



LOSING GROUND

**ERODING HEALTH INSURANCE COVERAGE
LEAVES KANSAS FARMERS WITH MEDICAL DEBT**

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The Access Project
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The Access Project (TAP) has served as a resource center for local communities working to improve health and healthcare access since 1998. The mission of TAP is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. TAP conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. TAP's fiscal sponsor is Third Sector New England, a non-profit with more than 40 years of experience in public and community health projects. TAP is affiliated with the Heller School for Social Policy and Management at Brandeis University.

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Executive Summary

Recent national research has brought attention to the widespread difficulty Americans have paying their medical bills. The Kaiser Family Foundation found that close to a quarter of Americans had problems paying medical bills in 2005, and that of those, 61% were covered by insurance.¹ The problem of medical debt is of particular concern because the consequences of the debt are so serious. Most directly, medical debt and unaffordable medical bills create a significant barrier to accessing care. Medical debt can also undermine a family's financial security through increased expenses, loss of savings and damaged credit ratings.

Farming is an important part of the Kansas economy, so any indications that medical debt is causing financial or health care difficulties for farm families has significant state policy implications. To examine medical debt among this population, The Access Project (TAP) collaborated with our local research partner, the Kansas Farmers Union (KFU), to survey their members. We adapted the questionnaire and methodology of an earlier TAP study conducted with users of community health centers in Kansas, resulting in the report *Playing by the Rules but Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security*.

Farm families face unique financial challenges, and medical costs play an important role. Kansas farm families' incomes, in particular the farm-generated portion, are volatile and unpredictable.

Following six years of growth, national projections for farm operation-related income in 2006 are unfavorable, with farm-generated income projected to decline by 48 percent.²

Since net farm family incomes are expected to decline and health care costs are likely to rise in 2006, it is reasonable to expect that health insurance and other medically-related costs will grow as a percentage of farm families' overall net income. Medical debt is thus one of the important sources of economic pressure many farm families currently face.

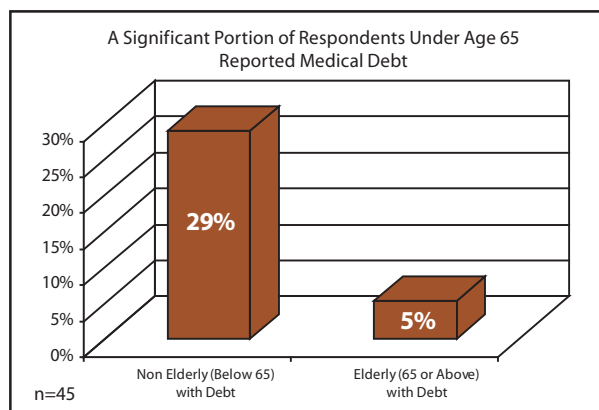
“ We need routine check-ups but put them off because of the money it costs. ”

KEY FINDINGS

In June of 2005, a questionnaire was mailed to 600 randomly selected members of the Kansas Farmers Union (KFU). Surveys were completed by 281 farm families (47% of the sample), with nearly equal representation from each of the six KFU regions in the state. Virtually all respondents (95%) said that all members of their household had health insurance continuously over the past 12 months. Overall, about one respondent in six (17%) reported having medical debt.

Medical debt was most common among respondents under age 65.

The overall rate of medical debt conceals a significant difference between the experience of respondents age 65 and over and those under 65. Only five percent of those 65 and over reported medical debt, while nearly a third (29%) of the non-elderly respondents said they had debt. These findings raise the question of whether the health insurance coverage of non-elderly survey respondents adequately protects them from financial risk.



More than one-third (36%) of larger households—those with three or more members—reported having medical debt, compared with 10 percent of smaller households.

Medical debt may be more of a concern for families with children or other dependents than it is for single people or childless couples.

Doctors and hospitals were most often cited as the source of the medical debt.

Nine out of ten (91%) respondents with medical debt said they owed money to doctors. Nearly as many (84%) owed hospitals, nearly two-thirds (64%) had outstanding prescription costs, half (51%) owed dentists, and 13% had debts from ambulance services.

Many of those with medical debt reported delaying needed primary care.

Many respondents said they delayed or avoided care because they felt uncomfortable about the debt (20%) or because they did not want to add to the money they owed for medical bills (47%).

