Approved: March 3, 2004
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairman Stephen Morris at 10:40 a.m. on February 9, 2004, in Room 123-S of the Capitol.

All members were present except:
Senator Christine Downey- excused
Senator Dave Jackson- excused

Committee staff present:
Alan Conroy, Director, Kansas Legislative Research Department
J. G. Scott, Chief Fiscal Analyst, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Susan Kannarr, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes
Judy Bromich, Administrative Analyst
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Terry Bernatis, State of Kansas Health Care Benefits Program, Kansas Department of Administration

Others attending:
See Attached List.

Bill Introductions

Senator Adkins moved, with a second by Senator Barone, to introduce the following four bills: An act concerning taxation on cigarettes and tobacco products; relating to rates and disposition of revenue (3rs1877); An act concerning mineral severance tax; relating to disposition of revenue; creating the gas valuation depletion trust fund and providing for distribution of moneys therefrom (3rs1797); An act amending the open records act; relating to application to certain records (3rs1860) and An act concerning open meetings; relating to executive sessions requiring recording thereof (3rs1861). Motion carried on a voice vote.

Chairman Morris called the committee's attention to discussion of:

SB 336--Establishment of a tobacco use prevention and control program

There was committee discussion and some additional information was distributed by Senator Barnett regarding Tobacco Cessation which was requested by the committee (Attachment 1).

Senator Schodorf moved, with a second by Senator Jordan, to amend **SB 336** to add language making the provisions of the bill subject to appropriations. Motion carried on a voice vote.

Senator Jordan moved, with a second by Senator Salmans, to recommend **SB 336** favorable for passage as amended. Motion carried on a roll call vote.

The Chairman called the committee's attention to discussion of:

SB 365--Deleting a provision in the post audit statute prohibiting a person who is regulated by the KCC from being audited by post audit

The committee discussed a balloon amendment presented by the Division of Legislative Post Audit. Legislative Post Audit. Legislative Post Audit defined the following information regarding the bill:

SB 365 amends K.S.A. 46-1114 to remove the blanket prohibition against Legislative Post Audit auditing KCC-regulated entities. The bill establishes a limited authority to audit those entities' compliance with laws

or regulations, collection or remittance of fees or taxes, or other matters directly related to State government programs or functions.

K.S.A. 46-1114 gives Legislative Post Audit access to a non-governmental entity's records to the same extent that the granting, contracting, or regulating State agency has access. Because the KCC has full access to all the records of the entities it regulates, this amendment would have the effect of limiting Legislative Post Audit only to those matters directly related to some governmental purpose. Under the amendment, Legislative Post Audit would not be authorized to conduct audits related to stock prices, dividends, shareholder disputes with management, or other financial or corporate-governance issues not directly related to a government activity.

Senator Barone moved adoption of, with a second by Senator Schodorf, the Legislative Post Audit balloon amendment for **SB 365** (Attachment 2). Motion carried on a voice vote.

Senator Schodorf moved, with a second by Senator Kerr, to recommend **SB 365** favorable for passage as amended. Motion carried on a roll call vote.

Chairman Morris welcomed Terry Bernatis, Health Care Benefits Administration, Kansas Department of Administration (Attachment 3). Ms. Bernatis presented an overview of the State of Kansas Health Care Benefits Program. She explained that the State of Kansas Healthcare Benefits Program is an employer-sponsored benefit program that provides medical, prescription drugs, dental, vision and hearing benefits for over 90,000 covered lives. Ms. Bernatis detailed four areas that included:

- Plan Design - 2004 Active Employee Open Enrollment Booklet
- Membership
- Contracting
- Funding and Budgeting

Ms. Bernatis addressed why the plan costs what it does and details are found in her written testimony. She noted that the plan design, and therefore, the cost of the program is driven by their plan participant's utilization of services and the cost for those services in the market place.

Copies of the 2003 and 2004 State of Kansas Open Enrollment booklets were distributed to the committee and are on file with the Health Care Benefits Administration office, Kansas Department of Administration.

