PERFORMANCE AUDIT REPORT

Reviewing the Health Care Plan for State Employees, Part I: Overview of the Contract Negotiating Process and the Proposed Health Care Plan for 1988

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

Legislative Division of Post Audit

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REVIEWING THE HEALTH CARE PLAN FOR STATE EMPLOYEES PART I: OVERVIEW OF THE CONTRACT NEGOTIATING PROCESS AND THE PROPOSED HEALTH CARE PLAN FOR 1988

OBTAINING AUDIT INFORMATION

This audit was conducted by Ellyn Rullestad and Ron Green, Senior Auditors, and Jim Davis, Curt Winegarner, and Tom Vittitow, Auditors, of the Division's staff. If you need any additional information about the audit's findings, please contact Ms. Rullestad at the Division's offices.

TABLE OF CONTENTS

REVIEWING THE HEALTH CARE PLAN FOR STATE EMPLOYEES

Summary of Legislative Post Audit's Findings

How was the contract for State employee health insurance bid? The State Employees Health Care Commission, established in 1984, was responsible for negotiating a health care benefits plan for State employees. That Commission first met in April 1987 to discuss the 1988 plan. The Commission reviewed information showing State employees' high use of hospital services and the loss Blue Cross and Blue Shield of Kansas was experiencing on the State's health care contract. As a result, Commissioners began to look for ways to contain costs. Some of the ideas the Commissioners began to explore included the possibility of establishing a smoker's discount, financial rewards for low use of benefits, health education programs, and wellness activities. Requests for proposals for both a traditional health care plan and a health maintenance organization plan were finalized in June 1987.

What prompted the Health Care Commission to negotiate the 1988 contract with Blue Cross and Blue Shield? The requests for proposals were mailed to 39 companies. A total of 10 companies responded to the health maintenance organization request, but only Blue Cross and Blue Shield responded to the request for traditional health care coverage. The initial proposal would have increased traditional care premiums by about 40 percent over the 1987 contract. Because Health Care Commission members thought the proposed rates would be unaffordable for the State and its employees, they spent several weeks negotiating a more favorable plan with Blue Cross. During the course of the negotiations, the Commissioners were convinced the only measure that would help contain health care costs would be to move to a managed care system. The resulting contract with Blue Cross and Blue Shield moves in this direction with the Blue Select option. Under that option, employees must designate a primary care physician to coordinate their health care needs. If the employee chooses to self-refer to another physician, the employee will have a larger out-of-pocket expense. Other changes in the new plan include the decision to require all employees to pay a portion of their health care premiums, and the decision to institute a smoker's surcharge to finance wellness activities.

How were doctors recruited or selected to participate in the plan? Blue Cross and Blue Shield was responsible for selecting primary care physicians. Initially, it tried to limit primary care physicians to those providers who agreed to serve HMO Kansas. Currently, that requirement is no longer applicable, although participating physicians must meet the same criteria as providers who serve HMO Kansas. Under both Blue Select and HMO Kansas plans, financial incentives are provided to physicians to hold down costs.

How does Kansas' 1988 health care plan compare with the 1987 plan, and with other employee health care plans? In general, the cost of Kansas' 1988 plan is substantially higher than the 1987 plan. Employees will pay higher monthly premiums and could have considerably more out-of-pocket expenses. When compared with other states, Kansas' employee health care plans tend to have higher monthly premiums for about the same level of benefits. Kansas pays a higher percentage of employee-only coverage than most other employers reviewed, but a lower percentage of family coverage.

REVIEWING THE HEALTH CARE PLAN FOR STATE EMPLOYEES PART I: OVERVIEW OF THE CONTRACT NEGOTIATING PROCESS AND THE PROPOSED HEALTH CARE PLAN FOR 1988

The State of Kansas provides health care benefits to its employees and their dependents, and pays a portion of each employee's monthly premium. The current health care contract began in January 1987 and runs through December 1987. The State Employees Health Care Commission began meeting in April to finalize a contract that would become effective January 1, 1988.

In September 1987, the Commission agreed to enter into a contract with Blue Cross and Blue Shield and with a number of health maintenance organizations to provide health insurance for State employees in 1988. In the October KANSAGRAM, a newsletter that is provided to employees along with their paychecks, State employees were apprised of the details of the negotiated health plan. There were a number of changes in the new plan. According to the KANSAGRAM:

> Most state employees (84 percent of total state employees) will have a choice of two health insurance options, both of which encourage managed health care: 1) one of a number of HMOs, depending on geographic locations; or 2) a self-referral option offering managed care through Kansas Blue Cross-Blue Shield. This option provides participants health benefits with low deductibles and coinsurance when authorized primary care physicians manage a participant's health care. Participants may, however, choose to see other physicians but with such self-referral will have higher deductibles and coinsurance.
>
> State employees in an area not served by an HMO or by the self-referral option (16 percent of total state employees) will have a traditional health insurance plan through Kansas Blue Cross-Blue Shield offered at the same premium as the self-referral option.

Other changes were also noted in the KANSAGRAM. For the first time, a monthly charge, based on income levels, will be instituted on all employees participating in the health insurance program. Non-smokers will receive a $10 discount on this monthly charge. In addition, a waiting period will be imposed on new State employees before they become eligible for the health plan.

The new health care plan represents a clear departure from previous plans. State employees have had numerous concerns about the plan, including the higher cost of the plan for the reduced level of benefits it provides, and the fear that an inadequate number of physicians were participating in the program. Legislators have also expressed concerns about the plan. An interim Ways and Means Committee added the State employees health care plan to its list of study topics and will hold hearings in early December. In addition, the Legislative Post Audit Committee directed the Legislative Division of Post Audit to conduct an audit concerning the Health Care Commission's process of developing the 1988 employee health care plan.

This audit addresses specific concerns about how the contract was bid, the negotiating process that took place in developing the 1988 contract, how doctors were recruited to participate in the plan, and how Kansas' health care coverage compares with other employee health care plans.

How Was the Contract for State Employee Health Insurance Bid?

The State Employees Health Care Commission was established in 1984. The Commission has broad statutory powers to develop and implement a health care benefits program for State employees. Members of the Commission include the Secretary of Administration, the Insurance Commissioner, and a member of the public appointed by the Governor.

The Commission is assisted by a small staff and currently has contracts with two consultants. One of the consultants has had on-going responsibilities with the Commission since its inception. That consultant, Martin E. Segal Company, will receive about $35,000 for work in fiscal year 1987 and the first half of fiscal year 1988. Martin E. Segal Company is responsible for reviewing the State's employee benefit program, providing technical assistance to the Commission, analyzing various provider reports, and preparing information for the annual report. The second consultant is a health administration professor at Wichita State University. That consultant will be paid up to $10,000 to provide technical assistance to the Commission, particularly in the development of wellness activities. The Commission has also begun to recruit a person with a strong background in the area of employee benefits to help it fulfill its increasingly complex duties.

On April 22, 1987, the Health Care Commission Met to Discuss the 1988 Health Care Benefits Plan For the First Time

Information was presented during the Commission's first meeting that showed State utilization of hospitalization services was higher than other Blue Cross groups Statewide. Also at that meeting, Blue Cross representatives presented a report on the 1987 health care contract that indicated the company would experience a loss on the State's traditional health plan. This was on top of the loss experienced on the State's traditional health care contract for the 1985-1986 period. That earlier loss had already been identified by the Commission's consultants, and had been presented in the Commission's annual report to the 1987 Legislature. The annual report had also concluded that the costs of the State health insurance plan for both the State and its employees would continue to increase at a significant rate. By April, the information presented on the 1987 contract's claims experience supported that conclusion.

Commissioners were concerned about the high cost of the State employees' health care plan and looked for ways to contain costs. In interviews with members of the Health Care Commission, the auditors were told that the members were very concerned about the escalation of health care costs and State employees' high use of the traditional plan. Based on the losses being experienced by the traditional Blue Cross plan, the Commissioners feared that any new health care plan would have ex-

tremely high premiums, that these premiums would continue to increase and become unaffordable for a large number of State employees, and that there was no foreseeable limit to these increases.