Medical debt contributed to reduced savings and increased credit card debt.

More than a third of respondents with debt (36%) said they had used a large part of their savings to pay medical bills and a third (33%) said they incurred or increased their credit card debt. Twenty percent of those with medical debt reported having been contacted by a collection agency.

DISCUSSION

The frequency of medical debt among insured farmers raises an important question—is their insurance fulfilling its fundamental purpose of protecting families from the financial hardship that can result from receiving needed medical care? If insurance premiums are too high, people may choose to purchase coverage with fewer benefits or higher deductibles in order to protect themselves against the possibility of bankrupting medical expenses. Such a decision may still leave families exposed with many smaller bills that create medical debt sizable enough to cause significant barriers to accessing care.

Insurers might reduce premiums by increasing deductible or other cost sharing amounts, as in new high-deductible, “consumer-driven” health plans. Or they might limit benefits, as some states now permit, and market low-cost, “bare bones” health plans. Efforts to make coverage more affordable may thus result in making actual care less affordable. Public policy must address both sides of this problem—both the affordability and the adequacy of health insurance coverage.

RECOMMENDATIONS

What can be done to make affordable and adequate insurance coverage available for a population with volatile and unpredictable incomes? Public subsidies that help people purchase market-based insurance products that provide adequate coverage is one promising approach.

The Kansas legislature recognized the importance of affordable health insurance in attracting and retaining a quality workforce when it created the Kansas Business Health Partnership in 2001. The partnership allows small employers to join together to obtain more favorable rates from insurers. The original plan included subsidies for low-income workers to assist them in paying their share of the premium, but implementation of the subsidies was delayed. In 2005, the legislature authorized \$500,000 for the subsidies.

Other states have experimented with a variety of public-private solutions that may also be instructive and relevant to the situation of Kansas farm families. Four are described in the report: MinnesotaCare, The West Virginia Small Business Plan, The Massachusetts Fishermen’s Partnership Health Plan, and Healthy New York. They each facilitate access to affordable, adequate coverage that limits financial barriers to accessing health care.

I. Background

Studies have recently confirmed the extent to which medical debt and bill problems affect Americans.

PREVALENCE OF MEDICAL DEBT

According to a national survey conducted by The Commonwealth Fund in 2005, one in three (34%) Americans had medical debt they were paying off over time or medical bill problems such as not being able to pay medical bills, being contacted by a collection agency about the bills, or having to change their way of life to pay them.³ The same study found that more than one in every five (21%) Americans had medical debt.

Another national survey conducted by the Kaiser Family Foundation in 2005 found that nearly a quarter (23%) of Americans had problems paying medical bills in the previous year, with one in five (21%) having an overdue bill.⁴ These problems disproportionately affected those with chronic illnesses, who were almost twice as likely as healthier adults to have an overdue medical bill (29% vs. 16%). Those with moderate and lower incomes were also at higher risk of having medical bill problems.

Not surprisingly, the uninsured are at greater risk of having medical debt or medical bill problems than the insured. The 2005 study found that 51% of those who were currently uninsured and 55% of those who were insured but had been uninsured at some time in the previous year had experi-

enced these problems, compared to 26% of the continuously insured.⁵ What is striking in this and other studies, however, is the high percentage of those with insurance who have medical bill problems. The Kaiser Family Foundation found that of the close to a quarter of Americans who had problems paying medical bills in the past year, more than 6 in 10 (61%) were covered by insurance.⁶ Another Kaiser study estimated that the number of adults at higher risk of incurring medical bills they might not be able to pay was 58 million; this included 22.9 million adults who were uninsured for the entire preceding year, 17.6 million uninsured for part of the preceding year, and 17.6 million who were continuously insured but with inadequate insurance.⁷ The Commonwealth Fund estimated that 12% of insured adults were underinsured; that is, insured all year but without adequate financial protection.⁸

These figures take on particular importance because current trends indicate that the number of underinsured will increase as health premiums, co-payments and deductibles rise. In the Kaiser survey, two-thirds (66%) of insured adults said their health insurance premiums had gone up in the previous five years, with more than a third (38%) saying they had gone up “a lot.”

