Approved: _____
Date February 26, 2002

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on February 19, 2002 in Room 210 Memorial Hall

All members were present except: Representative Sue Storm, Excused

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
Renea Jefferies, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Kyle L. Wendt, Health Benefits Administrator, State of Kansas Employee Health Care Comm.

Others attending: See Attached Sheet

The Chairman transferred **HB 2912 - Emergency Medical Services, professional levels, activities, licensure** to the Sub-Committee on Credentialing.

The Chairman stated that Kyle Wendt, of the employee Health Care Commission was giving a cost benefit analysis and was appearing voluntarily.

Kyle Wendt, Health Benefits Administrator to the state of Kansas Health Benefits Plan, stated the State of Kansas Employer Health Care Commission (HCC) governs the Group Health Insurance Plan (GHIP). The HCC is authorized the "negotiate and enter into contracts with qualified insurers, health maintenance organizations and other contracting parties for the purpose of establishing the state health care benefits program."

The GHIP's responsibilities include providing a variety of health insurance services to: (1) Active, retired, and disabled state employees and their dependents. (2) People on leave with pay. (3) Elected officials. (4) Blind vending facility operators. (5) Students at higher education institutions and (5) Educational entities-employees of school districts, community colleges and other educational entities (admitted spring, 1999) (Attachment 1).

The Chairman thanked Mr. Wendt for the presentation and stated this was good information.

The meeting adjourned at 2:20 p.m. and the next meeting will be February 20, 2002.

HEALTH AND HUMAN SERVICES

DATE February 19, 2002

NAME	REPRESENTING
[illegible]	Rep Faber
Rebecca Guerry	Federico Consulting
Randall Allen	Kansas Assn. of Counties
Matt Bergmann	Pat Hubbell Assoc.
Eric Collins	Kansas Governmental Consulting
Dave Heitmann	HCA -
Fred Palenske	BCBSKS

Testimony To The

HEALTH AND HUMAN SERVICES COMMITTEE

By

Kyle L. Wendt
Health Benefits Administrator
State of Kansas Employee Health Care Commission

February 19, 2002

RE: State of Kansas Group Health Insurance Plan (GHIP)

Mr. Chairman and members of the Committee. Thank you for the opportunity to appear before you today. I appear as the Health Benefits Administrator to the state of Kansas Health Benefits Plan that is established by K.S.A. 75-6501 to develop and provide for the implementation and administration of a state employee health care benefits program. This statute was enacted by the Legislature in 1984.

Statutory Authority

The State of Kansas Employer Health Care Commission (HCC) governs the Group Health Insurance Plan (GHIP). Under K.S.A. 75-6504, the HCC is authorized to "negotiate and enter into contracts with qualified insurers, health maintenance organizations and other contracting parties for the purpose of establishing the state health care benefits program." The HCC has the authority under K.S.A. 75-6506 to determine whether employees of other entities can be allowed to participate in the GHIP. (State law identifies a number of possible participants, but the HCC decides whether those groups actually will be offered the chance to join.)

Extent of Services

The GHIP's responsibilities include providing a variety of health insurance services to:

- Active, Retired, and disabled State employees and their dependents
- People on leave without pay
- Elected officials
- Blind vending facility operators
- Students at higher education institutions
- Educational entities-employees of school districts, community colleges and other educational entities (admitted Spring, 1999)

HsHHS
2-19-02
Atch #1

Generally, the State of Kansas bids and contracts with health plans for three-year periods. These plans include:

- medical
- prescription drug
- dental
- vision
- hearing discount program
- Long-term care
- Student health insurance
- Hearing discount program

We estimate the GHIPs cover an estimated 35,000 active employees, 9,500 Direct Bill members, 250 COBRA participants, and 2,000 educational group members for a total of 46,750 contracts. In total, the GHIP covers approximately 93,500 lives.

Effectiveness/Performance Feedback

A recent Performance Audit Report[1], conducted last July, reported the State of Kansas already achieves economies of scale because of its size which translate into lower premium costs, and that Kansas is using four of five strategies experts identified as helping to control health insurance costs. These include:

- Engaging in competitive bidding and negotiation processes
- Comparing the "loss ratios" of the carriers
- Being aware of the "risk charges" of the insurance carriers, and
- Offering two to three HMO plans to stimulate competition

The fifth strategy, equalizing employer costs across plans is included for consideration under the HCC's three to five year action/strategy plan[2]. Other cost containment alternatives and strategies, as indicated in the HCC's most recent Annual Report[2], include more aggressive use of the GHIPs PBM, encouraging managed care and preferred provider networks, the development of disease management programs, consumer education and emphasis on vendor and carrier relationships within the GHIP including performance guarantees.

A recently completed performance audit[3] of the Pharmacy Benefit Manager (PBM) indicated they are doing a good job as the state GHIP's PBM. In addition a new financial arrangement, implemented in PY 2001 with the PBM, allows them to retain all rebates and they in turn pay the state GHIP a flat dollar amount each month per contract holder. This arrangement is expected to net the state's GHIP $2 Million in FY 2002.

The new medical plan designs for PY 2002 produced some very exciting enrollment results. We saw over 6,000 active participants move out of Kansas Choice, our most expensive plan option, into more cost effective, managed care alternatives including preferred provider organization (PPO) and health maintenance organization (HMO) alternatives. In fact, approximately 41% of our employees are now enrolled in an HMO option.

Vendors/RFPs/Contracting Process

The state's GHIP currently contracts with eight different health care underwriters. These vendors include:

- Coventry Health Care (HMO)
- Mid America Health (HMO)
- Blue Cross and Blue Shield of Kansas-Third Party Administrator and (HMO)
- Preferred Health Systems Insurance Company-(PPO) and (HMO)
- Harrington Benefits Services, Inc.-Third Party Administrator (PPO)
- Delta Dental Plan of Kansas-(includes a PPO)
- AdvancePCS-(PBM)
- Vision Service Plan

When it is time to release a Request for Proposal (RFP), the HCC will release the request on a national basis. The HCC utilizes the services of an independent consulting and actuarial firm to assist it in the development of plan design options and evaluating health care plan carrier proposals. Although by statute, the HCC is exempt from the state's purchasing rules, the HCC voluntarily complies with these rules.

Cost Sharing

Employer (Composite Rate), Employee contributions, and Direct Bill (Retiree and COBRA participants) contributions generate reserves used to pay the costs of the GHIP. The current reserve amounts have allowed the HCC to self-fund the medical indemnity, a new PPO medical plan option, dental and prescription drug programs. Since 1996, the excess in these reserve accounts has allowed the HCC to absorb some of the cost increases to reduce the impact on agency budgets and plan participants. However, it is imperative that sufficient reserve amounts be maintained to assure the financial stability of the program. By the beginning of FY 2003, program reserves will be reduced to the minimum level required to assure the actuarial soundness of the program as required by statute.

Employer and Employee rates are developed annually, depending upon the expected participation level, administrative costs and claims experience of the state's GHIP. The GHIP's actuary assists the HCC in developing expected costs for a three-year time frame. Projected health plan costs are estimated at:

- $245,000,000 for FY 2002
- $276,000,000 for FY 2003
- $309,000,000 for FY 2004

Size of Staff

The HCC only has one direct staff person, that being myself, the Health Benefits Administrator. Through the Division of Personnel Services, I supervise a staff of 17 Full Time Employees, which provide the strategic and administrative support, needed for the state's GHIP. The HCC is also assisted by the voluntary efforts of 21 members of the Employee Advisory Committee, who represent both active and retired state employees interests.

From the recently completed Performance Audit Report[1] the question was asked "does the state health benefits program have enough staff, funding, and other resources to handle its current workload?" The Performance Audit Report indicated that staffing was appropriate given the current work load, that staffing levels generally were in the mid-range compared with other states reviewed, that revenues generated from educational groups have been grossly insufficient to cover the administrative costs of serving those groups, and that computerized membership systems are problematic. This question is especially important to note as the Performance Audit Report indicated that the GHIP doesn't have the computer systems, budget or staff to handle the increased workload if cities and counties are extended eligibility into the Program.

Long-Term Care Plan

The HCC also sponsors a voluntary Long-Term Care (LTC) plan underwritten by the Hartford Life Insurance Company. This plan has been available to active employees and their eligible dependents since 1998. This plan is a fully insured program, with rates developed by the Hartford, based upon their standard underwriting criteria for a group LTC program. The HCC is currently considering strategies that could make this plan a more attractive option to our employees and their eligible dependents.

In summary, I'm pleased to report that the state's group health insurance and long-term care programs are efficient and effectively managed. These statements are verified by the results of two recently completed Legislative Post Audits[1,2,] and the recently completed Pharmacy Benefit Manager[3] audit. The plan designs represent contemporary and competitive plan options. They offer excellent coverage at affordable prices. I'm attaching additional information which I know will be of interest to the Committee. Thank you and I stand for questions.

Attachments

[1]Performance Audit Report, The State Health Benefits Program, Part 2: Reviewing the Staffing and Structure of the Current Program, July 2001

[2]Kansas State Employees Health Care Commission Annual Report 2001 Plan Year

[3]Interim Report: Kansas Employees Health Care Commission Audit of AdvancePCS, November 30, 2001

[4]Performance Audit Report, The State Health Benefits Program, Part 1: Reviewing Issues Relating to Premium Costs and Management, April 2001

1-4

http://da.state.ks.us

DEPARTMENT OF ADMINISTRATION
Kansas State Employees Health Care Commission

BILL GRAVES
Governor

JOYCE H. GLASSCOCK
Acting Secretary of Administration

KYLE L. WENDT
Health Benefits Administrator
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Landon State Office Building
Topeka, KS 66612-1251
785-296-6280
FAX (785) 368-7180

January 3, 2002

The Honorable Dave Kerr
President of the Senate
Room 359-E, Statehouse
Topeka, Kansas 66612

The Honorable Kent Glasscock
Speaker of the House of Representatives
Room 380-W, Statehouse
Topeka, Kansas 66612

SUBJECT: State of Kansas Health Care Benefits Program Annual Report

Dear President Kerr and Speaker Glasscock:

In compliance with K.S.A. 75-6509, attached for your review is the state of Kansas Health Care Benefits Program Annual Report.

Sincerely,

Kyle L. Wendt
Health Benefits Administrator

KLW:bcl

Attachment

BACKGROUND

The Kansas State Employees Health Care Commission (HCC) was created by the 1984 Legislature through the enactment of K.S.A. 75-6501 et. seq.... to "develop and provide for the implementation and administration of a state healthcare benefits program . . . It may provide benefits for persons qualified to participate in the program for hospitalization, medical services, surgical services, non-medical remedial care and treatment rendered in accordance with a religious method of health and other health services." Under K.S.A. 75-6504, the HCC is authorized to "negotiate and enter into contracts with qualified insurers, health maintenance organizations and other contracting parties for the purpose of establishing the state healthcare benefits program."

The HCC is composed of five members. The Secretary of Administration and Commissioner of Insurance serve as members of the HCC as mandated by statute. The Governor appoints the other three members of the HCC and the statute requires one member to be a representative of the general public, one member to be a current state employee in the classified service and one member to be a retired state employee from the classified service. The Governor designated the Acting Secretary of Administration, Joyce Glasscock, as the Chair effective September 26, 2001. The Commissioners are:

Joyce Glasscock, Chair and Acting Secretary of Administration
Bryce Miller, retiree from the classified service
Duane Nightingale, representative of the general public
Kathleen Sebelius, Commissioner of Insurance
Dan Stanley, Chair and Secretary of Administration (through September 25, 2001)
Nelson Wong, current employee from the classified service

Consulting services are provided by The Segal Company. Segal was awarded the contract for consulting/actuarial services beginning January 1, 2001. Segal is an independent consulting firm specializing in employee benefits, compensation, actuarial services and human resource management with offices located in the United States and Canada.

The HCC re-implemented an Employee Advisory Committee (EAC) as provided by K.S.A. 75-6501(b) by adopting EAC By-laws on August 16, 1995. The Committee is composed of 21 members, 18 of whom are active employees and three are participating through Direct Bill. Each member serves a three-year term. Members are selected on the basis of geographic location, agency, gender, age, and plan participation in order to assure that a balanced membership representing a broad range of employee and Direct Bill members interests are represented. (Exhibit A) The EAC met five (5) times during 2001 and made significant contributions toward plan design decisions made by the HCC for Plan Year (PY) 2002.

PLAN YEAR 2001 EXECUTIVE SUMMARY

Medical/Dental/Prescription Drug Options

This was the third contract year for current medical and vision plans and the first year of the dental and pharmacy benefit management (PBM) contracts.

Current plan offerings are:

Indemnity Plan
Kansas Choice Senior

Point of Service Plans (POS)
Kansas Choice – Managed Indemnity Gatekeeper Model administered by Blue Cross Blue Shield of Kansas
Preferred Health Systems Insurance Company – Preferred Provider Organization (PPO) Non-Gatekeeper Model

Health Maintenance Organizations (HMO)

HealthNet (Name change to Mid America Health effective 1-1-02)
Premier Blue
Preferred Plus of Kansas
Coventry Health Care

Prescription Drug Program
AdvancePCS

Dental Plan
Delta Dental Plan of Kansas

Vision Insurance Plan
Vision Service Plan

Hearing Improvement Program
K-SHIP

Long Term Care

The HCC continued the voluntary Long Term Care (LTC) plan underwritten by the Hartford Life Insurance Company. This was the first contract extension period for the long term care plan.

Student Insurance

The HCC continued the Statewide Student Insurance Program with Student Resources for school year 2001-2002. The HCC implemented plan design recommendations suggested by the university health centers to better serve the student population.

Claims Analysis System

Implementation of the claims analysis system negotiated with The MedStat Group during 1999 was completed in PY 2001. Significant time has been invested to design and consolidate the data files provided to MedStat by contracting carriers. It is imperative that the data contained in the MedStat system accurately meet the reporting requirements outlined in Senate Bill No. 3, and to assure that plan design considerations are based on reliable information.

Educational Group

In 1999, the HCC established administrative procedures and eligibility requirements to allow for inclusion of unified school districts, community colleges, technical colleges, and vocational technical schools into the state plan. Enrollment of educational groups has continued to increase. Enrollment in the state Group Health Insurance Program (GHIP) is currently eighteen (18) groups with 1,956 contracts at the end of PY 2001.

Benefits Web Pages

The Benefits Website was further enhanced during PY 2001. It is located within the Division of Personnel Services (DPS) website at http://da.state.ks.us/ps/benefits.htm. This site contains administrative policies, open enrollment information, wellness activities, decision tools, and hot links to contracting medical, dental, vision care, hearing improvement, and prescription drug providers.

Direct Bill and Educational Group components are included in the separate HCC Website located at http://da.state.ks.us/hcc/default.htm. This site contains information regarding HCC membership, staffing, meeting dates, and other information pertaining to HCC activities

Web Based Open Enrollment

For PY 2002, open enrollment for active participants was conducted utilizing the AKSESS online system. More than 15,000 participants made changes to their GHIP coverage on the Internet.

Consulting Services Contract

The contract for consulting services was awarded to The Segal Company beginning January 1, 2001. Segal provided assistance to the HCC and staff, including actuarial services, developing plan design options and evaluating medical plan carrier proposals.

Hearing Improvement Program (K-SHIP)

On March 21, 2001, the HCC approved the sponsorship of the K-SHIP program. K-SHIP is a hearing improvement program utilizing the hearing and speech departments at contracting State universities, and allows employees and their covered family members to receive a discount on certain hearing services.

Services include hearing evaluations and testing as well as hearing testing required to determine the need for hearing aids. Hearing evaluations may be eligible for coverage under a GHIP option. However, K-SHIP is a value-added benefit and does not, in and of itself provide financial "direct-pay" benefits.

Employees who are enrolled in the state GHIP and their covered family members are eligible to participate in K-SHIP.

The following universities are contracting providers for PY 2001:

Fort Hays State University
Kansas State University
KU Medical Center
University of Kansas
Wichita State University

2001 ACTIVITIES & ACCOMPLISHMENTS

The HCC released the following Requests for Proposal (RFP). In addition, rate renewals were negotiated for all fully insured health plans.

	Released	Closed	Responses	Comments
Vision	2/22/01	3/22/01	9	Re-release 2002
Long Term Care	2/22/01	3/22/01	1	Current Contract Extended
Medical	3/1/01	4/13/01	14	2 Network Only, 6 Third Party Administrator (TPA), 1 POS, 4 HMO, 1 PPO
PBM-Audit	5/4/01	6/1/01	4	

- As a result of the negotiations, the HCC awarded the following contracts to begin January 1, 2002 for all GHIP participants:
  - HMOs: Coventry Health Care, HealthNet (re-named Mid America Health), Premier Blue and Preferred Plus of Kansas were all retained.
  - Blue Cross Blue Shield of Kansas (BCBS) was retained to provide administrative services for the Kansas Choice and the new Kansas Senior Plan C program. The healthcare provider network supporting this program is administered by BCBS, and provides nationwide access to in-network providers.
  - Preferred Health Systems Insurance Company (PHSIC) was retained as a fully insured PPO option. The healthcare provider network supporting this option is administered by Preferred Health Systems (PHS), and provides statewide access to PPO network providers.
  - Harrington Benefit Services, Inc. was retained as the Third Party Administrator (TPA) for the new PPO, Kansas Prefer. The healthcare provider network supporting this program is administered by Private HealthCare Systems (PHCS) and provides nationwide access to in-network providers.
  - The contract with Vision Service Plan was extended for one year and amended to include an enhanced vision plan with additional benefits for participants electing this option.
  - The Long Term Care contract was extended for one contract period.
  - A contract was awarded to Heritage Information Services to audit the state's GHIP Pharmacy Benefit Manager, AdvancePCS, Inc. Audit results concluded that AdvancePCS is administering a quality, efficient program for the HCC.

Service Area Modifications

There were no changes in the service areas during PY 2001.

Medical Benefit Changes

Mental Health Parity with medical services for "biologically based illness" was added to the Kansas Choice Plan for PY 2001. Otherwise, there were no significant benefit changes in the medical plans offered by the state during PY 2001.

Prescription Drug Benefit Changes

The plan design changes implemented in PY 2000 accomplished the goal of curbing utilization trends. However, these changes in and of themselves were not enough to curb rising utilization trends for PY 2001.

Prescription drug costs are increasing because of greater utilization and the increased price of drugs. Many factors contribute to increased drug utilization including aging members, the availability of more drugs that treat more conditions, drugs which have become more critical to treatment and prevention of numerous illnesses, and marketing campaigns by pharmaceutical companies to encourage the purchase of more expensive drugs in key categories.

Three modifications were made to the prescription drug program for PY 2001:

- Medications intended for self-injection were moved from medical to prescription drug coverage for better utilization data and additional cost savings.
- The out-of-pocket maximum which was eliminated for PY 2000 was reinstated on an indexed basis starting at $1,500 per person per year.
- Participants have access to a mail order prescription drug option with benefits, costs and plan design identical to that of the retail state GHIP network.

The mail order program was added based on feedback from retirees, employees in rural areas and other participants who have difficulty accessing a contracting retail state GHIP network pharmacy. The intent of the mail order option is to enhance access to pharmacy benefits. Benefits available through this mail order program are the same as available through any other contracting retail state GHIP pharmacy.

During PY 2001, the state's drug trend has consistently ranged between 20% and 30%. A "spike" at the beginning of the plan year is attributed to the re-introduction of an out-of-pocket maximum in PY 2001. (See Exhibit B, Rx Trends, 99, 00, 01.)

Dental Benefit Changes

Orthodontic coverage was added for members using the Delta Preferred Option (DPO) network of dentists and other contracting orthodontists.

- A $35 deductible was implemented for major restorative service, e.g., crown
- The benefit level for regular restorative dentistry, oral surgery, endodontics, and periodontics was increased from 50% to 60%.

Vision Insurance Plan Changes

This was the third year of the Vision Service Plan program. There were no benefit modifications for the Vision Service Plan program for PY 2001.

State Contribution for Dependent Coverage

The PY 2001 state contribution continues to be approximately 35% of the cost of dependent coverage for full time employees.

Direct Bill Subsidy

Direct Bill participants continue to participate in the state's GHIP by paying the premium for coverage for themselves and any covered dependents. The original intent was for Direct Bill participants to pay the full cost of coverage. Effective January 1, 1989, a complex financial arrangement was developed for the Blue Select and Blue Cross Traditional programs, the prescription drug plan for those participants, and the dental plan for all participants, which were fully insured programs. Blue Cross and Blue Shield premiums for Direct Bill participants were set at 85% of requested premium level (requested premium minus 15% withheld by the state) with the state retaining any money left in the reserve account after the final settlement. Through the years, some of the withheld premiums were used to pay for claims incurred by plan participants, including Direct Bill participants. The subsidy ranged from $0 to $115 depending on level of coverage. Prior to 1996, Direct Bill premiums were not adjusted to include these additional costs and the participants in the Blue Cross and Blue Shield Traditional programs inadvertently received a subsidy.

For PY 1996, the state entered into a self-insured contract with Blue Cross and Blue Shield and Delta Dental that eliminated the 15% withhold. The HCC made the decision that as a result of the change in the funding arrangement, it would again adhere to the concept that Direct Bill participants should pay 100% of their cost of coverage. The HCC decided to phase out the remaining Blue Cross subsidy during the next few years. However, because of rate increases to Direct Bill participants for the past several plan years, including PY 2001 the phase out of the remaining subsidy has been postponed.

The HCC currently supports the contribution of approximately $108,000 per month ($1.3 Million per year) toward the cost of medical coverage for retired state of Kansas Direct Bill members enrolled in Kansas Choice or Kansas Choice Senior. On an individual basis the contributions range from $0 to $115.

Direct Bill Outreach

The HCC has continued to emphasize the importance of the Direct Bill participant group through a variety of outreach activities. This group is comprised of nearly 10,000 contracts, the majority of whom are retirees and their dependents. In addition to conducting five pre-retirement seminars throughout the year, staff conducted 11 Direct

Bill open enrollment meetings between October 15 and November 5, 2001 in various locations throughout the State of Kansas.

The open enrollment period specific to Direct Bill participants was changed to October 15 through November 16, 2001. This was done to emphasize changes in healthcare plans that affect retirees, and to highlight a new self-funded Medicare supplement called Kansas Senior Plan C.

In addition, a call-in center dedicated to Direct Bill participants was in operation during open enrollment. This is the second year of the center's operation, which again was staffed by State of Kansas retirees. More than 1,450 calls were received during the open enrollment period, and nearly 55% of the calls were inquiries about the new Kansas Senior Plan C option.

The *Direct Bill News*, a newsletter that provides healthcare tips, plan information, and other items of interest to participants, is published quarterly. A satisfaction survey was included with one issue this year. The survey indicated overwhelming approval of the newsletter content and usefulness to Direct Bill participants. Copies of the 2001 newsletters are included with this report. See exhibit C.

Educational Group Participation

K.A.R. 108-1-3 was made permanent on January 11, 2000. This was the last step in the regulatory process that detailed participant eligibility in the state's GHIP for educational groups. The HCC adopted a strategy that allowed an educational group to phase in or "ramp-up" the contribution for employee or dependent coverage during a period of three years for the employee and five years for dependent contribution to allow for budget increases to occur for those educational entities needing time to make budget changes.

Educational group participation has grown steadily as indicated in Figures 1a-b. Currently, fifteen unified school districts, one educational service center and two community colleges are participating in the group with a total of 1,956 contracts. Based on our continuing discussions with several school districts, more educational groups are expected to join in the first six months of PY 2002.

Figure 1a: Educational Entities

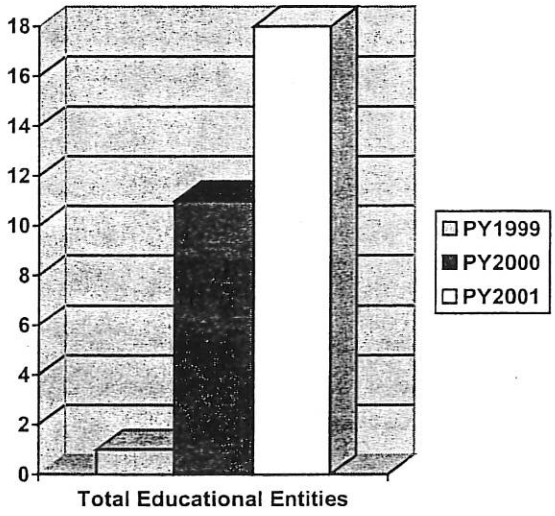
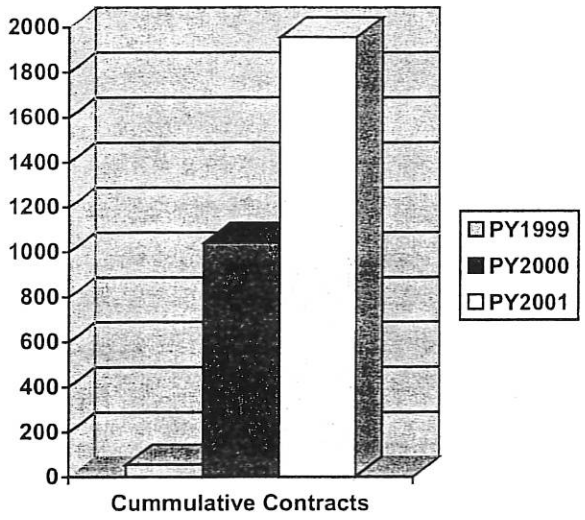


Figure 1b: Number of Contracts



The HCC has determined that the educational entity groups' claims experience in the GHIP will be pooled with the state employee groups' claims experience until the educational entities enrollment exceeds 1,250 participants in the self-insured indemnity plan. When this event occurs, the educational entities may be reviewed to determine how this group's claims experience compares to the claims of the state employee group. For any plan year that begins after at least 1,250 eligible self-insured indemnity contracts are enrolled, the HCC will decide whether all educational entities will be placed in a separate pool that is still a part of the state's GHIP.

Building Better Health

This website continues to be available to the state's GHIP participants. The Building Better Health Website can be found at http://kse.buildingbetterhealth.com. This website provides:

- List of formulary drugs
- Special Case Medications
- Lifestyle Medications
- Covered Injectibles
- Source of health & fitness information
- Access to AdvancePCS

Building Better Health continues to provide timely information on a number of health topics in addition to providing access to GHIP information.

Statewide Student Insurance Plan

The Statewide Student Insurance plan (SWSI) administered by Student Resources and underwritten by Mega Life and Health Insurance Company is available to all full time students at Kansas Regents universities. This is the second year of the contract with Student Resources. In response to input received from the university health centers as well as staff, a number of benefit changes were approved by the HCC. The separate benefits for medical expenses and major medical expenses were combined into comprehensive coverage for all medical expenses. The overall benefit maximums of $100,000 on the Limited plan and $250,000 on the Comprehensive plan remain unchanged. Coverage also was added for reproduction services. Repatriation and medical evacuation coverage was added to all policies. The HCC addressed university administrative staff concerns regarding the number of age tiers for rating students by moving to a two-tier rate structure. Tier one covers students who are less than 26 years of age and tier two covers students who are more than 26 years of age, effective PY 2001. As of the fall 2001 semester, enrollment in SWSI included 2,680 active students.

Separate policies are available to certain qualified Graduate Teaching Assistant (GTA), and Graduate Research Assistant (GRA) students working at a regents university. Eligible GRA and GTA students receive an employer contribution toward the cost of their insurance. The HCC has established the employer contribution at 50% of the more than 26 years of age rate for both the Limited and Comprehensive programs.

Enrollment in SWSI has continued to grow since implemented in 1998. As of the fall 2001 semester, 1,889 GRA/GTA students were enrolled and received an employer contribution. Meetings were held with university administrative staff to streamline processing for the increasing number of participants and the plan administration.

AKSESS On Line Open Enrollment

For the second year, the State of Kansas conducted open enrollment for PY 2002 GHIP coverage on the Internet. State employees used the AKSESS (Automated Kansas State Employees Service System) website at http://da.state.ks.us/aksess/default.htm to enroll or make changes in coverage during October 2001. More than 15,000 individuals made changes to their GHIP coverage using this Internet based service portal. The enrollment statistics exceeded expectations based on prior year AKSESS enrollments.

Performance Audit Report

Earlier this year, the GHIP was the subject of two Performance Audit Reports, conducted by the Legislative Division of Post Audit. The two audits were titled:

- The State Health Benefits Program Part 1: Reviewing Issues Relating to Premium Costs and Management (April 2001)
- The State Health Benefits Program Part 2: Reviewing the Staffing and Structure of the Current Program (July 2001)

The results of both audits were very favorable regarding the operation and administrative staff of the GHIP and the Executive Summary of each audit can be found in Exhibit D.

