Approved _____
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Senator Paul Hess at
Chairperson

11:00 a.m./~~p.m.~~/ on February 3, 1983, 19__ in room 123-S of the Capitol.

All members were present except:
Senators Doyen and Harder

Committee staff present:
Research Department: Marlin Rein, Sherry Brown, Mary Galligan, Ed Ahrens
Revisor's Office: Norman Furse
Committee: Mark Skinner, Administrative Aide; Doris Fager, Secretary

Conferees appearing before the committee:
John L. Kuykendall, Martin E. Segal Company, Consultants and Actuaries

Mr. Kuykendall distributed copies of his "General Review and Analysis of the State of Kansas' Group Health Program." (See Attachment A) Following his review of the report, committee members were given opportunity to question him.

In connection with the chart concerning comparative health care cost component for the entire nation, Senator Hein asked if Mr. Kuykendall knew what would be included in that cost for subsidizing Medicare. Mr. Kuykendall said he did not have that figure, but felt it would be comparable for the Kansas plan as it would be for the rest of the nation.

During additional questioning, Mr. Kuykendall indicated that private plans of health insurance have experienced high increases comparable to those of the State's group health program, and added that most programs as large as the state's are not currently insured on a "winner-take-all" basis.

In answer to questions from Senator Talkington, Mr. Kuykendall said that it is possible to save money with the present provider if some of his suggestions were followed. He further stated that he didn't think it would be a good alternative for the state to take over the health insurance program by providing its own personnel; consequently, he had not estimated the cost of that alternative.

Mr. Kuykendall answered a further question from Senator Talkington by stating that if you are going to save money, you are going to need to cut down on service in the health care field. He admitted there would be a problem with shifting costs to the individual's account, but noted that the plan can be re-structured to save money. In connection with educating employees to use out-patient services instead of in-patient services, etc., Mr. Kuykendall stressed that it would be a difficult task.

Senator Warren asked if costs could be cut by contracting for a five year period instead for one year, as is currently being done for state employees. Mr. Kuykendall said the idea is worth consideration; however, he was not certain how much would be saved.

Senator Bogina asked if the "major medical only" type plan might be the most desirable from a cost standpoint. Mr. Kuykendall said that, in general, that is true. He explained that the average plan purchased by a business is cutting back to that type of plan, but the average state plan has remained with the same format as that of the State of Kansas.

Senator Werts asked a question concerning negotiation with providers in different areas of the state. Mr. Kuykendall suggested that all hospitals and staffs should have an equal opportunity to negotiate in the areas where there are state employees. In that manner, it would be possible to determine who would give the best price break. In addition, there could be an employee incentive plan built into the system.

Following additional questions, the meeting was adjourned by the Chairman.

GENERAL REVIEW AND ANALYSIS

OF THE STATE OF KANSAS'

GROUP HEALTH PROGRAM

January, 1983

MARTIN E. SEGAL COMPANY

CONSULTANTS AND ACTUARIES

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January 28, 1983

Mr. Patrick J. Hurley, Secretary
Department of Administration
State of Kansas
State House, Second Floor
Topeka, Kansas 66612

Dear Mr. Hurley:

We are pleased to present this study of the State of Kansas' Group Health Program. For ease of presentation, our report begins with an Executive Summary and Introduction. It is divided into the following sections:

I. BACKGROUND OF THE PROGRAM
II. COVERAGE PROCUREMENT PROCEDURES
III. CURRENT UNDERWRITING STRUCTURE
IV. FUNDING ALTERNATIVES
V. ADMINISTRATION ALTERNATIVES
IV. HEALTH BENEFIT PROVISIONS
VII. COST CONTAINMENT MECHANISMS
VIII. SUMMARY AND CONCLUSIONS

We look forward to discussing this report with you in detail.

Sincerely,

John L. Kuykendall

John L. Kuykendall

JLK:slb

EXECUTIVE SUMMARY

THE STATE'S GROUP HEALTH PROGRAM PROVIDES EXCELLENT BENEFITS TO ITS PARTICIPANTS.

THE COST OF THE PROGRAM HAS INCREASED AT A RATE IN EXCESS OF THE GENERAL RATE OF MEDICAL CARE INFLATION DURING THE PERIOD 1981-1983. IT IS EXPECTED TO INCREASE AGAIN BY APPROXIMATELY 40% FOR THE 1983-84 POLICY YEAR.

PROJECTED HEALTH PREMIUMS FOR THE 1983-84 POLICY YEAR TOTAL OVER $64,000,000. THE EMPLOYEE COVERAGE PORTION OF THIS (STATE PAID IN PAST YEARS) IS EXPECTED TO EXCEED $40,000,000.

THE CURRENT SYSTEM OF COVERAGE PROCUREMENT FOR THE STATE'S GROUP HEALTH PROGRAM HAS RESULTED IN VERY FEW INSURANCE CARRIERS BIDDING EACH YEAR.

A REVIEW OF THE UNDERWRITING AND ADMINISTRATION OF THE CURRENT PROGRAM REVEALS THAT APPROXIMATELY $1,500,000 COULD BE SAVED IF THE PROGRAM WERE TO BE SELF-FUNDED, BASED ON PROJECTED EXPENDITURES FOR THE 1983-84 PLAN YEAR. SINCE THE STATE CONTRIBUTES APPROXIMATELY 63.5% OF THE PROGRAM'S TOTAL COST, ITS SAVINGS WOULD BE APPROXIMATELY $952,500.

