health is: (Choose one choice only)
- Excellent
 - Very Good
 - Good
 - Fair
 - Poor
9. During the past 12 months, about how much did you or your household spend for medical care, including dental care? (Do NOT include the amount you pay for health insurance premiums, or any costs for which you expect to be paid back.)
- \$0
 - Less than \$500
 - \$500 to less than \$2,000
 - \$2,000 to less than \$5,000
 - \$5,000 or more
 - Not sure
10. Which category describes the total yearly income for your household?
- \$0 to less than \$7,500
 - \$7,500 to less than \$15,000
 - \$15,000 to less than \$35,000
 - \$35,000 to less than \$60,000
 - \$60,000 or more

Appendix 2: Post-game survey questions

If you select the post-game survey questions, these are the questions your game participants will be asked to answer.

1. Playing the CHAT game was: (Choose one choice only)
 - Very enjoyable
 - Fairly enjoyable
 - Fairly unenjoyable
 - Very unenjoyable
2. Playing the CHAT game was: (Choose one choice only)
 - Very easy to understand
 - Fairly easy to understand
 - Fairly hard to understand
 - Very hard to understand
3. Playing the CHAT game was: (Choose one choice only)
 - Very easy to do
 - Fairly easy to do
 - Fairly hard to do
 - Very hard to do
4. Playing the CHAT game was: (Choose one choice only)
 - Very informative
 - Fairly informative
 - Fairly uninformative
 - Very uninformative
5. Choose the one answer that best reflects your feelings.
 - I could not have played the CHAT game without the group facilitator here.
 - I could have played the CHAT game without the group facilitator here.
6. Would you recommend CHAT to others?
 - Yes
 - No
7. Would you be willing to accept the group's choice of health plan?
 - Yes
 - No
8. How much would you trust a group of consumers using CHAT - like the group today - to design a health insurance plan for you/your family?
 - A great deal
 - Somewhat
 - A little
 - Not at all

	Strongly Disagree	Disagree	Agree	Strongly Agree
9. When I think about the game I feel angry.				
10. When I think about the game I feel frustrated.				
11. I learned a lot playing the CHAT game.				
12. The information presented in CHAT was clear.				
13. The way the group reached its decision was fair.				
14. Information given to us was believable.				
15. I was satisfied with the group's decision.				
16. I had lots of chances to share my views.				
17. We had enough information to make good decisions.				
18. The way the group reached its decision was equally fair to each member of the group.				
19. Health care choices offered in the game were realistic.				
20. During the game, I was treated with				

respect.				
21. The group's decision was more favorable for others in the group than for me.				
22. Choices in the game included all the choices I could have wanted.				
23. What I wanted was not considered by the group in arriving at a solution.				
24. We had enough time to make good decisions.				
25. The group's decision was favorable for me.				
26. The group tried to be fair.				/tr>
27. Discussion during the game was open and honest.				



Attachment B
Community Survey Results



**Web-based Survey of
Community Perspectives
on Health Care Coverage
and Costs**

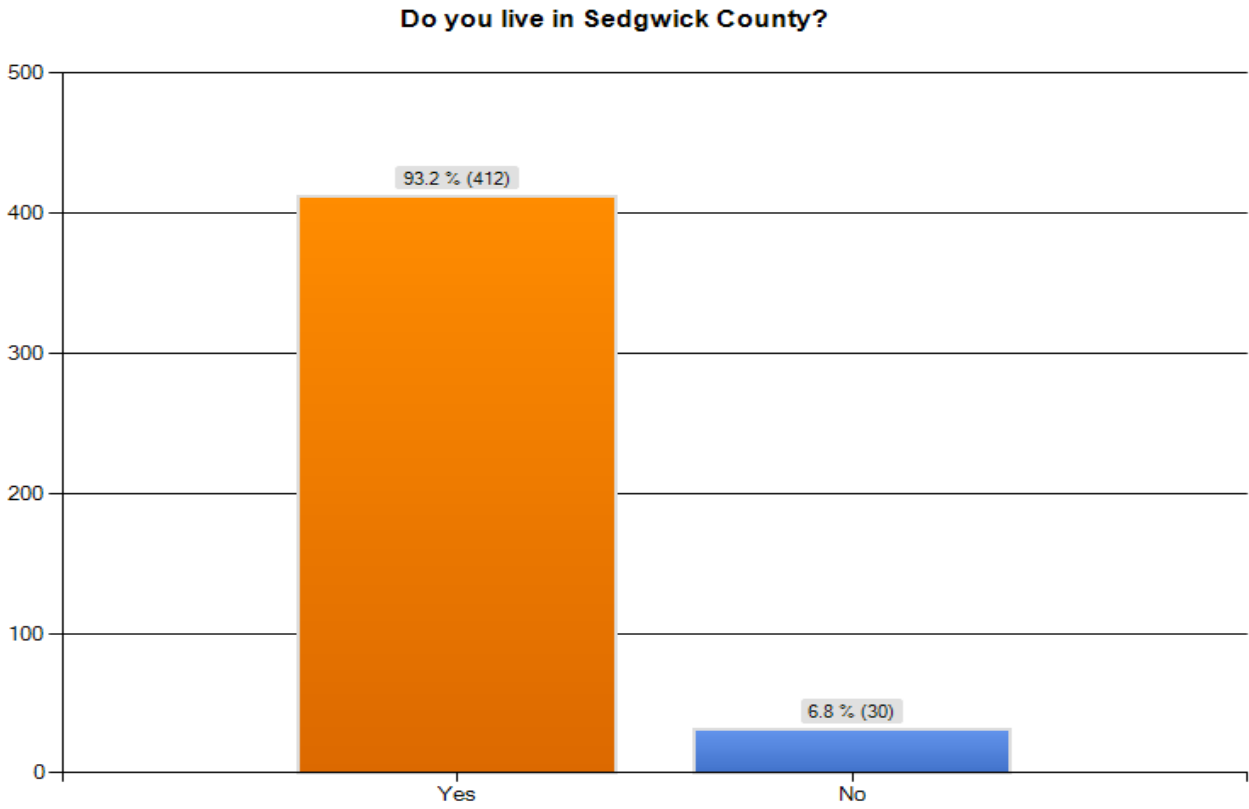
September 2009

Community Survey

- Between June and mid-August 2009
- 434 completed surveys in total:
 - Included web survey and hard copy (in both English and Spanish)
- 196 (43%) of the respondents did not have health insurance – this was the group that were of most interest.

Question 1

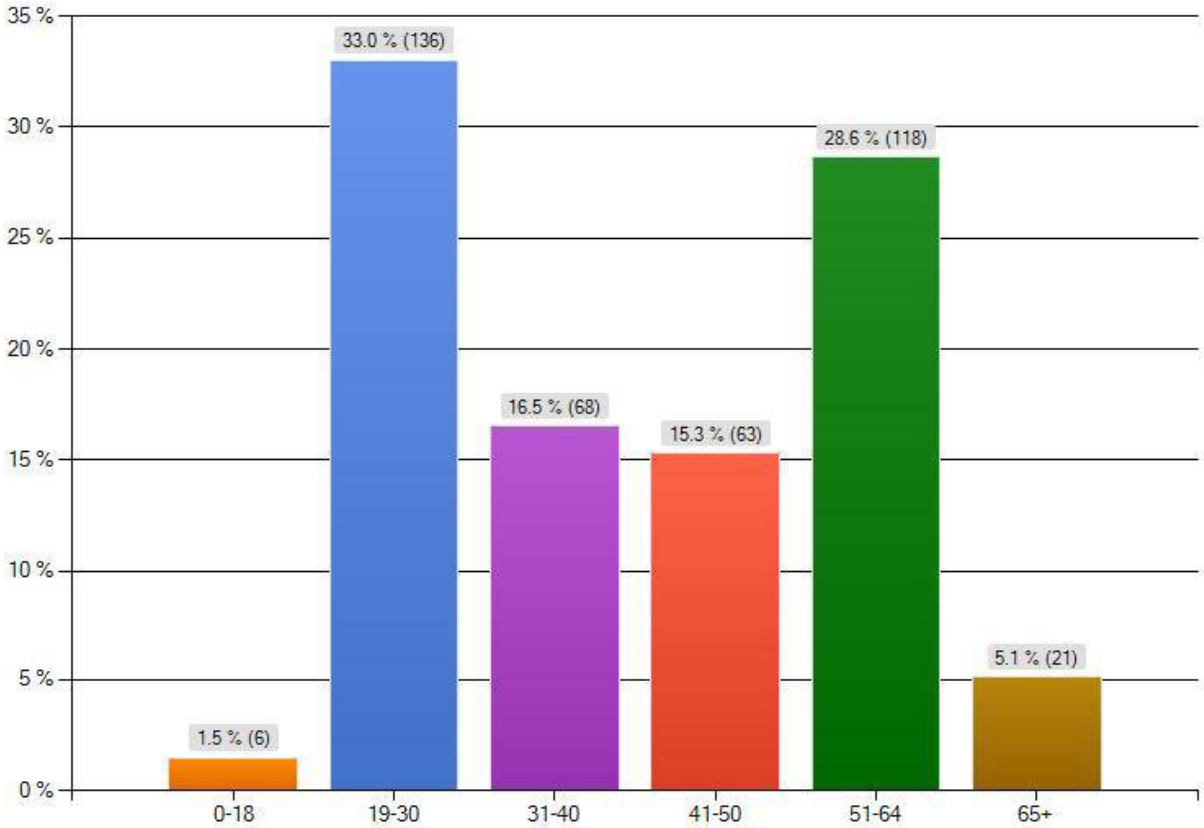
1. Do you live in Sedgwick County?		
Answer Options	Response Percent	Response Count
Yes	93.2%	412
No	6.8%	30
answered question		442



Question 2

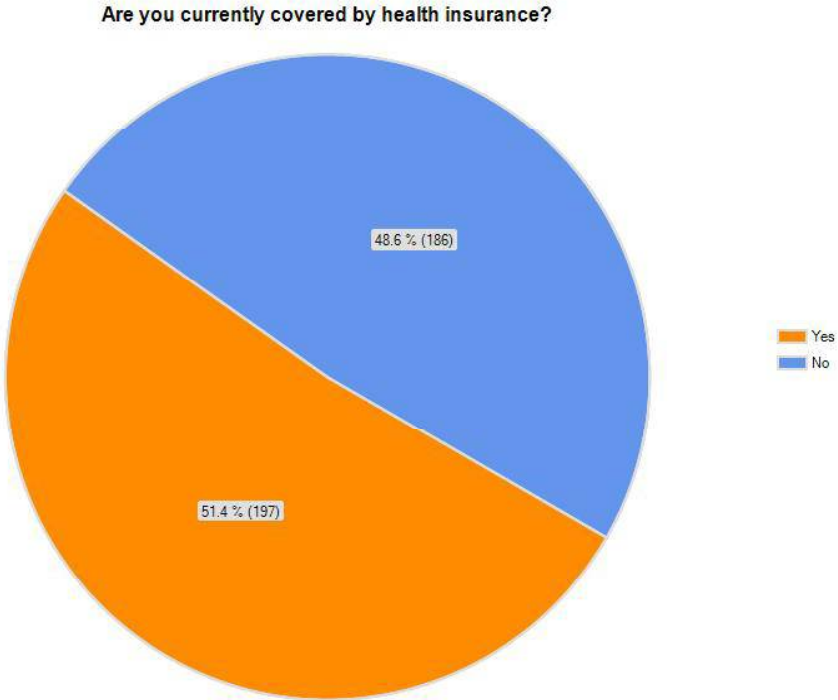
2. What is your age?			
Answer Options		Response Percent	Response Count
0-18	End of survey	1.5%	6
19-30		33.0%	136
31-40		16.5%	68
41-50		15.3%	63
51-64		28.6%	118
65+	End of survey	5.1%	21
answered question			412

What is your age?



