ED.04 - K-12 Benefit Program Consolidation

with the goals of federal grant programs and interest areas among foundations with a focus on public education.

- Identify qualified grant writers.
- Host a workshop with key grants management personnel to discuss best practices and approaches utilized in other states. Maryland and Minnesota have reorganized and centralized grants management in recent years using this type of workshop approach.

Recommendation #3 – Pursue Cost Savings Opportunities through Centralization and Shared Services Agreements

Centralizing IT functions can improve standardization, improve internal communication, facilitate best practice sharing, and reduce duplication of effort. Development and implementation of a support system for centralized IT personnel can help ensure that agencies are able to access timely technical support. Coordinating similar functions across state agencies can also reduce duplication of effort and improve the quality and efficiency of service provided to constituents. In addition, it can facilitate the creation of policies, programs and guidelines that integrate the perspectives of both agencies.

- Shift a portion of the IT positions currently housed within the KSDE to a centralized IT Division.
- Identify additional opportunities where costs for FTEs that focus on data collection can be shared across state agencies.

Background and Findings

- The IT Department represents nearly 25% of KSDE's personnel costs.
- Many of these positions are "split-funded" across state and federal sources. Redeployment of resources should be done to maximize utility of non-state funded sources.
- The KSDE IT staff created a series of customized applications to collect program data and comply with federal reporting requirements.
- KSDE IT staff supports internal KSDE employees and approximately 40,000 external school district staff and partner users across more than 100 web-based applications.
- Descriptions of the roles and responsibilities for different departments within the KSDE include similar functions related to data collection and reporting.

Recommendation #3 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$500	$500	$500	$500	$500

Key Assumptions

- The custom-developed IT applications can be combined or integrated so that all required data collection activities take place.

Critical Steps to Implement

- Conduct in-depth analysis of the IT Department functions as well as the roles and responsibilities of each IT staff member and the applications they manage.
- Explore alternative staffing models drawing on practices used by other states.
- Explore alternative data collection applications to consolidate the current data collection processes.

Recommendation #4 – K-12 Benefit Program Consolidation

- Currently, K-12 school districts have the opportunity to participate in the State Employee Health Plan (SEHP), though few of the 286 districts are participating because of the current state contribution structure.
- Due to the current purchasing and administration structure, there is significant opportunity for cost savings and efficiency through the development of a consolidated health insurance plan for K-12 district employees and their dependents. This consolidated program will provide greater plan choice offerings and improved contribution structure for members, while reducing the administrative cost and burden of providing healthcare across the districts. The State Employ-

ee Health Plan currently covers approximately 44,000 members and their dependents. The K-12 employee base is significantly larger, with approximately 69,000 full-time employees.

- Statewide Health Program for K-12 School Districts – The State should consolidate the health plans offered by K-12 school districts to reduce costs, increase administrative efficiencies, and standardize offerings to attract and retain Kansas State teachers. This program will offer participants a choice between multiple health plans ranging in benefit levels. To achieve the greatest savings, the consolidated program would leverage the current State Employee Health Plan contracts and organizational structure. Assuming the districts' current contribution structure, the districts can save an estimated 20%-25% of total health care spend. Assuming the plan begins January 1, 2017, savings for the last six months of FY 2017 are estimated at $40 million.

Background and Findings

- The K-12 school districts have the opportunity to participate in the State Employee Health Plan, though a relatively small number of districts currently participate.
- A strong deterrent from participating in the SEHP is that the employer contribution requirements do not align with the current contribution structure in many of the districts. Typically, the districts pay a significant portion for the employee only coverage, but little for any dependents.
- Although a few districts participate in health trust programs or associations, the school districts are generally sourcing and managing health care individually—a very expensive and inefficient approach.
- Many small districts are facing unsustainable, large increases in cost each year.
- Based on the sample of collected data, most districts provide a choice of one to three plans for employees.
- Based on the sample census files provided by the K-12 districts, the active population has an average age of 44 and is 77% female, while the SEHP has an average age of 46 and is 52% female. Therefore, it is recommended the two populations remain in separate risk pools, with health plans and benefit levels reflecting the covered group.
- Based on the premium information provided by the sample size of approximately 15,500 employees, total district healthcare spending is estimated to be $300 million - $350 million annually.

