



COST OF CARE LISTENING TOUR 2026

What Kansas Leaders Told Us About the Cost of Care

What we heard, question by question

Prepared for the Kansas Health Foundation

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Contents

Executive Summary	3
Key Takeaways	4
Methods	5
Who We Talked With	5
Question 1: Why Do Kansans Delay, Skip, or Stop Care Because of Cost?	6
Question 2: What Happens When People Avoid Care?	8
Question 3: If You Could Change One Thing, What Would It Be?	9
Question 4: Where Can KHF Add the Most Value, and Who Else Should Be Involved?	10
Question 5: What Else?	12
Cross-Cutting Themes	13
Limitations	14
Conclusion	14
Recommendations for the Next Listening Tour	15
Appendix A: How the Analysis Was Done	17
Appendix B: CoLoop's Results Next to the Final Numbers	18
Appendix C: Full Results	23
Appendix D: Category Definitions	26
Appendix E: More About Who We Talked With	29
Appendix F: Specific Ideas People Named	29
Appendix G: The Five Questions	30

Executive Summary

In July and August of 2026, Kansas Health Foundation staff, board members, and partners sat down with leaders across Kansas and asked five questions about the cost of care. This report shares what those leaders said.

There were 53 conversations with people from about 48 organizations: neighborhood groups, rural hospitals, clinics, advocacy organizations, funders, state agencies, and the Legislature. The Institute of Development (IOD) organized and analyzed all 53 write-ups. A second report compares what these leaders said with the 54 strategies that came out of the Partner Summit.

One limit up front. No one was interviewed specifically as a person who has skipped care. What we know about patients comes through the people who serve them and, in several conversations, the leaders' own experience.

Seven things we heard

- 1. Cost is a stack, not a price.** The bill is one layer. Getting there, missing work, and figuring out the system are the others. Most people named several at once.
- 2. Having insurance does not mean you can afford care.** About seven in ten conversations described Kansans who have coverage and still skip care because of deductibles and copays. Nearly as many described people with no coverage at all.
- 3. Nearly everyone sees the same ending.** Nine out of ten conversations described a manageable condition becoming a serious one. Most added that the care that follows costs more.
- 4. The most common fix is a person, not a program.** Navigators, community health workers, and patient advocates were proposed more often than anything else, followed by plain information about help that already exists, and then Medicaid expansion.
- 5. People want KHF to bring them together.** More than half asked KHF to convene partners who do not usually sit at the same table.
- 6. Leaders are not sure what KHF can do on policy.** One asked KHF to lobby, others asked it to influence legislation, and one said it cannot lobby. That confusion is worth clearing up.
- 7. Cost is not the only thing keeping people away.** Leaders who work with Native, Latino, and Black communities described providers who do not understand their patients' culture or language and, in two conversations, patients who were not believed.

Four terms used in this report

Term	What it means
Listening Tour	53 conversations about the cost of care, led by Kansas Health Foundation (KHF) staff, board members, and partners in 2026.
Partner Summit	The June 2026 gathering where 12 tables of partners produced 54 strategies for lowering the cost of care.
Blueprint	KHF's plan for lowering the cost of care. KHF's working timeline shows a release in spring 2027. The 54 strategies are a starting list that will help shape it.
FuseKS	KHF's annual gathering of community partners, advocates, funders, and policymakers. At FuseKS in April 2027, partners refine the draft of Cost of Care Blueprint priorities. The final Blueprint is released afterward.

Key Takeaways

These are IOD's takeaways for KHF's Cost of Care work. Each one is grounded in what people said.

1. **Treat navigators as a permanent part of the system and take on the question of who pays for them.** Leaders are already asking. What is missing is lasting payment that reaches community organizations as well as clinics.
2. **Talk about coverage and affordability together.** A message about coverage alone will lose leaders who see a second, equally large problem: people with insurance who still cannot afford to use it.
3. **Say plainly what KHF can and cannot do on policy.** Leaders hold different beliefs about it. A short, clear statement would help them plan their own roles.
4. **Convene with the people closest to the problem in the room, and recruit the sectors that were missing.** Hear directly from Kansans who have gone without care. Insurers and employers were named often as essential, and only one insurer and no large employers were part of these conversations.
5. **Fund in the form leaders asked for.** Flexible, multi-year, and where possible combined with other Kansas funders' dollars.
6. **Build the economic case.** Leaders want Kansas data showing what avoided care costs later. It is the argument they believe policymakers will hear.
7. **Look at what is not yet among the 54 Partner Summit strategies.** Transportation, mental health care, dental care, and payment for navigators came up again and again. Report 2 covers this.

Methods

The person who led each conversation wrote it up on KHF’s Listening Tour form. We worked from those 53 write-ups. They are summaries, not word-for-word transcripts.

We used **CoLoop**, an AI analysis tool for qualitative research, to sort what people said into categories IOD defined. CoLoop’s answers cite the passages they come from, so a person can check them. CoLoop states that it does not use customer data to train AI models.

We then checked CoLoop’s sorting again with IOD’s lead analyst, who sorted the same 53 conversations independently, and they agreed about 93 percent of the time. Every disagreement was checked against the original write-up. IOD’s lead analyst reviewed those flagged disagreements, set the rules for close calls, and approved the final numbers. Appendix A explains the process, and Appendix B shows CoLoop’s results next to the final numbers.

How to read the numbers

- A number such as “29 of 53” means 29 conversations raised that point somewhere.
- No one was handed a list to react to. A low number means few people brought it up. It does not mean few people agree.
- One rule matters throughout. We counted something as a **proposed solution** only when the person proposed it. Saying “Kansas has not expanded Medicaid” names a problem. Saying “Kansas should expand Medicaid” proposes a fix.
- Words in quotation marks come from the interviewers’ write-ups. They may be the note-taker’s wording. We describe people by their role and leave out names.

Who We Talked With

The conversations lean toward community organizations and rural hospitals. They tell us a great deal about patients, mostly through the people who serve them.

