PERFORMANCE AUDIT REPORT

K-12 Health Insurance: Evaluating the Financial Impact of Establishing a Consolidated K-12 Health Insurance Plan

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

February 2017

R-17-001

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February 8, 2017

To: Members, Legislative Post Audit Committee

This report contains the findings, conclusions, and recommendations from our completed performance audit, *K-12 Health Insurance: Evaluating the Financial Impact of Establishing a Consolidated K-12 Health Insurance Plan*. The audit was requested by Senator Ty Masterson. The audit team included Matt Etzel, Amanda Schlumpberger, Meghan Flanders, Brad Hoff, Kristen Rottinghaus, and Leyton Gunn. Justin Stowe was the audit manager. Segal Consulting, the Kansas Department of Health and Environment's contracted actuarial firm, were consultants to the team.

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

Sincerely,

Scott Frank
Legislative Post Auditor

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K-12 Health Insurance: Evaluating the Financial Impact of Establishing a Consolidated K-12 Health Insurance Plan

Background Information

In October 2015, the Legislature entered into a $2.6 million contract with the consulting firm Alvarez & Marsal (A&M) to perform an efficiency evaluation of state government. Among other things, that contract required A&M to develop recommendations for ways in which state government could become more efficient. A&M's final efficiency report was presented to the Legislature in February 2016 and included more than 100 efficiency recommendations.

A key recommendation from the A&M efficiency study was for the state to consolidate the health insurance plans offered by K-12 school districts into a single, statewide pool which would be administered by the State Employee Health Plan. A&M contended consolidating health plans would reduce costs, increase administrative efficiencies, and standardize offerings, which would in turn help attract and retain Kansas teachers. A&M estimated consolidating K-12 health insurance plans could reduce school health insurance expenditures by up to 25%, resulting in savings of approximately $80 million a year. Although A&M performed a broad analysis of a consolidated plan, it did not include specific information about how each school district might be affected or what the state's various options might be in adopting such a plan.

Legislators have expressed interest in knowing more about the type of health insurance coverage currently offered by K-12 school districts, and how each district's financial position might be affected if the state established a consolidated K-12 health insurance plan.

Objectives, Scope and Methodology

On April 26, 2016, the Legislative Post Audit Committee approved a request from Senator Ty Masterson for an audit examining the financial impact of establishing a consolidated K-12 health insurance plan. This performance audit answers the following questions:

1. **How much could the state save by consolidating K-12 health insurance, and how would it affect districts' current coverage levels?**

2. **What options would the state have in structuring a consolidated K-12 health insurance plan?**

To answer question one, we worked in conjunction with officials from the Kansas Department of Health and Environment (KDHE) and its contracted actuarial firm, Segal Consulting. In the 2016 A&M report, the consultants suggested an actuarial analysis would be necessary to develop refined cost and savings estimates. We gathered the necessary data for such an analysis and assessed the data's reliability. The actuary at Segal Consulting then used that data to estimate the savings associated with consolidating K-12 health insurance across the state.

Our role in this audit project was primarily to collect and assess the reliability of school district healthcare data required for an actuarial savings analysis. We worked with the actuary to determine which data would be needed, and then collected data on the health plans, enrollment in those plans, and when possible two years of claims data for a sample of 101 of the state's 286 school districts. We selected a judgmental sample of 29 districts that were among the top spending districts on healthcare in the state, as they would likely have the greatest impact on consolidation. We also sampled 72 other districts associated with the Southeast Kansas Education Service Center (Greenbush) and the Education Services and Staff Development Association of Central Kansas (ESSDACK). In total, these 101 districts represented 73% of districts' healthcare expenditures on premiums statewide during the 2014-15 school year. All 101 districts are listed in ***Appendix D*** of the report.

The actuary used our sample data to estimate savings related to administrative efficiencies and changes to employee coverage and contributions associated with 101 districts joining the non-state employee pool within the State Employee Health Plan (SEHP). As part of this estimate, the actuary used the minimum value calculator developed by the U.S. Department of Health and Human Services (HHS) to model the actuarial values—a measure of how much of an employee's health coverage is paid for by a plan—for the healthcare data we submitted. Because this actuarial estimate is based on a sample of districts, the total savings achieved through consolidation would likely be somewhat greater than the estimates included in this report.

The sophisticated nature of the actuary's analysis limited our ability to fully assess their work. However, the testing we were able to conduct to assess the accuracy of the results did not identify any significant errors or inaccuracies. We performed extensive test work to assess the reliability of the data given to us by school districts. We also used the minimum value calculator developed by HHS to verify a small number of the actuarial values reported in the actuarial analysis. We performed several analytic tests to check savings estimates against other information available to us about

individual districts' current health coverage. Across all of this test work, we did not find any significant errors that led us to conclude that the data we collected or the actuarial analysis was unreliable for the purpose of this audit.

Additionally, the actuary told us they performed multiple levels of review on the district level data, actuarial values, and various calculations they used in generating the cost savings associated with consolidating K-12 health insurance. Overall, the actuary determined the results of the analysis were reasonable.

To answer question two, we identified and evaluated important design and implementation decisions that policymakers would face if the state decided to consolidate K-12 health insurance plans. To do this, we interviewed officials at the Kansas Department of Health and Environment, Kansas Insurance Department, and the Kansas State Department of Education. We also interviewed officials from the Kansas Association of School Boards, the Kansas National Education Association, the Greenbush service center, and the ESSDACK service center to understand stakeholder opinions on those key decisions. Additionally, we researched other states that have consolidated K-12 health insurance to understand their plan designs. Those states included Nebraska, New Jersey, Oregon, and Texas.

Finally, the nature of the audit objectives did not require us to test or evaluate any internal controls as part of this audit.

Compliance with Generally Accepted Government Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Finally, it is possible that the actuaries at Segal Consulting could be given future actuarial work related to K-12 health insurance consolidation in the state. That creates a potential independence issue for Segal Consulting because the results of their analysis in this report could influence the need for future work, which could benefit them financially. However, it is not certain they would be given this work because KDHE periodically solicits new bids for its actuarial services. Moreover, our evaluation of their work and their savings results give us no reason to believe that it is biased or unreliable in any way.

Kansas School Districts Provided Health Insurance to Employees at a Cost of About $326 Million in 2014-15

Health insurance is a complex and complicated subject area, involving several different concepts and terms. A list of basic health insurance terms used throughout the report is provided below. ***Appendix C*** contains a more detailed list of many other health insurance terms used in this report and in the healthcare industry.

- Plan – All elements of a given healthcare option including the type of plan, the premiums charged and the coverage levels.
- Premiums – The total amount the employer and its employees pay for healthcare coverage from an insurance provider.
- Coverage – The types of medical procedures covered under each healthcare plan, as well as the amount the employees must pay for each procedure. Deductibles, coinsurance payments, copayments, and out-of-pocket maximums are all components of healthcare coverage.

According to Kansas Department of Education expenditure data, school districts spent $326 million on health insurance premiums during the 2014-15 school year. These expenditures represent the school districts' share of health insurance premiums. They do not include direct costs paid by the employees, or their share of insurance premiums.

- **In the 2014-15 school year, school districts employed about 69,000 full-time equivalent employees, most of whom were eligible for healthcare coverage through their districts**. Of that total, about 42,000 employees were certified staff who typically are eligible for health insurance. The other 27,000 employees were non-certified staff who may or may not be eligible depending on the individual district's policy and number of hours they work.
- **Health insurance expenditures accounted for about 5% of total district expenditures statewide in recent years.** For example, total K-12 education expenditures were about $6.1 billion during the 2014-15 school year. Of that total, districts spent about $326 million on healthcare costs for employees, representing about 5% of total district expenditures. That percentage has been consistent during recent years.
- **In the 2014-15 school year, 20 school districts accounted for 60% of all district spending on health insurance.** In total, those 20 districts accounted for about $195 million of the $326 million spent on K-12 healthcare in the state in 2014-15. The five districts that spent the most on employee health insurance were Wichita ($47.9 million), Olathe ($20.6 million), Blue Valley ($19.0 million), Shawnee Mission ($18.4 million) and Kansas City ($14.3 million). Conversely, four districts did not report any expenditures on health insurance that year (Ellinwood, Northern Valley, Macksville, and Eureka).

School districts can either purchase health insurance independently or join other districts in a group risk pool. The size and demographic makeup of each school district directly affects the cost of the health insurance available to them. Some districts are large enough to purchase health insurance independently from an insurance provider, while other districts need to pool together to get reasonable rates and coverage for their employees.

We identified four group risk pools available to Kansas school districts. One group risk pool is the non-state employee pool within the State Employee Health Plan (SEHP). That pool currently includes 28 districts and about 8,100 school district and municipal employees. The other three group risk pools are administered by the Southeast Kansas Education Service Center (Greenbush), the Education Services and Staff Development Association of Central Kansas (ESSDACK), and the Kansas Educational Insurance Trust (KEIT). As of 2016, 34 districts purchased health insurance through Greenbush and 38 through ESSDACK. We were unable to determine how many districts participated in KEIT.

Regardless of whether districts contract directly with an insurance provider or through a group risk pool, Blue Cross Blue Shield (BCBS) was the most common insurance provider for our sample of 101 districts. Specifically, BCBS administered 91% of plans offered by our sample.

School districts can have fully-insured or self-insured health insurance plans. A district's size and its healthcare costs are the primary factors which determine whether it is fully-insured or self-insured. The differences between these two types of plans is described in more detail below.

- **Under a fully-insured plan, the insurance provider is responsible for employee health care claims and is compensated for taking on this risk.** Fully-insured plans place less risk on school districts because the districts are not directly responsible for paying actual employee health costs. Instead, the provider pays for all covered medical costs. However, premiums for these plans are typically more expensive because the provider must account for the possibility of large, catastrophic claims. Additionally, fully-insured plans also include profit margins, which are not included in self-insured plans. Finally, providers may increase a fully-insured district's premiums to account for the previous year's medical costs.

- **Under a self-insured plan, the employer is responsible for employee health care claims and potentially saves money by assuming this risk.** In these cases, the district still contracts with an insurance provider to process claims, but the provider is not responsible for paying the claims themselves. Instead, districts pay their employees' medical claims using the premiums they collect

throughout the year. However, to protect their healthcare funds from large, catastrophic claims, self-insured districts often purchase additional catastrophic insurance through an insurance provider. Although the additional coverage can be expensive, self-insured plans are typically cheaper than full-insured plans because they do not include profit margins for a provider.

The Alvarez & Marsal (A&M) Efficiency Study Concluded that School Districts Could Lower Insurance Costs by $80 Million Annually by Consolidating K-12 Health Insurance

For the 2016 Legislative Session, the Legislature commissioned Alvarez & Marsal (A&M)—a consulting firm based in New York—to conduct an efficiency review of Kansas government. Their final report was completed and presented to the Legislature in February 2016. Among other things, that study found that operational efficiencies and savings could be achieved by consolidating K-12 health insurance statewide.

A&M's February 2016 efficiency study recommended the state consider a consolidated K-12 health insurance plan. A&M's recommendation was based on an analysis of 15,500 (or about 22%) of the state's 69,000 school district employees. A&M's savings estimate assumed that districts' current employer contributions would stay the same, that K-12 employees would be placed in their own risk pool, and that all school districts would be required to participate in consolidation. A&M also recommended the state conduct a more thorough actuarial analysis to develop refined cost and savings estimates. Our work with KDHE's actuary on this audit helps fulfill that recommendation.