Recommendation #4 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$40,000	$80,000	$80,000	$80,000	$80,000

Key Assumptions

- The sample census size appropriately reflects the current population of K-12 full-time employees.
- The information collected from the sample districts is representative of current plan costs, designs and contribution structures.
- Estimates are determined assuming each district continues with their current contribution structure. However, it is recommended the final program have a consistent contribution structure across all districts.
- All K-12 school districts are required to participate in the consolidated health program. Unless local control on health insurance choice is legislatively abated, the capture of the estimated savings will vary significantly if local school districts choose not to participate.
- Cost savings will be achieved by spreading the health risk across the entire K-12 population.
- The K-12 program can leverage all current SEHP relationships.
- The SEHP would require 10-15 additional staff members to administer the K-12 program, which would be a cost of approximately $500,000 to $750,000 per year.
- Fees for actuarial assistance with the program design and implementation are estimated at approximately $500,000, annually.

Critical Steps to Implement

The estimated savings provided is based on broad, conservative assumptions of the overall risk pool, cur-

rent plan options and costs at the districts, indicating that there is opportunity for savings through a consolidated program. In order to develop refined cost and savings figures, the State must take a number of critical steps, including:

- Establish a project management team and healthcare committee (similar to SEHP) for detailed assessment of 286 districts in order to determine actual recommended program with actual premiums for consolidated program.
- Expand current actuarial services contract scope to conduct the assessment or issue a RFP for new actuarial service provider for the detailed assessment of all 286 district programs.
- Collect complete health plan information from each district including:
  - » Detailed census data for all K-12 employees and retirees
  - » Current plan detail and plan design
  - » Current and historical cost/contribution
  - » Historical claims
  - » Benefit eligibility and district administrative structure
- Provide analysis for potential program designs and cost impacts addressing plan options including, but not limited to:
  - » Number of plan options and specific plan designs
  - » Cost and contribution structure
  - » Administrative structure (i.e district opt-in/ opt-out)
- Gain key stakeholder consensus and support to encourage local district participation in this new approach. Key stakeholders include: Kansas Association of School Boards (KASB), Kansas National Education Association (KNEA), Kansas School Superintendents Association (KSSA), and the United School Administrators of Kansas. This could be achieved through participation in the proposed healthcare committee.
- Establish health plan with current SEHP third party administrator—Blue Cross Blue Shield of Kansas.
- Increase SEHP staff by 10-15 employees to administer the K-12 program.

Assuming district participation, it is anticipated K-12 consolidation of health benefits can be completed for a January 1, 2017 effective date. The implementation will take significant time and manpower. In the event the program does not utilize the current SEHP actuary or third party administrator and an RFP is needed, the effective date of the program may be delayed. The recommendation would require a change in statute that would require all districts to purchase health insurance through the newly founded program.

Recommendation #5 – Collaboratively Source Select Categories on a Statewide Basis

- The school districts should join the Department of Administration (DOA) and strategically source specific spend categories to drive greater cost savings for the school districts.

Background and Findings

School districts execute their procurement activities in a decentralized manner and independent of the state's Procurement and Contracts group. At their discretion, each school district can utilize state contracts negotiated by the Procurement and Contracts group, utilize cooperative agreements or negotiate contracts individually. This level of autonomy makes it difficult for the school districts to truly leverage their collective volumes fully with each other and the state, since contracting phases are not synchronized, spend data is not consolidated or analyzed and requirements are not standardized.

Despite these challenges, there are some categories of spend that are still suitable for collective sourcing with the state. A&M analyzed FY15 expenditure data from seven school districts (Blue Valley, Kansas City Kansas, Lawrence, Olathe, Shawnee Mission, Topeka and Wichita). This expenditure data represents approximately $443 million or 30% of the overall addressable school district spend. The evaluation identified seven categories that should be included in the first three waves of a statewide strategic sourcing event outlined in Procurement Recommendation #1. In these cases, either the school districts are utilizing the state's con-

ED.02 - New Grant and Foundation Opportunities

Recommendation #2 – Apply for Additional Funds from Public and Private Sources

KSDE should centralize ownership and management of applying for grant funds. Centralizing the grants management process will improve access to additional funds by increasing internal capacity to develop strong grant applications. It will also likely result in the creation of strong portfolios of grants that are organized with clear goals and outcomes for education in Kansas. Finally, centralizing grant management will make it easier to ensure effective, efficient and compliant grants management practices:

- Review the list of identified federal grant programs for which KSDE is eligible to apply, to determine the degree to which these opportunities advance KSDE's educational goals and desired outcomes and prepare applicable application(s) .
- Apply for new federal funds expected to be available this fiscal year and pursue discretionary grant opportunities that align with KSDE's policy goals. Particular attention should be given to the US Department of Education's priority focus areas including:
  - » A new Equity and Outcomes Pilot with Title I Funds
  - » $11.7 billion for the IDEA Grants to States
  - » $750 million for the Preschool Development Grants
  - » $504 million for the IDEA Grants for Infants and Families program
  - » $2.3 billion for Improving Teacher Quality State Grants
  - » $1 billion in 2016 for Teaching for Tomorrow (TFT)
  - » $350 million for Excellent Educators Grants
  - » $200 million for improved Educational Technology State Grants
- Develop an outreach and communications strategy to create effective working relationships with a prioritized set of foundations within Kansas, who may be interested in providing fiscal support to advance KSDE's programmatic goals.

Recommendation #2 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$299	$299	$299	$299	$299

Key Assumptions

- The estimated increase in federal funding levels is based on the identification of four example education related grants that peer states have received that Kansas did not receive.
- The estimated value for those grants was based on the average award received for the peer states that received funding, which totaled $3.3 million in average awards.
- A probability of award of 10 percent was applied to the grants to create a net potential value.
- One of the four grants identified required the negotiation of matching funds in the award, which was assumed to require a 50 percent match to obtain funds.
- The value of the priority focus areas have not been estimated, and represent potential for increased federal funding above the current estimate provided
- Anticipated federal funding opportunities will materialize.
- KSDE will have the resources necessary to prepare and submit high quality grant applications that clearly express Kansas' goals and desired outcomes for public education.
- KSDE's goals and objectives can be articulated in such a way that policy goals can be easily aligned with foundations' interest areas.

Critical Steps to Implement

The critical steps necessary to complete the implementation of the recommendation include:

- Develop a consolidated statement of KSDE's education policy goals.
- Develop a strategy for using federal education programs to advance KSDE's strategic goals and objectives.
- Align KSDE's education policy and outcome goals

with the goals of federal grant programs and interest areas among foundations with a focus on public education.

- Identify qualified grant writers.
- Host a workshop with key grants management personnel to discuss best practices and approaches utilized in other states. Maryland and Minnesota have reorganized and centralized grants management in recent years using this type of workshop approach.

Recommendation #3 – Pursue Cost Savings Opportunities through Centralization and Shared Services Agreements

Centralizing IT functions can improve standardization, improve internal communication, facilitate best practice sharing, and reduce duplication of effort. Development and implementation of a support system for centralized IT personnel can help ensure that agencies are able to access timely technical support. Coordinating similar functions across state agencies can also reduce duplication of effort and improve the quality and efficiency of service provided to constituents. In addition, it can facilitate the creation of policies, programs and guidelines that integrate the perspectives of both agencies.

- Shift a portion of the IT positions currently housed within the KSDE to a centralized IT Division.
- Identify additional opportunities where costs for FTEs that focus on data collection can be shared across state agencies.

Background and Findings

- The IT Department represents nearly 25% of KSDE's personnel costs.
- Many of these positions are "split-funded" across state and federal sources. Redeployment of resources should be done to maximize utility of non-state funded sources.
- The KSDE IT staff created a series of customized applications to collect program data and comply with federal reporting requirements.
- KSDE IT staff supports internal KSDE employees and approximately 40,000 external school district staff and partner users across more than 100 web-based applications.
- Descriptions of the roles and responsibilities for different departments within the KSDE include similar functions related to data collection and reporting.

Recommendation #3 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$500	$500	$500	$500	$500

Key Assumptions

- The custom-developed IT applications can be combined or integrated so that all required data collection activities take place.

Critical Steps to Implement

- Conduct in-depth analysis of the IT Department functions as well as the roles and responsibilities of each IT staff member and the applications they manage.
- Explore alternative staffing models drawing on practices used by other states.
- Explore alternative data collection applications to consolidate the current data collection processes.

