LEGISLATURE OF KANSAS

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To: Members, Legislative Post Audit Committee

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Representative John Ballou	Senator Dave Kerr
Representative Dean Newton	Senator Derek Schmidt
Representative Dan Thimesch	Senator Chris Steineger

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

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

Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

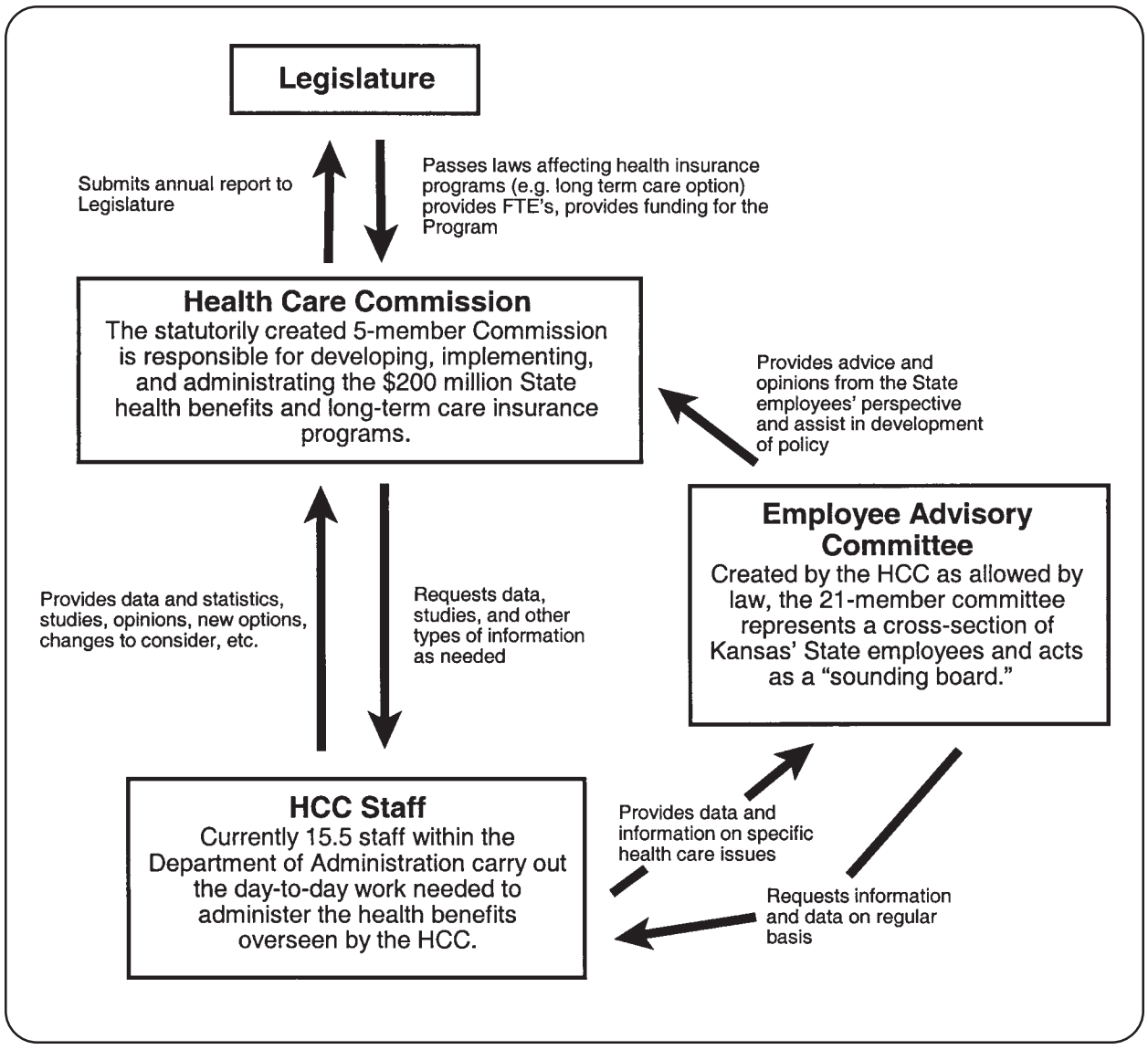
sources, we interviewed Department of Administration officials and Program staff to identify tasks that aren't being completed because of the current workload. We also compared Kansas' staffing to the other 7 states we surveyed. Finally, to determine if health insurance rates would be lower if the State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

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

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

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

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



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

In 1999, the Commission Opened the Program to Educational Entities

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

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

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

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

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

Source: Health Care Benefits staff, Department of Administration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: LPA surveys