The meeting adjourned at 11:50 a.m. The next meeting is scheduled for February 10, 2004.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE February 9, 2004

NAME	REPRESENTING
Alan Dunkel	Budget
Julia Thomas	DOB
Bill Curtis	Ks Assoc of School Bds
Mike Kelly	DOA
Pam Maxwell	Blue Cross Blue Shield of Ks
JAN SIDES	SEAK/AARP
Guy Beinstein	DOB A
Linda McCourley	Dept of Adm.
Lenne Ann Lower	KAHP
Mike Hutfles	Ks. Gov't. Consulting
TOM DAY	KCC
H Brown	DofA
Debra Francisco	KDHE
Karla Mumert	KDHE
K A Mo	Hein Law Firm
Barb Hinton	Post Audit

Population Level Interventions – Smoke Free/Clean Indoor Air Laws

- The *Surgeon General's 2000 Report on Reducing Tobacco Use* found that clean indoor air laws that prohibit smoking "have been shown to decrease daily tobacco consumption and to increase smoking cessation among smokers."[14]

- According to the *National Cancer Institute's* exhaustive review of the scientific literature related to population-based cessation programs:

  > "Multiple workplace observations have demonstrated that instituting a change in workplace smoking restrictions is accompanied by an increase in cessation attempts and a reduction in number of cigarettes smoked per day by continuing smokers. Once restrictions on smoking in the workplace have been successfully implemented, they continue to have effects. Observations ... demonstrate that being employed in a workplace where smoking is banned is associated with a reduction in the number of cigarettes smoked per day and an increase in the success rate of smokers who are attempting to quit."[15]

- A study in the August 9, 2000 issue of the *Journal of the American Medical Association* found that, "The results from these national surveys [on youth smoking] strongly suggest that smoke-free workplaces and homes are associated with significantly lower rates of adolescent smoking."[16]

What are the benefits of quitting?

Quitting produces fast, major health benefits, some within minutes from smoking that last cigarette.

At 20 minutes after last cigarette: blood pressure decreases; pulse rate drops; and body temperature of hands and feet increases.

At 8 hours after quitting: carbon monoxide level in blood drops to normal; and oxygen level in blood increases to normal.

At 24 hours after quitting: chance of a heart attack decreases.

At 48 hours after quitting: nerve endings start regrowing; and ability to smell and taste is enhanced.

After 2 weeks to 3 months: circulation improves; walking becomes easier; lung function increases.

After 1 to 9 months: coughing, sinus congestion, fatigue, shortness of breath decreases.

After 1 year: excess risk of coronary heart disease is decreased to half that of a smoker.

After 5 to 15 years: stroke risk is reduced to that of people who have never smoked.

After 10 years: risk of lung cancer drops to as little as one-half that of continuing smokers; risk of cancer of the mouth, throat, esophagus, bladder, kidney, and pancreas decreases; risk of ulcer decreases.

After 15 years: risk of coronary heart disease is now similar to that of people who have never smoked; and risk of death returns to nearly the level of people who have never smoked.[17]

Senate Ways and Means
2-9-04
Attachment 1

CAMPAIGN for TOBACCO-FREE Kids®

TOBACCO CESSATION: AN OVERVIEW

"Recent comprehensive analyses of hundreds of research reports have revealed that numerous, effective tobacco dependence treatments now exist. Not only do such treatments more than double a smoker's likelihood of achieving long-term abstinence, but also research shows that such treatments are highly cost-effective. In terms of life-years saved per dollar spent, effective counseling and medications for smoking cessation have been found to be among the most cost-effective healthcare practices. In fact, tobacco dependence treatment is more cost effective than the treatment of hypertension, diabetes and hyperlipidemia."

- A Nation Action Plan for Tobacco Cessation (February 2003)[1]

What is Tobacco Cessation?