At the same time, the Commission began to explore alternatives for containing costs. They discussed the concept of managed care. Nearly one-third of all State employees were already enrolled in a health maintenance organization, and Commission members expected that this number would continue to grow. To some extent, then, managed care was seen as one of the waves of the future. Interest was also developing in ways to keep State employees healthy as another way to contain health care costs. Some of the ideas that were explored included a premium discount for non-smokers, health education programs, and wellness programs. Commissioners agreed to hire a consultant to analyze and make recommendations relating to wellness matters. Finally, because the Commissioners wanted as many companies as possible to bid on the health care contract so that it would be competitive, a three-year contract was discussed.

Requests for Proposals Were Finalized in June 1987

The Commission's primary consultant developed two Requests for Proposals. One was for a traditional type of health care plan, similar to the Blue Cross plan already in force, while the other was for a health maintenance organization plan. The Commission reviewed the Requests for Proposals at its June 4, 1987, meeting. The finalized proposals invited bidders to elaborate on some of the new initiatives that had been included in the request: procedural and other aspects of incorporating a non-smoker's discount within the premium rate structure; a workable incentive mechanism through which subscribers could be financially rewarded for non-usage or low usage of benefits; health education programs with a demonstrated direct relationship between patient education and reduced hospitalizations. The Requests for Proposals also indicated the Commission would consider negotiating a three-year contract.

What Prompted the Health Care Commission to Negotiate the 1988 Contract with Blue Cross and Blue Shield?

Under State law, the Health Care Commission is authorized to negotiate and enter into contracts with qualified insurers, health maintenance organizations, and other contracting parties for the purpose of establishing the State health care benefits program. Such contracts may be for up to three years, and are not required to go to the lowest bidder.

In early June 1987, Requests for Proposals were mailed to 39 companies. Responses were due August 3, 1987. The Commission received proposals from 10 health maintenance organizations, and eventually approved five of them. Blue Cross and Blue Shield of Kansas was the only company that responded to the proposal for the traditional portion of the 1988 health benefits contract. As described below, the Commission decided that neither the State nor its employees could afford to accept

the initial proposal for the traditional plan. As a result, Commissioners decided to negotiate a State employees' health care plan with Blue Cross and Blue Shield.

A Consultant's Review of Blue Cross and Blue Shield's Initial Proposal Showed Projected Increases in Premiums of More than 40 Percent for Traditional Care

In early August 1987, the Blue Cross proposal was sent to the Commission's primary consultant, Martin E. Segal Company, for review and analysis. Blue Cross' proposal for a traditional health care plan was based on the higher-than-average utilization of medical services by State employees, and on the losses the company was projecting for the 1987 contract. The Commission's consultant reviewed the proposal and agreed there would be a loss on the 1987 contract, based on the utilization and claims information supplied by Blue Cross and Blue Shield. These losses were due to the traditional program. The consultant also estimated that the 1985-1986 contract would result in a loss of at least $7.5 million. The data supplied by Blue Cross and Blue Shield for the 1985-86 contract were audited by the State Insurance Department and found to be accurate, although no full-blown audit was done to determine if the services paid for were medically necessary. Both the audit report and the consultant's summary of the Blue Cross proposal were reviewed by the Commission at its August 13 meeting.

The initial Blue Cross proposal would have meant premium increases of at least 40 percent for traditional care, and about 19 percent for the Choice Care option. (That option is similar to the traditional option, but it has lower deductibles and coinsurance, and requires use of a contracting hospital to obtain maximum benefits.) Blue Cross' initial proposal would have increased annual premiums for the traditional plan by more than $16 million. Based on the available information, the consultant indicated these increases were consistent with the trend factors de-

The Kansas Insurance Department Recently Completed Audits of Blue Cross and the State Employees Group Health Insurance Plan

In August 1987, the Insurance Department released two audit reports on Blue Cross and Blue Shield of Kansas. The first audit, covering the financial condition and business affairs of the company, noted several areas of concern. These included improper reconciliation procedures, insufficient controls over transaction vouchers, and poor documentation to support its annual statement figures. On November 9, the Insurance Commissioner sent a letter to Blue Cross and Blue Shield, requesting the company to advise the Insurance Department on what actions have been taken or will be taken to resolve these problems. On November 23, Blue Cross responded with a letter to the Insurance Department.

The second audit covered only the State Employees Group Health Insurance Plan. The examiners reviewed a sample of 363 claim payments made in January 1987, including all claims in excess of $10,000. The examiners checked to determine whether each claim was made properly and that the claimant or dependent was eligible for benefits; they found no errors in the sampled claims. This review did not include verifying that services were medically necessary or that charged services were actually performed.

The second audit showed a significant reversal in the profitability of the State Employees Group Plan for Blue Cross and Blue Shield. On the 1983-84 contract, Blue Cross made a profit (premiums received minus claims and company retention) of more than $7.3 million. On the 1984-85 contract, the profit of nearly $3 million was credited back to the State under a newly adopted provision. In contrast to those years, the 1985-86 contract (a 17-month period) showed a loss of $8.4 million.

veloped from the State program's actual experience. The consultant's report to the Commission states, "If the rapid escalation in the State's health care costs is to be tempered, major steps need to be taken to accomplish this goal."

Commission members told the auditors they spent little time discussing the level of increases that would occur if the Choice Care option were selected. Rather, the Commission focused its efforts on the steep increases that would occur in the traditional plan premiums, and used the traditional plan as the starting point for their negotiations with Blue Cross.

The Health Care Commission thought the proposed rates would not be affordable for State government or State employees. To try to obtain a more affordable proposal, the Commission set dates later in August to negotiate the 1988 contract. Commissioners also directed staff to look specifically at various alternatives for lowering premium costs, such as reduced benefits, a high/low option, nonsmoking discounts, and encouragement of health-related activities.

At the next meeting of the Health Care Commission, discussion of alternatives continued. Commissioners reviewed the results of a random State employee telephone survey and the August KANSAGRAM survey that were designed to find out employees' opinions about health care and prevention efforts. This survey effort was the only point at which the Commission obtained employee input. An advisory committee made up of employees from various State agencies had been formed when the Health Care Commission was first established, but that committee was not asked to participate in the discussions of the 1988 contract.

1987 Health Care Enrollment

A total of 42,080 people were enrolled in one of the State's health care plans as of October 1, 1987. Of those, 34,957 were active employees and 7,123 were in the retirants category [a]. The following table breaks down the enrollment by type of plan, and type of membership.

Traditional Blue Cross/Blue Shield

	Active State Employees	Retirants	Total
Single	14,044	4,282	18,326
Family	7,032	2,619	9,651
Total	21,076	6,901	27,977

Blue Cross/Blue Shield: Choice Care

	Active State Employees	Retirants	Total
Single	1,458	12	1,470
Family	792	4	796
Total	2,250	16	2,216

Health Maintenance Organizations

	Active State Employees	Retirants	Total
Single	6,427	117	6,544
Family	5,204	89	5,293
Total	11,631	206	11,837

(a) The retirants category includes legislators, retirants, dependents of deceased employees, dependents of retired employees, employees on leave without pay, and employees on a medical disability. Basically, the category includes all those people who pay the State directly for their health care coverage.

Blue Cross presented the State of Kansas utilization analysis for 1986 and 1987 at the same meeting. The self-referral option presented in Blue Cross' proposal was discussed, as were other alternative plan arrangements. Numerous questions were

raised about the State's health care plan and the reasons it was so costly. Blue Cross indicated that one of the reasons for the high cost of the traditional health care plan was that the younger and healthier employees were selecting health maintenance organizations. This "adverse selection process" left relatively older and more intensive users of the health care plan in the traditional plan. Commissioners also began to consider some policy issues that would affect the way health care benefits are provided, such as requiring single employees to pay for part of their health insurance coverage, providing for a non-smoker's discount, seriously looking at the feasibility of self-funding the health insurance plan, and requiring a waiting period for health care eligibility.