Type of organization	Conversations
Community organizations	21
Hospitals and health systems	10
Associations and advocacy organizations	5
Legislators	4
Safety-net and charitable care	3
Funders	3
State agencies and boards	2
Others: an insurer, a pharmacy, a private clinic, a mental health provider, a university	5

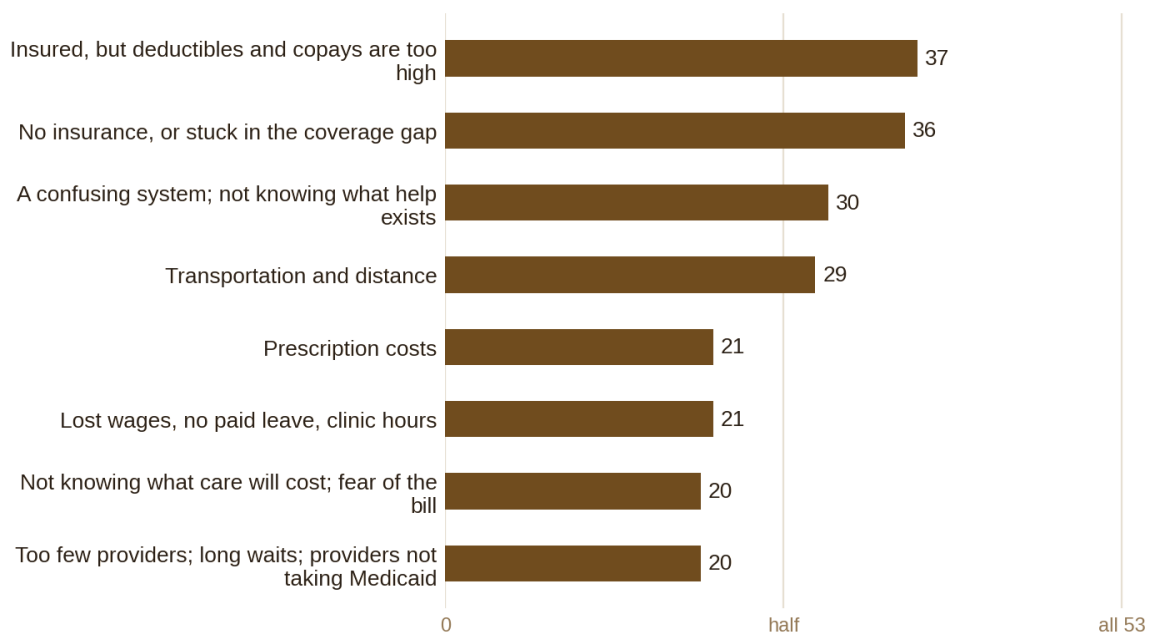
Twenty conversations were with leaders outside the metro areas, 18 were in Wichita, Topeka, or the Kansas City area, and 15 were with people in statewide roles. IOD assigned these labels from the write-ups.

Whose voice is missing

- **Kansans who have avoided care, speaking for themselves.** No one was interviewed in that role. Their experience reaches us through professionals describing their clients, their neighbors, and sometimes their own families.
- **Insurers and employers.** One commercial insurer took part. No one took part on behalf of the private companies that run Kansas Medicaid, a chamber of commerce, or a large employer.
- **Dentists, tribal governments, and school health staff.** Dental care came up in 15 conversations, and no dental provider was in the room.

Question 1: Why Do Kansans Delay, Skip, or Stop Care Because of Cost?

People described cost as a stack. The typical conversation named five different barriers.



Number of conversations, out of 53, that named each barrier. Top eight shown. Full list in Appendix C.

What we heard

- **Having insurance does not mean you can afford care.** People who are insured and still cannot afford care (underinsured) came up in 37 conversations. People with no insurance came up in 36. One clinician is quoted in the write-up as saying:

“People have insurance. The bigger problem is whether they can actually afford to use that insurance.”

A community leader described high-deductible plans as feeling “like not having insurance at all.”

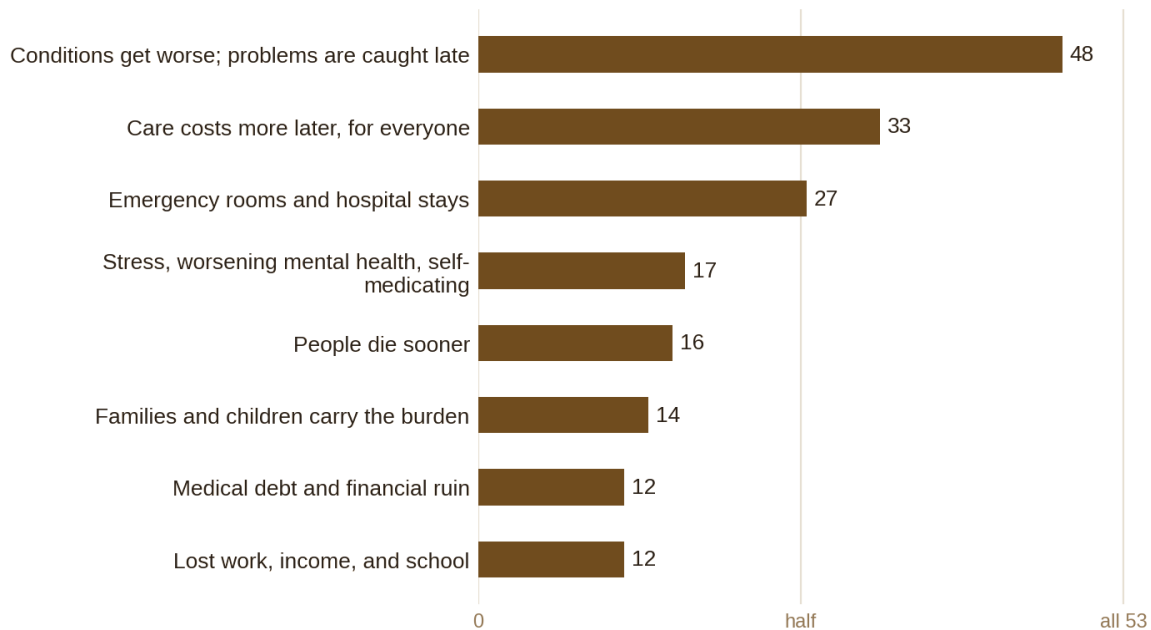
- **The missing middle.** At least 13 conversations described working people who earn too much to get help and too little to pay: a retiree whose copays and prescriptions can run about a third of a fixed monthly income, a small-business owner quoted \$1,200 a month for coverage.
- **Not knowing the price is its own barrier.** Twenty conversations described people staying away because they cannot find out what care will cost, or because they fear the bill. One foundation leader is quoted in the write-up as putting it in a patient’s words:

“They’re worried about what’s going to be the co-pay, what’s going to be my prescription cost, what’s going to be my cost for missing work.”

- **Distance turns into money.** Transportation came up in 29 conversations, and not only rural ones. More than half of the metro conversations raised it too. A 30-minute specialist visit can cost a day of wages plus gas, food, and sometimes a hotel.
- **The costs around the visit.** Lost wages (21 conversations), childcare and family demands (15), and having to choose food or rent first (14) work like a second copay.
- **Help exists, and people do not know it.** Thirty conversations described a system too confusing to navigate. One described a longtime resident who never learned that a local clinic serves Native patients at low or no cost.
- **Cost is not the only thing keeping people away.** Leaders who work with Native, Latino, and Black communities described providers who do not understand their patients’ culture or language and, in two conversations, patients who were not believed. Eleven conversations named distrust, racism, or language and cultural barriers.
- **Pride and fear sit under the numbers.** Eleven conversations named pride, stigma, a belief that care can wait, or fear of a diagnosis. One described farmers and working families turning down public coverage they qualify for. Another heard people call charity care something for those who “really need it.” Four conversations named fear of immigration enforcement, including families avoiding doctors for nearly two years.