COST CONTAINMENT MECHANISMS COULD BE AGGRESSIVELY PURSUED BY THE STATE IF THE PROGRAM WERE SELF-FUNDED. SIZEABLE REDUCTIONS IN INCURRED MEDICAL COSTS COULD BE REALIZED. IF A REDUCTION OF ONLY FIVE PERCENT (5%) WAS ATTAINED, THE SAVINGS TO THE PROGRAM WOULD EXCEED $3,000,000, BASED ON EXPECTED MEDICAL CLAIMS DURING THE 1983-84 PLAN YEAR. THE COSTS TO IMPLEMENT SUCH PROGRAMS WOULD BE FAR LESS THAN THE DOLLARS SAVED. SINCE THE STATE CONTRIBUTES APPROXIMATELY 63.5% OF THE PROGRAM'S COST, ITS SAVINGS WOULD EXCEED $1,900,000 FOR EACH 5% REDUCTION IN MEDICAL COSTS.

IMPLEMENTING SELF-FUNDING OF THE PROGRAM, COUPLED WITH AGGRESSIVE COST CONTAINMENT PROGRAMS, FOR THE 1984-85 PLAN YEAR WOULD ALLOW FOR A SIGNIFICANT LESSENING OF THE EXPECTED INCREASE IN THE COST OF THE STATE'S GROUP HEALTH PROGRAM FOR THAT YEAR. IT WOULD ALSO HELP RESTRICT THE GROWTH OF THE PROGRAM'S COST IN FUTURE YEARS.

DUE TO THE NEED FOR ADVANCE PLANNING OF SUCH A CHANGEOVER, IT WOULD BE DIFFICULT TO IMPLEMENT IT BEFORE THE 1984-85 PLAN YEAR.

INTRODUCTION

The Martin E. Segal Company has been retained by the State of Kansas to review and analyze the State's existing Group Health Program. Our findings will be summarized in this report.

This report covers the background of the program, current procedures for procuring the insured coverage and the current underwriting structure. It also reviews the current plan of medical benefits, with particular emphasis on those portions of the plan that may have an adverse effect on claims experience.

Alternative methods of funding the program will be explored. In addition, the current system of administration of the benefits will be compared to available alternatives.

Cost containment mechanisms will be reviewed. The purpose of this section will be to provide an overview of the current policies and practices that control the dramatic rises in medical claim costs that have impacted on the State's program.

The final section will summarize our findings. It will also review the proven methods of enhanced cash flow, benefit design and plan administration that should enable the State of Kansas and its employees to maximize the value of its Group Health Program.

I. BACKGROUND OF THE PROGRAM

The State of Kansas offers an insured health plan, underwritten by Blue Cross and Blue Shield, to its employees and their eligible dependents. It also offers coverage through Health Maintenance Organizations to its employees in certain geographical areas on a "dual choice" basis.

In the late 1960's, the series of individual agency plans were consolidated into one State Group Health Program. In 1969, the Kansas legislature provided for State payment of the single member premium. In that same year, responsibility for the purchase of the Group Health Insurance coverage was placed with the Committee on Surety Bonds and Insurance.

The procedures for the procurement of the coverage will be discussed in Section II.

The plan design of the health benefit program has remained unaltered since the inception of the consolidated program.

In light of the upward spiraling increase in the cost of the plan funding the benefits, it is particularly appropriate to examine the program in an attempt to insure that the Group Health Program is designed, funded and administered in the most cost effective manner.

II. COVERAGE PROCUREMENT PROCEDURES

The insurance coverage that provides the benefits under the Group Health Program is procured by the Committee on Surety Bonds and Insurance. It is guided by the statutes prescribed for the purchase of supplies, materials, equipment or contractual services under K.S.A. 75-3738 to 75-3744. These general purchasing statutes require that the insurance must be purchased on the basis of competitive bids.

The Committee holds a meeting in March or April of each year to discuss the upcoming bid specification. Representatives of the current carrier(s), as well as potential bidders, are invited to attend this meeting or to offer comments or suggestions.

In addition, input is solicited from the Benefit Review Committee, appointed by the State Personnel Director. The Kansas Association of Public Employees is also invited to offer suggestions and comments. Representatives of the Division of Accounts and Reports and the Insurance Department's Accident and Health and Consumer Assistance Divisions also provide input.

It can thus be seen that input is obtained from various State interests, State employees, current carriers and prospective bidders.

The Committee then authorizes the Director of Purchases to prepare the bid specifications. When approved by the Committee, they are distributed to approximately seventy-five individuals and organizations who have expressed an interest in receiving the material. This is done in April of each year.

The bid opening is conducted in early May. The new contract commences August 1 of each year.

Our research has shown that the State rarely receives more than one or two bids in response to its specifications for the insured health benefit program.

In addition, Blue Cross and Blue Shield of Kansas has been the provider of these benefits since the inception of the consolidated State plan, with the exception of a two-year period when the coverage was provided by The Equitable Life Assurance Society of the United States. It is our understanding that Blue Cross and Blue Shield of Kansas has been the sole bidder in recent years.

This obviously gives rise to questions regarding the nature of the bidding process and the competitiveness of the current carriers. It is our observation that the current system of procurement of the coverages discourages competition. Thus, although the program is competitively bid annually, the desired cost control benefit of the bidding procedure is not being realized.

Most health plans of the State's size retain actuarial consultants who can monitor the performance of your providers, including the areas of insurance coverage and administrative services. This allows a more comprehensive assessment of performance, while providing some stability in the relationship between the State's large group of plan participants and the providers of the services.

If the State were allowed more flexibility in contracting for and monitoring the insurance coverage and services relating to its health plan, the overall level of competitiveness and the relationship between the State and its contractors in this area could be significantly enhanced.