PLAN YEAR 2002 PREVIEW

PLANS

Medical plans available to participants will be:

- Coventry Health Care (HMO)
- Mid America Health (HMO) (formerly HealthNet)
- Premier Blue (HMO)
- Preferred Plus of Kansas (HMO)
- Kansas Choice (Managed Indemnity Plan)
- Preferred Health Systems Insurance Company (PPO)
- Kansas Prefer (PPO) (New)
- Kansas Senior Plan C (New)

Prescription Drug Program will continue to be administered by AdvancePCS, a Prescription Benefit Manager (PBM).

Dental Plan will continue to be administered by Delta Dental Plan of Kansas.

Vision Insurance Plan, a voluntary, employee pay all option will continue to be available through the Vision Service Plan. Two options will be available.

The Hearing Improvement Program (K-SHIP) will continue to be available as a value-added program for those members requiring hearing evaluations and testing.

Name Change

HealthNet is being renamed Mid America Health, effective January 1, 2002. There are no network changes associated with the renaming.

Service Area Modifications

The most significant change is the addition of a new PPO option, Kansas Prefer, which is a self-funded plan administered by Harrington Benefit Services, Inc. The plan utilizes Private HealthCare Systems (PHCS), a national network of healthcare providers. Other minor changes include the addition of several new counties into the designated HMOs, as listed below:

Coventry Health Care: Anderson and Pratt in Kansas; Daviess in Missouri
Mid America Health: Coffey, Franklin, Jefferson, and Osage
Preferred Plus of Kansas: Greenwood

PY 2002 will be the first year that a managed care option is available to all participants. Managed care is a system of health care delivery that influences utilization and costs of services and measures performance. The goal is a system that delivers value

by giving people access to quality, cost-effective health care. The state's GHIP provides several managed care options including a managed indemnity program, preferred provider organization, and health maintenance organizations.

Medical Benefit Changes

For PY 2002, the HCC selected a combination of plan design changes, and funding decisions that address cost containment issues as well as support the idea of employee/retiree choice. The HCC made decisions that reflected the findings of the Legislative Post Audit [1] and industry trends regarding greater participant contributions either by increased premiums or greater out-of-pocket costs. For state employees and retirees, the HCC chose to not increase premiums for PY 2002. Rather, the HCC approved plan design changes, which shifted a greater portion of the costs of healthcare services to participants who use the services while providing viable less expensive GHIP choices for all participants. The cost increases to participants are reflected in changes to deductibles, co-insurance, co-pays, and out-of-pocket maximums for in-patient and out-patient services, depending on the GHIP option. The HCC eliminated the primary care physician "gatekeeper" requirement under the state's GHIP managed indemnity option. As noted previously, the HCC added a second PPO option, which provides another plan alternative to the most expensive GHIP option (Kansas Choice). Both of the PPO options provide $300 for wellness/preventive services. Enclosed is an illustration of the different active employee GHIP options that compares the various benefits and participant costs. (See Exhibit E)

Kansas Senior Plan C

1200 enrolled

This is a new self-funded healthcare program that specifically addresses the needs of Medicare-eligible retirees and their Medicare-eligible dependents. This GHIP option offers the same medical benefits as a Medicare Supplemental Plan C, plus prescription drug and dental coverage. The Kansas Senior Plan C option will be administered by Blue Cross Blue Shield of Kansas. AdvancePCS and Delta Dental of Kansas currently administer the prescription drug and dental components, respectively.

For PY 2002, the HCC determined that there would be no premium increase to Direct Bill members. Therefore, all retired Direct Bill members will continue to receive a subsidy next year and the subsidy will include prescription drug, and dental as well as medical coverage. The individual subsidy amounts per month will range from $38.95 to $216.81. **Depending on a retiree's enrollment choices, this could more than triple -- and perhaps even quadruple the subsidy currently being paid for these Direct Bill members.**

Prescription Drug Benefit Changes

Because of the rate of increase in the cost of the prescription drug program for PY 2001, the HCC modified the prescription drug benefits for PY 2002. The modification in

1 The State Health Benefits Program, Part 1: Reviewing Issues Relating to premium Costs and Management, A Report to the Legislative Post Audit Committee by the Legislative Division of Post Audit, State of Kansas, April 2001.

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copay percentages is designed to encourage greater use of generics whenever possible. The state GHIP continues to realize generic drug utilization at a decreasing trend level as compared to formulary brand name utilization. (See Exhibit F, generic and formulary utilization rate chart.)

Three changes were made to the prescription drug program for PY 2002:

- Participant co-insurance: generic drugs will be reduced from 25% to 20%; formulary brand increased from 25% to 30%
- Copay for special case medications will increase from $50 to $60 *
- The annual out of pocket maximum changed to $2,100*

* These plan features were previously indexed by plan utilization factors.

The mail order program added in PY 2001 will be continued.

Dental Benefit Changes

There will be no changes in dental coverage for PY 2002.

Vision Benefits Changes

The voluntary Vision Service Plan (VSP) program will be available again during PY 2002. Based upon input from the EAC, the HCC approved offering two different vision benefit programs for PY 2002.

For PY 2002 enrollment is estimated at 10,060 contracts under the Basic Plan, and 5,103 contracts under the Enhanced Plan.

The plan offered in prior plan years has been renamed the Basic Plan and covers lenses and frames every two years or contacts every two years. Rates for the Basic Plan are unchanged for PY 2002. The new plan option named the Enhanced Plan, has all the benefits of the Basic Plan, plus lens replacement every year and coverage for no-line bifocals, scratch resistance and ultraviolet lens coatings. The Laser Care Vision Benefit for photorefractive keratectomy (PRK) and Laser-assisted in-situ keratomileusis (LASIK) is available under both plans. A participant does not have to be enrolled in the medical plan to enroll in vision coverage through the VSP.

Long Term Care

The HCC continues to offer a voluntary Long Term Care (LTC) insurance plan insured by Hartford Life. The HCC is working with Hartford Life to develop a HCC website link to a Hartford supported website to enhance the visibility and provide for the voluntary enrollment of the Long Term Care insurance plan to eligible members.

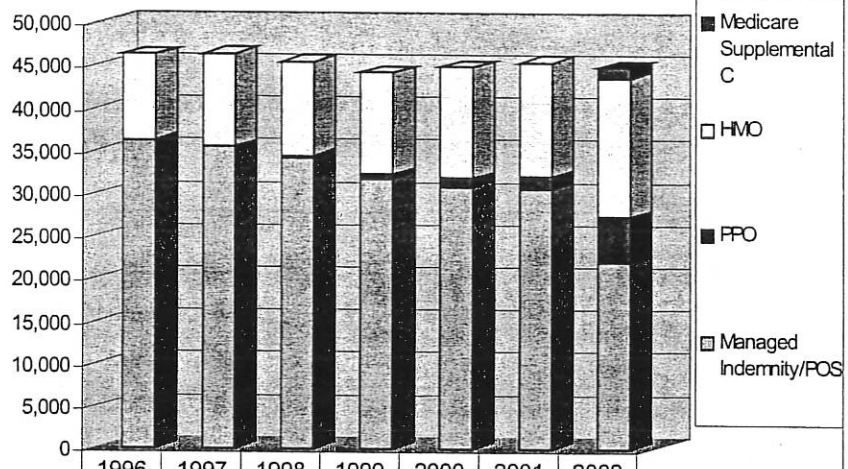
Other

The HCC approved the indexing of all plan features including deductibles, co-pays and out-of-pocket amounts to be indexed by plan utilization factors.

PARTICIPATION

Active employees, retirees, employees receiving long term disability payments, employees on leave without pay, qualified beneficiaries on COBRA, as well as other individuals identified in K.A.R. 108-1-1 participate in group health insurance plans. During PY 2001, an average of 34,612 active employees, 9,382 direct bill members, 252 enrolled participants under COBRA, and 1,232 Educational group members participated in the health insurance program for a total of 45,478 contracts. In total, the GHIP covers approximately 85,200 lives. See figure 2 for an illustration of participation by plan type.

Figure 2: Plan Participation by Category
1996 - 2002*



	1996	1997	1998	1999	2000	2001	2002
Medicare Supplemental C							1,266
HMO	9,986	10,828	11,079	11,961	13,038	13,362	16,331
PPO	92	103	292	510	1,005	1,526	5,407
Managed Indemnity/POS	36,165	35,428	34,139	31,790	30,823	30,590	21,935

*projected

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COST PROJECTIONS

Figure 3 illustrates the anticipated cost projections for the next three years.

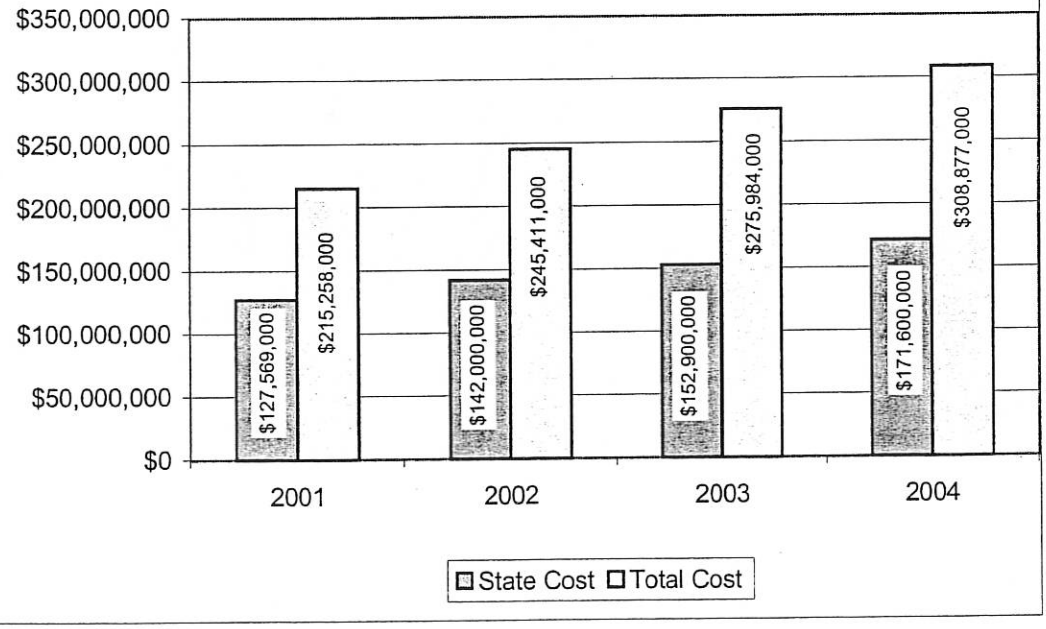
An unknown factor at this time is the on-going rate of medical inflation. However, the following trend assumptions were used to project GHIP costs for FY 2002 to FY 2004:

- Self-insured medical claims: 12%
- Insured HMO premiums: 10%
- Self-Insured RX claims: 20%
- Self-insured dental claims: 8%

These trend assumptions will change, as additional data becomes available.

Bids received during rate renewal negotiations were as high as 26% for the PY 2002. The prescription drug component continues to exceed the general rate of medical care inflation.

Figure 3: KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION Projected Health Plan Costs 2001 - 2004



Note: FY 2002 projected state cost includes the use of $18.9 million in GHIP excess reserves. After FY 2002, the balance of GHIP excess reserves is projected to be $0.

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Overall Plan Cost

Exhibit G indicates that the total cost of the group health insurance plan for PY 2001 will be approximately $218,489,151, which is 1.5% greater than estimated in the PY 2000 Annual Report. The annual total cost estimate is revised each year as more recent claims experience is collected. Of the $218 million cost of the health plan, $127 million represents expenditure of state funds (including the use of excess GHIP reserves).

COST CONTAINMENT ALTERNATIVES AND STRATEGIES

The HCC is continuing to study and develop cost containment alternatives. These strategies were incorporated into the Request for Proposal for 2002 to 2004 medical benefits. The EAC continues to be an active partner with the HCC as it deals with all aspects of the GHIP.

Strategic Areas

Prescription drug costs continue to rise faster than the medical inflation rate. Additional cost savings for the GHIP could be obtained through more aggressive use of the PBM. The Pharmacy Advisory Committee (PhAC) continues to support the HCC in this important area. Members of the PhAC include AdvancePCS, medical pharmacy directors of our contracting medical plans as well as a member of the EAC. The plan design implemented in PY 2002 will continue to be monitored to assure continued satisfaction of participants' needs and cost efficiency. Emphasis will continue to be placed on the use of generic drugs whenever possible.

Dental Plan - Continue to encourage managed care and preferred provider networks as well as encouraging and supporting the preventive care activities of plan participants. Emphasis will be placed on the potential expansion of the DPO network.

Disease management programs, consumer education and emphasis on management of vendor and carrier relationships within the GHIP are keys to lowering healthcare costs for the long term. More emphasis is being directed at disease management programs, which give participants tools, such as information on treatment options and physician and hospital care to better manage their own care. Efforts in this area are a natural application of HealthQuest, the state's employee wellness and health promotion program.

The HCC will continue to look to the EAC, as well as other focused participant groups for ideas and support for changes in the GHIP.

Performance Guarantees – An important component of the negotiation of the healthcare contracts for PY 2002 to PY 2004 was the refinement of performance guarantees included in the terms of the state contract. These performance guarantees are designed to assure that all parties involved in providing health benefits to state GHIP participants understand the expectations of the state, and will help to provide continued quality services to participants of the state GHIP.

All carriers contracting with the State of Kansas for the provision of health benefits have agreed to performance standards in the areas of:

- Membership Processing and Identification Cards
- Timeliness of Preauthorization/Predetermination(s)
- Enforcement of provider contracts
- Telephone responsiveness
- Claims processing accuracy and timeliness

It is the expectation of the HCC that these performance standards will increase member satisfaction and improve administrative effectiveness over the next several years. Performance guarantees will continue to be refined to address current and emerging contracting issues. Staff will review "best practices" of other employer plans to assure that the state's GHIP stays up-to-date in this important plan management area.

FUNDING

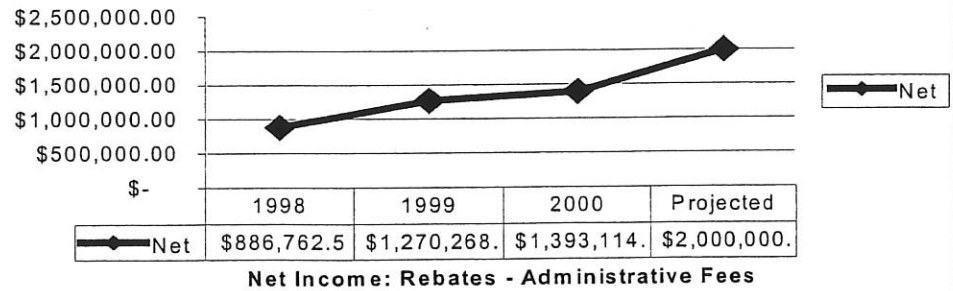
Reserve Accounts

The minimum premium funding arrangement with Blue Cross Blue Shield was established on January 1, 1989. Each contract period thereafter was assigned a separate reserve account. During the last four minimum premium contract years, the state was successful in retaining excess premium not spent on premiums and retention expenses. Since the contractual obligation of the minimum premium arrangement has been completed with Blue Cross Blue Shield of Kansas, these GHIP excess reserves are no longer encumbered to pay any additional claims run out. Therefore, they have been used during PY 2001 to offset the total cost of the GHIP. The composite rate (agency contribution) charged for PY 2001 is approximately 9% higher than the PY 2000 composite rate. The GHIP reserve balance at the end of FY 2001 was approximately $44 million. It is projected that the "no GHIP employee/retiree premium increase" strategy approved by the HCC for the PY 2002 will deplete the excess reserve balance to $0 by the end of FY 2002. Therefore, the unavailability of excess reserves will have a significant impact on future agency contributions.

Prescription Drug Plan

For PY 2001, the HCC renewed the pharmacy benefit management contract with AdvancePCS. AdvancePCS is the PBM for the prescription drug component of the state's GHIP. The HCC entered into a three-year, self-insured prescription plan Administrative Services Only (ASO) contract with AdvancePCS with a contingent contract with National Pharmacy Administrators in the event AdvancePCS did not meet performance expectations. A performance audit of AdvancePCS was completed earlier this year, and indicated AdvancePCS is doing a good job as the state GHIP's PBM. Under the prior contract with AdvancePCS, the state paid an administrative fee of $.76 per primary participant per month and retained all manufacturer's rebates on the medications purchased by plan members. This arrangement was changed for the new contract beginning with PY 2001. Under the new arrangement, AdvancePCS retains all rebates and pays the state's GHIP $3.83 per primary contract holder per month. The chart below shows the relative value of the new arrangement compared to the former arrangement.

Figure 4:
Administrative Arrangement: AdvancePCS



	1998	1999	2000	Projected
Net	$886,762.5	$1,270,268.	$1,393,114.	$2,000,000.

Net Income: Rebates - Administrative Fees

FUTURE DIRECTION

The HCC has made significant short-term changes to the benefit options and funding mechanisms for the state's GHIP for PY 2002. It is hoped that these changes will provide the anticipated savings for PY 2002. However, long term savings will more likely be realized by the development of disease management programs, consumer education and emphasis on management of vendor and carrier relationships within the GHIP. The following outline the basic plan parameters and action plans/strategies that will continue for the next three to five years.

Emphasis on Managed Care Options

The managed care options currently cost less than the indemnity plans offered to state participants. The state will continue to encourage competition and development of managed care networks in non-metropolitan areas of the state to increase participation in cost effective options. However, recent premium trends within the HMO industry and provider contracting issues raise concerns regarding the future ability of managed care programs to continue to contain costs and effectively coordinate the delivery of healthcare services. The cost and quality of care available through contracting managed care organizations will continue to be closely monitored to determine the appropriateness of continuing this strategy.

Simplification of Administrative Policies

The state GHIP is comprehensive and provides participants with a number of options with a great deal of selection. However, the number of choices available to participants and administrative processes may be difficult for some participants to comprehend. Efforts are ongoing to identify areas where the program options may be streamlined and simplified to enhance communications, understanding and efficiency. For example, PY 1996 provided 11 different medical plan options from which an employee could choose. In PY 2002, the number of choices has been streamlined to seven choices.

Use of Reserves

The current reserve amounts have allowed the HCC to self-fund the medical indemnity, dental and prescription drug programs. The excess in these reserve accounts has allowed the HCC to absorb some of the cost increases to reduce the impact on agency budgets, and to plan participants. However, it is imperative that sufficient reserve amounts be maintained to assure the financial stability of the program. By the beginning of FY 2003, program reserves will be reduced to the minimum level required to assure the actuarial soundness of the program as required by statute. As a result, if trends continue agencies and/or participants will see an increase in their plan costs that reflect the elimination of the excess reserve funding as well as increases in plan costs.

Employer Contribution for Employee Coverage

For many years, agencies have contributed the same amount for the cost of their employees GHIP option choices regardless of which GHIP option an employee elected to enroll. An alternative to help control future premium costs is to base the agency (composite rate) employer rate on one of the lower cost managed care GHIP options (either PPO or HMO). The difference in costs between the more expensive GHIP option and the employer composite rate plan would be the responsibility of the participant if they elect the more expensive plan option.

Employee Contribution for Employee Coverage

For PY 2000, employee contributions were changed to a percentage basis. Employees cost of coverage varies based on their plan selection. The state contributes approximately 95% of the cost of single only coverage, which is a very generous contribution rate compared to national employer statistics.

Employee Contribution for Dependent Coverage

The state currently contributes approximately 35% of the cost of dependent coverage. However, the state's contribution to dependent coverage continues to be less than average, as compared to national employer statistics. It is important to monitor the amount the state contributes for dependent coverage because this affects the overall participant level of the GHIP. The cost of managed care options and plan design will be continuously monitored to assure a cost effective alternative is available for participants to provide coverage for their dependents.

Demand Management

Integration of the HealthQuest program with the group health administration will continue by targeting specific intervention areas, which will provide the greatest impact on the utilization of services by plan participants. In addition, the program will be expanded to provide information and tools for participants to enhance their healthcare decision-making. Further partnering with employees may be expanded through the use of catastrophic care programs combined with medical spending accounts to allow participants greater flexibility in the selection and utilization of healthcare services. Additional emphasis will be placed on the healthcare decisions of plan participants in order to provide a coordinated approach to cost control and quality improvement.

Stop Loss

Claims and utilization data will continue to be monitored very closely to determine any future need for stop loss insurance. Current analysis shows that purchasing stop loss insurance is not necessary. However, should the claims analysis system indicate unpredictable variability in the group experience, stop loss coverage may be considered to protect the stability of the plan.

Other Entities

On November 13, 2001 the Commercial and Financial Institutions Insurance Committee recommended that the HCC bring cities and counties into the state GHIP. This recommendation was the conclusion of two hearings held this summer in which the Special Committee heard testimony regarding the allowance of cities and counties to opt into the state GHIP and the status of school district participation in the program. Staff provided written testimony at each of the two hearings.

At the December 5, 2001 HCC meeting, staff made the Health Care Commissioners aware of the Special Committee's recommendation regarding the inclusion of cities and counties into the state's GHIP.

In preparation for future discussion and decision making by HCC regarding the Special Committee's recommendation, staff plans to prepare a survey instrument to be sent to all of the cities and counties, requesting they notify staff of their level of interest in joining the state's GHIP. If an interest were expressed, staff also would request the provision of an estimated entry date, and other information such as potential enrollment. Staff also will request the GHIP's chief legal counsel to draft a regulation regarding eligibility provisions for the cities and counties.

Upon receipt of the responses, staff will prepare a report for the HCC and present to the Commissioners at the next scheduled HCC meeting for their review and discussion.

BILL NEWS
State Health Plan Continuation Program
Kansas State Employees Health Care Commission
1st Quarter 2001

First Direct Bill Call Center A Success

During the October 2000 Open Enrollment period, Direct Bill participants were provided with a dedicated call-in service center designed to answer questions regarding changes in health insurance coverage, costs of individual plans and options, and other general health care issues. Feedback from participants indicated that this was a valuable and meaningful service. A significant factor in that success was being able to have their concerns addressed by fellow retirees.

The center was staffed by fifteen paid volunteer retirees supervised by Division of Personnel Services staff. Depending on activity level, as many as three staff, and as few as one were assigned to a four-hour shift. Nearly 700 calls were answered ranging from how to integrate State health care coverage with Medicare, to changes in coverage for Plan Year 2001.

On November 20, 2000, volunteers and staff (pictured at right) met for a debriefing session to discuss ways in which the service center could be improved for the 2001 Open Enrollment period. Feedback was generally positive during this session and many suggestions were discussed to enhance the open enrollment process for Direct Bill participants next year. Future issues will address the suggestions discussed at the feedback session, including alternative ways to keep participants informed of important health care issues.

Generic Drugs-A Pharmacist's Perspective

The following is excerpted from an article entitled, Generic Drugs – A Pharmacist's Perspective by Kent Richardson, RPH, of the Pharmacy Network of Kansas.

When a pharmacist fills your prescription with a generic drug, you can feel comfortable and secure, because generic drugs are equal to brand-name drugs, but cost much less. Most of the time, generic drugs are manufactured by the same companies that produce brand-name drugs. Many generic companies are divisions of brand-name drug manufacturers.

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Inside This Issue

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Generic Drugs...*(continued from page 1)*

Why Generic Drugs Are A Better Value

One of the greatest costs a drug company incurs is for the research and development of a new drug. Once the 17 to 20 year patent has expired for a brand-name drug, generic drug manufacturers can produce the medication without the cost of research and development. Generic drug companies spend less on advertising and promotion for their products because physicians are already familiar with the product. Pharmacists inform you, the patient, as soon as a generic is available.

Strict FDA regulations assure that the generic drugs you receive are just as effective as more expensive brand-name drugs. **Generics can cost as much as 75 percent less than their brand-name alternatives!** So, by using generic drugs, you and your health plan can save money without any decrease in the quality of care you receive. In addition to tests performed prior to market entry, FDA regularly assesses the quality of products in the marketplace and thoroughly researches and evaluates reports of alleged drug product inequivalence. **To date there are no documented examples of a generic product manufactured to meet its approved specifications that could not be used interchangeably with the corresponding brand-name drug.**

For both brand-name and generic drugs, FDA works with pharmaceutical companies to assure that all drugs marketed in the U.S. meet specifications for identity, strength, quality, purity and potency. In approving a generic drug product, the FDA requires many rigorous tests and procedures to assure that the generic drug is interchangeable with the brand-

(continued on page 3)

CONTACTS:

If you have a claim problem, please contact your health care provider. Their telephone numbers are listed on the front page of the 2001 "blue" Book, on your ID card, and on the provider's website.

If you have a billing or membership question, call eBenX at 800-345-4725. If you do not get a satisfactory resolution to your problem, write to:

Benefits Section
Division of Personnel Services
900 SW Jackson St., Room 951-S
Topeka, KS 66612
Spud Kent: 785-296-4084

To contact any of the Health Care Commission members, staff or Employee Advisory Committee members, use the same address listed above. Following are the Health Care Commission and Employee Advisory Committee members, and staff for the Health Care Commission.

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Staff and Committees: **Terry D. Bernatis**: Health Benefits Administrator; **Steve Ashley**: Benefits Manager; **Bonnie Long**: Office Specialist, Benefits Administration; **Sharon Bolyard**: President, EAC; **Allen Humphrey**: Vice President, EAC; **Judy Lambert**: Secretary, EAC; Retiree members of the EAC: **Merle Bolton**, **Glenda Moore-Yocum**, **Dr. Frederick Holmes**.

Looking for more information about health and health trends? David Ross, employee advisory council member, recommends the following website:

www.healthforumjournal.com

If you have a favorite health related website to share with us, please send it to the following e-mail address:

spud.kent@state.ks.us

or call at 785-296-4084.

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Generic Drugs...*(Continued from page 2)*

name drug under all approved indications and conditions of use. For this reason, FDA approved product labeling does not recommend that any additional tests need to be performed by the health care provider when a switch occurs from a brand-name drug product to a generic equivalent drug product, from a generic equivalent to a brand-name drug product, or from one generic product to another when both are deemed equivalent to a brand-name drug product. Brand-name drug products and therapeutically equivalent generic drug products are identified in the FDA publication, "Approved Drug Products with Therapeutic Equivalence Evaluations," frequently called the "Orange Book."

Consult Your Pharmacist

Pharmacists are the final safeguards when it comes to the public's utilization of prescription drugs. Pharmacists also have the broadest knowledge when it comes to cost-effective drug therapy. Pharmacists understand how drugs work, they know how much they cost and they know whom to believe when various claims are made in regards to prescription drugs.

There are products in which small changes in the dose and/or blood concentration could potentially result in clinically important changes in drug efficacy or safety. Usually, these drugs require frequent adjustments in the dose of the drug and careful patient monitoring irrespective of whether the drug is a brand or generic drug product. These drugs may sometimes be described in FDA approved drug labeling as narrow therapeutic range drugs. **Ask your pharmacist if the drug you are taking is in this narrow therapeutic range category. If it is, your pharmacist will work with you and your physician to make sure that the drug therapy you receive is optimal for you.**

Summary

In a letter to the National Association Boards of Pharmacy, Roger L. Williams, M.D., Deputy Center Director for Pharmaceutical Science Center for Drug Evaluation and Research, wrote "If one therapeutically equivalent drug is substituted for another, the physician, pharmacist, and patient have FDA's assurance that the physician should see the same clinical results and safety profile. Any differences that could exist should be no greater than one would expect if one lot of the innovator's product was substituted for another." You can interpret this to say **generic drugs are safe and a great value!**

AdvancePCS announces prescription drug formulary changes for 2001

These limited changes reflect either alternative formulary agents or FDA approved generic equivalents that were be effective December 24, 2000. Remember, the use of a formulary medication results in a lower co-pay for you (25% vs. 50%). Questions regarding these changes may be directed to AdvancePCS at 800-294-6324 or to the AdvancePCS website at www.kse.advparadigm.com. If you are taking a drug that is changing on the formulary, you were sent a letter in November, 2000.

The state of Kansas continues to be a national leader in designing a plan that has had RX increases of less than 10%, which is half the national cost increase trend of 18 to 20 percent.