A&M estimated approximately $80 million in annual savings from consolidating K-12 health insurance plans. This savings estimate did not include specific details about the effect of a consolidated plan on coverage levels or on individual school districts. However, A&M's savings estimate did include a one-time cost of $500,000 to perform an actuarial study of existing K-12 plans. It also included an estimate of up to $750,000 a year in ongoing costs to administer the plan through the SEHP. The actuary's estimates presented in this report do not include these potential additional costs.

Requirements Under the Federal Affordable Care Act (ACA) Could Affect Consolidated K-12 Health Insurance

Passed in 2010, the Affordable Care Act (ACA) established numerous requirements related to health insurance coverage. We identified some requirements under the ACA that are relevant to this audit because they would affect changes to K-12 insurance. Those requirements are summarized below. Note, any changes made to the ACA in the coming years could affect the requirements discussed in this section.

Under the ACA, employers with 50 or more full time equivalent (FTE) employees must provide health insurance coverage. Based on staffing reports compiled by the Kansas Department of Education, 228 of the state's 286 school districts had 50 or more FTE for the 2014-15 school year. However, these numbers should be seen as an approximation of how many districts fall under the ACA requirement due to potential differences in how FTE are counted at the state and federal levels. Additionally, these employers must offer health insurance to at least 95% of all employees. Failure to meet these requirements could result in a financial penalty against a district.

The ACA also sets several requirements on health insurance premiums and establishes minimum coverage levels. Our review of the ACA found several other requirements that could be applicable to healthcare offered to school district employees. These requirements included:

- Employers must cover employees' preventive care in full.
- Employers must provide health insurance that can, on average, cover at least 60% of employee's annual medical costs.
- A health insurance plan cannot have annual or lifetime benefit limits.
- Individuals cannot be denied health insurance because of a preexisting health condition.
- Dependent children under 26 years old must be allowed to remain on their parents' healthcare plan.
- Employees cannot be charged more than 9.5% of their gross household income for individual health insurance.

Although this is not an exhaustive list of ACA requirements, it highlights the requirements important to consider when deciding whether to consolidate K-12 health insurance statewide.

Some Kansas school districts currently have "grandfathered plans" which are exempt from some ACA requirements. Districts that had health plans before the Affordable Care Act went into effect (March 23, 2010) can keep those plans under a 'grandfathered status', meaning those districts are not subject to several requirements of the ACA. Not participating in these requirements often saves districts money on health insurance. For example, districts with a grandfathered status are not required to cover employees' preventive care in full. Districts can keep their grandfathered status as long as they do not substantially change the benefits or costs associated with their plans. A move to a consolidated state plan would likely constitute a substantial change, removing those districts' grandfathered status. The actuarial analysis in question one takes this into account.

Question 1: How Much Could the State Save by Consolidating K-12 Health Insurance, and How Would it Affect Districts' Current Coverage Levels?

Depending on the plan design, consolidating K-12 health insurance plans for the 101 districts in our sample could save an estimated $63 million a year (p. 9). *Specifically, consolidation would generate an estimated $38 million in annual savings through increased plan efficiencies (p. 10). Additionally, consolidation would also generate $25 million a year in savings for districts by shifting costs to employees (p. 13). We found that KDHE's actuarial savings estimate is based on more data and better assumptions than savings estimates previously reported by both A&M and LPA (p. 17). Also, we found that joining a pool administered by and modeled after the SEHP is just one option available to consolidate K-12 health insurance in the state (p. 18). Finally, any savings from consolidation would be realized by school districts unless a mechanism is developed to transfer them to the state (p. 19).*

Depending on the Plan Design, Consolidating K-12 Health Insurance Plans for the 101 Districts in Our Sample Could Save an Estimated $63 Million a Year

Under a memorandum of understanding, we worked with the Kansas Department of Health and Environment (KDHE) and its actuary at Segal Consulting to develop a detailed savings estimate associated with consolidating K-12 health insurance plans statewide.

We collected and assessed the reliability of healthcare data for a sample of 101 of the state's 286 school districts on behalf of KDHE's actuary. We selected a judgmental sample of 29 districts that were among the top spending districts on healthcare in the state, as they would likely have the greatest impact on consolidation. We also selected 72 other districts associated with the Southeast Kansas Education Service Center (Greenbush) and the Education Services and Staff Development Association of Central Kansas (ESSDACK). In total, these 101 districts represented 73% of districts' health insurance expenditures on premiums statewide during the 2014-15 school year. More information on group risk pools can be found on page 6 of the Overview. ***Appendix D*** contains a list of all 101 districts sampled.

We worked with the actuary to understand what data they needed to conduct their analysis. We then worked with the school districts and service centers to collect benefit, enrollment, and claims data for our sample of 101 districts and performed extensive analytical test work to ensure its reliability.

KDHE's actuary used our data to estimate the savings associated with 101 districts joining a pool modeled after and administered by the State Employee Health Plan. The actuary

used the minimum value calculator developed by the U.S. Department of Health and Human Services to model the actuarial values for the health insurance plans we submitted. He then used those values and other district level data to estimate the savings associated with the 101 districts in our sample joining a plan modeled after and administered by the State Employee Health Plan (SEHP).

The actuary used the school district pool of the SEHP as the baseline for his cost savings estimates. Currently, districts that join the SEHP must join a pool separate from all other state employees. The plan options, coverage levels, and employer contribution rates are the same for both pools administered by the SEHP. The actuary used the school district pool as the baseline of his analysis because it provided the best approximation of what a consolidated K-12 plan might look like.

The actuary estimated consolidating K-12 health insurance could save the 101 districts in our sample a total of $63 million a year. The complete results of the actuary's analysis can be found in ***Appendix B***. In general, the actuarial analysis showed that consolidating K-12 health insurance could save the 101 districts in our sample about $63 million a year. Of that total, the actuary concluded that $38 million was associated with increased plan efficiencies while the remaining $25 million was associated with shifting costs onto district employees. Additionally, the $25 million estimate is highly contingent on the plan design chosen for consolidation.

These estimates are somewhat less than what A&M estimated in their efficiency study. It is important to note that unlike A&M, this savings estimate is not projected across all 286 districts in the state. Rather, this estimate is based on a sample of 101 of the state's school districts. Additional differences between our methodology and A&M's methodology are discussed on page 17.

Consolidation Would Generate an Estimated $38 Million in Annual Savings Through Increased Plan Efficiencies

Consolidating K-12 health insurance statewide could make the plans more efficient by reducing administrative costs and eliminating the need for catastrophic coverage. These administrative efficiencies are based on creating a larger group pool and would not directly affect employee benefits.

- **Consolidating health insurance coverage would reduce the total administrative fees paid by districts.** Districts pay various administrative and network access fees as part of their premiums. These fees pay providers for access to their medical networks, for administering the health care plan, and for other healthcare services. One large consolidated group would likely pay lower administrative fees than individual districts would pay in total.

- **Consolidating health insurance coverage would also eliminate the need for catastrophic claims insurance, resulting in additional savings.** Self-insured districts pay for their employee's medical claims. Occasionally, an employee may have a catastrophic claim that is too expensive for the district to cover. To protect themselves against this possibility, many self-insured districts purchase additional catastrophic claim insurance. Catastrophic insurance pays 100% of a claim past an agreed upon limit. Although it lowers a district's risk, catastrophic claim insurance can be extremely expensive because it must cover the increased risk assumed by the provider.

  Extremely large self-insured plans do not need to purchase catastrophic insurance. That is because very large plans typically have enough funds in reserve to cover catastrophic claims. The actuary concluded that a consolidated group of K-12 districts would be sufficiently large to no longer need catastrophic claim insurance, resulting in significant savings for several districts in our sample. Specifically, the actuary estimated that 35% of districts' catastrophic insurance premiums were associated with administrative fees and could be eliminated under consolidation. The actuary assumed the remaining 65% was associated with actual claims and would remain a cost under consolidation. The actuary's methodology is described in more detail in ***Appendix B***.

Savings achieved through plan efficiencies have little impact on employee benefits because they are the result of better economies of scale and reduced risk from joining a large, consolidated pool. However, consolidation also requires districts to switch health insurance plans. For many districts, switching plans will affect their employee's benefits and create additional costs for either the district or the employees. These issues are explained more fully on pages 13 to 17.

Consolidating K-12 health insurance into a pool administered by the SEHP would create an estimated $38 million in annual savings through increased plan efficiencies for our sample of districts. Consolidation eliminates the need for districts to purchase catastrophic claim insurance. It also reduces the amount districts pay providers in administration fees through increased economies of scale. KDHE's actuary estimated the 101 districts in our sample would pay about $38 million less in health insurance costs because of these efficiencies. ***Figure 1-1*** on the next page shows how much each district could save through increased efficiencies under a consolidated K-12 plan. As the figure shows, all sampled districts achieved at least some savings from increased plan efficiency. However, district size, employee demographics, and the design of their current plans resulted in some districts saving more than others.

Figure 1-1
Summary of District Savings Through Consolidating K-12 Health Insurance to a Plan Modeled After the SEHP for a sample 101 School Districts as of 2017

District or Group Name	Number of Enrolled Employees	Savings from Increased Efficiencies	District Savings from Cost Shifts to Employees		Total Net Savings to Districts
			Reduced Employee Coverage (a)	Reduced Employer Contributions (a)	
Individual Districts					
Topeka	2,399	**$2,891,000**	$991,000	($170,000)	**$3,712,000**
Kansas City	3,314	**$2,297,000**	$1,577,000	($5,249,000)	**($1,375,000)**
Wichita	6,114	**$2,219,000**	$3,616,000	$20,278,000	**$26,113,000**
Olathe	3,490	**$2,126,000**	$3,148,000	($3,357,000)	**$1,917,000**
Shawnee Mission	3,024	**$1,884,000**	$3,129,000	($1,162,000)	**$3,851,000**
Lawrence	1,694	**$1,868,000**	$185,000	$1,946,000	**$3,999,000**
Blue Valley	2,939	**$1,809,000**	$2,320,000	($1,809,000)	**$2,320,000**
Salina	1,162	**$1,717,000**	$1,276,000	($806,000)	**$2,187,000**
Dodge City	551	**$1,343,000**	$122,000	$387,000	**$1,852,000**
Garden City	1,079	**$1,283,000**	$962,000	$783,000	**$3,028,000**
Geary	742	**$1,082,000**	$228,000	($4,000)	**$1,306,000**
Emporia	558	**$793,000**	$119,000	($645,000)	**$267,000**
Hutchinson	512	**$726,000**	$364,000	($164,000)	**$926,000**
Haysville	467	**$724,000**	$276,000	($312,000)	**$688,000**
Auburn-Washburn	679	**$708,000**	($351,000)	($269,000)	**$88,000**
Liberal	453	**$691,000**	$259,000	($499,000)	**$451,000**
Gardner Edgerton	642	**$620,000**	$255,000	$395,000	**$1,270,000**
Derby	591	**$616,000**	($111,000)	($358,000)	**$147,000**
DeSoto	727	**$574,000**	($205,000)	($434,000)	**($65,000)**
Winfield	480	**$543,000**	$49,000	($174,000)	**$418,000**
Newton	433	**$530,000**	$116,000	($178,000)	**$468,000**
Spring Hill	285	**$497,000**	$110,000	$130,000	**$737,000**
Turner	410	**$492,000**	$93,000	($747,000)	**($162,000)**
Lansing	222	**$400,000**	$80,000	($46,000)	**$434,000**
Hugoton	157	**$272,000**	$137,000	$51,000	**$460,000**
Great Bend	365	**$261,000**	$269,000	$35,000	**$565,000**
Paola	259	**$250,000**	$162,000	($286,000)	**$126,000**
Russell	128	**$196,000**	$53,000	$203,000	**$452,000**
Beloit	145	**$189,000**	$101,000	($29,000)	**$261,000**
Group Pools					
Greenbush (38 districts)	3,399	**$5,750,000**	$3,170,000	($4,047,000)	**$4,873,000**
ESSDACK (34 districts)	2,370	**$2,597,000**	$1,443,000	($2,326,000)	**$1,714,000**
Total	**39,790**	**$ 37,948,000**	**$ 23,943,000**	**$ 1,137,000**	**$ 63,028,000**

(a) A negative value represents a cost increase for districts.
(b) The Greenbush and ESSDACK groups represent a total of 72 school districts. However, savings from consolidating these districts is shown at the group level because of how plans in those groups are constructed.
Source: Audited cost savings estimates from KDHE's actuarial analysis of savings associated with K-12 health insurance consolidation.