III. CURRENT UNDERWRITING STRUCTURE

The present underwriting of the group medical insurance program is "conventional" in that premium payments are made monthly at a pre-determined amount which is based on prior and expected claims experience. This represents a fully insured approach to providing the program's benefits and has the advantage to the State of limiting its monthly or annual liability to the amount of these premium payments. In the event that claims and expenses of the program exceed the premium paid by the State, a deficit results for the carrier(s). Conversely, in the event of favorable claims experience where premium exceeds the claims and expenses, a surplus is created which is not returnable to the State. This type of underwriting is very unusual for a program that covers over 35,000 employees.

The State remits premiums to its current carrier forty-five (45) days after the due date. This allows greater use of cash during the year.

The State's cost for the Group Health Program has risen dramatically. The State's initial contribution per employee for health insurance was $8.32 per month. This cost rose to $43.74 for the 1980-81 contract year, $54.92 for 1981-82, and $66.70 for 1982-83. The estimated cost for 1983-84 will be approximately $94.50 per employee per month. A comparison of the State's increased costs with those of the medical component of the Consumer Price Index is contained in Exhibit A.

Exhibit B compares the premium income received from the State Plan to the incurred claims and the carrier's retention (cost of doing business). The gain or loss figures do not reflect the interest earnings that are generated on the monthly cash flow of the program nor on the reserves that are held by

the carrier for incurred but unreported claims. The amount of these reserves, as calculated by the carrier, was $5,933,584 at the close of the contract year ending July 31, 1982.

The reasonableness of these incurred claim estimates is analyzed in Exhibit C. This compares the year-end estimates with the actual claims that subsequently emerged after the end of each plan year-end. This Exhibit shows that the estimates were quite close to the claims that actually emerged.

The retention charge shown in Exhibit B is 4.5%. This is composed of 2.25% operating expense, .75% premium tax, .50% risk charge, .50% contingency reserve charge and .50% charge for the privilege of guaranteed conversion to an individual policy for terminated plan participants.

These retention charge components will be analyzed in a later Section of this report, reflecting ways in which the State can save significant amounts of money by restructuring the current methods of funding and administering the health program.

Exhibit A

STATE OF KANSAS

COST INCREASE COMPARISON

Year	Increase in Medical Cost Component of the Consumer Price Index*	Increase in Employer Cost of State of Kansas Group Health Program**
1982	11.0%	26.3%
1981	12.5%	19.2%
1980	10.0%	16.2%
1979	10.6%	5.7%
1978	9.2%	20.0%

* Based on All Urban Consumers.
Source: Department of Labor, Bureau of Labor Statistics.

** Source: State of Kansas, Budget Division.

Exhibit B

STATE OF KANSAS

TEN-YEAR EXPERIENCE SUMMARY

Period	Income	Incurred Claims Expense	Loss Ratio	Retention	Gain or Loss
7/71 - 7/73	$14,654,611	$14,046,428	95.8	$ 586,184	$ 21,999
8/73 - 7/74	10,263,200	9,888,719	96.4	410,528	- 36,047
8/74 - 7/75	11,774,716	12,138,332	103.1	470,989	- 834,605
8/75 - 7/76	15,555,952	14,638,581	94.1	622,238	+ 295,133
8/76 - 7/77	18,724,206	17,758,202	94.8	842,589	+ 123,415
8/77 - 7/78	22,089,876	20,159,449	91.3	994,044	+ 936,383
8/78 - 7/79	22,971,617	23,418,408	101.9	1,033,723	- 1,480,514
8/79 - 7/80	25,817,710	27,433,082*	106.3	1,161,797	- 2,777,169
8/80 - 7/81	31,064,804	33,547,028**	108.0	1,397,916	- 3,880,140
8/81 - 7/82	37,378,914	38,276,917***	102.4	1,682,051	- 2,580,054

* As paid through 7/31/82.
** From specs, includes some estimate.
*** Estimate incurred, from final report.

Source: Blue Cross and Blue Shield of Kansas.

Exhibit C

STATE OF KANSAS

COMPARISON OF ESTIMATED INCURRED CLAIMS IN YEAR-END REPORTS TO LATEST INCURRED CLAIMS FOR SAME PERIOD

12 Months Ending	Actual Compared to Estimated Incurred Claims	
	Estimate Made at Year-End	Latest Actual*
7/82	$38,276,917	$38,276,917**
7/81	33,046,476	33,547,028
7/80	27,208,061	27,433,082
7/79	22,866,134	23,418,408
7/78	19,591,604	20,159,449
7/77	17,578,166	17,758,202

* May include a small estimate for incurred claims that are still unpaid.

** This is an estimated figure. There were $35,402,281 of claims incurred during 8/1/81 - 7/31/82 and paid through 9/30/82.

Source: Blue Cross and Blue Shield of Kansas.

IV. FUNDING ALTERNATIVES

INTRODUCTION

Our Company provides consulting and actuarial services to a number of large plans providing benefits on a self-funded and/or a stop-loss basis. Therefore, we are prepared to advise The State of Kansas to the extent that the experience of these other plans might be a useful guide.

We recognize that in some circles insurance companies (including service plans) are viewed as expensive and expendable factors in funding health care plans. In other areas of opinion, the idea of direct payment is considered as a dangerous and improper manner of providing protection against the economic consequences of sickness and death. We believe that discussions on the basis of such broad generalization offer little help in arriving at a sound decision in any particular situation. In short, we do not see how any constructive objective can be attained through the advocacy of one general view or the other, when the specific facts in any given situation can be readily determined and considered.

It may be helpful to outline the role played by insurance companies (including service plans) in insured plans, and then indicate what questions arise when a plan undertakes to continue the same benefits on a non-insured basis.