After a Series of Negotiations with Blue Cross, The Health Care Commission Adopted Numerous Measures Intended to Reduce the Costs of the Health Care Plan

In late August and early September 1987, the Commission reviewed many alternate combinations of plans prepared by Blue Cross. Even though some plans were presented that might have provided State employees with more options, Commission members indicated to the auditors that they were convinced the only thing that was not a stop-gap measure in controlling health care costs was to move towards a managed care system, and to emphasize preventive health care rather than treatment. Commission members said they thought that anything less would not satisfactorily address the problem of escalating health care costs.

In September 1987, the Commision adopted several measures that changed the way health care was provided to State employees. One change was the decision to require all employees to pay up to $10 a month for a portion of their health care premiums, based on their income levels. Employees earning up to $17,000 will pay $1 a month, those earning $17,000-$30,000 will pay $5 a month, and those earning more than $30,000 will pay $10 a month. The State previously paid the entire single premium.

A second change was to levy an additional monthly charge on all employees to finance wellness programs. This $10 monthly smoker's charge can be waived if an employee agrees not to use tobacco products. Other changes moved the State closer to a full managed care system, in an effort to help contain medical costs and hold down premiums. These measures included the following:

- — Addition of the Blue Select option, which combines elements of managed care (including the primary care physician) with elements of the traditional plan (including self-referral with deductible and higher coinsurance).
- — Inclusion of five health maintenance organizations.
- — Retention of the traditional care program only in areas not served by the Blue Select program.
- — Adoption of a 60-day waiting period for new employees to be eligible for health insurance benefits.
- — Recommendation of an 11.7 percent increase in the State agency contribution for each employee in 1988.

These basic elements were agreed upon September 10, 1987. Commission decisions resulted in an increase of 9.5 percent in family premium rates. However, actual increases will be greater because of the variable monthly surcharges. Some technical problems with the Blue Cross contract language were still being discussed in November. As of November 23, the contract had not been signed.

The final result is a contract that meets the objectives of the Health Care Commission. The new plan for 1988 meets the four principal objectives of the Commission. As described by the Chairman of the Health Care Commission, these objectives were the following:

1. To move the State employee group toward "managed care"
2. To hold down the increase in premiums for family coverage
3. To create incentives for preventive health care and thereby reduce long-term health care costs for the State employees group
4. To prepare the State employees group for exercising the option of self- insurance in the near future

The members of the Commission told the auditors that they felt they had done the best they could to fashion a plan that would address the long-term problems in the State employees plan. Nevertheless, it is apparent that the new plan is a major departure from previous plans. All employees will pay a monthly charge for participation in the plan; the actual charge will be from $1 up to $20 per month, depending upon income and smoking factors. For most State employees, the traditional plan is no longer an option. All employees who choose a health maintenance organization or Blue Select must select a primary care physician. Under Blue Select, employees can choose any other doctor as in the past, but they will pay higher costs for this self-referral.

Monetary Effects of the New Health Plan

Those State employees affected the most will be the high users of medical services under the 1988 plan. The greatest potential financial impact will be felt by employees who choose the Blue Select program. Even if no medical services are required, the monthly premium in 1988 will be at least 10 percent higher than the traditional care family rate in 1987. If extensive medical services are required, the family could pay more than $5,000 out-of-pocket. The following table compares the maximum possible payments for the 1987 traditional plan and the 1988 Blue Select self-referral plan that is the most similar to the 1987 plan.

Maximum Annual Out-of-Pocket Payments for an Employee With Family Coverage

	1987 Traditional	1988 Blue Select Self-Referral
Deductible	$ 200	$ 400
Coinsurance	400	2,000
Inpatient Copay.	0	500
Premiums	1,897	2,317
Total	$2,497	$5,217

Note: 1988 payments could also include emergency room payments ($25 per visit), outpatient prescription drug copayments ($3 for generic drugs, $7 for brand-name drugs), and any additional coinsurance under the primary care option.

As the table shows, the maximum out-of-pocket expenses in 1988 will be more than twice the 1987 expenses if a family makes full use of medical services under the self-referral portion of the Blue Select plan. Appendices C and D compare the maximum out-of-pocket expenses for single and family plans under the 1987 and 1988 health care contracts.

How Were Doctors Recruited or Selected to Participate in the Plan?

The new health care benefits plan requires most State employees to designate a primary care physician to manage their health care needs. Employees who selected a health maintenance organization option have always had to designate a primary care physician to coordinate their

health care needs, so this requirement is not new to them. But for employees who have used the traditional plan in the past, this requirement is new. To receive health care under the Blue Select option at the most economical rates, an employee must obtain services from the designated primary care physician, or from providers that the employee is referred to by the primary care physician. Employees who choose the Blue Select option are allowed to refer themselves to other health care providers, but they still must designate a primary care physician on their enrollment form.

When the State health care plan was first presented, many State employees found that their personal or family physicians were not among the primary care physicians listed for the Blue Select health care option. Other employees expressed concern that few or even no primary care physicians were listed in their communities. The auditors interviewed officials of Blue Cross and Blue Shield of Kansas to determine how providers were chosen to be primary care physicians for the 1988 plan.

Blue Cross and Blue Shield Initially Tried to Limit Primary Care Physicians To Those Providers Who Agreed to Serve HMO Kansas

In addition to the State employees' group, only the City of Wichita's employee group and Blue Cross and Blue Shield's own employees will have their health care needs provided through the Blue Select option. A Blue Cross official indicated that several other groups are currently considering the Blue Select option. Blue Cross and Blue Shield began establishing a primary care physician list for Blue Select during the spring of 1987. The Blue Select option will first be effective in Kansas in January 1988.

Blue Cross and Blue Shield initially contacted only those physicians who had contracted to be primary care physicians in a health maintenance organization. Outside the HMO Kansas area, primary care physicians in larger Kansas cities (Dodge City, Pittsburg, Hays, etc.) were contacted for interest. Membership in a health maintenance organization was not required. Over time, as word about the Blue Select plan spread, other physicians began to contact Blue Cross and Blue Shield about participation in the plan. Any physician requesting information about the plan was contacted for consideration as a possible Blue Select primary care physician. Initially, doctors who were in an HMO Kansas service area were expected to sign with HMO Kansas if they also wished to participate as a primary care physician in the Blue Select plan..

The initial directory that was given to State employees listed 410 primary care physicians for the Blue Select area. Of those, 18 accepted established patients only. Another 63 physicians were listed as pediatricians, four of which accepted established patients only. It should be noted that Blue Cross listed the 473 pediatricians and primary care physicians in the Blue Select directory by location. Some physicians practice in more than one location and were listed in multiple locations. As a result, the auditors' numbers include some double-counting of physicians. In addition to these doctors, the directory listed 677 primary care physicians and pediatricians who served the Kansas City metropolitan area.

Blue Cross Currently Does Not Require Blue Select Physicians to Participate In a Health Maintenance Organization, But Certain Criteria Must Be Met

Following publication of the State health care plan for State employees in October 1987, Blue Cross began to receive complaints and inquiries from physicians about the plan. As a result, Blue Cross decided to end the requirement that primary care physicians for Blue Select had to be primary care physicians for a health maintenance organization as well. However, participating physicians still had to sign an agreement and meet certain eligibility requirements.

A Blue Cross and Blue Shield of Kansas official told the auditors the company looked at the availability of primary care physicians across the State and determined that all areas, with the exception of the Topeka area, would have adequate coverage. The official said that in Topeka, there would likely be a need to increase the number of primary care physicians. With the changes in the requirements for participation, more primary care physicians are being added to the Blue Select physician list. On November 18, 1987, Blue Cross issued an addendum to the primary care physician directory. A total of 87 additional physicians, including four pediatricians, were added to the list. An official of the company indicated that one or two more updates to the directory could be expected before the start of the plan in January 1988.

The criteria for primary care physicians are the same as the criteria for providers who have contracted to serve HMO Kansas. Doctors who contract to be primary care physicians for Blue Select must meet the same screening criteria that are required for HMO Kansas primary care physicians. One criterion is that the physician practice in one of four areas: general pediatrics, general practice, family practice, or internal medicine. Additional criteria are designed to ensure that primary care physicians will be available to personally provide the total primary care needs for all their patients. For example, the physicians must be able to provide services on a 24-hour basis, treat minor illnesses, conduct routine physicials, and manage uncomplicated chronic problems on a timely basis. According to Blue Cross officials, their experience with HMO Kansas has confirmed that this type of service can best be provided by physicians in the four specialties. Appendix A presents a list of screening criteria.