Recommendation #4 – K-12 Benefit Program Consolidation

- Currently, K-12 school districts have the opportunity to participate in the State Employee Health Plan (SEHP), though few of the 286 districts are participating because of the current state contribution structure.
- Due to the current purchasing and administration structure, there is significant opportunity for cost savings and efficiency through the development of a consolidated health insurance plan for K-12 district employees and their dependents. This consolidated program will provide greater plan choice offerings and improved contribution structure for members, while reducing the administrative cost and burden of providing healthcare across the districts. The State Employ-

SEHP.01 – Plan Changes

State	Carrier	Type	Deductible	ER/State HSA Contribution
Arkansas	Arkansas	HSA	$4,350/$8,500	None
	BCBS	HSA	$2,000/$3,000	None
	Qualchoice	PPO	$1,000/$2,000	N/A
Colorado	UHC	HSA	$1,500/$3,00	None
		HSA	$1,500/$3,00	N/A
	Kaiser	PPO	$1,500/$3,00	None
			$750/$1,500	N/a
Missouri	UMR	HSA	$1,650/$3,300	$300/$600
		PPO	$600/$1,200	N/A
		PPO	$300/$600	N/A
Nebraska	UHC	HSA	$2,600/$5,300	None
		PPO	$1,000/$2,000	N/A
		PPO	$600/$1,200	N/A
South Dakota	Dakota Care	HSA	$1,800/$3,600	$300/$600
		PPO	$1,250/$3,125	N/A
		PPO	$750/$1,875	N/A

Summary

A&M's approach to the SEHP recommendations focused on furthering the Health Care Commission's health plan initiatives, cost reduction, and the alignment of an administrative structure that would allow the SEHP to function more effectively.

All opportunities included within this section are medium to long-term opportunities. The assessment team worked collaboratively with SEHP staff and health plan actuary, Aon Hewitt, to develop these recommendations, which address plan design, administrative efficiency, and leveraged solutions to generate savings in the next five years.

It is expected that most of these recommendations can be executed without statute or regulatory changes; however, we have also included a number of recommendations that may require Governor approval or regulatory changes.

Recommendations

Recommendation #1 – Execute Opportunities for Cost Savings through Plan Design Changes

Over the past several years, the State Employee Health Plan has taken steps to lessen the rising cost of healthcare through plan design changes. However, there are opportunities to further reduce the cost of benefits through strategic plan design changes, and the implementation of a population health management program. Specifically, the SEHP should consider:

- **Total Replacement Consumer Driven Health Plan –** The State can improve overall consumer engagement in healthcare choices and reduce costs by offering "Plan C," the Consumer Driven Health Plan, with Health Savings Account (HSA) or Health Reimbursement Account (HRA). Additionally, the State should reduce employer contributions to $500 for single and $1,250 for family, in order to reduce employer cost and move toward similar state benchmark HSA contribution amounts. This change in the employer contribution will bring the actuarial value (or overall value of benefits paid by the plan) to approximately the equivalent of the actuarial value of the current Plan A. The total replacement Consumer Driven Health Plan would result in savings to the SEHP

		Target Savings and Revenue Estimate *(All values in 2015 dollars, in 000s)*					
Rec #	Recommendation Name	FY17	FY18	FY19	FY20	FY21	Total
1	Execute on opportunities for cost savings through plan design changes	$13,750	$27,500	$27,500	$27,500	$27,500	$123,750
2	Implement Retiree Exchange Platform	$5,750	$12,000	$12,936	$13,945	$15,033	$59,664
3	Increase organizational efficiency of SEHP	$165	$165	$165	$165	$165	$825
SEHP Total		**$19,665**	**$39,665**	**$40,601**	**$41,610**	**$42,698**	**$184,239**

of approximately $12.5 million to $15 million in FY2017.

- **Population Health Management –** The SEHP member population is relatively stable and credible, and as such, long-term savings can be realized through claims management and risk reduction—achieved by the monitoring and management of individual healthcare outcomes, otherwise known as Population Health Management. SEHP has leveraged the Truven Health Analytics technology through partnership with Medicaid. Truven is a powerful population health management analytics tool. Some analytics are being performed; however, it would be beneficial to incorporate a clinical perspective to the data. This can be achieved without additional cost through the current Third Party Administrator (TPA) or for objectivity, through the hiring of a consultant. Although we believe additional savings are achievable, a full review of the SEHP claims is needed to provide an estimate. No savings estimate for this sub-recommendation is included in figures shown.