Question 2: What Happens When People Avoid Care?

Nearly everyone, 48 of 53, said the same thing: conditions that could have been managed get worse, and the care that follows costs more.



Number of conversations, out of 53, that named each consequence. Top eight shown. Full list in Appendix C.

What we heard

- **People ration.** Dialysis once a week in place of three times. A month of pills stretched to two. Prescriptions shared between neighbors. Insulin rationed.
- **People self-medicate, and it is not safe.** One state-level leader described patients buying from fake online pharmacies and receiving the wrong medication, or pills laced with fentanyl. A community leader overheard a customer buying cigarettes say it was “cheaper than therapy.”
- **Rural communities get caught in a spiral.** People cannot afford or reach the local hospital, so fewer patients come; the hospital looks unneeded and closes, and care becomes even harder to access. One leader traced a closed hospital through to county ambulance costs and higher property taxes on small businesses.
- **Avoiding care gets passed down.** Children raised in homes that use care only in emergencies carry that habit into adulthood.
- **The weight lands on helpers too.** One organization added mental health support for its own navigators because of what they hear from patients every day.

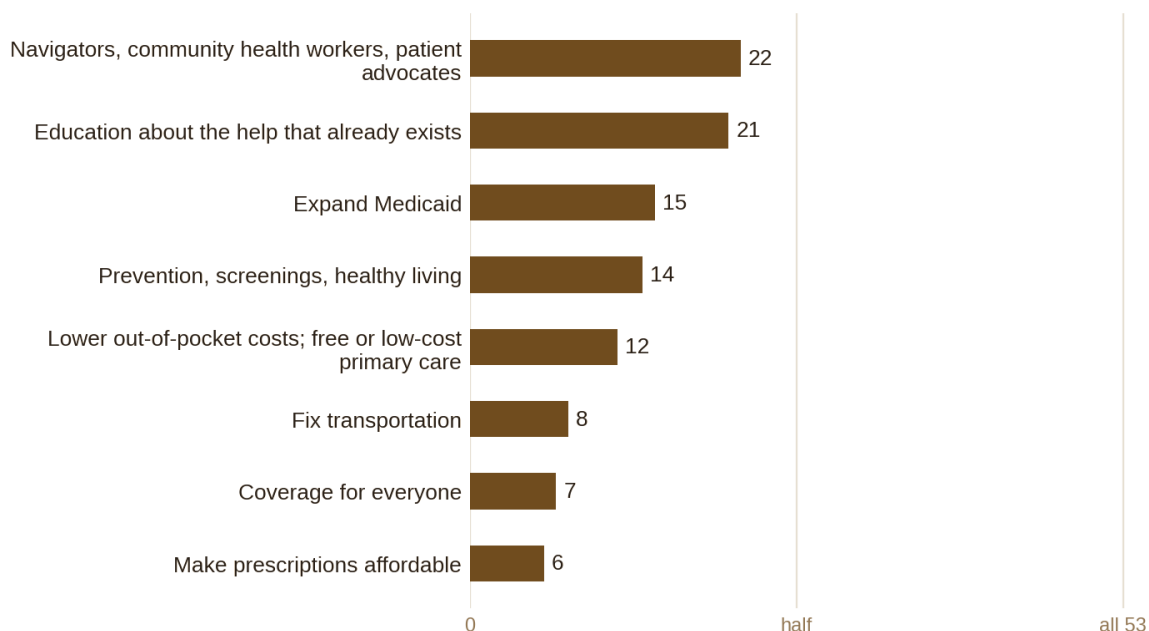
“Sometimes when you’re NOT sick is the most critical time to be getting care.”

One voice cut against the common account. One rural hospital leader said more insured than uninsured people are filling the local emergency room. Others tied emergency room use to being uninsured. Check this against hospital data before it goes further.

Question 3: If You Could Change One Thing, What Would It Be?

Two fixes led: a person to help people through the system, and coverage for more Kansans. Many people refused to pick just one. One called for “a CHORUS of solutions.”

The first direction is helping people get through the system we have: navigators and plain information. The second is changing who is covered: Medicaid expansion and coverage for everyone. Nineteen conversations proposed expansion, coverage for everyone, or both.



Number of conversations, out of 53, that proposed each idea. Top eight shown. Full list in Appendix C.

What we heard

- **Medicaid expansion has support and doubt side by side.** Fifteen conversations proposed it. One community leader called it the “lowest hanging fruit.” Another leader doubted it is still achievable. At least two supporters added that expansion will not fix things for people who are insured and still cannot afford care.
- **Every call we counted as universal coverage came from a community organization.** A safety-net leader and a state-level leader made related but narrower points.

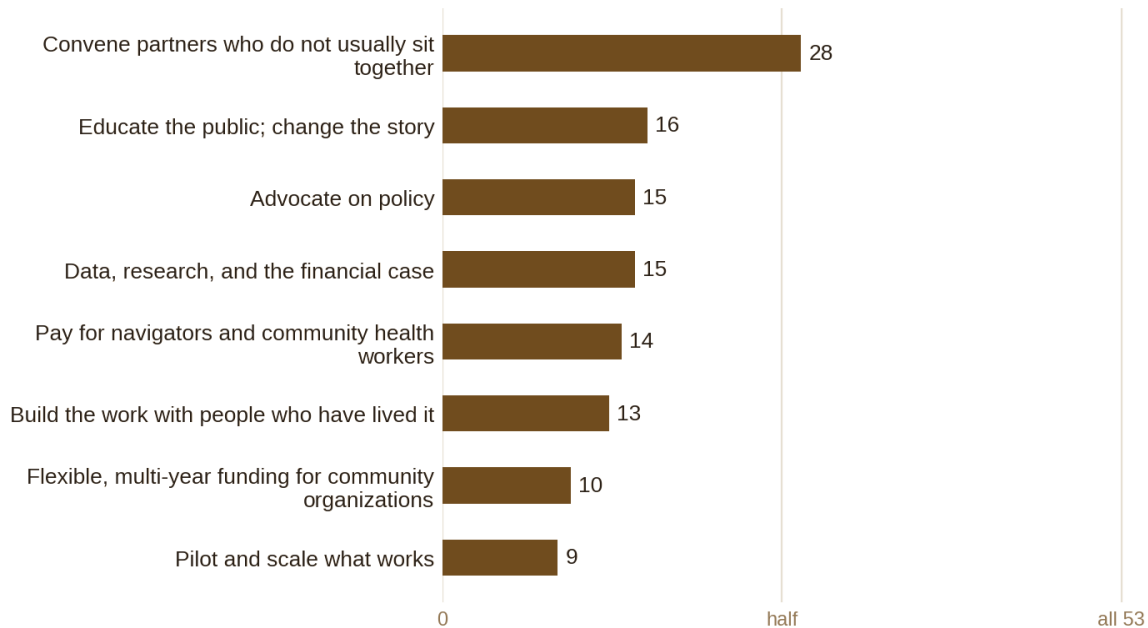
- **Not everyone believes education is the answer.** Twenty-one conversations proposed it, often as KHF's job. One leader pushed back: teach someone their insurance and "insurance will change again." The real question is whether to fix what people know or fix how complicated the system is.
- **"Navigator" and "community health worker" do not mean the same thing to everyone.** One leader is quoted in the write-up as saying, "A community health worker is not a navigator." Others use the titles interchangeably. Whichever term KHF uses, define it.
- **The sticking point for navigation is payment.** Leaders said community health worker time can be billed only in limited ways. They want payment to reach community organizations as well as clinics. One leader was frustrated that funders pay for a navigator for one year and stop.
- **Drug costs: widely felt, rarely solved.** Twenty-one conversations named prescription costs as a barrier. Only six proposed a fix, mostly help with paying. One proposed a price cap on a specific drug.