There would still be significant efficiency savings even if some school districts did not join a consolidated plan administered by the SEHP. According to KDHE's actuary, each district individually contributes to the $38 million in efficiency savings. Consequently, efficiency savings would not be eliminated entirely if some districts did not join a consolidated plan. Rather, efficiency savings would only be reduced by the amount shown in ***Figure 1-1*** for the districts that do not join. Although not every district needs to join, several districts would need to consolidate their health insurance to create a pool large enough to avoid the need for catastrophic claims insurance.

Consolidation Would Also Generate $25 Million a Year in Savings for Districts by Shifting Costs to Employees

Having districts join a consolidated plan creates significant opportunities for savings through increased plan efficiency which would likely have little effect on employees. However, consolidation may also result in changes to coverage levels or employee contribution rates. These changes can shift healthcare costs from the district onto its employees or vice versa.

A consolidated plan that reduces coverage would achieve some savings by shifting costs to employees. Health insurance pays a portion of a person's medical costs. Coverage is a term used to describe how much of those costs a plan will pay. Generally, the greater the coverage, the more the plan will pay. A plan's coverage is determined through the following health insurance mechanisms:

- Deductible – The amount of money an employee must pay each year to cover medical expenses before the health insurance policy starts paying.
- Coinsurance – The amount an employee is required to pay for medical care after they have met their deductible.
- Co-payment – A flat fee an employee pays every time he or she receives medical service.
- Out-of-Pocket Maximum – The cap on how much an employee will pay in a given year for health insurance through deductibles, coinsurance, and co-payments.

Plans with low deductibles, low coinsurance, low co-payment rates, and low out-of-pocket maximums are typically considered high-coverage plans. Although high-coverage plans pay more medical costs, they typically have more expensive premiums. That is because premiums are designed to recoup the medical costs paid under a given plan. Every year, providers and districts calculate how much they think their plans will pay in medical costs and adjust premiums to ensure they will have enough to pay for those claims.

Regardless of whether districts consolidate, switching to a plan with lower coverage reduces monthly premiums, but increases the amount employees will pay for medical services. Based on the actuarial analysis, it is likely that the plans offered under consolidation would have lower coverage than what some districts currently offer. Because most districts pay the majority share of insurance premiums, they are likely to realize most of the savings from less expensive premiums. Conversely, employees would realize only modest savings from less expensive premiums but significant cost increases from paying a greater share of their medical claims.

Similarly, a consolidated plan that increases the employees' share of the insurance premiums would achieve savings by shifting costs to the employees. Employers pay a share of insurance premiums as a benefit to their employees. The share paid by the employer is known as an employer contribution rate, and is often expressed as a percentage. For example, an 80% employer contribution rate means the employer pays 80% of an insurance premium, while the employee pays the remaining 20%. In some cases, the employer contribution rate is agreed to as part of the collective bargaining process between a district and its employees.

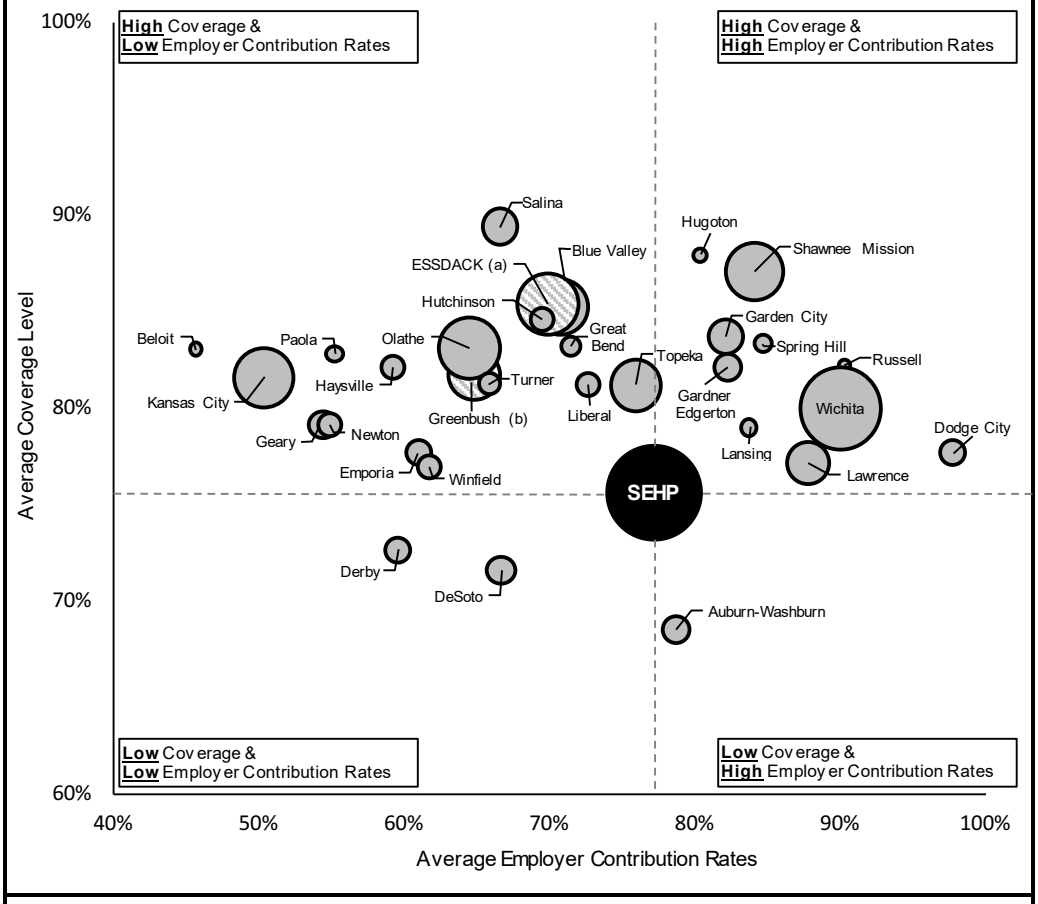
Under a consolidated plan, the state could require all districts to contribute the same amount toward their insurance premiums. For some districts, this rate may be less than what they currently contribute. Although this would reduce district expenditures, it would also increase the share of the premium paid for by employees. Other districts may see the opposite effect.

Consolidating K-12 health insurance to a plan modeled after the SEHP would reduce coverage for most of the districts in our sample, reducing costs by a total of about $24 million a year. Consolidation could result in changes to employee coverage levels, shifting healthcare costs from the district onto its employees or vice versa. We examined how consolidating K-12 insurance to a plan modeled after the SEHP would affect current coverage for the 101 districts in our sample. The results of that analysis are described below.

- **On average, the current health insurance plans for the districts in our sample covered about 81% of employees' medical costs.** Health insurance coverage is commonly expressed as a percentage. This percentage is an indication of how much of an employee's medical costs a plan will pay. For example, a plan with a 75% coverage rate will pay for 75% of an average employee's medical costs each year while the employee would be responsible for paying the remaining 25%.

KDHE's actuary calculated the coverage level for each plan offered by our sample of 101 districts. We used those numbers to calculate an average coverage rate for each district under their current plans. ***Figure 1-2*** below shows the average coverage levels for each district in our sample along the vertical axis. As the figure shows, current coverage levels vary significantly from district to district. The average coverage rate for our sampled districts ranged from 69% to 89% and the average coverage rate across all sampled districts was 81%.

Figure 1-2
Comparison of Current Coverage Levels and Employer Contribution Rates for a Sample of 101 Districts to the State Employee Health Plan as of 2017



(a) The ESSDACK group pool represents 38 school districts
(b) The Greenbush group pool represents 34 school districts
Source: LPA analysis of how district coverage levels and contribution rates would be affected by consolidating under the school district pool within the State Employee Health Plan.

- **Consolidating districts' health insurance into a plan modeled after the SEHP would reduce health insurance coverage for 98 of the 101 districts sampled.** As ***Figure 1-2*** above shows, the SEHP has an average coverage level of 76%, which was lower than the average coverage for 98 of the 101 sampled districts. On average, these districts would see a 6% reduction in coverage levels by joining this type of plan, with some districts losing between 10% to 14%. The three remaining districts would see an increase in coverage levels.

- **Reducing coverage accounts for about $24 million of the estimated savings.** Joining a plan like the SEHP would reduce healthcare coverage for most sampled districts. This means employees in those districts would be responsible for a greater share of their medical costs each year. As ***Figure 1-1*** on page 12 shows, the actuary estimated that joining this type of plan would save districts a net total of about $24 million by shifting more healthcare costs to their employees.

Consolidating K-12 health insurance to a plan modeled after the SEHP would also increase the employees' share of premiums in Wichita and other districts, further reducing district costs by about $1 million a year. Consolidation could result in changes to employer contribution levels, potentially shifting premium costs from the district onto its employees or vice versa. We examined how consolidating K-12 insurance to a plan modeled after the SEHP would affect current employer contribution rates for the 101 districts in our sample. The results of that analysis are described below.

- **The average employer contribution rate for the districts in our sample was 71% of insurance premiums.** KDHE's actuary provided us with an average contribution rate for each plan offered by our sample of districts and group pools. Because most districts offer multiple plans, we needed to calculate an average contribution rate across plans in order to make a district-to-district comparison. In general, these averages are meant to be a general indicator of the contribution rates for the districts in our sample, though the actual rates may vary slightly.

  Figure 1-2 on the previous page shows the average employer contribution rates for our sample districts along the horizontal axis of the graph. As the figure shows, districts in our sample paid anywhere from 46% to 98% of health insurance premiums. On average, we found that districts paid about 71% of the premiums, with employees responsible for the remaining 29%.

- **On average, joining a plan like the SEHP would increase employer contribution rates for 90 of the 101 sampled districts (89%), shifting about $22 million in premiums from employees to districts.** On average, the state's plan pays about 77% of insurance premiums. As ***Figure 1-2*** on the previous page shows, 18 of the individual districts sampled contributed less toward their employees' premiums than the state's plan. Additionally, the average contribution rates for the ESSDACK and Greenbush groups—representing a total of 72 districts—were also less than the state's plan. If these districts joined this type of plan they would pay anywhere between 1% to 32% more of the insurance premiums each month. KDHE's actuary estimated this would shift about $22 million in premiums from employees to districts each year.

- **Joining a plan like the SEHP would decrease employer contribution rates for Wichita and 10 other sampled districts (11%), shifting about $23 million in premiums from districts to employees.** As ***Figure 1-2*** on the previous page shows, 11 of the

districts sampled contributed more toward employee premiums than the state's plan. If those 11 districts joined this type of plan, they would pay between 2% to 21% less of the insurance premiums each month. KDHE's actuary estimated this would shift about $23 million in premium costs from districts to employees each year.