Over half of insured adults (52%) said their co-payments had risen in that time period, and almost half (49%) said their deductibles had risen.⁹ In 2005, health insurance premiums increased by 9.2 percent, more than two and half times the overall rate of inflation (3.5%) and almost three and half times the rate of increase in workers' earnings (2.7%).¹⁰

CONSEQUENCES OF MEDICAL DEBT

The widespread prevalence of medical debt is of particular concern because the consequences of the debt are so serious. Most directly, medical debt and unaffordable medical bills create a significant barrier to accessing care. According to the Commonwealth Fund, adults with any medical bill or medical debt problem were more than three times as likely as those without these problems to have gone without needed care in the previous year (63% vs. 19%).¹¹ Moreover, access problems related to debt are not limited to the uninsured. In fact, a Kaiser study found that insured adults with medical debt tend to behave more like the uninsured than like the insured without medical debt in their care seeking behavior. For example, 29 percent of the uninsured and 28 percent of the privately insured with medical debt reported postponing care due to cost, compared to only 6 percent of the privately insured without medical debt. Similarly, 25 percent of the uninsured and 30 percent of the privately insured with medical debt reported

skipping a test or treatment due to cost, compared to only 8 percent of the privately insured without debt.¹²

However, the consequences of medical debt are not limited to diminished access to health care. Medical debt can also undermine a family's financial security through increased expenses, loss of savings and damaged credit ratings. According to a Commonwealth Fund analysis, among adults with medical debt or bill problems, over a quarter (26%) were unable to pay for basic necessities, such as food, heat, or rent because of these bills. In addition, more than a third (39%) used up all their savings, a quarter (26%) took on credit [care] card debt, and one in nine (11%) took out a mortgage against their home or a loan in order to pay off those bills.¹³ A recent Access Project survey conducted in eight cities found that a quarter of respondents with medical debt experienced housing problems, such as the inability to qualify for a mortgage, to make mortgage or rent payments, or to secure or maintain a home. This included a fifth of those respondents who were insured when they accrued the debt.¹⁴ Moreover, people who owe medical bills may find themselves in court and subject to legal judgments, including wage garnishment and liens on their homes, which may lead to foreclosure.¹⁵ And medical expenses or lost income due to illness or injury are factors in about half of all personal bankruptcies.¹⁶

II. Medical Debt in Kansas

The Access Project has conducted two previous studies exploring the effects of medical debt among Kansans. The first, entitled *Heartache in the Heartland: Kansans Speak about the Burden of Medical Debt* was based on a focus group discussion conducted in 2005 in a health center in Emporia, in eastern Kansas. It found barriers to health care due to inadequate insurance and financial consequences resulting from unpaid medical bills.

The second, entitled *Playing by the Rules but Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security* was based on a survey of over 1,000 clients of four community health centers across the state. Some of the key findings from that study were:

- Most survey respondents reported currently owing money for medical bills. More than half the members of all racial and ethnic groups represented in the sample reported having medical debt.
- About half of the respondents with medical debt said they had delayed a doctor's visit because of the debt; about 4 in 10 delayed a visit to a dentist.
- One respondent in five reported using a large portion of savings to pay their medical bills, and twice that number borrowed money from friends or family members. Others put bills on their credit cards, took out loans, or borrowed against their homes.
- Medical debt and its associated health care access and financial problems were almost as common among respondents who had health insurance as those without.
- The problems associated with medical debt resulted from even relatively small amounts of debt, and the likelihood of experiencing such problems increased dramatically with even small increases in the amount of debt.

These findings are consistent with results of Access Project research in other states, and with national studies on the subject. The report established that medical debt is a significant barrier to accessing care and a serious financial burden for many Kansans.

MEDICAL DEBT AMONG FARM FAMILIES

Collaborating with our local research partner, the Kansas Farmers Union (KFU), we adapted the questionnaire and methodology of our earlier Kansas study to examine this distinct population. Because farming is such an important part of the Kansas economy and way of life, any indications that medical debt is causing financial or health care difficulties for farm families has significant state policy implications.