Appendix F lists the specific ideas people named, from a health plan owned by community health centers to telehealth across state lines.

Question 4: Where Can KHF Add the Most Value, and Who Else Should Be Involved?

The most common ask was for KHF to bring people together. Twenty-eight of 53 conversations said so.

Keep in mind who was asking. KHF staff, board members, and partners led these conversations, and some of the people answering are grantees.



Number of conversations, out of 53, that named each role for KHF. Top eight shown. Full list in Appendix C.

What we heard about KHF's role

- **People disagree about whether KHF can do policy.** One conversation said “Lobby for Medicaid expansion.” Another said KHF “should be influencing legislation.” A hospital leader said KHF is “unable to lobby” and that its example is “more influential than lobbying.” Another was unsure KHF can educate candidates “without being partisan.”
- **The sharpest policy point.** One community leader observed that the cost of care is more about policy than food or upward mobility was, and that Kansas is weakest at building lasting local capacity to move policy. The suggestion: make health an economic development issue so business sees its stake.
- **How KHF funds matters as much as how much.** Unrestricted, local, and patient. “Foundations need to trust the people to do the work.” One leader said the loss of KHF’s small capacity-building grants is felt.
- **Pooled funding has a Kansas precedent.** One leader recalled funders sharing one application and pooled dollars for dental hubs around 2010 and asked what the Cost of Care version would be.
- **Support for the fellows model comes with a caution.** Seven conversations endorsed KHF’s fellows program or the Kansas Leadership Center’s approach to developing local leaders. One warned that a new issue and a new cohort every year strains partners and rewards activity over impact.
- **“Here is the Blueprint, now what?”** One leader asked that question and wants KHF to measure what partners achieve together.

- **Some feedback was harder to hear.** One leader said KHF’s language is built for the educated and its events are not comfortable for ordinary people. One long-time clinician did not know what KHF offers until a grant made the connection and now sees KHF as a hub.

Who else should be involved

Who	Conversations (of 53)
Providers, hospitals, clinics, community health centers	28
People with lived experience	24
Grassroots and culturally specific organizations	21
Legislators and local government	14
Insurers and managed care companies	12
Schools, colleges, and young people	12
Employers and small business	11
State agencies and health departments; other funders; community health workers and doulas	8 each
Faith leaders; mental health organizations; transportation, housing, childcare, and food organizations	5 each

The people closest to the problem. Twenty-four conversations named people with lived experience among those who must be involved. Thirteen went further and asked KHF to build the work with them. The same was said of frontline staff. One foundation leader is quoted in the write-up as saying of them:

“And see them as experts. And be partners in building things together and not just telling them this is how it needs to be done.”

Question 5: What Else?

Given an open floor, people raised mental health, the basics underneath cost, and direct advice for KHF. Forty-one conversations included a closing comment.

- **Mental health.** It came up in at least 24 conversations overall, sometimes unprompted at the end: too few mental health resources in southwest Kansas, and the need for crisis lines that fit Native communities.
- **What sits underneath cost.** Housing, transportation, and food as central to health costs. Whether Kansas is a place young people can thrive. Social connection and civic health.
- **Advice for KHF, offered under Questions 4 and 5.** Ask the community before building programs. Bring legislators to work beside providers for a day. Include people with lived

experience as full members. And from one leader: “Don’t overanalyze. Start somewhere. Do something.”

Stories from the conversations

Story, as written up	What it shows
“I feel like Kansas keeps telling neighborhoods like mine to go die slowly.”	What disinvestment feels like from inside a neighborhood
A patient reached a donated-care program with stage 4 cancer. Flexible funds paid for the ambulance that took her home to die with family.	Where avoided preventive care ends, and what flexible money can do
A young woman learned Kansas Medicaid would cover her only if she were pregnant, a single parent, or disabled: “So the state of Kansas wants me knocked up and to have a baby.”	Eligibility rules, in a client’s words
A man pressed his medical alert button, then refused the ambulance because he did not want to pay for the ride.	Fear of the bill overriding an emergency
A husband with diabetes stayed on his medication after six months with a navigator, and still does nearly 10 years later.	What a navigator changes
A food pantry saves families \$600 to \$700 a month, money that can then go toward insurance.	Help with basics is also help with health costs
Before a neighborhood organization added a nurse, about 10 people a week needed emergency care. Ambulance calls then fell.	Care close to home prevents emergencies
A low-cost exercise class resolved a woman’s pain, and her surgery was cancelled.	Low-cost prevention avoiding high-cost care

Cross-Cutting Themes

Three points did not fit under any one question, and KHF should not lose them.

1. **Trust is built locally and slowly.** Twenty-one conversations asked KHF to work with grassroots and culturally specific organizations. Two conversations put it at 70 or more positive contacts before someone accepts help.
2. **Some believe the system is complicated on purpose.** A smaller group argued that complexity pays: “privatized gains and socialized losses,” and “our healthcare system works exactly as it was designed, to make money.”
3. **Rural systems are fragile, and rural voices are not all aligned.** Hospital-sector leaders want KHF to use the Rural Health Transformation Program, a new federal fund for rural health care. One leader said that money “is going to hospitals” with a different model.