Question 3

3. Are you currently covered by health insurance?		
Answer Options	Response Percent	Response Count
Yes → Jump to Q. 10	51.4%	197
No → Continue to Q. 4	48.6%	186
<i>answered question</i>		383

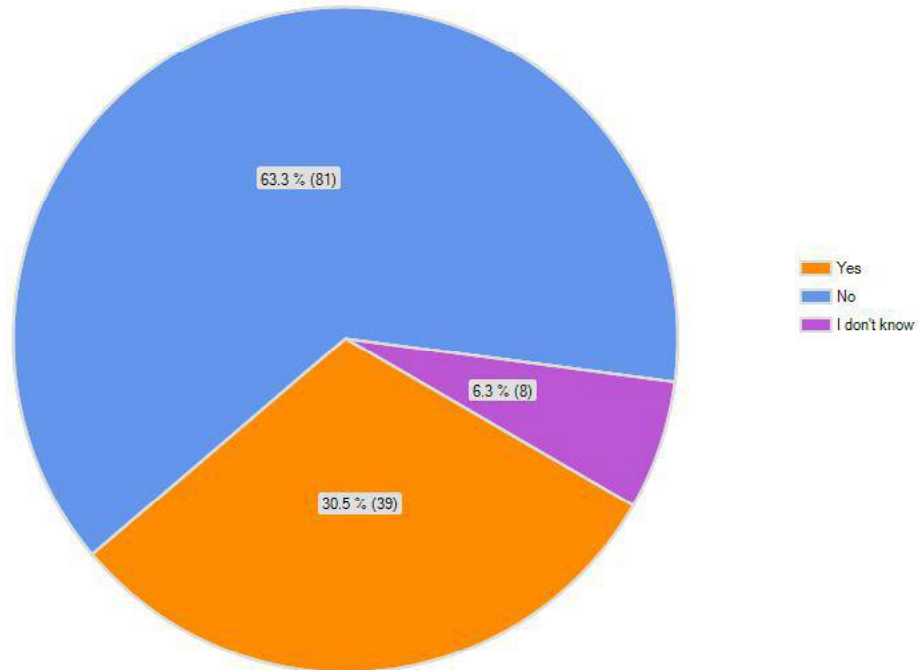


Question 4

4. Which of these would best describe your current work status?

Answer Options	Response Percent	Response Count
Employed for wages (full time)	32.2%	58
Employed for wages (part time)	21.1%	38
Self-employed	8.3%	15
Unemployed	35.6%	64
Retired	2.8%	5
answered question		180

If you are employed, does your employer offer health coverage that you could enroll in?

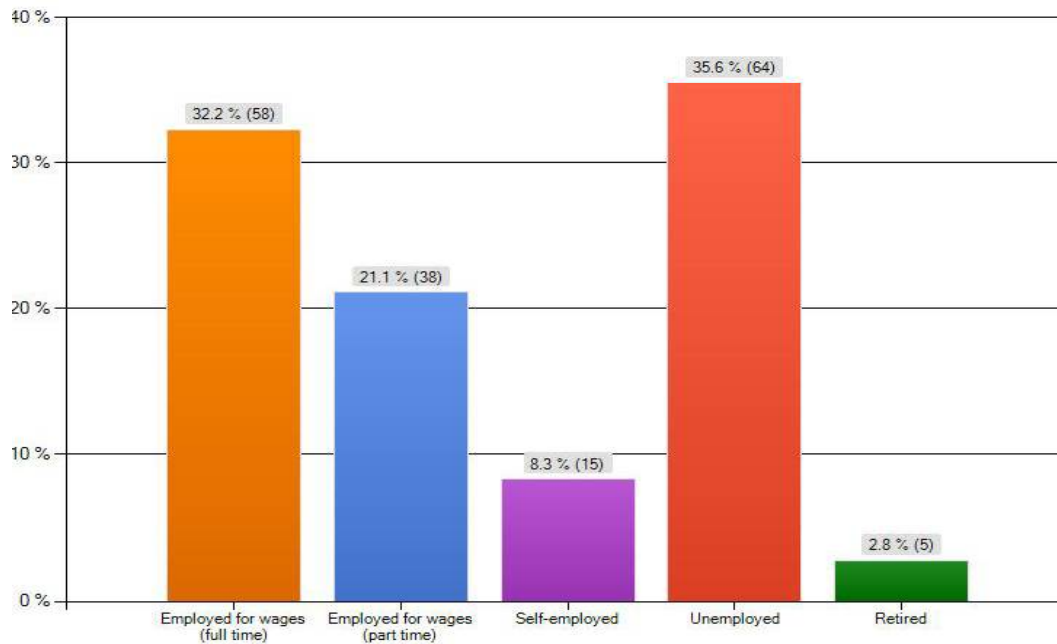


Question 5

5. If you are employed, does your employer offer health coverage that you could enroll in?

Answer Options	Response Percent	Response Count
Yes	30.5%	39
No	63.3%	81
I don't know	6.3%	8
answered question		128

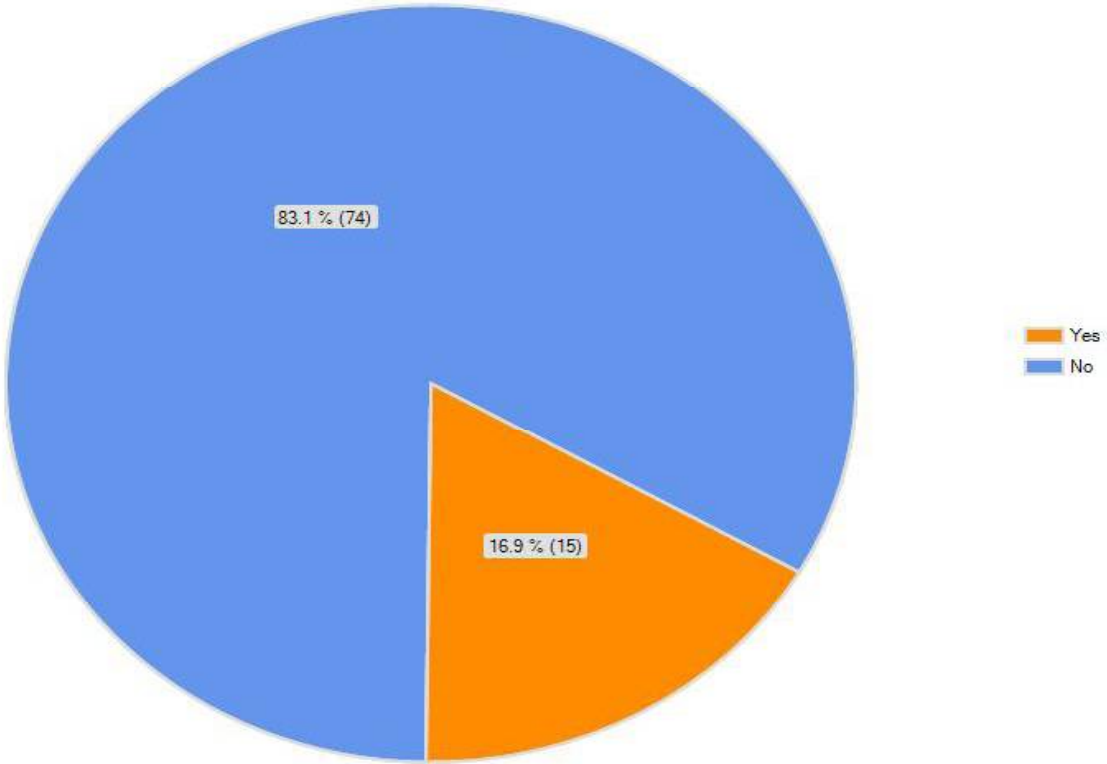
Which of these would best describe your current work status?



Question 6

6. If your employer offers coverage, did you enroll?		
Answer Options	Response Percent	Response Count
Yes	16.9%	15
No	83.1%	74
answered question		89

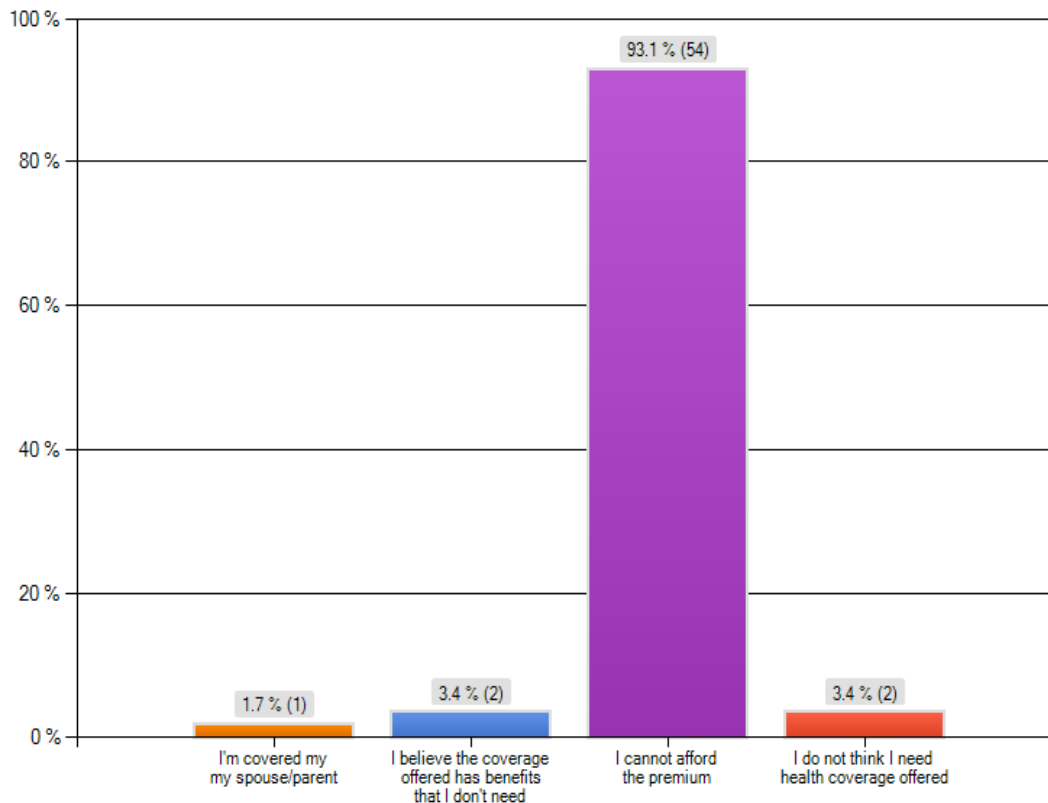
If your employer offers coverage, did you enroll?