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Frequently Asked Questions

Q. Why did Blue Cross Traditional change its name to Kansas Choice Senior?

A. Since 1996, the State of Kansas has self-insured the Blue Cross Traditional plan for its Direct Bill participants. This means that the State assumes all risks and pays all claims of its participants under the plan. The State has contracted with Blue Cross as the "third party administrator" to process the claims. For this reason, the Health Care Commission felt the name change was appropriate to reflect the State of Kansas' role as the plan sponsor and insurer.

Q. What is eBenX and what do they have to do with my health insurance plan?

A. eBenX is the "third party administrator" retained to manage enrollment, coverage changes, and billing for Direct Bill and COBRA participants.

Q. Why is the State's health care group for retirees called "Direct Bill?" Why not give it a more meaningful name such as the Retirees Health Care System?

A. Participants in the Direct Bill system no longer are paid employees or eligible dependents of paid employees. Therefore, they must be billed directly for premiums, rather than have premiums deducted from their paychecks. While the majority of Direct Bill participants are retirees or dependents of retirees, the group also includes active employees who are on leave without pay status and former employees who are not retirees and their dependents who are eligible to continue with State of Kansas health insurance.

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Health Care Commission
900 SW Jackson St.
Room 951-S
Topeka, KS 66612

DIRECT BILL NEWS

2nd Quarter 2001

State Health Plan Continuation Program

Kansas State Employees Health Care Commission

Keeping Healthy When You're Over 60

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Why should I try to stay healthy over 60?

Staying fit and healthy is important for everyone, regardless of age. For some people, getting older means settling into the arm chair or snoozing in front of the TV. Relaxation is a good thing, but it is important to stay active as you become older. We know, for instance, that staying active can help prevent diseases like heart disease and diabetes. In addition, it reduces the effects of osteoporosis and arthritis, and helps you stay mobile and maintain your independence as you age. A healthy lifestyle will help you live longer and will improve your quality of life for years to come.

What should I eat?

It is true that the body's energy needs decrease with advancing age, but it is important that you continue to enjoy your food and have sufficient amounts to help you stay active. Try to choose a variety of foods from the four main food groups:

1. Bread, other cereals and potatoes,
2. Fruits and vegetables – especially those high in vitamins B and C,
3. Milk and dairy foods,
4. Meat, fish and alternatives (such as beans or lentils).

Osteoporosis (a disease in which bones become thinner and more prone to breaks or fractures) can be a problem in older people, especially women. Eating a diet rich in calcium (milk and diary foods are the best source) and staying physically active are good ways to help reduce this bone loss. Vitamin D helps you absorb calcium more efficiently, so it is possible that your doctor will recommend that you take a supplement for this. Other foods high in vitamin D, such as oily fish and margarine, should also be eaten regularly.

What is the best way to stay physically active?

Research has shown that elderly people, even those who have never exercised before, can benefit from physical activity. We used to think that only vigorous exercise could improve fitness: we now know that moderate, regular exercise is just as beneficial. If you have not exercised regularly throughout your life, you should see your doctor before starting any new fitness program. The frequency and duration of your activity is more important than how hard you do it. Brisk walking for 20– 30 minutes, most days of the week, is a great way to get fit.

(Continued on page 2)

Prior Authorization Not Required for Some Kansas Choice Senior Participants

The Kansas Choice Senior ID cards issued by Blue Cross Blue Shield of Kansas state "IP CARE AND N/M REQUIRES PRIOR AUTH/PCP AUTH REQUIRED." This statement **does not apply** to Kansas Choice Senior participants who are Medicare eligible.

Page 13 of the Kansas Choice Senior policy certificate that was mailed to Direct Bill participants in late December states that the requirement for prior authorization for admission to hospitals and medical care facilities **"does not apply** in cases where Medicare is the primary payer or where Kansas Choice Senior is the secondary payer."

We hope this clarifies any confusion that may exist regarding prior authorization. ❖

Inside This Issue

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Health Care Commission Meetings

- Remaining 2001 Schedule -

June 6, 2001
August 22, 2001
December 5, 2001

Meetings are at 1:30 p.m. in the KPERS Boardroom located at 611 S Kansas Avenue in Topeka.

utes, most days of the week, is a great way to get fit.

Keeping Healthy... *(Continued from page 1)*

Exercise does not have to be continuous: three, 10-minute sessions are just as beneficial. Normal activity counts too. Gardening, walking the dog, or choosing the stairs instead of the escalator will get your heart pumping and inject exercise into your day. To avoid injuries, always remember to warm up and cool down whenever you exercise. A warm-up can include five minutes of brisk walking followed by light, gentle stretches. Do the same after you've finished exercising until your heart rate has returned to normal and you feel cool.

All you need for exercising is comfortable, loose clothing that is suitable for the weather and a good pair of well- fitting shoes. Remember to drink plenty of water before, during and after your exercise.

While a little soreness is OK after you first start exercising, pain is definitely not. Stop exercising immediately if you feel:

- a tight feeling in your chest,
- pain in your chest, arms or jaw,
- severe shortness of breath,
- a rapid throbbing or fluttering of your heart,
- dizzy, faint or sick to your stomach.

If you follow these simple guidelines and keep up a regular exercise regimen, you will improve your strength, aerobic capacity, flexibility, and your overall sense of well-being.

Is it too late to give up smoking?

No matter how old you are, it is never too late to stop smoking. Giving up smoking now can increase the length of your life, whether you are 25 or 65 and will certainly improve your quality of life. As soon as you give up cigarettes, your health will improve immediately and it will continue to do so over time. Quitting smoking is never easy and may take a few attempts, but it is well worth the effort.

There is plenty of help available to help you stop smoking, including comple-

Kyle Wendt is the new Health Benefits Administrator for the State of Kansas. He succeeds Terry Bernatis who has been appointed as Assistant Director, Division of Personnel Services.

Website of Interest

Just want some useful information for keeping healthy?

Log on to **http://kse.buildingbetterhealth.com.** This site is also linked to the Division of Personnel Services website under Benefits Administration. A few examples of topics are: ***Battling Osteoporosis***, ***Sinusitis***, and ***Preventing Exercise Injuries***.

Seminar Held for EAC Members

Steve Ashley, Contract Administrator for the Benefits Administration Section of the Division of Personnel Services, conducted a 3-hour seminar on health insurance and related topics for new Employee Advisory Committee(EAC) members. In attendance was Dr. Frederick Holmes, formerly with the K. U. Medical Center, who represents retirees on the EAC.

REGULATION CHANGES LIMIT RETURN TO DIRECT BILL HEALTH INSURANCE

- Information you need to know -

Changes to K.A.R. 108-1-1, which became effective January 21, 2001, limit the return to Direct Bill health insurance coverage if a participant elects to drop coverage. Significant aspects of these changes are:

- Each direct bill participant enrolled in the state health care benefits program on or after January 21, 2001, must maintain continuous coverage to stay in the health care benefits program.
- Any prior direct bill participant who discontinued coverage before January 21, 2001, and who is not participating on that date, may reenroll ONE TIME, unless that person has not previously discontinued and returned to direct bill coverage before January 21, 2001.
- Any person who discontinues direct bill coverage and maintains continuous coverage in a Medicare risk plan may return to the state health care benefits program during the annual open enrollment period.

Frequently Asked Questions

Q. Where can I find a list of qualifying events that allow me to make mid-year changes to my health insurance coverage?

A. The "qualifying events" that allow for mid-year changes are found on pages 20 and 21 of the blue booklet, Open Enrollment Information and Options for Retirees & Direct Bill Participants, that was sent to you. These events are the same as for active employees.

Q. I am a retiree not yet Medicare eligible who is covered by Kansas Choice (formerly Blue Select.) If I move out of state, will I be able to select a new primary care physician in the state where I reside?

A. No. All of the contracting primary care physicians in the Kansas Choice plan are geographically located in Kansas. Therefore, unless you wish to return to your primary care physician in Kansas each time you need medical service, you will need to use the self-referring option that exists under the Kansas Choice plan.

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DIRECT BILL NEWSLETTER CUSTOMER SURVEY

To determine whether we are providing the content, quality of presentation, and level of information in the Direct Bill Newsletter that readers desire, we ask that you take a few minutes to complete and return the enclosed survey. You may also complete the survey online by accessing our website at http://da.state.ks.us/hcc/direct.htm. This information will help us to ensure that we are providing our readers with a worthwhile and quality publication. We will be unable to provide individual responses to survey questions, but will tabulate the results and incorporate suggestions as much as possible in future issues of the Newsletter.

1 The Direct Bill Newsletter articles and features are:

__ of great value __ of value __ of some value __ of limited value __of no value

2 Direct Bill articles and features are:

____ about the right length ____ too brief ____ too lengthy

3 I find the format of the Direct Bill Newsletter:

____ enhances the content ____detracts from the content ____ no opinion

Comments_____

_____

4 Subjects/features I would like to see included in future issues are:

5 Subjects/features I would like to see excluded from future issues are:

6 Overall, I would rate the Direct Bill Newsletter as:

____Excellent ____Very Good ____ Good ____ Fair ____Poor

PLEASE FOLD IN TWO AND TAPE SHUT SO THAT RETURN ADDRESS IS ON THE OUTSIDE FOR MAILING. **PLEASE AFFIX POSTAGE IF YOU ARE RETURNING THIS SURVEY BY MAIL.** YOU DO NOT NEED TO MAIL YOUR SURVEY RESPONSE IF YOU COMPLETED IT ONLINE.

Please complete by May 11, 2001.

Please tape here.
Do not staple.

Please place
stamp here.

RETURN TO:

Division of Personnel Services
Benefits Administration
900 SW Jackson Street, Room 951-S
Topeka, KS 66612

DIRECT BILL NEWS

3rd Quarter 2001 State Health Plan Continuation Program

Kansas State Employees Health Care Commission

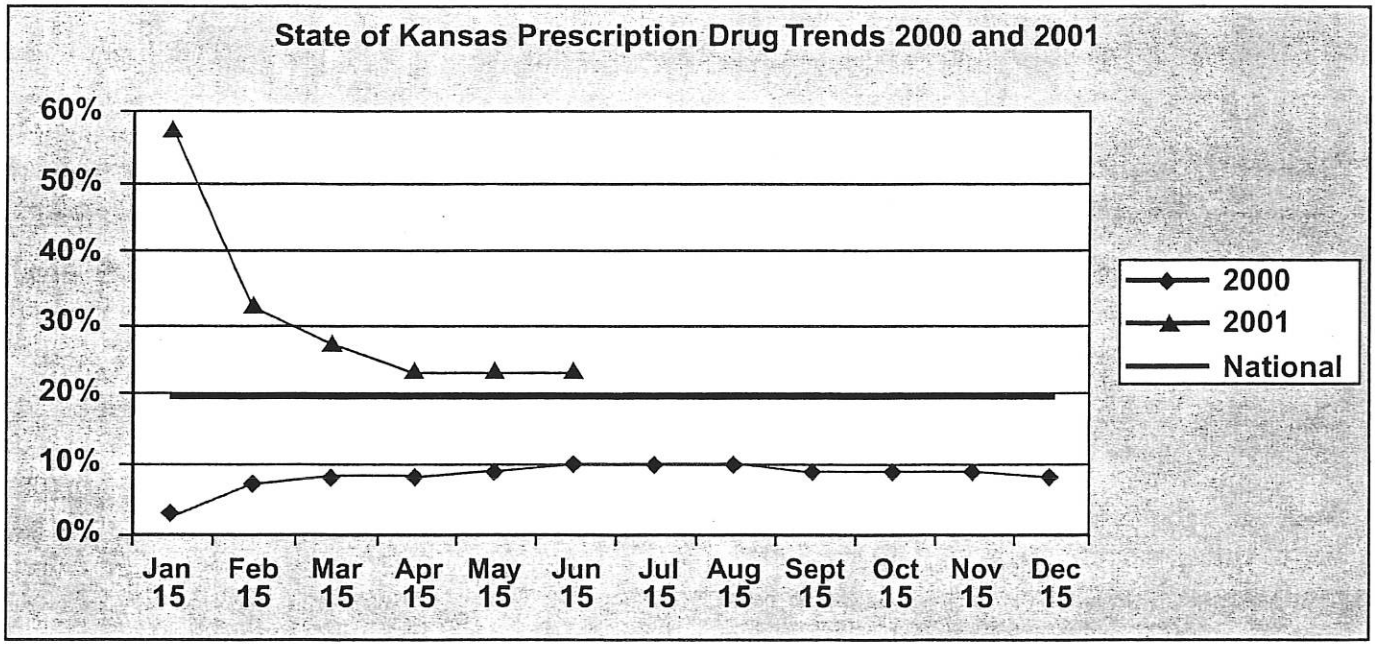
Rx Drugs Continue to Increase Overall Cost of Health Insurance

The following chart compares State of Kansas 1st Quarter 2001 prescription drug cost data to our 1st Quarter 2000 data and to 2000 nationwide data.

During 1999, cost increases for the State's prescription drug program were between 20% and 30%. By 2000, we were able to reduce cost increases below 10% by judicious use of formulary and generic drugs. The annual cost increase for prescription drugs nationally was approximately 19% for Calendar Year 2000. However, in 2001, the State's prescription drug trend is once again showing cost increases greater than 20%.

What are the reasons for this change? In addition to the increasing cost of drugs, the number of prescriptions filled has increased by more than 20% over a similar period in 2000. This increase in usage applies to all categories of prescription drugs.

All plan participants are again urged to ask their physicians to prescribe generic drugs whenever possible, and to consider prescribing formulary drugs when generics are not available.



Inside This Issue

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Meet the New Health Benefits Administrator

Kyle L. Wendt is the new Health Benefits Administrator, and the Division of Personnel Services Benefits Manager. In these roles, Kyle is responsible for the State of Kansas Employee Benefit Programs, and the State's self-insured worker's compensation fund. Kyle replaces Terry Bernatis who has assumed responsibility of Deputy Director of the Division of Personnel Services.

Kyle most recently served as Director of Compensation for the Sunbeam Corporation. Previously, he served as Director of Corporate Human Resources for the Coleman Company, Inc. where he was responsible for employee benefits, relocation, and corporate human resource programs.

He is a native Kansan, graduating from Seaman High School in Topeka, and Kansas State University in Manhattan. While living in Wichita, he completed work towards a Master's in Business Administration degree through Friends University. He holds professional certifications as a Senior Professional Human Resources (SPHR), Certified Compensation Professional (CCP), and Fellow, Life Management Institute (FLMI).

Kyle and his wife, Cathy, live in Osage City with their teenage daughters, Lindsay and Anna.

Generics Add Up

Formulary (brand-name) drugs are generally more costly than generic drugs. Generics, at 1/3 to 1/2 the average cost of formulary drugs, are one of the most efficient means of reducing drug spending.

On average the generic substitution rate for our participants is 35% versus 45% nationally.

Did you know that raising our level by 10% could result in savings of $2.5 million annually?

CONTACTS:

If you have a health care claim problem, please contact your health plan provider. Their telephone numbers are listed on the front page of the 2001 "blue" book, on your ID card, and on the provider's website.

If you have a billing or membership question, call eBenX at 1- 800-345-4725. If you still have questions after contacting eBenX, write or call Spud Kent:

Benefits Section
Division of Personnel Services
900 SW Jackson St., Room 951-S
Topeka, KS 66612
1-785-296-4084
e-mail: Spud.Kent@state.ks.us

To contact any of the Health Care Commission members, staff or Employee Advisory Committee members, use the same address or telephone number listed above.

Health Care Commission: **Dan Stanley**: Chair and Secretary of Administration; **Bryce Miller**: Retiree from Classified Service; **Duane Nightingale**: Representative of the General Public; **Kathleen Sebelius**: Commissioner of Insurance; **Nelson Wong**: Representative from the Classified Service.

Staff and Committees: **Kyle Wendt**: Health Benefits Administrator; **Bonnie Long**: Office Specialist, Benefits Administration; **Sharon Bolyard**: President, EAC; **Mike Jacobs**: Vice President, EAC; **Judy Lambert**: Secretary, EAC; Retiree members of the EAC: **Merle Bolton**, **Glenda Moore-Yocom**, **Dr. Frederick Holmes**.

MOVING?

If you are moving or have recently moved, please be sure to notify eBenX in writing at:

eBenX/State of Kansas Direct Bill
605 North Highway 169, Suite LL
Minneapolis, MN 55441-6465

They will then notify your health plan provider, Delta Dental and Advance PCS. They will also notify Vision Service Plan if you are enrolled in the optional vision coverage.

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Should I Consider Long Term Care Insurance?

Many of us have had personal experience with a friend or loved one who has had an extended stay in a residential care facility (RCF). Some of us also know how quickly an extended stay can deplete an individual's assets, imposing a financial burden on the individual or family members who must support the individual. When admitted to an RCF, the average stay for adults over 65 is 2.5 years, at a cost of $46,000 or more per year. Many financial planners are asking their clients to consider long term care insurance in their retirement planning. This insurance may provide peace of mind and a significant measure of financial stability.

Long term care goes by many names. You may also hear about skilled nursing or intermediate nursing care or facilities, personal care, custodial care, supervisory care, assisted living or home care. When hearing these terms it is important to request additional information and clarification by what is meant and included within each level of care. What is important to realize is that health insurance does not cover care that is delivered to assist a person with what are called "activities of daily living" such as eating, bathing, toileting, dressing, getting into or out of bed, or ensuring that medications are taken appropriately. These are the types of activities long term care insurance is designed to provide for.

Long term care insurance is offered to employees and retirees of the State of Kansas. The plan is currently administered by the Hartford Life Insurance Company. Services covered include coverage for RCF's, assisted living, adult day care, home health care, respite care and supportive services such as wheelchair ramps.

For details about these services, information on how to enroll and the cost of the plan, you can call the Hartford's toll free number **1-888-810-9331** and request an enrollment kit, without obligation.

Majority Responding to Survey Like the Direct Bill Newsletter

A total of 356 Direct Bill participants completed and returned the survey that was included in the 2nd Quarter 2001 Direct Bill Newsletter. The feedback and comments are greatly appreciated, and will be used as information in future newsletters. Over 93% of those who responded opted to return the surveys by mail instead of the internet.

Three hundred thirteen or 88% of the completed surveys gave the newsletter a favorable rating (good to excellent). Only 25 or 7% of the responses were negative (a rating of fair to poor). The remaining 5% of surveys received either were not completely filled out, or contained comments that did not contribute to the rating.

The majority of those who responded appear to like the format, content, and length of the newsletter. Some stated that the information related to health and wellness is unnecessary because it is available from so many other publications directed toward senior citizens. Many are concerned about the rising cost of health insurance and want more information about the insurance options that lie ahead for them. A few suggested that the newsletter was an unnecessary cost that could be applied to the lowering of future health insurance premiums.

Some requested information about KPERS retirement, which is beyond the scope and purpose of the Direct Bill Health Insurance Program. Inquiries and other information of this nature may be directed to the KPERS Hotline at 1-888-ASK-KPERS (1-888-275-5737) or 296-6166 in Topeka. In addition, the KPERS website is http://www.kpers.org.

Committee Member Wanted:

Are you interested in playing a major role with the state's health benefit plan? The Employee Advisory Committee (EAC) of the Kansas State Employees Health Care Commission (HCC) is accepting applications for a new Medicare-eligible direct bill committee member to serve a three-year term beginning January 1, 2002.

The main purpose of the EAC is to study health plan related issues and to make recommendations to the HCC. This process allows plan participants to provide their input into important health plan decisions.

To be considered for this committee, write the Health Benefits Office no later than October 18, 2001:

Attn: EAC
900 SW Jackson, Room 951-S
Topeka, Kansas 66612,

or e-mail: benefits@state.ks.us

Frequently Asked Questions

Q. I'm retired and becoming eligible for Medicare. Is it possible to keep the State insurance as primary?

A. No. All State of Kansas Group Health Insurance policies have a Medicare Exclusion Rider. This means that what Medicare paid (or would have paid if you had enrolled) is subtracted from the total bill submitted by the provider. What is left is processed just like any other claim — subject to the deductibles and co-payment requirements of the plan. HMO members will still continue to pay their $10 office visit co-pay. Members on Kansas Choice will be changed to Kansas Choice Senior. This plan has a $200 deductible per year and a 20% co-insurance with an out of pocket limit on co-insurance of $500 per person. However, there is no longer a $50/day co-payment for inpatient hospital stays when Medicare pays primary.

Due to the Medicare Exclusion Rider it is very important that you enroll in both Part A and Part B of Medicare when you are retired or no longer actively employed. The retiree will be responsible for any plan deductibles, co-insurance, co-payments **and the portion of the claims that would have been covered by Medicare had they enrolled.** This applies even if the retiree is not entitled to free coverage of Part A and/or must pay additional fees for Part B.

Q. I did not take out Part B of Medicare when I was first eligible and now my state insurance is not paying claims—what do I do?

A. Contact your local Social Security office immediately to see when you will be able to enroll in Part B. Until you are enrolled in Part B, you are responsible for amounts that Medicare would have paid.

Q. How do I know if I am enrolled in both parts of Medicare?

A. Your Medicare card will indicate the coverage you have and the dates it became effective. It is very possible for Part A and Part B to have different effective dates — particularly if you work beyond your 65th birthday. Part A is called "Hospital Insurance" on your card and Part B is called "Medical Insurance."

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DIRECT BILL NEWS

4th Quarter 2001 State Health Plan Continuation Program

Kansas State Employees Health Care Commission

SPECIAL OPEN ENROLLMENT EDITION

IMPORTANT DIRECT BILL OPEN ENROLLMENT INFORMATION

Open enrollment period for direct bill participants is changing to October 15 through November 16, 2001.

This year, open enrollment begins on October 15 and continues through November 16, 2001. **You do not need to take any action during open enrollment unless you wish to make a change in your health insurance plan.**

We again will be operating a **Direct Bill Customer Service Center** during open enrollment that will be staffed by retirees. The telephone-based Customer Service Center will be operational weekdays from **October 15, 2001 through November 16, 2001, between the hours of 8:30 AM to 4:30 PM, Central Standard Time.** The toll free number if you reside outside of Topeka is **1-866-363-8108.** If you reside in the Topeka area, the number is **291-3122. These numbers will not be operational until the Center opens on October 15, 2001.**

We have requested that eBenX mail booklets and other open enrollment information to you in late September. Please review the information carefully. It is designed to help you make informed decisions about your health insurance coverage options prior to open enrollment.

As you review the information you'll also want to note the changes in the current health insurance plans for 2002. Participants eligible for Medicare will want to pay special attention to a new option for 2002 named ***Kansas Senior Plan C*** that includes prescription and dental coverage. To expand provider availability, a new self-insured preferred provider organization (PPO) option will also be offered, named ***Kansas Prefer***.

The highlights of new plans and changes to existing plans are discussed in this newsletter .

KANSAS CHOICE

Kansas Choice continues to be a self-insured managed indemnity plan option administered by Blue Cross Blue Shield of Kansas. However, some important changes will occur regarding this plan for Plan Year 2002. ***Kansas Choice*** will merge with the ***Kansas Choice Senior*** plan option. If you are currently enrolled in ***Kansas Choice Senior***, and want to stay in this plan as it is merged into ***Kansas Choice*** in 2002, **you do not need to make any changes during open enrollment.** Additionally, effective January 1, 2002, ***Kansas Choice*** no longer requires participants to select and utilize a primary care physician to receive full plan benefits. Participants will be free to select any participating provider within the Blue Cross Blue Shield provider directory.Non-participating provider coverage will still be available, but participants will be responsible for higher deductibles and coinsurance amounts.

Inside This Issue

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NEW CHOICES FOR PLAN YEAR 2002

KANSAS SENIOR PLAN C

This is a new self-insured health care plan, sponsored by the State of Kansas for Medicare-eligible retirees and their Medicare-eligible dependents. This plan offers the same medical benefits as a Medicare Supplemental Plan C, offered by several commercial carriers, **plus prescription drug and dental coverage**. For example, Blue Cross Blue Shield of Kansas markets a similar benefit plan called "Plan 65-C." To enroll in this plan, the retiree and all covered dependents must be eligible for and enrolled in both Medicare Part A and Part B coverage. The level of coverage can be maximized under the ***Kansas Senior Plan C*** option by using physicians and hospitals that accept Medicare assignment for your claims.

The basic medical benefits of this plan are coverage in full of the Medicare Part A and B deductibles and coinsurances, Medicare Part A and B blood, Skilled Nursing Facility coinsurance for days 21-100, and an additional 365 hospital days per lifetime. The medical portion of this plan will pay what Medicare approves, but does **not** pay. In other words, if Medicare does not cover the service, there is no benefit under the medical portion of ***Kansas Senior Plan C***.

Prescription drug coverage is provided for medications and supplies not covered by Medicare. Dental benefits are the same benefits as those for all group insurance plan participants.

HEALTHNET will be changing names! Effective January 1, 2002, it will be called **Mid America Health HMO.** No enrollment changes are required if you wish to remain in this plan.

KANSAS PREFER

Kansas Prefer is a self-insured Preferred Provider Organization (PPO) administered for the State of Kansas by Harrington Benefits, Inc.

Kansas Prefer combines comprehensive medical coverage with a PPO network to offer a choice between two benefit levels. When a participant selects a provider within the network, they maximize their benefit coverage under the plan. When a participant selects and receives medical services outside the network, they will be responsible for any amount over the allowed charge, in addition to higher deductibles and coinsurance amounts.

Participants and covered dependents are not required to select a primary care physician. However, all non-emergency hospital admissions require pre-authorization by Harrington Benefits, Inc.

Participant Costs to remain the same for Plan Year 2002

That's correct, there will be no participant cost increase for State retirees next year! However, this does not mean health care cost is not continuing to rise. Because of the plan changes which will be implemented next plan year, which include cost increases for the participants who use the plans, the Health Care Commission decided to keep participant contribution amounts at their 2001 levels. We all need to continue to be wise users of the group health insurance plans' benefits-especially benefits like prescription drug coverage. Over utilization of plan benefits can be one of the causes of potential participant cost increases in future years. Please review your open enrollment information carefully for more details.

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UNDERSTANDING THE JARGON

Here are some definitions we hope will help you better understand the different health care plans, and allow you to make informed choices.

Health Benefits – The services and products (coverage) a health plan offers a group or individual.

Benefit Package – Services an insurer, government agency, or health plan offer to a group or individual under the terms of a contract.

Self-Funded Plan --The employer assumes the functions, responsibilities, and risks of an insurer. The employer maintains a separate fund that is financed with participant contributions or premiums. When participants file claims for health care services, those claims are paid for with moneys from that fund. The employer assumes the risk that medical claims for a given time period might exceed the premiums that have been collected.

Fully Insured Plan - The employer hires an insurance company to assume the risk of paying claims for premium moneys. All premiums are paid to the insurance company.

Indemnity – An insurance program in which the insured person is reimbursed for covered expenses.

Preferred Provider Organization (PPO) – An insurance program in which contracts are established with providers of medical care. Providers under such contracts are called preferred providers. Usually, the benefit design provides significantly better benefits (lower copayments) for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons generally are allowed benefits for non-participating provider services with significantly higher copayments.

Managed Care – A system of health care delivery that influences utilization and cost of services, and measures performance. The goal is a system that delivers value by giving people access to quality, cost effective health care.

Health Maintenance Organization – An entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. Under the Federal HMO Act, HMOs must operate within a specified geographic area, have an agreed upon set of basic and supplemental health maintenance and treatment services, and a voluntary enrolled group of people.

Third Party Administrator (TPA) – An independent person or corporate entity that administers group benefits, claims and administration for a self-insured organization or group. A TPA does not insure the risk.

Deductible-The amount of medical costs the participant is responsible for before insurance coverage will pay anything.

Co-insurance-The percentage of medical costs the participant will have to pay once the deductible has been satisfied.

Co-payment-A set amount the participant is required to pay from their own pocket for certain medical services, such as $10 for every office visit or $50 for an emergency room visit.

Generic Drug Usage

Did you know that substituting generic drugs for multi-source brand-name drugs could mean substantial cost savings to you and our prescription drug program? And even more important is the fact that generic drugs are generally as safe and effective as brand-name drugs.

The next time you need to have a prescription filled, ask your physician about a generic drug alternative that may be available to you. Many brand-name drugs are in generic form, such as:

- Prozac - anti-depressant
- Daypro - non steroidal anti-inflamatory
- Buspar - anti-anxiety
- Lotrisone cream - treats fungal infections
- Zantac - acid control and anti-ulcer

With your physician's help, you can decide whether switching to a generic drug is right for you.