Farm families face unique financial challenges, and medical costs play an important role. Nationally, health care spending has grown steadily—by an average rate of 8.1 percent annually between 1999 to 2004.¹⁷ This growth is reflected in health insurance premiums, which grew for families in Kansas by 41 percent between 2000 and 2003.¹⁸ In contrast, Kansans' incomes have not grown nearly as quickly: median household income grew by just over \$1,000, from \$40,624 to \$41,638, between 1999 and 2004.¹⁹

Kansas farm families' incomes, in particular the farm-generated portion, are volatile and unpredictable. The average farm-generated income among Kansas farms has fluctuated, ranging from about \$20,000 in 2001, down to less than \$10,000 in 2002, and up to nearly \$49,000 in 2004.²⁰

Clearly, net farm-generated income is affected by many factors, including weather, market fluctuations and changes in production input costs. National projections for farm operation-related income in 2006 are unfavorable, following six years of growth. In 2006, farm-generated income is projected to decline by 48 percent.²¹

In the context of farm economics, medical costs can be thought of as another input cost. For example, just as energy costs are projected to significantly reduce net farm income in 2006,²² the inexorable growth in health care costs will affect farmers' bottom lines. Health insurance and other medical costs ranged between 10 and 15 percent of net farm income among Kansas families from 2001 to 2004.²³ Because in 2006 net farm family incomes are projected to decline and health care costs are likely to rise, it is reasonable to expect that health insurance and other medically-related costs for farm families will grow as a percentage of these families' overall net income. Already, farmers in many areas say that health care costs are becoming more of an issue than day-to-day farm operating costs.²⁴

Medical debt, then, is an important source of the economic pressures many farm families face.

III. Methodology

Data for this study were collected via a mail survey. The Kansas Farmers Union mailed 600 questionnaires to a randomly selected list of its members between June and September 2005. Surveys were sent to 100 members in each of six KFU regions throughout the state. A total of 281 surveys were returned to the KFU office, an overall response rate of 47 percent. Regional response rates ranged from 36 percent to 54 percent. Data analysis was performed by The Access Project and its research partners at Brandeis University.

The sample size is small, and it is possible that a larger survey would produce different results. However, while care must be exercised not to over-generalize, the study was random and had a reasonable response rate (47%). Additionally, 43% of the sample was between the ages of 45 to 64. Notably, this is reflective of the average age range of principal farm operators both nationally and in Kansas. The average age of all U.S. principal farm operators in the 2002 Census was 55.3 years of age, while in 2005, the average age of the principal farm operator in Kansas was reported to be 56 years of age.²⁵ Until more complete data are available, these findings represent the best existing on the issue of medical debt among Kansas farm families.

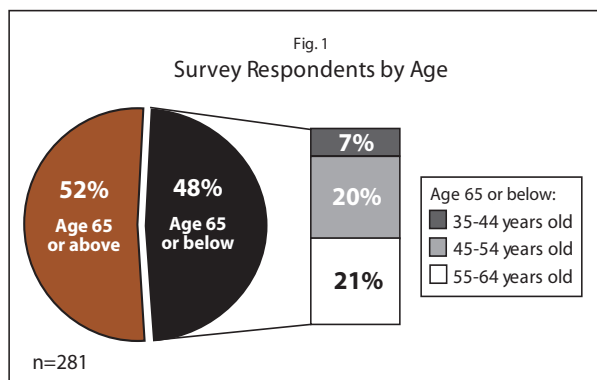
IV. Findings

DEMOGRAPHICS OF RESPONDENTS

Two hundred and eighty one surveys were completed. (All the results reported here exclude non-responses; not all questions were answered by all respondents). Three-quarters (75%) of the respondents were male. Six out of seven respondents (83%) were married; 99 percent were white.

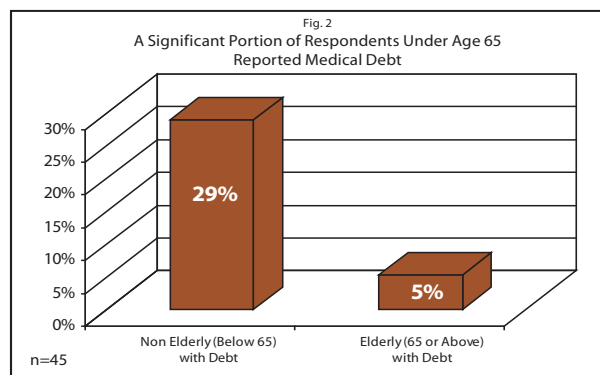
More than half (52%) were age 65 and above, and another one-fifth (21%) were between 55 and 64. Twenty percent were between 45 and 54, and the remainder (7%), was younger than 45.