Question 7

7. If no, why did you chose not to enroll?		
Answer Options	Response Percent	Response Count
I'm covered by my spouse/parent	1.7%	1
I believe the coverage offered has benefits that I don't need	3.4%	2
I cannot afford the premium	93.1%	54
I do not think I need health coverage offered	3.4%	2
Other (please specify)		23
answered question		58

If no, why did you chose not to enroll?

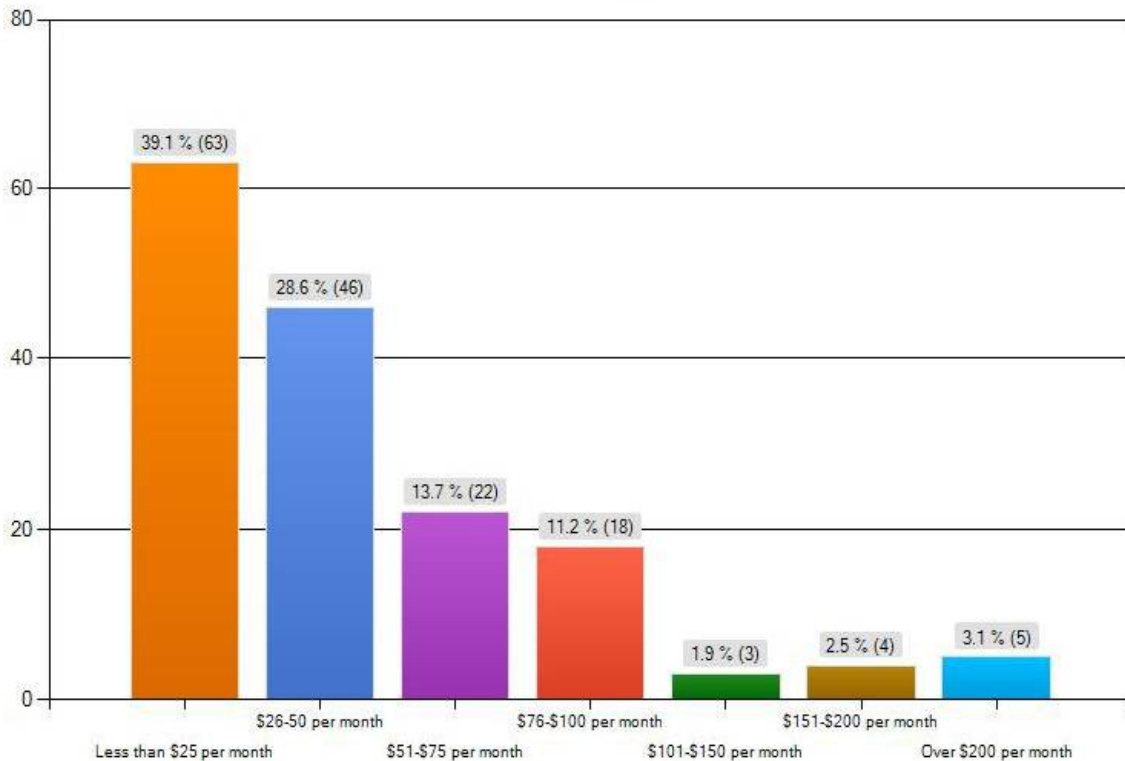


Question 8

8. What is the highest amount of money you are willing and able to pay for individual health care coverage per month (note that family coverage may be more)? Please consider your current pay when answering.

Answer Options	Response Percent	Response Count
Less than \$25 per month	39.1%	63
\$26-50 per month	28.6%	46
\$51-\$75 per month	13.7%	22
\$76-\$100 per month	11.2%	18
\$101-\$150 per month	1.9%	3
\$151-\$200 per month	2.5%	4
Over \$200 per month	3.1%	5

What is the highest amount of money you are willing and able to pay for individual health care coverage per month (note that family coverage may be more)? Please consider your current pay when answering.



Question 9

9. Please rank the types of coverage you believe you and your family need most.

Answer Options	1	2	3	4	5	6	7	8
Primary Care (visits to a family doctor)	115	14	3	7	5	2	1	7
Tests (lab, x-rays, etc.)	27	30	32	11	17	10	9	0
Pharmacy (medication)	31	31	28	11	13	7	8	7
Specialty Care (visits to a specialist)	20	10	10	29	14	27	11	7
Mental Health/ Substance Abuse Services	15	3	6	3	8	8	11	71
Hospitalization (pays part or all of your hospital bill)	43	21	15	19	24	14	5	8
Emergency Room	35	15	13	21	21	20	11	5
Other services such as physical therapy, home health visits, chiropractic care, etc.	11	6	10	7	14	18	43	24

answered question 110

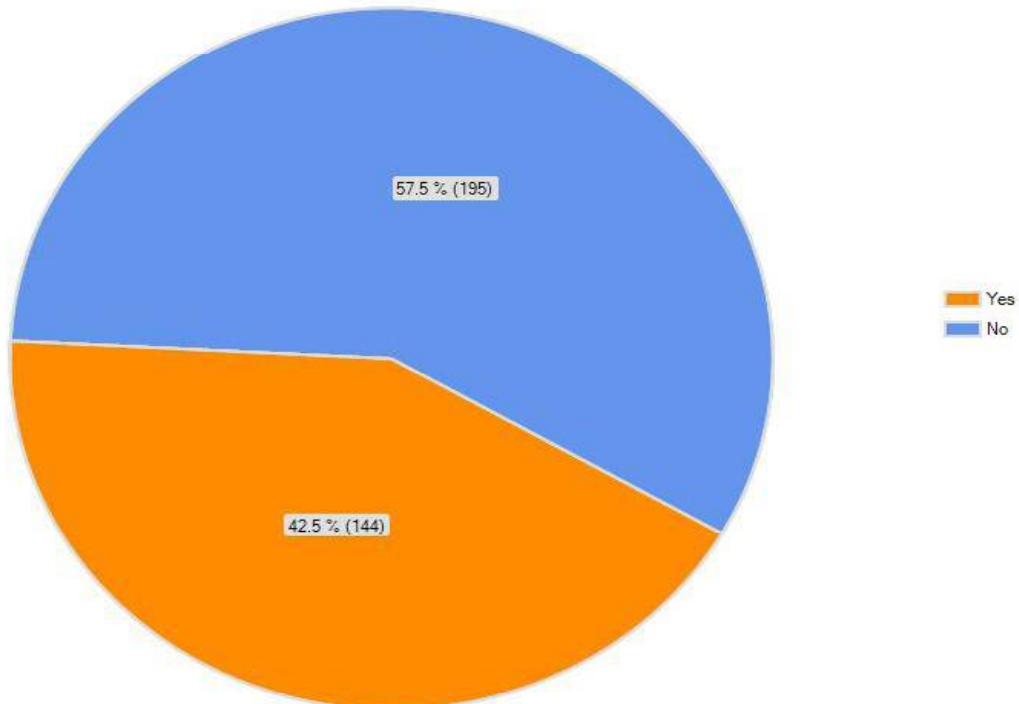


•Results were compiled by calculating a weighted rank. Each time a coverage preference received a first place vote it received 8 points, a second place vote received 7 points, etc. Coverage preferences were then tallied and ranked by their point values

Question 10

10. Would you be willing to contribute money to help pay for insurance coverage for people who cannot afford it?		
Answer Options	Response Percent	Response Count
Yes	42.5%	144
No	57.5%	195
answered question		339

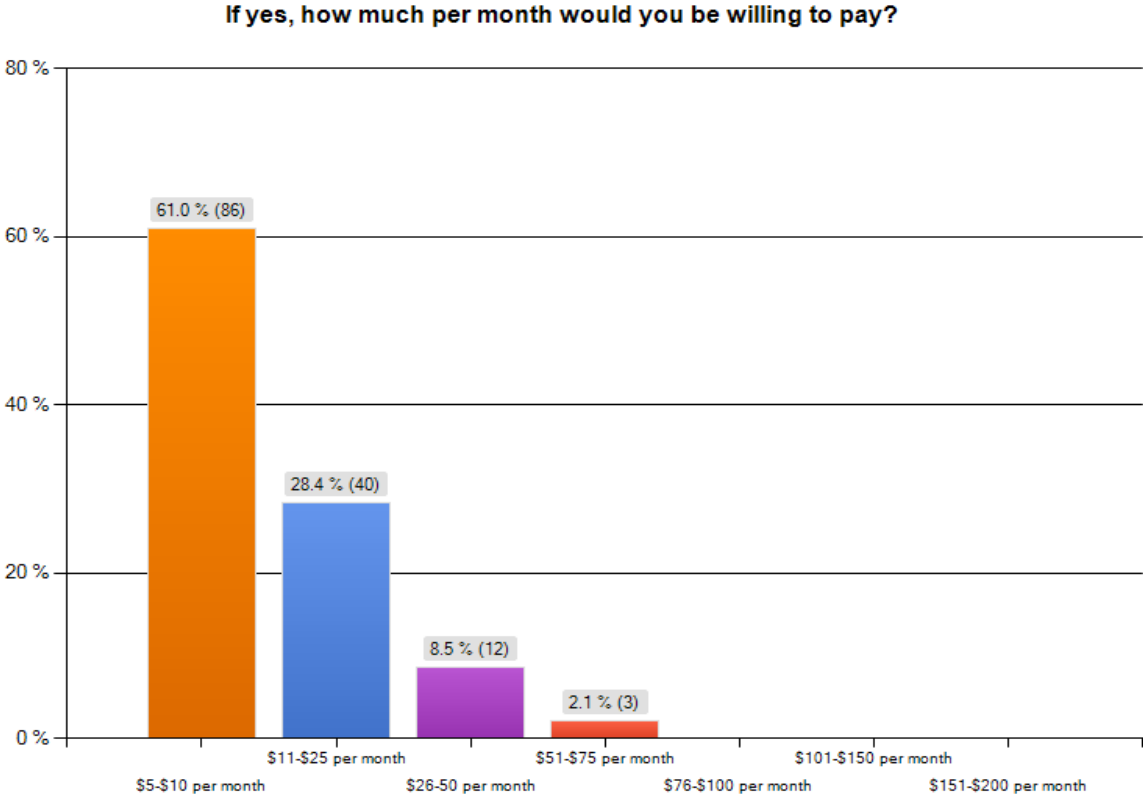
Would you be willing to contribute money to help pay for insurance coverage for people who cannot afford it?