Wichita accounts for about 89% of the total cost shift related to increasing employee's share of premiums. As **Figure *1-1*** on page 12 shows, paying an employer contribution rate similar to the SEHP would reduce Wichita school district costs by about $20 million a year. That is because, on average, Wichita currently covers a very large share (90%) of its employee's health insurance premiums. Moving to the SEHP rate of 77% would significantly reduce Wichita's cost and require its employees to cover the remainder. If Wichita did not participate in this plan, the net savings achieved through changes in employer contribution rates would shift from a $1 million savings to a $19 million cost increase for the plan.

KDHE's Actuarial Savings Estimate is Based on More Data and Better Assumptions than Savings Estimates Previously Reported by Both A&M and LPA

The Alvarez and Marsal (A&M) efficiency study relied on less information and different assumptions than the analysis performed by the KDHE actuary. In total, A&M identified $80 million in mostly efficiency savings associated with consolidating K-12 health insurance. Similarly, KDHE's actuary identified $63 million in total savings associated with consolidation. However, only $38 million of the actuary's total estimate was associated with efficiency savings. The remaining $25 million was associated with shifting costs to district employees. Several other factors help explain the differences between the estimate created by the KDHE actuary and the estimate reported by A&M.

- A&M based their estimate on a sample of 15,500 district employees whereas the KDHE actuary's sample included almost 40,000.
- A&M assumed its sample was representative of all districts in the state and projected their savings accordingly whereas the actuary's savings estimate is specific to the 101 sampled districts.
- A&M's estimate assumed that all district employees would join a high-deductible health plan whereas the KDHE actuary assumed a blend of standard and high-deductible health plans within the SEHP.
- A&M's estimate included a one-time cost of $500,000 to perform an actuarial study of existing K-12 plans to develop a refined cost and savings estimate. It also included an estimate of up to $750,000 a year in ongoing costs to administer the plan through the SEHP. The actuary's estimates presented in this report does not account for these potential costs.

Our 2010 audit of K-12 health insurance concluded that only a few school districts would benefit from joining a single statewide pool, but several important factors limited that analysis. For example, sparse and often unreliable claims information, far less detailed coverage information, and a much smaller sample of districts limited our 2010 analysis. Moreover, because we did not have the assistance of a professional actuary, our 2010 audit methodology was unable to estimate savings resulting from a consolidated pool. Savings we could not estimate in 2010 included lower administrative fees associated with a consolidated insurance pool and savings achieved by eliminating unnecessary coverage for catastrophic claims. We are confident that the much more robust data we collected as part of this audit, as well as the actuarial model used to estimate savings, provides a much better estimate of potential savings than those we identified in 2010.

OTHER FINDINGS

Joining a Pool Administered by and Modeled After the SEHP is Just One Option Available to Consolidate K-12 Health Insurance in the State

The full actuarial analysis conducted by KDHE's actuary is included as ***Appendix B*** of this report. In it, KDHE's actuary recommended consolidating the state's district-level plans into the current school district pool of the State Employee Health Plan. As mentioned above, the actuary used the State Employee Health Plan as the baseline of his analysis because it provided the best approximation of what a consolidated K-12 plan might look like.

School districts could save a total of $63 million a year ($38 million through efficiencies and $25 million through cost shifts) by consolidating under a pool administered by and modeled after the SEHP. The SEHP already has a separate pool designated for school districts. If districts were to join that pool within the current SEHP, they would achieve savings in two ways. First, districts could save an estimated $38 million a year associated with increased efficiencies (lower administrative costs and reduced catastrophic claim coverage). Additionally, districts could save an estimated $25 million a year by offering plans modeled after the SEHP. Although this is the option recommended in the analysis by KDHE's actuary, this additional $25 million is gained by shifting costs to school district employees and not through increased efficiency.

School districts could still achieve $38 million in savings through increased efficiencies by consolidating under a pool administered by the SEHP but modeled after a different set of plans. This option would require the state to develop a separate set of plans under the SEHP specifically for school districts. Depending on how those plans are designed, districts may be able to consolidate under a plan with similar or better coverage than

they currently offer. Districts would still achieve significant efficiency savings under this option because the plans would still be administered by the SEHP. However, consolidating to plans with higher coverage or employer contribution rates than the SEHP would likely reduce or could even eliminate the additional $25 million in savings associated with cost shifts to district employees. It is also possible that joining a plan with significantly higher coverage or employer contribution rates could significantly increase health insurance costs for some districts.

Any Savings from Consolidation Would be Realized by School Districts Unless a Mechanism Is Developed to Transfer Them to the State

Consolidating 101 districts' health insurance under a plan similar to the SEHP would generate about $63 million in net savings across the 101 districts sampled. To achieve these savings, health insurance costs at most of the districts sampled were reduced. However, as ***Figure 1-1*** on page 12 shows, three districts in our sample saw a net cost increase associated with joining a plan modeled after the SEHP. Currently, any savings or costs resulting from consolidation would be realized at the district level, and not the state level.

If the Legislature intends for the state budget to benefit from savings achieved through K-12 health insurance consolidation, it would need to develop a mechanism to transfer those savings from districts to the state. Depending on the mechanism chosen, the state may also become responsible for any additional costs from consolidation. Options for how savings from consolidation could be transferred to the state are provided in question two of the report on page 21.

Question 2: What Options Would the State Have in Structuring a Consolidated K-12 Health Insurance Plan?

The Legislature has several decisions to make regarding the implementation and savings associated with consolidating K-12 health insurance statewide. *Specifically, the Legislature would need to decide whether the state or school districts keep the potential savings from consolidation (p. 21). Additionally, the Legislature would also need to make several key decisions that could affect how much is saved through consolidation (p. 22). We also noted that the time needed to implement a consolidated K-12 health insurance plan and several other factors will make it difficult for the state to achieve the savings outlined in the Governor's Fiscal Year 2018 Budget (p. 25). Finally, we identified two other issues that should be considered if the Legislature decides to consolidate K-12 health insurance (p. 26).*

The Legislature Would Need to Decide Whether the State or School Districts Keep the Potential Savings from Consolidation

As noted in question one, districts and not the state will recover savings achieved through consolidation of K-12 health insurance unless the Legislature acts to recoup those savings. How savings should be handled is clearly a policy decision and not ours to make. Nonetheless, we wanted to provide legislators with some of the potential options to handle the savings, and the effects those options would have on the state and districts if a consolidated plan is implemented.

The Legislature could allow districts to keep any savings realized through consolidation as a form of additional funding. In this scenario, the districts would still administer and pay for their employees' health insurance. Any savings realized through consolidation would remain with the individual districts and they would choose how best to apply any savings within their budgets. The state could consider the savings a form of additional funding for school districts. Kansas State Department of Education (KSDE) officials told us this is their preferred option, and that it would help incentivize districts to join the consolidated pool. However, under this option districts would be responsible for any additional costs associated with consolidation.

The Legislature could recoup any savings realized through consolidation by reducing school district funding by the actuarially estimated saving amounts. This is a simple and somewhat blunt method of reallocating savings from school districts back to the state. Moreover, because of the large number of variables involved in the savings calculations and the complex nature of health insurance in general, any savings estimate is

almost certain to vary under different conditions. Although the savings estimates included in this report provide a good approximation of the savings that might be achieved through consolidation, they are probably less reliable as a budgetary tool. Additionally, districts would remain responsible for any additional costs associated with consolidation under this option.

Alternatively, the Legislature could allow the state to administer and pay for all K-12 health insurance and reduce district funding by the entire cost of coverage. Under this option, school districts would no longer pay for health insurance out of their budgets. Instead, the state would be responsible for administering and paying districts' share of health insurance premiums and district funding would be reduced accordingly. This would ensure that the state would realize all the savings achieved through consolidation. However, it would also mean that the state would become solely responsible for funding any increases in healthcare costs for district employees.

The Legislature Would Also Need to Make Several Key Decisions That Could Affect How Much is Saved Through Consolidation

We used a 2015 state of Washington study to identify other states that have consolidated K-12 health insurance. We researched consolidation in Nebraska, New Jersey, Oregon, and Texas and contacted state officials from those states when possible to determine how they approached important plan design and implementation decisions. ***Figure 2-1*** on the next page summarizes the results of our research.

The Legislature would need to decide whether all districts would be required to participate, or if some districts could opt out of consolidation. In talking to other state officials and through our research we found that:

- **Requiring mandatory participation maximizes state savings but could negatively affect some districts.** Not all districts would have to join a consolidated pool to generate savings, but fewer participating districts will result in fewer savings. Kansas Department of Health and Environment (KDHE) officials told us that many districts do not want to join the state's plan because they already have good coverage or cannot pay the required employer share of premiums that Kansas law requires for the state plan. Kansas Association of School Boards (KASB) and ESSDACK officials also expressed similar concerns. Additionally, the Kansas National Education Association (KNEA) and Greenbush officials told us some districts use the quality of their health insurance plans to help recruit and retain employees. Requiring mandatory participation may affect their ability to attract and retain teachers if the consolidated plan is significantly worse than the one they currently offer.

Figure 2-1
Key Design and Implementation Factors in Other States with Consolidated K-12 Health Insurance Programs

State	Program	Year Est.	Mandatory Participation	Mandatory Employer Contribution	Number of Plans Offered	Types of Plans Offered (c)	Implementation Timeline
Nebraska	Educators Health Alliance	1967	**No**	**No**	7	PPOs and HDHPs with HSAs	Unknown
New Jersey (a)	New Jersey School Employees' Health Benefits Program	2007	**No**	**Yes** Employee contribution rates are set based on their salary and districts pay the remaining share of the premium.	20	PPOs, HMOs, and HDHPs	Unknown
Oregon	Oregon Educators Benefit Board (OEBB)	2007	**No** School districts can opt out, but must be able to show they can receive equal health insurance benefits from another source.	**No**	11	HMOs and PPOs	1.5 years
Texas	TRS-Active Care	2001	**Partially Mandatory** Only districts with fewer than 500 employees must join, but any district that joins (regardless of size) must remain in the plan.	**Yes** School districts are required to contribute a minimum of $150 per employee, per month and can pay more if they chose. (b)	6	PPOs, HMOs, and HDHP	1.5 years

(a) The information on New Jersey is based on a 2015 state of Washington report, and information from New Jersey government websites. We were unable to confirm the information with New Jersey officials.
(b) In Texas, the state also contributes a fixed rate of $75 per employee, per month.
(c) Preferred Provider Organization (PPO), High Deductible Health Plan (HDHP), Health Savings Account (HSA), Health Maintenance Organization (HMO)
Source: LPA summary of selected state consolidated K-12 health insurance programs.

- **None of the four states we reviewed required all districts to participate in their consolidated health insurance program.** Only Texas has any kind of participation requirement, which is that any district with less than 500 employees must participate in the consolidated plan. However, once a district joins the Texas pool,

they must stay in it. In Texas, nearly 90% of districts participated in the program. In Nebraska, Oregon, and New Jersey participation was optional. In Nebraska, all but four school districts participate. Officials in Oregon told us that only a small number of districts have opted out of their consolidated pool. We were unable to confirm district participation with officials in New Jersey.

The Legislature would also need to decide whether districts would have any discretion over their share of the insurance premiums. Currently, Kansas school districts decide how much they will contribute to help pay for employee health insurance premiums. Ultimately, the effect of a mandatory contribution rate will be decided by what that rate is and whether the state or districts are responsible for paying it.