Insurance companies receive premium payments from the policyholder and, in return for these payments, they honor claims made by or on behalf of those insured. They also render other related services to the policyholder. A part of the premium is retained by the insurance carrier to cover such items as premium taxes (if applicable), risk and contingency charges, commissions (if applicable) and its own expenses and profit. The questions that confront a policyholder concerning self-funding may be stated as follows:

1. Can the State contract for Administrative Services Only which the insurance carrier provides?
2. What money, if any, would the State save if the insurance carrier were displaced?
3. What additional cost, if any, will be incurred by the State?
4. What risk will be involved if the State substitutes itself for the insurance carrier?
5. Will any additional burdens be imposed on the State?

In the following pages, we will discuss each of these questions and provide a statement of the facts which we believe pertinent to their resolution.

This study is designed to furnish sufficient information to enable the State to arrive at a sound decision. How this matter is resolved will necessarily involve the judgement of those empowered to make the decision.

GENERAL DISCUSSION OF SELF-FUNDING

THE RISK FACTOR

There undoubtedly is a problem of risk involved in the self-funding of benefits under any circumstances; however, it is important to distinguish between what we will, for the sake of succinctness, refer to as Ordinary Risk and Catastrophic Risk. The distinction, as will be seen, is an important one.

By Ordinary Risk we mean the danger of high rather than normal or average utilization of claims. In addition, Ordinary Risk also includes the problem of inflationary costs. Our knowledge today indicates the unlikeliness of an ultimate norm for any group due to steadily rising medical, vision and dental costs. Hence, while utilization may reach a plateau, the cost of medical, vision and dental care will continue to add more liability to a given group.

Premiums are normally based on an expectation that claims will accumulate somewhere between 70% to 85% of such premiums. When claims rise above this maximum, the experience is considered to be poor. It is not uncommon for experience ratios of 80%, 100%, or higher to develop in any Plan from time to time, and in certain cases this pattern of poor experience develops into the ultimate norm for that group.

By Catastrophic Risk we mean a stunning and sudden rise in claims experience which may be due to a common accident, epidemic or similar catastrophe; in short, a rise of several hundred percent in claims experience within a brief period. (For the most part, when referring to catastrophic loss, actuaries refer only to catastrophic mortality.)

Having completed these definitions, let it be stated that an insurance carrier provides ultimate protection only against Catastrophic Risk. The losses suffered from Ordinary Risk, that is, excessive losses which come about in an ordinary way, are, under normal conditions, ultimately expected to be paid for by the policyholder. When a catastrophe occurs, the insurance carrier - assuming that it has reasonable assets - may be counted upon to absorb the losses involved. On the other hand, when poor claims experience occurs, it is the general practice of insurance companies to:

1. increase their rates in order to cover the newly estimated risk; and
2. recover their losses in future years through various formulae.

The explanation of this apparent paradox is a simple one. If, as a result of a common accident or some similar disaster, the Plan's insurance carrier were to suffer a very substantial and unusual loss involving, let us say, many hundreds of thousands of dollars, the carrier would have little choice but to absorb this loss and maintain the status quo with respect to their rates of

insurance and their retention objectives. This is so because if they did otherwise, the Policyholder would secure a new underwriter for their benefit program. The primary purpose of the insurance company is to provide protection against risk and the Policyholder, whose first obligation is to the beneficiaries of the Plan, would not face any moral or practical dilemma in respect to changing insurance carriers under these conditions. On the other hand, if "ordinary" poor claims experience were to result in excess premium losses of 10%, 20% or 30% in a given year, the insurance carrier would feel comparatively safe in attempting to regain these losses through an increase in rates and reductions in future dividends. They would reason, intelligently enough, that the Policyholder would probably not find it advisable to change insurance carriers each time that excessive claims experience produced a proportionate increase in insurance company charges - the cost involved in changing carriers, as well as the normal administrative difficulties, might not make it worthwhile to change carriers under such conditions. Moreover, under these circumstances the Policyholder would eventually have difficulty in finding a new insurance carrier that would not require premium charges comparable to those that the old one was demanding. In such cases, the new prospective carrier would review the case in the light of the Plan's past experience and a reputable company would have no keen desire to "buy" the Plan's business by underwriting the benefits at a cost which might well result in a loss to them. On the contrary, if the losses suffered by the old carrier were the result of a catastrophe, new insurance carriers would be agreeable to accepting a transfer of the policies at normal rates, just because such losses were the result of change and did not represent a real pattern of experience of the Plan.

In summary, lacking a catastrophe, the Policyholder must expect that they will ultimately pay to their insurance carrier the full amount of all claim

losses, plus the carrier's retention for taxes, expenses and underwriting profit, if any. If for example, the Plan's experience with medical, visual or dental benefits were to worsen in future years, or if the number of death claims rose substantially above present levels, the insurance carriers will take appropriate action through adjustments in premium and retention to recoup such losses as may have occurred and, to the degree possible, protect itself against such future losses as might be indicated.

It is extremely difficult, if not impossible, to be able to determine to what extent the Plan would be subject to a catastrophic loss. All sorts of situations could be conjured up where a large part of the membership is struck down by an epidemic of great proportions. Needless to say, in order to meet such a contingency, the Plan would require a reserve.

As to accidents, the employees insured by this Plan work in many different places of employment and it would appear that the only occasion on which a truly significant portion of the employees might be subject to a common accident would be at a large meeting, general convention, outing, etc.

There is at least one abnormal condition under which this group, like all others, might be subject to common disaster. Since extensive destruction through nuclear attack is, unfortunately, within the realm of possibility, individuals must decide whether this point is or is not a valid one.

In this connection, however, the question arises as to the adequacy of insurance company reserves in the event that a disaster of such proportion were to occur. We have queried insurance companies on this question and many of them feel that current reserves are sufficient to enable them to meet such a situation. However, we think that it must be apparent to anyone that a good deal of guesswork

is involved in such an estimate. It is extremely difficult to predict exactly what the situation of insurance companies and their policyholders would be under conditions of even limited nuclear warfare - if such condition can be judged a realistic possibility. A safe opinion might be that insurance companies would pay at least some portion of the benefit dollars due.