Most of the respondents (73%) lived in households of one or two people. Only two percent were in households of more than five. The median household income of survey respondents was \$45,000.



MEDICAL DEBT

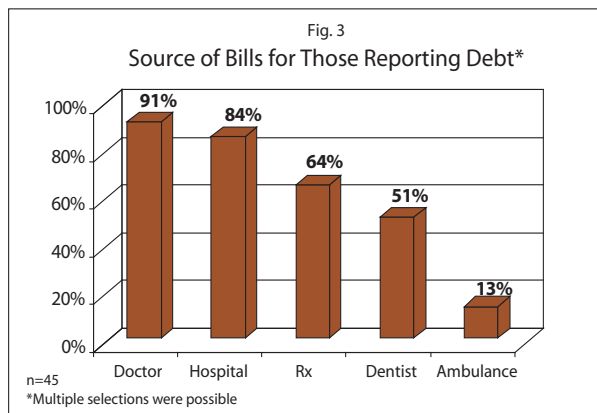
Overall, about one respondent in six (17%) reported having medical debt. However, this statistic conceals a significant difference between the experience of respondents age 65 and over and those under 65. Only five percent of those 65 and over reported medical debt, while nearly a third (29%) of the non-elderly respondents said they had medical debt. Indeed, 84 percent of the respondents with medical debt were under age 65, although they account for less than half of the sample.



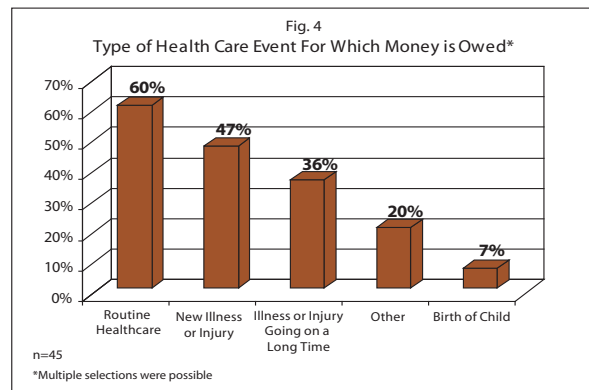
More than one-third (36%) of larger households—those with three or more members—reported having medical debt, compared with 10 percent of smaller households. This suggests that medical debt may be more of a concern for families with children or other dependents than for single people or childless couples.

The median amount of medical debt was \$2,500 among those who reported having debt.

Nine out of ten (91%) respondents with medical debt said they owed money to doctors. Nearly as many (84%) owed hospitals, nearly two-thirds (64%) had outstanding prescription costs, half (51%) owed dentists, and 13% had debts from ambulance services.



Respondents provided further detail about the type of health care event for which the money was owed. Nearly 60% reported owing for routine health care, 46% owed due to an injury or new illness, 35% for a chronic illness or injury, and 6% owed for the birth of a child. Close to 20% owed for another type of event, most commonly eye glasses and nursing home care.



The role of insurance

One explanation of the observed disparity in medical debt between older and younger respondents might be that those age 65 and over have insurance coverage through Medicare, while younger people might be going without insurance. That is not the case in this study. Virtually all respondents (95%) said that all members of their household had health insurance continuously over the past 12 months. This finding raises the question of whether the health insurance covering many of the younger survey respondents adequately protects them from financial risk. (The survey did not ask whether respondents were insured at the time the debt was incurred.)

Even some respondents without debt wrote about the burden of paying for insurance:

“Although we currently don’t have large amounts of medical debt, the cost of our health insurance is a very large burden on our finances. If things don’t improve we may be forced to drop our health insurance.”

“Insurance takes out a big part of our income, yet our deductible is out of this world. The only reason we keep paying for health insurance is if we would happen to have an accident on the farm or if cancer would, by chance, strike our family again.”

“[My] employer went to a high deductible Blue Cross Blue Shield plan to lower their premiums, so we [husband and wife] pay the first \$6,000 deductible per year. If we stay healthy, this is not a large problem, but with heart bypass, colonoscopies, and stress tests this last year, it has been a tough year.”