Location mattered in one visible way. Leaders in statewide roles talked about how coverage is designed and regulated. Local leaders talked about getting one person through the door. Appendix C has the numbers by location.

How this connects to the measures KHF tracks

KHF tracks Kansas's health using America's Health Rankings. Here is where those measures touch what we heard.

What we heard	Related America's Health Rankings measures
Coverage and affordability	Uninsured; Avoided Care Due to Cost. The Uninsured measure misses people who are insured and still cannot afford care. Avoided Care Due to Cost captures them.
Navigators and community health workers	Dedicated Health Care Provider; Primary Care Providers
Avoided care costs more later	Preventable Hospitalizations; Premature Death
Mental health	Frequent Mental Distress; Mental Health Providers
Dental care	Dental Visit; Dental Providers
What sits underneath cost	Food Insecurity; Severe Housing Problems

Limitations

- **These are write-ups, not transcripts.** Each one reflects what the interviewer heard, remembered, and chose to enter. Most conversations were not recorded. About a quarter of the write-ups (14 of 53) appear to have been drafted with a recorder or an AI note-taking tool.
- **The write-ups are uneven.** Some are a few lines, and some run several pages. Longer write-ups naturally show more themes.
- **These leaders were invited.** They are people KHF and its partners know, so they do not represent all of Kansas. No one was interviewed as a person who has avoided care.
- **People were talking to KHF.** Staff, board members, and partners led the conversations, and some of the people answering are grantees.
- **Counts show what came up, not how many agree.** No one was asked about each theme.
- **Figures that people quoted in conversation were not checked.**
- **AI tools did part of the sorting.** CoLoop's results cite their source text, IOD's lead analyst sorted every conversation independently, every disagreement was checked against the write-up, and IOD made the final calls. AI tools can share blind spots, which is why the human sort matters.

Conclusion

Across 53 conversations, Kansas leaders described the same problem from many directions. The cost of care is a stack of costs: the premium, the deductible, the prescription, the ride, the lost day of work. About seven in ten conversations described people who have insurance and still cannot afford to use it. Nine in ten described manageable conditions becoming serious ones.

Leaders were just as clear about what helps:

- A person to walk with families through the system.
- Plain information about help that already exists.
- Coverage that reaches more Kansans.
- Care that comes before the crisis.

More than half asked KHF to bring people together. Nearly half named people with lived experience as voices who need to be involved.

One caution goes with these findings. They reflect what leaders told KHF staff, board members, and partners, as written up afterward. They are a strong read on what leaders see. They do not replace hearing directly from Kansans who have gone without care.

Recommendations for the Next Listening Tour

These are about how the listening was done, not what was heard. They apply to any future listening tour.

1. **Have an independent partner conduct the interviews or train the interviewers.** People can answer a funder differently than they answer a neutral party, especially when the question is what the funder should do. If KHF keeps staff, board members, and partners as interviewers because of the relationships it builds, give them a short training on staying neutral, asking follow-up questions, and taking notes.
2. **Have the questions and the form designed by someone trained in interview design and test them first.** Most of the form worked. A few things did not.
 - Question 4 asks two questions in one.
 - Question 3 asks for one thing, and many leaders said there is no one thing.
 - The Key Quote field was filled in 2 of 53 times.
 - A character limit cut at least one answer short.
 - The file we received did not show who led each conversation, when, or in what format.

A pilot with three to five people would catch issues like these.

3. **Record every conversation, with permission.** Most conversations in this round were not recorded. The write-ups vary widely in length and detail, so a topic missing from a write-up may still have been raised in the room. Recordings and transcripts make quotations exact and counts firmer. Where someone declines, use a standard note-taking form.
4. **Add two or three focus groups with people who have lived the issue.** No one in this round was interviewed as a Kansan who has skipped care. Focus groups would test whether leaders' descriptions match daily experience, surface what leaders cannot see, and show which themes cut across communities. Hold them with trusted community organizations, pay people for their time, and offer language access.
5. **Decide up front who needs to be heard, and recruit to that list.** Leaders named insurers in 12 conversations and employers in 11 as people who need to be involved. One

commercial insurer took part. No large employer, chamber of commerce, or Medicaid managed care company did.

6. **Settle consent during the conversation.** Settle three things before the conversation ends: whether the person's words can be quoted, whether their story can be shared, and how they want to be described.

Appendix A: How the Analysis Was Done

The approach

KHF asked for a content analysis. That means sorting what people said into defined categories and counting how many conversations fall into each. IOD built the categories from the conversations themselves, then wrote a definition for each one (Appendix D).

About CoLoop

CoLoop (coloop.ai) describes itself as “an AI analysis tool for qualitative research.” It is made by Genie Technology Limited, which lists a London address. Its main feature is the analysis grid: a table where each row is a participant and each column is a question you ask of the material. A column can return a written summary, direct quotes, a yes or no, or a set of categories you define. CoLoop’s documentation says every generated answer is cited. The company states that customer data is never used to train AI models and that it has SOC 2 Type 1 and Type 2 reports.

What we did, step by step

1. **Getting to know the data.** The first step was reading. We read every write-up in full and every answer to all five questions. We did this before building any categories and before any software touched the data. During this read, we did four additional things:
 - We cleaned files.
 - We mapped what we had: who was interviewed, from what kind of organization, in what part of the state, and how complete each write-up was.
 - We noted the limits. The write-ups are interviewers’ summaries, not word-for-word transcripts. Some were drafted with AI note-taking tools, some were cut short, some covered group conversation instead of one person, and some participants had also attended the Partner Summit. Each of these affects how much weight a number can carry, so we named them up front.
 - We looked for what kept coming up. The list of categories and their definitions was built from what people said in these conversations, in language close to their own.
2. **Prepared the material.** We repaired damaged characters in the export and loaded one file per conversation into CoLoop. Participants were identified by code (P01 to P53). The interviewer’s own reflections (the key story and key themes notes) were labeled as interviewer context. All of the text is the interviewer’s summary of what the person said.
3. **Let CoLoop find its own themes.** Before it saw IOD’s categories, CoLoop produced its own themes for each question. Appendix B shows all 23. The leading themes match ours, with one exception under Question 4.
4. **Had CoLoop sort every conversation into IOD’s categories,** using the written definitions in Appendix D, plus two yes-or-no checks on Medicaid expansion and navigators.

5. **Checked the sorting.** IOD’s lead analyst sorted the same 53 conversations independently and agreed with CoLoop about 93 percent of the time. Every disagreement was checked against the original write-up, with the supporting wording recorded.
6. **Made the final calls.** IOD’s lead analyst reviewed the flagged disagreements, set the rules below, and approved the final numbers. Where the text was too unclear to call, the category was not applied.