STOP-LOSS COVERAGE

DEFINITION

Stop-Loss coverage is a form of reinsurance by which a self-insured plan responsible for benefit payments limits or controls the extent to which it is liable for payment. A plan accomplishes this by transferring the risk of the catastrophic claim payments to an excess carrier or reinsuror. Stop-Loss coverage can be defined more simply by stating that it is a form of catastrophic Major Medical coverage utilizing high deductibles and high limits.

TYPES OF STOP-LOSS COVERAGE

1. Specific or Individual Stop-Loss - This form of Stop-Loss coverage protects the plan against the possibility that paid claims for a specific individual will exceed an agreed-upon deductible. For example, Stop-Loss coverage could begin to operate at a point say, where $50,000 of Medical benefits for an individual have been paid by a self-insured plan. Thereafter, the reinsuror assumes liability for claims over that amount up to the point where the carrier has paid out the maximum. The benefit period is usually 12 to 24 months and expenses are generally payable at 100% with no co-insurance. The self-insured portion of the plan (deductible) must be satisfied usually in a 12-month period.

2. Aggregate Stop-Loss Coverage - This form of Stop-Loss coverage protects the plan from the possibility that paid claims during a 12-month period will exceed an agreed-upon aggregate annual deductible. The deductible is normally established at 120% to 130% of expected annual paid claims. In other words, the carrier commences benefit payments where the fund's aggregate claims exceed expected paid claims by 20% to 30%. The point at which the carrier starts to assume liability for claim payments is called the "attachment point". The buffer zone between projected paid claims and the attachment point is called the risk corridor and, as you can see, is set high enough to absorb random fluctuation in claim levels.
3. Combination Individual and Aggregate Stop-Loss Coverage - This form of Stop-Loss coverage protects the plan from an individual claim that might become catastrophic and from an overall aggregate cost overrun.

Various combinations of Stop-Loss coverage may be appropriate for use by the State plan. This would be decided by the State, based on input from its professional advisors.

POTENTIAL SAVINGS

The question of whether a plan should "self-fund" should be resolved on an individual basis depending on all of the circumstances in a particular situation. We will now proceed to an analysis of the State of Kansas' Group Health Plan.

In order to evaluate the potential savings if the Plan's medical care benefits were self-funded, we would have to utilize the actual retention charged for the 1981-82 policy year as provided by Blue Cross and Blue Shield of Kansas. Additional administrative expenses which could develop as a result of increased administrative duties and responsibilities must also be considered.

1. Under current law the Plan is subject to State Premium tax of .75%. If the Plan were to self-insure, premium taxes would not be payable at the present time. For the 1983-84 policy year, these taxes are estimated to total $482,380. Since these taxes currently are paid to the State, net savings would not be realized in this area.

2. Among the other factors to be considered in the carrier's retention formula are claims service, general administration, conversion privilege and overhead expenses. According to Blue Cross and Blue Shield of Kansas, these charges totalled 2.75% of premium. This is estimated to total $1,768,725 for the 1983-84 policy year. The State's share of this cost would be approximately $1,123,140.

3. A significant part of the carrier's retention formula is the portion assessed for risk charges and contingency charges. These charges amounted to one-half of one percent for <u>each</u> type of charge, or a total of one percent. If the State chose to self-insure its program, it is estimated that $643,170 would be saved in the 1983-84 policy year. The State's share of this savings would be approximately $408,410.

   If Stop-Loss coverage was purchased, some of this savings would be reduced. There would, however, be no need to contribute to the carrier's contingency reserves, which protect it against unforeseen and/or catastrophic losses throughout its entire operation.

The State would also generate considerable additional income from interest earned on the incurred but unreported claim reserves and the month-to-month cash flow of the Program. The incurred claim reserves are estimated to be $8,100,000 at the end of the 1983-84 policy year. If the State could earn 10% on these reserves and the cash flow, the total return would exceed $810,000 for the year.

There would be some additional expenses to be paid by the program, depending on the type of administration selected (Administrative Services Only, Third Party Claims Processing, "In-house" Claims Processing, etc.). In addition, specific programs relating to Cost Containment efforts, which will be discussed elsewhere in this report, would have a cost component. Also, consulting and actuarial services will be required to ensure the successful implementation and ongoing success of the self-funded plan.

Based on the above factors, it would appear that the State Program could save in excess of 1.5 million dollars ($1,500,000) if it decided to self-fund the benefits. Depending on the type of plan administration and cost containment selected, savings in future years would be significantly greater. Based on the State's contribution to the current plan, its savings would be approximately $952,500.

The added flexibility that such a self-funded program would give to the State could allow it to implement specific measures that would significantly impact the actual level of claims incurred each year. This is a major reason to consider modifying the current program. A combination of cost containment measures could be selected by the State that would potentially reduce expected incurred medical claim costs by a large amount.

Each savings of five percent (5%) in the incurred claim cost would mean a dollar savings of over three million dollars ($3,000,000) to the State's Program. The dollar outlay to set up these cost containment programs would be far less than the savings to be realized. The State's share of each 5% reduction in claims cost would exceed $1,900,000.

V. ADMINISTRATION ALTERNATIVES

The State's current program is administered by the carrier on a fully insured basis. Under this approach, Blue Cross and Blue Shield of Kansas provides many types of services, including claims administration, general office service, legal services and certain actuarial services and reports. These services are outlined in Exhibit D.

The main question to be considered is whether some or all of these various services can be provided more efficiently in another manner.