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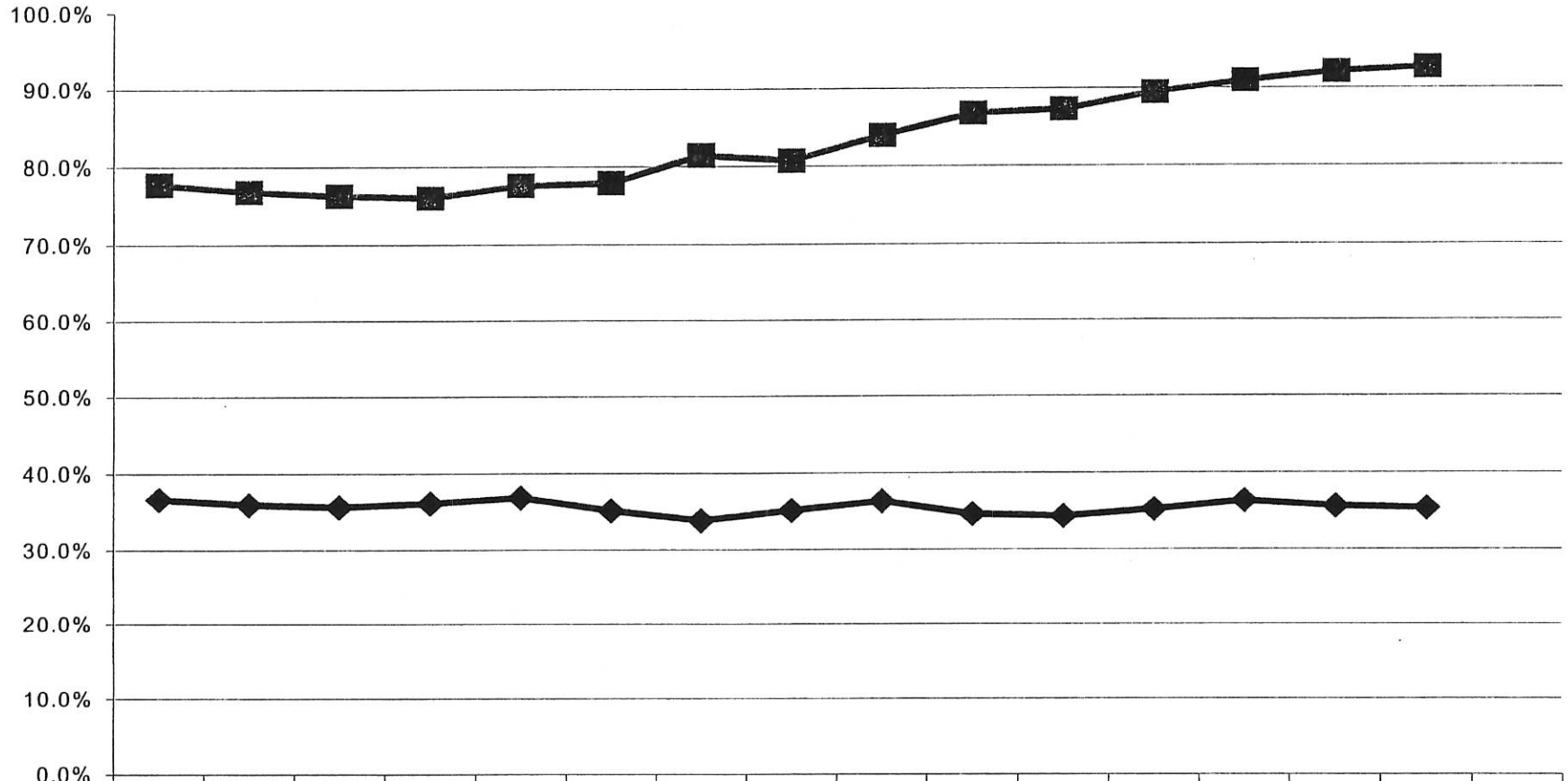
Medical	Kansas Choice (Managed Indemnity Plan)	PPOs (2 choices)	HMOs (4 choices)
Deductible	*Network: $300pp/$600 fam Non-Network $600 pp/$1200 fam*	$200 pp/$400 fam	See in-patient/outpatient services below
Coinsurance	*Network 20% to max $2000pp/$4,000 Fam Non-Network: 30% to max $4,000 pp/$8,000 fam*	*Network: Insured pays 10% to max $1,000 person/$2,000 Family Non-Network: Insured pays 30% to max $3,000/$6,000*	None
Office Visit Co-payment	Subject to deductibles and coinsurance	*Network: $15 copay Non-Network: Subject to deductibles and coinsurance*	$10
Preventive Services	Limited and subject to deductible and coinsurance	Allow $300pp; then deductible and coinsurance; limited out of Network	
Lifetime Maximum	$2,000,000	$2,000,000	$2,000,000
Inpatient Services	Subject to deductibles and coinsurance	Subject to deductibles and coinsurance	$200pp/$400 family
Outpatient Services	subject to deductibles and copays	Subject to deductibles and coinsurance	Out Patient surgery, $100/occurrence
Inpatient Nervous/Mental	As above with Network: 60 day limit Non-Network: 30 day limit	As above with Network: 60 day limit; Non-Network: 30 day limit	As above with a 60 day limit
Outpatient Nervous/Mental	*Network: 25 limit; first 3 paid @ 100%, next 22 visits -$25ea Non- Network: 25 limit; first 3 @100%; next 22 @ 50%*	*Network: 25 limit; first 3 paid @ 100%, next 22 visits -$25ea Non- Network: 25 limit; first 3 @100%; next 22 @ 50%*	First three visits paid @ 100%, next 22 visits subject to $25 co-payment, additional visits paid @ 50%
Mental Health Parity	Benefits same as medical for certain identified mental health conditions.	Benefits same as medical for certain identified mental health conditions.	Benefits same as medical for certain identified mental health conditions.
Home Health Care/Hospice	Covered in full up to $2,500 pp/yr, home hospice lifetime max $5,000	Home Health pre-approved. Hospice limit $5,000 Network: Covered in full Non-Network: Subject to deductibles and coinsurance (70%)	Covered full 50 visit maximum
Emergency Care	$75 copay then subject to deductible and coinsurance unless hospitalized within 24 hrs	$75 copay then subject to deductible and coinsurance unless hospitalized within 24 hrs	Covered in full-$50 copay unless hospitalized within 24 hours
Durable Medical Equipment	Subject to deductibles and coinsurance - limit $2,500 pp/year	Limit $4,500 person/year	20% coinsurance to $5,000/pp allowable charges
Vision	Refraction Exam-subject to deductible and coinsurance	One exam/yr Network: Pd in full Non-Network: subject to deductibles and coinsurance	Refraction exam-$10 copay

Generic and Formulary Utilization Rates



	1 Qtr 1998	2 Qtr 1998	3 Qtr 1998	4 Qtr 1998	1 Qtr 1999	2 Qtr 1999	3 Qtr 1999	4 Qtr 1999	1 Qtr 2000	2 Qtr 2000	3 Qtr 2000	4 Qtr 2000	1 Qtr 2001	2 Qtr 2001	3 Qtr 2001	4 Qtr 2001
Generic	36.7%	36.0%	35.7%	36.2%	36.9%	35.2%	33.9%	35.2%	36.4%	34.7%	34.4%	35.3%	36.4%	35.7%	35.4%	
Formulary	77.8%	76.9%	76.4%	76.1%	77.7%	78.0%	81.5%	80.8%	84.0%	86.8%	87.3%	89.5%	91.0%	92.2%	92.8%	

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KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION
2001 Comparison of Actual and Estimated Health Plan Costs (Unaudited)[1]

		Actual 2001 Year-to-Date	Annualized
1.	**2001 Estimated Total Cost**		$ 215,258,000
2.	**2001 Actual Total Cost**		
	a. BCBS Self-Insured Claims	$ 78,219,426	$ 98,489,098
	b. AdvancePCS Rx Drug Claims	33,410,321	46,336,116
	c. Delta Dental Claims	10,305,411	13,202,300
	e. Insured HMO/PPO Premiums	40,085,803	53,447,737
	f. Vision Service Plan	283,730	378,307
	g. ASO Fees	4,645,515	6,194,020
	h Health Promotion & Admin	464,919	619,892
	i. Total	$ 167,415,125	$ 218,489,151
3.	% Difference from Estimated [2i. / 1. - 1]		1.50%
4	**2001 Employee, Direct Bill, USD, COBRA Contributions**		$ 91,444,059
5.	**2001 State Cost**		
	a. Estimated [1. – 4.]		$ 127,569,000
	b. Actual [2i. – 4.]		127,045,092
	c. % Difference [5b. / 5a. - 1]		-0.41%

[1] *Based on data through 9/30/2001 annualized through December, 2001*
Includes rebates and refunds as State cost

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Larry Hayes, Will Sanders

I. SUMMARY OF FINDINGS

Overall:

- Heritage Information Systems, Inc. ("Heritage") was retained by KSEHCC to perform an audit of AdvancePCS ("APCS"), KSEHCC's Pharmacy Benefit Manager.
- Heritage, in business since 1980, is a consulting firm, specializing in pharmacy auditing, utilization review, disease management and pharmacy managed care consulting services.
- The audit period was limited to those claims paid between January 1, 2000 and June 30, 2001 and involved the audit and analysis of more than 2 million claims paid by APCS on behalf of KSEHCC. Heritage analyzed all claim transactions, thus any claim-level adjustments or reversals should already be reflected in the audit database.
- Auditors used judgmental and random sampling, global data modeling and the reprocessing of 100% of the claims to identify any errors, oversights or program defects. The analysis also focused on the identification of additional opportunities for program enhancement and development.
- APCS appears to be administering a quality, efficient program for KSEHCC. Indications are that KSEHCC is generally satisfied with the service level provided by APCS.
- Many of the issues/defects identified during the audit appear to be "legacy" issues that have already been identified, addressed and resolved, this conclusion being documented and validated by the measured improvement in contract performance over the term of KSEHCC's relationship with APCS.
- In Heritage's opinion, APCS appears to be performing very well. While no formal industry standards exist against which to measure APCS performance, Heritage's experience suggests that APCS is providing a quality program. Managed pharmacy benefits are extremely difficult to administer, and some level of program defects is expected. While these defects should be addressed and rectified, and settlements executed, it is Heritage's opinion that another PBM would most likely not be able to provide a definably better level of service.
- KSEHCC should consider several benefit modifications that could save significant program dollars. These may include: *a firm exclusion of all DESI drugs, and a more aggressive policy that creates incentive for the member to use generic products.*
- APCS staff was responsive and cooperative throughout the audit process, and supplied Heritage with documentation, research and responses as requested.

Enrollment Issues/Recommendations:

- Overall, more than 99% of all claims appear to have been paid correctly.
- Over 98% were adjudicated properly and matched the corresponding enrollment and coverage information listed on KSEHCC's system.
- Though some errors were identified, most of these appear to have been implementation-related and have been identified and resolved by both parties.
- A number of coverage gaps did occur as a result of retirements that involved retroactive enrollment on the eBenX system. These periods of non-coverage generated paper claims. According to and consistent with HCC guidelines, these claims paid at 100% of charges.
- Additional information is required from APCS regarding several enrollment issues.

*Claim Quantity Issues/**Recommendations**:*

- During Heritage's review of more than 2 million paid claims, 140 claims were identified that paid at quantities in excess of the prepackaged quantities in which prescriptions were dispensed. These generated overpayments of $2,114.
- Heritage identified six (6) claims that paid at inflated quantities due to inaccurate data entry. These errors generated overpayments of $96, but may also result in failed Drug Utilization Review (DUR) and other system edits, and erroneous rebate requests from manufacturers.
- Heritage identified 568 initial-fill claims for quantities greater than a single "Unit of Use." Had APCS limited these claims to a single unit of use, payments would have been reduced by $28,495.
- **APCS: APCS indicated that an enhancement request was underway to rectify the package quantity issue. APCS has the opportunity to pursue this and other "hard" program edits that will reject any claims with errant quantities.**
- **APCS: As an interim measure, APCS should program a query that generates an exception report identifying every claim with an errant quantity in each pay cycle. If the errant claims are manually identified, they can be reported to the Plan, and adjusted/corrected pre-payment.**
- **KSEHCC: KSEHCC should collect a total of $2,210 for overbilled quantity overcharges identified and reported by Heritage.**
- **KSEHCC: KSEHCC should collect a total of $28,495 for "Unit of Use" overcharges identified and reported by Heritage.**

*Lifestyle Claim Issues/**Recommendations**:*

- KSEHCC paid a total of $842 for 31 Lifestyle medication claims that were erroneously processed by APCS. All of these claims were processed the same day, and were the result of a programming ("code roll") error.
- The inappropriate payment of Lifestyle drugs appears to have been the result of an isolated error, and does not appear to require additional edits or programming.
- **KSEHCC: Heritage recommends that KSEHCC verify that its benefit design to exclude all DESI drugs, regardless of placement on the APCS formulary, be strictly adhered to by APCS.**
- **KSEHCC: KSEHCC should recover the $842 in overpayments identified by Heritage.**

*Copayment Misapplication Issues/**Recommendations**:*

- The audit documented incorrectly applied co-payments that caused potential overpayments by KSEHCC and its members. Potential overpayments by KSEHCC range from $7,089, to $135,654. Potential member overpayments range from $0 to $29,319.
- Many of the errors were the result of Prior Approvals (PA), while others were caused by an error in the removal of drugs from the formulary. These specific errors were not the result of KSEHCC PA requests. Rather, they resulted from user error during the PA process at APCS.
- "Highly visible" errors of this nature can generate significant membership dissatisfaction.
- Up to 12,386 claims with suspect copayments require further review and response by APCS. This number represents less than 1% of the total number of claims reviewed.
- **APCS: APCS should implement safeguards that prevent the application of a Prior Approval from generating an incorrect copayment.**

- KSEHCC & APCS: More proactive formulary communication between Participants and APCS is recommended.
- KSEHCC & APCS: Investigate the implementation of a comprehensive Drug Utilization Review Program. Proactive communication with members (via letter or DUR profile) will generate a higher degree of formulary compliance, minimizing the risk of improperly processed non-formulary items. KSEHCC should consider working more closely with APCS's clinical staff to determine what opportunities exist.

Performance Issues/Recommendations:

- APCS appears to be in compliance with the majority of performance guarantees described in the Agreement.
- According to reports provided by APCS, it appears that they are not in compliance with the Mail-Order Claims Processing Accuracy standard, and are subject to a $12,000 penalty.
- Based on claim defects and errors identified during the audit, it appears that APCS is not in compliance with the Retail Claims Processing Accuracy standard, and is subject to an $8,000 penalty.
- Other performance measures cannot be assessed until the close of the calendar year. KSEHCC should request updated performance reports at that time to determine if additional penalties are due.
- KSEHCC: KSEHCC should request payment of the combined $20,000 in Claim Processing Accuracy penalties.
- KSEHCC: APCS met the contractual obligations related to the audit of participating pharmacies in the state of Kansas. However, Heritage's recommends that KSEHCC expand its contract language to include a guarantee that out-of-state audits (especially in border states) will also include KSEHCC member claims.
- APCS: The methodologies utilized by APCS to mange the paper claims processing system are highly inadequate. Areas of improvement would include:
  - Increased automation of the claims processing system.
  - Improve the process for archiving membership and claims data (microfilm, scanning of documents-importing them into processing system and allowing look-up capability for all applicable levels of the customer service process.)
  - Establish documented protocol for defining the movement of documentation (claims related data) between claims processing and client advocate departments and reconciling the sending and receiving of this data.
  - There are no "hard-edits" applied to paper claims. APCS should consider this in the development of a more comprehensive edit system for KSEHCC.

PERFORMANCE AUDIT REPORT

The State Health Benefits Program, Part I: Reviewing Issues Relating to Premium Costs and Management

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
April 2001

01-14

Legislative Post Audit Committee
Legislative Division of Post Audit

THE LEGISLATIVE POST Audit Committee and its audit agency, the Legislative Division of Post Audit, are the audit arm of Kansas government. The programs and activities of State government now cost about $8 billion a year. As legislators and administrators try increasingly to allocate tax dollars effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by Legislative Post Audit helps provide that information.

We conduct our audit work in accordance with applicable government auditing standards set forth by the U.S. General Accounting Office. These standards pertain to the auditor's professional qualifications, the quality of the audit work, and the characteristics of professional and meaningful reports. The standards also have been endorsed by the American Institute of Certified Public Accountants and adopted by the Legislative Post Audit Committee.

The Legislative Post Audit Committee is a bipartisan committee comprising five senators and five representatives. Of the Senate members, three are appointed by the President of the Senate and two are appointed by the Senate Minority Leader. Of the Representatives, three are appointed by the Speaker of the House and two are appointed by the Minority Leader.

Audits are performed at the direction of the Legislative Post Audit Committee. Legislators or committees should make their requests for performance audits through the Chairman or any other member of the Committee. Copies of all completed performance audits are available from the Division's office.

LEGISLATIVE POST AUDIT COMMITTEE

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Representative John Ballou
Representative Dean Newton
Representative Dan Thimesch

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Legislature of Kansas

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March 29, 2001

To: Members, Legislative Post Audit Committee

Representative Lisa Benlon, Chair
Representative Richard Alldritt
Representative John Ballou
Representative Dean Newton
Representative Dan Thimesch
Senator Lynn Jenkins, Vice-Chair
Senator Anthony Hensley
Senator Dave Kerr
Senator Derek Schmidt
Senator Chris Steineger

This report contains the findings from our completed performance audit, *The State Health Benefits Program, Part I: Reviewing Issues Relating to Premium Costs and Management.*

We would be happy to discuss the findings presented in this report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Question 1: Are the Premiums For the State Employee Health Care Program Too High for the Level of Benefits Provided?

Kansas' current health care premiums are somewhat higher than the average for our comparison groups' rates, but generally are well within the mid-range. *Our comparison group included the 4 surrounding states and Iowa, Sedgwick and Shawnee Counties, and the Wichita and Topeka school districts. Kansas' monthly premiums for conventional plans were $260 for employee-only coverage and $727 for family coverage, compared with averages of $245 and $610 per month for our comparison groups. Our analysis of premiums for HMO plans produced similar findings.*

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Kansas' premiums also were higher than average compared with the results of surveys of state employee health benefit plans conducted by national firms. The 1998-2000 surveys of state employee health benefit plans conducted by The Segal Company showed that Kansas' rates were higher than all 5 neighboring states' rates in 1998 and 1999, but had dropped to 3rd highest in 2000 when the other states had large increases in their rates.

Kansas employees pay far less "out of pocket" for their medical costs than employees in most of the comparison groups. *In a conventional health care plan, an employee's out-of-pocket costs can include a deductible, co-insurance, and co-payments. Because Kansas' conventional health care plan has no deductible and low out-of-pocket maximums, Kansas employees pay less out-of-pocket than most of their counterparts. Generally, entities that require their employees to pay more out-of-pocket costs for their health care have the lowest premiums.*

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Question 2: Are Selected Aspects of the Program Being Properly Managed or Overseen?

Issues relating to the Health Benefits Administrator position: *In 1995, the Health Care Commission's Technical Administrator position was combined with the top position in the Benefits Management Section in the Division of Personnel Services. The responsibilities of the 2 positions overlapped a lot and were combined to be more efficient. The most recent person to hold this position was well-qualified, more than fulfilling the requirements given in the position description. Part of this position's responsibilities is to serve on a team of people who handle negotiations for health care benefits providers.*

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Issues relating to the oversight of funds used to pay health insurance benefits: *All moneys related to the Health Benefits Program are held within funds in the State Treasury, and all interest earned on those funds is credited to the State. A reserve fund was created with a portion of the premiums State agencies paid between 1989 to 1995 in case claims and administrative expenses were higher than expected. Since 1996, the fund has been used to help pay premiums for agencies, and to pay operating expenses and salaries within the Benefits Management Section of the Division of Personnel. By the end of fiscal year 2002, moneys in the Reserve Fund will no longer be available to offset the State's premium contributions or pay salaries and other operating expenses for health benefits staff.*

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Issues relating to the use of incurred costs in a self-funded health care plan: *To set the premium rate for a coming year, one must determine the costs from the prior year. In coming up with the previous year's costs, the Program's consultant uses both the amount of claims already paid, and an estimate of the costs that have been incurred but not yet paid for that plan year. Actuaries who prepare cost projections told us it doesn't matter if incurred or actual paid costs are used to make these cost projections–if done correctly, both will produce a similar projection. However, it wouldn't be appropriate to reimburse the third party administrator on the basis of costs incurred but not paid. Under the State's self-funded medical plan, Blue Cross doesn't get reimbursed on a "cost-incurred" basis; it gets reimbursed only for claims it actually has paid to providers.*

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Question 3: Are There Any Potential Problems With the Multiple Roles Blue Cross and Blue Shield Is Required To Carry Out Under the State's Health Care Contract?

Under its administrative services only (ASO) contract, Blue Cross and Blue Shield's role is similar to other states' ASO contractors. *Further, although Kansas' contract with Blue Cross specifically mentions that Blue Cross will "advise and assist in a consultative capacity," the services it provides primarily involve feedback on the self-funded program, and are no different from the services other states receive from their contractors. In addition, Kansas has a separate contract with a professional consultant who helps negotiate and prepare requests for proposal, among other things. Like Blue Cross, other states' contractors also offer a network of providers for those states' self-funded plans. Industry representatives we spoke with indicated it isn't unusual or inappropriate for the same company to provide both administrative services and the network of medical providers for a self-funded plan.*

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This audit was conducted by Chris Clarke, John Curran, Scott Frank, Joe Lawhon, Katrin Osterhaus, and LeAnn Schmitt. Cindy Lash was the audit manager. If you need any additional information about the audit's findings, please contact Ms. Clarke or Mr. Lawhon at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.

The State Health Benefits Program, Part I: Reviewing Issues Relating to Premium Costs and Management

The State employee health care program provides health care, dental, and drug benefits for State employees. The current program has 3 self-funded components that use third-party administrators: Blue Cross and Blue Shield for the Kansas Choice and Kansas Choice Senior medical coverage, Delta Dental for dental coverage, and AdvancePCS for drug coverage.

In addition to the self-funded component, the State contracts with 4 Health Maintenance Organizations (HMOs) and one Preferred Provider Organization (PPO) for additional medical coverage. All the medical contracts are in the final year of the contracts, and will be renegotiated this summer with the new contracts going into effect in January 2002.

Some national surveys have shown that Kansas' State employees' average medical premium costs were above the averages for government health care plans. Given such reports, legislative concerns have been raised that the State and its employees may be paying too much for their health care premiums. A related concern is whether the "incurred cost" method being used to develop premium rates is appropriate for a self-funded program, and whether its use may have a negative impact on the cost of the program.

Other specific concerns have been raised about whether the State has hired professionals with the appropriate expertise to manage the program, whether funds associated with the program are being properly managed and overseen, and whether Blue Cross and Blue Shield may have conflicting roles as the entity that acts as the third-party administrator for the health care program, provides consulting services, processes and pays claims, handles appeals, etc. This performance audit answers the following questions:

1. **Are the premiums for the State employee health care program too high for the level of benefits provided?**

2. **Are selected aspects of the program being properly managed or overseen?**

3. **Are there any potential problems with the multiple roles Blue Cross and Blue Shield is required to carry out under the State's health care contract?**

To obtain comparative information about premiums and rates, we surveyed the 4 surrounding states and Iowa, as well as 4 public employers within Kansas. We also reviewed various surveys of health care plans for state employee groups or other governmental entities.

To address the concerns about administrator qualifications, oversight of funds, and use of incurred costs, we reviewed statutes, regulations, position descriptions, and resumes to determine the qualifications of the Health Benefits Administrator. We also reviewed State accounting records and interviewed Division of Personnel staff about the oversight of funds. In addition, we interviewed representatives of the current and former consulting actuarial firms doing work for the Department of Administration, as well as officials from Blue Cross and Blue Shield. Finally, we reviewed certain contracts and payment documentation.

To determine whether Blue Cross and Blue Shield has conflicting roles, we reviewed the duties outlined in the company's contract, contacted other states, and interviewed industry experts.

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in Appendix A.

In conducting this audit, we followed all applicable government auditing standards set forth by the U.S. General Accounting Office.

Overview of the State's Health Benefits Program

In Kansas, the Health Care Commission Is Responsible For Managing the Health Care Benefits Program for the State

The State's Health Care Commission, established in 1984, is responsible for implementing and administering the health care benefits program for State employees. By statute, members of the Commission include the Secretary of Administration, the Commissioner of Insurance, a current employee from the State classified service, a person retired from the classified service, and a representative of the general public.

The Commission issues periodic Requests for Proposals for the State's health care benefits program, which includes the medical, prescription drug, dental, vision and long-term care plans, as well as a student health care plan. With the help of a consultant, the Commission negotiates with bidders for the design and cost of the health plan.

The Commission has a staff of 16.5 within the Department of Administration's Division of Personnel Services. This staff includes a statutorily created Health Benefits Administrator position, as well as other staff to administer the programs.

As allowed by law, the Commission also has an Employee Advisory Committee, which comprises 21 members, most of whom are active employees. Committee members are selected based on geographic location, agency, gender, age, and plan participation to represent a cross section of Kansas' employees. They provide input to the design of the health care plan and to funding issues that should be considered by the Commission.

The State's Health Care Plan Covers Multiple Groups, and Currently Offers 7 Different Medical Plans

The following people are eligible to enroll in the State's health care plans:

- Elected officials of the State
- Active full, or part-time State employees who are not classified temporary
- Retired State employees
- Persons in a postgraduate residency training program in medicine at the University of Kansas Medical Center
- Blind persons licensed to operate a vending facility
- Any above person that is lawfully on leave without pay
- Full-time students in Regents Institutions
- Employees of unified school districts, community and technical colleges, and vocational technical schools

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For calendar year 2001, the State's health care program includes 7 medical plans from which participants may choose. A total of about 45,000 participants are enrolled and about 90,000 people are covered, including dependents. The types of medical plans currently offered, the number of employees covered by each plan, and the general availability of plans across the State are described in the table below.

State Health Care Plans Available For 2001

Health Care Plan	Type of Plan & Description	Availability	# of Participants (and % of total)
CONVENTIONAL PLANS			
Kansas Choice (BCBS)	**Point-Of-Service (self-funded)** Participant chooses a Primary Care Physician (PCP). Participant is allowed to see other doctors without a referral from the PCP, but will have to pay more.	105 counties (throughout Kansas)	23,029 (51%)
Kansas Choice Senior (BCBS)	**Indemnity (self-funded)** Participant may seek care from the physician of their choice. This operates like a traditional fee-for-service plan.	105 counties (throughout Kansas)	7,561 (17%)
Preferred Health Systems	**Preferred Provider Organization (PPO) -** Participant can choose whether or not to use doctors in the PPO network. There is no PCP designated. If participant sees a doctor outside the PPO network, it will cost more.	88 counties (except Northeast Kansas)	1,526 (3%)
HEALTH MAINTENANCE ORGANIZATIONS (HMO)			
Premier Blue (BCBS)	**HMO** - must use doctors and other providers in the HMO network. Participant chooses a PCP, and must get approval from the PCP before seeing a specialist.	55 counties (Eastern Kansas)	7,798 (17%)
Coventry Health Care		26 counties (South Central and Northeast Kansas)	2,627 (6%)
Preferred Plus		16 counties (Southeast Kansas)	1,926 (4%)
HealthNet		11 counties (Northeast Kansas)	1,011 (2%)
			Total 45,478

Source: Data from Division of Personnel Services, Health Benefits Section, and the Health Care Commission

Employees also can participate in the State's flexible spending program, which is not administered by the Health Care Commission. This program allows employees to save money by depositing pre-tax dollars into health care and dependent care flexible spending accounts. The employee can use these funds to pay for allowable expenses that aren't reimbursed by medical, dental, vision, or prescription drug plans.

In 1996, the Health Care Commission Started Self-Funding Several Health Care Programs

Before 1996 all health care plans offered by the State were fully insured. However, when the insurer for the State's largest health care program proposed a double-digit increase in premium rates for 1996, the Health Care Commission decided to self-fund two health care plans and the dental plan. In 1997, the Commission decided to also self-fund the prescription drug plan. The box below describes the differences between fully insured and self-funded plans.

In part, the switch from fully-insured to self-funded was possible because of large reserves (approximately $84 million, as of January 1, 1996) that had built up over several years. These reserves are more fully explained in Question 2.