Under both the Blue Select and HMO plans, incentives are provided to physicians to hold down costs. One of the objectives of the managed care program is to hold down increases in medical costs. Under the Blue Select option, primary care physicians are reimbursed on a fee-for-service basis at rates established by Blue Cross and Blue Shield. However, they are also eligible to receive "incentive" payments if their patients' monthly costs are lower than average. The incentive is for the primary care physicians to keep their patients' expenses as low as possible.

To calculate the amount of the Blue Select incentive payment, Blue Cross computes the average claims expenses for each primary care physician. The average is based on total Blue Select claims for all employees who designated that physician as their primary care physician, whether or not those employees incurred any medical

expenses. The primary care physicians are then ranked from lowest average cost to highest average cost. The incentive payment is calculated on the total claims payments to the primary care physician less lab and x-ray services, as follows:

Primary Care Physicians' Whose Costs Per Patient Fall in This Percentile...	**Receive This Incentive Payment...**
20% with lowest average cost	15% of claims
30% with next lowest average cost	10% of claims
20% with next lowest average cost	5% of claims
30% with highest average cost	0% of claims

Under the HMO Kansas option, primary care physicians are generally reimbursed on a prepaid basis for most routine services. Other services are reimbursed on a fee-for-service basis, including surgery, obstetrics, and referrals to other physicians. Primary care physicians for HMO Kansas receive monthly payments of 75 percent of the agreed prepaid amount for each member who selected the physician. The prepaid amount is based on the number, sex, and age of the physician's patients in the plan.

The other 25 percent of the prepaid amount is withheld by HMO Kansas until the end of the year. In general terms, this money is withheld as an incentive for physicians to limit the number of unnecessary patient services and referrals for non-prepaid services. If a doctor is successful in keeping the number and cost of these other services down, the full 25 percent of the prepaid amount that was withheld is paid to the physician.

In more specific terms, HMO Kansas allocates a portion of a "shared risk fund" for use by each contracting physician for the services that are paid for on a fee-for-service basis. If a primary care physician's share of the shared risk fund exceeds the payments from that fund for his or her patients, then the primary care physician will receive 70 percent of the remaining part of the shared risk fund and the 25 percent withheld from the prepaid amount. However, if payments from the shared risk fund exceed the primary care physician's share of that fund, then the primary care physician will receive none of the shared risk fund, and half of the excess payments will be deducted from the 25 percent prepaid amount before it is paid to the primary care physician.

How Does Kansas' 1988 Health Care Plan Compare With the 1987 Plan, and With Other Employee Health Care Plans?

To answer this question, the auditors reviewed Kansas' 1987 State employee health care benefits and compared them with the benefits offered to employees for 1988. They contacted officials in Nebraska, Missouri, Colorado, and Iowa to obtain information outlining state employee health care benefits in those states. The auditors also contacted officials from Blue Cross and Blue Shield of Kansas to obtain information about health care benefits provided to federal employees and to Blue Cross' own employees.

In general, the auditors found that the cost of Kansas' State employee health benefits will be substantially higher in 1988 than in 1987. In addition, those employees will pay higher monthly premiums and could have considerably more out-of-pocket expenses in 1988 than in 1987. The auditors found that Kansas' employee health care plans tend to have higher total monthly premiums than those of the other states reviewed, but provide about the same level of benefits. Kansas pays a higher percentage of employee-only coverages than most other employers reviewed, but a lower percentage of full family coverages than most other employers reviewed.

Kansas' State Employee Health Benefits Will Cost More in 1988 Than in 1987

In 1987, State employees had three basic choices of health care plans: Traditional, Choice Care, and coverage from a number of health maintenance organizations. In 1988, most State employees will no longer have the option of choosing the Traditional plan. In addition, Choice Care is no longer an available option. In place of these options, most State employees, excluding those in the Kansas City area or in rural areas, will have to choose between HMO Kansas and a new plan called Blue Select. Blue Select incorporates elements of both an HMO and a traditional plan. Like HMO Kansas, Blue Select requires the employee to designate a primary care physician from a pre-approved list. However, it allows the employee to obtain medical services from someone other than the primary care physician at a reduced level of coverage.

State Employees Health Care: Comparison of 1987 and 1988 Plans

Plan	Monthly Premium [a] (single/family)	Employee-Paid Portion [a] (single/family)	Deductible (single/family)	Coinsurance (single/family)
1987				
Traditional	$93/251	$0/158	$100/200	80/20% to $200/400
Choice Care	$92/249	$0/157	$50/100	80/20% to $100/200
HMO Kansas	$82/185	$0/102	None	None
1988 [b][c]				
Traditional	$112/286	$1 - 10/ $174 - 183	$200/400	80/20% to $500/1,000
Blue Select, Self-Referral	$112/286	$1 - 10/ $174 - 183	$200/400	70/30% to $1,000/2,000
Blue Select, Primary Care	$112/286	$1 - 10/ $174 - 183	None	80/20% to $500/1,000
HMO Kansas	$90/216	$1 - 10/ $127 - 136	None	None

a) Amounts rounded to the nearest dollar.
b) The employee's share of monthly premiums varies according to salary level.
c) Tobacco users are subject to an additional $10 charge.

As the table shows, monthly premiums for State employee health insurance will be higher in 1988 than they were in 1987. The employee's contribution toward these premiums will also be higher; for the first time, employees with single coverage will pay a portion of the premium. In addition, employees will be subject to much higher out-of-pocket expenses for both single and family coverage in 1988. The table in Appendix E describes both years' plans in more detail.

In 1988, Kansas' State Employee Health Benefits Will Cost More Than Other Employers' Health Benefits

The auditors contacted officials in Nebraska, Missouri, Colorado, Iowa, and Oklahoma to obtain information outlining those states' employee health care benefits. The auditors also contacted officials from Blue Cross/Blue Shield of Kansas to obtain information about the health care benefits provided to federal employees and Blue Cross/Blue Shield's own employees.

The auditors received information from all of those sources except the State of Oklahoma, which did not respond in time to be included in this audit report. In addition, the information obtained from Iowa was not in a form that lent itself to ready comparison with Kansas' plans or those of the other sources contacted. Therefore, for purposes of this report, Kansas' State employee health care benefits are compared with the benefits provided for employees of Nebraska, Missouri, Colorado, the federal government, and Blue Cross and Blue Shield.

The employers whose plans were reviewed offer a wide variety of plan choices, including traditional-type plans, health maintenance organizations (HMOs), and plans that combine elements of both. To provide meaningful comparisons, the auditors selected the plan from each employer that most closely approximated the benefits offered under Kansas' main plans: Blue Select Self-Referral, Blue Select Primary Care, and HMO Kansas. The auditors chose the health maintenance organization plan in each state that was sponsored by Blue Cross as the plan most comparable to HMO Kansas. Because Kansas' Traditional plan will only be available to a small percentage of State employees in 1988, the auditors did not include that plan in their comparisons.

The table on the next page compares benefits and costs of Kansas' plans and comparable plans offered by other states, the federal government, and Blue Cross and Blue Shield.

As the table shows, premium costs for Kansas' employees participating in self-referral plans are higher than costs for other states' employees, but are comparable to costs for federal and Blue Cross and Blue Shield employees. Kansas employees with single coverage pay a smaller amount toward the monthly premium than employees of most of the other states, the federal government, and Blue Cross. However, Kansas employees with family coverage pay a larger amount toward the monthly premium than any of the other employee groups. In addition, Kansas' deductibles and coinsurance are generally higher than those of the other employers examined.