Most plans that are of the magnitude of the State of Kansas programs have considered this question. The three main ways of providing these various types of services are:

1. On an administrative services only (ASO) basis, where all functions are performed by the insurance carrier.
2. On a self-administation basis, where all of these functions are performed by the State.
3. On a basis that "unbundles" the various services, having various services performed by various parties (i.e., claims administation by a professional third party claims adjudicator, general administration and legal services performed by the State, and actuarial and special report services performed by a consulting actuarial firm.)

Many large groups have tried "in-house" claims processing. Of these, some have dealt successfully with the problems of hiring, training and retaining qualified claims personnel; procuring a "state of the art" computerized claims adjudication system; rigorous persuit of savings through coordination of benefits, subrogation and other means and the many other tasks that must

be performed in order to have the plan viewed by its participants and the State as an efficient, cost effective program.

Other large plans have chosen to retain a professional claims adjudication firm to perform these services. Whether this is an insurance carrier (or service plan) or a "third party administrator", many plans feel that this expertise is more efficiently obtained from a qualified professional.

In the State's situation, it would appear best to begin its self-funded program, if that is the State's desire, by using the insurance carrier's administrative services only or professional third party outside claims administration approach. This would allow for the smoothest, most efficeint transition from the current program to a new, self-funded program. This lack of disruption is very important from the standpoint of the reaction of the current plan participants.

The question of the possibility of handling the claims adjudication function "in house" could then be dealt with a year or two after the transition of the plan from fully insured to self-funded.

This would not preclude having the State immediately start performing some general administrative services and some vital monitoring and cost containment functions that could be very well handled on this basis.

Some further consideration could allow the State to make the final decision on this matter well before the expiration of the 1983-84 insurance contract. This would allow a smooth transition to a self-funded program in the latter half of 1984, if desired.

Exhibit D

CLAIMS ADMINISTRATION

Provide ID cards to employees

Provide Incoming Claims System Control

Confidentiality Control

Claims Review (Claims per contract year 80/81 - 240,000
Estimate 81/82 - 300,000)

- Duplication of Claim
- Appropriate Service for Diagnosis
- Appropriate charge

Coordination of Benefits Check

- Workers Compensation
- No-Fault
- Duplicate Coverage

Determination System for Disputed Claims

- Medical Expert on Staff

Refund System for Claims Paid in Error

Medical Payment Record System per employee and dependent

Benefit Interpretation

Bonding of Employees

Claims Denial

- Notice to Employee
- Notice to Provider

Claims Payment System

- Coordinate with Medicare Intermediary

GENERAL OFFICE SERVICE

Receive applications and maintain eligibility files.

Maintain eligibility files by agency for budgetary and cost allocation purposes.

Make necessary adjustments on late reported terminations from group.

Process automatic conversions to non-group for terminations.

Input subscriber information (status changes and claims information) for immediate access on inquiries.

Provide Customer Service to answer approximately 55,000 inquiries each year.

Respond to out-of-state provider inquiries on eligibility.

Prepare, print and distribute 50,000 each of contracts, benefits booklets and summaries (each year if changes in Plan.)

Make oral presentations to Agency Employee groups, as requested.

LEGAL SERVICES:

Draw Up Contract (Under 65
(Over 64 & Disabled

Make Legal Response to Inquiries

Review Federal and State Laws

Defend State on Court Action

Collect Refunds due State

ACTUARIAL SERVICES AND REPORTS:

Calculate Rates (Renewal Rates
(Budget Rates
(Rates for New/Optional Benefits

Project Medical Cost and Use Trends

Provide Information For State Employees Group Specifications
(Indemnity Allowances to Approximate Full Coverage
(Experience

Provide Hospital Utilization Comparisons Between State Group and All Groups

Income and Expense Reports Prepared Monthly

Provide Annual Final Utilization Reports, Including Utilization by Type of Service

Separate Experience Between Employees and Dependents

Provide Cost Containment Savings Reports

Source: Blue Cross and Blue Shield of Kansas.

VI. HEALTH BENEFIT PROVISIONS

The State of Kansas Group Health Program features a very generous plan of benefits. This benefit plan has been essentially unaltered since the inception of the consolidated plan.

Full coverage is provided for inpatient hospitalizations. No deductible or co-payment is required from the patient for these benefits.

In addition, excellent coverage is provided for out-patient charges incurred at a hospital. Again, deductibles and co-payments are not required from the patient.

Full benefits are also provided for surgical services, anesthesia and assistant surgeon charges. In-hospital Doctor calls are provided in full.

Additional full coverage benefits are provided in case of accidental injury.

In addition to the Basic Benefits outlined above, the plan provides for Major Medical coverage. This covers expenses that are not covered under the Basic Benefits, such as calls at a Doctor's office, prescription drugs, laboratory services, physical therapy, private duty nursing, ambulance services, "well baby care" and other services.

These Major Medical benefits are also quite generous. The deductible is $100 per person per calendar year, subject to a maximum of only $200 for all covered family members.

After satisfaction of the deductible, Major Medical benefits are payable at 80% of the next $1,000 of eligible charges, then payable at 100% for the remainder of the calendar year.

Therefore, if all services rendered were Usual, Customary and Reasonable and eligible for normal payment, the most that a covered individual would have to pay in a year, regardless of the extent of illness or injury, would be $300 ($100 deductible plus $200 of co-insurance payments).

Thus, the Basic and Major Medical benefits, taken as a whole, provide payment for a broad range of covered services. However, we feel that the program has several major weaknesses. Specifically:

- In terms of controlling costs and encouraging proper utilization of increasingly expensive medical/surgical/hospital resources and their alternatives, the program contains some inappropriate incentives. Specifically, the covered individual participates in very little of the cost of most care. Studies have shown that such plans result in higher utilization than plans that require the participant to pay at least some part of the cost of care. The goal is to have the plan members spend the plan's health care dollars as if they were their own.