Background and Findings

- The current deductible for Plan C is $2,750 for single coverage and $5,500 for family coverage.
- The State and participating Non-State Employers provide $1,500 or $2,250 contribution to individuals enrolled in the HSA/HRA plan in employee only or employee family, respectively. This contribution is embedded in the monthly rate charged to each agency.
- State benchmarks indicate that most states sponsor high deductible health plans with HSAs (5 out of 5 benchmark states sponsor these plans). Two states sponsoring these plans provide a small employer contribution to the HSA, while the other three benchmark states provide no contribution at all.
- The current actuarial value of Plan A is approximately 77% while the current actuarial value of Plan C is approximately 89%, when considering all employer contributions. This means that on average, Plan A covers 77% of the cost of covered benefits, while Plan C currently covers 89% of the cost of covered benefits. The recommended change would bring the total replacement plan to an actuarial value similar to that of the current Plan A.
- The State is currently providing a premium discount of $480/year for participation in the wellness program. This will decrease to $240/year in 2016. Participation in the program is satisfied by a participant obtaining 30 credits through activities including:
  - » Biometric Screening
  - » Preventive Exams
  - » Tobacco Cessation Program
  - » Wellness Challenges
  - » Virtual Health Coaching, etc.
- SEHP currently uses the data analytics software from Truven Health Analytics to collect all claims data. However, according to SEHP staff, no population health management program is in place and health data is not being actively monitored.
- Variations to this recommended plan design could also produce similar results. i.e. more than one high deductible plan offering. Additional plan design variations would require additional in-depth actuarial analysis.

Recommendation #1 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$13,750	**$27,500**	**$27,500**	**$27,500**	**$27,500**

Key Assumptions

- Estimates assume the current contribution structure (employer vs. employee contribution amounts) remains the same as 2016 levels.
- All estimates are derived using 2016 benefit plan design and contribution levels, and do not take into consideration any planned changes for 2017.
- Savings assume that SEHP's membership count and tier enrollment remains relatively consistent with current levels.
- Estimates are based on the average of the high and low range of savings values.
- Since the State currently contracts with Truven, we have assumed there would be no initial capi-

tal required to implement the population health management program. Additionally, the State can leverage on-staff physicians at the carriers to analyze the data and drive the population health programs.

Critical Steps to Implement

The critical steps necessary to complete the implementation of the plan design recommendations include:

- Projections will need to be maintained by SEHP actuary to update strategy for 2017 Plan Year for any deviation in plan claims experience.
- Recommendations will need to follow the Kansas Health Care Commission process for ultimate approval.
- The SEHP should develop a communication campaign regarding plan changes and provide education to all SEHP participants regarding Consumer Driven Health Plans.
- Population Health Management program and internal program managers must be designated by SEHP staff. Clinical expertise should be engaged either through TPA or consultant.

To realize savings as soon as possible, this recommendation should be implemented for the next SEHP plan year, beginning January 1, 2017.

Recommendation #2 – Implement Retiree Exchange Platform

Per Statute, Kansas provides pre-65 and post-65 retirees access to the SEHP. The state has tried to limit the liability for these retirees by requiring all Medicare-Eligible Retirees to join a fully-insured Medicare supplement plan effective January 1, 2016; however, a Governmental Accounting Standards Board (GASB) liability remains. In order to remove the liability for future payments and reduce the current retiree subsidy, Kansas should:

- **Implement Retiree Exchange Platform –** Retiree specific platforms provide pre-65 and post-65 retirees with a choice of healthcare plans and provider networks. These platforms also provide the retiree with additional resources targeted to the specific needs of retirees. Moving the Kansas retirees to an exchange platform would increase retiree choice of plans and networks while removing SEHP's current subsidy and GASB liability for future payments for pre-65 retirees. Savings to the SEHP fund from removing the current retiree liability are estimated at $5.75 million for the last six months of FY2017. The full year of savings will be realized in FY2018, with an estimated savings of $12.0 million.