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

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

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

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

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

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

Issues for Future Administration of the Health Benefits Program

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

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

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

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

CONCLUSION

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

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

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

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

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

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

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

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

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

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

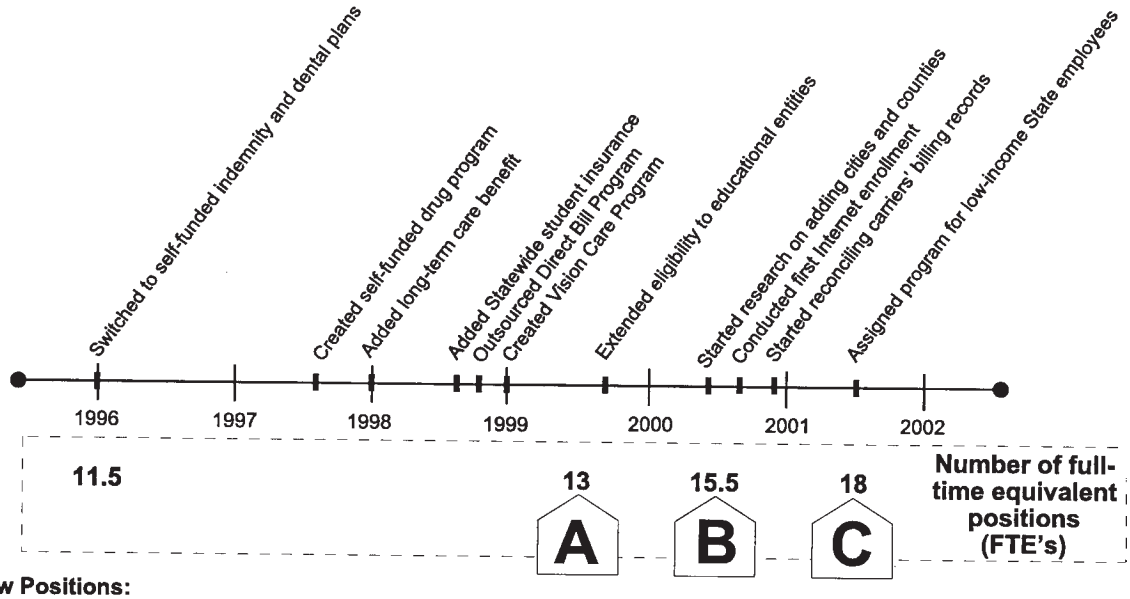
Staffing Levels For the Health Benefits Program Have Increased By 57% Since 1996 But Program Responsibilities Have Also Increased Significantly During that Time

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

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

The timeline below shows the added responsibilities and duties.

The Health Benefits Program Added Responsibilities and Staffing Levels



New Positions:

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

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

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

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

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

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

Source: Department of Administration, Benefits Administration Section

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

Hospital Authority Owes State for Unpaid Claims

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

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

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

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

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

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

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

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

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

Until 2000:

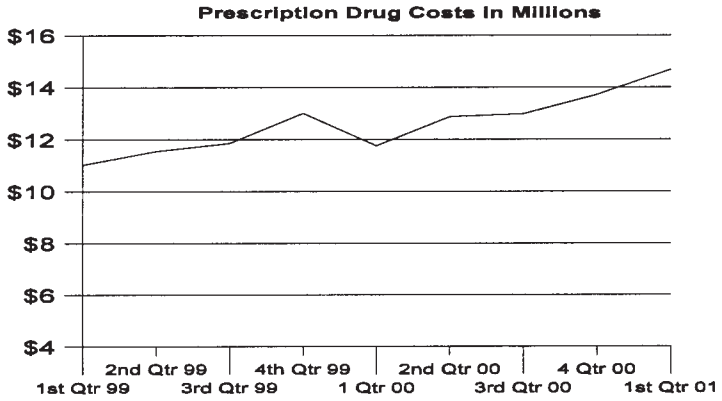
- *Members paid a minimum of $5 per generic prescriptions and $10 per brand name prescriptions, or 25% of the actual cost of the drug, whichever was greater (not to exceed $50 per prescription)*

From 2000 on:

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: LPA survey. Data are self-reported.

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

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

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

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

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

Fees Collected and Related Expenditures for Education Groups

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

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

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

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

Health Benefits Program Given Another Responsibility, But No Additional Funding

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

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

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

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

The Program's Computerized Membership Systems Are Problematic

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

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

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

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

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

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

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

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

CONCLUSION

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

RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Strategies to Control Health Insurance Costs

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

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

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

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

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

APPENDIX A

Scope Statement

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

SCOPE STATEMENT

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

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

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

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

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

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

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

Estimated completion time: 8-10 weeks

APPENDIX B

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

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

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

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

APPENDIX C

Agency Response

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

STATE OF KANSAS

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DAN STANLEY, *Secretary*

BILL GRAVES, *Governor*

July 17, 2001

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

Dear Ms. Hinton:

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

Clarifications

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

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

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

Audit Conclusion

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

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

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

Response to Audit Findings

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

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

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

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

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

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

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

Sincerely,

Dan Stanley
Secretary of Administration