Rules we applied

- A solution, a role for KHF, or a strategy counts only when the person proposes or endorses it. Naming the problem does not count.
- A list of who should be involved is not the same as asking KHF to convene. The write-up has to say KHF should bring people together.
- Naming people with lived experience as who to involve is counted under “who else should be involved.” It counts as a role for KHF only when the person asks KHF to build or decide the work with them.
- Policy advocacy counts as a role for KHF only when the person asks KHF to advocate or influence.
- Skipped, rationed, shared, or stopped medication all count as medication rationing.
- Adults putting their children’s care ahead of their own counts under family demands.

Where CoLoop needed correcting

CoLoop was most reliable on consequences. It needed correction in two main ways. It counted a list of who to involve as a request to convene (42 conversations before review, 28 after). And it tended to miss barriers, solutions, and KHF roles that people raised outside the question where you would expect them, for example, a proposal for navigators made under Question 4. Appendix B shows every category side by side.

Appendix B: CoLoop’s Results Next to the Final Numbers

CoLoop’s own 23 themes, before it saw IOD’s categories

Question	CoLoop’s theme	CoLoop count	Closest IOD category	Final count
1	High Direct Costs	46	Insured, but costs too high (CoLoop’s theme is broader and includes drug costs and bills)	37
1	Lack of Insurance	33	No insurance or coverage gap	36
1	System Complexity and Confusion	28	A confusing system	30
1	Transportation and Distance Barriers	28	Transportation and distance	29

Question	CoLoop's theme	CoLoop count	Closest IOD category	Final count
1	Time and Work Constraints	23	Lost wages, no paid leave	21
1	Provider Shortages	20	Too few providers	20
1	Lack of Resource Awareness	13	Part of "a confusing system" in IOD's list	30
1	Fear and Stigma	9	Pride, stigma, fear of a diagnosis	11
2	Delayed Diagnosis and Worsened Health	48	Conditions get worse	48
2	Increased Emergency Room Reliance	22	Emergency rooms and hospital stays	27
2	Financial Strain and Medical Debt	19	Medical debt (CoLoop's theme is broader)	12
2	Interconnected Physical and Mental Decline	14	Stress, worsening mental health	17
2	Systemic Costs and Higher Premiums	7	Care costs more later (CoLoop's theme is narrower)	33
3	Expand Medicaid	14	Expand Medicaid	15
3	Universal Healthcare or Coverage for All	10	Coverage for everyone	7
3	Increase Health Education and System Navigation	19	Education about existing help	21
3	Scale Community Health Workers and Neighborhood Infrastructure	12	Navigators, community health workers	22
3	Mobile and Accessible Care Delivery	5	Bring care to people	5
4	Convene diverse stakeholders	44	Convene partners	28
4	Support navigation models	20	Pay for navigators	14
4	Fund community organizations	12	Flexible funding for community organizations	10
4	Expand insurance coverage	25	No direct match. CoLoop treated a solution as a role for KHF. Closest: advocate on policy	15
4	Support workforce and telehealth	7	Invest in workforce and rural health	5

CoLoop's themes for who should be involved

CoLoop's theme	Conversations
Care providers and navigation staff	21
Grassroots and local anchors	21
Employers and cross-sector systems	15
Public officials and state agencies	14
Funders, conveners, and coalitions	14
People directly affected by access barriers	13
Culturally specific and regional communities	6

Every category: CoLoop's count and the final count

The final count is the number used in this report. Where the two differ by three or more, the last column says why.

Barriers

Category	CoLoop	Final	Why they differ
Insured, but deductibles and copays are too high	35	37	
No insurance, or stuck in the coverage gap	32	36	Brief mentions missed at first and found in final review
A confusing system; not knowing what help exists	24	30	CoLoop missed barriers named outside Question 1
Transportation and distance	28	29	
Prescription costs	19	21	
Lost wages, no paid leave, clinic hours	21	21	
Not knowing what care will cost; fear of the bill	20	20	
Too few providers; long waits; providers not taking Medicaid	18	20	
Childcare and family demands	17	15	
Choosing food, rent, or utilities over care	12	14	
Insurance denials and prior authorization	11	14	CoLoop missed barriers named outside Question 1
Distrust, racism, language and cultural barriers	8	11	CoLoop missed barriers named outside Question 1
Pride, stigma, "I can wait," fear of a diagnosis	10	11	
Dental, vision, or specialty care out of reach	8	11	CoLoop missed brief mentions
Gaps in mental health and addiction care	6	8	

Category	CoLoop	Final	Why they differ
Fear of immigration enforcement	2	4	

Consequences

Category	CoLoop	Final	Why they differ
Conditions get worse; problems are caught late	47	48	
Care costs more later, for everyone	31	33	
Emergency rooms and hospital stays	27	27	
Stress, worsening mental health, self-medicating	15	17	
People die sooner	13	16	CoLoop missed brief mentions
Families and children carry the burden	16	14	
Medical debt and financial ruin	11	12	
Lost work, income, and school	12	12	
Strain on hospitals, clinics, and rural economies	12	12	
Rationing, sharing, or stopping medication	11	11	
People lose trust and give up on the system	5	5	
Housing loss or jail	4	5	

Proposed solutions

Category	CoLoop	Final	Why they differ
Navigators, community health workers, patient advocates	15	22	CoLoop missed proposals made outside Question 3
Education about the help that already exists	14	21	CoLoop missed proposals made outside Question 3
Expand Medicaid	14	15	
Prevention, screenings, healthy living	17	14	CoLoop counted prevention named as a value, not proposed
Lower out-of-pocket costs; free or low-cost primary care	12	12	
Fix transportation	4	8	CoLoop missed proposals made outside Question 3
Coverage for everyone	7	7	

Category	CoLoop	Final	Why they differ
Make prescriptions affordable	3	6	CoLoop missed proposals made outside Question 3
Rein in insurers: denials, networks, prior authorization	6	6	
Less paperwork; shared records and data	6	6	
New models: direct primary care, memberships, clinic-owned plans	5	6	
Clear prices up front	4	5	
Bring care to people: mobile, school, pop-up	5	5	
Grow community health centers and free clinics	5	5	
Recruit, keep, and pay the health workforce	6	5	
Housing, food, childcare, paid leave	3	5	
Medical debt relief and charity care	4	4	
Local partners working as one	3	4	
Take the profit motive out	3	3	
Telehealth across state lines	2	2	
More insurance options and competition	2	1	