Depending upon who you ask, the answer to the question, "what is tobacco cessation?" can have multiple answers, all of which are correct. Ultimately, cessation is about getting tobacco users to stop using tobacco. It is in the means of achieving this goal that the responses differ. There are two main approaches: individual treatment services and interventions and population-based approaches. Individual services include behavioral treatment (individual or group counseling, face-to-face or phone counseling) and pharmacotherapy such as the use of nicotine replacement products like nicotine gum, patch and lozenges. Population-based approaches include such interventions as increases in cigarette excise taxes, clean indoor air/smoke free workplace laws, and paid media campaigns. There are also services that bridge the gap between population-based and individual to link both approaches, including health care systems changes, education of health care providers on cessation, and telephone quitlines.

Why is Quitting Tobacco Use So Difficult?

The *Surgeon General* has concluded that:

- "Cigarettes and other forms of tobacco are addicting.
- Nicotine is the drug in tobacco that causes addiction.
- The pharmacologic and behavioral processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine."[2]

According to the *National Institute on Drug Abuse*:

- "The use of tobacco products may be the Nation's most critical public health problem. It is, in fact, addiction to nicotine that is at the root of this enormous health, social, and financial burden."[3]
- "[N]icotine is addictive. Most smokers use tobacco regularly because they are addicted to nicotine. Addiction is characterized by compulsive drug-seeking and use, even in the face of negative health consequences, and tobacco use certainly fits the description."[4]

U.S. Public Health Service Clinical Treatment Guidelines state:

- "Tobacco dependence shows many features of a chronic disease. Although a minority of tobacco users achieve permanent abstinence in an initial quit attempt, the majority persist in tobacco use for many years and typically cycle through multiple periods of relapse and

remission. A failure to appreciate the chronic nature of tobacco dependence may undercut clinicians' motivation to treat tobacco use consistently."[5]

- "[M]uch smoking cessation research and clinical practice over the last three decades has focused on identifying the ideal intervention that would turn all smokers into permanent non-smokers ... A more productive approach is to recognize the chronicity of tobacco dependence. A chronic disease model has many appealing aspects. It recognizes the long-term nature of the disorder with an expectation that patients may have periods of relapse and remission. If tobacco dependence is recognized as a chronic condition, clinicians will better understand the relapsing nature of the ailment and the requirement for ongoing, rather than just acute, care."[6]

How Effective are Cessation Services?

Individual Level Interventions - Counseling

The U.S. Public Health Service Clinical Treatment Guidelines confirm the fact that the more frequent a tobacco user talks to and interacts with his/her doctor, dentist, pharmacist, nurse, psychologist (or other health care professional involved his/her quit attempt), the greater the chances he/she has of successfully quitting and remaining abstinent. The clinical guidelines concluded that four specific types of counseling and behavioral therapy categories yield statistically significant increases in abstinence (in relation to no intervention), including:

- providing practical counseling such as problem solving skills, training/relapse prevention, and stress management;
- providing support during a smoker's direct contact with a clinician;
- intervening to increase social support in the smoker's environment; and,
- using aversive smoking procedures (rapid smoking, rapid puffing, other smoking exposure).[7]

Individual Level Interventions - Pharmacotherapy

In addition to counseling, the PHS Guidelines strongly recommend the use of drug treatment (where clinically appropriate) in conjunction with counseling, to increase the likelihood of a successful quit attempt. The types of drugs recommended break down into two main categories – those that are nicotine-based (nicotine replacement therapies) and those that treat other symptoms experienced by individuals attempting to quit (e.g., depression). The treatments recommended include:

- Nicotine Gum (commercially available as: Nicorette, Nicorette Mint, Nicorette Orange, generic)[8] has an established record of clinical efficacy and increases long-term abstinence rates (over placebo – no drug treatment) by 30 to 80 percent. It is available only as an over-the-counter product.
- Nicotine Patch (commercially available as: Nicoderm CQ, Nicotrol, Habitrol, generic) has an established record of clinical efficacy and approximately doubles long-term abstinence rates (over placebo – no drug treatment). It is available both over-the-counter and as a prescription medication.
- Nicotine Inhaler (commercially available as: Nicotrol Inhaler) has an established record of clinical efficacy and more than doubles long-term abstinence rates (over placebo – no drug treatment). It is available only as a prescription medication.