- **A mandatory contribution rate could require some districts to pay less of their employees' premiums, saving districts money but reducing employee benefits.** In question one we saw that moving a sample of 101 districts to an employer contribution rate similar to the SEHP resulted in 11 districts paying less of their employees' health insurance premiums. This would save those districts money, but would do so by requiring district employees to pay a greater share of their monthly premiums. Additionally, KNEA and Greenbush officials told us that some districts use higher employer contribution rates to attract and retain teachers to their district. Requiring districts to lower this rate may make it more difficult for them to attract and retain teachers. Finally, KNEA officials told us that during contract negotiations employees at some districts gave up pay increases in favor of higher employer contributions toward their health insurance. A mandatory contribution rate could affect previous agreements made between districts and employees as part of their collective bargaining process.

- **Similarly, a mandatory contribution rate could require other districts to pay more of their employees' premiums, increasing districts' costs but improving employee benefits.** In question one we also saw that moving a sample of 101 districts to an employer contribution rate similar to the SEHP resulted in 90 districts paying more toward their employees' health insurance premiums. Although this would benefit district employees, KHDE officials told us it could be difficult for some districts to pay for the additional amount within their current budgets. However, if the state administered the consolidated plan, the state, not districts, would be responsible for any cost increases.

- **Only two of the states we reviewed had mandatory requirements on employer contribution rates.** Nebraska and Oregon allowed local districts to set their employer contribution rates individually. By contrast, Texas requires a minimum employer contribution of $150 per employee per month but allows districts to contribute more if they choose. In New Jersey, employee contribution amounts are set based on an employee's annual salary. The employer pays the remaining premium cost.

Finally, either the Legislature or KDHE officials would need to decide how many different plan options to offer. Consolidating K-12 health insurance does not require that districts are only offered one type of plan. For example, currently the State Employee Health Plan is consolidated for all state employees but offers employees two plan choices.

- **Offering multiple plans increases coverage variety and pricing options, but could adversely affect savings.** Currently each district chooses how many and what kind of plans to offer its employees. Under a consolidated K-12 health insurance plan like the one used in our model, districts would have to choose from the plan(s) the state decides to offer. More plan options under consolidation would allow districts to retain more control over the types of plans and variety of coverage they can offer their employees. However, offering a large variety of plans could affect savings, because employees could select plans that are more specific to their medical needs.

- **All four states we reviewed offered multiple plan types and options to their districts.** Nebraska offers 7 plan options and Oregon offers 11 plan options. These two states operate their plans like small healthcare exchange markets in which employers can decide which of the plans to offer their employees. Texas has 6 plans and New Jersey has 20 plan options, but it is unclear if these states require all districts in their programs to offer all plans to their employees. As ***Figure 2-1*** on page 23 shows, these four states offered a variety of plan types to their employees, including High Deductible Health Plans (HDHP), Preferred Provider Organizations (PPO), and Health Maintenance Organizations (HMO).

The Time Needed to Implement a Consolidated K-12 Health Insurance Plan and Several Other Factors Will Make It Difficult for the State to Achieve the Savings Outlined in the Governor's FY 2018 Budget

Consolidating K-12 health insurance across the state would likely be a long and complex process. Our review of other states found that it took about 18 months for Oregon and Texas to implement their consolidated K-12 health insurance models. The time required to implement a consolidated plan and several other factors will have a significant impact on how quickly savings can be achieved.

The Governor's budget assumed consolidating K-12 health insurance would generate $40 million in savings in fiscal year 2018, and $80 million in fiscal year 2019. These savings estimates are based on the results of A&M's efficiency study, not the results of KDHE's actuary's analysis. Although there are a number of variables that could influence when and how much savings could result from K-12 health care consolidation, the estimates in the Governor's Budget appear aggressive.

Based on the results of the actuary's analysis, those estimates appear high without significant cost shift to district employees. In total, KDHE's actuary identified $63 million in total savings

associated with consolidating K-12 health insurance under a plan similar to the SEHP. However, only $38 million of that total was associated with efficiency savings. The remaining $25 million was associated with shifting costs to district employees. Therefore, it seems unlikely the state could save $80 million a year without consolidating K-12 health insurance to a plan that shifts a significant amount of costs onto district employees.

The timeline proposed in the Governor's Budget to achieve these savings appears aggressive. The Governor's fiscal year 2018 budget shows the state realizing savings from consolidating K-12 health insurance in fiscal year 2018. This timeline appears aggressive for two reasons, discussed below.

- **Several factors will make it difficult for the state to fully implement a consolidated K-12 health insurance model quickly.** According to the state of Washington's 2015 study, time could be needed to establish contracts with vendors, select health insurance plans, educate K-12 employees on the available plans, and establish an administrative and operational infrastructure to handle the new participants. However, it is possible that utilizing the state's existing pool for district employees could help speed up some aspects of the implementation process. Finally, KDHE's actuary told us that premiums will also need to be set, which would require additional actuarial work and time.

- **Several factors will also make it difficult for school districts to achieve all potential savings from consolidation quickly.** Districts will need to allow their current employee health insurance contracts to expire. These contracts are based on health insurance plan years, which vary from district to district. Therefore, it may be some time before all districts can join a consolidated plan, which could delay savings. Also, self-insured districts will continue to pay claims from previous years, so it could take time before maximum potential savings are achieved. Consolidating before districts have a chance to address these issues could result in additional costs and consequences to school districts.

We Identified Two Other Issues That Should be Considered if the Legislature Decides to Consolidate K-12 Health Insurance

Self-insured districts would have to determine what to do with their existing reserve funds. Self-insured districts collect premiums from their employees and deposit those premiums into a district-operated fund to pay for employee medical claims. In years when claims are less than expected, districts can build up a reserve, which is used to protect against years when claims are more than expected. Districts will need to decide what to do with these funds under a consolidated model because eventually the funds would no longer be used to pay for claims. Although it would be difficult, KNEA officials told us it is possible to reimburse employees for the premiums they have already paid if districts decided to pursue that as an option.

The provider networks established under a consolidated K-12 health insurance system could require employees to switch medical professionals. KNEA officials told us that the provider networks offered under a new consolidated plan may not cover employees' current medical professionals. This means some employees would have to get medical services elsewhere. Switching to a new doctor could disrupt the medical care employees currently receive. Additionally, KNEA, KASB, and Greenbush officials expressed concern over the availability of medical professionals in rural parts of the state. Switching to a new health insurance provider may result in some employees in rural Kansas traveling significant distances to receive covered medical services. If the Legislature were to consolidate K-12 health insurance, it would need to keep in mind how changes in current provider network arrangements may affect employees.

Conclusion

The 2016 Alvarez & Marsal efficiency study, which was commissioned by the Legislature, recommended consolidating the health insurance plans for K-12 school districts into a single pool which could be administered by the state. Based on an analysis of a limited sample of school districts, A&M estimated consolidating all districts' health insurance would save approximately $80 million annually. The results of the analysis conducted by KDHE's actuary confirm that consolidating K-12 health insurance plans across the state does appear to have the potential to generate significant savings, including $38 million through increased plan efficiencies.

However, it is also important to consider how consolidation may affect the coverage levels and employer contribution rates of Kansas school districts. These vary substantially from district to district, and moving school districts into a consolidated pool is likely to create winners and losers.

Additionally, consolidating K-12 health insurance across the state would be an extremely complicated and complex process. Several important decisions will need to be made before consolidation is possible. If done correctly, it may be possible to both reduce K-12 health insurance costs statewide and provide a better, and more equitable health insurance to Kansas educators.

APPENDIX A
Agency Response

On January 27, 2017, we provided copies of the draft audit report to the Kansas State Department of Education, the Kansas Department of Health and Environment, the Kansas Insurance Commission, and Segal Consulting. These agencies were not required to submit a formal response because this audit did not have any agency recommendations. None of the four agencies chose to submit a formal response.

APPENDIX B
Segal Consulting's Actuarial Report and Savings Table

To develop a more sophisticated and accurate savings estimated related to health insurance savings achieved by consolidating existing K-12 school district plans, we worked collaboratively with Segal Consulting—an actuarial firm under contract with the Kansas Department for Health and Environment (KDHE). We developed a Memorandum of Understanding with KDHE under which we agreed to collect, clean, and provide school district health insurance and claims data to the consultants. KDHE agreed to pay for the actuarial analysis performed by Segal Consulting based on that information. A copy of the actuary's report and a table providing information on savings achieved by each plan included in our sample is included in this Appendix.

Although the results and conclusions included in this report should be attributed to Segal Consulting, we performed extensive test work to confirm the general reliability and accuracy of the results based on our knowledge of K-12 school district health plans and expenditures.

Segal Consulting

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MEMORANDUM

To: Group Insurance Board

From: Patrick Klein FSA, MAAA

Date: December 16, 2016

Re: K-12 Benefit Consolidation

Segal Consulting ("Segal") has conducted a financial analysis regarding the consolidation of benefits provision for state employees of Kansas's K-12 school districts. Currently, the school districts can participate in the State Employee Health Plan (SEHP), though most have their own district-level health plans. Consolidating these district-level plans into the SEHP will have a significant impact on the employees as well as the districts.

We estimate savings from three main areas: administrative and risk efficiencies, claims reductions, and employee/retiree contribution increases. For 2017, the estimated savings are as follows:

Admin/Risk Savings	Claims Savings	Employee Contribution Increases	Total Savings
$37,900,000	$23,900,000	$1,100,000	$62,900,000

These savings are derived by comparing the current health plans within the K-12 school districts to the State Baseline Plan. This plan was created by blending the two current State plans (Plan A and Plan C) with 75% weight on Plan A. The estimate stated above only represents the savings based on the plans submitted. Because some of the districts were not selected for the analysis the savings stated above could vary. There is an appendix to this memo illustrating the savings for each district's plan(s).

Project Background

Segal was retained by the State to conduct a full review of the recommendation made by Alvarez & Marsal in the Kansas Statewide Efficiency Review. In the report, they estimated the consolidation would result in annual savings of $80 million. Note that this savings estimate would have included all of the districts.

Initial Steps

The Legislative Division of Post Audit (LPA) selected the districts to be analyzed based on the volume of the employee cost share portion of the premium. The selected districts are responsible for 73% of the total employee premium from all districts. Segal worked with LPA to create a data request, which was then sent to the selected districts. The request included the following components:

- Plan Information – Plan Name, Network Name, and School District Name/Number
- Premiums – Total Premiums, Employee Premiums, Employer Premiums, and any Incentives/Surcharges
- Benefit Design – Deductible, Coinsurance, OOP Maximum, Inpatient Benefits, Outpatient Benefits, Physician Benefits, Prescription Drug Benefits, and any H.R.A/H.S.A. Plan Funding
- Enrollment – Employee Count by Plan Tier, Total Member Count, and Age/Sex Member Distribution
- Experience Detail –Annual Medical and Rx Claims, Large Claims Over a $50K Threshold, Administrative Fees, and Reinsurance Premiums

The data we received is a large subset of the data for the entire Kansas K-12 school system and includes 39,790 active employees and pre-Medicare retirees. We received and analyzed data from the following districts:

Auburn-Washburn	*Great Bend*	*Olathe*
Blue Valley	*Greenbush**	*Paola*
Dodge City	*Haysville*	*Russell*
Beloit	*Hugoton*	*Salina*
Derby	*Hutchinson*	*SMSD*
Desoto	*Kansas City*	*Spring Hill*
Emporia	*Lansing*	*Topeka*
*ESSDACK**	*Lawrence*	*Turner*
Garden City	*Liberal*	*Wichita*
Geary	*Newton*	*Winfield*

* *(Trust comprised of several districts that share a uniform benefits option)*

Using the Minimum Value Calculator that was developed by the Department of Health and Human Services (HHS), we modeled the actuarial values of the plans submitted by the districts. An actuarial value refers to the percentage the plan will pay for a standard population's health care expenses, while the enrollees themselves will pay the compliment through some combination of deductibles, copays, and coinsurance.