Background and Findings

- Per 2012 Kansas Statue 12-5040[1], all local governments providing employer sponsored health care must extend the offer of coverage to pre-65 retirees. Employers may require retirees to pay up to 125% of the cost for similarly situated employees.
- The State Employee Health Plan allows retirees, their spouses, and survivors access to the medical and dental plans sponsored by the SEHP.
- Beginning in 2016, SEHP will require all Medicare-Eligible Retirees (post-65) to participate in the fully-insured Medicare plans.
- All pre-65 retirees will continue to have the option to continue participation in the SEHP self-funded plans in FY 2016. Although retirees are required to pay their "full cost of coverage," the SEHP fund is paying for any claims in excess of the premium collected.
- Pre-65 retirees will experience a 22.5% increase in their required contributions beginning in 2016 as an attempt by the SEHP to more accurately charge retirees for their full cost of coverage.
- In 2016, pre-65 retiree contributions for the BCBS KS plans are as follows:
  - » Plan A: $638.08 for single, $1,895.02 for family
  - » Plan C: $471.02 for single, $1,484.80 for family
- Premium amounts for 2016 Aetna pre-65 retirees are slightly higher than BCBS contribution amounts.
- The average employer contribution on retir-

1 http://kslegislature.org/li_2012/m/statute/012_000_0000_chapter/012_050_0000_article/012_050_0040_section/012_050_0040_k.pdf

SEHP.02 – Retiree Liability

tal required to implement the population health management program. Additionally, the State can leverage on-staff physicians at the carriers to analyze the data and drive the population health programs.

Critical Steps to Implement

The critical steps necessary to complete the implementation of the plan design recommendations include:

- Projections will need to be maintained by SEHP actuary to update strategy for 2017 Plan Year for any deviation in plan claims experience.
- Recommendations will need to follow the Kansas Health Care Commission process for ultimate approval.
- The SEHP should develop a communication campaign regarding plan changes and provide education to all SEHP participants regarding Consumer Driven Health Plans.
- Population Health Management program and internal program managers must be designated by SEHP staff. Clinical expertise should be engaged either through TPA or consultant.

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- **Implement Retiree Exchange Platform –** Retiree specific platforms provide pre-65 and post-65 retirees with a choice of healthcare plans and provider networks. These platforms also provide the retiree with additional resources targeted to the specific needs of retirees. Moving the Kansas retirees to an exchange platform would increase retiree choice of plans and networks while removing SEHP's current subsidy and GASB liability for future payments for pre-65 retirees. Savings to the SEHP fund from removing the current retiree liability are estimated at $5.75 million for the last six months of FY2017. The full year of savings will be realized in FY2018, with an estimated savings of $12.0 million.

Background and Findings

- Per 2012 Kansas Statue 12-5040[1], all local governments providing employer sponsored health care must extend the offer of coverage to pre-65 retirees. Employers may require retirees to pay up to 125% of the cost for similarly situated employees.
- The State Employee Health Plan allows retirees, their spouses, and survivors access to the medical and dental plans sponsored by the SEHP.
- Beginning in 2016, SEHP will require all Medicare-Eligible Retirees (post-65) to participate in the fully-insured Medicare plans.
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1 http://kslegislature.org/li_2012/m/statute/012_000_0000_chapter/012_050_0000_article/012_050_0040_section/012_050_0040_k.pdf

ee specific exchanges are $100 per retiree per month.

- In 2016, an average participant contribution for single coverage under a "Gold" plan, or a plan with 80% actuarial value, ranged from $500 to $700 per month for a 55 year old in Topeka Kansas. Actual contributions are determined based on the plan elected and participant age, gender and dependents covered.
- GASB requires all governmental entities sponsoring Other Postemployment Benefits (OPEB) to accrue for the obligations under the plan[2].
- Despite moving the Medicare-Eligible Retirees to a fully-insured platform, SEHP continues to have a GASB liability for those current and future pre-65 retirees.
- Approximately 50% of all active employees and 22% of their spouses who retire and meet the eligibility criteria will participate in the plan, according to the 2015 Actuarial Report for GASB OPEB Valuation provided by the SEHP actuary, Aon.