- Nicotine Nasal Spray (commercially available as: Nicotrol NS) has an established record of clinical efficacy and more than doubles long-term abstinence rates (over placebo – no drug treatment). It is available only as a prescription medication.

- Bupropion SR (commercially available as: Zyban) has an established record of clinical efficacy and approximately doubles long-term abstinence rates (over placebo – no drug treatment). This is a non-nicotine medication and is available only in prescription as either a smoking cessation product (Zyban) or an anti-depressant (Wellbutrin).

[Note, a nicotine lozenge, known as Commit, has since been approved by FDA for use as an approved, over-the-counter, nicotine-based cessation aid – but it was not studied as part of the PHS Guideline review.]

How Do Individual Tobacco Cessation Services Compare to Other Preventive Services?

A study in the July 2001 issue of *American Journal of Preventive Medicine* provided an exhaustive research review that ranks the effectiveness of various clinical preventive services recommended by the U.S. Preventive Services Task Force, using a one to ten scale, with ten being the highest possible score.[9] Of the thirty preventive services evaluated, tobacco cessation ranked second in its degree of effectiveness, scoring a nine out of 10 (the highest ranking was for childhood vaccines which scored a 10). Among other preventive services covered by Medicare, colorectal cancer screening received a score of eight and mammography screening scored a six.

Population Level Interventions – Excise Tax Increases

- Numerous economic studies in peer-reviewed journals have documented that cigarette tax or price increases reduce both adult and underage smoking. The general consensus is that every 10 percent increase in the real price of cigarettes will reduce overall cigarette consumption by approximately three to five percent and reduce the number of kids who smoke by about six or seven percent.[10]

- As with cigarettes, raising the price of smokeless tobacco products through state tax increases or other means will prompt a reduction in smokeless tobacco use, especially among adolescents and young adults. For example, one recent study found that a 10 percent increase in smokeless tobacco prices reduces adult consumption by 3.7 percent and reduces male youth consumption by 5.9 percent, with two-thirds of that reduction coming from kids stopping any use of smokeless tobacco at all.[11]

- Low-income smokers are much more likely to quit because of state tobacco-tax increases than higher-income smokers. State cigarette-tax work much more powerfully to prompt lower-income smokers to quit or cutback and to stop lower-income kids from every starting than they do among higher-income smokers and youths.[12] Most notably, smokers with family incomes at or below the national median are four times as likely to quit as those with higher incomes because of cigarette price increases.[13] Accordingly, low-income families that currently suffer from direct and secondhand smoking-caused health risks, disease, and related costs are much more likely to have those harms and costs reduced by a cigarette tax increase than similar families with higher-incomes. And those cost reductions (including reduced family expenditures on cigarettes) will also mean more to the lower-income households.

Are Tobacco Cessation Insurance Benefits/Services Cost Effective?

According to the PHS Clinical Treatment Guidelines:

- "[S]moking cessation treatments … are cost-effective in relation to other medical interventions. Cost-effectiveness analyses have shown that smoking cessation treatments compare quite favorably with routine medical interventions such as the treatment of hypertension and hypercholesterolemia, and with other preventive interventions such as periodic mammography."[18]

- "Treating tobacco dependence is particularly important economically in that it can prevent a variety of costly chronic diseases, including heart disease, cancer, and pulmonary disease. In fact, smoking cessation treatment has been referred to as the 'gold standard' of preventive interventions."[19]

- "For hospitalized patients, successful tobacco abstinence not only reduces general medical costs in the short-term, but also reduces the number of future hospitalizations. Smoking cessation interventions for pregnant women are especially cost-effective because they result in fewer low birth weight babies and perinatal deaths, fewer physical, cognitive, and behavioral problems during infancy and childhood, and also yield important health benefits for the mother."[20]