Consequences of medical debt

Previous studies on medical debt revealed that the presence of debt both deterred people from seeking needed medical care and affected families' finances. The experiences of the farmers who responded to this survey were consistent with these earlier findings. About one-quarter (24%) of respondents with medical debt said they delayed dental visits because of the medical debt, one in five (20%) delayed doctor visits, and about one out of nine (11%) delayed filling a prescription.

Respondents said they delayed or avoided care because they felt uncomfortable about the debt (20%) or because they did not want to add to the money they owed for medical bills (47%). One respondent wrote: "We need routine check-ups but put them off because of the money it costs."

In addition to affecting access to health care, unpaid medical bills had broader financial effects. For example, more than a third of respondents with debt (36%) said they had used a large part of their savings to pay medical bills and a third (33%) said they incurred or increased their credit card debt. Twenty percent of those with medical debt reported having been contacted by a collection agency. One respondent wrote:

"My bill is paid on every month with whatever I have left after paying bills. I've cut back on some luxuries (magazines, books, etc.) so I do have money left over for this bill. The hospital I owe is a community one; they're just happy to get any amount of money. They've never pressured me for payment. At this rate, however, I'll be paying for a while."

V. Discussion & Recommendations

Medical debt is not uncommon among the Kansas farm families who responded to this survey, particularly those with members under 65 years old. This was true even though almost all respondents to the survey had health insurance coverage. Though this survey did not ask for specifics about insurance plans—deductibles and other cost sharing, covered and uncovered services, annual or lifetime caps—this is a logical next area of inquiry to pursue. Not all insurance is equivalent: it appears from this study that respondents who have access to Medicare coverage—those who are over age 65—had much less of a problem with medical debt than their younger counterparts, even though older people are more likely to have more extensive medical needs. The frequency of medical debt among non-elderly insured farmers raises the issue of whether their insurance is fulfilling its fundamental purpose—to protect them from the financial hardship that can result from receiving needed medical care.

An explanation of the paradox that even those with insurance coverage have medical debt may lie in the trade-offs people feel they must make between affordable premiums and comprehensive coverage. If insurance premiums are too costly, people may choose to purchase coverage with fewer benefits or higher deductibles. Such a decision may leave families exposed to bills that accumulate and create debt that is sizable enough to cause access and financial problems.

Thus, families can face two distinct financial challenges regarding their health care: affording coverage—represented by the insurance premium—and affording needed care, whether they are covered or not. Focusing on these challenges separately may solve one at the expense of the other. For example, an insurer might reduce premiums by increasing deductibles or other cost sharing amounts, as in new high-deductible, “consumer-driven” health plans. Or they might limit benefits, as some states now permit, and market low-cost, “bare bones” health plans. In both of these cases, efforts to make coverage more affordable

could result in actual care becoming less affordable, potentially leaving someone with such coverage with no better financial access to care. In the public policy arena, therefore, both sides of this coin—the affordability and adequacy of health insurance coverage—must be addressed together.

What might be done to make affordable insurance available that adequately protects a population with volatile and unpredictable incomes? One approach is for the government to subsidize the purchase of market-based insurance products. In fact, the Kansas legislature recognized this potential, and the importance of affordable health insurance in attracting and retaining a quality workforce, when it created the Kansas Business Health Partnership in 2001. The partnership allows small employers to pool together to obtain more favorable rates from insurers. The original plan included subsidies for low-income workers to assist with the employee share of the premium, but implementation of the subsidies was delayed. However, in 2005 the legislature authorized \$500,000 for the subsidies.

Other states have also experimented with public-private solutions. These initiatives might be instructive and relevant to the situation of Kansas farm families.

MinnesotaCare (MNCare)

MinnesotaCare is a reduced cost health coverage program, primarily for families who do not have access to employer-subsidized insurance (ESI) and cannot afford private insurance on their own. The program is administered by the state, and enrollees receive coverage through Blue Cross and Blue Shield of Minnesota. MNCare enrollees pay a monthly premium based on income, family size and number of family members enrolled in the program. The benefits are fairly comprehensive, although there are some co-payments and benefit limits for adults without children.