Recommendation #2 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$5,750	$12,000	$12,936	$13,945	$15,033

Key Assumptions

- Estimate of savings do not consider any changes to retiree contributions from the CY2016 levels
- Estimates are based on the average of the high and low range of savings values
- Savings assume current retiree claims experience remains stable and increases with 7.8% trend, as estimated by the 2016 Segal Health Plan Cost Trend Survey[3]
- Savings assume retirees will to an exchange platform for January 1, 2017 and the SEHP will realize savings for the last six months of FY17

Critical Steps to Implement

The critical steps necessary to complete the implementation of the plan design recommendations include:

- Issuance of a Request For Proposal (RFP) for the retiree exchange platform
- Oversight and monitoring by SEHP staff of the awarded vendor
- Ample communication plan and timeline for all retirees to successfully understand new options through the exchange
- Transfer all current retiree members to the exchange platform
- Change KS Statue 12-5040 to indicate that employers can make a group health plan available, or a plan of similar design, network, and cost

The expected time to implement this recommendation is 12 months and changes can become effective the beginning of the 2017 plan year (January 1, 2017). In the event that an RFP is needed for the retiree exchange, it can be completed in advance, before the 2017 plan year for a January 1, 2017 effective date.

Recommendation #3 – Increase Organizational Efficiency of the SEHP

The State Employee Health Plan is currently running an efficient organization with the lean staff it employs. However, SEHP can increase administrative efficiencies and reduce duplicative effort through a realignment of the organization and member requirements for State Employers and Non-State Employers.

- **Reposition the SEHP under the Kansas Department of Administration –** The SEHP is currently housed in the Division of Health Care Finance, within the Kansas Department of Health & Environment. The current employment structure of the SEHP staff creates a misalignment of priorities due to the differing role of the Department of Administration (DOA) and the KDHE, within the Kansas Government. It is recommended that the plan transition into an ancillary agency of the DOA responsible for managing the administra-

2 Other Postemployment Benefits: A Plain-Language Summary of GASB Statements No. 43 and No. 45. (n.d.). Retrieved December 2, 2015, from http://www.gasb.org/cs/ContentServer?c=Document_C&pagename=GASB/Document_C/GASBDocumentPage&cid=1176156714369

3 2016 Segal Health Plan Cost Trend Survey. (2015). Retrieved November 27, 2015, from https://www.segalco.com/media/2139/me-trend-survey-2016.pdf

SEHP.03 – SEHP Organization

ee specific exchanges are $100 per retiree per month.

- In 2016, an average participant contribution for single coverage under a "Gold" plan, or a plan with 80% actuarial value, ranged from $500 to $700 per month for a 55 year old in Topeka Kansas. Actual contributions are determined based on the plan elected and participant age, gender and dependents covered.
- GASB requires all governmental entities sponsoring Other Postemployment Benefits (OPEB) to accrue for the obligations under the plan[2].
- Despite moving the Medicare-Eligible Retirees to a fully-insured platform, SEHP continues to have a GASB liability for those current and future pre-65 retirees.
- Approximately 50% of all active employees and 22% of their spouses who retire and meet the eligibility criteria will participate in the plan, according to the 2015 Actuarial Report for GASB OPEB Valuation provided by the SEHP actuary, Aon.

Recommendation #2 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$5,750	$12,000	$12,936	$13,945	$15,033

Key Assumptions

- Estimate of savings do not consider any changes to retiree contributions from the CY2016 levels
- Estimates are based on the average of the high and low range of savings values
- Savings assume current retiree claims experience remains stable and increases with 7.8% trend, as estimated by the 2016 Segal Health Plan Cost Trend Survey[3]
- Savings assume retirees will to an exchange platform for January 1, 2017 and the SEHP will realize savings for the last six months of FY17

Critical Steps to Implement

The critical steps necessary to complete the implementation of the plan design recommendations include:

- Issuance of a Request For Proposal (RFP) for the retiree exchange platform
- Oversight and monitoring by SEHP staff of the awarded vendor
- Ample communication plan and timeline for all retirees to successfully understand new options through the exchange
- Transfer all current retiree members to the exchange platform
- Change KS Statue 12-5040 to indicate that employers can make a group health plan available, or a plan of similar design, network, and cost

The expected time to implement this recommendation is 12 months and changes can become effective the beginning of the 2017 plan year (January 1, 2017). In the event that an RFP is needed for the retiree exchange, it can be completed in advance, before the 2017 plan year for a January 1, 2017 effective date.