Cost Considerations

❖ Claims Savings

On average, the actuarial values of the district-level plans are higher than the actuarial value of the State Baseline Plan. Meaning, the district-level plans, and thereby the districts, are currently paying a higher percentage of their members' healthcare claims than what the districts would be paying if the members were covered under the State Baseline Plan. If the districts abandoned their district-level plans and moved their members to the State Baseline Plan, we estimate the annual claims savings to be $23.9 million.

While the districts would realize savings because the percentage of claims they pay would decrease by a certain amount, the percentage the employees and retirees pay out-of-pocket would increase by the same amount. Thus, the savings are being achieved through cost shifting.

❖ Administration and Profit Savings

For many districts the membership in the district-level plans is too small for the district-level plans to take on the risk of being self-insured; therefore, many of the district-level plans are fully insured. The districts pay premiums to insurance companies for administration services, risk, profit and premium taxes. Because smaller membership groups are riskier for the insurance companies to insure, the insurance premiums for these small-membership districts is much higher than if the membership group was larger.

Even the district-level plans that are self-insured have memberships that are still quite small compared to the membership in the State Baseline Plan. They purchase stop-loss reinsurance to mitigate the claims variability risk they face due to their small memberships. The reinsurance premiums they pay run at even higher margins than the fully insured premiums. In addition to the reinsurance premiums, they also must pay administrative fees to a third party administrator (TPA) or insurance carrier they hire to handle network access and claims processing. Due to economies of scale, these administrative fees are higher for plans with small memberships than for plans with large memberships.

If districts switched their members to the State Baseline Plan, the members would be added to a much larger member group, providing many cost-reducing benefits to the districts. The members would be covered under a self-insured plan, but because of the large member group, claims variability would decrease significantly, and there would be no need to purchase stop-loss reinsurance. As mentioned before, the administrative fees the districts pay to a TPA would decrease because the TPA would be managing a much larger group. Administrative costs would mirror the current fees paid by the State Baseline Plan. The aggregate savings for lower administrative fees and elimination of fully insured and reinsurance premiums is estimated to be $37.9 million. These savings do not result from cost shifting so they benefit the districts as well as the employees.

While the potential savings are not included in the figure above, it is important to note that adding more participants to SEHP could give the State more leverage to reduce the

administrative fees when renewing its contracts with the current medical and pharmacy vendors.

❖ Employee Contributions

Because the district-level plans all have fairly unique cost-sharing policies, employees pay a wide variety of contribution amounts. We compared the contributions the employees are currently paying to what they would pay under the State Baseline Plan. On average, the employee contribution was lower in district-level plans than under the State Baseline Plan. Meaning, if the members were moved to the State Baseline Plan, the members would be responsible for a larger share of the premiums, thereby creating savings for the districts. While it varies greatly depending on the district, overall we expect these savings to be $1.1 million annually. These savings are achieved through cost shifting.

Assumptions and Methodology

❖ Assumptions

- The analysis focusses on the active employees and pre-Medicare retirees included in the data provided by the districts.
- SEHP currently offers two benefit designs (Plan A and Plan C) with two different medical vendors (BCBS and UHC). Members are categorized under two different risk pools (State and Non-State).
  - We assumed members would be categorized in the Non-State risk pool when moving from the district-level plans to the State Baseline Plan.
  - BCBS has an overwhelming majority of membership, and 75% of all members are currently enrolled in Plan A. This lead us to assume that 75% of members moving out of the district-level plans would elect the 2017 BCBS Plan A when moving into the State Baseline Plan.
- We assumed the members moving into the State Baseline Plan would not receive any wellness contribution credits or additional account funding due to wellness currently offered under SEHP.
- We trended the historical benefit data provided by the districts to 2017 to get a better comparison to the State Baseline Plan's data. The trends we used are 6% for claims and fully insured premiums, 2% for administrative fees, and 15% for reinsurance premiums.
- We assumed an 80% loss ratio for fully insured premiums and a 65% loss ratio for reinsurance premiums. These assumptions were substantiated when reviewing the districts' submissions.
  - The fully insured district-level plans that reported the claims portion of the premium had loss ratios close to the assumption. Likewise, the self-insured district-level plans that

reported claims reimbursements from reinsurance also had loss ratios close to the assumption.

The key assumptions driving the savings estimates are the loss ratio and Plan A/Plan C election assumptions. The table below shows how the savings change as we change these key assumptions. It also provides perspective on the sensitivity of the assumptions selected.

Sensitivity Testing							
Scenarios	Enrollment	Fully Insured Loss Ratio	Reinsurance Loss Ratio	Savings (in millions)			
				Admin/Risk	Claims	EE Contrib. Increases	Total
Base Scenario	**75% A**	**80%**	**65%**	**$ 37.9**	**$ 23.9**	**$ 1.1**	**$ 62.9**
Scenario 1	100% A	Base	Base	$ 37.9	$ 27.5	$ 10.3	$ 75.7
Scenario 2	0% A	Base	Base	$ 37.9	$ 13.3	$ (26.2)	$ 25.0
Scenario 3	Base	90%	Base	$ 26.8	$ 24.7	$ 1.1	$ 52.6
Scenario 4	Base	70%	Base	$ 49.1	$ 23.1	$ 1.1	$ 73.3
Scenario 5	Base	Base	80%	$ 33.0	$ 23.9	$ 1.1	$ 58.0
Scenario 6	Base	Base	50%	$ 42.9	$ 23.9	$ 1.1	$ 67.9

❖ Methodology

- Claims Savings Calculation: We divided the actuarial value of each district-level plan by the blended State Baseline Plan's actuarial value of 75.6% to come up with the relative value of each district-level plan. We then multiplied the relative value by that district's 2017 expected paid claims amount if the plan was fully insured or by the district's reported claims if the plan was self-insured.
  - The expected paid claims amount for a fully insured plan was calculated as *Premium Rates * 80% Loss Ratio.*
  - In this calculation we trended claims and premiums to 2017.
- Administrative/Risk Savings Calculation: We calculated the difference between each district-level plan's expected administrative and risk costs and the 2017 administrative fee paid by the State Baseline Plan ($25.29 PEPM). We then multiplied the difference by the number of participating employees and pre-Medicare retirees in that district-level plan.
  - The expected administrative and risk costs for fully insured districts was calculated as *Premium Rate * (1- 80% Loss Ratio or 20%).* For the self-insured calculation, *Reported Admin Costs + Reinsurance Premium * (1- 65% Loss Ratio or 35%).*
  - For both calculations we trended the claims and premiums to 2017.

Contribution savings calculation: We calculated the difference between the current employee contributions for each district to the blended state plan's contributions. We compared the contribution at the tier level and assumed no tier migration.

Potential Problems

Consolidating the district-level plans into SEHP would significantly disrupt the districts' members. Members would be forced to navigate new benefit designs. If members were required

to change their insurance provider, their current doctors may not be included in the new provider's network. Additionally, many members may be required to pay a significantly different amount for their coverage under SEHP. For example, some districts allow active employees and pre-Medicare retirees to pay the same contributions, but SEHP does not provide a subsidy for retirees. Therefore, these retirees would see a sharp increase in their contributions. Also, several districts provide no or very little subsidy for the dependent tiers. Because SEHP provides subsidies to dependent tiers, making coverage more affordable for dependents, more employees may begin claiming dependents on their insurance.

Recommendation

We recommend consolidating the district-level plans into SEHP. Although the claims reductions and employee contribution increases create savings due to cost shifting, the administrative efficiencies create $37.9 million of real savings for the State. There is the potential that these savings will increase when districts not included in this analysis are consolidated into SEHP.