Over the Last Few Years, the Health Benefits Program Expanded To Include Certain Students and Educational Entities

In the fall of 1998, the Health Care Commission began offering health care benefits to full-time students, as well as graduate research and graduate teaching assistants at Kansas Regents' institutions. Also, in 1999 the Commission established administrative procedures and eligibility requirements to allow unified school districts, community colleges, technical colleges, and vocational technical schools into the State's health benefit plan. In calendar year 2000, 5,875 students participated, as well as about 1,000 school district employees.

Different Approaches to Providing Employee Health Insurance: Self-Funded and Fully-Insured Plans

In our contacts with other states and public entities, we encountered 2 basic ways of providing group health care coverage for employees–"self-funded" plans and "fully-insured" plans. In general, those terms may be described as follows:

- In a self-funded plan, the employer assumes the functions, responsibilities, and risks of an insurer. The employer maintains a separate fund that is financed with employer and employee contributions (throughout the audit these contributions are referred to as premiums). When employees file claims for health care services, those claims are paid for with moneys from that fund. The employer assumes the risk that medical claims for a given time period might exceed the premiums that have been collected.

- In a fully insured plan, the employer hires an insurance company to assume the risk of paying claims from premium moneys. All premiums are paid to the insurance company.

Not all plans purely self-funded or fully insured. Some plans contain elements of each type of plan. For example, an employer could opt to self-fund health care claims up to a certain total and purchase additional insurance to protect it against unusually high claims. Also, many employers with self-funded plans hire a third-party, often an insurance company, to administer the plan and process claims.

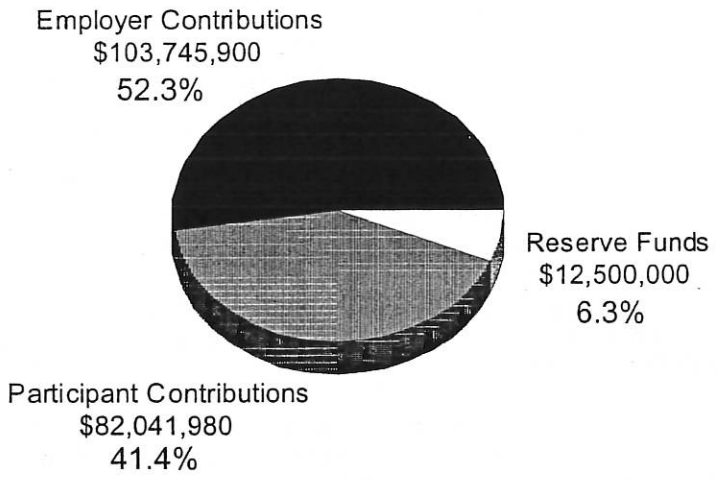
The Kansas State Employees Health Care Commission AT A GLANCE

Authority: The Health Care Commission was created by the 1984 Legislature through enactment of K.S.A. 75-6501 (*et. seq.*) Its mission was to "develop and provide for the implementation and administration of a State health care benefits program..."

Staffing: The Commission is composed of 5 members, and is assisted by a 21 member Employee Advisory Committee (as provided by K.S.A. 75-6501(b)), as well as 16.5 full-time equivalent staff of the Department of Administration, Division of Personnel, Benefits Administration section.

Participants: As of January 1, 2001 there were a total of about 45,000 participans in the various medical plans, representing about 90,000 people covered (includes spouses and children).

Funding for CY 2000 Health Plan Costs (estimated)



Total Funding: $198,287,898

Question 1: Are the Premiums For the State Employee Health Care Program Too High For the Level of Benefits Provided?

Kansas' health care premiums are somewhat higher than the average premiums paid by our comparison groups, but usually fell well within the mid-range. Kansas' premiums may be higher than average because Kansas employees pay far less out-of-pocket for their medical costs than employees in most of those other groups. In general, health care plans that require employees to pay more out-of-pocket costs for their health care have lower premiums.

Kansas' Current Health Care Premiums Are Somewhat Higher Than the Average for Our Comparison Groups' Rates, But Generally Are Well Within the Mid-Range

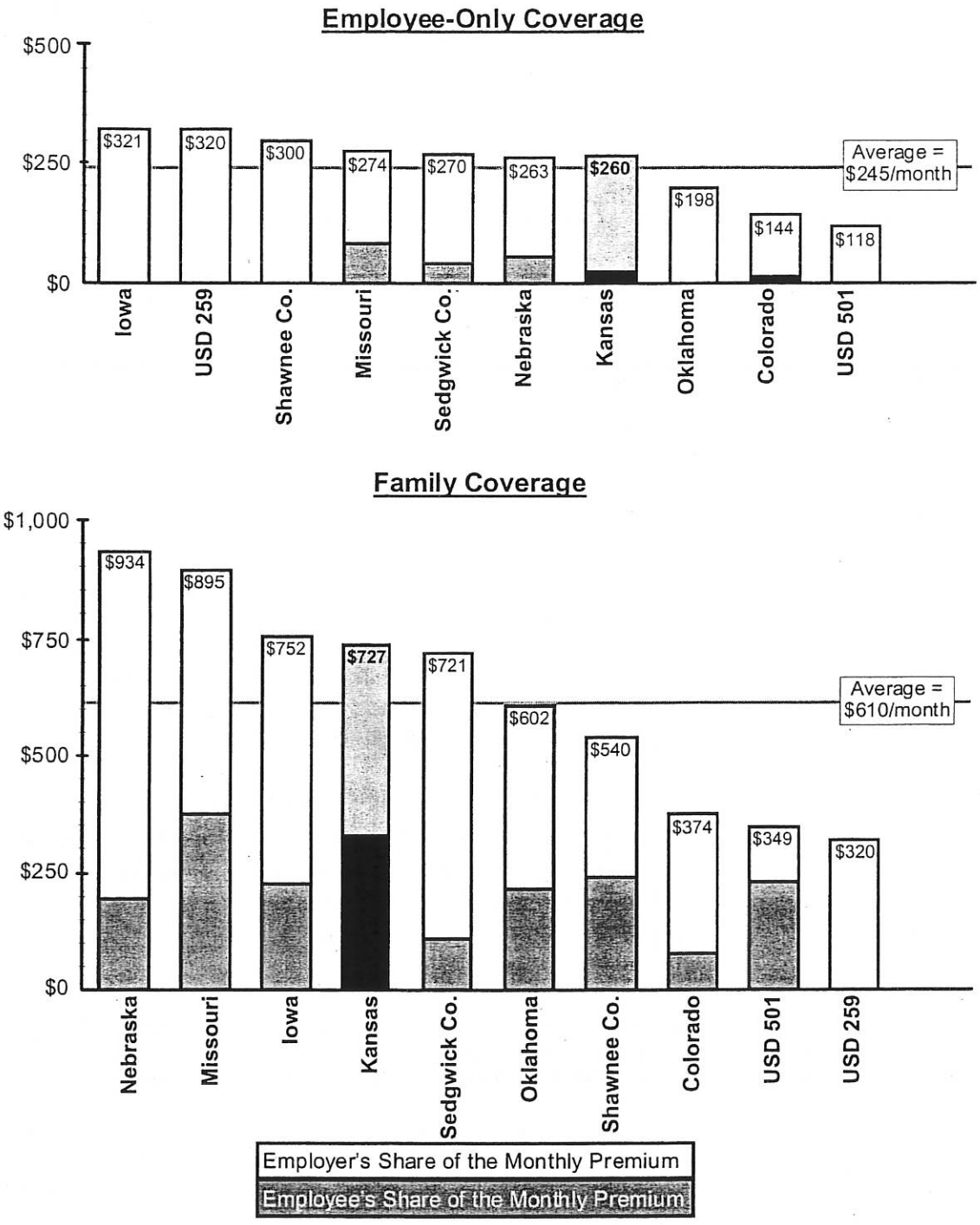
To determine how Kansas' 2001 health care premium rates compare with other entities, we obtained information from the 4 surrounding states and Iowa, from Sedgwick and Shawnee Counties, and from the Wichita and Topeka school districts. We asked for information about their largest conventional health care plans and their largest health maintenance organizations (HMOs). The types of plans that fall under the "conventional" heading are described in the table on page 4. Detailed results for our survey are found in Appendix B.

Given the scope of this audit, we didn't attempt to compare the details of the coverage offered under each plan. Certain basic services like in-patient and out-patient services, office visits, and routine physicals are covered to some extent by all the plans. The entities we reviewed had a mix of self-funded and fully insured plans. The differences between these types of plans are described in the box on page 5.

In general, our comparisons show that Kansas' 2001 monthly premiums are slightly higher than the averages for our comparison group, but generally fall in the mid-range of these rates. These comparisons are illustrated in the graphs on the next 2 pages. When interpreting these graphs, it's important to consider the following points:

- Premiums are paid each month to pay for the cost of medical coverage. The premiums shown in the graphs are total monthly figures. In general, both the employer and the employee pay part of the monthly premium.
- Although Kansas has separate premiums for health care and prescription drug coverage, most of our comparison groups combined them into one premium. To make the premiums comparable, we added Kansas' prescription drug plan premiums in with the medical plan premiums.
- Because plans may have multiple levels of family coverage (for example, employee and spouse, employee and child, full family), we used the maximum full-family coverage for our comparisons. Also, where premiums vary because of such factors as salary levels or the employee's use of tobacco, we chose the maximum premium possible.

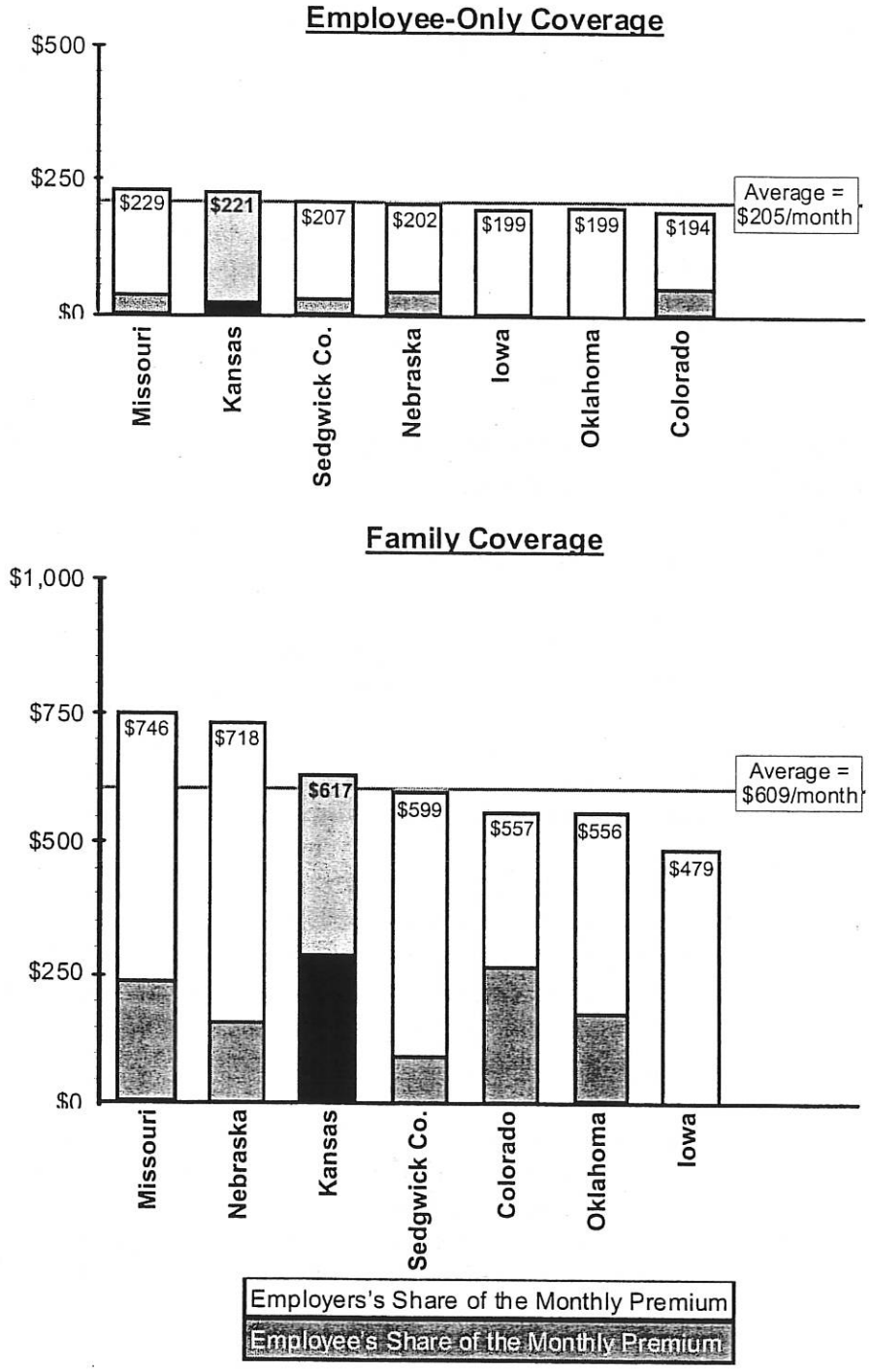
Maximum Monthly Premiums in Conventional Plans



Averages Exclude Kansas

Source: LPA Survey

Maximum Monthly Premiums in HMO Plans



Averages Exclude Kansas

Source: LPA Survey

Kansas' premiums also were higher than average compared with the results of surveys conducted by national firms. We looked at various surveys of 1999 and 2000 health care plans for state employee groups or government entities reported by such groups as The Segal Company and Workplace Economics. The results varied, but in general they showed that Kansas' premiums were higher than average.

The 1998-2000 surveys of state employee health benefit plans conducted by The Segal Company showed that Kansas' rates were higher than all 5 neighboring states' rates in 1998 and 1999, but had dropped to 3rd highest in 2000 when the other states had large increases in their rates. This information is shown in more detail in Appendix C.

Kansas Employees Pay Far Less "Out-of-Pocket" for Their Medical Costs Than Employees In Most of the Comparison Groups

In a conventional health care plan, an employee's out-of-pocket costs can include the following:

- **a deductible**–the amount of medical costs the employee is responsible for before insurance coverage will pay anything
- **co-insurance**–the percentage of medical costs the employee will have to pay once the deductible has been satisfied. (If co-insurance is 80/20, the employee is responsible for paying 20% of the cost, and the plan will cover 80%)
- **co-payments**–some plans require employees to pay a set amount from their own pockets for certain medical services, such as $10 for every office visit, or $25 for an emergency room visit.

Under many health care plans, there's usually a maximum placed on the amount an employee would have to pay for medical services covered by the plan in any one year. Usually only the deductible and co-insurance payments count toward that maximum. HMOs generally don't have deductibles or co-insurance requirements but may require a co-payment for certain services.

For our analysis, we looked at deductible amounts, co-insurance rates, and maximum out-of-pocket costs for 2001. We excluded co-payments because it's impossible to predict how often these services might be used. We also "applied" those amounts and rates to various levels of medical costs that might be incurred in a year ($500, $1,000, etc. . .). These figures are shown in the table at right.

As the first table shows, Kansas is one of 3 entities that doesn't require its employees to pay a deductible, and its maximum yearly out-of-pocket costs are among the lowest. The second table shows

The Out-of-Pocket Expenses Kansas Employees Pay for Health Care Are Lower Than the Other Entities We Looked At

Out-of-Pocket Expenses for Conventional Plans

	Deductible		Co-Insurance Percentage	Maximum Amount Payable	
	Employee Only	Full Family		Employee Only	Full Family
Colorado	$1,000	$1,000	10%	$6,000	$6,000
Iowa	$300	$400	20%	$600	$800
Kansas	**$0**	**$0**	**20%**	**$500**	**$1,000**
Missouri	$0	$0	0%	$0	$0
Nebraska	$200	$400	15%	$1,000	$2,000
Oklahoma	$300	$900	20%	$2,300	$6,900
Sedgwick Co.	$0	$0	0%	$0	$0
Shawnee Co.	$200	$600	20%	$1,200	$3,600
USD 259	$250	$500	20%	$650	$1,300
USD 501	$400	$800	30%	$3,000	$6,000

Source: LPA Survey

How Much An Employee Will Pay In a Year . . .

		If Medical Costs Incurred In 1 Year Are:			
		$500	$1,000	$5,000	$100,000
Employee Only Coverage	Colorado	$500	$1,000	$1,400	$6,000
	USD 501	$430	$580	$1,780	$3,000
	Oklahoma	$340	$440	$1,240	$2,300
	Shawnee County	$260	$360	$1,160	$1,200
	Nebraska	$245	$320	$920	$1,000
	USD 259	$300	$400	$650	$650
	Iowa	$340	$440	$600	$600
	Kansas	**$100**	**$200**	**$500**	**$500**
	Missouri	$0	$0	$0	$0
	Sedgwick County	$0	$0	$0	$0
Full Family Coverage	Oklahoma	$500	$920	$1,720	$6,900
	Colorado	$500	$1,000	$1,400	$6,000
	USD 501	$500	$860	$2,060	$6,000
	Shawnee County	$500	$680	$1,480	$3,600
	Nebraska	$415	$490	$1,090	$2,000
	USD 259	$500	$600	$1,300	$1,300
	Kansas	**$100**	**$200**	**$1,000**	**$1,000**
	Iowa	$420	$520	$800	$800
	Missouri	$0	$0	$0	$0
	Sedgwick County	$0	$0	$0	$0

Source: LPA Calculations

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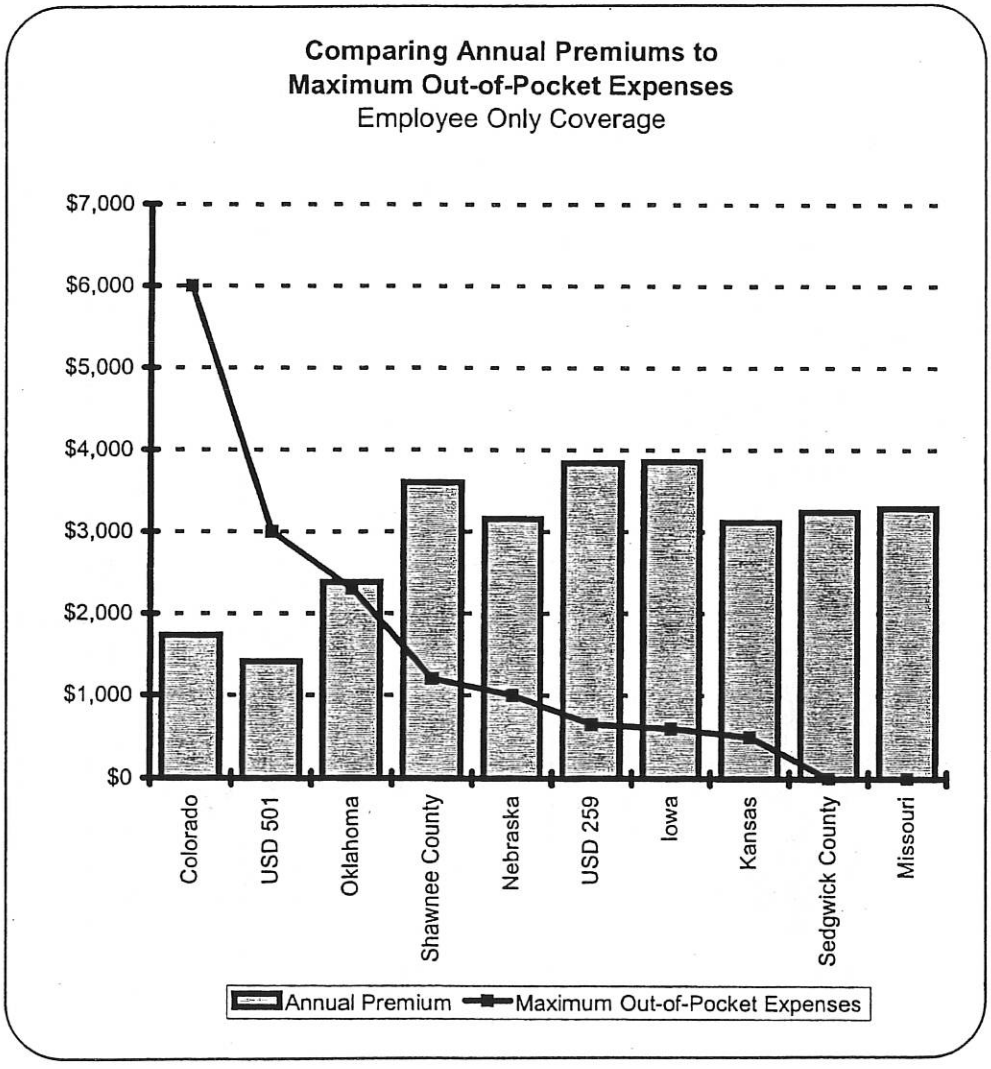
that Kansas' health care plan has no deductible and low out-of-pocket maximums. Therefore, Kansas employees pay less out-of-pocket under all 4 scenarios than most of their counterparts in the comparison groups. Appendix D provides relevant information.

Generally, entities that require their employees to pay more out-of-pocket costs for their health care have the lowest premiums. With any type of insurance, the higher your deductible (in other words, the more you agree to pay out-of-pocket to cover costs), the lower your insurance premium will be.

In comparing the maximum out-of-pocket costs and total monthly premiums for our sample group, we saw that plans where employees were required to shoulder more of their own medical costs generally had lower premiums, and vice-versa. The graph below for employee-only coverage illustrates this concept.



Many other variables can affect insurance premium rates, but information comparing Kansas with other states in these areas isn't readily available. In this audit, we compared total monthly premiums for our sample group with the deductibles, co-insurance requirements, and maximum out-of-pocket costs for employees. However, the cost of a health care program is affected by a variety of other factors, including:

- the specific medical services covered by the plan
- the amount the plan will pay for those services
- which services participants use and how much they use them (utilization of services)
- how the plan is funded (i.e., self-funded versus fully insured)
- whether the plan includes elements of managed care (i.e., requiring participants to get prior approval for certain services, or negotiating discounted fees with doctors and hospitals)

In general, comparative information about the first 3 factors isn't readily available, and may not be available at all in some cases. In the future, the Department may want its consultant to look at this and other issues.

Question 2: Are Selected Aspects of the Program Being Properly Managed or Overseen?

This question focused on specific concerns in 3 areas, none of which appeared to be a problem. Regarding questions about the Health Benefits Administrator position, we noted the position had been combined with a similar position 6 years ago to eliminate the overlap that existed, and has been filled by a well-qualified individual since then. Regarding questions about whether the Program's funds are being properly managed and overseen, we found they're being deposited into the State Treasury, and the interest being earned on them stays with the Program. Regarding concerns about the use of "incurred" costs in a self-funded program, we found there's no problem considering costs that have been incurred but not yet paid when projecting what future Program costs will be. It wouldn't be appropriate for the Program to reimburse the company handling its self-funded plan on the basis of claims that had only been incurred but not yet paid, and we didn't find that to be happening.

Issues Relating to the Health Benefits Administrator Position

Questions had been raised about whether the State had upheld its commitment to staff the position with a person who had the knowledge and expertise needed to effectively carry out the Administrator's responsibilities. Our findings in this area are summarized below:

- **Several years ago the Health Benefits Administrator position was combined with another benefits manager position to eliminate overlap and duplication between the 2 positions.** The Office of Health Benefits Administrator existed as a separate entity from 1984 until its consolidation with the Division of Personnel Services in 1996. Before 1995, the Health Care Commission had its own full-time Technical Administrator to manage the program. According to Department officials, the person in that position spent a considerable amount of time having to coordinate with the person who headed up the Benefits Management Section within the Division of Personnel Services that was responsible for the administration of the plan. An internal Department analysis showed the responsibilities of the 2 positions overlapped a lot.

  In 1995, State law was changed at the Department's request to consolidate the 2 positions, and to allow the new position to be either classified or unclassified. The new position currently is

in the classified service. The person in this position has 2 titles and 2 separate reporting responsibilities. As Health Benefits Administrator, that person reports to the Chair of the Health Care Commission. As Benefits Manager, that person reports to the Director of Personnel.

In March 2001, the person who's held this position since 1995 accepted the position of Assistant Director of the Division of Personnel Services, and a new Health Benefits Administrator was hired.

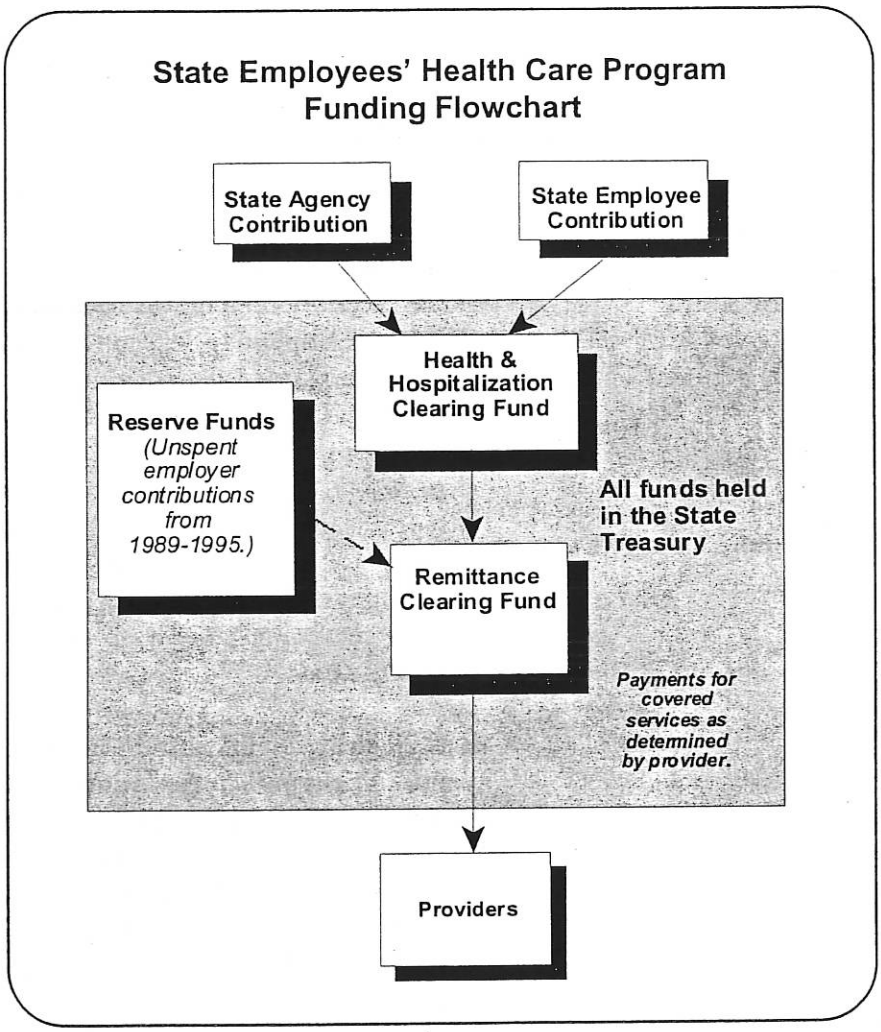
- **The most recent Health Benefits Administrator appears to have been well qualified for the job.** Qualifications and requirements for this position have always been included in the job description; nothing has been specified in law or regulation. The job description for the combined Health Benefits Administrator-Manager position calls for general managerial and supervisory experience, with 5 years' experience working with benefit plans preferred. The person who held this job until March 2001 met all the qualifications. She had 6 years of benefits analysis experience in Kansas before becoming the Administrator, plus many years experience at supervisory and managerial levels in prior positions. Neither position descriptions nor resumes were available for previous Administrators.

- **The Health Benefits Administrator is part of a team of people who handle negotiations**. The negotiation team consists of the hired consultant (currently the Segal Company), legal counsel from the Department of Administration, a representative from the Insurance Department, contract managers from the Benefits Management Section, and a representative from the Health Care Commission. Although the Health Benefits Administrator position is the coordinator of the negotiation process, other team members are active in the process. For example, the consultant determines whether the bid amount is justified, and can make counter-offers.

Issues Relating to the Oversight of Funds Used to Pay Health Care Benefits

As the graphic on the next page shows, the Program's funds come from 3 sources: State agency contributions, State employee contributions, and a "reserve" fund. The reserve fund includes a portion of the premiums State agencies paid between 1989 to 1995 that were held in reserve (segregated by year) in case claims and administrative expenses were higher than expected. As the reserve fund grew over the years, those moneys also were used to help smooth out premium increases.