Question 11

11. If yes, how much per month would you be willing to pay?

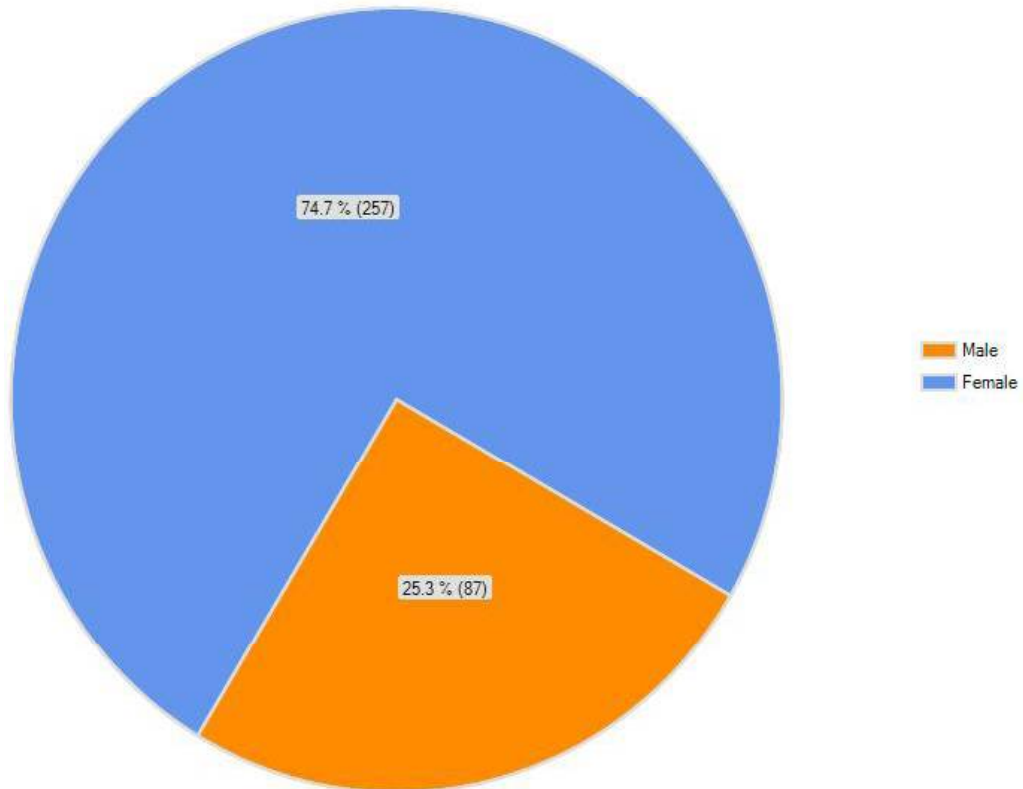
Answer Options	Response Percent	Response Count
\$5-\$10 per month	61.0%	86
\$11-\$25 per month	28.4%	40
\$26-50 per month	8.5%	12
\$51-\$75 per month	2.1%	3
\$76-\$100 per month	0.0%	0
\$101-\$150 per month	0.0%	0
\$151-\$200 per month	0.0%	0
Comment		49
answered question		141



Question 12

12. What is your gender?		
Answer Options	Response Percent	Response Count
Male	25.3%	87
Female	74.7%	257
<i>answered question</i>		344

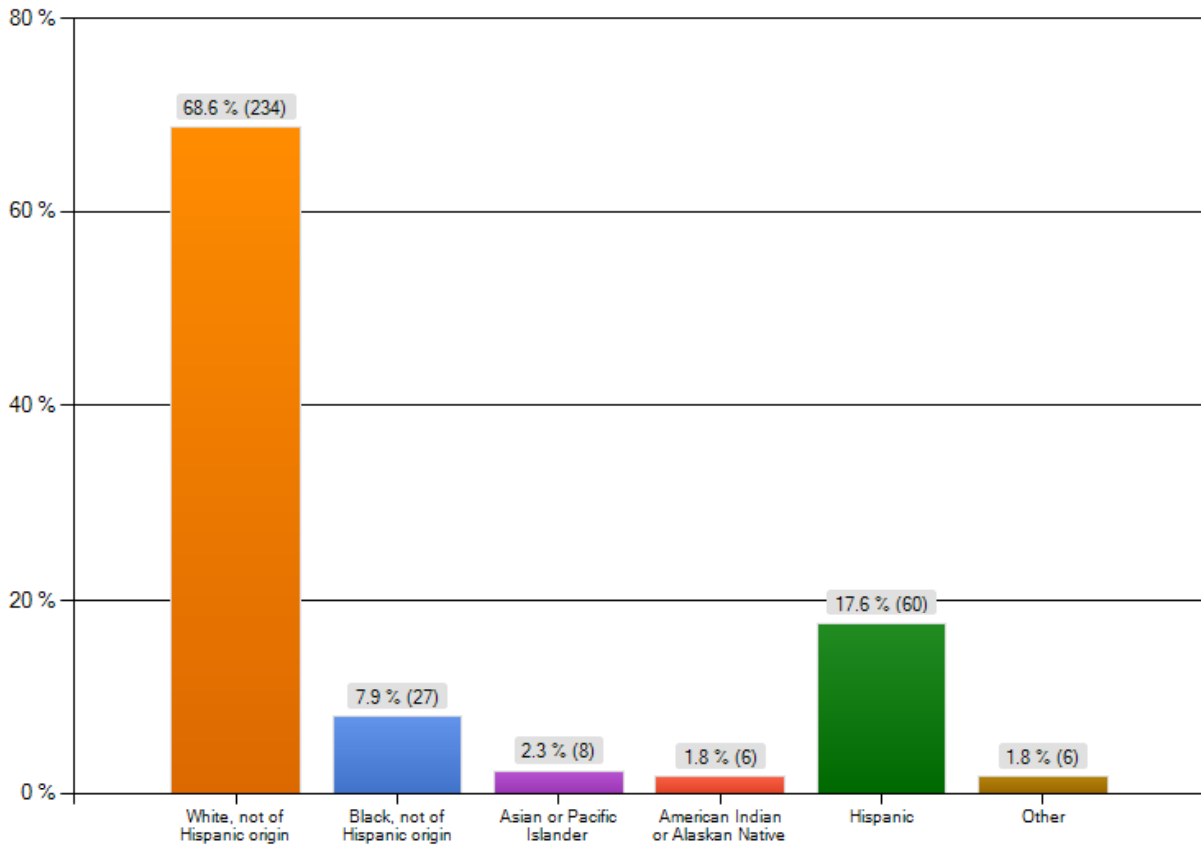
What is your gender?



Question 13

13. Which best describes your race/ethnicity?		
Answer Options	Response Percent	Response Count
White, not of Hispanic origin	68.6%	234
Black, not of Hispanic origin	7.9%	27
Asian or Pacific Islander	2.3%	8
American Indian or Alaskan Native	1.8%	6
Hispanic	17.6%	60
Other	1.8%	6
Other (please specify)		3
answered question		341

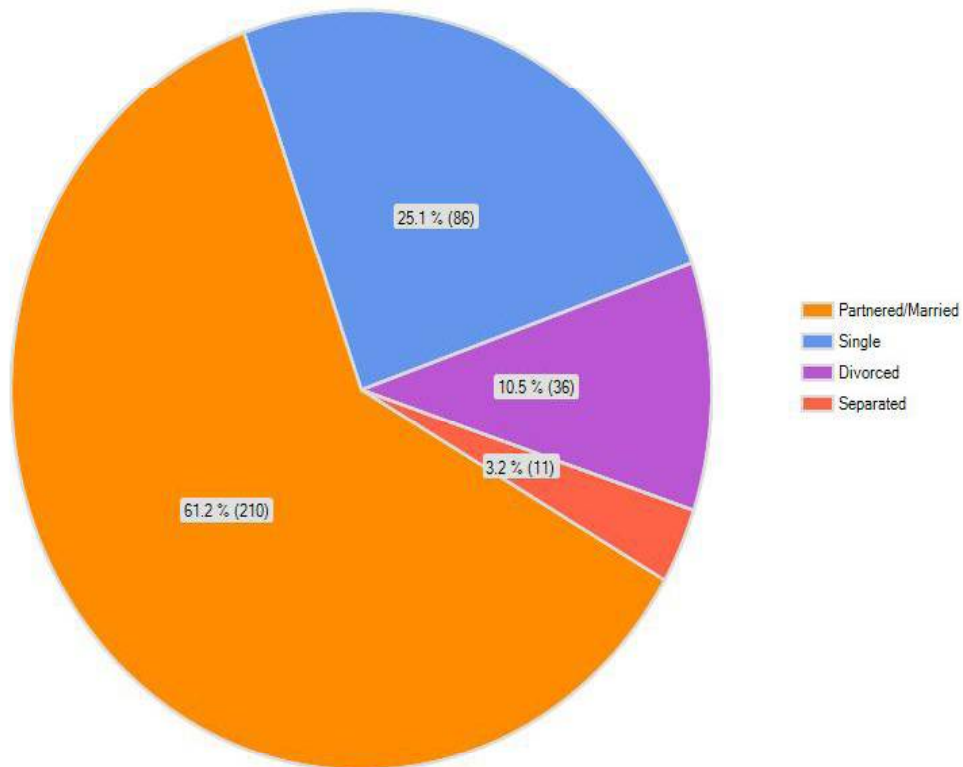
Which best describes your race/ethnicity?