1988 Employee Health Care: Comparison of Kansas' With Other Employers' Plans

Plan (g)	Monthly Premium (single/ family) (a)	Employee Portion (single/ family)	Deductible (single/ family)	Coinsurance (single/ family)	Employee Annual Costs (single/family) (e) Minimum	Maximum
Blue Select Self-Referral						
Kansas (c)	$112/286	$1 - 10/ $174 - 183 (b)	$200/400	70/30% to $1,000/2,000	$12 - 120/ $2,088 - 2,196	$1,212 - 1,320 $4,488 - 4,596 (f)
Colorado (d)	$90/211	$24/145	$175/350	80/20% to $1,000 incl. ded.	$288/ 1,740	$1,288/ 2,740
Nebraska	$59/210	$12/44	$100/200	80/20% to $4,000 incl. ded.	$144/ 528	$4,000/ 4,000
Missouri	$89/256	$0/167	$150/450	80/20% to $1,000/2,000	$0/ 2,004	$1,150/ 4,454
Federal	$137/283	$30/58	$250/person	75/25% to $2,500 incl. ded.	$360/ 696	$2,500/ 2,500
Blue Cross/ Blue Shield	$118/266	$12/28	None	80/20% to $400/800	$144/ 336	$544/ 1,136
Blue Select Primary Care						
Kansas (c)	$112/286	$1 - 10/ $174 - 183 (b)	None	80/20% to $500/1,000	$12 - 120/ $2,088 - 2,196	$512 - 620/ $3,088 - 3,196
Blue Cross/ Blue Shield	$118/266	$12/28	None	None	$144/ 336	same
HMO						
Kansas (c)	$90/216	$1 - 10/ $127 - 136 (b)	None	None	$12 - 120/ $1,524 - 1,632	same
Colorado (d)	$82/203	$16/137	None	None	$192/1,644	same
Nebraska	$71/212	$24/47	None	None	$288/564	same

a) Amounts rounded to the nearest dollar.
b) The Kansas employee's share of monthly premiums varies according to salary level.
c) Tobacco users are subject to an additional $10 monthly charge in Kansas.
d) Monthly premiums can be reduced by $6 for non-smokers in Colorado.
e) Does not include any additional deductibles or copayments associated with dental care, eye care, hospital stays, prescription drugs, etc. See Appendix E for these types of charges.
f) These costs are associated only with the Blue Select Self-Referral option. Employees may also be subject to coinsurance under the Blue Select Primary Care option. See Appendices C and D.
g) Effective Dates: Kansas, Federal, Blue Cross--January 1 - December 31, 1988; Colorado--August 1, 1987 - December 31, 1988; Nebraska--August 1, 1987 - July 31, 1988; and Missouri--July 1, 1987 - June 30, 1988.

The table also shows a comparison of health maintenance organization plans. Generally, these plans have no deductibles or coinsurance, but for both single and family coverage, the Kansas premiums are higher than the other states.

Currently, only the Kansas State employees group, the Blue Cross employees group, and the City of Wichita's employees group have signed up for the Blue Select-primary care option. The table compares the Kansas Blue Select plan with that of the Blue Cross employees. As it shows, the Kansas premium is slightly higher for family coverage. However, Kansas employees with family coverage pay a much larger amount toward the monthly premium than Blue Cross employees. Finally, the table shows that although neither plan has a deductible, the Kansas plan requires a coinsurance of up to $1,000 per family. In contrast, the Blue Cross employees' plan has no coinsurance requirement. Appendix E presents more detail on the various comparisons summarized above.

APPENDIX A

Blue Select Primary Care Physician
Eligibility Screening Criteria

The following table shows the requirements that a physician must agree to meet to be selected to participate in the Blue Select health care benefits plan for State employees.

Personal and Practice Requirements:

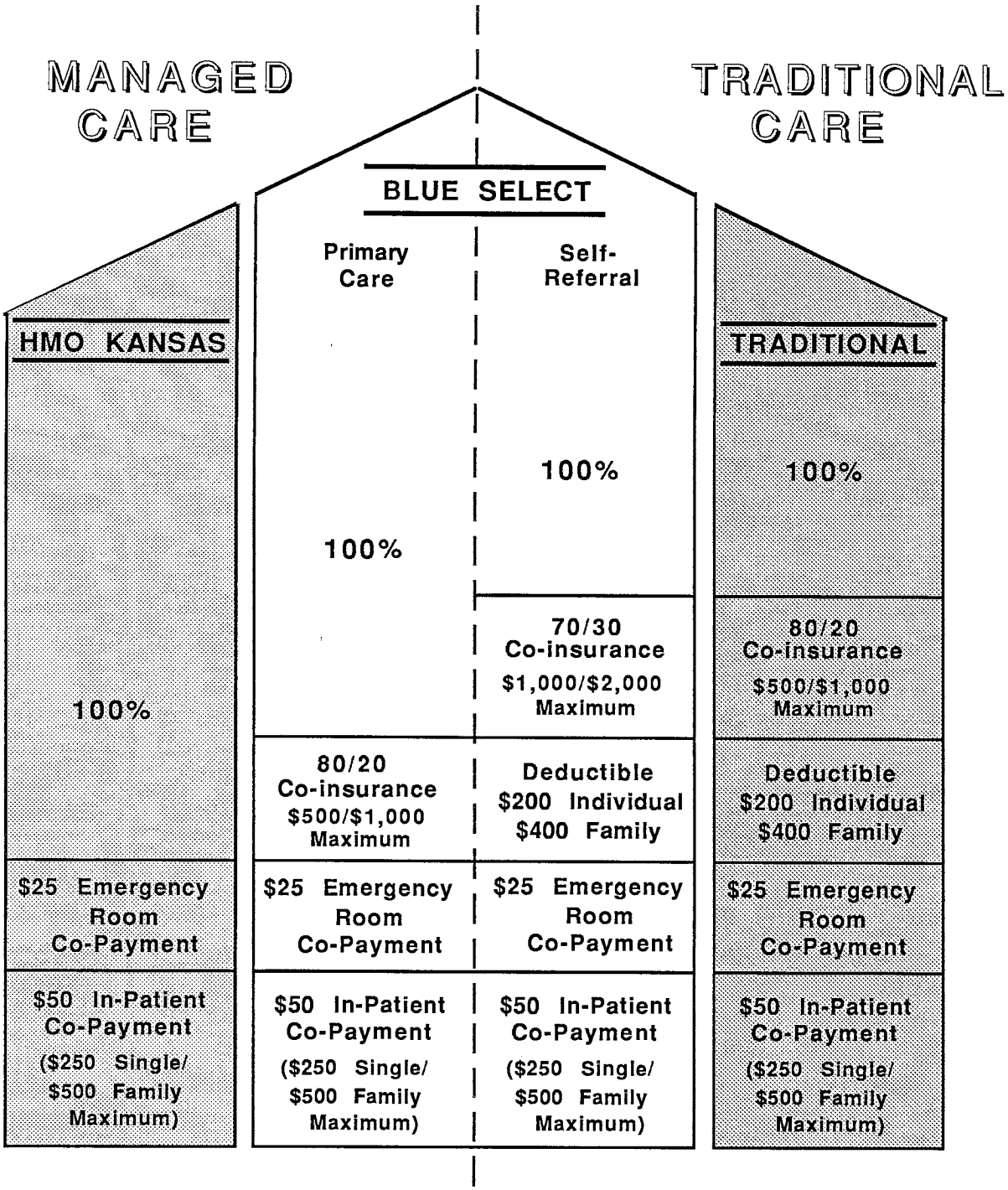
- Be an unrestricted doctor of osteopathy or doctor of medicine licensed in Kansas
- Have a current narcotics (DEA) number
- Be an active non-probationary staff member in the department of family practice, pediatrics, or medicine with at least one hospital which has contracted with Blue Cross and Blue Shield in the primary care physician's program area
- Be in family practice, general practice, general pediatrics, or internal medicine
- Provide total primary care services for the majority of his or her current patients
- Personally provide all primary care services to persons selecting this program (such as treatment for upper respritory infections, flu, minor illnesses, routine physicals, injections, management of uncomplicated chronic diseases, and the like.)
- Be a Blue Cross Blue Shield of Kansas contracting physician
- Never have been expelled or suspended from receiving payment under the Medicare or Medicaid programs
- Never have been convicted of a criminal offense

Office Practice Responsibilities:

- Be available to provide primary care including emergency care on a 24-hour a day, seven days a week basis personally or through pre-designated covering physicians
- Provide an answering machine or answering service that provides instructions to reach the primary care physician or covering physician 24 hours a day
- Provide timely assessment and appropriate referral authorization for members requiring care by another doctor
- Utilize doctors who contract with Blue Cross and Blue Shield of Kansas, when available for necessary referral care
- Provide quality care in a timely cost-effective manner
- Abide by the Blue Cross and Blue Shield of Kansas quality of care and utilization review policies as established for primary care physicians including review of hospital and office records
- Contact Blue Cross and Blue Shield of Kansas to precertify all admissions except life threatening emergencies and maternity
- Care by the physician and his/her office staff is to be provided in a professional, courteous, supportive manner

APPENDIX B

Blue Cross and Blue Shield Options Available to State Employees in 1988



In 1988, most State employees have to choose either HMO Kansas or Blue Select. The Blue Select plan includes a primary care portion, which applies when services are provided or pre-authorized by the primary care physician. (No authorizations are required for eye exams, maternity, services, dental services, or life-threatening emergency services.) Blue Select also includes a self-referral portion, which applies to services outside of the primary care criteria. If services are received under both portions in one year, the employee would pay for coinsurance and deductibles separately under both portions of the Blue Select plan.

APPENDIX C

SINGLE Coverage: Employee's Maximum Annual Out-of-Pocket Expense

Blue Cross Plans	Employee-Paid Premiums	Deductible	Coinsurance	Inpatient Copayment	Maximum Expense
1987 Plans					
Traditional	0	100	200	0	300
Choice Care	0	50	100	0	150
HMO Kansas	0	0	0	0	0
1988 Plans					
Traditional	240	200	500	250	1,190
HMO Kansas	240	0	0	250	490
Blue Select, Primary Care	240	0	500	250	990
Blue Select, Self-Referral	240	200	1,000	250	1,690
Blue Select, Combination	240	200	1,500	250	2,190

Note 1: 1988 premiums include the $10 monthly participation charge and the $10 monthly smoker surcharge.

Note 2: Blue Select, Combination, means that maximum out-of-pocket expenses are incurred under both the Primary Care and Self-Referral portions of the plan.

Note 3: Under all 1988 options, an additional charge of $25 would be incurred for each emergency room visit.

Note 4: Additional out-of-pocket expenses could be incurred for outpatient drugs. Under HMO Kansas, all outpatient drugs are fully paid by the employee. Under 1988 Traditional and Blue Select plans, a copayment is required of $3 for generic drugs, $7 for brand-name drugs.

Note 5: Under all plans, additional out-of-pocket expenses could be incurred for dental services, vision care, and durable medical equipment.

APPENDIX D

FAMILY Coverage: Employee's Maximum Annual Out-of-Pocket Expense

Blue Cross Plans	Employee-Paid Premiums	Deductible	Coinsurance	Inpatient Copayment	Maximum Expense
1987 Plans					
Traditional	1,897	200	400	0	2,497
Choice Care	1,886	100	200	0	2,186
HMO Kansas	1,229	0	0	0	1,229
1988 Plans					
Traditional	2,317	400	1,000	500	4,217
HMO Kansas	1,756	0	0	500	2,256
Blue Select, Primary Care	2,317	0	1,000	500	3,817
Blue Select, Self-Referral	2,317	400	2,000	500	5,217
Blue Select, Combination	2,317	400	3,000	500	6,217

Note 1: 1988 premiums include the $10 monthly participation charge and the $10 monthly smoker surcharge.

Note 2: Blue Select, Combination, means that maximum out-of-pocket expenses are incurred under both the Primary Care and Self-Referral portions of the plan.

Note 3: Under all 1988 options, an additional charge of $25 would be incurred for each emergency room visit.

Note 4: Additional out-of-pocket expenses could be incurred for outpatient drugs. Under HMO Kansas, all outpatient drugs are fully paid by the employee. Under 1988 Traditional and Blue Select plans, a copayment is required of $3 for generic drugs, $7 for brand-name drugs.

Note 5: Under all plans, additional out-of-pocket expenses could be incurred for dental services, vision care, and durable medical equipment.

APPENDIX E

The following tables present various comparisons of Kansas' current health care plan:
The first table compares Kansas' 1988 plan to its 1987 plan.

The second table compares HMO Kansas to similar plans in Colorado and Nebraska.

The third table compares the Kansas Blue Select self-referral option to similar plans offered by other states, the federal government, and Blue Cross and Blue Shield.

The fourth table compares the Kansas Blue Select primary care option to a similar plan offered by Blue Cross and Blue Shield to its employees.

COMPARISON OF KANSAS HEALTH CARE PLANS: 1987 AND 1988

	KANSAS-1988	KANSAS-1988	KANSAS-1987	KANSAS-1987
PLAN NAME AND CARRIER	Blue Select, Primary Care-Blue Cross	Blue Select, Self-Referral-Blue Cross	Traditional Plan-Blue Cross/Blue Shield	Choice Care Plan Blue Cross/Blue Shield
COSTS: Single/Family	$112/286 (a)	$112/286 (a)	$93/251 (a)	$92/249 (a)
Employee's Share:				
Single	$1 - 10 (b,c)	$1 - 10 (b,c)	$0	$0
Family	$174 - 183	$174 - 183	$158	$157
State's Share:				
Single	$102 - 111	$102 - 111	$93	$92
Family	$102 - 111	$102 - 111	$93	$92
DEDUCTIBLE:				
Single	none	$200	$100	$50
Family	none	$400	$200	$100
COINSURANCE:				
Single	80/20% to $500	70/30% to $1,000	80/20% to $200	80/20% to $100
Family	80/20% to $1,000	70/30% to $2,000	80/20% to $400	80/20% to $200
BENEFITS:				
In-Patient Services	Empl. pays $50/day up to $250 ($500 family), then covered subj. to ded. & co-ins.	Empl. pays $50/day up to $250 ($500 family), then covered subj. to ded. & co-ins.	Covered subject to ded. & co-ins.	Covered subject to ded. & co-ins., but benefits reduced if certain hospitals not used
Out-Patient Services	Covered subject to ded. & co-ins.	Covered subject to ded. & co-ins.	Covered subject to ded. & co-ins. but benefits reduced if certain providers not used	Covered subject to ded. & co-ins.,
Office Visits/ Routine Physical Exams	Covered subject to ded. & co-ins.	Covered subject to ded. & co-ins.	Covered subject to ded. & co-ins. providers not used	Covered subject to ded. & co-ins., but benefits reduced if certain
Dental	50% covered	50% covered	50% covered	50% covered
Other Benefits	• Eye exams subject to co-ins. • $25 copay for in-area emerg. care • Copay for out-patient drugs: $3 generic; $7 name brands	• Eye exams subject to co-ins. co-ins. • $25 copay for in-area emerg. care • Copay for out-patient drugs: $3 generic; $7 name brands	•Eye exams subject to ded. & co-ins. •Emergency care subject to deductible & co-ins. •Prescription drugs covered subject to deductible & coinsurance	•Eye exams subject to ded. & •Emergency care subject to deductible & co-ins. •Prescription drugs covered subject to deductible & coinsurance
COST CONTAINMENT MEASURES	• Pre-admission certification for most in-patient	• Pre-admission certification for most in-patient	• Pre-admission certification for most in-patient	• Pre-admission certification for most in-patient

a) Amounts are rounded to the nearest whole dollar
b) Tobacco users are subject to an additional $10 surcharge
c) Amounts vary with salary