Kansas
Department of Health and Environment

APPENDIX

K-12 School District Benefit Consolidation

									SAVINGS		
District Name/Plan #	Employees	Tier Factor	AV	Premium PEPM	Claims PEPM	Admin+Profit PEPM	EE Contribution PEPM	EE Cost Share	ASO Profit	Claims Savings	EE Contribution
Blended Non-STATE (Baseline)	**8,122**	**1.66**	**75.6%**	**$ 1,038**	**$ 1,013**	**$ 25**	**$ 237**	**23%**			
Non-STATE PLAN A 2017	5,938	1.62	74.7%	$ 1,093	$ 1,068	$ 25	$ 258	24%			
Non-STATE PLAN C 2017	2,184	1.76	78.4%	$ 875	$ 850	$ 25	$ 174	20%			
DISTRICTS TOTAL	**39,790**	**1.35**	**81.9%**	**$ 760**	**$ 655**	**$ 105**	**$ 198**	**27%**	**$ 37,948,000**	**$ 23,943,000**	**$ 1,137,000**
Auburn-Washburn Plan 1	55	1.13	76.7%	$ 633	$ 507	$ 127	$ 205	32%	$ 67,000	$ 5,000	$ (67,000)
Auburn-Washburn Plan 2	184	1.16	76.7%	$ 710	$ 568	$ 142	$ 283	40%	$ 258,000	$ 17,000	$ (397,000)
Auburn-Washburn Plan 3	76	1.02	66.5%	$ 439	$ 351	$ 88	$ 11	2%	$ 57,000	$ (44,000)	$ 58,000
Auburn-Washburn Plan 4	365	1.14	63.6%	$ 498	$ 399	$ 100	$ 70	14%	$ 326,000	$ (329,000)	$ 137,000
Dodge City Plan 1	4	1.00	79.8%	$ 921	$ 693	$ 228	$ 932	101%	$ 10,000	$ 2,000	$ (32,000)
Dodge City Plan 2	17	1.00	78.7%	$ 921	$ 693	$ 228	$ 239	26%	$ 40,000	$ 5,000	$ (33,000)
Dodge City Plan 3	531	1.00	77.6%	$ 921	$ 693	$ 228	$ 7	1%	$ 1,293,000	$ 115,000	$ 452,000
Beloit Plan 1	145	1.83	83.1%	$ 780	$ 647	$ 134	$ 424	54%	$ 189,000	$ 101,000	$ (29,000)
Derby Plan 1	104	1.22	80.2%	$ 727	$ 581	$ 145	$ 421	58%	$ 149,000	$ 41,000	$ (240,000)
Derby Plan 2	41	1.13	75.8%	$ 605	$ 484	$ 121	$ 286	47%	$ 48,000	$ 1,000	$ (58,000)
Derby Plan 3	302	1.21	70.8%	$ 524	$ 419	$ 105	$ 194	37%	$ 288,000	$ (103,000)	$ (47,000)
Derby Plan 4	28	1.47	75.5%	$ 691	$ 553	$ 138	$ 416	60%	$ 37,000	$ -	$ (13,000)
Derby Plan 5	116	1.16	68.9%	$ 464	$ 371	$ 93	$ 122	26%	$ 94,000	$ (50,000)	$ -
Emporia Plan 1	310	1.55	81.0%	$ 774	$ 619	$ 155	$ 341	44%	$ 482,000	$ 153,000	$ (488,000)
Emporia Plan 2	206	1.46	76.3%	$ 692	$ 554	$ 138	$ 259	37%	$ 279,000	$ 13,000	$ (191,000)
Emporia Plan 3	43	1.18	60.0%	$ 438	$ 350	$ 88	$ 46	10%	$ 32,000	$ (47,000)	$ 34,000
ESSDACK Plan 1	780	1.42	87.0%	$ 815	$ 698	$ 117	$ 334	41%	$ 855,000	$ 853,000	$ (1,211,000)
ESSDACK Plan 2	978	1.42	80.6%	$ 815	$ 698	$ 117	$ 274	34%	$ 1,072,000	$ 510,000	$ (808,000)
ESSDACK Plan 3	612	1.42	76.8%	$ 815	$ 698	$ 117	$ 246	30%	$ 670,000	$ 80,000	$ (307,000)
Garden City Plan 1	555	1.51	87.1%	$ 902	$ 780	$ 123	$ 214	24%	$ 648,000	$ 685,000	$ 126,000
Garden City Plan 2	471	1.55	80.0%	$ 902	$ 780	$ 122	$ 110	12%	$ 546,000	$ 242,000	$ 529,000
Garden City Plan 3	54	1.63	81.3%	$ 943	$ 780	$ 164	$ 70	7%	$ 89,000	$ 35,000	$ 128,000
Gardner Edg Plan 1	424	1.23	79.7%	$ 594	$ 495	$ 99	$ 123	21%	$ 376,000	$ 130,000	$ 151,000
Gardner Edg Plan 2	20	1.15	83.4%	$ 883	$ 774	$ 109	$ 173	20%	$ 21,000	$ 18,000	$ (17,000)
Gardner Edg Plan 3	198	1.33	87.0%	$ 463	$ 344	$ 119	$ 52	11%	$ 223,000	$ 107,000	$ 261,000
Geary Plan 1	295	1.32	82.4%	$ 620	$ 496	$ 124	$ 261	42%	$ 349,000	$ 145,000	$ (69,000)
Geary Plan 2	377	2.05	78.9%	$ 863	$ 690	$ 173	$ 443	51%	$ 666,000	$ 128,000	$ 26,000
Geary Plan 3	70	1.33	67.0%	$ 525	$ 420	$ 105	$ 151	29%	$ 67,000	$ (45,000)	$ 39,000
Great Bend Plan 1	189	1.51	83.8%	$ 1,051	$ 959	$ 92	$ 314	30%	$ 152,000	$ 212,000	$ (27,000)
Great Bend Plan 2	176	1.20	82.6%	$ 399	$ 322	$ 77	$ 108	27%	$ 109,000	$ 57,000	$ 62,000
Greenbush Plan 1	917	1.40	93.4%	$ 938	$ 750	$ 188	$ 355	38%	$ 1,785,000	$ 1,570,000	$ (2,044,000)
Greenbush Plan 2	1,649	1.36	85.0%	$ 845	$ 676	$ 169	$ 265	31%	$ 2,842,000	$ 1,474,000	$ (2,038,000)
Greenbush Plan 3	834	1.25	77.4%	$ 688	$ 550	$ 138	$ 132	19%	$ 1,123,000	$ 126,000	$ 35,000
Haysville Plan 1	225	1.50	83.8%	$ 809	$ 647	$ 162	$ 353	44%	$ 368,000	$ 170,000	$ (232,000)
Haysville Plan 2	242	1.52	80.6%	$ 740	$ 592	$ 148	$ 282	38%	$ 356,000	$ 106,000	$ (80,000)
Kansas City Plan 1	583	1.11	86.7%	$ 1,023	$ 942	$ 81	$ 370	36%	$ 390,000	$ 844,000	$ (1,159,000)
Kansas City Plan 2	1,633	1.10	82.7%	$ 448	$ 366	$ 82	$ 312	70%	$ 1,118,000	$ 615,000	$ (3,766,000)
Kansas City Plan 3	811	1.13	78.0%	$ 616	$ 530	$ 86	$ 200	32%	$ 593,000	$ 159,000	$ (477,000)
Kansas City Plan 4	164	1.09	74.4%	$ 1,194	$ 1,115	$ 79	$ 132	11%	$ 106,000	$ (37,000)	$ 119,000
Kansas City Plan 5	123	1.11	75.3%	$ 821	$ 735	$ 86	$ 105	13%	$ 90,000	$ (4,000)	$ 34,000
Lansing Plan 1	15	1.29	83.9%	$ 1,033	$ 827	$ 207	$ 303	29%	$ 33,000	$ 15,000	$ (31,000)
Lansing Plan 2	52	1.19	80.0%	$ 843	$ 674	$ 169	$ 149	18%	$ 89,000	$ 23,000	$ (21,000)
Lansing Plan 3	155	1.25	78.2%	$ 873	$ 698	$ 175	$ 127	15%	$ 278,000	$ 42,000	$ 6,000
Liberal Plan 1	126	1.34	83.0%	$ 1,320	$ 1,167	$ 153	$ 475	36%	$ 192,000	$ 157,000	$ (383,000)
Liberal Plan 2	327	1.07	80.5%	$ 582	$ 429	$ 153	$ 140	24%	$ 499,000	$ 102,000	$ (116,000)
Newton Plan 1	154	1.29	82.8%	$ 652	$ 522	$ 130	$ 313	48%	$ 194,000	$ 83,000	$ (140,000)
Newton Plan 2	115	1.35	78.4%	$ 644	$ 515	$ 129	$ 305	47%	$ 142,000	$ 25,000	$ 10,000
Newton Plan 3	165	1.39	76.3%	$ 616	$ 493	$ 123	$ 252	41%	$ 194,000	$ 8,000	$ (48,000)
Paola Plan 1	31	1.24	87.7%	$ 1,262	$ 1,159	$ 103	$ 476	38%	$ 29,000	$ 59,000	$ (107,000)
Paola Plan 2	109	1.41	84.4%	$ 658	$ 545	$ 113	$ 430	65%	$ 115,000	$ 74,000	$ (283,000)
Paola Plan 3	119	1.22	80.1%	$ 459	$ 359	$ 99	$ 127	28%	$ 106,000	$ 29,000	$ 104,000

Kansas
Department of Health and Environment
Division of Health Care Finance

APPENDIX

K-12 School District Benefit Consolidation

									SAVINGS		
District Name/Plan #	**Employees**	**Tier Factor**	**AV**	**Premium PEPM**	**Claims PEPM**	**Admin+Profit PEPM**	**EE Contribution PEPM**	**EE Cost Share**	**ASO Profit**	**Claims Savings**	**EE Contribution**
Blended Non-STATE (Baseline)	**8,122**	**1.66**	**75.6%**	**$ 1,038**	**$ 1,013**	**$ 25**	**$ 237**	**23%**			
Non-STATE PLAN A 2017	5,938	1.62	74.7%	$ 1,093	$ 1,068	$ 25	$ 258	24%			
Non-STATE PLAN C 2017	2,184	1.76	78.4%	$ 875	$ 850	$ 25	$ 174	20%			
DISTRICTS TOTAL	**39,790**	**1.35**	**81.9%**	**$ 760**	**$ 655**	**$ 105**	**$ 198**	**27%**	**$ 37,948,000**	**$ 23,943,000**	**$ 1,137,000**
Russell Plan 1	128	1.32	82.2%	$ 583	$ 430	$ 153	$ 57	10%	$ 196,000	$ 53,000	$ 203,000
Salina Plan 1	1,162	1.38	89.4%	$ 742	$ 594	$ 148	$ 248	33%	$ 1,717,000	$ 1,276,000	$ (806,000)
SMSD Plan 1	418	1.11	83.4%	$ 303	$ 223	$ 79	$ (14)	-5%	$ 271,000	$ 105,000	$ 571,000
SMSD Plan 2	1,994	1.08	87.0%	$ 738	$ 661	$ 76	$ 145	20%	$ 1,224,000	$ 2,070,000	$ (1,280,000)
SMSD Plan 3	611	1.09	90.0%	$ 893	$ 815	$ 78	$ 157	18%	$ 389,000	$ 954,000	$ (453,000)
Topeka Plan 1	2,399	1.06	81.2%	$ 629	$ 503	$ 126	$ 151	24%	$ 2,891,000	$ 991,000	$ (170,000)
Turner Plan 1	67	1.07	84.4%	$ 548	$ 439	$ 110	$ 258	47%	$ 68,000	$ 37,000	$ (121,000)
Turner Plan 2	211	1.02	87.3%	$ 719	$ 596	$ 123	$ 288	40%	$ 248,000	$ 201,000	$ (465,000)
Turner Plan 3	133	1.11	70.0%	$ 1,270	$ 1,134	$ 136	$ 231	18%	$ 176,000	$ (145,000)	$ (161,000)
Winfield Plan 1	190	1.37	78.1%	$ 657	$ 526	$ 131	$ 302	46%	$ 242,000	$ 38,000	$ (123,000)
Winfield Plan 2	290	1.22	76.2%	$ 558	$ 447	$ 112	$ 186	33%	$ 301,000	$ 11,000	$ (51,000)
Lawrence Plan 1	1,531	1.12	76.7%	$ 588	$ 470	$ 118	$ 70	12%	$ 1,694,000	$ 121,000	$ 1,785,000
Lawrence Plan 2	163	1.15	81.5%	$ 570	$ 456	$ 114	$ 88	15%	$ 174,000	$ 64,000	$ 161,000
Hugoton Plan 1	157	1.26	87.9%	$ 690	$ 520	$ 170	$ 135	20%	$ 272,000	$ 137,000	$ 51,000
DeSoto Plan 1	97	1.07	73.9%	$ 333	$ 199	$ 133	$ 42	13%	$ 126,000	$ (5,000)	$ 63,000
DeSoto Plan 2	132	1.22	74.6%	$ 578	$ 520	$ 58	$ 173	30%	$ 52,000	$ (11,000)	$ (39,000)
DeSoto Plan 3	140	1.23	69.0%	$ 390	$ 259	$ 131	$ 152	39%	$ 177,000	$ (42,000)	$ (50,000)
DeSoto Plan 4	267	1.24	69.5%	$ 569	$ 490	$ 79	$ 225	40%	$ 171,000	$ (137,000)	$ (241,000)
DeSoto Plan 5	92	1.17	74.9%	$ 985	$ 916	$ 68	$ 329	33%	$ 48,000	$ (10,000)	$ (167,000)
Hutchingson Plan 1	214	1.25	80.1%	$ 744	$ 595	$ 149	$ 277	37%	$ 317,000	$ 86,000	$ (85,000)
Hutchingson Plan 2	298	1.31	87.9%	$ 698	$ 558	$ 140	$ 179	26%	$ 409,000	$ 278,000	$ (79,000)
Wichita Plan 1	6,114	1.84	80.0%	$ 957	$ 901	$ 56	$ 96	10%	$ 2,219,000	$ 3,616,000	$ 20,278,000
Spring Hill Plan 1	57	1.09	77.8%	$ 314	$ 153	$ 161	$ 40	13%	$ 92,000	$ 3,000	$ 38,000
Spring Hill Plan 2	168	1.10	83.9%	$ 636	$ 466	$ 170	$ 66	10%	$ 291,000	$ 92,000	$ 68,000
Spring Hill Plan 3	61	1.24	86.9%	$ 345	$ 162	$ 183	$ 109	32%	$ 114,000	$ 15,000	$ 24,000
Olathe Plan 1	484	1.29	84.7%	$ 908	$ 841	$ 67	$ 395	44%	$ 245,000	$ 523,000	$ (1,163,000)
Olathe Plan 2	134	1.32	76.7%	$ 777	$ 709	$ 68	$ 405	52%	$ 68,000	$ 16,000	$ (317,000)
Olathe Plan 3	2,315	1.42	84.6%	$ 946	$ 867	$ 78	$ 291	31%	$ 1,475,000	$ 2,555,000	$ (1,721,000)
Olathe Plan 4	558	1.34	77.0%	$ 530	$ 455	$ 76	$ 234	44%	$ 338,000	$ 54,000	$ (156,000)
Blue Valley Plan 1	1,078	1.28	91.1%	$ 591	$ 512	$ 79	$ 177	30%	$ 698,000	$ 1,122,000	$ (240,000)
Blue Valley Plan 2	1,232	1.19	80.0%	$ 623	$ 550	$ 74	$ 158	25%	$ 714,000	$ 444,000	$ (422,000)
Blue Valley Plan 3	93	1.20	83.0%	$ 834	$ 759	$ 75	$ 404	48%	$ 56,000	$ 75,000	$ (160,000)
Blue Valley Plan 4	536	1.28	86.0%	$ 954	$ 876	$ 78	$ 319	33%	$ 341,000	$ 679,000	$ (987,000)

APPENDIX C
List of Healthcare Terms

This appendix includes a list of terms used in describing health insurance costs, plans, and coverage used in this report and throughout the healthcare industry.