Question 14

14. Which would best describe your marital status?		
Answer Options	Response Percent	Response Count
Single	25.1%	86
Partnered/ Married	61.2%	210
Separated	3.2%	11
Divorced	10.5%	36
<i>answered question</i>		343

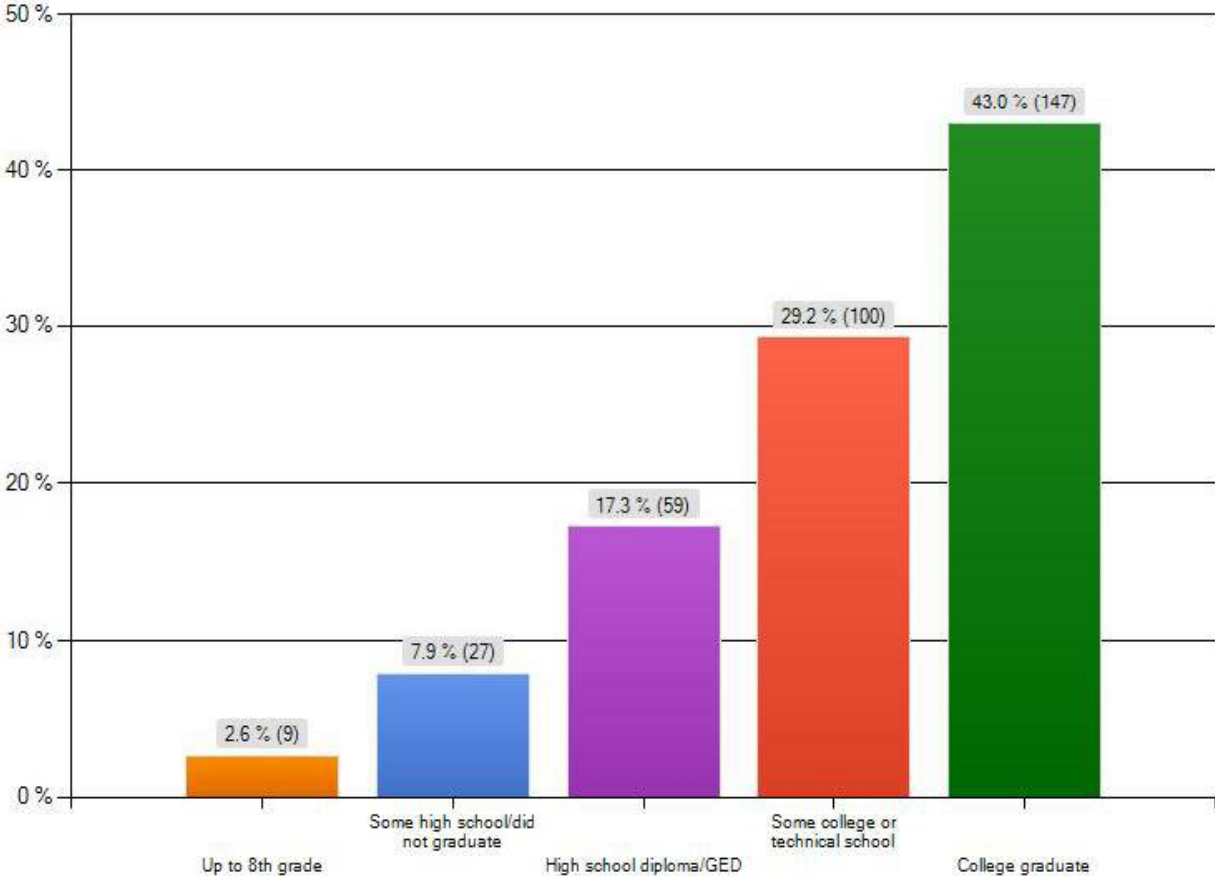
Which would best describe your marital status?



Question 15

15. What is the highest level of education you completed?		
Answer Options	Response Percent	Response Count
Up to 8th grade	2.6%	9
Some high school/did not graduate	7.9%	27
High school diploma/GED	17.3%	59
Some college or technical school	29.2%	100
College graduate	43.0%	147
answered question		342

What is the highest level of education you completed?

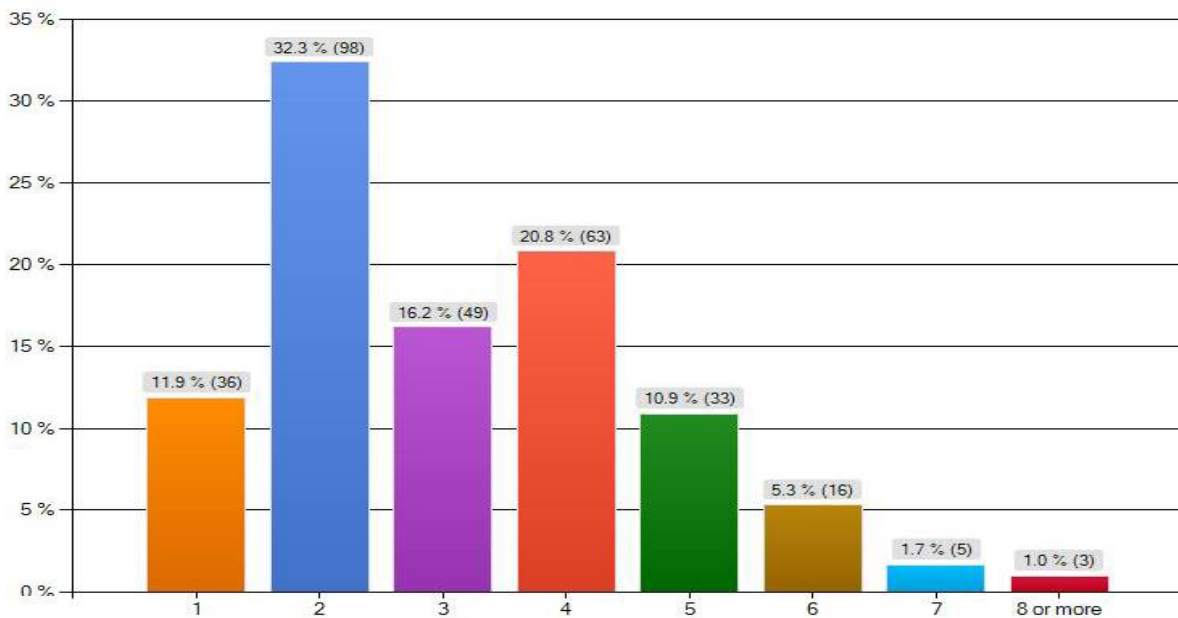


Question 16

16. Please indicate below the total number of people living in your household (include yourself, spouse or partner, children and anyone else who lives with you). Note: this question was added midway through the survey

Answer Options	Response Percent	Response Count
1	11.9%	36
2	32.3%	98
3	16.2%	49
4	20.8%	63
5	10.9%	33
6	5.3%	16
7	1.7%	5
8 or more	1.0%	3
answered question		303

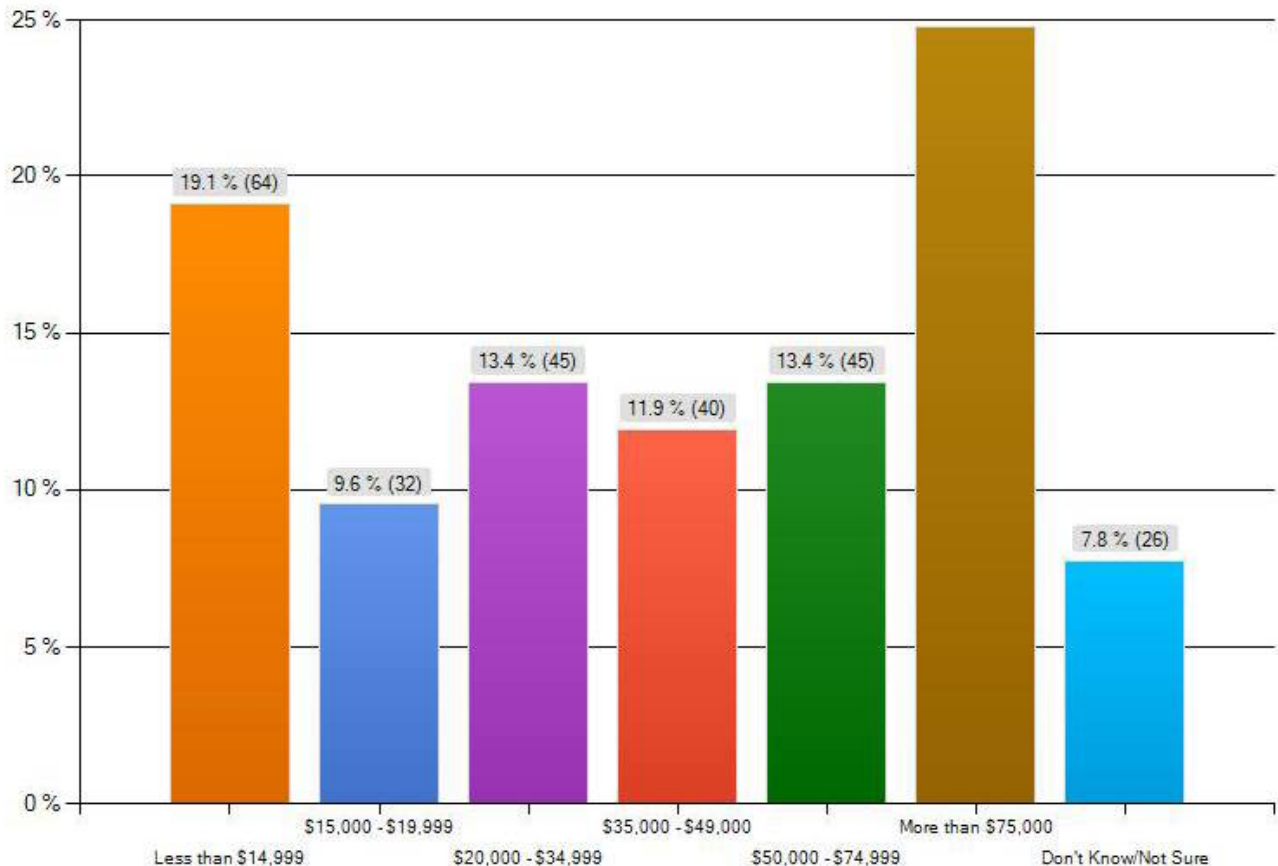
Please indicate below the total number of people living in your household (include yourself, spouse or partner, children and anyone else who lives with you).