National Center for Tobacco Free Kids, October 21, 2003 / Matt Barry

More Campaign for Tobacco-Free Kids factsheets on cessation are on the TFK website at: http://tobaccofreekids.org/research/factsheets/index.php?CategoryID=25, including:

- *Tobacco Cessation Works: An Overview of Best Practices and State Experiences*
- *Benefits from Tobacco Use Cessation*
- *Resources for Quitting Smoking*
- *How Safe Are Novel Nicotine Products?*
- *State Cessation Statistics & Potential Savings from Reducing Smoking by One Percentage Point*

---

[1] *Preventing 3 Million Premature Deaths, Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation*, Prepared by the Subcommittee on Cessation, Michael C. Fiore, M.D., M.P.H., Chair, Interagency Committee on Smoking and Health, February 3, 2003.

[2] The Health Consequences Of Smoking: Nicotine Addiction - A *Report of the Surgeon General* (1988), U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health, Rockville, Maryland 20857, http://www.cdc.gov/tobacco/sgr_1988.htm.

[3] National Institute on Drug Abuse Research Report Series: Nicotine Addiction, *NIH Publication No. 01-4342*, http://www.nida.nih.gov/researchreports/nicotine/nicotine.html.

[4] Ibid.

[5] Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf.

[6] Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf.

[7] Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf.

[8] These listings here and elsewhere on this factsheet of actual brands are NOT product endorsements but just statements of fact about products available to consumers.

[9] Coffield, A, et al. "Priorities Among Recommended Clinical Preventive Services," *American Journal of Preventive Medicine*, July 2001, 21(1),

Proposed amendment
February 9, 2004

Senate Ways and Means
2-9-04
Attachment 2

Session of 2004

SENATE BILL No. 365

By Committee on Ways and Means

1-26

AN ACT concerning legislative post audit; relating to persons subject to audits; amending K.S.A. 46-1114 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 46-1114 is hereby amended to read as follows: 46-1114. (a) The legislative post audit committee is hereby authorized to direct the post auditor and the division of post audit to make an audit of any type described in K.S.A. 46-1106 or 46-1108, and amendments to these sections, of any records or matters of any person specified in this section, and may direct the object in detail of any such audit.

(b) Upon receiving any such direction, the post auditor with the division of post audit, shall make such audit and shall have access to all books, accounts, records, files, documents and correspondence, confidential or otherwise, to the same extent permitted under subsection (g) of K.S.A. 46-1106 and amendments thereto, except that such access shall be subject to the limitations established under subsection (d) of this section.

(c) Audits authorized by this section are the following:

(1) Audit of any local subdivision of government or agency or instrumentality thereof which receives any distribution of moneys from or through the state.

(2) Audit of any person who receives any grant or gift from or through the state.

(3) Audit of the contract relationships and the fiscal records related thereto of any person who contracts with the state.

(4) Audit of any person who is regulated or licensed by any state agency or who operates or functions for the benefit of any state institution; ~~except that this subsection (c)(4) shall not include audit of any person regulated by the state corporation commission;~~ except that any audit of any person regulated by the state corporation commission shall address only compliance with laws or regulations, collection or remittance of taxes or fees, or other matters related directly to state government programs or functions. Any such audit authorized under this subsection shall not address corporate governance or financial issues except as they may relate directly to state government programs or functions

(d) (1) Access to all books, accounts, records, files, documents and correspondence, confidential or otherwise, as authorized under subsection (b) of this section of any nongovernmental person audited under authority of subsection (c)(2) of this section shall be limited to those books, accounts, records, files, documents and correspondence, confidential or otherwise, of such person to which the state governmental

agency which administers the grant or gift and provides for the disbursement thereof is authorized under law to have access.