KHF role

Category	CoLoop	Final	Why they differ
Convene partners who do not usually sit together	42	28	CoLoop counted lists of who to involve as convening
Educate the public; change the story	16	16	
Advocate on policy	15	15	
Data, research, and the financial case	13	15	
Pay for navigators and community health workers	12	14	
Build the work with people who have lived it	19	13	CoLoop counted naming people with lived experience as a role for KHF
Flexible, multi-year funding for community organizations	6	10	CoLoop missed funding requests stated briefly
Pilot and scale what works	9	9	
Develop leaders; the fellows model	6	7	

Category	CoLoop	Final	Why they differ
Invest in workforce and rural health	4	5	
Align and pool funding with other funders	2	4	
Focus on equity and disparities	6	4	
Stay for the long haul; measure shared impact	1	3	

Appendix C: Full Results

Barriers (Question 1)

Category	Conversations (of 53)	Share
Insured, but deductibles and copays are too high	37	70%
No insurance, or stuck in the coverage gap	36	68%
A confusing system; not knowing what help exists	30	57%
Transportation and distance	29	55%
Prescription costs	21	40%
Lost wages, no paid leave, clinic hours	21	40%
Not knowing what care will cost; fear of the bill	20	38%
Too few providers; long waits; providers not taking Medicaid	20	38%
Childcare and family demands	15	28%
Choosing food, rent, or utilities over care	14	26%
Insurance denials and prior authorization	14	26%
Distrust, racism, language and cultural barriers	11	21%
Pride, stigma, "I can wait," fear of a diagnosis	11	21%
Dental, vision, or specialty care out of reach	11	21%
Gaps in mental health and addiction care	8	15%
Fear of immigration enforcement	4	8%

Consequences (Question 2)

Category	Conversations (of 53)	Share
Conditions get worse; problems are caught late	48	91%
Care costs more later, for everyone	33	62%
Emergency rooms and hospital stays	27	51%

Category	Conversations (of 53)	Share
Stress, worsening mental health, self-medicating	17	32%
People die sooner	16	30%
Families and children carry the burden	14	26%
Medical debt and financial ruin	12	23%
Lost work, income, and school	12	23%
Strain on hospitals, clinics, and rural economies	12	23%
Rationing, sharing, or stopping medication	11	21%
People lose trust and give up on the system	5	9%
Housing loss or jail	5	9%

Proposed solutions (Question 3)

Category	Conversations (of 53)	Share
Navigators, community health workers, patient advocates	22	42%
Education about the help that already exists	21	40%
Expand Medicaid	15	28%
Prevention, screenings, healthy living	14	26%
Lower out-of-pocket costs; free or low-cost primary care	12	23%
Fix transportation	8	15%
Coverage for everyone	7	13%
Make prescriptions affordable	6	11%
Rein in insurers: denials, networks, prior authorization	6	11%
Less paperwork; shared records and data	6	11%
New models: direct primary care, memberships, clinic-owned plans	6	11%
Clear prices up front	5	9%
Bring care to people: mobile, school, pop-up	5	9%
Grow community health centers and free clinics	5	9%
Recruit, keep, and pay the health workforce	5	9%
Housing, food, childcare, paid leave	5	9%
Medical debt relief and charity care	4	8%
Local partners working as one	4	8%
Take the profit motive out	3	6%
Telehealth across state lines	2	4%

Category	Conversations (of 53)	Share
More insurance options and competition	1	2%

KHF role (Question 4)

Category	Conversations (of 53)	Share
Convene partners who do not usually sit together	28	53%
Educate the public; change the story	16	30%
Advocate on policy	15	28%
Data, research, and the financial case	15	28%
Pay for navigators and community health workers	14	26%
Build the work with people who have lived it	13	25%
Flexible, multi-year funding for community organizations	10	19%
Pilot and scale what works	9	17%
Develop leaders; the fellows model	7	13%
Invest in workforce and rural health	5	9%
Align and pool funding with other funders	4	8%
Focus on equity and disparities	4	8%
Stay for the long haul; measure shared impact	3	6%

By location

These groups are small. Read the differences as questions to ask, not conclusions.

	Metro (18)	Outside metro (20)	Statewide role (15)
Named being underinsured as a barrier	16	10	11
Named transportation as a barrier	10	11	8
Proposed Medicaid expansion	7	4	4
Proposed navigators or community health workers	9	10	3
Asked KHF to pay for navigation	7	6	1
Named insurance denials or prior authorization as a barrier	3	4	7
Proposed reining in insurers	0	1	5

Appendix D: Category Definitions

Barriers (Question 1)

Category	Counted when the write-up names or proposes...
No insurance, or stuck in the coverage gap	No insurance, no Medicaid expansion, or earning too much for Medicaid and too little for private coverage.
Insured, but deductibles and copays are too high	Premiums, deductibles, copays, or out-of-pocket costs make insurance too expensive to use.
Prescription costs	The price of drugs leads people to ration, skip, or abandon prescriptions.
Not knowing what care will cost; fear of the bill	People cannot learn the price in advance, fear a surprise bill or several bills, or cannot predict the cost.
A confusing system; not knowing what help exists	Confusing paperwork, low insurance literacy, difficulty navigating the system, or not knowing what help exists.
Transportation and distance	Distance, travel expense, or no reliable transportation to reach care.
Lost wages, no paid leave, clinic hours	Cannot take time off, lose pay for appointments, or clinic hours conflict with work.
Childcare and family demands	Childcare, caregiving, or putting family members' needs first.
Too few providers; long waits; providers not taking Medicaid	Long waits, too few providers, thin networks, or providers who do not take Medicaid or Medicare.
Choosing food, rent, or utilities over care	Choosing rent, food, utilities, or other basic needs over care.
Distrust, racism, language and cultural barriers	Distrust of the health system, discrimination, lack of culturally or linguistically appropriate care, or language barriers.
Fear of immigration enforcement	Avoiding care or coverage out of fear of immigration enforcement.
Pride, stigma, "I can wait," fear of a diagnosis	Pride, stigma about public programs or asking for help, a belief that care can wait, or fear of a diagnosis.
Insurance denials and prior authorization	Insurer prior authorization, claim denials, step therapy, or other payer-imposed hurdles.
Dental, vision, or specialty care out of reach	Dental, vision, or specialty care that is not covered or is out of reach.
Gaps in mental health and addiction care	Mental health or substance use care that is not covered, unavailable, or avoided because of stigma.

Consequences (Question 2)

Category	Counted when the write-up names or proposes...
Conditions get worse; problems are caught late	Untreated or delayed care leads to worse conditions, later diagnosis, or preventable complications.