Question 17

17. What is the annual income of everyone living in your household?		
Answer Options	Response Percent	Response Count
Less than \$14,999	19.1%	64
\$15,000 - \$19,999	9.6%	32
\$20,000 - \$34,999	13.4%	45
\$35,000 - \$49,000	11.9%	40
\$50,000 - \$74,999	13.4%	45
More than \$75,000	24.8%	83
Don't Know/Not Sure	7.8%	26
answered question		335

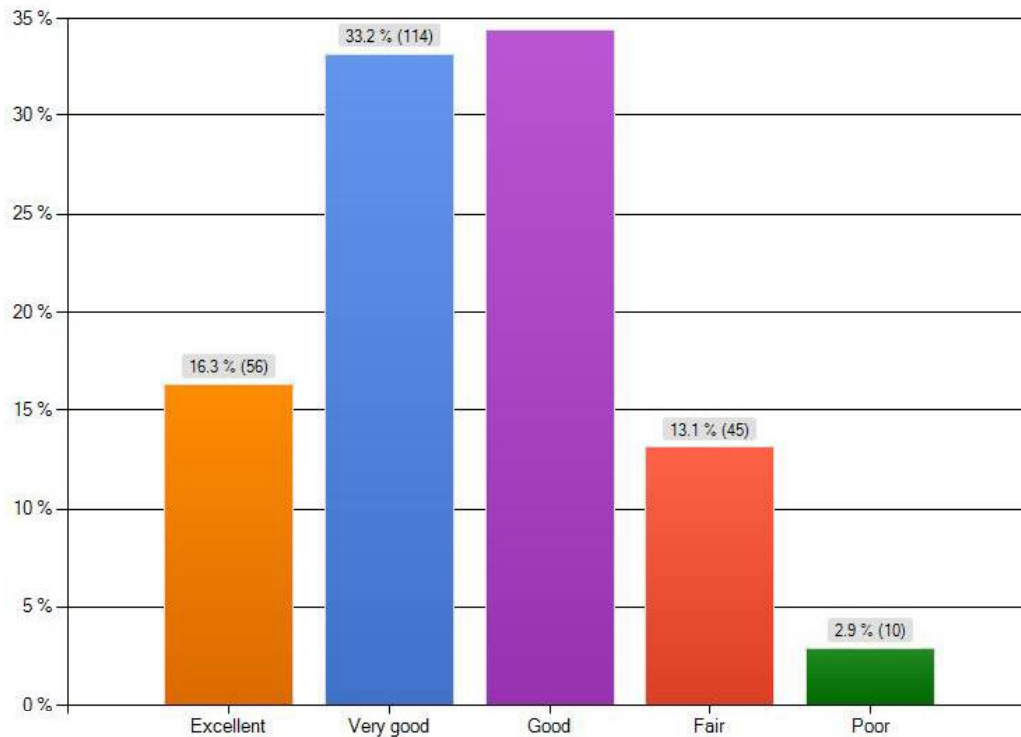
What is the annual income of everyone living in your household?



Question 18

18. How would you best describe your health in general?		
Answer Options	Response Percent	Response Count
Excellent	16.3%	56
Very good	33.2%	114
Good	34.4%	118
Fair	13.1%	45
Poor	2.9%	10
answered question		343

How would you best describe your health in general?

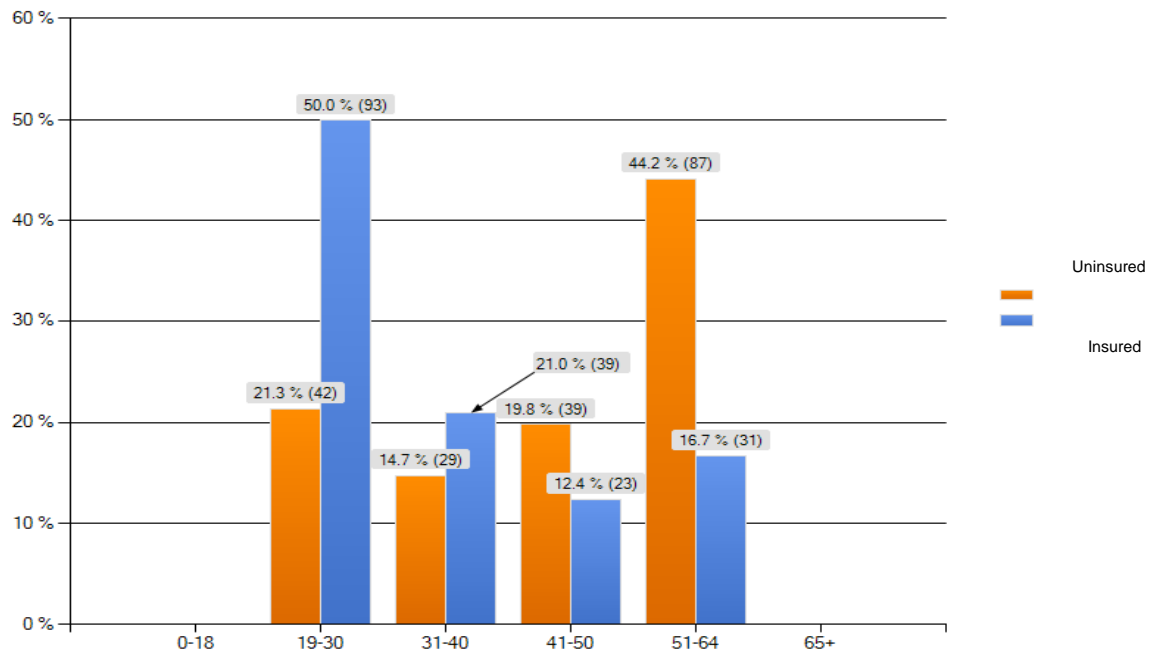


****Some differences were found between those survey respondents who reported they had health insurance and those who reported they did not have health insurance. Overall, those without health insurance were younger (Figure A), had less education (Figure B), were more likely to have incomes less than \$14,999 (Figure C), and reported worse health status (Figure D) than those respondents with health insurance.***

Question 19

What is your age? (Insured vs. Uninsured)				
Answer Options	Are you currently covered by health insurance?		Response Percent	Response Count
	Yes	No		
0-18	0	0	0.0%	0
19-30	42	93	35.2%	135
31-40	29	39	17.8%	68
41-50	39	23	16.2%	62
51-64	87	31	30.8%	118
65+	0	0	0.0%	0
answered question				383

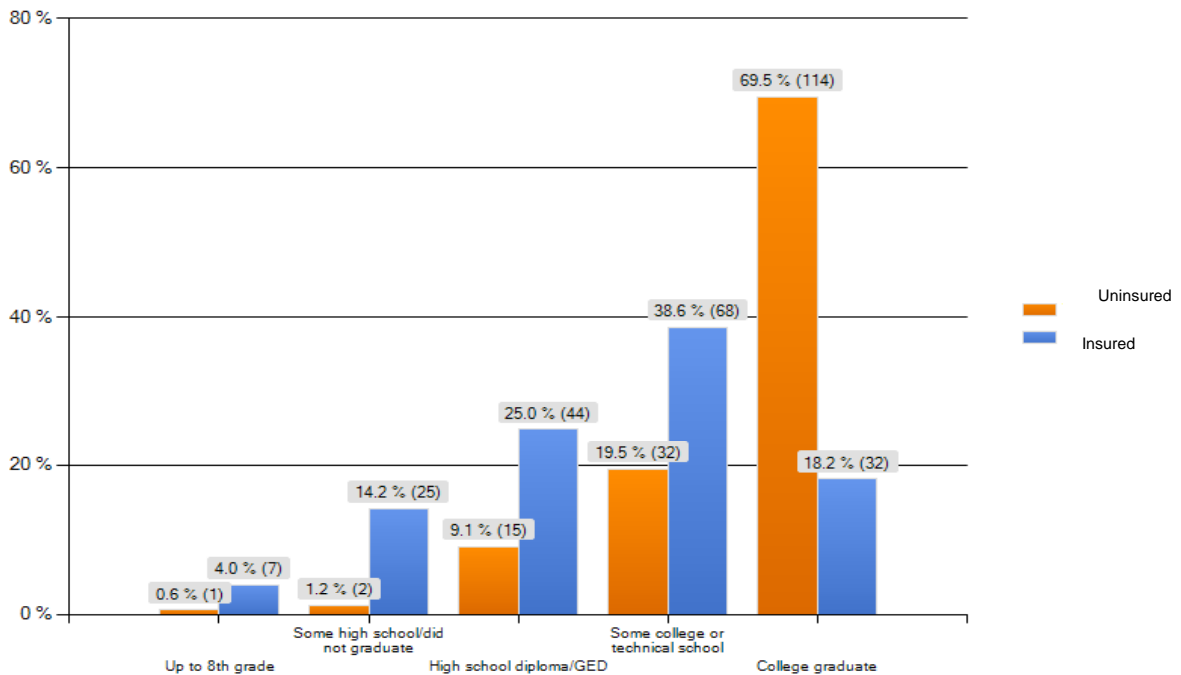
Figure A: Age (Insured vs. Uninsured)



Question 20

What is the highest level of education you completed?				
Answer Options	Are you currently covered by health insurance?		Response Percent	Response Count
	Yes	No		
Up to 8th grade	1	7	2.4%	8
Some high school/did not graduate	2	25	7.9%	27
High school diploma/GED	15	44	17.4%	59
Some college or technical school	32	68	29.4%	100
College graduate	114	32	42.9%	146
answered question				340

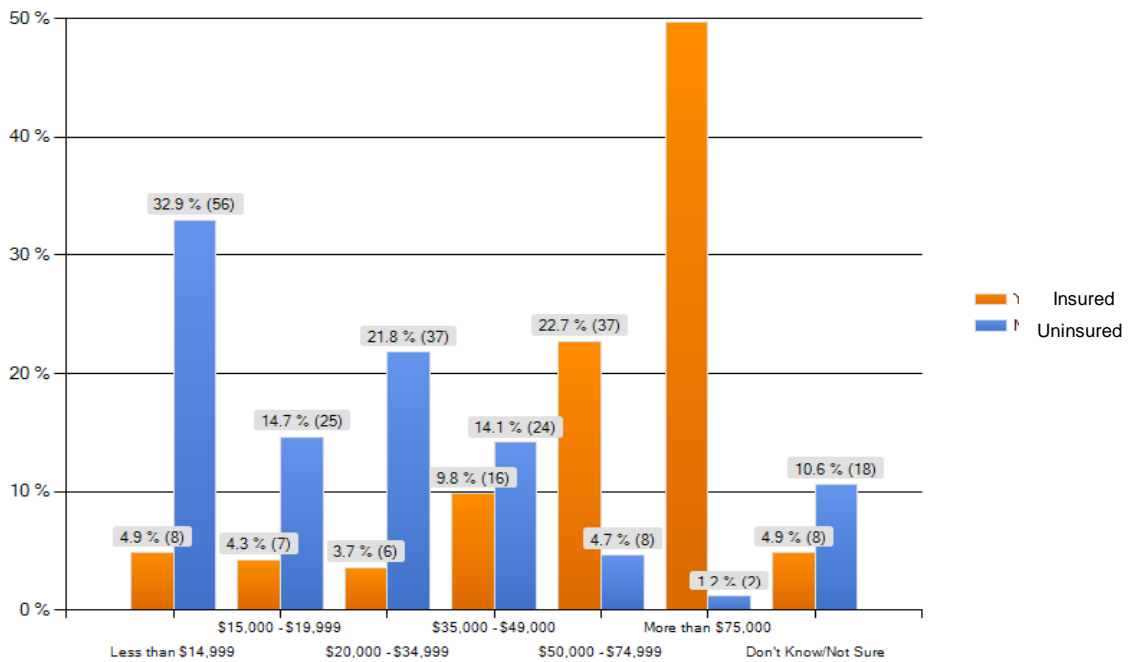
Figure B: Level of education (Insured vs. Uninsured)