(2) Access to all books, accounts, records, files, documents and correspondence, confidential or otherwise, as authorized under subsection (b) of this section of any nongovernmental person audited under authority of subsection (c)(3) of this section shall be limited to those books, accounts, records, files, documents and correspondence, confidential or otherwise, of such person to which the state governmental agency which contracts with such person is authorized under law to have access.

(3) Access to all books, accounts, records, files, documents and correspondence, confidential or otherwise, as authorized under subsection (b) of this section of any nongovernmental person audited under authority of subsection (c)(4) of this section shall be limited to those books, accounts, records, files, documents and correspondence, confidential or otherwise, of such person to which the state governmental agency which regulates or licenses such person or the state institution on whose behalf such person operates or functions is authorized under law to have access.

Sec. 2. K.S.A. 46-1114 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Testimony to the
Senate Ways and Means Committee
By
Terry D. Bernatis
Health Care Benefits Administration
February 9, 2004
Overview – State of Kansas Health Care Benefits Program

Thank you Mr. Chairman for the opportunity to provide information about the State of Kansas Health Benefits Program. My name is Terry Bernatis, and I work with the State of Kansas Health Care Benefits Program in the Department of Administration.

The Health Care Commission was established in 1984 (K.S.A. 75-6501 et seq.) to develop and implement a state health care benefits program. Its charge is to provide benefits for persons qualified to participate in the program for hospitalization, medical services, surgical services, and non-medical remedial care. The Health Care Commission establishes qualifications for benefits, services covered, schedule of benefits, conversion privileges, deductible amounts, co-insurance levels, limitations on eligibility and "other reasonable provisions" to run the program.

The Health Care Commission consists of five members: the Secretary of Administration, the Insurance Commissioner and three appointees of the Governor; an active classified employee, a retired classified employee and a representative of the general public (K.S.A. 75-6502(a)).

The Health Care Commission may establish an advisory committee (K.S.A. 75-6510(b)). It is composed of twenty-one members who serve three-year rolling terms. Eighteen members are active employees, two are Medicare eligible retirees and one is a non-Medicare eligible retiree.

Statute provides for one technical administrator (K.S.A. 75-6503(b), Linda DeCoursey, and the Department of Administration provides additional resources to administer the plan.

In its simplest terms, the State of Kansas Health Care Benefits Program is an employer sponsored benefit program that provides medical, prescription drugs, dental, vision and hearing benefits for over 90,000 covered lives. The program provides multiple medical options, a prescription drug plan, a dental plan, a voluntary vision plan and a hearing improvement program that utilizes the Hearing and Speech Departments at Ft. Hays, K-State, KU, KUMed and Wichita State.

The vast majority of the plan is self-insured. We hire third party administrators to process claims and only collect enough money from the state and plan participants to pay those claims. This is very different from the plan that existed prior to 1996 when the plan was fully funded and an insurance company was hired to not only pay claims but to

assume the risk as well. The state and plan participants paid a retention fee to the insurance company and a reserve fund was required. During those days, contract negations were about a premium and whether that amount realistically represented the cost of the plan. Today, we know exactly what the cost of the plan is and establish rates to only pay for claims costs and administrative fees.

In order to give you a quick but comprehensive overview of the plan, there are four areas that I would like to go through with you including plan design, membership, contracting, funding and budgeting.

PLAN DESIGN – 2004 Active Employee Open Enrollment Booklet

Medical Options

Active participants in the state health plan have six options from which to choose. Direct Bill participants (those who continue on the state plan either as former elected officials, people on leave without pay or retirees) have seven options depending on whether they are Medicare eligible or not. There are two plan designs: the PPO (Preferred Provider Organization) and the HMO (Health Maintenance Organization). Except for very small differences, the plan design of the PPOs are identical and the plan design for the HMOs are identical. This standardization of the designs started in 1996 to eliminate the ability of vendors to "cherry pick" what they considered the best risk. Knowing what the plan design is allows employees to choose an option with the network they want that has the degree of managed care that most closely meets their needs.