Recommendation #3 – Increase Organizational Efficiency of the SEHP

The State Employee Health Plan is currently running an efficient organization with the lean staff it employs. However, SEHP can increase administrative efficiencies and reduce duplicative effort through a realignment of the organization and member requirements for State Employers and Non-State Employers.

- **Reposition the SEHP under the Kansas Department of Administration –** The SEHP is currently housed in the Division of Health Care Finance, within the Kansas Department of Health & Environment. The current employment structure of the SEHP staff creates a misalignment of priorities due to the differing role of the Department of Administration (DOA) and the KDHE, within the Kansas Government. It is recommended that the plan transition into an ancillary agency of the DOA responsible for managing the administra-

2 Other Postemployment Benefits: A Plain-Language Summary of GASB Statements No. 43 and No. 45. (n.d.). Retrieved December 2, 2015, from http://www.gasb.org/cs/ContentServer?c=Document_C&pagename=GASB/Document_C/GASBDocumentPage&cid=1176156714369

3 2016 Segal Health Plan Cost Trend Survey. (2015). Retrieved November 27, 2015, from https://www.segalco.com/media/2139/me-trend-survey-2016.pdf

tion of the benefit program available to state employees, retirees, and their dependents, as well as employees of certain other government entities. This structure would allow for better coordination and communication between the DOA and SEHP.

- **Streamline Payroll Deduction File Requirements –** To better utilize SEHP staff, decrease enrollment and deduction errors, and increase administrative efficiency, the State should require all State universities, or "regents," to employ the payroll system used by the DOA. This could provide the SEHP approximately $165,000 in savings annually, for time lost, cash outlays for system updates to accommodate regent changes, and cost for potential payroll errors.

Background and Findings

- Based on state benchmarks, State health plans are typically structured within the Department of Administration (DOA), or another state agency that handles Human Resource functions.
- Effective July 1, 2011, the staff that administers the SEHP became part of the Division of Health Care Finance (DHCF) within the KDHE. The Director of the State Employee Health Benefits Program reports to the Director of the DHCF.
- The Health Care Commission (HCC) was developed by Kansas statute in 1984. The HCC is comprised of five members—the Secretary of Administration, Commissioner of Insurance, and three members appointed by the Governor. The statute requires one member to be a representative of the general public, one a current State employee in classified service, and one a retired State employee from the classified service.
- Per statute, the HCC, headed by the Secretary of the Department of Administration (DOA), has the authority to make any changes to the administration and implementation of the State Employee Health Plan.
- The SEHP produces one payroll deduction file for the DOA and seven other payroll deduction files for the various regents across the State. This results in multiple additional checks and balances working with each of the various regents. Additionally this poses inefficiencies as the SEHP must:
  - » Produce the files earlier than necessary or appropriate.
  - » Work with each regent to reconcile any payroll file issues.
  - » Accommodate limited reporting from the regents—not all reports that are provided by DOA are available with the regents payroll systems.
  - » Reconcile the regent payroll files after the payroll calculation cycle and subsequent payroll file creation cycle are both closed, causing a lag in reporting and increase in potential for error.

Recommendation #3 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$165	$165	$165	$165	$165

Key Assumptions

- The Governor and DOA would grant SEHP the authority to reorganize its structure.
- SEHP staff developed saving estimates from streamlining the payroll deduction files.
- Savings estimates do not account for any investment cost that would be incurred through the purchase of new payroll systems.
- Savings will be realized when the payroll systems are consolidated and the number of payroll deduction files provided reduces to one.

Critical Steps to Implement

The critical steps necessary to complete the administrative recommendations include:

- Request approval from the Governor to realign SEHP under the DOA
- Make appropriate administrative changes to reflect SEHP staff employment by DOA
- Implement standardized payroll system for all regents
- Train regent employees on payroll deduction file requirements

The expected time to implement this recommendation is six to twelve months for the regents to adopt the State payroll system. The recommendation is not expected to require statutory or regulatory changes;

however, it may require newly established statutory requirements to impose the requirement upon the regents.