The program also contains a number of strong points. In terms of pure dollar reimbursement, the State plan provides an excellent level of payment to covered employees and their dependents. Very little money must be contributed by them to the cost of their health care.

Another strong point is that the plan contains provisions which allow it to coordinate benefits with other group plans and other sources of payment. These provisions are important means of preventing the use of State funds from paying unnecessary claims dollars which would duplicate reimbursement received from other sources.

Our recommendation is that the State consider modifying the plan benefits, either now or in the future, to provide for more participation in the cost of health care by the plan participants.

This would involve reducing the level of "first dollar reimbursement" benefits (Basic Benefits) under the plan. Thus, more expenses would be subject to the deductible and co-insurance features of the Major Medical portion of the plan.

The plan would still, of course, recognize the full prevailing level of Usual, Customary and Reasonable charges for reimbursement. But the plan members would feel a direct cost impact to them in the event of overutilization.

This would accomplish the generally recognized goal of health plans, which is to provide all the protection possible to those in legitimate need, while guarding against unnecessary overutilization of medical services and the subsequent wasting of State funds.

VII. COST CONTAINMENT MECHANISMS

There are few problems as universally acknowledged as the inflationary costs of medical care. They are considered to be out of control: a reckless runaway. Organized purchasers of health care, government agencies, prepayment plans, insurers, as well as the public have come to expect and demand that something be done.

In the long run, reduced cost will have to come from reduced demand. Hospital costs are not likely to decrease, nor are physicians or other health professionals likely to work less. Reducing demand does not necessarily mean rationing or withholding services. What it does mean, instead, is a rational use of all available resources.

As an employer with significant impact in the State, the State of Kansas has an almost limitless number of possibilities which can be pursued to effect reduced demand and subsequent containment of health benefit costs.

The purpose of this section is to introduce and briefly describe some possible cost containment mechanisms. If the State wishes to explore any one or several of them in specific additional detail, we are prepared to provide additional information and assist the State in designing and implementing specific, effective programs.

Benefit Plan Design can have a significant effect on cost containment. Often, the physician and his patient have more than one alternative means of taking care of a single health problem. Where such choices exist, the final selection of choices is often determined by the economics, i.e., which alternate course of treatment will trigger greater benefits from the health benefit plan and thus require the least out-of-pocket expense to the patient. Sound benefit design

acknowledges that such choices do exist. When appropriate, the benefit plan should encourage selection of the less expensive, while still offering comprehensive coverage for the expensive course of treatment when such is the only indicated alternative. In addition, sound benefit design requires patient participation in the cost of health care so that the patient knows very clearly he must be involved with the physician in the decision-making process when alternate courses of treatment are available.

In accordance with these concepts, a frequently recommended health benefit plan requires patient participation in the $100 "front-end" deductible and the 20% co-insurance. It encourages the use of out-patient facilities for diagnostic testing by the use of an unscheduled x-ray and laboratory expense benefit, and it provides equal and substantial benefit payment for both in-patient and out-patient care while still protecting the patient's family against large health expenses by means of the 100% co-insurance feature and the large lifetime maximum.

By closely analyzing specific details of the State's loss experience, other cost containment features can be incorporated in the design of the State's health benefit plan which are consistent with the concepts we have discussed here. Certainly, it is appropriate and necessary to periodically reassess benefit plan design in search of improved cost containment.

Second Surgical Opinion is a program whose goal is to reduce the amount of unnecessary surgery. It requires (or it can be a voluntary program) employees to get a second physician's opinion on the necessity of non-emergency surgery. Physicians have long had wide latitude in deciding when a patient should be hospitalized, whether a patient's problem should be treated conservatively or

by surgery, and, if surgery is decided upon, when to operate. Yet, studies continue to show that a significant number of surgical procedures performed are unnecessary.

Second Surgical Opinion is not a new program. It is a formal organization of traditional medical practice - consultation with a specialist - with one major difference: the patient initiates the consultation, not the primary physician.

It is a simple program and an inexpensive one. The key to its success is a grid of surgical specialists, geographically distributed to cover a dispersed population of employees. These specialists are most frequently "board certified" and they agree to assume the responsibility for making judgements on the professional opinions of other physicians and surgeons.

The consulting surgeon is not allowed to perform the surgery. In situations where the consulting surgeon does not confirm the initial recommendation, the program will pay for a third opinion if the patient requests one. In any event, the final decision is up to the patient, who can ignore the second opinion and go ahead with the surgery anyway.

Although there are still some dissenters, the majority of groups who provide a Second Surgical Opinion program have demonstrated overall cost savings. The percentage of averted surgeries is not large, but the dollars saved by the plan in not having to reimburse the averted surgical, hospital and associated expenses are usually more than sufficient to both pay for second surgical opinions in full and for the relatively small administrative costs which the plan would incur in implementing a Second Surgical Opinion program.

Provider Utilization Review consists of a set of screening procedures to "flag" hospitals, doctors, dentists or patients that vary from established norms and also to correlate the services provided with the listed diagnosis.

The most thorough procedure for utilization review involves computer analysis, then personal review by a trained person (generally a nurse), then perhaps analysis by a physician responsible for this function and finally referral to a utilization review board composed of physicians. The idea is to identify inappropriate hospital usage and call this to the physician's attention. Education and peer pressure are the main tools used in assuring compliance; professional sanctions are available but are seldom used.

Pre-admission Testing enables patients scheduled for necessary non-emergency hospitalization to get the required x-ray and laboratory tests performed on an out-patient basis. This saves part of the hospital confinement and enables people to stay at work longer before being hospitalized.