There were several changes in the plan design for 2004 as indicated on Page 5 of the 2004 Active Employee Open Enrollment Booklet. Most notably:

- The in-network deductible was eliminated in the PPO options. This was done so that there would be first dollar coverage for plan participants.
- Implementation of a "tiered co-insurance structure." In other words, the more services a person uses, the higher plan payment on those services.
- Indexing of all possible cost share items. This provides for consistent cost sharing over Plan Years between the state and the participant.
- Increase of co-payments for HMOs. It had been many years since the co-payment had been changed and all carriers indicated that they no longer offered a $10 co-payment program in their standard book of business.
- Introduction of co-insurance to the HMOs. This provides participants knowledge of the true cost of services.
- A pilot program that allowed Direct Bill participants to choose a prescription drug option that requires mail order and generic substitution.

Prescription Drug

Regardless of medical option, the prescription drug plan is the same for all plan participants. This is particularly significant because it gives a total picture of prescription drug utilization and allows a plan design that is comprehensive yet very cost effective. The plan also utilizes a "tiered co-insurance structure." In other words, a participant's co-insurance is less for generic drugs and more for non-preferred brand drugs. The prescription drug plan is self-insured. The state is assuming the risk, not an insurance company. We receive a $5.00 per month per ~~contact~~ contract payment from AdvancePCS, our Prescription Benefit Manager and do not pay an administrative fee. This arrangement allows us to use this income stream for budgeting purposes that decreases both the state and participants costs.

This plan design has been very successful for the state and its participants. Our trend is less than half of the national average. In other words, it runs less than 10% whereas the national average over the past several years has approached 20%. It means that both the state and the participants are saving money. In fact, we have just reached a new high of 44.4% generic substitution rate. Less than 3% of the remaining brand name medications could be filled by a generic medication. We have achieved "mandatory generic substitution" without having to mandate it; participants have made cost effective decisions regarding their prescription drugs.

Dental Plan

The dental plan is self insured and it is administered by Delta Dental of Kansas. For Plan Year 2004, not only was the annual deductible for major services indexed, the maximum annual benefit was also indexed to $1,600 from $1,500.

MEMBERSHIP

As I mentioned before, the plan covers 90,037 lives. There are 35,009 state employee contracts, 5,481 non-state group employer employee contracts, 9,320 Direct Bill participant contracts, both state and non-state, and 225 COBRA contracts. An additional 40,002 participants are dependents. Currently, the following non-state groups are allowed to participate on a voluntary basis in the state plan: Unified School Districts, Community Colleges, Vocational Technical Schools, Technical Colleges, cities, counties, and townships. Beginning April 1, 2004, County Extension personnel, not for profit community mental health

centers and special districts (rural water districts and ground water districts) will also be participating in the plan.

CONTRACTING

As provided by statute (K.S.A. 75-6504(b)), the Health Care Commission advertises for proposals and negotiates with respondents. Although exempt from Purchasing statutes, the Commission utilizes Purchasing RPF "boilerplate" language and all RFPs are released under their letterhead. This assures fair and equitable purchasing processes and outcomes. Currently the Health Care Commission has contracts with:

- Blue Cross and Blue Shield of Kansas - medical
- Coventry – medical
- Preferred Health Systems - medical
- Harrington - medical
- LabOne – lab card services
- Delta Dental of Kansas - dental
- AdvancePCS – prescription drug
- Superior Vision Services - vision
- MedStat – claims analysis
- CompLink – billing services
- Segal – consulting and actuarial services

FUNDING AND BUDGETING

There are two funding streams to finance this program: employer and plan participant. Prior to this plan year, the state paid on average 95% of the cost of an active employees cost of coverage and 35% of the cost of dependent coverage. That funding formula was changed for Plan Year 2004 so that the state pays an average of 95% of the cost of the lowest cost plan available for a participant and 35% of the cost of the lowest cost dependent coverage. Non-state employer groups are required to pay at least what the state pays for an employer contribution (K.S.A. 75-6506(d)). USDs are allowed to "ramp up" to required employer contribution. From Plan Year 1996 through Plan Year 2003, the reserve account that accumulated as a result of the minimum premium arrangement with Blue Cross and Blue Shield of Kansas through 1995 was drawn down in order to defray employer increases. There is no longer a reserve account, but there is $9.9 MM in an Incurred But Not Reported Fund. Our actuaries indicate that the true IBNR is close to $30 MM.