When the State switched from a fully insured plan to a self-funded plan in 1996, the reserve fund contained about $84 million. Those funds have been used since then to cover part of the agencies' premiums for health insurance, and to help pay salaries and other operating expenses. No new money has flowed into the Reserve Fund since 1995 other than the interest being generated.



The graphic also shows how moneys flow into the Health and Hospitalization Clearing Fund and into the Remittance Clearing Fund. That's the fund providers are paid from. Some operating costs for the Division of Personnel Services are paid from the Reserve Fund.

When this audit was approved, questions were raised about where premium moneys were being held, and whether Program moneys were being properly managed and overseen. Our findings are summarized on the next page:

- **All moneys related to the Health Benefits Program are held within funds in the State Treasury, and all interest earned on those funds is credited to the State.** Along with other moneys in the State Treasury, these moneys are invested by the Pooled Money Investment Board. In addition, the moneys in the State Treasury are audited each year to ensure they've been properly accounted for and spent.

  There may be some confusion between these funds and the moneys State employees contribute when they participate in the State's flexible spending accounts under the Cafeteria Benefits Plan. These are separate, optional programs for State employees who can choose to have an amount withheld from their paychecks on a pre-tax basis to help pay for dependent care or for out-of-pocket medical expenses for themselves or their family members.

  The flexible benefits spending accounts currently are administered by a company called ASI from Missouri. Moneys withheld from employees' checks are wired to a bank in Missouri that partners with ASI. When employees submit claims to ASI, those claims are paid out of that account. It is a State account, and the money is considered State money until a valid claim is filed. ASI performs a bank reconciliation on the account, and sends a copy to the State.

By the end of fiscal year 2002, moneys in the Reserve Fund will no longer be available to offset the State's premium contributions or to pay salaries and other operating expenses. The Reserve Fund had a balance of about $39 million at the end of fiscal year 2000. Health Benefits staff have determined the State needs to maintain a balance of about $29 million in the Reserve Fund as a safety net for the State's self-funded health care plan. That way, if costs should exceed the amount of premiums taken in during a year, there's money available to pay those costs.

Staff estimate that moneys in the Reserve Fund will be reduced to this minimum balance by the end of fiscal year 2002. In other words, the State will no longer be able to use the moneys in this fund to supplement State agency premiums, cushion increases, and pay operating expenses. As a result, in fiscal year 2003 agencies will see an increase in composite rates that reflect the lack of reserve funding, as well as increases in plan costs.

Issues Relating to the Use of Incurred Costs In a Self-Funded Health Care Program

To set the self-funded plan's premiums for the next year, the Program's consultant estimates how many employees will participate and what their medical costs will be that year. This estimate is based in part on the cost of claims from the previous year.

In coming up with the previous year's costs, the Program's consultant uses both the amount of claims already paid, and an estimate of the costs that have been incurred but not yet paid for that plan year. (For example, an employee may have had an operation in mid-December, but all the bills related to that operation may not get sent in for payment until February or March the next year.)

Questions have been raised about the appropriateness of including an estimate of "claims incurred" in the consultant's cost projections, instead of using only the claims actually paid during the year. (A "claims incurred" method ties the claim to the date the service actually was provided, while a "claims paid" method ties the claim to the date the provider gets paid for the service.)

Questions also have been raised about whether the Program is reimbursing Blue Cross and Blue Shield, the third-party administrator of the State's self-funded medical plan, for claims providers had submitted but Blue Cross hadn't yet paid. If that were true, Blue Cross would get the benefit of earning interest on the funds until it needed them. Our findings in these areas are summarized below:

- **Actuaries who prepare cost projections told us it doesn't matter which method is used in making those cost projections.** If the calculations are done correctly, they said, both methods will produce a similar projection. We reviewed the Program consultant's methodology for cost projections, and found it to be reasonable.

- **Under the State's self-funded medical plan, Blue Cross doesn't get reimbursed on a "cost- incurred" basis; it gets reimbursed only for claims it actually has paid to providers.** The actuaries we talked with said it would be inappropriate under a self-funded plan for the administrator to be reimbursed on a cost-incurred basis. That's because the State should be the party that gets to earn the maximum interest on all Program moneys until they are needed, and to manage Program funds as it sees fit.

Because the contract language in this area could be subject to differing interpretations, we interviewed officials from the Health Benefits Program and Blue Cross, as well as legal staff from the Department of Administration. They concurred that the contract required the State to reimburse Blue Cross only for claims it had already paid to providers. Our testwork on a sample of claims submitted for reimbursement showed the State was properly reimbursing Blue Cross only for claims it had actually paid.

Question 3: Are There Any Potential Problems With the Multiple Roles Blue Cross and Blue Shield Is Required To Carry Out Under the State's Health Care Contract?

Blue Cross' responsibilities as the third-party administrator for the State's self-funded medical plan are very similar to the responsibilities of contractors in other states that have self-funded plans. Other states don't specify in their contracts that the administrator will do any "consulting," as Kansas' contract does. However, the types of consulting services/feedback Blue Cross provides under this contract are no different from what other states receive from their contractors. Like other states, Kansas has a separate contract for a professional consultant who performs actuarial services and other analyses related to the entire health insurance program. Finally, third party administrators for other states' self-funded plans generally provide their own network of doctors for that plan, as Blue Cross does in Kansas. These and other findings are discussed in the sections that follow.

Under Its Administrative Services Only (ASO) Contract, Blue Cross and Blue Shield's Role Is Similar to Other States' ASO Contractors

Blue Cross provides administrative services for the State's self-funded health benefits plan. Its responsibilities under this contract include the following:

- accounting
- processing claims, paying providers, and reviewing appealed claims
- conducting quality assurance reviews
- providing marketing and customer service

According to industry experts, these are common duties required under an Administrative Services Only contract. In addition, Blue Cross must provide utilization reports and other information about the self-funded medical plan to the Health Care Commission on a regular basis.

A concern was raised that Blue Cross was responsible for processing claims for all the State's health care contractors, which would give it access to proprietary information about those contractors' operations. This isn't the case. Under its ASO contract, Blue Cross processes claims only for the State's self-funded program (Kansas Choice and Kansas Choice Senior). The State's other HMO or health care contractors process their own claims.

Although Kansas' contract with Blue Cross specifically mentions that Blue Cross will "advise and assist in a consultative capacity," the services it provides are no different

from the services other states receive from their contractors. Blue Cross' consulting role can be more appropriately described as providing feedback regarding certain issues related to the self-funded program, including form design, documentation, claims issues, and revision of benefits. According to Health Care Commission officials, such feedback usually is verbal. Further, Kansas' Health Benefits Administrator told us all the State's health care contractors provide operational feedback regarding their own plans. Also, the other third-party administrators for the dental and drug programs have the same language in their contracts.

We contacted officials in 5 other states that contract with a third-party administrator to run their self-funded programs. Although none of their ASO contracts included a "consulting" component, officials in 3 states said they get informal feedback from their contractors, much like the feedback Kansas gets from Blue Cross, without having this contractual provision.

Kansas has a separate contract with a professional consultant. The Health Care Commission contracts with a professional consulting company to advise it about issues related to the whole health benefits program, not just the self-funded component. That consultant was William M. Mercer, Inc. until January 2001, when The Segal Company became the consultant.

The consultant helps prepare the Requests for Proposal and contracts for the State's health insurance plans, helps in the negotiations between the Commission and providers, and provides utilization, actuarial, and trend analyses that the Commission uses in considering the impact of various changes to the plans and in setting premium rates.

Like Blue Cross, other states' contractors also provide a network of providers for those states' self-funded plans. Of the 5 states we contacted, 4 hire their self-funded plan administrators using Administrative Services Only contracts, and rent the network of medical providers for that plan from the same contractor.

Industry representatives we spoke with indicated it isn't unusual or inappropriate for the same company to provide both administrative services and the network of medical providers for a self-funded plan. Further, they said bidding the provision of administrative services separately from the network wouldn't necessarily lead to lower costs. An official from another state said it would be an "administrative nightmare" to have one company process claims and another company provide the access to the network.

APPENDIX A

Scope Statement

On February 28, 2001, the Legislative Post Audit Committee combined two scope statements on State health benefits into one audit. The audit will be issued in two parts. This appendix contains the scope statement approved by the Committee for Part I, which was requested by Senator Kerr.

SCOPE STATEMENT

The State Health Benefits Program: Reviewing Issues Relating to Premium Costs and Management

The State employee health care program provides health care, dental, and drug benefits for State employees. The current program has three contractors: Blue Cross and Blue Shield for the medical coverage, Delta Dental for dental coverage, and Advanced PCS for drug coverage. The medical program is in the last year of its contract, and will be renegotiated this summer with the new contract going into effect January 1, 2002.

Published reports have shown that State employees' average medical premium costs for 1999 were as much as 25% above the averages for government health care plans. Given such reports, legislative concerns have been raised that the State and its employees may be paying too much for their health care premiums for the level of benefits being provided. A related concern is whether the "incurred cost" method being used to develop premium rates is appropriate for a self-insured program, and whether its use may have a negative impact on the cost of the program.

Other specific concerns have been raised about whether the State has hired professionals with the appropriate expertise to manage the program, whether reserve funds associated with the program are being properly managed and overseen, and whether Blue Cross and Blue Shield may have conflicting roles as the entity that administers the health care program, provides consulting services, processes and pays claims, handles appeals, etc. A performance audit to address these concerns would answer the following questions:

1. **Does it appear that premiums for the State employee health care program are too high for the level of benefits being provided?** For this question, we'd focus only on health care premiums, not on dental or prescription drug premiums. We'd compare the State's medical premium costs and benefit levels with those of other comparable entities. Some of this information would be obtained from published reports, while other information would be obtained directly from other states or employers. We'd also interview people from our comparison groups to make certain those comparisons were appropriate, and to obtain additional information as needed. Finally, we'd determine whether it's appropriate to use "incurred costs" when developing premium rates for a self-insured program, and if not whether that method has a negative impact on the cost of the program.

2. **Are selected aspects of the program being properly managed or overseen?** We'd review the employment history and qualifications of the people who've managed the program, determine whether they possessed the requisite expertise, and if not determine why. We'd also review contracts and interview officials responsible for administering the health care program to determine what requirements have been established for managing and overseeing reserve or discretionary funds. We'd compare those procedures against best practices, and point out any weaknesses we note. We'd perform other test work as needed.

3. **Are there any potential problems with the multiple roles Blue Cross and Blue Shield is required to carry out under the State's health care contract?** We'd determine what contractual responsibilities Blue Cross and Blue Shield has, and understand what role the plan consultant plays. We'd also contact a sample of other states with self-insured health care programs to identify and compare the responsibilities they assign their plan administrators and plan consultants. We'd discuss any significant differences or potential conflicts in the way Kansas has set up its program in this area with officials in Kansas, other states, and experts in the field. We'd perform other test work as needed.

Estimated time to complete: 3-4 weeks with 2 teams of auditors

APPENDIX B

Summary of Survey of State Health Care Plans

This appendix provides a summary of the survey information we gathered in this audit for Question 1. The table contains information about the premium amounts paid for health care coverage and certain other information pertaining to amounts that could be paid by employees, such as deductibles and co-insurances rates.

	Kansas	Colorado	Iowa	Missouri
Plan Dates	Calendar Year	Calendar Year	Calendar Year	Calendar Year
Largest Conventional				
Name of Plan	Kansas Choice	ABCBSC Prime Centennial	3 Plus - Wellmark	United Healthcare Choice (Premium)
Plan Type	POS	PPO	Indemnity	POS
Financing	Self-Funded	Fully-Insured	Fully-Insured	Fully-Insured
Retirees Are:				
Included In This Plan	Yes	No	Yes	Yes
Pooled With Active Employees	Yes	N/A	Yes	No
Medical Premiums (a)				
Single Coverage				
Employer Share	$236	$142	$321	$193
Total	$260	$144	$321	$274
Family Coverage				
Employer Share	$399	$298	$527	$523
Total	$727	$374	$752	$895
Deductible				
Single Coverage	$0	$1,000	$300	$0
Family Coverage	$0	$1,000	$400	$0
Co-insurance	80/20%	90/10%	80/20%	100%
Max. Out-of-Pocket				
Single Coverage	$500	$6,000	$600	$0
Family Coverage	$1,000	$6,000	$800	$0
Life-Time Benefit Max.	$2,000,000	None	None	$0
Co-payments & Co-insurance For Specific Services (b)				
Office Visits	80/20%	90/10%	80/20%	$10
Inpatient Services	$50	90/10%	80/20%	100%
Emergency Room Visits	$25	90/10%	100%	$50
Prescription Drug Benefits				
Generic Drugs	75/25%	$15	80/20%	$5
Formulary Drugs	75/25%	$25	80/20%	$15

	Kansas	Colorado	Iowa	Missouri
% of Employee's in HMO's	35%	68%	26%	77%
Largest HMO				
Plan Name	Premier Blue	Aetna U.S. Healthcare	Blue Advantage - Wellmark	United Healthcare Select HMO
Financing	Fully-Insured	Fully-Insured	Fully-Insured	Fully-Insured
Retirees Are:				
Included In This Plan	Yes	No	Yes	Yes
Pooled With Active Employees	Yes	N/A	Yes	No
Medical Premiums (a)				
Single Coverage				
Employer Share	$200	$142	$199	$195
Total	$221	$194	$199	$229
Family Coverage				
Employer Share	$339	$298	$479	$519
Total	$617	$557	$479	$746
Co-payments & Co-insurance For Specific Services (b)				
Office Visits	$10	$15	$10	$10
Inpatient Services	100%	$200	100%	100%
Emergency Room Visits	$50	$25	$50	$50
Prescription Drug Benefits				
Generic Drugs	75/25%	$10	$5	$5
Formulary Drugs	75/25%	$20	$15	$15

(a) Includes prescription drug benefits.
(b) Some restrictions may apply.

Nebraska	Oklahoma	Shawnee Co.	Sedgwick Co.	USD 259	USD 501
Calendar Year	7/1 to 6/30	Calendar Year	Calendar Year	8/1 to 7/31	10/1 - 9/30
Blue Preferred - High Option PPO Fully-Insured	Health Choice PPO Self-Funded	BC/BS - Blue Choice PPO Self-Funded	Blue Select POS Self-Funded	USD 259 Self-Fund Plan PPO Self-Funded	Blue Choice PPO Fully-Insured
Yes Yes	Yes No	Yes Yes	Yes Yes	Yes Yes	Yes Yes
$208 $263	$198 $198	$300 $300	$230 $270	$320 $320	$118 $118
$738 $934	$387 $602	$300 $540	$613 $721	$320 $320	$118 $349
$200 $400 85/15%	$300 $900 80/20%	$200 $600 80/20%	$0 $0 100%	$250 $500 80/20%	$400 $800 70/30%
$1,000 $2,000 $2,000,000	$2,300 $6,900 $1,000,000	$1,200 $3,600 $2,000,000	$0 $0 None	$650 $1,300 $1,000,000	$3,000 $6,000 $2,000,000
85/15% 85/15% $50	$20 80/20% $100	$20 80/20% $50	100% 100% $25	80/20% 80/20% $25	$15 70/30% $50
$10 $15	$20 N/A	$10 $30	$5 $15	N/A N/A	$50 deductible, 70/30% co-insurance

Nebraska	Oklahoma	Shawnee Co.	Sedgwick Co.	USD 259	USD 501
35%	37%	N/A	44%	N/A	N/A
Blue Prime Advantage Fully-Insured	Pacificare Fully-Insured	No HMO	Preferred Plus of Kansas Fully-Insured	No HMO	No HMO
Yes Yes	Yes No		Yes Yes		
$160 $202	$199 $199		$176 $207		
$568 $718	$387 $556		$509 $599		
$10 100% $50	$10 $50 $50		100% 100% $50		
$10 $15	$10 $15		$5 $15		

APPENDIX C

Comparing State Health Care Premiums 1998-2001

	1999 and 2000 The Segal Company Survey			2001 LPA Survey	Average Annual Percent Change (1998-2001)
Employee-Only Coverage	1998	1999	2000	2001	
Colorado [1]	$167	$185	$145	$144	-4.8%
Iowa	$193	$193	$264	$321	18.5%
Kansas	**$215 (1st)**	**$231 (1st)**	**$255 [2] (3rd)**	**$260 (4th)**	**6.5%**
Missouri	$209	$215	$262	$274	9.4%
Nebraska	$151	$158	$230	$263	20.3%
Oklahoma	$148	$171	$175	$198	10.2%
Average	*$180*	*$192*	*$221*	*$243*	*10.5%*
Family Coverage					
Colorado [1]	$442	$486	$349	$374	-5.4%
Iowa	$471	$496	$619	$752	16.9%
Kansas	**$602 (1st)**	**$648 (1st)**	**$714 [2] (3rd)**	**$727 (4th)**	**6.5%**
Missouri	$506	$521	$757	$895	20.9%
Nebraska	$536	$562	$818	$934	20.3%
Oklahoma	$416	$516	$522	$602	13.1%
Average	*$495*	*$538*	*$629*	*$714*	*13.0%*

[1] Colorado made significant changes in its primary non-HMO health care plan between 1999 and 2000.
[2] from State of Kansas 2000 Open Enrollment Information

Sources: 1999 Survey of Survey of State Employee Health Benefit Plans, The Segal Company
2000 Survey of Survey of State Employee Health Benefit Plans, The Segal Company
LPA Survey

APPENDIX D

Comparing Maximum Health Care Expenses For State Employees

This appendix provides a table that shows the maximum amount that employees could have to spend in year 2001 for health care under a conventional plan. The table includes costs for the employee's share of premiums, amounts for the employee's share of medical expenses, which includes deductibles and any co-insurance payments.

	Employee Only Coverage			
	Employee Share of Annual Premiums	Deductible	Maximum Rate of Co-Insurance	Maximum Annual Employee Expenses
Colorado	$29	$1,000	$5,000	$6,029
USD 501	$0	$400	$2,600	$3,000
Oklahoma	$0	$300	$2,000	$2,300
Nebraska	$663	$200	$800	$1,663
Shawnee County	$0	$200	$1,000	$1,200
Missouri	$972	$0	$0	$972
Kansas	**$290**	**$0**	**$500**	**$790**
USD 259	$0	$250	$400	$650
Iowa	$0	$300	$300	$600
Sedgwick County	$486	$0	$0	$486

	Full-Family Coverage			
	Employee Share of Annual Premiums	Deductible	Maximum Rate of Co-Insurance	Maximum Annual Employee Expenses
Oklahoma	$2,579	$900	$6,000	$9,479
USD 501	$2,771	$800	$5,200	$8,771
Colorado	$920	$1,000	$5,000	$6,920
Shawnee County	$2,885	$600	$3,000	$6,485
Kansas	**$3,936**	**$0**	**$1,000**	**$4,936**
Missouri	$4,464	$0	$0	$4,464
Nebraska	$2,354	$400	$1,600	$4,354
Iowa	$2,708	$400	$400	$3,508
USD 259	$0	$500	$800	$1,300
Sedgwick County	$1,298	$0	$0	$1,298

Source: Calculated from LPA Survey

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APPENDIX E

On March 26th, we provide copies of the draft report to the Department of Administration. The Department's response is included as this Appendix.

STATE OF KANSAS

DEPARTMENT OF ADMINISTRATION
State Capitol
Room 263-E
Topeka, Kansas 66612-1572
(785) 296-3011
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DAN STANLEY, *Secretary*

BILL GRAVES, *Governor*

March 28, 2001

LEGISLATIVE POST AUDIT
MAR 27 2001

Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
800 SW Jackson Street, Suite 1200
Topeka, Kansas 66612

RE: HCC Response to LPA Report

Dear Ms. Hinton:

Thank you for this opportunity to reply to your report, "The State Health Benefits Program: Reviewing Issues Relating to Premium Costs and Management." The Health Care Commission has striven to provide a quality, cost effective program. It is gratifying to note that your report indicates that we have been successful.

Given the extreme time constraints associated with this audit, I certainly appreciate the quality of work and the professionalism of the audit staff. I am looking forward to the second part of the audit that will assess the staffing and governance of the plan. The two reports should provide a firm foundation for continued professional management of the health care plan.

Sincerely,

Dan Stanley
Secretary of Administration

DS:TDB

cc: Terry Bernatis

PERFORMANCE AUDIT REPORT

The State Health Benefits Program, Part 2: Reviewing the Staffing and Structure of the Current Program

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
July 2001

01-14.2

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Legislative Post Audit Committee
Legislative Division of Post Audit

THE LEGISLATIVE POST Audit Committee and its audit agency, the Legislative Division of Post Audit, are the audit arm of Kansas government. The programs and activities of State government now cost about $9 billion a year. As legislators and administrators try increasingly to allocate tax dollars effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by Legislative Post Audit helps provide that information.

We conduct our audit work in accordance with applicable government auditing standards set forth by the U.S. General Accounting Office. These standards pertain to the auditor's professional qualifications, the quality of the audit work, and the characteristics of professional and meaningful reports. The standards also have been endorsed by the American Institute of Certified Public Accountants and adopted by the Legislative Post Audit Committee.

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July 19, 2001

To: Members, Legislative Post Audit Committee

Representative Lisa Benlon, Chair	Senator Lynn Jenkins, Vice-Chair
Representative Richard Alldritt	Senator Anthony Hensley
Representative John Ballou	Senator Dave Kerr
Representative Dean Newton	Senator Derek Schmidt
Representative Dan Thimesch	Senator Chris Steineger

This report contains the findings, conclusions, and recommendations from our completed performance audit, *The State Health Benefits Program, Part 2: Reviewing the Staffing and Structure of the Current Program.*

The report includes several recommendations for the Health Care Commission, Program staff, and the Department of Administration. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton

Barbara J. Hinton
Legislative Post Auditor

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EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Question 1: Is the Program's Structure Appropriate Given Its Responsibilities, and How Does That Structure Compare to Those of Comparable Programs in Other States?

The current structure of the State Health Benefits Program is appropriate, given the types of employees who currently are participating in the plan. *The Program's current placement in the Department of Administration is appropriate because it allows coordination of all State employee human resource programs--from health and other benefits to compensation and leave policies–for the 77% of the Program's members who are active State employees. Other advantages include the sharing of staff and other resources within the Department, and the ease of making automatic payroll deductions for premiums for active employees by using the States' computer system.*

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The governance of the Program is also appropriate because the Commission's statutory membership is designed to make policy decisions in the best interest of active and retired State employees. The Commission also has an Employee Advisory Committee comprised of 21 active and retired State employees. Fully 98% of the Program's participants are active or retired State employees.

Even though the Commission allowed educational entities to join the Program in 1999, it was directed by the Legislature to protect State employees from cost increases or benefit reductions that could result from adding new members. In response, the Commission established certain criteria educational groups had to meet to be eligible for the Program. As a result, only a small number of educational entities have joined.

The structure of Kansas' program is typical of programs that serve almost exclusively State employees. *Of the 7 states we contacted, (surrounding states, Iowa, New Mexico, and North Dakota) the states that served only or predominately state employees (like Kansas) tended to be located in a multi-function state agency. On the other hand, Missouri and North Dakota, which serve the highest percentage of non-state employees, house their program in a separate benefits agency and are governed by a commission. If the Commission decides to allow other public entities to participate in the Program, the scope of the Program's services would be broader than any of the other state programs, located within another state agency, that we reviewed.*

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The current structure may not be appropriate if the Commission decides to expand the program to include additional public entities. *Most Commission and Advisory Committee officials said that, if additional non-State entities are allowed to join, the Program's*

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placement and governance won't be logical anymore. If this happens, the Commission and the Legislature will need to decide whether to expand the State employee health benefits program, or create a public employee health benefits program. Issues to consider include the make-up of the Commission, accountability to participants, and cost to administer the Program.

Some decisions about structure--such as location, governance, and cost--may be influenced by the number of non-State public employees in the Program. To date, only about 1,000 non-State employees (2% of the total) participate in the Program. However, about 84,000 school employees could join the State's plan if their districts chose to meet the State's requirements. In addition, approximately 28,000 city and county employees potentially could join, if allowed by the Commission to do so.

Question 1 Conclusion ..... page 11

Question 2: Does the State Health Benefits Program Have Enough Staff, Funding, and Other Resources to Handle Its Current Workload?

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Given the new positions added for 2002, the Program should have enough staff to handle most of its current workload. *Since 1996 a number of changes have been made to the Program, including self-funding the indemnity and dental plans, adding new types of insurance, and allowing additional groups to join the Program. To handle the increased workload, the Program's staffing levels have increased from 11.5 full-time-equivalent positions to 15.5 (1.5 drawn from other areas within the Department in 1999, and 2.5 added by the Legislature in fiscal year 2000). The Legislature also approved 2.5 new positions for fiscal year 2002, bringing the total to 18. Commission staff identified several important responsibilities they thought they weren't able to adequately address with their existing staffing levels, but the newly authorized positions for fiscal year 2002 will help address those areas, including reconciliation of insurance carriers' bills to State enrollment records and contract oversight. We also noted that several important processes haven't been documented, which could cause problems if key employees were to leave.*

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Kansas staffing levels generally were in the mid-range compared with other states we reviewed. *Compared to the 4 surrounding states, Iowa, New Mexico and North Dakota, Kansas generally fell in the middle when looking at the number of staff per 10,000 participants and per plan. States that had fewer employees per participant and per plan generally only offered benefits to state employees, while those with more employees tended to offer benefits to non-state-employee groups as well.*

variations and no common trend that would indicate any direct relationship between the number of participants and the cost of the plan.

This audit was conducted by LeAnn Schmitt, John Curran and Katrin Osterhaus. Cindy Lash was the audit manager. If you need any additional information about the audit's findings, please contact Ms. Schmitt at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.

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The State Health Benefits Program, Part 2: Reviewing the Staffing and Structure of the Current Program

The State Health Benefits Program, overseen by the State Employees Health Care Commission, administers health insurance contracts for State employees and their dependents. In recent years, both the number of contracts and the types of people covered by the Program have been expanded. According to the Department of Administration, about 45,500 participants are enrolled, and 90,000 lives are covered, including dependents. To provide this coverage, Program staff administer 17 health plan and administrative contracts, as well as 11 contracts with educational entities. More detail about all the contracts is provided in Appendix C.