COMPARISON OF HEALTH MAINTENANCE ORGANIZATION PLANS

	KANSAS	COLORADO	NEBRASKA
PLAN NAME AND CARRIER	HMO Kansas Blue Cross/Blue Shield	HMO Colorado Blue Cross/Blue Shield	HMO Nebraska Blue Cross/Blue Shield
COSTS [a]:			
Single/Family	$90/216 [b,c]	$82/203	$71/212
Employee Share Single	$1 - 10	$ 16	$24
Employee Share Family	$127 - 136	$137	$47
State Share Single	$80 - 89	$66	$47
State Share Family (amounts vary w/salary)	$80 - 89	$66	$166
DEDUCTIBLE:	None	None	None
COINSURANCE:	None	None	None
BENEFITS:			
In-Patient Services	Employee pays $50/day for 1st 5 days up to $250, (10 days, $500 family), then fully covered when authorized by Primary Care Physican (PCP)	Fully covered when authorized by PCP	Employee pays $25/day up to 10 days, then fully covered when authorized by PCP
Out-Patient Services	Fully covered when authorized by PCP	Fully covered when authorized by PCP	Fully covered when authorized by PCP
Office Visits/Routine Physical Exams	Fully covered when authorized by PCP	Fully covered when authorized by PCP after $5 copayment per visit	Fully covered when authorized by PCP
Dental Coverage	50% for covered services	Coverage provided under 1 of 2 plans, w/varying deductibles & coinsurance	No coverage
Other Benefits	• Eye exams covered; eyewear covered at 50% up to $50 per person • $25 copayment for in-area emergency care, unless hospitalized	• Prescription drugs fully covered subject to $3 copayment • Eye exams fully covered	• Eye exams fully covered • Emergency care fully covered subject to in-patient copayment • Out-patient presc. drugs fully covered subject to $5 copayment • Maximum out-of-pocket costs for all copayments: single = $1,800 family = $5,100
RESTRICTIONS:	• PCP prior authorization required for all services except dental, vision, & life-threatening emergencies	• PCP prior authorization required for all services except for out-of-area emergencies, then must notify w/in 72 hours	• Out-of-area services not covered except for emergency services • Services not authorized or provided by PCP are not covered

a) Amounts rounded to nearest whole dollars
b) Tobacco users are subject to an additional $10 surcharge
c) Amounts vary with salary

COMPARISON OF SELF-REFERRAL PLAN:

	KANSAS	COLORADO	NEBRASKA
PLAN NAME AND CARRIER	Blue Select, Self-Referral--Blue Cross/Blue Shield	State Employees and Officials Group Ins--Colorado (Self-Insured)	Health Care Program for the State of Nebraska--High Option Blue Cross/Blue Shield
COSTS [a]:			
Single/Family	$112/286	$90/211	$59/210
Employee Share Single	$1 - 10 [b,c]	$24 [d]	$12
Employee Share Family	$174 - 183	$145	$44
Employer Share Single	$102 - 111	$66	$47
Employer Share Family	$102 - 111	$66	$166
DEDUCTIBLE:			
Single	$200	$175	$100
Family	$400	$350	$200
COINSURANCE:			
Single	70/30% to $1,000	80/20% to $1,000 (including deductible)	80/20% to $4,000
Family	70/30% to $2,000	80/20% to $1,000 (including deductible)	80/20% to $4,000
BENEFITS:			
In-Patient Services	Employee pays $50/day to $250 ($500 family), then covered subject to deductible & coinsurance	Services are covered subject to deductible & coinsurance	Services are paid in full, not subject to deductible or coinsurance
Out-Patient Service	Services covered subject to ded. & co-ins.	Services covered subject to ded. & co-ins.	Services are paid in full, not subject to deductible
Office Visits/ Routine Physicals	Services are covered subject to deductible & coinsurance	Office visits covered subject to deductible & coinsurance	Some office visits covered subject to deductible & coinsurance; routine physical exams not covered
Dental Coverage	50% for covered services	Coverage provided under 1 of 2 plans, each with varying ded., co-ins.	No coverage
Other Benefits	• Eye exams covered subject to coinsurance • $25 copayment for in-area emergency care, unless hospitalized • Copayment for out-patient presc drugs: $3 generic; $7 name brands	• Emergency care covered subject to deductible & coinsurance • Out-patient prescription drugs covered at 80% after deductible	• Emergency care fully paid • Out-patient presc drugs covered subject to deductible & coninsurance (in-patient drugs fully covered)
COST CONTAINMENT MEASURES	• Pre-admission cert. req. for most in-patient services	• Pre-admission cert. req. for most in-patient services, surgeries • 2nd opinion required for some surgeries • Review of length & type of in-patient services	• Pre-admission cert. req. for most in-patient services • 2nd opinion for some surgeries • Review of length, type in-patient services • Necessary pre-admission tests: out-patient basis • Some surgeries: out-patient

a) Amounts rounded to the nearest whole dollar; b) $10 surcharge on tobacco users;
c) Varies with salary; d) Non-smokers discount available

KANSAS AND OTHER EMPLOYERS

MISSOURI	FEDERAL	BLUE CROSS/BLUE SHIELD
Missouri State Employees'-- Medical Care Plan Missouri (Self-Insured)	Federal Employees Health Benefit Program--Standard Option Blue Cross/Blue Shield	Employee Benefit Plan-- Blue Select Blue Cross/Blue Shield
$89/256	$137/283	$118/266
none $167	$30 $58	$12 $28
$89 $89	$107 $225	$106 $238
$150 $450	$250 $250 (per person)	none none
80/20% to $1,000 80/20% to $2,000	75/25% to $2,500 (including deductible) 75/25% to $2,500 (including deductible)	80/20% to $400 80/20% to $800
Services covered subject to deductible & coinsurance	Paid in full after $100 deductible per admission	Covered subject to deductible & coinsurance
Services covered subject to deductible & coinsurance	Covered subj. to ded. & co-ins. (70% non-member facilities)	Covered subject to deductible & coinsurance
Some office visits covered subject to deductible & coinsurance; routine physical exams not covered	Some office visits covered subject to deductible & coinsurance; routine physical exams not covered	Covered subject to deductible & coinsurance
No coverage services	Covered up to specified amounts for named services	Covered at 100% for routine & peridontics; 50% for dentures & restorations
• Emergency care covered subject to deductible & coinsurance • Prescription drugs covered subject to deductible & coinsurance	• Emergency care fully covered • Prescription drugs covered at 75%; 100% after $5 co-ins. per prescription mail order copayment	• Vision care covered at 100% with no deductible • Deductible for out-patient prescription drugs: $3 generic; $5 for name brands (subject to coinsurance)
• Surgeries done on out-patient basis paid in full, deductible waived • 2nd opinion required for some surgeries • Necessary pre-admission tests done on out-patient basis, paid in full deductible waived • Some surgeries must be done on out-patient basis	• 2nd opinion, pre-admission review, & prior authorization programs are available in some regions	• Pre-ad certification req for most in-patient services

COMPARISON OF BLUE SELECT PROGRAMS: KANSAS AND BLUE CROSS AND BLUE SHIELD

	KANSAS	BLUE CROSS/BLUE SHIELD
PLAN NAME AND CARRIER	Blue Select--Primary Care Blue Cross/Blue Shield	Blue Select--Primary Care Blue Cross/Blue Shield
COSTS [a]:		
Single/Family	$112/286	$118/266
Employee's Share Single	$1 - 10 [b,c]	$12
Employee's Share Family	$174 - 183	$28
Employer's Share Single	$102 - 111	$106
Employer's Share Family	$102 - 111	$238
DEDUCTIBLE:	None	None
COINSURANCE:		
Single	80/20% up to $500	None
Family	80/20% up to $1,000	None
BENEFITS:		
In-Patient Services	Employee pays $50/day for 1st 5 days up to $250 (10 days, $500 family), then fully covered when authorized by primary care physician	Covered when authorized by primary care physician
Out-Patient Services	Covered when authorized subject to coinsurance	Covered when authorized by primary care physician
Dental Coverage	50% of covered charges, no referral needed	100% for routine & peridontics, 50% for dentures & restorations, no referral needed
Other Benefits	• Eye exams covered, no referral required, subject to coinsurance • $25 copayment for in-area emergency care unless hospitalized • Prescription drug copayments: $3 generic, $7 brand-name	• Eye exams covered, no referral required • a $25 copayment for in-area emergency care unless hospitalized • Prescription drug copayments: $3 generic, $5 brand-name

a) Amounts rounded to nearest whole dollar
b) Tobacco users are subject to an additional $10 surcharge
c) Amounts vary by salary

APPENDIX F

Agency Responses

On November 24, 1987, copies of the draft audit report were sent to the the Health Care Commission and Blue Cross and Blue Shield for review and comment. The written responses are included in this appendix.