Not only does such a program eliminate certain hospitalizations for diagnostic testing altogether, but it also provides encouragement for people to take part in pre-admission testing. To develop a formal program requires some cooperation with the more frequently used local hospitals. Generally, the program works as follows:

1. It must be confirmed that surgery has been scheduled and that a room has been reserved in a hospital.
2. The attending physician must order the pre-surgical tests.
3. The tests are done at the hospital where the surgery will be performed and no payment will be made for procedures that are duplicated once the hospital admission has commenced.

Hospital Admissions Review is a procedure which can be used to help control in-patient hospitalization. Admissions review attempts to answer - in advance, if at all possible - the question of whether or not a proposed non-emergency hospitalization is an essential one. Under a typical program, each proposed hospital admission and proposed length of hospital stay is reviewed by other practicing physicians.

In the majority of cases, the review decisions do not differ from those of the patient's admitting physician. Where there are such differences, and if they are not resolved through a predetermined appeals process, the patient and his physician are notified that the health benefit plan will not pay benefits for the admission or for the entire length of stay ordered by the physician.

Health Education and Preventive Health Care Programs also can play an important part in encouraging employees to take better care of themselves and in helping them obtain health services on a timely basis and with reasonable economy.

There are many possible reasons for undertaking such preventive health care and health education programs. These reasons have to be identified and assessed by the State as part of the process of designing a meaningful program, should it be determined that such a program is appropriate.

For employees, the promise of such programs is one of better long term health, possibly of freedom from the debilitating effects of chronic disease. For the employer, any program which can have a measurable impact on people's health or on the means by which they seek and obtain health care services can result in financial savings. The latter can result from direct savings in health benefit plan costs, as well as savings in other areas, such as disability retirement, absenteeism, etc.

The end product of a preventive health care program is unlikely to be perfect health for all members; nothing can assure that. But a rational program can aid substantially by providing greater availability of information and promoting the logical use of that information.

There is a broad range of components which can be made part of an effective health education and preventive health care program. Our purpose in this section is to introduce the State to some of these possible components. The most common answer at present to the cost-benefit dilemma is to make efforts to reduce the costs. By approaching the project incrementally, i.e., one program at a time rather than through an ambitious comprehensive program, the cost effectiveness can better be determined. Some of the more limited objective type programs which the State may find of interest are:

Smoking control programs

Obesity control programs

Alcohol and drug abuse programs

Tension control programs

Hypertension control programs

Cardiovascular risk intervention programs

Health Maintenance Organizations (HMO's) can be viewed as aggregates of cost control measures. That is, each HMO is responsible for providing a comprehensive range of health services to its enrolled population for a pre-determined cost or premium. In order to be viable, each HMO must incorporate a variety of utilization control and cost control measures into its regular operation. As organized systems for health care, HMOs are in a position to balance the health care needs of members with the necessity for economy.

Nationwide, HMOs have built an impressive record in cost containment, while the benefits they offer are usually more comprehensive than are available to the employee under his standard health benefit. The State currently utilizes HMOs in various locations.

Preferred Provider Organizations (PPOs) are cost saving mechanisms that, unlike HMOs, preserve employees' freedom to choose their own doctors and hospitals.

Under this concept, reduced levels of charges are negotiated with providers of care, based upon certain quantified savings that they can realize through prompt payment by the Plan, reduction of their bad debt ratio and more efficient use of their services and facilities by a greater number of patients.

The State's program is large enough to realize substantial savings through PPO agreements with physicians and hospitals in major metropolitan areas. Similar programs around the country are being viewed as very successful cost containment mechanisms.

Community Involvement is less apparent as an available means of cost containment but, given the appropriate State commitment, can be as effective as any of the more direct procedures outlined in this section. As health care costs continue to rise, it becomes more necessary than ever that purchasers of health care involve themselves in health care pricing. Because the State is a significant purchaser of health care services in Kansas, its officers and employees have multiple possibilities available to provide input to the pricing mechanisms that relate to health care. Serving as trustees on hospital boards of directors, as committee members of citizen review committees, as volunteer members of State Health Department task forces, and as members of the Health Systems Agencies and serving similar committees and task forces which utilize input from the community,

all are examples of what we are suggesting. As a means of affecting the future of Kansas health care costs, facilities and services, it is entirely appropriate that the State encourage input into as many health care related boards, committees and task forces as exist.

In summary, there are a number of specific plans that the State and its employees can implement that will have a significant impact on the direct claims cost of its health plan. It is a very realistic assumption that a combination of these cost containment measures could save the State's Program in excess of five percent of its expected incurred claims cost. This equates to a savings of over $3,000,000 for the 1983-84 plan year. The cost to implement these programs would be far less than the dollars saved. The State's share of each five percent reduction in claims cost would exceed $1,900,000.

VIII. SUMMARY AND CONCLUSIONS

This study has evaluated the State's Group Health Program. It is felt that significant savings could be realized by converting the present plan to a self-funded program.

In addition, alternative methods of administation should be explored. This could result in a significant impact on the cost of the program, particularly with regard to implementing certain monitoring and cost containment activities, both directly by the State and through the utilization of outside resources.

The design of the plan benefits should be reviewed, with an eye towards future plan modifications. These could have a direct impact on reducing the cost of health claims under the program through modification of patterns of overutilization and abuse that may have arisen due to the current benefit plan design.

In these times of economic difficulty, it behooves the State to muster all the sophisticated resources at its disposal to ensure that its health plan incorporates the most proven, effective means of cost containment while still keeping benefits at an appropriate level.

Other States, as well as major corporations similar in size to the State of Kansas' Group Health Plan, have implemented these suggested modifications. Based upon our experience in this field, we believe that the State of Kansas could design and implement a very effective self-funded program, with an effective date of late 1984. Obviously, a great deal of work would be involved in this project, but the cost savings to the State would be very significant in future years.