The Secretary of Administration and Legislators have expressed concerns that the Program's current funding and administrative structure is inadequate to meet the needs and expectations of the participants. In particular, concerns have been expressed about whether the current structure (being a part of the Department of Administration's Division of Personnel Services) is the most appropriate, and whether the Program has enough staff and other resources. Finally, concerns have been raised about whether the State could get better premium rates if there were fewer health plans with more participants in each plan. This performance audit answers the following questions:

1. **Is the Program's structure appropriate given its responsibilities, and how does that structure compare to those of comparable programs in other states?**

2. **Does the State Health Benefits Program have enough staff, funding, and other resources to handle its current workload?**

3. **Would the State and its employees likely get lower health insurance rates if the State offered fewer plans with more participants in each plan?**

To determine whether the Program's structure is appropriate, we interviewed members of the Health Care Commission and its staff, as well as several members of the Employee Advisory Committee to identify any problems they perceived with the current structure. We also compared the structure of Kansas' program to the structure of health benefits programs in 7 other states. To assess whether the Program has enough staff, funding, and other re-

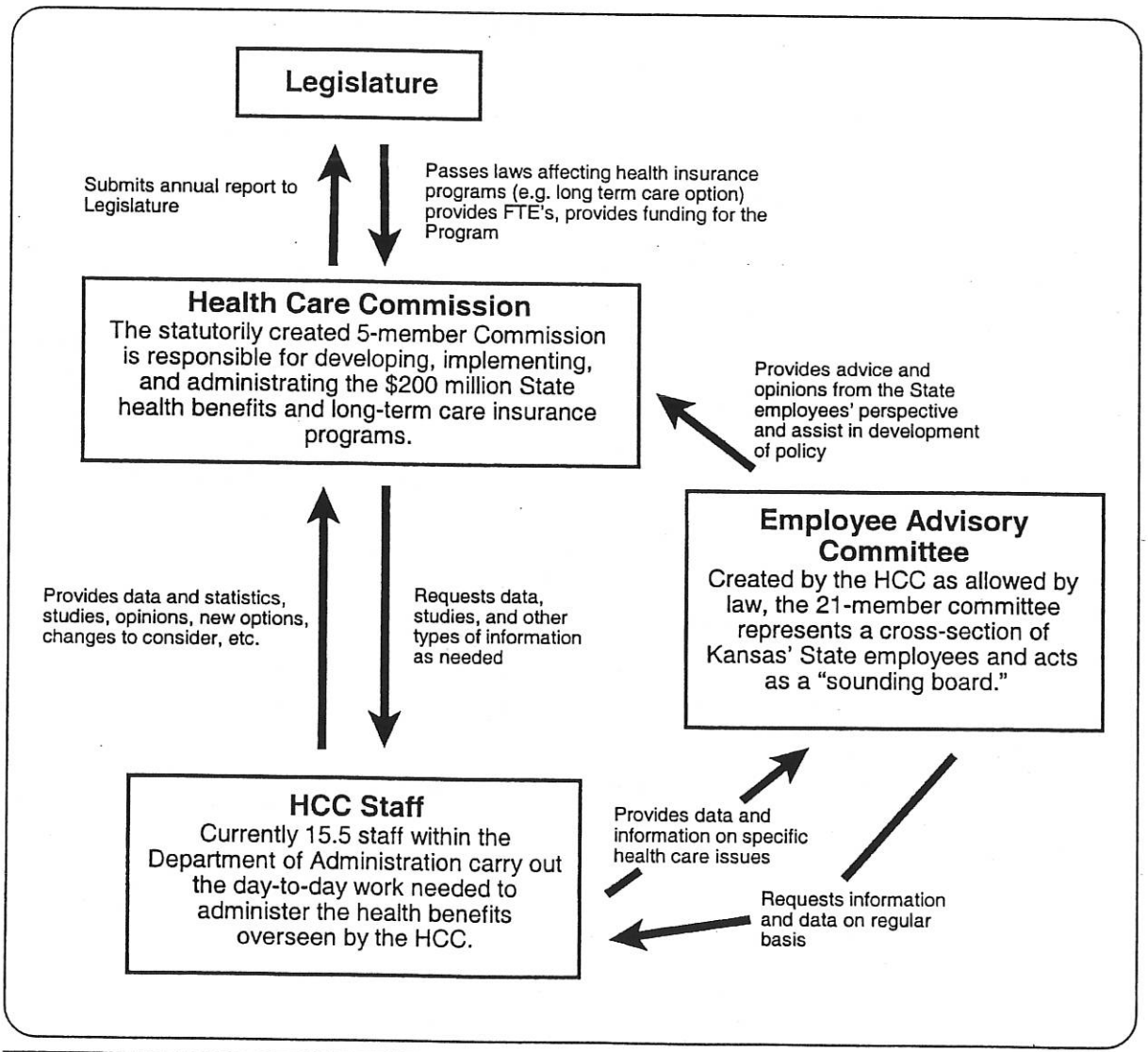
sources, we interviewed Department of Administration officials and Program staff to identify tasks that aren't being completed because of the current workload. We also compared Kansas' staffing to the other 7 states we surveyed. Finally, to determine if health insurance rates would be lower if the State offered fewer plans, we contacted several industry experts, reviewed relevant literature, and conducted statistical analyses of Kansas' and other state's programs to look for relationships between premium costs and the number of program participants.

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in Appendix A.

In conducting this audit, we followed all applicable government auditing standards. Our findings begin on page 5, following a brief overview.

In Kansas, the Health Care Commission Is Responsible For Managing the Health Care Benefits Program For the State

The State's Health Benefits Program is part of the Department of Administration's Division of Personnel Services. The Program is run by 15.5 full-time staff and is overseen by the State's Health Care Commission, which is responsible for implementing and administering the Health Benefits Program. The Commission was statutorily created in 1984 to include the Secretary of Administration, the Commissioner of Insurance, a current employee from the State classified service, a person retired from the classified service, and a representative of the general public. As allowed by law, the Commission also has an Employee Advisory Committee, comprised of 21 active and retired State employees. The graphic below shows how various entities involved in the Program fit together.



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The Program's responsibilities include providing a variety of health insurance services to active, retired, and disabled State employees and their dependents, people on leave without pay, elected officials, blind vending facility operators, students at higher education institutions, and most recently, employees of school districts, community colleges, and other educational entities.

In 1999, the Commission Opened the Program to Educational Entities

The Health Care Commission's statutory authority to allow a variety of other groups to participate in the State employee health plan has increased steadily. Specifically, the law has been broadened to allow coverage to include:

- County, township, city, special district, and other local governmental entities (since 1984)
- School districts (since 1990)
- Licensed child care facilities providing residential group foster care for children (since 1992)
- Nonprofit community health centers (since 1992)
- Nonprofit community facilities for the mentally disabled (since 1992)
- Nonprofit independent living agencies (since 1992)

The Commission didn't act on its authority to include any of these groups until 1999, when it allowed employees of unified school districts, community colleges, technical colleges, and vocational-technical schools to join the State Health Benefits Program. However, strict eligibility criteria have resulted in only 8 school districts, 2 community colleges, and 1 service center joining the State's plan (this issue is discussed more fully in Question 1). As the table below shows, active State employees comprise about 3/4 of the Program's participants, while school employees represent only 2%.

Participation in the State Health Care Program, 1/1/01

State employees	Active State employees	34,978	77%
	Retired State employees (a)	9,451	21%
Sub-total		44,429	98%
Non-State employees	Active school employees	1,009	2%
	Retired school employees	40	0%
Sub-total		1,049	2%
TOTAL GROUP HEALTH INSURANCE		45,478	100%

Source: Health Care Benefits staff, Department of Administration

(a) This group is officially called "Direct bill participants." It comprises primarily retired State employees, but also includes people on leave without pay, elected officials, and blind vendors.

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Question 1: Is the Program's Structure Appropriate Given Its Responsibilities, and How Does That Structure Compare to Those of Comparable Programs in Other States?

Currently, the State Health Benefits Program's location within the Department of Administration and its oversight by the Health Care Commission is appropriate given the types of employees who currently are participating in the plan. The Program's structure is typical of programs that serve almost exclusively State employees. However, the structure may not be appropriate in the future if the Commission decides to expand the Program to include additional public entities.

The Current Structure of The State Health Benefits Program Is Appropriate, Given the Types of Employees Who Currently Are Participating In the Plan

In 1984 when the Legislature established the Health Benefits Program and the Health Care Commission, the Commission was given statutory authority to determine whether employees of other entities would be allowed to participate in the Program. (As noted in the Overview, State law identifies a number of groups as possible participants, but the Commission decides whether those groups actually will be offered the chance to join.) Up until 1999, the Program covered only active and retired State employees, as well as elected officials and blind vendors. Because of this, the Commission's focus has been on the needs of active and retired State employees.

In evaluating the appropriateness of the structure of the Program in relation to its responsibilities, we looked at 2 elements: the physical placement of the Program within State government and the governance–who oversees the Program on behalf of the employees who are served.

The Program's current placement in the Department of Administration is appropriate because it allows coordination of all State employee benefits. As shown in the table on page 4, 98% of the Program's members are active or retired State employees. For active employees, the current placement of the Program means that administration of all health benefits (medical, prescription drug, vision, dental, and long-term care) is handled by people who work closely with the administration of their other human resource programs, such as deferred compensation, flexible spending, workers' compensation, and leave programs, providing for one point of contact. State officials said having these benefits within one division provides the following advantages:

- allows for coordinated management of all human resource programs
- allows for sharing of staff and other resources
- allows for a single point-of-contact for benefits for State employees

In addition, having the Health Benefits Program located in the Department of Administration makes it easy to make automatic payroll deductions for health benefits for active employees, because payroll and health benefits information are on the same computer system.

The current governance of the Program is appropriate because the Commission's statutory membership is designed to make policy decisions in the best interest of active and retired State employees. As mentioned in the Overview, the Commission consists of the Secretary of Administration, the Commissioner of Insurance, an active State employee, a retired State employee, and a member from the general public. By statute, these individuals are in charge of administering and implementing the State Health Benefits Program. Because 98% of participants are active and retired State employees, the current governance provides appropriate representation.

Even though the Commission allowed other groups to join the Program, it was directed by the Legislature to protect State employees from cost increases or benefit reductions that could result from adding new members. In Spring 1999, the Commission issued regulations that allowed employees of unified school districts, community colleges, technical colleges, and vocational-technical schools to join the Program. At the same time, the Commission took a number of steps, as directed by the Legislature, to try to ensure that State employees wouldn't be negatively affected by this decision. A summary of these criteria can be found in the profile box on the facing page.

In addition, the Commission plans to evaluate school employees' insurance claims to see if those claims are negatively affecting State employees' premiums. If they are, the Commission could pool the school employees and set their premiums separately.

However, before the evaluation can be done there must be at least 1,250 school employees in the State's self-funded insurance plan.

Requirements for Educational Entities to be Eligible for the State Health Benefits Program

In a combined effort to come up with underwriting guidelines that would protect the State plan and its participants, the Commission's consultant and staff developed a list of requirements. The following table outlines these requirements and the rationale behind them:

Requirement	Rationale
Employee and employer contribution rates must be the same as state employees. *	These 2 requirements combined assure that the participation rate (and mix of single and dependent coverage) of school employees resembles that of the State. Without both, school employees may be less inclined to enroll their dependents. Without a certain proportion of children, who generally tend to be "cheaper," premium costs could increase.
At least 70% employee participation.	
No Internal Revenue Code Section 125 cash-out option for employees.	If given the option, healthy people tend to take cash instead of having insurance, which would increase premiums. In addition, State employees aren't allowed to cash-out, and allowing it would create an equity issue.
All part-time employees must work a minimum of 630 hours per year.	While eligibility regulations specify a 1,000 hour threshold to be eligible, the amount was prorated for educational entities to more closely match the work hours of educational staff. The 630 hour minimum allows part-time school employees to be eligible and is consistent with the school employees' eligibility requirement for KPERS.
Plan design and funding is not subject to negotiations.	Allowing educational entities to negotiate any of the plan design/funding would've created multiple plans specifically designed for individual employers. The Commission was requested to develop guidelines for participation in the ONE state plan.
Must elect to participate for a minimum of three years (5 years if school chooses ramp-up)	The state plan functions on a 3-year contract with insurance carriers. Because premiums are based on an estimate of eligible participants that carriers could compete fore, the State had to ensure than any school participants don't arbitrarily drop out during the contract period for which premiums are assured.
Must provide the established contribution to HealthQuest (the State of Kansas Health Promotion Program), provide a contact person, and participate in HealthQuest initiatives	HealthQuest is a preventative program established to reduce the cost of health care services (through risk reduction, enhanced self-care, etc.). Each State agency must contribute funds to support this program. This requirement ensures that entities participate equally in this cost-reducing program.
Must adhere to established administrative processes and procedures. The administrative manual is available on request	To treat State and educational entities the same, everybody must follow the same rules to enjoy the same rights. Examples of administrative processes include a 2 month waiting period before health insurance coverage starts and no pre-pre-existing limitations.
Retirees may continue participation once active employment has ceased	The same continuous participation requirement is placed on State employees. Allowing retirees to drop out and opt back in when they "need to", creates adverse selection since people "opt in" only when there are medical needs or other insurance isn't available. In addition, the State would loose the continuous payment of premiums from participants while they are healthy which is the backbone of affordable insurance.
Retirees must pay their premiums either through a KPERS deduction or automatic bank transfer	The same requirement is placed on Direct Bill participants. Without it, the resulting paperwork would create additional administrative costs for the program.

Because many educational entities couldn't make the employer contributions required in the State's plan, the first requirement created budgetary difficulties for those schools. To make it easier for educational entities to meet this requirement, the Commission allowed them to phase in, or "ramp up", the contribution for employee or dependent coverage over a period of 3 years for the employee and 5 years for dependent contribution.

Currently there are only 654 members in that plan. Although 2 small schools will join this fall, according to Department of Education officials, it's unlikely that many more schools will be able to afford to enroll any time soon. Because of the low participation rate, it will be a some time until the Commission can evaluate school employees' impact on the Program.

The Structure of Kansas' Program is Typical of Programs That Serve Almost Exclusively State Employees

We contacted health benefits officials in 7 states to see how their programs were structured. As the table below shows, states that served only or predominately state employees (like Kansas), tended to be located in a multi-function state agency, and were equally likely to be governed by the head of that agency or by a commission.

However, the 2 states that served the highest percentage of non-State employees, Missouri and North Dakota, each housed their program in a separate benefits agency and were governed by a commission. This may help them ensure adequate representation of all employees.

Comparison of the Structure of the Health Benefits Programs of Kansas and 7 Other States

	Who's eligible to participate?			Where is it located?		How is it governed? *(Who makes policy?)*	
States	**State Employees (% of Program Participants)**	**City and County Employees**	**School Employees and Others**	**Within a Multi-function State Agency**	**In a Separate Benefits State Agency**	**Agency Head**	**Commission**
Colorado(a)	√			√		√	
Iowa	√			√			√
Nebraska(b)	√			√		√	
Oklahoma(c)	√				√		√
Kansas	√(98%)		√	√			√
New Mexico(a)	√(94%)	√		√		√	
Missouri	√(85%)	√	√		√		√
North Dakota	√(80%)	√	√		√		√

Source: LPA surveys

(a) active state employees only
(b) active state employees plus retirees under the age of 65
(c) active state employees only. Active employees of schools, cities, and counties, and all retirees are under a separate agency

If the Commission decides to allow other public entities to participate in the Program, the scope of the Program's services, while working from within a division of a State agency, would be broader than in any other state we reviewed. Kansas would be serving active and retired employees, as well as State and a variety of non-State employees in its Program. The only states we surveyed that offer this breadth of service, Missouri and North Dakota, do so from stand-alone benefits agencies.

The Structure May Not Be Appropriate If the Commission Decides to Expand the Program To Include Additional Public Entities

Most Commission and Advisory Committee officials we interviewed said that if additional non-state entities are allowed to join the Program, the placement and governance won't be logical anymore. In general, they agreed with the overall sentiment expressed by one official, "if we are, as a matter of good policy, changing the State employees health plan into a public employee health plan, then the appropriate governance and administration should change before we add the other entities in order to be ready to handle such a philosophical change."

A number of issues need to be considered by the Commission and the Legislature as they decide whether to expand the State employee health benefits program, or create a public employee health benefit program. It would be possible to expand the Program by simply offering the existing health benefit program to more and different types of public employees. However, that option poses some potential problems in terms of location (State computer systems aren't set up to efficiently handle non-State employees) and governance (non-State entities participating in the Program have no input into the plan design or other decision making processes). These problems could be addressed by creating a public employee program, which might be a new separate agency.

The table on the next page shows some of the issues that the Commission and the Legislature will need to consider in deciding how the Program should be administered in the future. The table highlights the opposite sides for each issue, but there are many "middle ground" options that could be explored. Regardless of whether changes take place in the immediate future, it's not likely the issue will go away: *The 1999 Survey of State Employee Health Benefit Plans* published by the Segal Company noted that 38 of the 46 states responding include employees of other public employers within the state's plan.

Issues for Future Administration of the Health Benefits Program

Issues to Consider	Option: Expansion of the State Employee Plan	Option: Creation of a Public Employee Plan
Statutes	No changes necessary	Requires a name change to show intent for a true "public" health benefits plan.
Make-up of Commission	No changes necessary	Requires statutory change to add representatives from public entities to the Commission, to make balanced policy decisions.
Make up of Employee Advisory Committee	No changes necessary	Requires bylaws change to add representation from public entities.
Accountability to participants	No changes necessary	Plan design and funding should consider the needs of all eligible groups. Multiple plans may have to be designed for individual employee groups in order to be more responsive and accountable to each group. (Similar to KPERS offering different retirement plans to State employees, schools, judges, and police)
Premium Cost	New members should experience lower premiums or better benefits (otherwise they're not likely to join or to remain). Until there are enough new members to evaluate their claims experience separately, State employees' premiums could be positively or negatively affected by the new members.	Because of the likelihood of multiple plans for multiple groups, premium costs would likely vary based on the actual claims experiences of each group, as well as benefits, deductibles, and co-pays offered.
Physical Location	Program would likely need more office space.	Program would likely need to move to either a more "public employee"-based agency (KPERS has been suggested because it currently works with schools and local units of government) or become an independent agency. Staying within the State's Division of Personnel Services could raise concerns about giving preference to State employees' needs, and could also place an inequitable demand on the Division's resources if the Program isn't adequately funded.
Staffing	Program would likely need more staff to handle additional workload.	Program would need additional staff to administer such an enlarged program.
Cost to Administer the Program	Costs would increase to fund more office space and staff, as well as change or add to the computer resources.	Costs would increase because in addition to staff and office space, a new administrative structure might have to be funded–agency head, computer system, etc.

Some decisions about structure may be influenced by the number of non-State public employees in the program. Concerns about location, governance, staffing, space needs, and cost increase with the number of non-State employees served. To- date, only 2% of the Program's membership is non-State employees (slightly more than 1,000 people), which limits the impact these employees have on the functioning of the Program. However, 84,000 school employees could join the State's plan if their districts could afford to make the required employer contribution and are willing to accept the various requirements outlined on page 7. In addition, approximately 28,000 city and county employees potentially could join, if allowed by the Commission to do so.

No one could provide us with estimates of the number of school, city, or county employees that would be likely to join the Program. However, it's reasonable to think small employers, who have the least bargaining power in negotiating insurance premiums, would be most likely to join. This is true of the current 11 educational groups participating in the program. In addition, several people suggested that large school districts and large cities would probably be less interested in the State's program. And, while we don't have detailed membership information from the states we surveyed, for those that covered both State and non-State employees, non-State employees represented a fairly small proportion (ranging from 6% to 20%) of the total population served. This suggests those states may be attracting mostly small non-State groups to their programs.

Expanding the Program to include numerous, small non-State entities would create significant additional work for Program staff, but may limit concerns about location and governance.

CONCLUSION

While the structure of the Health Benefits Program currently is adequate, the addition of educational entities, interest by some cities and counties in joining the program, and the national trend toward expanding the membership of state employee health benefit programs suggest that a conscious decision needs to be made about the future structure of the Program.

It could remain essentially a State program, with other public employees allowed to participate under the current structure. However, if Kansas' program were opened to all the groups allowed by statute, it would be very broad and diverse program, which might well necessitate moving it out of the Department of Administration to provide adequate representation and visibility.

Question 2: Does the State Health Benefits Program Have Enough Staff, Funding, and Other Resources To Handle Its Current Workload?

With 2.5 new positions approved by the Legislature for fiscal year 2002, it appears the Health Benefits Program should have enough staff to handle most of its current workload. When compared to 7 other states, Kansas' staffing levels were about in the middle. Nevertheless, revenues generated for educational groups joining the State Program have been grossly insufficient to cover the administrative costs of serving those groups, and had to be supplemented with State General Fund moneys. In addition, the multiple computer systems now used for managing the Program's membership data are inefficient and problematic. Finally, if cities and counties are allowed to join the Program, current resources aren't likely to be sufficient.

Given the New Positions Added for 2002, the Program Should Have Enough Staff To Handle Most of Its Current Workload

Since 1996 a number of changes have been made to the Health Benefits Program, including self-funding and self-administering a major part of this Program, adding new types of insurance (i.e. long-term care) and allowing additional groups of people to join the Program. Given this increased workload, questions have been raised about whether the Program has enough staff to handle the increased responsibilities and participants.

As the box on the facing page shows, between fiscal years 1996 and 2002 the Program's staffing levels will have increased from 11.5 full-time-equivalent positions to 18. In all, 1.5 of the additional positions were reallocated from within the Department of Administration, and the Legislature authorized 5 new positions.

Commission staff identified several important responsibilities they thought they weren't able to adequately address with their existing staffing levels, but the newly authorized positions for fiscal year 2002 will help fill these needs. As noted below, each area could have potential cost savings implications for the State:

- **reconciling insurance carriers' bills to State enrollment records to make sure carriers are billing the State correctly for premiums.** The Commission's consultant said large entities typically carry out such reconciliations on a monthly basis. Commission staff started this process in 2000, and have reconciled calendar year 2000 premiums for active State employees for 5 of the 11 health insurance carriers who were under contract in 2000, and for the University of Kansas

Hospital Authority. However, Commission staff haven't reconciled premiums paid for State retirees and school district employees because membership records for these groups are difficult to work with, an issue discussed more on page 20.

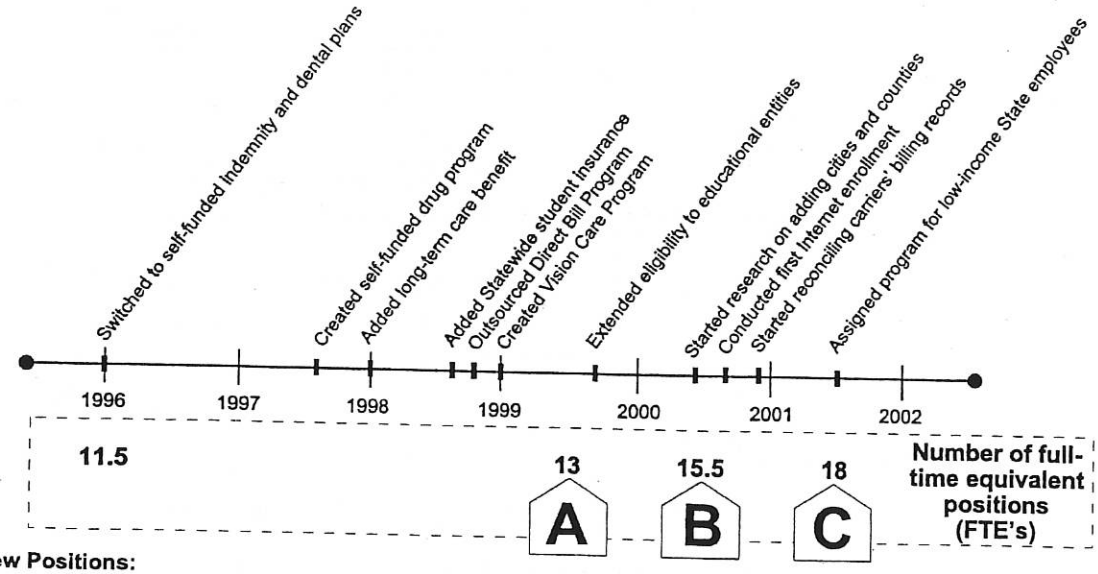
Staffing Levels For the Health Benefits Program Have Increased By 57% Since 1996 But Program Responsibilities Have Also Increased Significantly During that Time

Since 1996 a number of changes have been made to the Health Benefits Program, including adding new types of insurance and allowing additional groups of people to join the Program. Staffing has increased significantly, although generally after the fact. All of these changes have increased the workload of staff. For example, when a new insurance program is added, staff must write a request for proposal (RFP), promote the program to employees, and oversee the new contract. When new entities join the State Plan (like the educational entities), new procedures must be adopted to accommodate their needs.

Over the past several years, the Legislature has approved and provided funding for a total of 5 additional positions for Health Benefits (including 2.5 in FY 2002), and the Department of Administration has reallocated 1.5 positions from other functions to the Health Benefits Program.

The timeline below shows the added responsibilities and duties.

The Health Benefits Program Added Responsibilities and Staffing Levels



New Positions:

A The Benefits Administration Section reorganized and reassigned 1.5 FTE positions to the Health Benefits Program. 6 new positions to work with educational entities participating in the State Plan were approved for fiscal year 2000. Low participation by educational entities resulted in insufficient fees to fund new positions.

B The Legislature authorized 2.5 FTE positions in fiscal year 2000 for the Program, to be funded with money reallocated within the Department.

C The Legislature approved 2.5 FTE positions for fiscal year 2002 to assist in reconciling carriers' billing records, writing member communication materials, and overseeing the prescription drug program.

As the following table shows, the initial reconciliations have identified more than $1.5 million owed to the State, about $370,000 of which has been recovered to date. Apparently many of the overpayments to insurance carriers occurred because the State's "coverage period" is bi-weekly, and most carriers' computer systems are designed to handle monthly coverage periods. The Commission recently voted to explore a change to a monthly coverage period. The box at the bottom of the page provides more information about the Hospital Authority.

Kansas Overpayments to Health Insurance Carriers and Underpayments Owed By the University of Kansas Hospital Authority

Entity	Amount Owed to the State	Amount Recovered as of July 2001
Overpayments Made By the State to Health Insurance Carriers, Plan Year 2000		
Kaiser	$58,249	$58,249
Cigna	$187,671	$187,671
PPK/PHS	$123,222	$123,222
Coventry	$227,111	-
HealthNet	$159,827	-
Subtotal	***$756,080***	***$369,142***
Underpayments Made By the Kansas Hospital Authority to the State, Plan Year 1998		
KU Hospital Authority	$758,640	-
Total	***$1,514,720***	***$369,142***

Source: Department of Administration, Benefits Administration Section

Because of the potential for cost savings, one of the new positions authorized for fiscal year 2002 will be assigned to this area, allowing the Commission to expand its reconciliation effort to include monthly reconciliations for all plans and for all groups in the future.

Hospital Authority Owes State for Unpaid Claims

In 1998, the Commission and the University of Kansas Hospital Authority entered into an agreement allowing the approximately 2,300 Authority employees to continue in the Health Benefits Program. The Authority ceased participation in the Plan in 1999. While the Authority was participating, the Commission was paying claims on its behalf with the Authority later reimbursing the State. According to Department officials, while the Authority did make some payments, it still owes the State $758,640. In addition, the Authority was unable to produce the necessary electronic membership files, causing Program staff to maintain paper records of membership. This made processing membership and billing very labor and time intensive.

The Department first notified the Authority this January about the amount due to the State. Although there have been repeated efforts since then to collect the money, to date the Authority hasn't indicated any willingness to pay.

- **conducting in-depth analyses on claims data and usage trends, researching new plan designs, and improving member communication and education to help control costs, improve customer service, and increase member satisfaction.** Plan managers told us they're too consumed with day-to-day activities to be proactive in these areas. However, as the page 16 box on prescription drugs shows, staff time spent on these issues can provide a significant financial return for the State and its employees.

  The Program recently acquired the *automated* capability to analyze trends in the use of services. In addition, Commission officials told us the new positions authorized for fiscal year 2002 will help oversee the prescription drug program and write member communication materials. Officials weren't yet sure if the oversight effort would involve any of the types of claims analyses and plan research described above to help control costs or monitor contractors' performance. This appears to be an area where additional staff support could provide additional opportunities for cost-savings.

- **monitoring contractor performance to help ensure carriers meet performance standards relating to the quality of customer service, delivery of services, and accuracy in data processing.** The Commission's contracts with insurance carriers set out certain performance standards, as well as financial penalties that can be applied if standards aren't met. However, Program officials told us they didn't have enough staff to monitor whether the standards are being met. Instead, they rely on more informal methods to detect problems, such as member complaints. This is a reactive approach that's not likely to identify all problems, nor to prevent problems before they occur. And as the box on page 17 describes, contract oversight requires a large amount of staff time.

  The Commission's consultant told us large entities have moved toward more formal or active oversight because of a heightened concern with performance and customer service. We also noted this trend in the other states we contacted that had higher staffing levels than Kansas.

  Although Commission officials indicated the additional positions authorized for fiscal year 2002 may be assigned to do more proactive monitoring, it also seemed to us the Commission could do more with its existing staff resources. For example, Program staff don't review the monthly reports HMO contractors are required to submit on performance standards.

Changing the Prescription Drug Plan Design Saved the State Almost $7 Million, But Continued Cost Increases for Prescription Drugs are Still a Major Concern

From 1998 to 1999, prescription drug costs increased at a rate of 22%, which exceeded the national trend of 19%. Because of the rate of increase in the prescription drug program, the Health Care Commission modified the prescription drug benefit for 2000. According to health plan officials, this plan design change was designed to curb prescription drug cost increases, provide incentives for individuals to use generic and formulary brand name drugs whenever possible, and make members more aware of the actual cost of drugs. Here is a brief description of how the drug plan worked before and after the design change:

Until 2000:

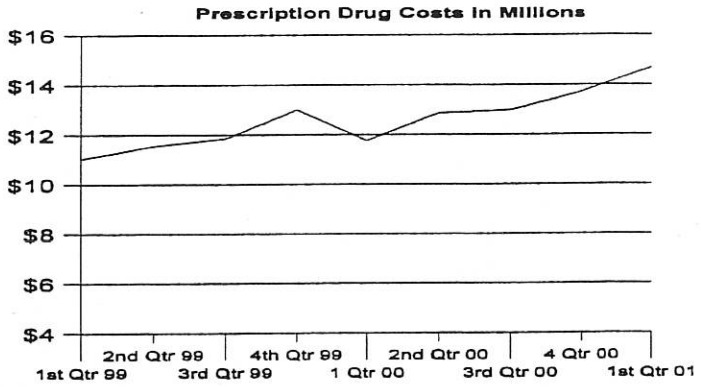
- *Members paid a minimum of $5 per generic prescriptions and $10 per brand name prescriptions, or 25% of the actual cost of the drug, whichever was greater (not to exceed $50 per prescription)*

From 2000 on:

- *Members pay 25% of the cost for drugs on the "formulary list" or for generic drugs. Members pay 50% for drugs not on the formulary list. For special case medications, members have a capped $50 out of pocket cost per prescription.*

The "formulary" is a list of brand name drugs that have been identified as cost-effective and for which Advance Paradigm Systems, Inc., the pharmacy benefits manager for the State of Kansas, has negotiated a better cost through its purchasing power (the company covers 75 million lives in all 50 states).