The Direct Bill continuation plan is designed as a participant pay all program.

Budget indices for group health insurance are due to the Division of Budget on June 1 prior to the fiscal year that starts in thirteen months. Additionally, projections are needed for the fiscal year that starts in twenty-five months from June 1.

WHY DOES THE PLAN COST WHAT IT DOES?

The plan design and therefore cost of the program is driven by our plan participant's utilization of services and the cost for those services in the market place. I think this is the hardest concept for our plan participants to understand. As I mentioned before, a large majority of our plan is self insured. The premium equivalent rates established by the actuaries includes the cost of services, the administration fee to the third party administrators, and seven tenths of one percent of plan costs for internal administrative costs, and fees for CompLink, MedStat and Segal. For our fully insured plans, the experience of our plans again drives the cost of the premium because it is based on our own plan design.

The best example I can give you about why the plan costs what it does and why the "rates" are what they are is to share with you the experience from June 1, 2001 through mid-summer 2003 which impacted the state's composite rates effective FY 2004 and FY 2005 and the participant rates effective January 1, 2004.

- Budget indices for Fiscal Year 2004 were due to the Division of Budget on June 1, 2002. The composite rates were based on actuarial models developed by Segal that took into consideration membership patterns, utilization of services through April 2002, projections of medical inflation, and negotiated fully insured rates. The composite rates were 20% greater than FY 2003 rates.
- Early Spring 2003 – Further analysis of claims indicated that participant utilization was greater than anticipated which had been based on national utilization patterns and adjusted upwards for our typical utilization pattern. The shortfall was predicated at $15 MM. Since the composite rate for Fiscal Year 2004 could not be increased, the Health Care Commission made the decision to: remove a 2% margin factor, remove the 2% IBNR development factor, change the contribution structure to pay for 95% of the lowest cost plan, index remaining participant cost sharing amounts, change the prescription drug co-insurance rates plus spend down the IBNR fund by $3 MM.

- Spring 2003 – Based on more mature and complete claims analysis and renewal rates from carriers that ranged from 19.8% to almost 30% it was determined that additional benefit design changes would have to be made in order to limit participant premium increases to approximately 10%. We knew that based on our prescription drug plan, people responded to plan designs that gave them choice and monetary incentives. We also knew that 5% of our participants used 50% of the cost of the plan and 55% of the participants only used 5% of the cost of the plan (see exhibit.) The plan for Plan Year 2004 was designed to assure that both types of participants received benefits under the program.

The plan design and costs associated with it are designed to re-engage participants in the cost of their health care. We know it worked with prescription drug and we have used the same techniques in the medical component. Our premiums must be sufficient to cover the cost of the claims we incur.

The same question about rates was asked by Legislative Post Audit in 2001 entitled *The State Health Benefits Program Part I: Reviewing Issues Relating to Premium Costs and Management*.

Question: Are the premiums for the State employee health care program too high for the level of benefits provided?
Answer: 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 for 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.
(For example the out of pocket maximums in 2001 for Colorado was $6,000 for employee only coverage and $3.000 for employee only coverage in USD 501. Three years later, the out-of-pocket maximum is still less at $2,200 in Kansas' PPO plans.)
Our premiums were within the average and yet our out-of-pocket costs were less.

Thank you for allowing us the opportunity to provide this overview. Included in your packets are both parts of the 2001 LPA, PY 2002 and PY 2003 Annual Reports, and a sample of information available to participants about the plan and how to be better consumers. I stand for questions.