General Terms

Adverse Selection	An outcome that occurs when healthy employees choose less expensive health insurance (or no health insurance), leaving less healthy employees in the pool, driving up costs. For employers, this occurs when an employer with relatively healthier employees leaves a risk pool because that employer can get a better deal outside the pool. Likewise, it occurs when an employer with less healthy employees joins a pool because it is cheaper.
Benefit Package	The set of services, such as physician visits, hospitalizations, prescription drugs, that are covered by an insurance policy or health plan. The benefit package will specify any cost sharing requirements for services, limits on particular services, and annual or lifetime spending limits.
Broker	An agent or broker is a person or business who can help people and entities apply for coverage and enroll in a Qualified Health Plan (QHP) or non-QHP. They can make specific recommendations about which plan a person or entity should enroll in. They are also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some brokers may only be able to sell plans from specific health insurers.
Dependent	A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.
Formulary	A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.
Health Plan Categories	Plans in the Marketplace are primarily separated into four health plan categories (Bronze, Silver, Gold, or Platinum) based on the percentage the plan pays of the average overall cost of providing essential health benefits to members (actuarial value). The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). Catastrophic plans are also available to those under 30.
Lifetime Limit	A cap on the total lifetime benefits the insured may get from their insurance company. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. The ACA allows lifetime limits on total number of visits, but does not allow lifetime limits on dollar amounts.
Experience Rating	A method of setting premiums for health insurance policies based on the claims history of an individual or group.

Terms Related to Healthcare Costs

Actuarial Equivalent	A health benefit plan that offers similar coverage to a standard benefit plan. Actuarially equivalent plans will not necessarily have the same premiums, cost sharing requirements, or even benefits, but the expected spending by insurers for the different plans will be the same.
Actuarial Value	The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, the insured is responsible for 30% of the costs of all covered benefits. However, the insured could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on actual health care needs and the terms of the insurance policy.

Annual Deductible Combined	The total amount that family members on a plan must pay out-of-pocket for health care or prescription drugs before the health plan begins to pay. (This occurs in most plans, not just Health Savings Accounts.)
Fee-for-Service	A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.
Medical Loss Ratio	A basic financial measurement used to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.
Minimum Value	A standard of minimum coverage that applies to job-based health plans. If an employer's plan meets this standard and is considered "affordable," the employee won't be eligible for a premium tax credit if they buy a Marketplace insurance plan instead. A health plan meets the minimum value standard if it's designed to pay at least 60% of the total cost of medical services for a standard population and its benefits include substantial coverage of physician and inpatient hospital services. The minimum value is the lowest actuarial value that a plan must have to be in a certain tier (e.g. Bronze, Silver, etc.)
Allowed Amount	The maximum amount on which payment is based for covered health care services. Also called 'eligible expense,' 'payment allowance,' or 'negotiated rate'.
Co-Insurance	The insured person's share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. The insured pays the co-insurance plus any deductibles owed.
Co-Payment	A fixed amount that the insured pays for a covered health care service, usually when they receive the service. This amount can vary by the type of covered health care service.
Deductible	The amount the insured owes for health care services before the insurance begins to pay. The deductible may not apply to all health care services.
In-network Co-insurance	The percent that the insured pays of the allowed amount for covered health care services from providers who contract with the health insurance plan. In-network co-insurance usually costs less for the insured than out-of-network co-insurance.
In-network Co-payment	A fixed amount that the insured pays for a covered health care service from providers who contract with the health insurance plan. In-network co-payments are usually less than out-of-network co-payments.
Out-of-network Co-insurance	The percent that the insured pays of the allowed amount for covered health care services from providers who do not contract with the health insurance plan. Out-of-network co-insurance usually costs more than in-network co-insurance.
Out-of-network Co-payment	A fixed amount that the insured pays for a covered health care service from providers who do not contract with the health insurance plan. Out-of-network co-payments are usually more than in-network co-payments.
Premium	The amount that must be paid by the insured for his or her health insurance or plan. The insured and their employer usually pay this monthly, quarterly, or yearly.
Capitation	A method of paying for health care services under which providers receive a set payment for each person or "covered life" instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members.
Out-of-Pocket Maximum	A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.

Terms Related to Healthcare Laws

COBRA	A federal law that may allow someone to temporarily keep their health coverage after their employment ends, they lose coverage as a dependent of the covered employee, or another qualifying event. If someone elects COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, they pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.
Community Rating	A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.
Guaranteed Renewal	A requirement that the health insurance issuer must offer to renew the insured's policy as long as they continue to pay premiums. Except in some states, guaranteed renewal doesn't limit how much they can be charged if they renew coverage. K.S.A. 40-2257 outlines reasons why an insurer may non-renew a plan, this includes things such as an individual committing fraud or and individual failing to pay premiums or contributions in accordance with the health coverage.

Terms Related to Healthcare Plans

Accountable Care Organization	A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.
Catastrophic Health Plan	Health plans that meet all of the requirements applicable to other Qualified Health Plans (QHPs) but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met. The premium amount you pay each month for health care is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher.
Conversion	The ability, in some states, to switch your job-based coverage to an individual policy when you lose eligibility for job-based coverage. Family members not covered under a job-based policy may also be able to convert to an individual policy if they lose dependent status (for example, after a divorce).
Co-op	A non-profit organization in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state, or local level and can include doctors, hospitals, and businesses as member-owners.
Employer or Union Retiree Plans	Plans that provide health and drug coverage to former employees or members, and, in some cases, their families. These plans are offered to people through their (or a spouse's) former employer or employee organization. Many of these plans aren't legally required to meet many of the provisions of the Affordable Care Act, including providing coverage for children up to age 26.
Exclusive Provider Organization (EPO) Plan	A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan’s network (except in an emergency). Some of these plans require the insured to use a gatekeeper, such as a primary care physician who manages and authorizes treatment.
Flexible Benefits Plan	A benefit program that offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, the insured can choose how their remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes the insured can contribute more for additional coverage. Also known as a Cafeteria plan or IRS 125 Plan.

Flexible Spending Account (FSA)	An arrangement the insured sets up through their employer to pay for many of their out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin and medical devices. The insured decides how much of their pre-tax wages they want taken out of their paycheck and put into an FSA. They don't have to pay taxes on this money. Their employer's plan sets a limit on the amount they can put into an FSA each year. There is no carry-over of FSA funds.
Grandfathered Health Plan	Grandfathered plans (in force on or before March 23, 2010) are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. New employees and new family members may be added to grandfathered group plans after March 23, 2010.
Health Maintenance Organization (HMO)	A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally will not cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.
Health Reimbursement Account (HRA)	Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.
Health Savings Account (HSA)	A type of savings account that allows the insured to set aside money on a pre-tax basis to pay for qualified medical expenses if they have a "high deductible" health insurance plan. Combining a High Deductible Health Plan with a Health Savings Account (HSA) allows the insured to pay for certain medical expenses, like their deductible and copayments, with untaxed dollars. High-deductible plans usually have lower monthly premiums than plans with lower deductibles. Unlike a Flexible Spending Account (FSA), HSA funds roll over year to year if you do not spend them. The insured can take the funds with then if they change jobs or leave the work force. An HSA may also earn interest.
High Deductible Health Plan	A plan with a higher deductible than a traditional insurance plan. Usually the monthly premium is lower, but the insured has to pay more health care costs themselves (i.e. the deductible) before the insurance company starts to pay its share. A high deductible plan can be combined with a health savings account or a health reimbursement arrangement. This allows the insured to pay for certain medical expenses with untaxed dollars. For 2016, the IRS defines a high deductible health plan as any plan with a deductible of at least $1,300 for an individual or $2,600 for a family.
Point of Service (POS) Plan	A type of plan in which the insured pays less if they use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require the insured to get a referral from their primary care doctor in order to see a specialist.
Reinsurance	A reimbursement system that protects insurers from very high claims. It usually involves a third-party insurer paying part of an insurance company's claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.
Self-Insured Plan	Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered.
Preferred Provider	A provider who has a contract with a health insurer or plan to provide services to the insured at a discount. Some plans have "tiered" networks in which the insured must pay extra to see some providers.

APPENDIX D
Districts Sampled

This appendix includes a list of the 101 districts sampled as part of our analysis.

Individual Districts	
District Name	USD #
Auburn Washburn	437
Beloit	273
Blue Valley	229
De Soto	232
Derby	260
Dodge City	443
Emporia	253
Garden City	457
Gardner Edgerton	231
Geary County	475
Great Bend	428
Haysville	261
Hugoton	210
Hutchinson	308
Kansas City	500
Lansing	469
Lawrence	497
Liberal	480
Newton	373
Olathe	233
Paola	368
Russell County	407
Salina	305
Shawnee Mission	512
Spring Hill	230
Topeka	501
Turner-Kansas City	202
Wichita	259
Winfield	465

Greenbush Group Pool	
District Name	USD #
Baldwin City	348
Barber County North	254
Baxter Springs	508
Central	462
Central Plains	112
Chanute	413
Chapman	473
Chautauqua County Community	286
Cherokee	247
Cherryvale-Thayer	447
Clay County	379
Columbus	493
Ellsworth	327
Fredonia	484
Frontenac	249
Galena	499
Girard	248
Humboldt	258
Independence	446
Iola	257
Moundridge	423
North Lyon County	251
Northeast	246
Oswego	504
Ottawa	290
Parsons	503
Pittsburg Community	250
Pleasanton	344
Riverton	404
Southern Lyon County	252
Twin Valley	240
Wabaunsee	329
Wellsville	289
Woodson	366

ESSDACK Group Pool	
District Name	USD #
Anthony-Harper	361
Buhler	313
Burrton	369
Canton-Galva	419
Chase-Raymond	401
Cheney	268
Elkhart	218
Ellinwood	355
Fairfield	310
Goessel	411
Halstead	440
Haven	312
Haviland	474
Herington	487
Hesston	460
Hillsboro	410
Hoisington	431
Inman	448
Kingman	331
Little River	444
Lyons	405
Marion	408
McPherson	418
Ness City	303
Nickerson	309
Otis-Bison	403
Peabody	398
Pratt	382
Pretty Prairie	311
Remington	206
Scott County	466
Sedgwick	439
Smoky Valley	400
South Barber	255
St. John	350
Stafford	349
Sterling	376
Western Plains	106

APPENDIX E
Cited References

This appendix includes a list of the studies and reports cited in this report.

1. K-12 Benefit Consolidation Memo. (2016, December). *Segal Consulting*.

2. K-12 Education: Reviewing Issues Related to the Cost of the Health Care Benefits Provided By School Districts. (2010, April). *Kansas Legislative Division of Post Audit.*

3. Kansas Statewide Efficiency Review. (2016, February). *Alvarez & Marsal.*

4. The Governor's Budget Report Fiscal Year 2018. (2017, January). *Kansas Division of the Budget.*