Without the design change, prescription costs were projected to rise 22% from $47.4 million in 1999 to $57.9 million in 2000. By making the change, costs only rose 8% to $51.2 million, representing almost $7 million in savings.



While the design change has saved costs in the short-term, the graph above shows that the general cost trend continues. For example, in the first quarter of 2001, drug benefit costs increased again at a rate of 25%.

This increase mirrors current national trends of 20% to 25% and can be attributed to actual drug costs going up as well as heightened use of existing and newly available prescription drugs by individuals. Health benefits staff have emphasized that while they don't have control over actual costs of drugs, they will plan to control prescription cost increases by shifting their efforts towards:

- Improving the use of generic drugs (Kansas members use generic drugs 35% of the time, which is well below the national average of 45%).
- Improving the use of formulary drugs.

Outsourcing Of the Direct Bill Program To eBenX Requires a Level of Oversight That Hasn't Resulted In Staff Savings

Prior to October of 1999, Health Benefits Program staff administered the Direct Bill Program. This included processing membership and eligibility changes for members and billing them for their insurance coverage. Because the software used in these activities required Y2K testing and because Department of Administration officials thought the Program was understaffed, it was outsourced to a private company, eBenX.

During the transition of the Program to eBenX, members complained about poor customer service from the company and wondered why they weren't notified of the change. At the same time, an unrelated premium increase for these members compounded their confusion. In Legislative testimony on the issue, Senator Anthony Hensley quoted a retiree as saying, "While the State calls us 'direct bill participants' the State no longer wishes to have any 'direct' contact with us."

Problems with eBenX went beyond poor customer service. As one Program staff member put it, "eBenX hasn't gotten anything right." Staff members must regularly correct membership data that the company sends to the carrier, as well as communicating with Direct Bill members about their coverage. Department officials didn't totally blame the company for the problems, citing the State's bi-weekly coverage period as complicating eBenX's work with the State, and lack of oversight which Program officials attributed to lack of staff.

The Health Benefits Program has taken action to address these problems. Two staff members remain working on the Direct Bill Program, working with members and checking the data that the company sends to carriers. In addition, the Program sends out a quarterly newsletter and operates a volunteer phone bank during open enrollment to field questions, which requires part of the time of 2 additional staff members. A Direct Bill member who once testified before the Commission about eBenX thought that the State did a fairly good job addressing the problems.

We found missing reports for some standards and no reports at all for one contractor. Even with current staffing, these reports could be reviewed with minimal effort to ensure that carriers are meeting their contractual obligations.

During this audit we also noted that several important processes haven't been documented, which could cause problems if key employees were to leave. The Program has 5 long-time, front-line staff who are responsible for reviewing all membership and enrollment information, entering it into the proper databases, and answering questions for personnel officers in State agencies. The procedures they follow generally aren't documented, which increases the likelihood of mistakes and miscommunication among staff. The lack of written procedures also will make it difficult and time consuming to train new staff, which could result in a temporary erosion of customer service.

Kansas Staffing Levels Generally Were in the Mid-Range Compared With Other States We Reviewed

We surveyed the surrounding states and Iowa, as well as New Mexico and North Dakota (2 states that insure other public entities in addition to their state employees) to collect information on the number of employees who administer their programs. That information is summarized in the table on the next page.

Comparing Kansas With Other States On Employee Benefits Staffing
Fiscal Year 2001

State	Staff per 10,000 Participants	Staff per Plan	Compared to Kansas...
Iowa	1.7	.8	• Iowa doesn't offer benefits to non-state employees • Iowa doesn't have a vision plan or a long-term care benefit
Nebraska	2.4	1.2	• Nebraska doesn't offer benefits to non-state employees or retired state employees
Kansas	*3.4 (a)*	*2.2 (a)*	*N/A*
Colorado	3.9	1.6	(b)
New Mexico	5.2	2.2	• New Mexico also offers benefits to city and county government employees (about 6% of its program)
North Dakota	6.0	6.5	• North Dakota also offers benefits to school district and city and county government employees (about 20% of its program)
Oklahoma	8.5	3.1	• Oklahoma has more staff
Missouri	12.7	4.8	• Missouri also offers benefits to school district and city and county government employees (about 15% of its program)

Source: LPA survey. Data are self-reported.

(a) In Part I of our audit, Program officials identified 16.5 FTE positions for the Health Benefits Program. They've revised that number to 15.5. This analysis is based on the revised number.

(b) Figures provided by Colorado may include staffing for programs not asked for in our survey.

As the table shows, Kansas generally fell in the middle when looking at the number of staff per 10,000 participants and per plan. States that had fewer employees per participant and per plan generally were the ones that only offered benefits to state employees, while those with more employees tended to offer benefits to non-state employee groups as well.

Revenues Generated From Educational Groups Have Been Grossly Insufficient To Cover the Administrative Costs of Serving Those Groups

Administrative expenses for school districts were supposed to be supported through an administrative fee built into premium rates, just as they are for State employees. However, as the table at right shows, expenses for educational entities have far outstripped fee revenues.

Fees Collected and Related Expenditures for Education Groups

Public School District Benefit Fund	Administrative Fees Collected	Administrative Related Expenditures for Educational Entities
FY 1999	-	$40,000 (a)
FY 2000	$9,166	$188,430
FY 2001	$66,077 (b)	$224,900 (c)

Source: STARS
(a) Actuarial study to examine the impacts of adding educational entities
(b) As of 6-5-01
(c) Budgeted expenditures (not actual)

The shortfall was driven by the limited number of participants–there simply weren't enough people paying administrative fees to allow the Health Benefits Program to recoup its start-up costs. These costs covered such things as travel for staff members explaining the Program to school districts. In addition, the participants represent many small districts, rather than just a few large districts, which creates more work and thus higher costs for the Program.

In fiscal year 2000, the Department of Administration reallocated approximately $188,000 of its State General Fund moneys to the Health Benefits Program to make up for the shortfall. An additional General Fund subsidy of $150,000 was needed in fiscal year 2001, and an $80,000 subsidy has been approved by the Legislature for fiscal year 2002.

Health Benefits Program Given Another Responsibility, But No Additional Funding

Federal law, which authorizes and provides funding for state child health insurance programs, specifically excludes coverage for dependents of state employees. Therefore, State employees in Kansas who meet income guidelines for the HealthWave Program can't enroll their children for coverage.

To address this, the 2001 Legislature passed a bill calling for the Health Care Commission to provide active State employees with financial assistance to cover eligible children in the State Health Benefits Program. The amount of financial assistance is to be determined by the Commission within the limits of existing resources. The legislation permits the Secretary of Administration, on behalf of the Health Benefits Program, to solicit funds from outside sources for the new program, a practice that Program officials haven't had to do before. Considering this, the Health Benefits Program may be ill-suited to administer a program of this nature.

Program officials cited this newest program as an example of their staff getting another responsibility without any additional resources.

If employees of cities and counties (or other eligible groups) are allowed to join the Program in the future but don't participate in large numbers, their administrative fees likely won't be sufficient to cover their costs. In that case, either State General Fund subsidies will be needed, or administrative fees will have to be increased.

The Program's Computerized Membership Systems Are Problematic

Membership and enrollment data for the Program's participants are contained in 3 non-integrated computer systems:

- active State employees' data resides in SHARP, the State's main computer system for payroll and benefits
- retirees' data resides with eBenX, a private contractor
- educational groups' data resides in an Access database in Health Benefits

The 3 separate computer systems make reporting on plan membership time consuming and difficult because reports must be obtained from 3 different sources. To report on membership in a particular HMO, for example, a report must be requested from eBenX, both SHARP and the Access database must be queried, and the data from the 3 sources must be combined manually.

The use of an Access database for educational entities is particularly troublesome because of the potential for error—insurance carriers' systems can't read the Access database, so Program staff send the carriers a hard copy that must be manually entered into their systems.

In addition, because of the incompatibility between Access and the carriers' systems, reconciliation of membership data to the carriers' billing, which could identify overpayments by the State, has not yet been attempted. Staff expect it will be a time-consuming, manual process.

The Department of Administration is testing a major upgrade to SHARP that may allow it to incorporate non-State employees into the system. This action would address many of the problems described above. However, the upgrade involves all facets of the SHARP system, so testing is extensive and isn't expected to be completed until early 2003. As a back-up plan, officials also are looking at the option of creating a non-State database within SHARP.

Program officials told us that, if eligibility for the State's Health Benefits Program is extended to cities and counties, they won't have the staff, information systems, or budget to handle the increased workload that would result. As discussed above, adding non-State employee members probably would create a financial burden on the Program, and would compound problems with existing computerized membership systems.

Significant staff time also would be spent explaining the plan to new entities. When educational entities were first allowed to join the State plan, the Program relied on existing staff to talk with schools. The Secretary of Administration indicated in legislative testimony that Program staff logged thousands of miles driving around the State during evenings and weekends to speak with interested groups. In fiscal year 2001, 2 new staff members were hired to do much of this work. If cities and counties are extended the same eligibility as educational groups, the same types of burdens will be placed on those staff.

CONCLUSION

Currently the Health Benefits Program has enough resources to handle its responsibilities, largely because it's been able to pull both staffing and funding from other areas of the Department of Administration to help meet its increased responsibilities. If the Program's scope of services is expanded—for example, by opening it up to city and county employees—the Program won't have enough resources to handle it. The Department, Commission, Program staff, and the Legislature all have a role in how the Program is expanded and changed, and all will need to play a role in ensuring the Program has sufficient resources in the future.

RECOMMENDATIONS

1. To help ensure that the Health Benefits Program will have sufficient staff, funding, and other resources if the Program is expanded to include cities and counties, the Health Care Commission and the Department of Administration should develop estimates of how many additional staff and how much more funding will be needed to handle such an expansion, and how those things will be added. This information should be provided to the Legislature before any decision is made to expand Program eligibility.

2. To help ensure that contractors are meeting their obligations, current Program staff need to make better use of the performance measures that are included in the contracts with providers. These

provisions need to be proactively evaluated rather than looking at them only after a problem arises.

3. To reduce the number of overpayments the State makes to insurance carriers, Program staff need to identify the reasons for these overpayments, then take the necessary corrective action.

4. To increase efficiency and ease of working with membership data, Program staff need to continue to work towards finding a solution that will allow all membership data to be maintained in one computer system.

5. To ensure that staff have clear responsibilities and to make it easier to train new staff or cross-train current staff, Program officials should document the work processes carried out in their office.

Question 3: Would the State and Its Employees Likely Get Lower Health Insurance Rates If the State Offered Fewer Plans With More Participants in Each Plan?

Kansas already has enough participants in each of its health insurance plans to achieve the lower costs that usually result from economies of scale. Furthermore, through our analysis of plan and participation data from Kansas and 7 other states, we didn't see a correlation between the number of participants within a plan and the plan's cost. Kansas already uses most of the strategies that experts mentioned as important in controlling health insurance costs. However, because the Reserve Fund, which has been used to help defray premium costs, is nearly depleted, the Commission will have to make tough choices if it is to minimize cost increases in the future.

Kansas Already Has a Large Enough Number of Participants In All Its Health Insurance Plans That Rates Are Not Likely To Change Significantly If Fewer Plans Were Offered

We talked with insurance consultants, business analysts, and business professors, and reviewed relevant literature. While we didn't find much literature on the subject, experts stated that the theory of reducing the number of plans to reduce premiums is more likely to work for smaller employers. Kansas would likely not see cost reductions because it already has large participation within all its health plans.

Experts said the theory of reducing the number of plans to lower premium costs generally applies to employers with fewer than 1,000 employees. When a small employer offers several plans to its employees, purchasing power is diluted and health insurance premium costs likely will rise because:

- √ Insurance carrier(s) bidding to provide insurance for a small group of people can't rate them on actual experience because the pool of employees isn't big enough. Carriers are more likely to use a "community experience rating" and will add a "risk charge" to cover themselves for extraordinary claims and to allow for the high likelihood of fluctuations in the actual claims submitted by that pool.

- √ Carriers will charge more because administrative costs are higher per employee with a small group of employees. In addition, the carrier may build in a higher profit margin to make sure that insuring such a small pool of participants is worth it to them.

If the small employer consolidates the number of plans offered, thereby forcing more participants into the resulting plan(s), it's more likely that such plan(s) will become big enough for the insurance company to rate the group based on actual experience

and to achieve economies of scale in administering the plan, both of which bring the cost down.

The State of Kansas has reached economies of scale, and reducing the number of plans likely wouldn't result in meaningful premium reductions. The State has a total of about 45,500 participants, and membership in the 7 plans ranges from 1,011 to 23,029. Currently, all plans are "experience-rated." This means insurance companies can base premiums on actual claims of people in the pool, which lessens or eliminates the need for a "risk charge" to cover potential extraordinary claims because the pool itself is stable and predictable.

In addition, carriers tend to have economies of scale in administrating the plan: salaries, overhead and other costs are spread over more participants, leading to cheaper premiums. Furthermore, we were told that carriers tend to lower their profit margins (which in turn reduces premiums) in order to get the State's business. This is because insurance carriers can use the fact they insure the State of Kansas as an advertisement.

Our own analysis of plan options showed that State participants currently have an average of 3 plans to choose between. Health Benefits staff said that, while they try to eliminate plans that don't have unique features, they realize the importance of providing some choice to the employees.

We Found No Correlation Between the Number of Participants and the Cost Per Plan In 8 States

We analyzed the number of participants per plan and plan costs for the surrounding states and Iowa, as well as New Mexico, North Dakota, and Kansas. We looked to see whether the cost of the plan goes down as the number of participants goes up.

In analyzing this information for 73 plans across 8 states, we found considerable variations and no common trends that would indicate any direct relationship between the number of participants and the cost of the plan. We looked for relationships between plan costs and participants within each state, as well as across all states.

Kansas Is Already Following a Number of Strategies to Help Control Premium Costs

While it doesn't seem that reducing the number of plans is likely to lower health insurance premiums for the State, experts we spoke with identified 5 practices that should be employed to control costs.

Kansas is using 4 of 5 strategies experts identified as helping to control health insurance costs. The table below explains these strategies and shows what Kansas does in each area. The only

Strategies to Control Health Insurance Costs

Strategies	How It Works	Does Kansas Use This Strategy?
Engage in competitive bidding & negotiation processes	• Competitive bidding assures that the employer gets various quotes from insurance companies for comparative analyses. • The negotiation process allows the State to try to lower costs for the same benefits or add benefits for the same costs.	• Kansas is using both tactics.
Compare the "loss ratios" of the carriers	• Insurance companies with lower loss ratios either have higher administrative costs or get a higher profit from the premium income they receive compared to insurance companies with higher loss ratios. • This means there may be room to negotiate down the overall cost for the company with lower loss ratios.	• Kansas' staff request the bidding companies to separate out the medical loss ratio from the administrative expenses and profit. • By comparing loss ratios of the bidding carriers with each other and to the industry (through the consultant's database), the State can ensure that loss ratios are similar and appropriate.
Be aware of the "risk charges" of the carriers	• Because the cost of plans with sizable participation should be based on the pool's true experience, carriers either reduce or drop the risk charge because the risk is more predictable and less volatile. • Employers should assess whether an insurance carrier's risk charge is in fact necessary.	• Kansas staff reviews the carriers' information regarding risk charges during the bidding and negotiation process.
Offer 2-3 HMO plans to stimulate competition	• Some participants will switch plans based on cost rather than network availability (this is especially true for younger, healthier participants). • When HMOs compete with each other, each HMO tries to offer its services as cheaply as possible to attract the most participants willing to switch based on cost.	• Kansas has standardized benefits across HMOs, which enables participants to quickly compare HMOs on cost. • Currently, participants can choose from an average of about 3 HMO or traditional plans. However, in western Kansas, fewer or no HMO plans are available, and participants have little or no choice.
Equalize employer contribution across plans	• Employers following this strategy contribute the same amount of money to every participant, regardless of the type or cost of the plan. • This way, the employer gives each employee an incentive to choose the cheapest plan available (which in turn stimulates competition).	• Kansas doesn't follow this strategy. Instead, the State pays varying amounts of the employer share, typically paying more for the more expensive plans, effectively subsidizing the more expensive plans. • However, staff said implementing this strategy would unfairly penalize participants in northwest Kansas who can only choose the most expensive plan. • Kansas' benefit administrator admitted this strategy is a good cost control measure, and said staff were currently exploring the issue.

strategy that Kansas doesn't employ is equalizing employer costs across plans. As discussed in the table, the State pays a higher portion of the premium for the more expensive plans, because those are the only plans available in western Kansas.

One way the Commission has minimized cost increases in the past has been to use the Reserve Fund, but that option won't be available in the future because the Fund is almost depleted. The Reserve Fund was created between 1989 and 1995 by putting a portion of the premiums State agencies paid into a special account to cover any unanticipated costs. By 1995, the Reserve Fund had accumulated $84 million. While the Commission implemented some plan design changes over the years to control costs, it also was able to keep the employer share of the premium increases down by drawing from money in the Reserve Fund.

Program staff project that, by the end of fiscal year 2002, the money in the Reserve Fund will approach $32 million. That's the minimum amount necessary to serve as a safety net for the State's self-funded health plan.

CONCLUSION While reducing the number of health insurance plans available through the State Health Benefits Program isn't likely to result in meaningful premium cost reductions, experts have cited 5 other strategies that should be employed to keep ever-rising health insurance costs at bay. Of those, the State of Kansas is following all but one, which officials say is currently being studied. Without the future ability to draw on the Reserve Fund moneys to keep agency costs down, the Commission will need to more actively manage the cost of the Program. Some of the tough choices it may have to make include plan design changes, such as increasing co-payments of participants, or reducing benefit options.

APPENDIX A

Scope Statement

On February 28, 2001, the Legislative Post Audit Committee combined two scope statements on State health benefits into one audit. The audit will be issued in two parts. This appendix contains the scope statement approved by the Committee for Part II, which was requested by the Joint Committee on Health Care Reform Oversight.

SCOPE STATEMENT

State Health Benefits: Reviewing the Staffing and Structure of the Current Program

The State Health Benefits Program, under the oversight of the State Employees Health Care Commission, administers health insurance contracts for government workers and their dependents. In recent years, both the number of contracts and the classes of people covered by the Program have been expanded. According to the Department of Administration, the number of people now covered is more than 87,000. New classes of people eligible for coverage include students at Regents institutions, as well as employees (and their dependents) of unified school districts, community colleges, and vo-tech schools. In addition to active employees and their families, others eligible for coverage include retirees, former State elected officials, disabled former State employees, surviving spouses and dependents of participants, persons on leave without pay, and blind vending facility operators. To provide this coverage, the Program administers 15 different health plan contracts.

Legislators have expressed concern that the Program's current funding and administrative structure is inadequate to meet the needs and expectations of the participants. In particular, concerns have been expressed about whether the current structure (being a part of the Department of Administration's Division of Personnel Services) is the most appropriate, and whether the Program has enough staff and other resources. Finally, concerns have been raised about whether the State could get better rates for Program participants if there were fewer health plan contracts with more participants in each plan.

A performance audit in this area would address the following questions:

1. **Does the State Health Benefits Program have enough staff, funding, and other resources to handle its current workload?** To answer this question, we'd look at changes over time in the number of plans and participants the Program staff must deal with. We'd document the staff's workload through interviews and observation, and would develop criteria for appropriate response times and other performance measures. Through our interviews, observations, and analyses, we'd attempt to conclude on whether the Program's staffing and other resources appear adequate to administer the contracts effectively, answer inquiries from participants in a timely manner, and so forth. If possible, we'd also conclude on the level of additional funding needed to allow staff to deal adequately with its increased workload.

2. **Is the Program's structure appropriate given its responsibilities, and how does that structure compare to those of comparable programs in other states?** To answer this question, we'd contact a sample of surrounding and similar states, or those we identify as having good schemes for administering employee health benefits. We'd gather information on administrative structure, workload, duties, staff/participant ratios, available resources, and the like, and compare those data to corresponding information on the Kansas Program. If possible, we'd identify procedures or systems in other states that Kansas officials may wish to consider adopting. We'd try to assess whether states with fewer plans tend to need fewer staff to administer their health benefits.

3. **Would State employees likely get lower health insurance rates if the State offered fewer plans with more participants in each plan?** To answer this question, we'd interview persons knowledgeable about health insurance rates and review available literature. Through our work in question 2, we'd find out how many plans are administered in other states, the number of participants in each, and how rates seem to differ based on the amount of the employer subsidy, benefits offered, and the size of the participant pool. We'd conduct additional work in this area as needed.

Estimated completion time: 8-10 weeks

APPENDIX B

Details of the Contracts the Health Care Commission Currently Has In Place

This appendix provides a detailed list of all 28 contracts that the Health Care Commission currently has in place to administer the Health Benefits Program. Of those, 13 contracts are directly related to providing health insurance coverage, 4 contracts aid in administrating the Program, and (at the time of this report) 11 contracts govern how coverage is provided to participating educational groups.

Details of the 28 Contracts the Health Care Commission Currently has In Place

	Name of Contract	Details/Description
1	Kansas Choice health plan	Self insured managed Indemnity/Point of Service option
2	Premier Blue health plan	Fully insured Health Maintenance Organization (HMO) option
3	HealthNet health plan	Fully insured HMO option
4	Coventry health plan	Fully insured HMO option
5	Preferred Plus health plan	Fully insured HMO option
6	Preferred Health Systems health plan	Fully insured Preferred Provider Organization (PPO) option
7	Delta Dental plan	Self insured dental services of participants enrolled in medical coverage
8	Hartford long term care plan	Optional insurance coverage to pay some or all of the costs of assisted living when a person is unable to take care of their daily living needs
9	Advance PCS	Prescription benefit manager for the self-insured prescription drug program. Participants enrolled in medical coverage will automatically be enrolled in prescription drug coverage
10	Vision Service Plan (VSP)	Optional insurance coverage for participants to pay for eye examinations, and partial cost coverage for lenses and frame, contact lenses and other
11	Student Resources health plan	Health insurance coverage for full time students, as well as graduate research and graduate teaching assistants at Kansas Regents' institutions
12 & 13	KSHIP Hearing Benefits Program (2 contracts)	Provides discount hearing services through the University of Kansas, University of Kansas Medical Center, and Wichita State University
14	eBenX administrative contract	Contractor provides Direct Bill database support including membership enrollment and billing
15	National Prescription Administrators (NPA)	A back-up prescription benefit manager for the self-insured prescription drug program
16	Segal Consulting Services	Contractor helps prepare the Requests for Proposals, helps in negotiations with providers, and provides utilization, actuarial, and trend analyses
17	MedStat	Allows Program officials to analyze health care information through the use of a database
18 - 28	11 Educational group contracts	USD 242 (Weskan), USD 272 (Waconda), USD 281 (Hill City), USD 288 (Central Heights), USD 283 (Elk Valley) USD 300 (Coldwater), USD 392 (Osborne), USD 421 (Lyndon), Cloud County Community College, Labette Community College, and Southeast Kansas Education Service Center

APPENDIX C

Agency Response

We provided copies of the draft audit report to the Department of Administration on July 10. We made a number of changes to the draft to improve the accuracy of the report, but nothing that changed our findings or conclusions.

STATE OF KANSAS

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DAN STANLEY, *Secretary*

BILL GRAVES, *Governor*

July 17, 2001

Barbara J. Hinton
Legislative Division of Post Audit
Mercantile Bank Tower
800 SW Jackson Street, Suite 1200
Topeka, Kansas 66612-2212

Dear Ms. Hinton:

This will acknowledge receipt of the completed performance audit, *State Health Benefits: Reviewing the Staffing and Structure of the Current Program*. We appreciate the willingness of the Legislative Post Audit Committee and your staff to conduct this audit at my request. Your staff made a significant investment of time and interest to understand the complex issues of managing the group health insurance program. The value of this investment is now reflected in the thorough and quality audit report, which we will use as a planning tool to improve the overall management of the Program. We have completed our review of the report and would like to clarify items that relate to the Department of Administration and respond to the audit findings.

Clarifications

1. Page 1, Paragraph 1: Thank you for reflecting that the Program administers 17 different health plan and administrative contracts. However, we still believe that it is important to note that the Program also administers 11 contracts regarding group health insurance coverage for the educational entities. The number of educational entity contracts is expected to grow in the future.

2. Page 12, Paragraph 1: We understand that comparing Kansas with other states to make meaningful observations regarding benefits staffing levels was difficult, because it is not known whether those states have adequate staffing. Perhaps an alternate method of comparison, if time could have allowed, would have been to use staffing models developed by independent sources that are based more on the complexity of the various benefit plans themselves.

3. Page 18, First paragraph: Again understanding how difficult it was to compare benefits staffing levels between the seven states, we're not sure that linking of staff per 10,000 participants and per plan is the best way to determine appropriate staffing levels. When the measure of staff per 10,000 participants is looked at individually, Kansas falls in the low range of peer states. Therefore we believe a more appropriate comparison would be to weight a plan's staffing needs according to its complexity.

Audit Conclusion

We agree with the conclusion that the structure of the Health Benefit Program is adequate. We also share the conclusion that if membership in the Program is expanded to non-state employees that a conscious decision will need to be made about the future structure of the Program.

We generally do not agree with the conclusion that the Health Benefits Program has enough resources to handle its responsibilities. The fact that the Health Benefits Program must borrow resources from other areas within the Department of Administration in and of itself points out a lack of adequate resources.

We agree with the conclusion that reducing the number of health insurance plans isn't likely to result in meaningful premium cost reductions.

Response to Audit Findings

Staff agrees with the audit's recommendation that if the Program is expanded to include cities and counties, the Health Care Commission and the Department of Administration should develop estimates of how many additional staff and how much more funding will be needed to handle such an expansion, and how those things will be added. This information should be given to the Legislature before any decision is made to expand the Program eligibility. However, this recommendation assumes that staff will know about the eligibility expansion before the decision is made. It also assumes staff will have a chance to make an appeal for additional resources, and then have such appeal responded to favorably. It is programs like SB 19 (from Legislative Session 2001), *the HealthWave Program subsidy* (see Text Box, page 19) and SB 3 (from Legislative Session 1999), *the test tracking of statewide health insurance mandates within the state's group health insurance program* that are approved without the provision of adequate resources to carry them out that cause staffing and administrative shortfalls.

A second audit suggestion was for staff to make better use of the performance measures included in the contracts with providers. We agree that these performance measures should be reviewed in a proactive method, and have already adopted this recommendation. However, current and future demands upon staff's time will govern and affect our abilities to implement fully this recommendation to a successful conclusion.

A third audit suggestion was for staff to identify the reasons for overpayments to the State's insurance carriers and to take corrective action to reduce the number of overpayments.

We agree and have already adopted this recommendation. We plan to add a member to our staff whose primary job responsibility is to fulfill the requirements of a regular, routine reconciliation process with the state's insurance carriers and to determine the most efficient and effective manner to complete this process.

A fourth suggestion is to find a membership database that can be contained within one automated system. We agree with this recommendation and are already working towards this solution. However, we see this as both a short-term and long-term process. Therefore, while we are considering a membership database that would be fully integrated with our next version of PeopleSoft (Version 8.3, to be upgraded in early 2003), we also are contemplating how our membership database issues can be addressed within our current PeopleSoft environment.

A fifth suggestion is for staff to document the work processes carried out in their office. We agree, and have already adopted this recommendation. Our solution is to develop a set of desk reference procedural manuals. The completion of this documentation will be a part of the evaluation completed during the employee's annual review process.

Thank you again for the opportunity to comment on this report.

Sincerely,

Dan Stanley
Secretary of Administration