About 125,000 people were enrolled in the program as of April 2006. The projected cost for FY 2006 is \$441 million, of which 8 percent comes from premiums, 58 percent from state appropriations, and 34 percent from federal programs. The state portion comes from the Health Care Access Fund, financed by a 2 percent tax on all medical providers.

A MNCare expansion made the program available to additional childless adults. In particular, it benefited dairy farmers, smaller farmers, and those living in areas where off-farm income opportunities that provide health coverage is low. Approximately 15 percent of farm families became eligible under the MNCare expansion and benefited from the program.

The West Virginia Small Business Plan²⁶

The Small Business Plan was created by the West Virginia legislature in 2004. It is a “marriage” between the private market and the purchasing power of the West Virginia Public Employees Insurance Agency (PEIA), the agency that provides health insurance coverage for state employees and retirees. PEIA is the largest self-insured program in the state, with over 100,000 covered lives in three separate risk pools. Essentially, the program allows insurance carriers to access the provider rates negotiated by this powerful payer and to market coverage based on these rates to small employers with 2 to 50 employees.

The result is an insurance product that costs 20 to 25 percent less than retail rates. The savings are realized through the purchasing power of the state, without the state directly subsidizing the plan. Participating insurers are also required to reduce their administrative margin. Reduced benefits are not part of the cost reduction strategy. Since the plan was launched in 2005, one carrier—Mountain State BlueCross BlueShield—has offered products through the Small Business Plan.

The Massachusetts Fishermen's Partnership Health Plan (MFP)

The Massachusetts Fishermen's Partnership is an organization of 18 fishing organizations from around Massachusetts. In 1996, MFP sponsored a survey to collect information about health access and coverage among workers in the state's fishing industry. The survey was undertaken because of serious economic distress and dislocation in the fishing industry, which left large numbers of families without health insurance and with serious problems gaining access to healthcare.

The survey revealed that 43 percent of adults and 34 percent of children were uninsured, confirming that individuals and households in the fishing community were greatly in need of improved access to affordable health insurance.

The MFP worked with a local health system and federal and state officials to develop a comprehensive, affordable health plan for fishing families. The MFP uses the Tufts Health Plan network of physicians and hospitals to provide quality coverage with small co-payments. The comprehensive coverage includes preventive health care, office visits, and chiropractic, hospitalization and emergency services. The premium costs are subsidized by both state and federal funds.

Healthy New York²⁷

The Healthy New York program uses publicly-financed reinsurance to enable insurers to reduce premiums offered to small employers. Employers with 50 or fewer previously uninsured low-wage employees may purchase coverage through the program. The state acts as an "insurer of insurers" by reimbursing health plans for 90 percent of any claims between \$5,000 and \$75,000 paid for a member in a calendar year. This reduces the risk that insurers face when providing coverage to small groups. In such groups, a single large claim can mean a substantial loss for the insurer and, in turn, a big rise in premiums for the employer.

Healthy New York had about 107,000 members purchasing coverage from 21 health plans as of the end of 2005. Most members responding to a survey reported paying between \$125 and \$200 per month for coverage. Reinsurance in 2005 cost the state an estimated \$58 million.

VI. Conclusion

It is well established that medical debt is widespread and creates barriers to accessing health care, thus jeopardizing people's health. Medical debt is even common among people with health insurance, raising questions about the adequacy of some insurance products in protecting policyholders from damaging financial exposure.

The Kansas farmers who responded to our survey exemplify this phenomenon. Most of them are insured, yet many of them suffer from medical debt and its consequences. Many may pay health insurance premiums to purchase coverage that protects them from catastrophic expenses, but still leaves them vulnerable to debt from the accumulation of smaller and more frequent costs.

It is a legitimate function of state government, for both public health and economic reasons, to protect its citizens' health. The ability to afford health care directly affects access to care, which in turn affects health. A number of states recognize this function and have acted in various ways to facilitate access to affordable, adequate coverage. Kansas itself has taken an initial step in this policy direction. Further progress would benefit all Kansans who face the financial challenge of purchasing adequate coverage, including its farmers.



VII. Endnotes

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26 As described in State Coverage Initiatives, an initiative of The Robert Wood Johnson Foundation, <http://www.statecoverage.net/westvirginiaprofile.htm>.

27 As described in State Coverage Initiatives, <http://www.statecoverage.net/newyorkprofile.htm>.

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