Category	Counted when the write-up names or proposes...
Emergency rooms and hospital stays	People end up in the emergency room, in crisis care, or hospitalized.
Care costs more later, for everyone	Avoided care costs more later, for the person, providers, payers, or the system.
People die sooner	Death, preventable death, or shortened life.
Medical debt and financial ruin	Medical debt, collections, bankruptcy, or household financial instability.
Lost work, income, and school	Lost jobs, lost income, reduced productivity, or missed school.
Stress, worsening mental health, self-medicating	Stress, worsening mental health, self-medication, or substance use.
Families and children carry the burden	Burden on family or caregivers, effects on children, or avoidance becoming a family norm.
Rationing, sharing, or stopping medication	People ration, split, share, or stop medication.
Strain on hospitals, clinics, and rural economies	Uncompensated care, strain on hospitals or clinics, rural closures, or harm to the local economy.
People lose trust and give up on the system	People lose trust in, or disengage from, the health system.
Housing loss or jail	Homelessness, housing instability, jail, or other criminal-legal involvement.

Proposed solutions (Question 3)

Category	Counted when the write-up names or proposes...
Expand Medicaid	Expanding Medicaid (KanCare) in Kansas. Noting that Kansas has not expanded does not count.
Coverage for everyone	Universal or single-payer coverage, health care for all, Medicare for all, or a lower Medicare age.
Lower out-of-pocket costs; free or low-cost primary care	Capping or lowering deductibles, copays, or premiums, or making primary and preventive care free or low cost.
Clear prices up front	Up-front prices, cost estimates, simpler billing, or other ways to make costs predictable.
Navigators, community health workers, patient advocates	Navigators, community health workers, patient advocates, case managers, or care coordination.
Education about the help that already exists	Educating people about existing resources, how insurance works, or how to advocate for themselves.
Bring care to people: mobile, school, pop-up	Mobile units, pop-up or school-based care, health fairs, or other ways of taking care to people.
Grow community health centers and free clinics	Growing or funding community health centers, free or low-cost clinics, or donated-care programs.

Category	Counted when the write-up names or proposes...
Recruit, keep, and pay the health workforce	Recruiting and retaining providers, residencies, top-of-license practice, care extenders, or higher reimbursement.
Make prescriptions affordable	Lower drug prices, caps such as on insulin, or other prescription affordability measures.
Rein in insurers: denials, networks, prior authorization	Regulating insurers or managed care: prior authorization reform, network adequacy, parity, oversight.
Less paperwork; shared records and data	Simpler paperwork and enrollment, shared records, or person-level data systems.
New models: direct primary care, memberships, clinic-owned plans	Direct primary care, membership or voucher models, a clinic-owned plan, employer direct contracting, or value-based payment.
Telehealth across state lines	Telehealth, virtual care, or cross-state licensure.
Fix transportation	Rides, transportation funding or services, or other ways to solve getting to care.
Housing, food, childcare, paid leave	Housing, food, childcare, paid leave, or other supports for social drivers of health.
Medical debt relief and charity care	Medical debt relief, charity-care standards, a fallback cost-relief fund, or standardized sliding fee scales.
Take the profit motive out	Removing or limiting profit in health care, insurance, or pharmaceuticals.
Prevention, screenings, healthy living	Prevention, screenings, healthy living, public health, or holistic care.
Local partners working as one	Local coalitions or cross-sector coordination as the way to reduce cost barriers.
More insurance options and competition	More insurance options, more carriers, or more market competition.

KHF role (Question 4)

Category	Counted when the write-up names or proposes...
Convene partners who do not usually sit together	Bring organizations, sectors, or leaders together, including unlikely partners. A list of who to engage does not count by itself.
Flexible, multi-year funding for community organizations	Fund community organizations, especially flexible, unrestricted, multi-year, or capacity-building grants.
Pay for navigators and community health workers	Fund, sustain, or build payment mechanisms for community health workers, navigators, or similar roles.
Advocate on policy	Advocate on policy, influence legislators, or use its voice and standing with lawmakers.
Educate the public; change the story	Run or fund public education, awareness campaigns, narrative change, or storytelling.

Category	Counted when the write-up names or proposes...
Data, research, and the financial case	Produce or fund data, research, the financial case, needs assessment, or resource mapping.
Pilot and scale what works	Pilot, test, evaluate, or scale promising models or programs.
Align and pool funding with other funders	Align with other funders or create pooled funding.
Develop leaders; the fellows model	Develop leaders, run a fellows cohort, or use a Kansas Leadership Center style model.
Build the work with people who have lived it	Involve people with lived experience or specific communities in designing the work.
Stay for the long haul; measure shared impact	Take a long-term stewardship role, measure collective impact, or mind the pace of the work.
Invest in workforce and rural health	Invest in the health workforce or rural health, including the Rural Health Transformation Program.
Focus on equity and disparities	Focus the work on equity, disparities, or specific groups such as women or communities of color.

Appendix E: More About Who We Talked With

- Three write-ups cover conversations with two or more people.
- Three write-ups from one rural health center may come from a shared conversation.
- Four organizations or health systems account for nine of the 53 conversations, so about 48 organizations are represented.
- At least four of the people we talked with also took part in the June Partner Summit.
- In one conversation, the discussion covered KHF's process more than the five questions.
- KHF's form also collects the interviewer, date, method, and interview category. Those fields were not in the export IOD received, so we could not look at differences by interviewer.

Appendix F: Specific Ideas People Named

Idea	Offered by
A health plan owned by community health centers, for people who lost coverage	Safety-net leader
A need-based fallback modeled on utility shut-off protections	State-level leader
A low-cost membership or voucher for primary care visits	Community organization
Direct primary care networks, with labs and imaging at cost	Clinician
Help for hospitals to contract directly with self-insured employers	Hospital leader
A single, publicly sponsored electronic medical record	Health system leader

Idea	Offered by
County-level care collaboratives for prenatal through postpartum care	Community organization
A person-level data system shared across agencies	Community organization
Telehealth licensing across state lines for border communities	Community organization
A price cap on a specific drug, and prior authorization reform	Policymaker
Caps on deductibles and copays, and paid sick leave	Policymaker
Medicaid coverage for vaccines given at pharmacies	Health care provider
Letting every type of provider practice to the full extent of their training, and centralized credentialing	Association leader
More residency slots, and a statewide tool for assessing rural recruitment	Health system leaders
A care team with a social worker, patient advocate, and caregiver support	Community organization

Appendix G: The Five Questions

For Question 5, two boxes held no comment from the participant (one pointed to another section, and one was the interviewer's own note), so they are not counted.

Listening Tour question	Conversations with an answer
1. From your perspective, what are the most common reasons Kansans delay, skip, or stop getting health care because of cost?	52
2. What are the biggest consequences when people avoid care because of cost?	51
3. If you could change one thing to reduce the cost of care, what would it be and why?	53
4. If KHF chooses to mobilize around this issue, where could KHF add the greatest value? Who else should be engaged in this work?	52
5. Additional comments or insights you'd like us to consider?	41