Question 21

What is the annual income of everyone living in your household?				
Answer Options	Are you currently covered by health insurance?		Response Percent	Response Count
	Yes	No		
Less than \$14,999	8	56	19.2%	64
\$15,000 - \$19,999	7	25	9.6%	32
\$20,000 - \$34,999	6	37	12.9%	43
\$35,000 - \$49,000	16	24	12.0%	40
\$50,000 - \$74,999	37	8	13.5%	45
More than \$75,000	81	2	24.9%	83
Don't Know/Not Sure	8	18	7.8%	26
answered question				333

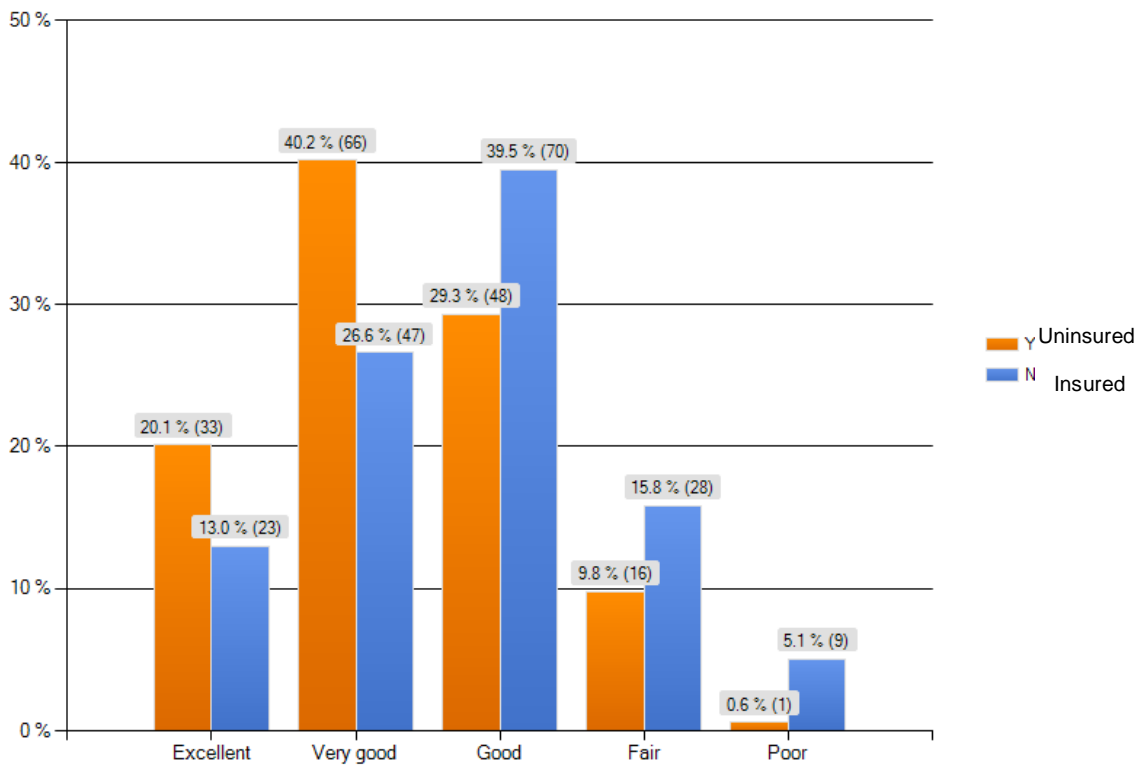
Figure C: Annual income (Insured vs. Uninsured)



Question 22

How would you best describe your health in general?				
Answer Options	Are you currently covered by health insurance?		Response Percent	Response Count
	Yes	No		
Excellent	33	23	16.4%	56
Very good	66	47	33.1%	113
Good	48	70	34.6%	118
Fair	16	28	12.9%	44
Poor	1	9	2.9%	10
answered question				341

Figure D. Health Status (Insured vs. Uninsured)



Attachment C

Overview of Local Access Models

Local access models are community initiatives that bring together multiple community organizations – profit, non-profit, public and private entities, health care providers and businesses – and financing sources to share the burden of care delivery, associated costs, and governance responsibilities to improve access to health services for those who voluntarily choose to participate.

A local access model is essentially a community cooperative that pools the resources of the community to address gaps in health care access for certain of its residents. These models are often referred to as “Access to Care Programs,” “Multi-Share Health Coverage Programs,” “Multi-Shares,” or “Three-Shares,” because they incorporate the efforts of multiple parties to fund and deliver the care. Their mission is to promote access to health care for those who have difficulty obtaining care because they are uninsured and lack the funds to pay for care out of their pockets.

The defining characteristic of a local access model is a collaboration of different community organizations, public and private health care delivery organizations, state, county, and/or city government, and philanthropic organizations that share the care delivery approach, its related costs, and the entity’s governance. Unlike traditional indemnity insurance, government sponsored health plans, or employer privately held financial risk, local access models are “owned” and operated by the community.

There are key distinctions between local access models and insurance. At the core of the notion of “insurance” are the following components:

- i Actuarially determined premium amounts that are adjusted to reflect the health of an individual based on historical medical conditions, age, gender, etc.
- i The transfer of financial risk from employer (or individual) to another entity (the insurance company)
- i The contractual obligation of participating providers to deliver care for a group of enrollees at the payment rates agreed to with the insurance company
- i The residual net gain or loss due to the transfer of risk and ability to manage costs by minimizing administrative costs and procuring favorable contract rates to providers is held by the insurer.

Local access models do not operate within the framework noted above. As explained by Lynn Blewett, et. al. from the State Health Access Data Assistance Center in their publication “Access

*to Care Programs: Overview of Programs and Preliminary Evidence of Perception of Insurance Coverage.*²²

“An Access to Care Program (ACP) [Blewett’s term for Local Access Models] is defined as a community initiative to offer health care services to the uninsured through an organizing entity. ACPs are characterized by:

- i An enrollment mechanism, which may or may not include a membership or monthly enrollment fee
- i Income eligibility requirements that provide free care or care on a sliding fee scale for low-income individuals
- i A defined set of benefits
- i A limited provider network
- i A contractual or agreed-upon relationship between the ACPs and providers of care that may include an agreement to provide free care or care at a reduced fee.”

Unlike insurance, local access models do not bear financial risk, and providers receive no guarantee of payment. Instead, the model focuses solely on access to care, and the costs of care delivery are shared by the community.

Accordingly, there is no need for local access models to assess any “risk” of their participants upon enrollment. Rather, people voluntarily choose to join the local model and anyone who meets the model’s target population profile is accepted. For example, a community may wish to assist people who are working for small employers that do not offer health insurance. In this case, anyone who meets those characteristics, regardless of that person’s health status or needs, may participate on a voluntary basis.

Local access models are entirely community-driven and community-oriented – we call ours the Community Coverage Initiative (CCI) to reflect its local focus. There are different structural possibilities, but most models are operated by non-profit organizations operated by members in the community. Governance varies, but typically a community establishes a Board of Directors whose membership reflects the diversity of the community’s interests and various stakeholders of the initiative.

The Board oversees various decision-making processes and ensures that disparate community voices are heard. Through these processes, the community decides which health care services the program will offer, which demographic group to target for assistance with access, and how the initiative will be funded. Communities are best able to assess and address their own needs, so they are the most sensible forum for reaching those whom the health care system currently leaves behind – such as the working uninsured and small business employers.

The financing of local access models is a collaborative effort. Employers, employees, and self-employed individuals participating in the local access model contribute an amount determined by the community. In most models, these contributions constitute about 60% of the cost of the program. The remaining amount, called the “community share,” is subsidized by obtaining financing from community organizations, philanthropy, and federal, state, county, and city funds.

²² Blewett, L, Ziegenfuss, J, Malik, N. 2007. Access to Care Programs; Overview of Programs and Preliminary Evidence of Perception of Insurance Coverage, March, 2007. Prepared for the US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation and the agency for Healthcare Research and Quality. Contract #290-00-0017

Program participants collaborate by making monthly contributions to the model and paying a portion of their service costs. Also, as community members, participants have a voice in the discussion about how the local access model should operate. Local access models target a specific demographic determined by the community to be in unique need, so they are responsive to their participants' health care needs.

HMOs and other commercial plans have implemented various programs to impact care delivered. However, local access models are better able to provide care coordination and case management of chronic diseases, because of their vantage point on local needs and understanding of provider approaches. In contrast, traditional insurance plans may focus more on the financial benefit of these programs to the insurance plan rather than the health outcome of the individual or the community overall.

Communities are best able to gauge their own needs, and tend to support prevention efforts so that care can be proactive rather than reactive. This approach results in improved health outcomes and lower costs over time. Local models often provide access to a "medical home" and other cost-effective means of coordinating care. Above all, these initiatives are attuned to their constituent communities, both by design and necessity – as with any cooperative, a local access model must offer services that meet its community's needs.

Local access models play a critical role in ensuring a community's health: In addition to generally strengthening the community's welfare, extending health care coverage has been proven to positively impact health outcomes and increased employee productivity. It is believed that there is an essential connection between health care access and health outcomes.

The lack of health care coverage causes roughly 18,000 unnecessary deaths every year in the U.S., and costs the country \$185 billion each year in decreased economic output attributable to lack of health care coverage.²³ Those lacking coverage bear the brunt of the negative impact, but a recent Institute of Medicine study noted that "[t]here are substantial spillover effects of community uninsurance on the access to – and satisfaction with – health care for the privately insured population."²⁴ By targeting and effectively addressing the coverage needs of those who would not otherwise have health care access, local access models support the community as a whole.

Examples of Currently Operating Local Access Models:

Local models already operate in disparate places throughout the U.S. Their models vary greatly, since by definition they are built to reflect their community's specific priorities. However, they all share the core focus of marshaling community resources to give participants access to health care that they could not otherwise obtain.

Access Health, Muskegon, Michigan

The pioneering exemplar of a local access model, Muskegon County collaborated with Mercy Health Partners, the former Hackley Health Systems, and other community businesses and safety

²³ Unnecessary death estimate from the Institute of Medicine, *Insuring America's Health*, pg. 9 (2004); Economic output cost estimate from The Commonwealth Fund study, "Health and Productivity among U.S. Workers" by Karen Davis et. al. (2005).