STATE OF KANSAS

DEPARTMENT OF ADMINISTRATION
State Capitol
Topeka 66612-1572
(913) 296-3011

H. Edward Flentje, *Secretary*

November 30, 1987

Meredith Williams
Legislative Post Auditor
109 West 9th, Suite 301
Topeka, Kansas

Dear Mr. Williams:

Thank you for the opportunity to review and comment on the draft audit report Reviewing the Health Care Plan For State Employees.

On balance the report accurately outlines the process the Commission followed in structuring a health benefits program for 1988. In adopting this program, the State Employees Health Care Commission sought to accomplish four principal objectives:

- to move the state employee group towards "managed care," a health plan in which the necessity of medical care is more carefully reviewed;
- to hold down the increase in premiums for family coverage;
- to create incentives for preventive health care and thereby reduce long-term health care costs for the state employees group; and
- to prepare the state employees group for exercising the option of self-insurance in the near future.

We look forward to discussing these matters further with you and your staff and with the Legislative Post Audit Committee. We hope that this report and any subsequent work you will be doing may lead to ways in which we can improve the health benefits program for state employees and retirees.

The staff is still reviewing the draft audit report for numerical correctness. We will call your office if any errors are found. Barbara Duncan and I both plan to be in attendance at the 10:00 a.m., December 7 Legislative Post Audit Committee meeting.

Sincerely,

H. Edward Flentje
Chairman, State Employee's
Health Care Commission

HEF:dp

cc: Fletcher Bell
Dr. Robert Harder
Barbara Duncan

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of Kansas

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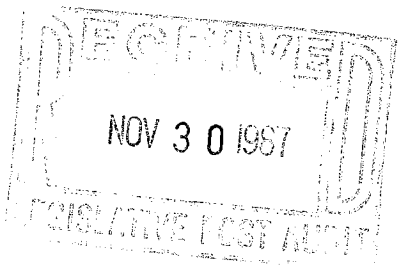
G. Wayne Johnston
President and
Chief Executive Officer

November 30, 1987



Meredith Williams
Legislative Post Auditor
109 West 9th, Suite 301
Topeka, Kansas 66612-1285

Dear Mr. Williams:

Thank you for the opportunity to review the draft copy of the performance audit report, Reviewing the Health Care Plan For State Employees. We found the report to be thorough and comprehensive.

There are, however, a few items that we ask you to consider as you prepare the final report on this subject.

The discussion on pages 8 and 9, involving physician selection and selection criteria, requires clarification. Please consider the following restatements:

"Blue Cross and Blue Shield Initially Contracted With Primary Care Physicians Who Had Previous Successful Experience With An HMO

In addition to the State employees' group, only the City of Wichita's employee group and Blue Cross and Blue Shield's own employees will have their health care needs provided through the Blue Select option. A Blue Cross official indicated that several other groups are currently considering the Blue Select option. Blue Cross and Blue Shield began establishing a primary care physician list for Blue Select during the spring of 1987, but did not begin marketing Blue Select until the Fall of 1987, with the first effective date to be January 1, 1988.

Blue Cross and Blue Shield initially contacted only those physicians who had contracted to be primary care physicians in an HMO. Outside the HMO Kansas area, primary care physicians in larger Kansas cities (Dodge City, Pittsburg, Hays, etc.) were contacted for interest. Membership in an HMO was not required. Over time, as word about the Blue Select plan spread, other physicians began to contact Blue Cross and Blue Shield about participation in the plan. Any physician requesting information about the plan was contacted for consideration as a possible Blue Select primary care physician. Initially, doctors who were in an HMO Kansas service area were expected to sign with HMO Kansas if they also wished to participate as a primary care physician in the Blue Select plan.

The initial directory that was given to State employees listed 410 primary care physicians. Of those, 18 accepted established patients only. Another 63 physicians were listed as pediatricians, four of which accepted established patients only. It should be noted that Blue Cross listed the 473 pediatricians and primary care physicians in the Blue Select directory by location. Some physicians practice in more than one location and were listed in multiple locations. As a result, the auditors' numbers include some double-counting of physicians. In addition to these doctors, the directory listed 477 primary care physicians and pediatricians who served the Kansas City metropolitan area.

Blue Cross currently does not require Blue Select physicians to participate in an HMO, but certain criteria must be met.

Following publication of the State health care plan for State employees in October, 1987, Blue Cross began to receive complaints and inquiries from physicians about the plan. As a result, Blue Cross decided to end the requirement that primary care physicians for Blue Select had to be primary care physicians for an HMO as well. However, participating physicians still had to sign an agreement and meet certain eligibility requirements.

A Blue Cross and Blue Shield of Kansas official told the auditors the company looked at the availability of primary care physicians across the State and determined that all areas, with the possible exception of the Topeka area, would have adequate coverage. The official said that in Topeka, there would likely be a need to increase the number of primary care physicians. With the changes in the requirements for participation, more primary care physicians are being added to the Blue Select physician list. On November 18, 1987, Blue Cross issued an addendum to the primary care physician directory. A total of 87 additional physicians, including four pediatricians, were added to the list. An official of the company indicated that one or two more updates to the directory could be expected before the start of the plan in January 1988.

The criteria for primary care physicians are the same as the criteria for providers who have contracted to serve HMO Kansas. Doctors who contract to be primary care physicians for Blue select must meet the same screening criteria that are required for HMO Kansas primary care physicians. One criterion is that the physician practice in one of four areas: general pediatrics, general practice, family practice, or internal medicine. Additional criteria are designed to ensure the primary care physicians will be available to personally provide the total primary care needs for all their patients. For example, the physicians must be able to provide services on a 24-hour basis, treat minor illnesses, conduct routine physicals, and manage uncomplicated chronic problems on a timely basis. According to Blue Cross officials, their experience with HMO Kansas has confirmed that this type of service can best be provided by physicians in the four specialties. Appendix A presents a list of screening criteria.

Under both the Blue Select and HMO plans, incentives are provided to physicians to hold down costs. One of the objectives of the managed care program is to hold down increases in medical costs. Under the Blue Select option, primary care physicians are reimbursed on a fee-for-service basis at rates established by Blue Cross and Blue Shield. However, they are also eligible to receive "incentive" payments if their patients' monthly costs are lower than average. The incentive is for the primary care physicians to keep their patients' expenses as low as possible by eliminating unnecessary services while maintaining quality patient care."

On page 11 the first sentence of the second paragraph should read "In 1987, State employees had three basic choices of health care plans: Traditional, Choice Care, and HMO coverage from one of a number of HMO's."

The comparison on page 13 presented a variety of programs. We were unable to determine if all the rates were applicable and in effect for all of the 1988 calendar year. Is this the case?

The second paragraph on page 14 states that the Kansas premium for both single and family coverage is slightly higher than the Blue Cross and Blue Shield employees group premium. The Kansas single premium of $112 is lower than the Blue Cross and Blue Shield employees premium of $118.

Physician criteria listed in Appendix A should include two additional criteria in the Office Practices section to be complete. These are:

-- Provide quality care in a timely cost effective manner

-- Care by the physician and his/her office staff is to be provided in a professional, courteous, supportive manner

Please also note in the Personnel section the reference in the third criteria to program would be clarified by referring to program area.

The dental coverage for Blue Cross and Blue Shield, Appendix E, Table 4 needs to be restated as follows: Covered at 100% for routine and periodontics, 50% for dentures and restorations. Please note that table labels for reference points will help us in future discussion of these comparisons.

We must point out that the Blue Select product is a single program with two options, not two separate programs. We recognize the difficulty of making comparison of the type presented in Appendix E. However, one must be careful in drawing conclusions. To illustrate this point Table 3 and Table 4 compare the self-referral and primary care components of the Blue select product with other products. The rates listed on both tables are product rates, not component related rates. No component related rates are available.

We appreciate the opportunity to comment. We hope that this contribution will assist you in the preparation of the final audit report.

Sincerely,

G. Wayne Johnston
President

GWJ:mm