²⁴ Institute of Medicine commissioned paper, *Spillovers of Uninsurance in Communities*, pg. 23 (2009).

net programs to create a coverage model that local small business employers could afford to offer their employees. Access Health targets moderate income, working uninsured employees of Muskegon and Northern Ottawa Counties. When an employer in these counties voluntarily joins Access Health, all of its uninsured permanent employees who meet a wage qualifier determined by Access Health (as of Jan. 1, 2008, the median wage of participants was \$12) may participate, regardless of health status. As with other local access models, the community is collectively responsible for the coverage and care of its participants.

Local providers provide comprehensive care with an emphasis on primary and preventive care. For example, the model includes an initiative that encourages employers to provide healthy work sites and employees to take an active role in living a healthy lifestyle. Another example: Since Access Health is not insurance, there were some instances of care that were beyond the model's scope of feasibility; however, Access Health nonetheless wished to facilitate participants' care. Accordingly, Access Health established an agreement with the state Medicaid office whereby if any Access Health participant becomes disabled, Medicaid will cover those members until they are able to return to work.

CareLink, Bexar County, Texas and the TexHealth Coalition

CareLink provides health care coverage to uninsured Bexar County residents with incomes below 200% of federal poverty guidelines who do not qualify for aid programs. CareLink is a financial assistance program of the University Health System – accordingly, it offers a monthly payment program to participants based on the participant's income and family size. Participants can access health care services provided by the University Health System, UT Medicine San Antonio, and Community Medicine Associates. In addition to promoting access to health care services, CareLink assists participants in navigating the local health care system and managing costs such that those who could not traditionally access coverage are now able to do so.

Due to a growing need and based on the success of local access models in other states and a pilot (now permanent) program in Galveston, Texas passed legislation in 2007 that allowed Texas communities to develop alternative methods of offering low-cost small business health plans. Six Texas counties (Galveston, Harris, Central Texas, Dallas, El Paso, and Brazos Valley) formed the TexHealth Coalition to create local access models and other alternative means of health care access. TexHealth local access models are developed by their individual communities and reflect local needs, but they share some characteristics. First, they all split the cost of health coverage among the employer, employee, and third parties within the community to offer more affordable coverage to the participant. Second, the plans target employers who employ between 2-50 employees who have not offered health care coverage during the prior 6-12 months. Finally, TexHealth models emphasize primary and preventive care to promote employees' overall wellness.

Healthy San Francisco, San Francisco, California

The Healthy San Francisco program harnesses the power of joint purchasing by pooling the funds from county tax dollars and contributions from the city, local business employers, and program participants. Healthy San Francisco targets people living at or below 500% of the

federal poverty guidelines. This city-wide program is operated by the San Francisco Department of Public Health. Healthy San Francisco provides participants with a primary care physician and a “Medical Home,” which is essentially a partnership approach to providing primary care that focuses on open access and coordinated care. The hope is that providing convenient and reliable access to health care will bolster other preventive care efforts.

Health Advantage, Marion County, Indiana

Health Advantage targets low-income uninsured residents of Marion County whose income is at or below 200% of the federal poverty guidelines and who do not qualify for safety net assistance programs. Health Advantage is funded by city and county property taxes. Like other local access models, Health Advantage is a health care cost assistance program. The Health and Hospital Corporation of Marion County works in concert with Indiana University’s Medical Group and Wishard Hospital’s health services to share the costs and governance of providing medical services to participants. Participants have access to a broad array of contracted health care providers, including Indiana University Medical Group, HealthNet, Citizen’s Health Center, Raphael Health Center, and other community providers.

Primary Care Program, Arizona

The Primary Care Program is truly a statewide initiative: It was established by statute (ARS 36-2907.05) and is administered by the Arizona Department of Health Services. The program was originally known as the Tobacco Tax Primary Care Program, which reflected its financing; currently, the program receives state funding (approximately \$13 million in 2007), and contracts with providers to offer covered services to participants. The Primary Care Program targets all uninsured Arizona residents living at or below 200% of the federal poverty guidelines who do not qualify for other aid programs. There is no “risk assessment” – any Arizona resident who meets the income qualification, regardless of health status or need, may participate. The Primary Care Program essentially acts as an additional safety net for those who are struggling yet do not qualify for other safety net services. It offers a sliding fee schedule of community-based primary care services for participants, so participants pay according to their ability to do so.

Conforming to State and Federal Regulations

None of the existing local models is regulated as a traditional insurance product. Because the insurance market has not been able to offer an option that would meet their needs, individuals enrolled with local access models. Therefore, in order to creatively address the needs of the residents they serve, these models generally operate outside of the traditional insurance arena.

Some state legislatures have passed enabling laws that allow for the operation of the models within established parameters outside of the Insurance Commissioners’ purview. Other states have allowed the models to be developed as demonstrations and have identified oversight to be accomplished through newly created boards or commissions. Some examples of enabling legislation that has been passed in other states are noted below:

Maine

“Dirigo Health is established as an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents and individuals on a voluntary basis”

Minnesota

“A community-based health care initiative may develop and operate a community-based health care coverage program that offers to eligible individuals and their dependents the option of purchasing through their employer health care coverage on a fixed prepaid basis without meeting the requirements of chapters [referenced chapters are those regulating insurance companies] ... Or any other law or rule that applies to entities licensed under these chapters...”

Oregon

“Requires Administrator of Office for Oregon Health Policy and Research to adopt rules for approval of community-based health care initiative and of community-based health care improvement programs operated by initiative...”

Texas:

“The purpose is to 1) improve the health of employees of small employers and their families by improving the employees’ access to health care and by reducing the number of those employees who are uninsured; 2) reduce the likelihood that those employees and their families will require services from state-funded entitlement programs such as Medicaid; 3) contribute to economic development by helping small businesses remain competitive with a healthy workforce and health care benefits that will attract employees; and 4) encourage innovative solutions for providing and funding health care services and benefits.... Local health care programs may be operated subject to the direct governance of the commissioners court of the participating county.”

Attachment D

American Community Survey & PUMAS

The Census Bureau's American Community Survey is an ongoing survey that produces important statistics about our nation's people and housing. It covers the same type of information that had been collected every 10 years from the decennial census long form questionnaire.

American Community Survey data are collected continuously over time in the last decade. This allows the Census Bureau to produce new data every year and provides community leaders and planners access to current data to address a wide range of current social and economic issues. The American Community Survey allows for more than a single snapshot of an area every ten years. Instead, the survey provides a moving picture of community characteristics — a more efficient use of taxpayer dollars. The American Community Survey is sent to about 3 million addresses in the U.S. and Puerto Rico every year.

For more information, see the American Community Survey Web page at <http://www.census.gov/acs>.

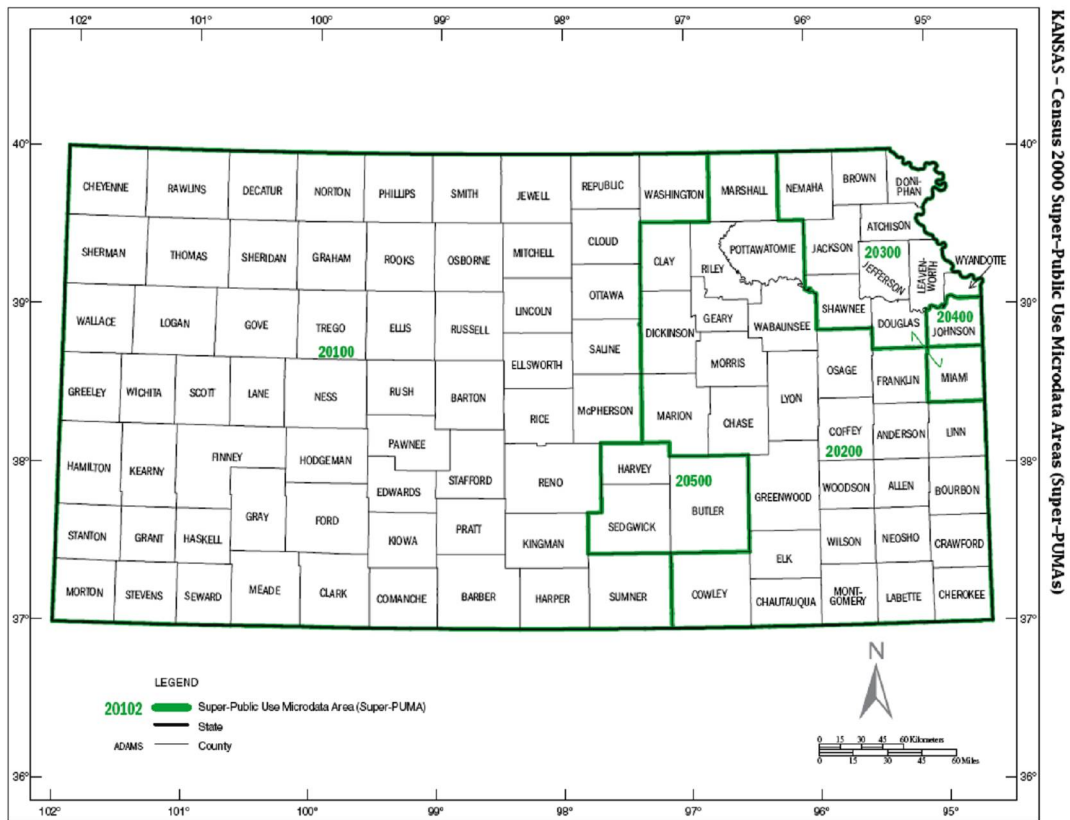
ACS Public Use Microdata Sample (PUMAS) Files

Public Use Microdata Sample files from the American Community Survey show a wide range of population and housing unit responses collected on individual ACS questionnaires. For example, they show how respondents answered questions on occupation, place of work, and so forth. The PUMAS files contain records for a subsample of ACS housing units and group quarters persons, with information on the characteristics of these housing units and group quarters persons plus the people in the selected housing units.

The records contain information from the completed ACS questionnaires for most questions for the selected subsample of housing units and group quarters persons. The questionnaire includes questions on age, sex, tenure, income, education, language spoken at home, journey to work, occupation, condominium status, shelter costs, vehicles available, and other subjects.

Currently PUMAS files are available in both 1-year estimate and 3-year estimate versions through the American Fact Finder (AFF). Public Use Microdata Sample files from the ACS show a wide range of population and housing unit responses collected on individual ACS questionnaires. By using the Public Use Microdata Areas, PUMAS, we are able to narrowly define the area of the country used for the projections in this report.

As demonstrated on the graph below, the geographic areas covered by the PUMAS in Kansas do not perfectly align with the service area contemplated in this initiative. We are only able to provide data for areas that closely match the Wichita market, but even at this, it is not a perfect match. It also includes only data on the civilian, non-institutionalized population. These public use files reflect a 1% sample of all data – so they are representative but not of the entire survey sample.



Specific to the data used in this report's analysis, researchers at the Kansas Health Institute used the data of PUMAs 01401, 01402 and 01403 as reflected in the map below:

