

PERFORMANCE AUDIT REPORT

**Reviewing the Process For Providing
Health Insurance Benefits
For State Employees**

**A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
June 1993**

Legislative Post Audit Committee

Legislative Division of Post Audit

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PERFORMANCE AUDIT REPORT

REVIEWING THE PROCESS FOR PROVIDING HEALTH INSURANCE BENEFITS FOR STATE EMPLOYEES

OBTAINING AUDIT INFORMATION

This audit was conducted by Sharon Patnode, Jim Davis, and Cindy Lash, Auditors, of the Division's staff. If you need any additional information about the audit's findings, please contact Ms. Patnode at the Division's office.

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REVIEWING THE PROCESS FOR PROVIDING HEALTH INSURANCE BENEFITS FOR STATE EMPLOYEES

Summary of Legislative Post Audit's Findings

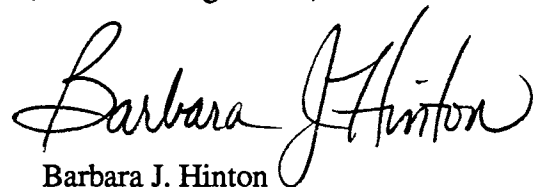
How do the health care benefits and costs for State employees compare to those in other states? In general, Kansas' health-care coverage compares favorably with the other states we reviewed. While deductibles and co-insurance requirements varied from state to state, Kansas' State employees paid among the lowest in maximum annual out-of-pocket costs. Kansas' health insurance premiums for employee-only and full-family coverage were among the most costly due, at least in part, to lower maximum annual out-of-pocket costs. In other words, there is a trade-off between premium levels and out-of-pocket costs for employees.

What steps does the State Employees Health Care Commission take to ensure that health care coverage provides reasonable benefits at the lowest cost? Those steps include the following: giving prospective insurers the option of bidding on a multi-year contract, seeking feedback from State agencies and insurers about possible ways to reduce costs, negotiating with bidders before signing health insurance contracts, and building cost containment measures--like requiring pre-certification for non-emergency hospital admissions--into the health insurance contract. Commissioners considered reducing premiums by increasing out-of-pocket expenses, but employees rejected this proposed change. In addition, the health insurance contract has been negotiated in a manner that allows the State to retain a portion of its premiums in years when claim expenses are low.

Do all State employees have equal access to the benefits provided by the State's health insurance plan? State employees do not have equal access to benefits because not all employees have access to the same insurance plans across the State. Employees and their dependents covered under the State's conventional health insurance plans have access to most general practice doctors, dentists, and hospitals in their cities. However, choices of practitioners are more limited for employees in managed-care plans. Choices of hospitals of limited in Wichita.

What would the impact be on State employee health insurance costs if the Regents' institutions became a separate group? If Regents' employees had been a separate group within the 1993 State employees' health insurance plan, that group's claims experience would have resulted in 18 percent lower premiums, causing premiums for the remaining group of State employees to increase by 14 percent. In the past, the Health Care Commission has not allowed one group of State employees to benefit at the expense of other employees. Therefore, it is likely that any savings resulting from the Regents employees forming a separate group would be distributed to all employees causing very little change in premiums.

This report includes several recommendations for improving the State employees' health insurance program. 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

REVIEWING THE PROCESS FOR PROVIDING HEALTH INSURANCE BENEFITS FOR STATE EMPLOYEES

The State Employees Health Care Commission was formed in 1984 and given statutory authority to develop and implement a health-care benefits program for State employees. The State of Kansas provides health-care benefits to its employees and their dependents, and pays a portion of each employee's monthly premium.

In recent years, the Commission has experienced contracting problems. For the last several years, Blue Cross and Blue Shield was the only company that offered a bid for a fully-insured health insurance program (one in which an insurance company assumes the risk for the total amount of any claims). In July 1992, Prudential Insurance Company announced it was withdrawing from the second year of its contract for State employee dental coverage.

Legislative concerns have been raised that the process for purchasing health insurance coverage for State employees does not provide the highest level of benefits for the least cost. For example, the Kansas State University Faculty Senate recently compared the University's health care benefits to the benefits of its peer institutions in other states. It contended that nearly all the other universities gave employees better benefits at a cheaper cost. Because of these concerns, the Legislative Post Audit Committee directed the Legislative Division of Post Audit to conduct a performance audit answering the following questions:

- 1. How do the health care benefits and costs for State employees compare to those in other states?**
- 2. What steps does the State Employees Health Care Commission take to ensure that health care coverage provides reasonable benefits at the lowest cost?**
- 3. Do all State employees have equal access to the benefits provided by the State's health insurance plan?**
- 4. What would the impact be on State employee health insurance costs if the Regents' institutions became a separate group?**

To answer these questions, we reviewed State statutes and regulations and interviewed State officials and health insurance officials in nearby states. We also surveyed State employees, doctors, dentists, and hospital administrators in eight cities across Kansas. In addition, we reviewed bids submitted for the 1993 medical and dental programs, and correspondence and Health Care Commission meeting minutes related to the 1993 bidding and contracting process.

To determine the effect of Regents' institution employees leaving the State health insurance program, we asked Blue Cross and Blue Shield to recompute premiums, and we tested for accuracy the information Blue Cross used in the recomputation. In conducting this audit, we followed all applicable government auditing standards set forth by the U.S. General Accounting Office.

In general, Kansas' health-care coverage compares favorably with the other states reviewed. While deductibles and co-insurance requirements varied from state to state, Kansas' State employees paid among the lowest in maximum annual out-of-pocket costs. Health insurance premiums for Kansas' State employees were higher, in large part because of these lower maximum annual out-of-pocket costs.

The Kansas Health Care Commission has taken a variety of steps to ensure that benefits are provided at reasonable costs, including trying to attract more bidders on the medical plan, reviewing options for cutting health insurance costs, and considering the possibility of becoming self-insured. Nonetheless, we found that efforts to gain input from State employees about changes or improvements in the health insurance plan could be improved. We also found that not all State employees have access to the same plans and, thus, to the same benefits. A number of employees we surveyed expressed dissatisfaction about doctors and hospitals available to them under their health-care plans, particularly in those areas where not all doctors or hospitals participated in the plan.

Finally, we found that if Regents' institution employees had been a separate group within the State's Blue Cross and Blue Shield health insurance program for the 1993 plan year, premiums for Regents' employees could have been 18 percent lower, while premiums for the remaining State employee group could have been 14 percent higher. These and other related findings will be discussed in more detail following a brief overview of the health insurance program.

Overview of the State Employees Health Insurance Program

The State's Health Care Commission, established in 1984, is responsible for negotiating a health-care benefits plan for State employees. Members of the Commission include the Commissioner of Insurance, the Secretary of Administration, a current State employee in the classified service, a person retired from the State classified service, and a representative of the general public. All members except the Insurance Commissioner and the Secretary of Administration are appointed by the Governor. The Commission is assisted by a staff of four and a consultant, whose primary role is chief contract negotiator.

The Commission issues requests for proposals for the medical, drug, dental, and health maintenance programs in May each year; proposals are due in late June. The Commission conducts contract negotiations and approves a contract by late August. There is an "open enrollment" each October, when State employees have the opportunity to change health insurance plans.

The State has multiple plans from which employees may choose. Every employee can select either Blue Cross and Blue Shield's Traditional or Blue Select plans, depending upon where in the State he or she lives. In addition, in some areas of the State health maintenance organizations (HMOs) are available to State employees.

The following table provides details regarding the insurance plans available to State employees in 1993, and describes the number of employees covered by each plan and the general availability of the plans across the State.

Health Insurance Plans Available To State Employees			
<u>Conventional Plans</u>	<u>Provider Choice</u>	<u>Where Available</u>	<u>Number of Employees Enrolled (a)</u>
Blue Select	Must choose a primary care physician	54 Counties	24,528
Traditional	Free choice of doctors	51 Counties	12,021

	<u>Provider Choice</u>	<u>Where Available</u>	<u>Number of Employees Enrolled (a)</u>
<u>Health Maintenance Organizations</u>			
HMO-Kansas	Must choose a plan doctor	26 Counties (b)	5,933
Kaiser Permanente, Humana-Medplan, Humana-Prime, and Metlife	Must choose a plan doctor	Kansas City area	2,510
Preferred Plus of Kansas	Must choose a plan doctor	South Central Kansas	1,597

- (a) The number of employees enrolled includes both active and retired employees as of February 1, 1993.
- (b) There are 26 counties in which HMO-Kansas providers are directly located. There are an additional 25 counties which include locations within 30 miles of an HMO doctor. Employees in these 25 counties may join HMO-Kansas but must travel 30 miles to visit a plan doctor.

As the table shows, the majority of employees are enrolled in the three Blue Cross/Blue Shield plans: Blue Select, Traditional, or HMO-Kansas. Health maintenance organizations are available only in selected areas of the State; the largest number are in the Kansas City and Wichita areas. A map showing the health insurance plans available to State employees across Kansas is shown on page 33 of this report.

In the graphic on the facing page, we call the Traditional and the Blue Select self-referral coverages "conventional care" because they contain deductibles and co-insurance provisions not generally found in managed care programs such as health maintenance organizations and the Blue Select primary care option. People insured by health maintenance organizations also must use doctors and hospitals within the HMO network, a restriction not typically found in conventional insurance plans.

Costs for the State's Health Insurance Program Have Increased More Than 40 Percent Since 1990

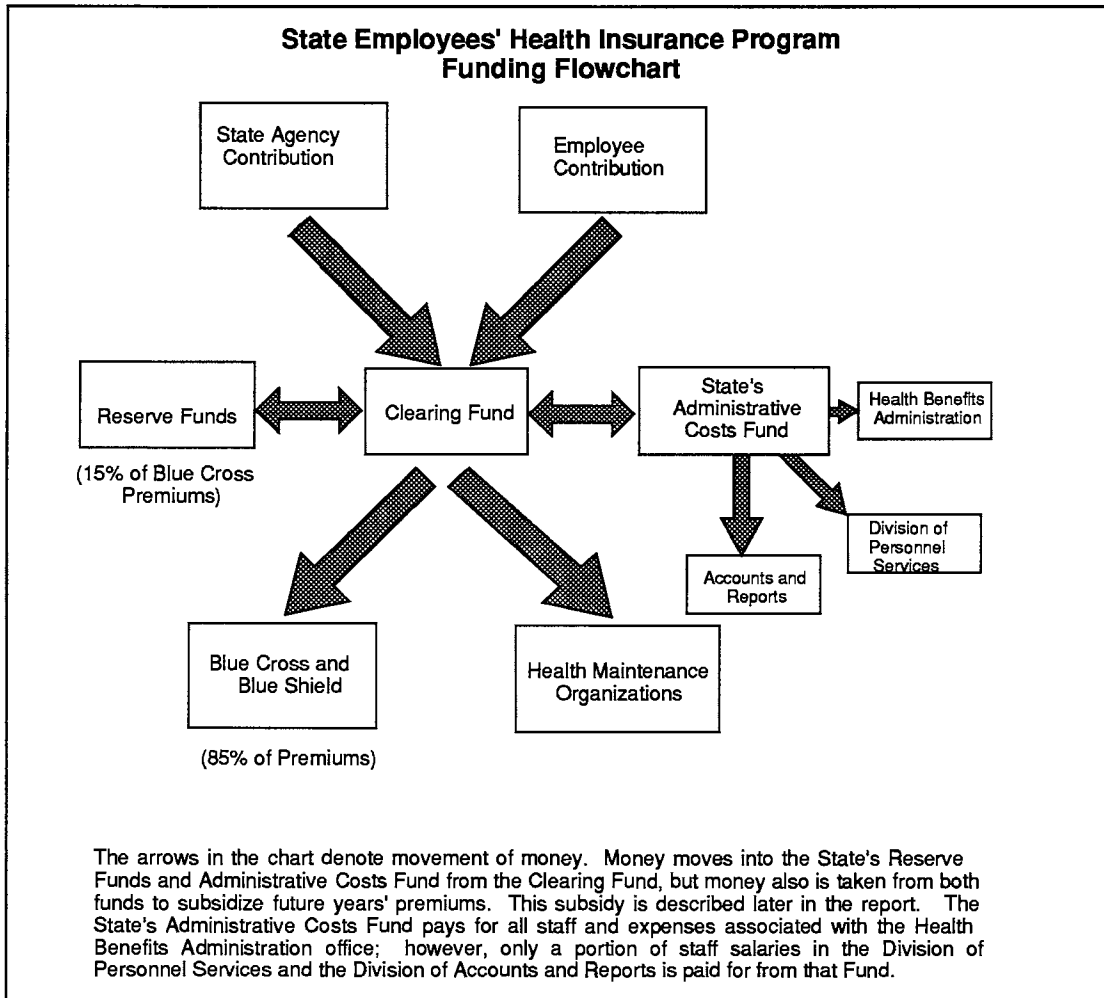
The State of Kansas provides health insurance benefits to its employees and their dependents, and pays a portion of each employee's monthly premium. The following flow chart shows how money flows from State agencies and employees to insurance companies. Overall, premiums are set at a level to cover the following:

- claims for medical costs
- administrative costs for the State, including the Health Benefits Administration office, the benefit analysis unit of the Division of Personnel Services, and a portion of staff in the Division of Accounts and Reports

Blue Cross and Blue Shield Options Available to State Employees in 1993

MANAGED CARE		CONVENTIONAL CARE		
HMO KANSAS		BLUE SELECT		TRADITIONAL
100%		Primary Care	Self-Referral	100%
No Deductible		No Deductible	Deductible \$200 Individual \$400 Family	Deductible \$200 Individual \$400 Family
\$10 per Office Visit		80/20 Co-insurance \$500/\$1,000 Maximum	70/30 Co-insurance \$1,000/\$2,000 Maximum	80/20 Co-insurance \$500/\$1,000 Maximum
\$25 Emergency Room Co-Payment		\$25 Emergency Room Co-Payment	\$25 Emergency Room Co-Payment	\$25 Emergency Room Co-Payment
\$50 In-Patient Co-Payment		\$50 In-Patient Co-Payment	\$50 In-Patient Co-Payment	\$50 In-Patient Co-Payment
(\$250 Single/ \$500 Family Maximum)		(\$250 Single/ \$500 Family Maximum)	(\$250 Single/ \$500 Family Maximum)	(\$250 Single/ \$500 Family Maximum)

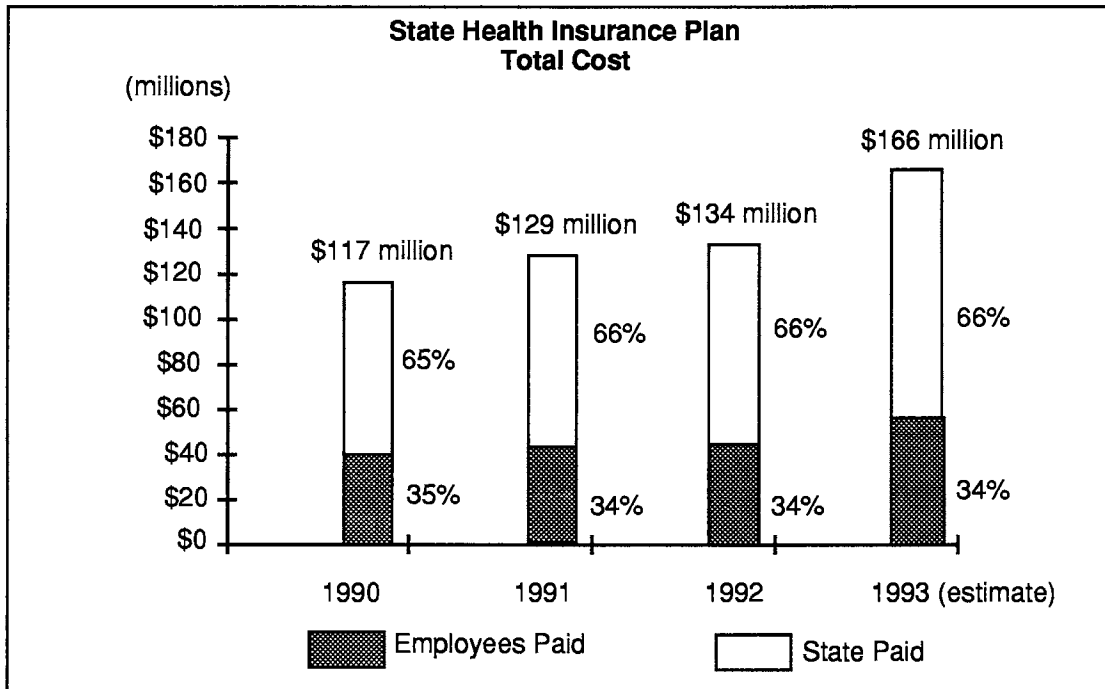
HMO-Kansas and the Blue Select primary-care option are managed care plans. Services are provided or pre-authorized by a primary-care physician. (No authorizations are required for eye exams, maternity services, or life-threatening emergency services.) Employees in the Blue Select primary-care option may refer themselves to physicians and still receive benefits under the self-referral option of Blue Select. However, if an employee in HMO Kansas uses a non-HMO doctor, no benefits will be paid. The Blue Select self-referral option and the Traditional plan are conventional care. Both allow employees to freely choose health care providers. Dental coverage is not included in this chart.



- administrative costs for the insurer, including the cost of maintaining a provider network and processing claims

As the chart on the facing page shows, for calendar year 1993, the State employees' health insurance program (including dependent coverage) is estimated to cost nearly \$166 million. That figure represents an increase of 42 percent over the 1990 total of nearly \$117 million, or an average increase of about 13 percent per year. Primary reasons for such increases include the following:

- *higher medical costs* (the medical consumer price index has risen by 20 percent since 1990)
- *an increase in the number of employees covered* (this number has increased by five percent over the three-year period)
- *an increase in State employees' claims experience* (as described in more detail later, claim amounts have increased 53 percent since 1989, either because of increased use of medical benefits or increased medical costs)



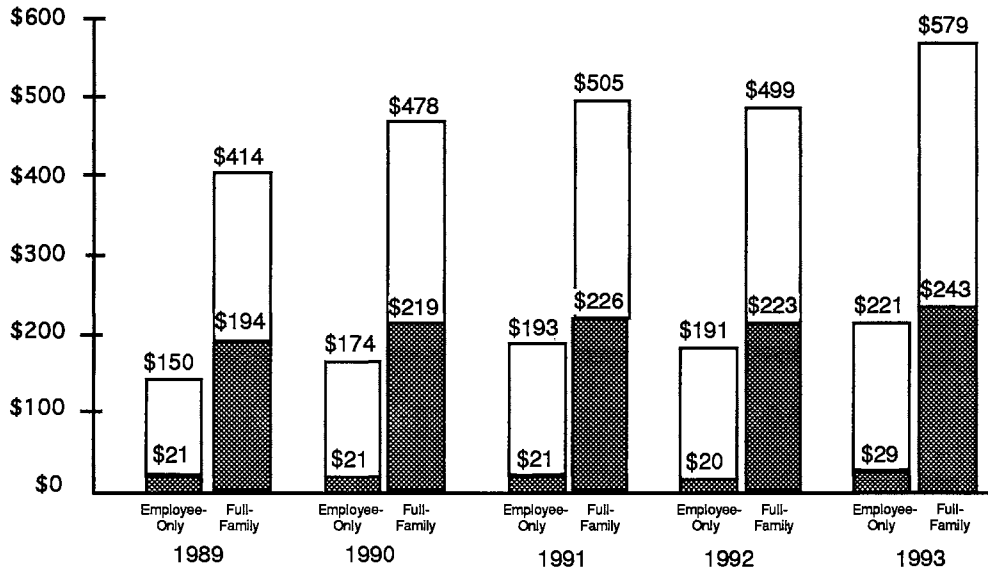
The accompanying graph also shows that the portion of premiums paid by employees and the State has remained fairly constant over the three-year period, at about 34 percent and 66 percent, respectively.

Because of rising premiums in recent years, the State has subsidized dependent care to make it more affordable for employees. Since 1989, premiums for all types of coverage have increased substantially. For the Traditional and Blue Select programs, premiums for employee-only coverage increased by 48 percent, and premiums for full-family coverage increased by about 40 percent. During the same time, premiums for HMO-Kansas employee-only coverage and full-family coverage increased 62 percent and 68 percent, respectively. The charts on the next page show these increases.

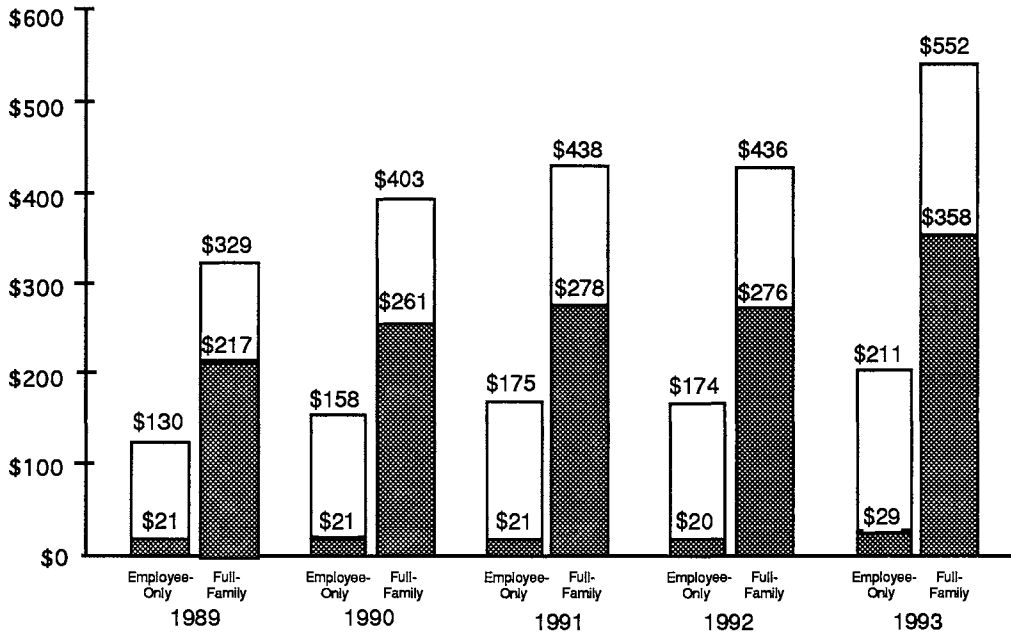
The charts also show that even though the total premiums for the various plans are different, employee-only coverage costs State workers the same under any of the plans. In contrast, the premium cost to the State worker for full-family coverage under the Traditional and Blue Select plans is much less than under the HMO-Kansas plan, even though the overall family premium for HMO-Kansas is somewhat less than the traditional plans.

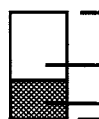
In 1989, the State began to subsidize full-family coverage for the Traditional and Blue Select plans to draw employees with dependents back into these plans from health maintenance organizations. For this reason, the employee's share of dependent coverage (shown by the darkened portion of the bars) for those plans did not increase as rapidly as it otherwise would have. In 1989, the State began paying 15 percent of the cost of covering employees' dependents. In 1993, that subsidy was increased to 25 percent.

**Maximum Monthly Premiums for Employee-Only and Full-Family Coverage
Blue Select and Traditional Programs, 1989 - 1993**



**Maximum Monthly Premiums for Employee-Only and Full-Family Coverage
HMO-Kansas Program, 1989 - 1993**




 Total Premium
 Premium Paid by the State
 Premium Paid by Employees

All the insurance plans for State employees have several different premium rate structures, such as: employee-only, full-family, employee and spouse, employee and child(ren), and married employees who both work for the State. Kansas' plans also have different premiums for different salary levels as well as for tobacco and non-tobacco users. For the purpose of simplicity and to compare maximum premiums in all states, this audit focused on employee-only and full-family premiums for employees in the highest salary category with the tobacco user surcharge.

**State Employees' Claim Amounts Have Increased
By More Than 50 Percent Since 1989, While Administrative Fees
Have Increased Nearly 40 Percent**

The total dollar amount of claims for employees covered by the Blue Select and Traditional plans increased from almost \$60 million in 1989 to an estimated \$91 million in 1992, an increase of 53 percent. As noted above, other reasons for increases would include the rising cost of medical care, increased use of medical benefits, and an increase in the number of covered employees in these plans.

(Claims information for health maintenance organizations is not available for this period. Until recently, these organizations reimbursed health care providers at a set fee per patient, regardless of the service provided. As a result, the amounts HMOs paid out did not reflect the medical services employees actually received.)

The following table shows total premiums and total claims in the Blue Select and Traditional plans, including medical, dental, and drug programs, for the years 1989 - 1992. The table also shows the total administrative fee received by Blue Cross and Blue Shield in that time period.

**Premiums, Claims, Administrative Fees,
and Claims and Fees as a Percent of Premiums
for the Blue Select and Traditional Plans
Plan Years 1989 - 1992**

Year	Total Premiums (a)	Total Claims	Administrative Fee	Claims and Administrative Fees as a % of Premiums
1989	\$70,074,818	\$59,674,956	\$4,835,737	92%
1990	\$89,982,974	\$70,955,666	\$6,118,842	86%
1991	\$105,159,319	\$83,087,502 (b)	\$6,314,650	85%
1992	\$101,710,151	\$91,008,300 (c)	\$6,643,606	96%

(a) Blue Cross does not receive the total premiums shown here because a portion of the premiums are kept in the State's reserve accounts. Blue Cross actually collected the following, including administrative fees: 1989 - \$64,510,118; 1990 - \$77,074,508; 1991 - \$89,402,152; 1992 - \$97,651,906.

(b) The Health Benefits Administration estimated this figure because all claims for 1991 will not be finally settled until July 1993.

(c) The Health Benefits Administration estimated this figure because all claims for 1992 will not be finally settled until July 1994.

As the table shows, administrative fees paid to Blue Cross and Blue Shield have risen from \$4.8 million in 1989 to \$6.6 million in 1992, an increase of 37 percent. That fee is based on the relationship between claims and premiums; as claims become a smaller percent of premiums, the administrative fee increases. According to the State's present contract with Blue Cross, the administrative fee cannot exceed 8.1 percent of claims. The administrative fee was increased in 1992 so that Blue Cross could create an incentive fund to encourage health care providers to hold down service costs.

Finally, the table shows that the State's premiums more than covered total claims in each of the last four years. The premium figures for 1992 dropped primarily because Blue Cross did not insure the dental program in 1992. Dental premiums in 1992 were sent to Prudential. In addition, claims paid to-date in 1992 increased over previous years.

How Do Health Insurance Benefits and Costs For State Employees Compare to Those in Other States?

Generally, Kansas' health-care coverage compares favorably with the other states reviewed. While deductibles and co-insurance requirements vary from state to state, Kansas' State employees pay among the lowest in maximum annual out-of-pocket costs. Health insurance premiums for Kansas' State employees were higher than other states, in large part because of these lower maximum annual out-of-pocket costs. These and other findings are discussed in the sections that follow.

In General, Kansas' Health-Care Coverage Compares Favorably With Other States

We reviewed state employee health insurance plans in the neighboring states of Colorado, Missouri, Nebraska, Oklahoma, and Iowa, including conventional health insurance plans and health maintenance organizations (referred to as HMOs). All the states we reviewed had both types of plans, although Missouri's and Oklahoma's HMOs were described as small, regional, and having relatively few participants. In addition, the states we reviewed had a mixture of self-insured and fully-insured plans. The differences between these types of plans is described in the box below.

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

In our contacts with other states, we encountered two basic ways to provide group health insurance for employees. Several of the states had "self-funded" or "self-insured" plans, while others were "fully insured." In general, those terms may be described as follows:

- States that are self-insured assume the functions, responsibilities, and risks of an insurer. For example, a special fund is established into which employees' premiums are deposited. Then, when employees use health services, claims are paid from moneys in that fund.

- States that are fully-insured hire an insurance company to assume the risk of paying claims from premium moneys the company collects from employees.

Also, there are "shades of gray" between the above "black and white" descriptions. For example, under a "minimum premium plan," a state would self-insure a fixed percentage of estimated claims, and hire an insurance company to insure the excess. In addition, many states with self-funded plans hire an insurance company to process claims.

The plans we reviewed provided coverage for basically the same types of services as the Kansas plans. The details of coverages vary from plan-to-plan in the different states, but certain basic services were covered to some extent by all the plans we reviewed. Such services included in-patient services, out-patient services, office visits/routine physicals, and dental work.

The box on the following page shows that the percentage of co-insurance Kansas employees have to pay (80/20) is higher than in other states. However, Kansas' plan has no deductible, which in most cases results in Kansas employees paying less for their health-care services. This point is illustrated at the bottom of the box on page 12.

**Examples of Coverages
Provided to State Employees (a)**

	Hospital Admissions/ Inpatient Services	Outpatient Services	Routine Physicals & Office Visits	Dental
Kansas deductible \$0 co-ins. 80/20%	Covered subject to \$50/day co-payment, w/a \$250 max./yr./individual; \$500/family and 80/20% co-insurance.	Subject to co-insurance of 80/20%. No deductible.	Subject to co-insurance of 80/20%. No deductible.	Coverage is generally 50/50% under a separate Blue Cross plan.
Colorado deduct \$100/200 co-ins 90/10%	Paid at 90% for unlimited days, subject to a deductible of \$100 individual/\$200 family.	Paid at 90% after \$100/\$200 deduct.	Paid at 90% after deductible—the frequency of covered visits varies with patients' age.	Dental Maint. Organization pays 100% for most services.
Iowa deduct \$0-100 co-ins 90/10%	Paid at 90% after \$100 deductible. Prior approval required.	Paid at 90% no deductible. Mandatory for some services.	Office visits paid at 90% with no deduct. Limit of 1 physical per member per year.	Diagnostic and preventive services gen'ly covered at 100%
Missouri deduct \$300/900 co-ins 90/10%	Covered subject to deductible and 90/10% co-insurance	Care and supplies are covered subject to deductible and 90/10% coinsurance.	Covered subject to deductible and 90/10% coinsurance, unless for preventive care.	Routine dental care is not covered. Only covers injuries.
Nebraska deduct \$150/300 co-ins 80/20%	Covered subject to deductible and 80/20% co-insurance.	Covered subject to deductible and 80/20% co-insurance.	Routine physicals are not covered. Non-routine office visits subject to deductible and co-insurance.	Must use plan dentists, with co-payments of varying amounts for each service.
Oklahoma deduct \$0 co-ins 0% various co-pay requirements	Covered subject to \$200 per confinement, then at 100% with no deductible.	Outpatient surgery has \$100 co-payment; associated services covered at 100%, with no deductible.	Covered with a \$15 co-payment per visit with no deductible.	Preventive services have no deductible & are paid at 100%. Basic services like fillings have a \$25 deductible and are paid at 80%.

[a] Coverages shown are for conventional (non-HMO) plans with the highest enrollments of state employees.

Amount incurred in one year for health care

		\$100	\$500	\$1,000	\$5,000
Example:					
Amount	KS	\$20	\$100	\$200	\$500 (a)
employee	CO	100	140	190	600 (a)
pays	(a)	Subject to a maximum annual cap.			

Kansas employees also pay among the lowest annual out-of-pocket amounts of the comparison states. That comparison is presented on page 17.

Many of the states have co-payment requirements in addition to deductibles and co-insurance. Co-payments are paid every time a service is provided. All states, except Missouri provide routine dental coverage. Missouri provides dental coverage only in the case of injuries. Kansas' dental plan with a 50 percent co-insurance requirement provides significantly lower coverage than the remaining four states. Appendix A provides a comprehensive summary of benefits provided by all the conventional plans and HMOs in the different states we reviewed.

Kansas' Total Health-Care Premiums Were the Highest of the States We Reviewed

Kansas' premiums were highest for both employee-only and full-family coverage in both the conventional health-care plans and HMOs.

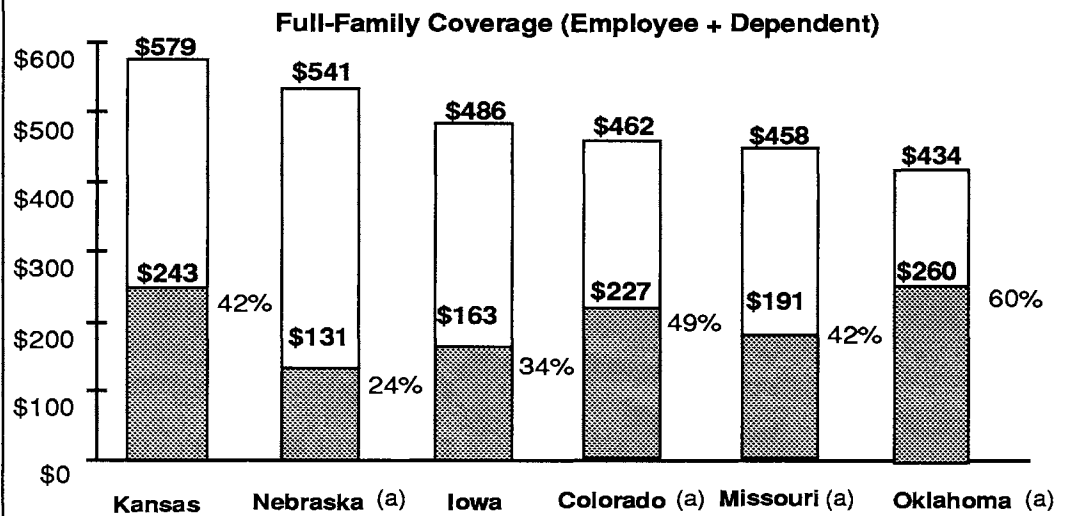
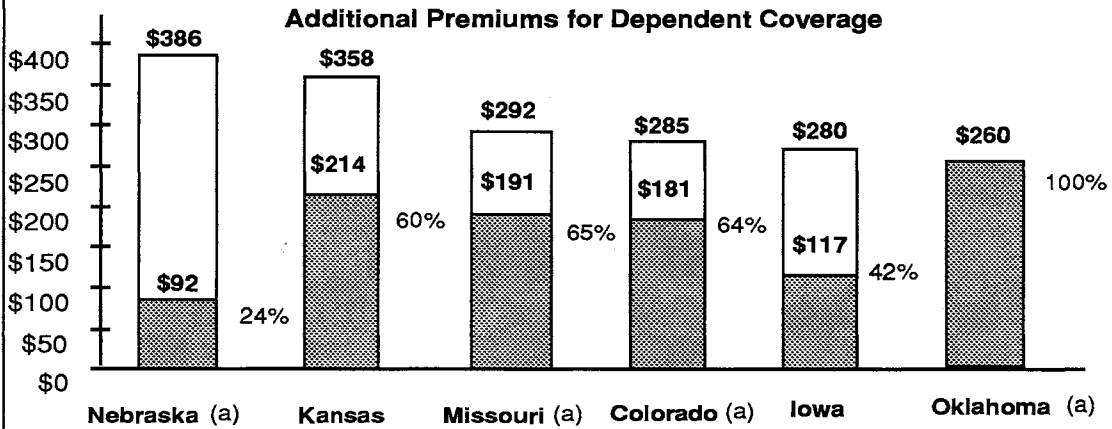
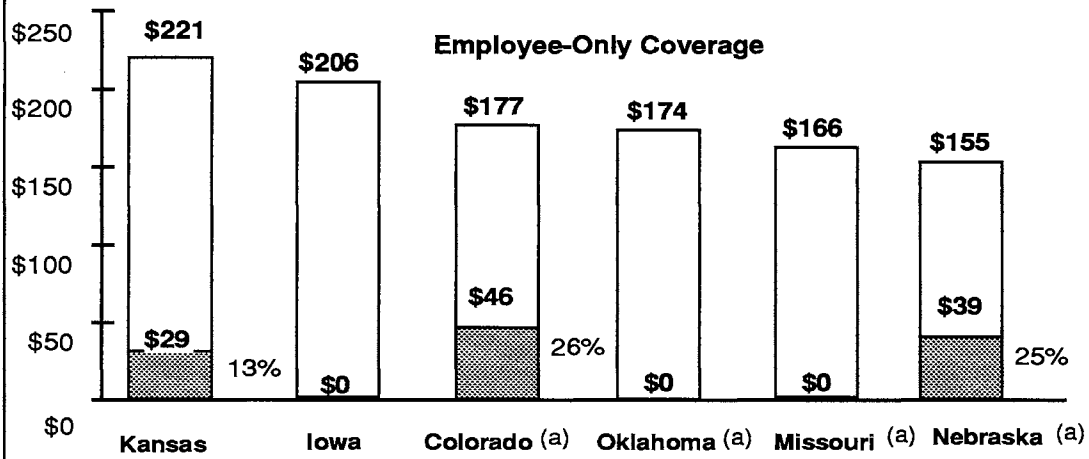
For conventional health-care plans, Kansas' premiums were significantly above the averages of the other states we reviewed. The graph on the next page shows the total maximum premiums for health insurance coverage, including medical, drug, and dental coverages, in the conventional health-care plans in Kansas and the other states we reviewed. (All of the states included in our review, except Iowa, have plans containing multiple levels of coverage, for example, employee-only, employee and spouse, employee and one child, and full-family. State employees in Kansas and Colorado pay higher or lower premiums based on factors such as salary level or whether they use tobacco products. In every state, we chose the maximum premium possible for comparison purposes.)

As the top chart on the graph shows, at \$221 Kansas had the highest total premiums for employee-only coverage in conventional health-care plans. This figure compares with an average of \$176 for the other states reviewed. This top chart also shows the following:

- Three of the six states—Iowa, Oklahoma, and Missouri—do not require employees to pay anything toward their employee-only coverage.
- Of the three that do, Kansas was lowest both in terms of dollars (\$29 compared with \$39 in Nebraska and \$46 in Colorado), and percentages (13 percent compared with 25-26 percent in the two other states).
- The four states with self-insured plans—Colorado, Oklahoma, Missouri, and Nebraska—had lower premiums than the two states with fully-insured plans (Kansas and Iowa).

The middle chart shows the additional cost of insuring an employee's dependents (excluding the employee-only portion of full-family coverage). As this chart shows, Kansas' premiums ranked second of the sixth states, both in terms of the total amount of additional premium, \$358, and the amount of the additional premium paid by the employee, \$214.

Maximum Premiums in Conventional Plans



Employee-Paid Portion of Premium (shaded box) State-Paid Portion of Premium (white box) (a) Self-insured states

Finally, the bottom chart shows the total cost of insuring an employee and his or her dependents (full-family coverage). This chart shows that Kansas had the highest total premium for full-family coverage—\$579—compared with an average of \$493 in the other states. The bottom chart also shows the following:

- All six states required employees to pay a portion of full-family coverage.
- Kansas ranked second only to Oklahoma in terms of the dollar amount employees were required to pay. However, Colorado and Oklahoma required employees to pay a higher percentage of the cost of full-family insurance coverage (42 percent in Kansas compared with 49 percent in Colorado and 60 percent in Oklahoma).
- Again, three of the four states with self-insured plans—Missouri, Colorado, and Oklahoma—had lower premiums.

For insurance coverage provided by health maintenance organizations, Kansas' premiums still were well above the averages of the other states we reviewed. The graph on page 16 shows the total maximum premiums for health insurance coverage in the main health maintenance organizations in Kansas (HMO-Kansas) and in three of the other states we reviewed. (Missouri and Oklahoma do not have comparable HMOs.)

As the top chart shows, at \$211 Kansas had the highest total premium for employee-only coverage in HMOs. This figure compares with an average of \$159 for the three other comparison states. This top chart also shows the following:

- Of the three states that require employees to pay something toward their employee-only coverage, Kansas was lowest in terms of percentage (14 percent compared with 18 and 26 percent), and about the lowest in terms of dollars paid.

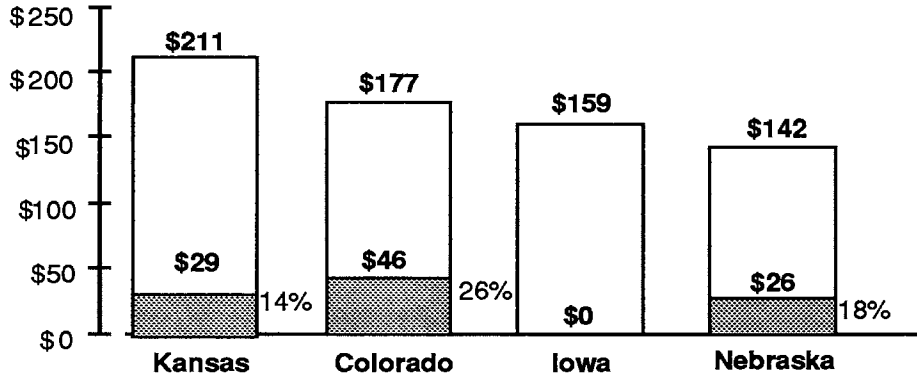
The middle chart on page 16 shows that Kansas' additional premiums for adding dependent coverage also are the highest, followed by Nebraska and Iowa. Unlike the three other states, however, Kansas employees are required to pay almost the full cost of this additional dependent coverage.

Finally, the bottom chart shows that Kansas had the highest total premiums for full-family coverage—\$552—compared with an average of \$472 in the other states. The bottom chart also shows the following:

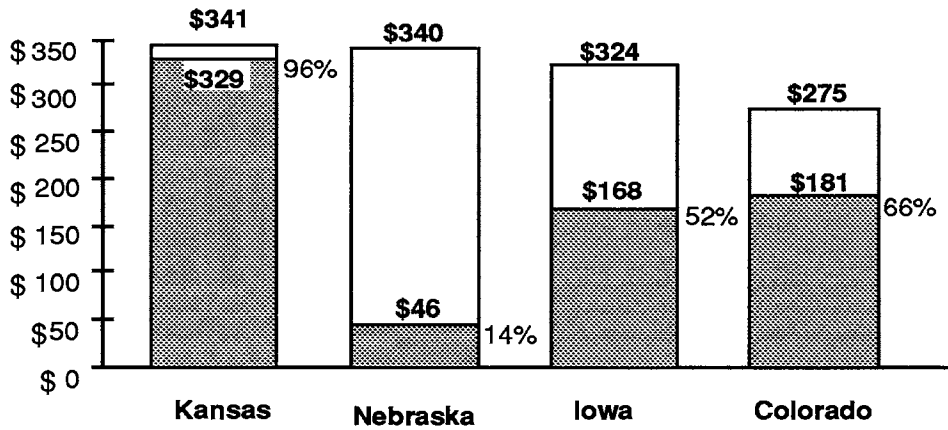
- The amount Kansas required its employees to pay was highest both in terms of dollars (\$358 in Kansas compared with \$227 in Colorado, the next closest state), and in terms of percentages (65 percent in Kansas compared with a range of 15-50 percent in the three other states).

Maximum Premiums for Health Maintenance Organizations

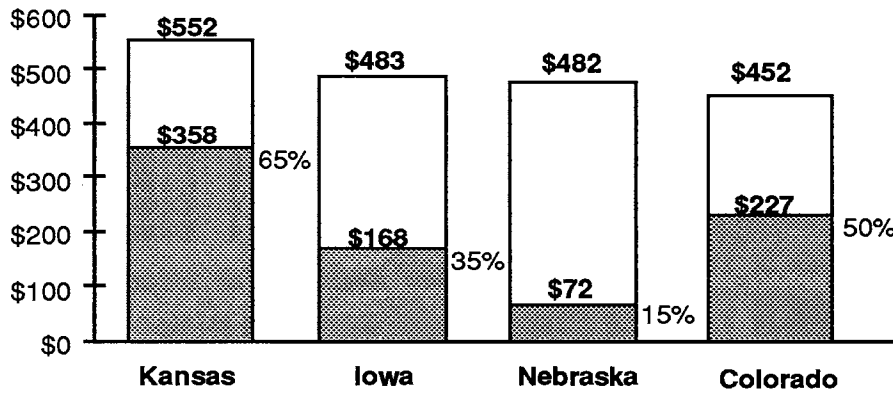
Employee-Only Coverage



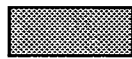
Additional Premiums for Dependent Coverage



Full-Family Coverage (Employee + Dependent)



Employee-Paid Portion
Of Premium

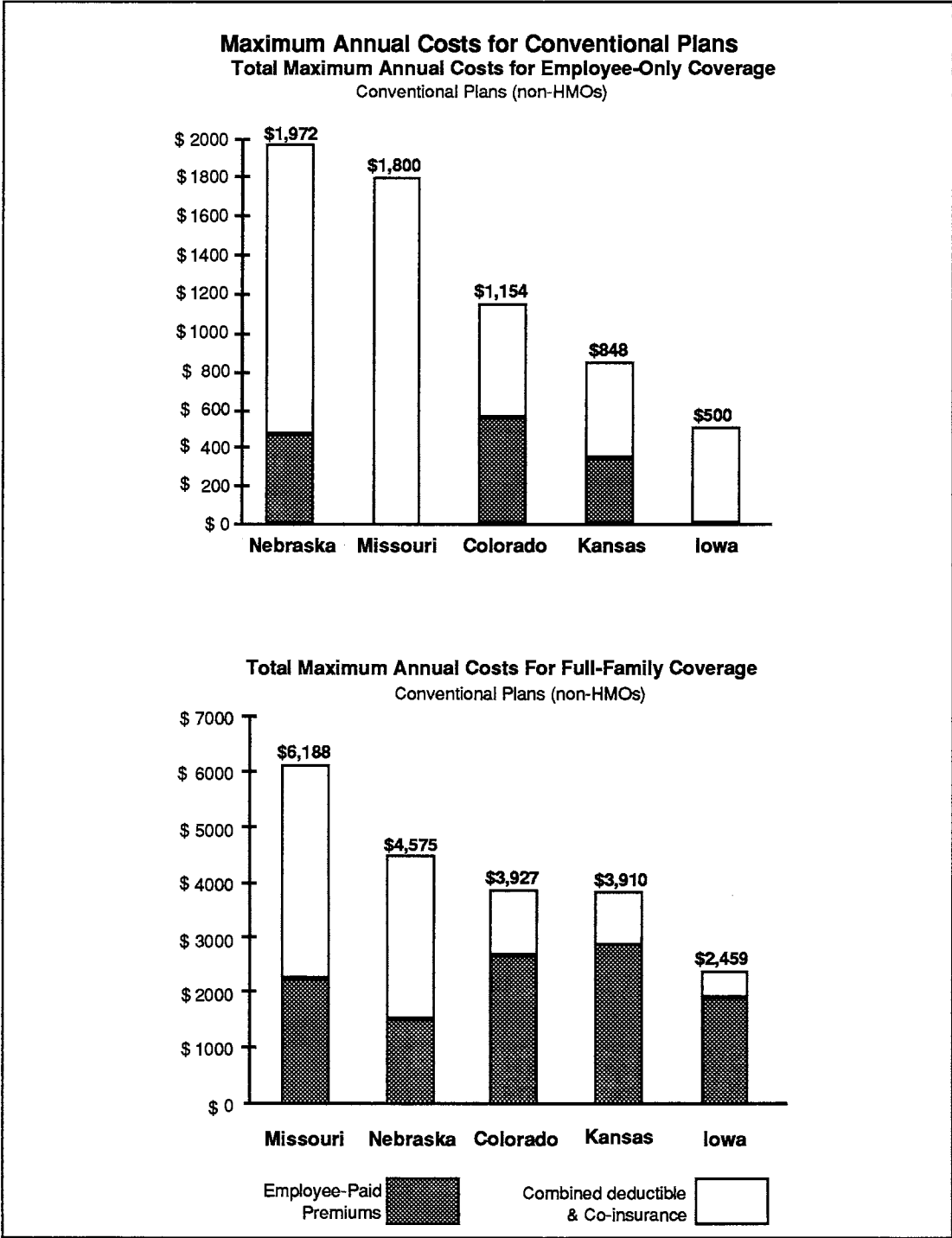


State-Paid Portion
Of Premium



Kansas' State Employees Have Among the Lowest Annual Out-of-Pocket Expenses for Their Health-Care Coverage

The graph below shows the maximum out-of-pocket expenses State employees would have to pay each year under a conventional health-care plan before their



medical expenses would be paid at 100 percent. This figure includes all deductibles, co-insurance, and premiums. (Oklahoma is excluded from these comparisons because that state's plan generally includes co-payments on services rather than deductibles and co-insurance, making maximum out-of-pocket expenses difficult to estimate.) In addition, no comparison is made for HMOs because employees generally do not have any out-of-pocket costs beyond any premiums they have to pay.

As the top chart on the previous page shows, Kansas employees' maximum annual out-of-pocket expense for employee-only coverage is \$848 per year. The bottom chart shows that their maximum out-of-pocket cost for full-family coverage is \$3,910. These figures for Kansas are among the lowest of the states we reviewed. These charts also show the following:

- The State with the highest maximum annual out-of-pocket expenses for employee-only coverage was Nebraska at \$1,972—\$1,100 more per year than in Kansas.
- Because Missouri and Iowa do not require employees to pay anything toward their employee-only coverage, out-of-pocket costs for their employees reflect only the total maximum deductibles and co-insurance they might pay in a year.
- The highest annual out-of-pocket maximum for full family coverage was in Missouri at \$6,188—nearly \$2,300 more than in Kansas.

Conclusion

While deductibles and co-insurance requirements vary from state to state, Kansas' State employees paid among the lowest in maximum annual out-of-pocket costs of all states we reviewed. Kansas' State employees appear to be paying higher premiums, at least in part, to keep annual out-of-pocket expenditures down. By raising annual deductibles and co-insurance, it seems likely that the State could lower its total premium costs. However, at the same time, heavy users of health insurance would be adversely affected by higher maximum annual out-of-pocket costs.

What Steps Does the State Employees Health Care Commission Take to Ensure that Health Care Coverage Provides Reasonable Benefits at the Lowest Cost?

The Commission has tried to increase competition among insurers, and has given insurers the option of bidding on a multi-year contract. It holds a strategy session each year to consider changes to the benefit structure and how those changes might affect premiums. The Commission sought feedback from State agencies and from the Employee Advisory Committee on potential changes to the contract, although it did not always do so in a timely fashion. One option the Commission considered was to reduce premiums by increasing out-of-pocket expenses, but employees rejected this proposed change. The Commission also negotiated with bidders before signing contracts for health, HMO, dental, and prescription drug services. Cost-containment measures also have been built into the contracts in an attempt to keep costs from rising as fast as they otherwise would. In addition, the health insurance contract has been negotiated in a manner that allows the State to retain a portion of its premiums in years when claims are low. These and other findings are discussed in the sections that follow.

The Kansas Health Care Commission Has Tried to Increase Competition For the Health Insurance Plan

Over the years, Kansas has had few bidders for its main health plan. In fact, Blue Cross has received the contract for State employees health insurance in every year since 1971. This lack of competition has been seen as a problem, and attempts have been made to attract more bidders by advertising the contract in national publications and, since 1990, by offering multi-year contracts. In addition, the Commission has indicated that it will consider bids for a self-insured plan, but stated it would give priority to fully-insured proposals. However, entities as large and geographically dispersed as the State present a significant financial risk for an insurer, and establishing a Statewide network of health care providers is a major undertaking.

Most companies that have chosen not to bid on the State's health care plan do not bid on such large groups or on governmental entities. The Department of Administration surveyed 27 large insurance companies in Fall 1992 to learn why they had not bid on the State's insurance plan. In an effort to stimulate competition for the State plan and acquire constructive suggestions, companies were asked to review the State's Request for Proposal and provide comments on content, as well as on two proposed changes to the bid procedures. One of the changes would have allowed additional time to submit a bid, while the other involved a change in the negotiating procedures.

Eight of the 12 respondents (75 percent) who had not bid on the State contract in the past indicated they either did not bid on groups as large as the State, or did not bid on governmental entities. Of the four remaining companies, one did not provide

fully-insured coverage for large groups, one did not have a Statewide network of providers, one (the State's previous dental carrier) said the State did not offer strong enough support for managed care, and one was operating under court order and could not bid on any new business. None of these companies commented on the content or structure of the State's Request for Proposal or on the proposed procedural changes.

Five companies that bid on the State contract in the past also received and responded to the survey. Based on these responses, the proposed schedule change was incorporated into the 1994 Request for Proposal (which may increase the number of bidders on those contracts), and the proposed change in negotiation procedures was dropped.

In all areas except dental services, the number of bidders increased in 1993. The table below shows the number of bidders and the winning bidders for health, drug, and dental plans available to State employees for the last four years.

<u>Type of Plan</u>	Number of Bidders and Winning Bidder			
	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>
Health	1 Blue Cross	1 Blue Cross	1 Blue Cross	3 Blue Cross
Prescription Drug	1 Blue Cross	1 Blue Cross	2 Blue Cross	10 Blue Cross
Dental	1 Blue Cross	1 Blue Cross	9 Prudential	6 Blue Cross
HMO	6 Family Health HMO Kansas Kaiser Perm. MedPlan Prime Health	6 Family Health HMO Kansas Kaiser Perm. MedPlan Prime Health	7 HMO-Kansas Kaiser Perm. MedPlan	8 HMO-Kansas Humana P.H. Kaiser Perm. MedPlan MetLife Preferred Plus

It is unclear why the number of bidders on the health plan tripled. There were no significant changes in the plan or the process that would account for this increase. However, many additional bidders may have been attracted to the prescription drug plan because of a new "mail-order drug program." The number of bidders for health maintenance organizations increased only slightly.

In spite of the increased number of bidders, Blue Cross was still the winning bidder for health, drug, and dental services. In the health and prescription drug areas,

The Prudential Insurance Company Withdrew From Its Contract With the State To Provide Dental Insurance

The Prudential Insurance Company was awarded a two-year contract for State employee dental coverage for the 1992 contract year. (Before 1992, Blue Cross and Blue Shield had the State's dental insurance contract.) In June 1992, Prudential put the State on notice that it would exercise its option to withdraw from the second year of the contract.

Under Prudential's plan, State employees were offered two levels of coverage. State employees were given the option of participating in a Dental Maintenance Organization, or "DMO." Employees participating in the DMO would receive full payment for preventive services. Those not participating in the DMO, would be covered at the rate of 60 percent for preventive services.

The reason cited for the company's withdrawal was that only eight percent of the State employee group chose the DMO option. According to the Health Care Commission's consultant, Prudential's premiums had been predicated on at least 50 percent participation in the DMO. The

Commission's consultant estimated that Prudential would lose more than \$1 million in 1992 if all dental care under the State employees' health plan was provided by non-DMO dentists.

A Prudential official indicated that the State had not supported the DMO option as the Company had hoped it would. In addition, the official said the State did not support a "well-designed enrollment process" resulting in the low percentage of State employees that enrolled in the DMO.

In its response to this audit, the Health Care Commission pointed out that it was Prudential's failure to contract with DMO dentists in the areas with large State employee concentrations that led to the lack of enrollment in the DMO. The Commission response indicated, "Prudential also declined to conduct a full open enrollment and elected to enroll employees by phone" contributing to lack of employee responsiveness to the DMO.

Blue Cross was the only bidder to offer a fully-insured plan, and as a result the Commission gave Blue Cross' bid preference over the other two bids. Four of the six dental bids were for fully-insured programs, but after extensive analysis of the bids, Blue Cross was selected because of its extensive network of dentists, who cannot bill State employees for charges that exceed Blue Cross' approved fee levels. Also, the Commission thought that Blue Cross' plan offered the best possibility of cost savings for the State.

Other states also have few bidders for fully-insured programs. Of the five states whose benefits and premiums we reviewed, only Iowa has a fully-insured plan similar to Kansas'. The four other states were self-insured. Iowa officials reported that in their past two bid cycles, Blue Cross of Iowa was the only company to bid on a fully-insured program. We also interviewed officials in North Dakota, one of only 16 states in the nation with a fully insured program for state employees. North Dakota has had only one bid cycle since becoming fully insured (before 1989 it was self-insured), but its only bidder also was Blue Cross of North Dakota.

The Commission Has Considered But Not Acted On Self-Insuring The State's Health Care Program

Four of the five states we surveyed were self-insured. These states, which tend to have lower insurance premiums than Kansas or Iowa (the two fully-insured states), provide all funds necessary to pay the claims and administrative expenses of their health plans. Missouri handles claims administration with in-house staff, while Colorado, Nebraska, and Oklahoma contract with insurance companies to process claims. The box on the following page describes the problems Oklahoma had when it used in-house staff to process claims.

Oklahoma Has Had Difficulties Administering Its Self-Insured Health Insurance Plan

Oklahoma's experience with self-insurance has been troublesome. The plan originally covered only State employees, and claims were processed by in-house staff. In 1988, the legislature doubled the number of employees covered by adding county and public education employees to the plan. No staff were added to handle the additional workload, and problems quickly arose with a large backlog of claims, claims being overpaid or paid to ineligible people, and the like. The accounting and operating systems reportedly had no internal controls. Then, in 1989, the legislature froze premium rates because they thought they had been rising too rapidly.

The health insurance plan had net operating losses in 1988, 1989, and 1990 and was technically insolvent when the legislature appropriated a \$30 million cash infusion in May 1990. In July, premium rates were determined on an actuarial basis for the first time. A lengthy audit was begun, which, in January 1991 reported that \$85 million of the plan's liabilities were actually assets.

Inadequate bookkeeping practices over the years had resulted in insufficient accounting information to actually determine the system's financial statements, so auditors had assumed the worst in estimating liabilities. Then, at some point, plan officials had transferred assets of the health and dental insurance fund into the life insurance and disability funds. When the auditors re-created accounting records for several previous years, and transferred the assets back to the health and dental fund, they removed \$85 million of liabilities.

Officials in these states told us they thought they had better control over premiums and benefits by being self-insured. They said the greatest disadvantage was the potential loss incurred by the State in a bad claim year. However, states can insure against such losses by purchasing stop-loss coverage. Claims have not always been predictable in Kansas. For example, in 1987, Blue Cross reportedly lost \$8.5 million on the Kansas State employees health insurance plan because claims were so much greater than premium income. In contrast, in 1989 claims and administrative fees were nearly \$65 million, only 92 percent of premiums, and in 1990 they were about \$77 million, only 86 percent of premiums.

Kansas statutes authorize the Health Care Commission to establish a self-funded program on an actuarially sound basis for part or all of the State employee benefit program, or to contract for all or part of the administration of a self-insured program. In mid-July 1992, the Health Benefits Administrator prepared a report for the Commission outlining the advantages of being self-insured versus remaining fully-insured. Although the report did not advocate a position, the information presented in

that report would suggest that many of the traditional advantages of self-insurance would not produce a large cost savings for the State. The advantages of becoming self-insured or remaining fully-insured, as reported by the Health Benefits Administrator, are described below.

Advantages of Self-Insurance

- ***To save risk premiums.*** Insurance companies figure a risk premium into their bid to compensate themselves for taking the chance that claims and administrative expenses will be greater than the total premiums paid. The State would not pay itself a risk premium if it were self-insured, but this savings

might be offset if a decision were made to purchase some type of coverage to prevent extreme losses.

- ***To save premium tax.*** Under federal law, self-insured plans are exempt from premium taxes. However, because premium taxes are paid to the State, much of the premium tax associated with the State plan amounts to shifting money from one pocket to another.
- ***To be excluded from State-mandated benefits.*** Federal law also allows self-insured plans to be exempt from State-mandated benefits, which in Kansas includes such things as care by an optometrist, dentist, podiatrist, chiropractor, or psychologist. In the past, the Health Care Commission has said the State plan should continue to provide these benefits even if the plan were self-insured.
- ***To improve the return on investment of reserves.*** Some insurance companies do not pay interest on the reserves they hold under a group plan. Under the State's contract with Blue Cross, however, the State holds most of the reserves and receives the interest on these monies.

Advantages of Being Fully-Insured

- ***To have the insurer assume the risk of greater-than-expected claims.*** Claims that exceed premiums are the responsibility of the insurance company.
- ***To continue to use the network of the insurer.*** These networks generally involve providers accepting a discount on their fees.
- ***To have a relatively even cash-flow requirement.*** Standard premiums are due each month, with the insurer absorbing the potentially uneven flow of claims.

According to the Health Benefits Administrator, there are no plans to self-insure the medical plan; however, self-insuring the dental plan is being considered. Commissioners took no action at the time they received the report regarding self-insuring the medical plan, but subsequently decided to consider self-insured proposals for the 1994 dental plan. The Health Benefits Administrator noted that the dental program is relatively small (annual premiums of \$7-8 million), claims have been stable for a number of years, and individual claims are limited to \$2,000 annually. Because of these factors, self-insuring the dental program is a limited risk for the State.

To be actuarially sound, according to the Health Benefits Administrator, the State will need to place an amount equal to two to three months premiums, or approximately \$1.5 million, in a reserve fund in case dental claims and administrative costs exceed the premiums received.

Each Year, the Commission Considers Changes That Would Affect the Costs and Benefits of the Plan

The Commission is charged with developing and providing for the implementation and administration of a State health care benefits program. Each year the Commission considers changes for the upcoming year.

In 1992, the Commission received feedback from the Employees' Advisory Committee and from the heads of approximately 20 State agencies on the 1993 plan. The Advisory Committee is charged with studying issues related to the health plan and providing recommendations to the Commission, advising the Commission on the effects of possible actions on employees, and providing an opportunity for employees to have their opinions considered in the decision making process of the Commission.

The Committee was invited to review and comment on the 1993 Request for Proposal. But because the Committee did not get to see the proposal until very late in the process, it was too late for the Commission to incorporate any of the Advisory Committee's suggestions, such as an enhanced well-child program, into the actual proposal. However, Committee members were asked to voice their opinion of the various bidders to the Health Care Commission. The Chairperson of the Advisory Committee stated that the current Commission actively seeks the Committee's opinions.

In Spring 1992, the Commission also sent surveys to the heads of approximately 20 State agencies. The Commission asked whether employees would prefer to keep the same benefits at a higher cost to the employee, or whether they would prefer a reduction in benefits to keep employee contributions at the same or lower levels. Commission members also wanted to know what types of benefit improvements or reductions would be most desired or acceptable. These agency heads overwhelmingly reported that employees preferred to keep the same benefits, even if they had to pay more.

At its Spring 1993 strategy session, the Commission considered a high-low coverage option for the State plan. Under such an option, employees would be able to choose between a lower monthly premium with higher deductibles and lower benefits, or a more expensive monthly premium with lower deductibles and better benefits. One concern was that lower paid employees would be attracted by the lower premium, but could experience financial disaster if they had significant medical problems.

Although not all the results from the 1993 survey of agency heads had been received by the time the Commission was considering this issue, those that had been received were opposed to offering a low-benefit choice. Ultimately, the Commission decided not to include this option.

At this session, the Commission also decided to ask Blue Cross to provide data on the number of health-care providers who also own ancillary services, such as laboratories and radiology centers. There is a concern that this practice may be contributing to rising medical costs. Ownership information could be used to determine whether these services are being overused by their physician-owners. For example, a doctor who also owned part of a lab might be ordering an excessive number of tests for patients.

In 1993, the Commission sent a more extended survey to heads of selected State agencies, but they did not solicit feedback from the Employee Advisory Committee. In addition to asking whether employees would like a high-low benefit option, the survey asked the following:

- whether employees would be willing to accept a reduction in the number of hospitals they could use in order to reduce plan and premium costs
- how they rated the cost to employees of "Employee Only" coverage
- how they felt about the subsidy for dependent care, and
- what types of plan changes they would like

Although not all survey responses were received by the time the 1994 Request for Proposal was prepared, the comments that had been received reportedly influenced its content. According to the Health Benefits Administrator, the responses indicated there was not enough support for a low-benefit option to include it in the plan, and that employees did not support limiting the network of hospitals they could enter.

The Chairperson of the Employee Advisory Committee said the Health Benefits Administrator initially asked her to call a meeting of the Committee to consider the 1994 Request for Proposal, but subsequently told her it was too late. It appears the Commission may be using the agency survey in lieu of recommendations from the Committee.

State Health Benefits Officials Told Us There May Be Advantages In Integrating Some Employee Benefit Programs

Benefit programs for State employees are distributed among several State agencies. Retirement, long-term disability, and life insurance programs reside at the Kansas Public Employees Retirement System office. Deferred compensation, flexible spending (KanElect), and wellness programs are administered by the Division of Personnel Services which also answers employees' questions regarding health insurance coverages. The Health Benefits Administration is responsible for developing requests for proposal and negotiating contracts for the medical, drug, and dental insurance programs.

During the course of this audit, we asked officials of the Health Care Commission and Health Benefits Administration if cost savings could be achieved by combining some of the State employees' benefits programs. We were

told by a Health Benefits Administration official that adding life insurance to the health insurance request for proposal might attract more bidders to the health insurance plan because life insurance, generally, is a money maker for insurance companies.

The Chairman of the Health Care Commission suggested that the integration of disability, workers' compensation, health, and auto insurance might present advantages such as increasing the State's leverage in negotiating the most cost effective insurance packages.

While integrating various insurances for bidding purposes may lead to cost savings, it also might discourage competition because too large or diverse a group of insurance plans is included in a bid package. Such a concept should be studied before any decision is made.

Cost-Management Practices Are Built Into the State Contract

The 1992 Survey of State Employee Health Benefit Plans published by the Martin E. Segal Company, an actuarial and consulting firm, listed the 22 cost management programs most frequently found in State plans. The Kansas plan contains more than 85 percent of these programs, including such things as:

Home health-care benefits, which allow a patient to receive skilled nursing care or therapeutic services in their own home for a limited amount of time as an alternative to admission to a nursing home or hospital.

Pre-certification for non-emergency hospital admissions to determine medical necessity.

Discounts for using generic drugs.

Employee wellness programs, including health-screening checks, weight-management and smoking-cessation classes, and exercise equipment.

One of the cost-management practices Kansas has not adopted is to audit the claims payer, Blue Cross, on a regular basis. However, Blue Cross receives an annual audit from an independent certified public accounting firm. In addition, an audit of the claims payment process carried out by this office in 1988 found no problems.

The Commission requires each company that bids on the State employee contract to outline the cost-management approaches it would use for the State program. Some of the steps taken by Blue Cross in all its contracts include:

The Competitive Allowance Program (CAP), under which payments to doctors and other professional providers are based on maximum fee allowances determined by Blue Cross.

Utilization reviews of inpatient and outpatient claims to monitor the quality of care provided and determine if services are medically necessary.

Coordination of benefits to ensure that duplicate payments are not made for employees or their family members who are covered by more than one health insurance program, workers' compensation, or auto insurance.

Financial incentives for doctors and other professional providers for performing services in the most cost-effective setting.

Hospital audits to validate hospital charges for a random sample of claims, as well as for large or unusual claims.

The Commission's Staff Agency, the Health Benefits Administration, Uses a Consultant To Provide Expertise In Bid Analysis and Contract Negotiation

Since its inception, the Health Benefits Administration has employed a consultant to take the lead in negotiating the State's health-care contracts and to provide outside expertise on such things as the State's Request for Proposal, trends in health-related areas, and how those trends might affect the State contract. For the last several years, the previous director of the Health Benefits Administration has served as the consultant. In fiscal year 1992, he received more than \$60,000 from the State in consulting fees.

The consultant has carried out many types of analyses for the State. The consultant regularly reviews bids from companies proposing to do business with the State, and provides written critiques of their plans and their rates. He analyzes how changes to the benefit structure would affect premiums, and calculates final composite rates. He has been the lead negotiator for the State in its contract negotiations with Blue Cross. The Chairman of the Health Care Commission noted that, in dealing with such a large and complex system, it is important to have access to an outsider who is removed from the day-to-day work and can look at the system with objectivity and detachment.

The Health Benefits Administration also has paid the consultant for work that could be performed by in-house staff. During our review, we found numerous cases in which the use of the consultant appeared to be inappropriate. For example, correspondence we reviewed showed that the consultant was paid to provide text for the Health Benefits Administrator's presentations to State employee groups, legislators, and the Health Care Commission. The consultant also prepared issue papers, responses to memos, many non-technical letters, and drafts of posters. Some examples include:

- a position paper on mail-order drugs, billed at \$438
- a critique of the Health Benefits Administrator's draft testimony to a House Appropriations subcommittee concerning use of the KU Medical Center, billed at \$250
- a draft of the type of poster that could be used to announce Open Enrollment, billed at \$625
- draft testimony for a House Appropriations subcommittee concerning the Health Care Commission's efforts to contain costs, billed at \$250
- a draft memo to the Health Care Commission Chairperson showing suggested language that the Health Benefits Administrator should use to express concern that he did not receive a raise or a performance evaluation in fiscal year 1992, billed at \$156.

In addition, during the course of the audit, we found that many of the requests for information we directed to the Health Benefits Administrator actually were being responded to by the consultant. Most of these questions were general - not technical - in nature, and should have been readily answerable by the Administrator. A review of the consultant's billing for February and March 1993, showed that he charged the State in excess of \$2,800 for responding to questions we posed to the Health Benefits Administrator. The box on the next page provides examples of inappropriate use of the consultant.

While all of these things were related to legitimate work of the agency, we question whether they should have been performed by a consultant who was paid \$125 per hour for his efforts, rather than by the Administrator and his staff.

In this audit, we did not review the work loads of the Administrator or his staff to determine whether additional help was needed to perform the day-to-day

types of work the consultant was being asked to do. We noted that the agency's budget requests showed that the Administrator did ask for an additional staff person in

**The Health Benefits Administration
Has Made Inappropriate Use Of Its Consultant**

When we reviewed correspondence from the consultant to the Health Benefits Administrator, we found many examples of the consultant performing work that we would have expected to be done by agency staff or by the Administrator.

The consultant billed the agency at the same pay, \$125 per hour, for this routine work as he did for the complex rate analyses he performed. Several examples are listed below. Draft memos and letters were to be sent out under the Administrator's name.

Draft response to a legislator's concern about State employees in Kansas City being hospitalized in Missouri. Amount billed - \$94

Charts and transparencies for Health Benefits Administrator to use in a presentation to school superintendents. Amount billed - \$625

Charts for Health Benefits Administrator's presentation in Wichita concerning differences in charges to State employees at different hospitals. Amount billed - \$563

Draft memo to the Health Care Commission concerning the hospital contracting situation in Wichita and draft letter to a legislator concerning a bid for the drug program by one of her constituents. Amount billed - \$438

Draft memo to the Health Care Commission responding to a memo sent to the Commission by the Division of Purchases regarding suggested strategies or changes to the health

plan. Amount billed - \$375 plus some portion of \$750 and \$844

Draft memo to a legislator regarding the addition of two new members to the Health Care Commission. Amount billed - \$250

Draft response to a Larned pharmacist concerning the rationale for the mail order drug program. Amount billed - \$156

Draft series of questions and answers about the dental plan to include in a position paper. Amount billed - \$312

Draft memo to the Secretary of Administration regarding a potential response to the Kansas Pharmacy Association's campaign to discredit the State's mail order drug program. Amount billed - \$375

Draft testimony for a legislative committee explaining the general parameters of the health benefit plan for 1993. Amount billed - \$375 plus some portion of \$813 and \$750

Draft speech to school district officials about joining the State health insurance plan. Amount billed - \$250 plus some portion of \$875

The consultant's contract has an annual cap of \$68,000. However, Health Benefits Administration officials told us that the consultant has "written off" several thousand dollars of fees over the past few years, meaning that the consultant may receive less in payment than is actually billed.

fiscal years 1992 and 1993. However, that request was not repeated for fiscal year 1994.

**Recent Contracts With Blue Cross and Blue Shield
Have Allowed the State To Build a Reserve Fund to Smooth Out
Premium Increases**

When the State contracted with Blue Cross and Blue Shield in 1989, an agreement was reached in which the State would pay Blue Cross only 85 percent of the annual premiums owed to the company. The remaining 15 percent of premiums would

be placed in a reserve account that Blue Cross could draw on only if claims and agreed-upon administrative expenses exceeded 85 percent of total premiums.

Those reserve funds have been used by the Health Care Commission to supplement General Fund moneys and pay a portion of rate increases over the years. Use of reserve funds kept the 1991 plan year rate increase at 10 percent, and the 1993 plan year increase at just below 20 percent. Based on information provided by the Health Benefits Administrator, it appears that, without using reserves, 1991 rates could have increased an additional 10 percent, and 1993 rates might have increased by as much as an additional five percent.

In recent years, the State has been able to retain much of the money in that reserve fund, which is invested through the Pooled Money Investment Board. Interest income is credited to the reserve fund. As of March 31, 1993, the reserve fund contained approximately \$31 million. However, not all of the \$31 million is free to be used by the Health Care Commission because final settlements based upon actual claims experience will not be paid to Blue Cross until all claims incurred in the years 1991 - 1993 have been paid.

The table on the following page shows reserve fund activity since the account was first established. As the table shows, the reserve fund's net receipts (money available for the State's use once all claims and administrative fees are paid) in 1990 and 1991 were much larger than in other years. In those two years, claims were significantly lower than premiums, so little of those two years' premiums-held-in-reserve had to be remitted to Blue Cross to cover claims amounts. Health Benefits Administration officials estimate 1992 reserve receipts will total approximately \$5 million.

The reserve fund balance to date is \$31 million, raising questions about whether premiums are set too high. Health Benefits Administration officials told us that reserve funds are necessary to smooth out premium increases over future years. They told us that they attempt to manage the health insurance program so that premiums do not increase more than 20 percent in any year. Officials estimate that the majority of reserve funds available now will be needed to keep projected increases within the 20 percent range over the next two years.

**Health Care Plan
Reserve Fund Activity by Calendar Year**

<u>Year</u>	<u>Net Receipts In The Reserve Fund</u>	<u>Premiums Subsidized by Reserves</u>
1989	\$6,775,629	\$0
1990	\$14,708,458	\$0
1991	\$15,592,761 (a)	\$10,025,285 (d)
1992	\$2,000,232 (b)	\$0 (e)
1993	<u>Not Applicable</u> (c)	<u>\$7,000,000</u> (f)
Cumulative Net Receipts	\$39,077,080	Cumulative Subsidy \$17,025,285

Total in Reserve Fund on 3/31/93 = \$31 million

- (a) Final settlement with Blue Cross for 1991 will not occur until July 1993. Officials with the Health Benefits Administration expect the State will retain nearly the whole balance in the reserve fund.
- (b) Final settlement with Blue Cross for 1992 will not occur until July 1994. Health Benefits Administration officials expect the State will end up with a reserve fund balance for this year of approximately \$4.5 million.
- (c) It is too soon in the year to estimate a year-end reserve balance, according to Health Benefits Administration officials.
- (d) The Health Care Commission decided that \$10 million was needed to keep premium increases in 1991 at 10 percent, an increase determined acceptable by the Commission.
- (e) When this audit was conducted, the final reserve balance for fiscal year 1993 could not be determined because the final settlement for that year was not yet complete.
- (f) The \$7 million subsidy for the 1993 plan year is an estimate made by Health Benefits Administration officials.

Conclusion

The Health Care Commission has tried to hold down costs in a variety of ways, including increasing competition for State contracts, offering multi-year contracts, negotiating with bidders, and building cost-containment measures into the services offered under the plan. However, use of a consultant for tasks that could be performed by agency staff is an unnecessary expense. The Commission has chosen to keep the State's insurance plans fully-insured in the past, but if its intention to self-insure the dental plan in 1994 is realized, it will begin to have the information necessary to determine whether it would be cost beneficial to self-insure the health plan as well. Employees have had an opportunity to provide feedback about the health benefits negotiated by the Commission, but the pro-

cess of acquiring this feedback should be improved. Finally, although the State has significant balances in its insurance reserve fund, which raises the issue of whether premiums were artificially high for several years, this reserve money goes to the State, rather than to the insurer, and can be used to minimize future premium increases.

Recommendations

1. The Health Care Commission and the Employee Advisory Committee should work closely together to ensure that the Committee has adequate time to review each year's Request for Proposal. In this way, the Committee can provide informed suggestions to the Commission about potential changes to the State's health-care plan. These groups should develop a schedule showing when information will be provided to the Advisory Committee, and when the Committee's response's are needed in order to be considered by the Commission.
2. The Health Care Commission should review correspondence and billings showing the type and cost of work performed by its consultant. Based on this review, the Commission should identify work that could be more cost-effectively performed by the staff of the Health Benefits Administrator. The Commission then should ensure that such work is no longer contracted to the consultant.

Do All State Employees Have Equal Access to the Benefits Provided by the State's Health Insurance Plan?

State employees do not have equal access to benefits because not all employees have access to the same plans. Depending on the area of the State in which employees live, they may have access to only one health insurance plan, or they may be able to choose between as many as six. In 1992, some graduate students did not have an equal opportunity to be considered as dependents, but that situation was remedied in the 1993 health-care plan. State employees and their dependents who are not covered under the State's managed-care options have access to most general-practice doctors, dentists, and hospitals in their cities at reduced rates. However, choices of practitioners are more limited for employees in managed-care plans, and choices of hospitals are limited in Wichita. Employees we surveyed in some cities also are unhappy with their choice of insurance options. Finally, some employees report that they cannot afford dependent coverage under the State plan. These and related findings will be discussed in more detail in the sections that follow.

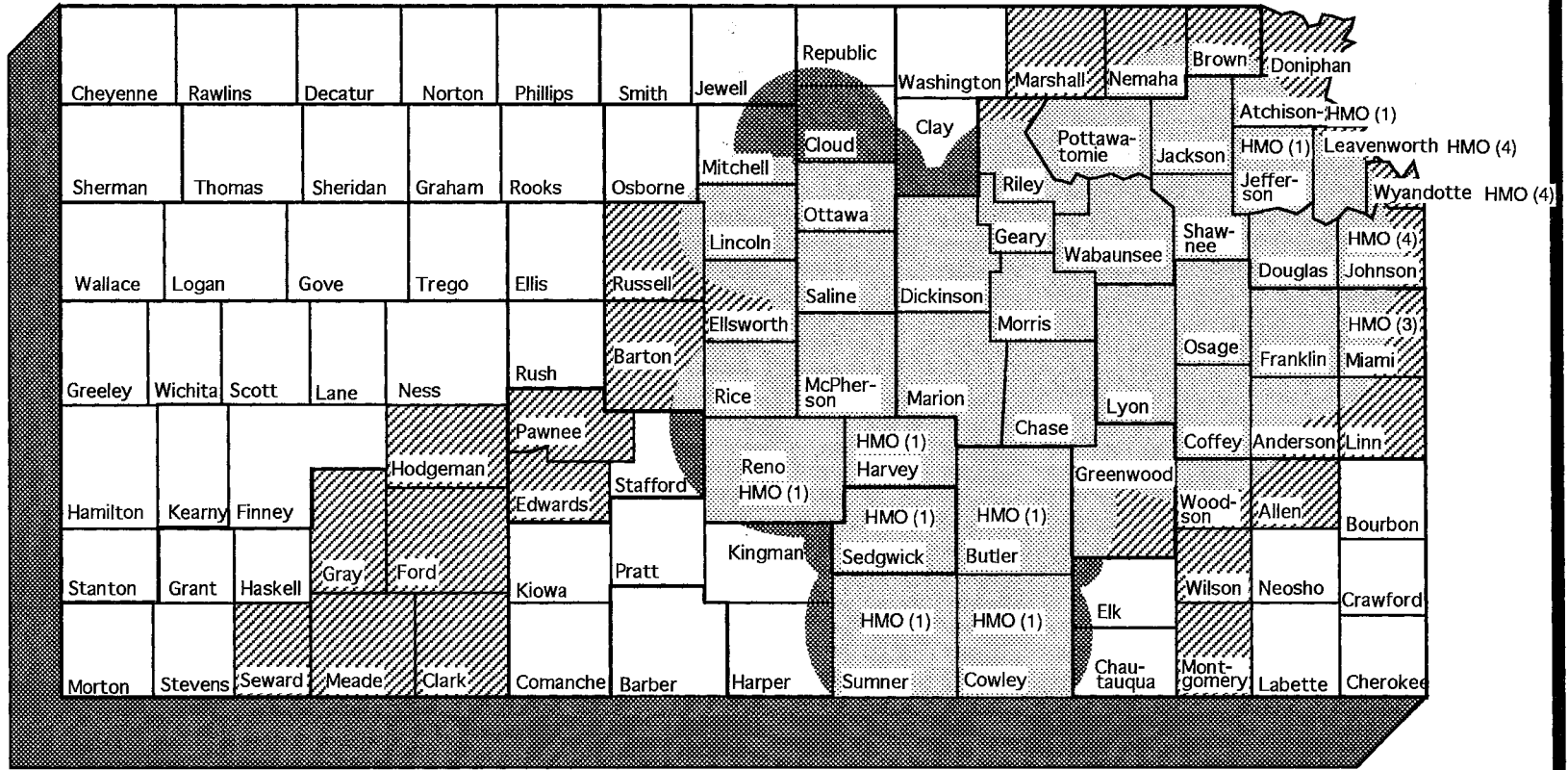
Employees in Almost Half of Kansas Counties Have Limited Or No Managed Care Insurance Plan Available

All State employees have access to at least one Blue Cross plan. Depending on where they live, employees may participate in the following:

- *Traditional program.* Under this plan, employees have a free choice of doctors.
- *Blue Select.* Under this plan, employees choose a primary-care doctor from a list of doctors who contract with Blue Cross and Blue Shield.
- *HMO Kansas.* Under this plan, employees must choose a primary-care doctor from a list of doctors who contract specifically with HMO Kansas.
- *HMOs in Kansas City and Sedgwick County areas.* Under these plans, primary-care doctors are chosen from a list of doctors who contract specifically with the HMOs.

Employees in 40 of the State's 105 counties have access only to the Blue Cross Traditional plan. Although they may go to any doctor they choose, they are subject to somewhat higher out-of-pocket expenses for deductibles and co-insurance: \$700 for an individual, and \$1,400 for a family. In another eight counties, people in only a limited part of the county have access to anything other than the Traditional plan.

Availability of Health Insurance Programs Under the State Plan



Blue Select

HMO Kansas or Traditional

HMO(#) = the number of non-Blue Cross HMOs available to State employees in the county.

Blue Select or HMO Kansas

Traditional

The shading on the map shows which counties have access to the various Blue Cross plans. In addition, the non-Blue Cross health maintenance organizations have been listed in the counties where they are available. The circular shading reflects Blue Cross' position that areas within a 30-mile radius of an HMO-Kansas primary-care physician have access to HMO-Kansas.

Blue Cross' proposal to expand the Blue Select program was turned down by the Health Care Commission. The Blue Select program was initiated in 1988, with 39 participating counties. The program has been expanded several times over the years, but the Commission declined to allow 12 additional counties to be added in 1993.

At the time, the Commission expressed concerns about how effective the managed-care plan has been, based on data that showed the Blue Select program had higher claims as a percent of premiums—88 percent—in 1991 than did the Traditional program—67 percent. (A lower percentage means that claims were a lower percentage of the premiums received.) Commissioners concluded that further information on the reasons for this difference was needed before expansion of the program could be justified. In addition, only a limited number of doctors in the counties proposed for expansion had indicated a willingness to contract as primary-care physicians.

Problems Resulting from the State's Definition Of a Dependent Have Been Addressed

In 1991, the Department of Administration's Legal Department determined that the definition of dependent needed to be narrowed to comply with the federal definition of dependent. According to Department officials, this compliance was needed to allow the State to continue offering the KanElect program, which allows State employees to set aside a portion of their pre-tax earnings to pay for such things as health insurance, child care, and the like. Before 1992, children could be claimed as dependents up to age 23. In 1992, the definition was narrowed to require that children between ages 19 and 23 be full-time students, unless they met some other qualifying criteria, such as severe handicap.

This change was not popular, and complaints were made that this definition was not being uniformly applied because different universities had different standards for what constituted a full-time student. Our review showed that the Regents' institutions' requirement for graduate students to be considered full-time varied from 5 hours to 12 hours per semester, depending on the university and on whether the student held an appointment as a graduate assistant or graduate teaching assistant. Thus, in 1992, graduate students under the age of 23 did not have equal opportunity to be considered a dependent for health insurance purposes.

In 1992, after further discussions with the Internal Revenue Service, the Department of Administration changed this portion of the dependent definition to re-

move all reference to student status. Beginning with the 1993 contract, dependent children may be covered up to age 23 without being a student.

State Employees and Their Dependents Who Are Not Covered Under a Managed-Care Plan Have Access to Most Doctors and Dentists, But Their Choices Are More Limited Under the State’s Managed-Care Options

To see how the differences in available plans affected State employees, we chose eight cities for review. These cities, which represented a variety in size, region of the State, and number of health options available, were Colby, Garden City, Liberal, Manhattan, Pittsburg, Salina, Topeka, and Wichita. And, because nearly 91 percent of State employees are covered by one of the Blue Cross plans, we chose to compare the benefits available under these plans in-depth.

Blue Cross has contracted with most general-practice doctors and dentists, but in some cities many doctors have not signed up as primary-care physicians under the Blue Select or HMO-Kansas programs. According to Blue Cross officials, 98 percent of all doctors in the State contract with Blue Cross under the Competitive Allowance Program. Under this program, doctors agree to accept the Blue Cross fee level as payment-in-full for services provided, and to “write off” any difference between that fee and their regular fees. These same doctors also may contract with Blue Cross to serve as primary-care physicians under the Blue Select or HMO-Kansas programs.

In the eight cities we reviewed, Blue Cross has contracted under the Competitive Allowance Program with 92 percent of the general-practice dentists and 97 percent of the doctors in general practice, family practice, and internal medicine. This information is shown in the accompanying table. Thus, those employees who are covered by the Traditional Plan and the Self-Referral part of Blue Select (the two non-managed-care options) have access to a reasonable selection of doctors and dentists for their general health-care needs, and can go to virtually any general practice doctor or dentist and receive the benefit of reduced fees.

Blue Select and HMO Kansas Contracting Doctors and Dentists Compared With the Total Number of Doctors and Dentists In Eight Kansas Communities

<u>Plan</u>	DOCTORS				DENTISTS			
	<u>Total Number</u>	<u>Contracting</u>		<u>Contracting as primary-care phys.</u>		<u>Total Number</u>	<u>Contracting</u>	
		<u>No.</u>	<u>Pct.</u>	<u>No.</u>	<u>Pct.</u>		<u>No.</u>	<u>Pct.</u>
Total	350	340	97			307	282	92
Blue Select				238	75			
HMO-Kansas				134	43			

The table also shows, however, that the percentage of doctors contracting as primary-care physicians under the Blue Select and HMO-Kansas programs in the cities we reviewed was markedly lower. Only 43 percent of the primary-care doctors in the four cities we reviewed that have HMO-Kansas have contracted with Blue Cross to serve as primary-care physicians for State employees enrolled in that plan. Three-fourths of the doctors in the five cities with the Blue Select plan have contracted with Blue Cross as primary-care physicians. In some individual cities, the percentages are considerably lower. For example, only two-thirds of the contracting general-practice doctors in Wichita have contracted with Blue Cross as primary-care physicians under the Blue Select plan. Appendix B summarizes this information on a city-by-city basis.

State employees covered by managed-care plans who refer themselves to doctors face additional costs. For example, under the Blue Select plan, an employee who uses the primary-care physician program pays maximum out-of-pocket expenses of \$500 individual and \$1,000 family per year. In contrast, employees referring themselves to doctors pay \$1,200 and \$2,400 maximum out-of-pocket expenses per year.

Except in Wichita, State Employees Had Access to All Acute-Care Hospitals in the Cities We Reviewed

Blue Cross officials reported that in 1992 they contracted with all acute-care hospitals in the State, and that in 1993, all but two Wichita hospitals were under contract. Thus, except in Wichita State employees can go to virtually any hospital and receive the benefit of reduced fees. Appendix B shows city-by-city information on hospitals.

The situation in Wichita, where only one of the city's three large acute-care hospitals and one small acute-care hospital are under contract, has been controversial. In Spring 1992, Blue Cross announced that it intended to contract with only two of the three large hospitals in 1993. Blue Cross officials stated they did this because representatives of all three hospitals had complained that reimbursement levels under the Competitive Allowance Program were approaching the level expected for a preferred-provider organization (PPO), without giving them the patient volume of such an arrangement. (Under a preferred-provider-organization arrangement, the number of contracting providers is reduced, and the providers agree to accept lower reimbursement because of increased patient volume.)

All three large hospitals were asked to bid on Blue Cross' request for proposal for 1993, but only one—Wesley Medical Center—responded. Although Blue Cross had intended to contract with two large hospitals, officials said they determined that Wesley could support the patient load that had been split between the three hospitals because it had 125 beds it was not using and was in the process of expanding its out-patient services. One of the other large hospitals signed a limited contract for ser-

vices Wesley could not provide, as well as for catastrophic and emergency services. In addition, Wichita's small acute-care hospital has continued to contract with Blue Cross.

State employees with Blue Cross in the Wichita area who require hospitalization suffer severe financial consequences if they are admitted to either of the non-contracting hospitals. Not only are they subject to those hospitals' standard rates, and the deductible and coinsurance requirements of whichever plan they participate in (Traditional, Blue Select, or HMO-Kansas), they also are subject to an additional coinsurance amount of up to \$1,000 for using a non-contracting hospital. In addition, State employees in Wichita who used one of the approximately 50 primary-care physicians whose practice was owned by a non-contracting hospital either had to change doctors or leave Blue Cross and join a health maintenance organization formed by these doctors.

Blue Cross officials reported that the fee level negotiated with Wesley had a significant positive impact on premiums for all State employees in 1993. (Blue Cross officials declined to provide specific cost information because they consider it to be proprietary. However, any cost savings realized from this contract would have an impact on total premiums.)

Although this contractual arrangement may be beneficial for the State in the short-term, it raises questions about whether, in the long run, it could lead to a situation that would be financially disadvantageous for the State. Presumably, the hospital that receives all the State's business will continue to expand its services to handle the increased patient load, which will make it more difficult for the non-contracting hospitals—which will experience a decline in patients—to be viable contenders for the contract in future years.

Doctors and Dentists Comments and Suggestions Regarding State Employees' Health Insurance

We asked doctors and dentists to provide us with comments regarding contracting with Blue Cross, as well as suggestions for cost containment measures. Doctors' suggestions in both areas concerning dealing with health insurance companies in general. Several doctors expressed frustration with administrative oversight and paperwork hassles presented by insurance companies. A Wichita doctor told us insurance companies had too much control over doctors. "I am able to practice good medicine without people telling me what to do." A Topeka doctor expressed a similar concern, telling us there should be fewer paperwork requirements, giving doctors more time to deal with medical problems. A Salina doctor indicated that administrative reviews should be decreased. "We are trying our level best."

A majority of dentists responding to our survey expressed dislike for Blue Cross reimbursement rates. One non-contracting dentist told us, "I find it unethical for my non-Blue Cross patients to pay higher fees to offset the losses incurred by acceptance of Blue Cross fees which don't provide me a reasonable return for my overhead costs." A non-contracting dentist in Wichita wrote, "I would never allow an insurance company to control fees." Dentists contracting with Blue Cross echoed this concern. One told us, "We do all the work and it ends up a job for no pay."

Several dentists presented suggestions for cost containment centering on an increased emphasis on preventive care. Dentists suggested rewarding patients who had regular teeth cleanings and check-ups with financial incentives. One dentist remarked that it would cost less to the employer to provide the bonus than to pay for more extensive work at a later date.

Most State Employees in the Cities We Reviewed Were Satisfied With Their Choice of Doctors, Dentists, and Hospitals, But Some Wanted Access to a Different Insurance Plan

We surveyed a random sample of 554 employees in the cities we reviewed. Slightly more than 300 surveys were returned, for a response rate of 55 percent. Overall, about 80 percent of employees said they were satisfied with their choice of doctors and dentists, and nearly 90 percent were satisfied with their choice of hospitals. There were some marked differences between the cities, however. About half the respondents from Wichita said they were dissatisfied with the number of hospitals available to them, and 40 percent of the respondents from Liberal were dissatisfied with the number of doctors available, even though six of the seven general-practice doctors in Liberal contract with Blue Cross for the Blue Select plan offered there.

About half the employees surveyed said they were satisfied with the health insurance plans available in their area. Another 20 percent said they did not know enough about other plans to make a judgment. Dissatisfaction showed up most strongly in Manhattan and Liberal.

One-third of the survey respondents from Manhattan said they would like to have access to a health maintenance organization. Technically, State employees in Manhattan have access to HMO-Kansas because they are within a 30-mile radius of doctors in Alma and Junction City who participate in HMO-Kansas. However, none of the doctors in Manhattan participate in HMO-Kansas. According to Blue Cross officials, Manhattan doctors had a bad experience with HMO-Kansas in the late 1980s, and officials think they would have a credibility problem trying to re-introduce HMO-Kansas in the city.

Nearly one-third of the survey respondents from Liberal, which is covered by Blue Select, said they wanted to move back to the Traditional program. Only 37 percent were satisfied with Blue Select. Liberal has been involved with the Blue Select program since it was instituted in 1988.

Some State Employees Report They Cannot Afford Dependent Coverage Under the State Health Insurance Plan

In 1989, the State began subsidizing health insurance coverage for State-employee dependents. High premiums for dependent coverage under the State plan had caused many employees to join health maintenance organizations or purchase policies independent of the State. In addition, a survey carried out by the Health Benefits Administration in June 1988 concluded that thousands of dependents of State employees did not have any health insurance coverage.

To address these problems, the State began subsidizing the dependent portion of its primary insurance plan (the Blue Cross Traditional and Blue Select programs). In 1993, the subsidy was raised from 15 percent to 25 percent of the premium in order

to keep employees' premiums at a level considered affordable by the Health Care Commission.

Forty percent of our survey respondents had dependents who were not covered by the State plan. As part of our survey of State employees, we asked whether they had dependents who were not covered on the State plan, and if so, why not. Of the 121 respondents who had dependents who were not covered, one-third said it was because the State insurance was too expensive, and 15 percent said they had no health insurance at all for their dependents.

Conclusion

As with many services in Kansas, health insurance options for State employees tend to be greatest in the most highly populated areas of the State. However, all employees have access to at least one of the State's insurance programs. State employees in managed-care plans have more limited access to doctors, dentists, and hospitals than employees in the Traditional plan. Overall, State employees reported they are satisfied with their health insurance, although employees in a few areas are unhappy with either the health care providers or the health insurance plans available to them. Even though the State subsidizes dependent health-care coverage under the Traditional and Blue Select plans, a small number of employees still find dependent coverage to be unaffordable.

What Would the Impact Be on State Employee Health Insurance Costs if the Regents' Institutions Became a Separate Group?

If Regents' employees had been a separate group within the 1993 State employees' health insurance plan, that group's claim experience would have entitled them to 18 percent lower premiums causing premiums for the remaining group of State employees to increase by 14 percent. Based on the Health Care Commission's past practices, however, premiums for both groups still might have been equalized in an attempt to keep insurance affordable for all State employees.

If Regents' Employees Had Been a Separate Group in 1993, That Group Would Have Had Lower Total Premiums

A December 1992 salary and benefit comparison study conducted by Kansas State University's Faculty Senate indicated Kansas' State employees paid more for health insurance than the other institutions studied. As a result, we were asked to determine what would happen to university employees' premiums if those employees left the present State employee health insurance program.

We asked Blue Cross and Blue Shield officials to recompute the 1993 premiums for the Traditional and Blue Select plans, rating all Regents' employees as one group and non-Regents' employees as a second group. (Because of problems involved in identifying Regents' employees in the HMO-Kansas plan, that plan was not included in this recomputation.) In general, retirees over the age of 65 were not included in either group. Regents' employees included all employees covered by Blue Cross in the State employees' health insurance program in the following agencies:

- Fort Hays State University
- Kansas State University, including Agricultural Extension Services and the College of Technology
- Emporia State University
- Pittsburg State University
- University of Kansas, including the Medical Centers in Kansas City and Wichita
- Wichita State University
- Board of Regents

Blue Cross officials told us they based their recalculations on 17 months of premiums and claims for the two groups between January 1991 and June 1992. This was the most recent period for which complete claims data were available, and was the period on which current 1993 rates were based. Recomputed premiums did not include premiums for drug or dental coverage. The Blue Cross scenario also assumed that the total cost of the health insurance program would have remain unchanged.

According to Blue Cross officials, the separate group of Regents' employees would have had 18 percent lower premiums during the 1993 plan year. Premiums for the remaining State employee groups would have been 14 percent higher. The table below describes the result of the Blue Cross recalculation of rates in greater detail.

Premiums for Blue Select and Traditional Plans Computed by Blue Cross and Blue Shield, With Regents' Agencies Rated Separately					
<u>Category</u>	<u>Current Premiums (a)</u>	<u>Regents' Agencies Rated Separately</u>	<u>% Difference</u>	<u>Non-Regents' Agencies Rated Separately</u>	<u>% Difference</u>
Employee Only	\$184	\$151	-18%	\$209	+14%
Employee/ Spouse	\$395	\$324	-18%	\$448	+14%
Employee/ Child(ren)	\$296	\$244	-18%	\$337	+14%
Family	\$495	\$407	-18%	\$562	+14%

(a) This column does not include drug and dental coverage.

Claims experience of the Regents' employees was much lower than non-Regents' employees. According to Blue Cross officials, the main reason the Regents' group would have had lower premiums under this scenario was that they had lower claims than the non-Regents' group during the 17-month period on which the recalculated rates were based. The following table provides additional information regarding the difference.

Claims Experience in Blue Select and Traditional Programs For Regents' and Non-Regents' Agencies January 1991 - May 1992		
	<u>Regents' Agencies</u>	<u>Non-Regents' Agencies</u>
Estimated Number of People Insured	22,257	29,085
Average Annualized Claims Amount Per Person	\$911	\$1,301

**When Similar Situations Have Occurred in the Past,
The Health Care Commission Has Provided a Subsidy
To Help Level-Out Premium Costs for State Employees**

The State's experience with health maintenance organizations provides an example of the result of the movement of employees with lower claims out of the conventional plans and into separate plans.

In our 1988 audit of the State health insurance plan, Blue Cross indicated that one reason for the high cost of the conventional 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 conventional plans, leading to higher claims in those plans. This eventually led to increased premiums for those employees in the conventional plans. For example, the employee-only 1990 premium increased 16 percent from the prior year. The full family premium increased by 15 percent. (The chart on page eight provides detailed information about employee-paid premiums since 1989.)

In an attempt to help level-out premium costs for State employees, the Health Care Commission started subsidizing dependent coverage for employees in the Traditional and Blue Select plans by 15 percent in 1989. The subsidy amount was increased to 25 percent in 1993. Health Care Commission officials told us the subsidy was necessary to keep the cost of health insurance affordable to all State employees. The subsidy also was used to bring younger and healthier employees, who had gone to the health maintenance organizations, back into the conventional plan.

The accompanying table shows what likely would have happened to State employees' share of their family health insurance premiums if Regents' employees had been a separate group in 1993. The table shows both what would have happened if the Health Care Commission had not acted to level-out premiums, as well as what would have happened if the Commission had followed its past practices of subsidizing full-family coverage to make it affordable to all State employees.

Comparing Potential Premiums If Regents' Employees Had Been A Separate Group in 1993					
	Current 1993 Premium for Full-Family Coverage (a)	Premiums for separate employee groups without adjustment to level-out emp. premiums		Premiums for separate employee groups with adjustment to level-out emp. premiums	
		<u>Regents</u>	<u>Non-Regents</u>	<u>Regents</u>	<u>Non-Regents</u>
Employee's Share	\$203	\$166	\$231	\$203	\$203
State's Share	<u>292</u>	<u>241</u>	<u>331</u>	<u>204</u>	<u>359</u>
Total Premium	\$495	\$407	\$562	\$407	\$562

(a) This column does not include drug and dental coverage.

As the middle columns on the table show, we estimated that Regent employees' premiums for full-family health-care coverage (excluding drug and dental coverage) would have been \$166 in 1993, compared with \$231 for other employees without some action on the part of the Health Care Commission to level-out employees' premiums. However, if the Health Care Commission wanted to equalize these two groups' health-care costs, it would set employee-paid premiums at \$203 for both groups and adjust the portion of the premium the State pays.

Conclusion

Even though total premiums for Regents' employees might have been lower in 1993 if they had been a separate group, the State's experience regarding health maintenance organizations should be considered. When a group of presumably younger and healthier employees left the main insurance plan to join health maintenance organizations, premiums for employees in the main plan increased. The Health Care Commission, committed to a policy of providing affordable health insurance for employees in the main plan, subsidized that plan's family premiums. If Regents' employees separate from the main group, premiums for the majority of State employees could increase, potentially causing increased State subsidies for non-Regents' employees. This could outweigh any benefit the State would receive by insuring Regents' employees as a separate group.

APPENDIX A

Comparison of Health Insurance Plans Offered To State Employees In a Sample of Other States

This Appendix provides a summary of coverages and benefits offered to state employees in Kansas, Colorado, Iowa, Missouri, Nebraska, and Oklahoma. The plans we reviewed and included here are each states' conventional plans and main HMOs, if any. The coverages and benefits shown are summaries of the plans we reviewed. Space considerations did not allow us to present every coverage and benefit detail for all the plans we reviewed.

In an effort to get as much information about each plan in as small a space as possible, we abbreviated several terms. The following is a key to those abbreviations:

BCBS: Blue Cross and Blue Shield
CI: Co-insurance
CP: Co-payment
CY: Calendar Year
DAFR: Date of Assumption of Financial Responsibility
DMO: Dental Maintenance Organization
DOB: Date of Birth
HMO: Health Maintenance Organization
IP: Inpatient
IA: In Area
OA: Out of Area
OP: Out-patient
PCP: Primary Care Physician
SVS: Services
UCR: Usual, Customary, and Reasonable

Coverages and Benefits	Kansas Blue Select Primary Care Benefits	Kansas Blue Select Self-Referral	Kansas BCBS—Traditional	HMO Kansas
Maximum Annual Out-of-Pocket Expense	\$500 per individual (<i>\$0 ded.+ \$500 CI</i>) \$1000 per family (<i>\$0 ded.+ \$1000 CI</i>) <i>CI = 20% of covered charges.</i>	\$1200 per individual (<i>\$200 ded.+ \$1000 CI</i>) \$2400 per family (<i>\$400 ded.+ \$2000 CI</i>) <i>CI = 30% of covered charges.</i>	\$700 individual (<i>\$200 ded.+ \$500 CI</i>) \$1400 family (<i>\$400 ded.+ \$1000 CI</i>) <i>CP = 20% of covered charges.</i>	NA—No deductible or co-ins.; CPs only for some services. Covered services gen'ly paid at 100% after CP.
Physician Selection and Prior Authorizations	PCP must provide/authorize all services. Prior authorization not required for maternity, routine eye exams, emergency & ambulance for life threatening conditions.	May select provider of choice. Prior authorization required for hospital adm., but not for maternity, routine eye exams, emergency & ambulance for life threatening conditions.	May select provider of choice; prior auth. required for hospital adm. Prior auth. not req. for maternity & emergency.	PCP must provide/authorize all services. Prior authorization not required for maternity, routine eye exams, emergency & ambulance for life threatening conditions.
Hospital Admissions and Inpatient Services	Covered when auth. by PCP, subject to co-ins. & IP hospital admission CP. (Individ.— \$50/day for 1st 5 days w/max. of \$250/CY; family—\$50/day for 1st 10 days w/max. of \$500/CY.)	Covered subject to deductible & co-insurance. Also subject to IP hospital admission CP. (individ.— \$50/day for 1st 5 days w/max. of \$250/CY; family—\$50/day for 1st 10 days w/max. of \$500/CY.)	Covered subject to deductible & co-insurance. Also subject to in-patient hospital admission CP. (individ.— \$50/day for 1st 5 days w/max. of \$250/CY; family—\$50/day for 1st 10 days w/max. of \$500/CY.)	Covered when auth. by PCP, subject to IP hospital adm. CP (individ.— \$50/day for 1st 5 days w/max. of \$250/CY; family—\$50/day for 1st 10 days w/max. of \$500/CY.)
Outpatient Services	Covered when provided or auth. by PCP, subject to 80/20 co-ins.	Covered, subject to deductible & 70/30 CI.	Covered, subject to deductible & 80/20 CI.	Covered when provided or authorized. by PCP; \$10 CP per visit.
Prescription Drugs (outpatient unless otherwise noted)	Same for all Kansas plans: IP drugs covered; \$5 CP for generics & insulin, \$10 CP for brand name.			
Office Visits and Routine Physicals	Covered when provided or auth. by PCP, subject to co-ins. (Gen'ly excludes physicals for non-preventative purpose.)	Covered subject to deductible & co-ins. (excludes physicals for non-preventative purpose.)	Covered subject to deductible & co-insurance. (excludes physicals for non-preventative purposes.)	Covered when provided or auth. by PCP. \$10 CP per visit. (gen'ly excludes physicals for non-preventative purpose.)
Dental	Dental coverage is under a separate plan with Blue Cross and Blue Shield. In general, covered services are paid at 50%.			

Colorado Custom Plus (Comprehensive)	Colorado Family Economy Plan (Comprehensive)	Colorado— PRIME Health Plan PRIME Providers	Colorado— PRIME Health Plan non-PRIME Providers	Colorado HMO Colorado
\$1150 individual (<i>\$150 ded. + \$1000 CI</i>) \$2300 family (<i>\$300 ded. + \$2000 CI</i>) <i>CI = 20% of covered charges.</i>	\$2500 individual (<i>\$500 ded. + \$2000 CI</i>) \$5000 family (<i>\$1000 ded. + \$4000 CI</i>) <i>CI = 20% of covered charges.</i>	\$600 individual (<i>\$100 ded. + \$500 CI</i>) \$1200 family (<i>\$200 ded. + \$1000 CI</i>) <i>CI = 10% of covered charges.</i>	\$1800 individual (<i>\$300 ded. + \$1500 CI</i>) \$3600 family (<i>\$600 ded. + \$3000 CI</i>) <i>CI = 30% of covered charges.</i>	<i>(NA—no ded. or co-ins; CPs only for some svcs; e.g. office visits, hospital admissions, & drugs. Covered svcs gen'ly paid at 100% after applicable CP)</i>
Unrestricted (but employee responsible for charges over max. of non-participating providers). Prior auth. req. for: dental svcs; home health; hospice; cosmetic surgery; obesity; upper or lower jaw augmentation.	Unrestricted (but employee responsible for charges over max. of non-participating providers). Prior auth. req. for: dental svcs; home health; hospice; cosmetic surgery; obesity; upper or lower jaw augmentation.	Unrestricted, w/in PRIME network. Prior auth. req. for: dental svcs; home health; hospice; cosmetic surgery; obesity; upper or lower jaw augmentation.	Unrestricted (but employee responsible for charges over max. of non-participating providers). Prior auth. req. for: dental svcs; home health; hospice; cosmetic surgery; obesity; upper or lower jaw augmentation.	Must select a Primary Care Physician. PCP must provide or authorize all health care services.
Paid at 80% (significant reduction of benefits for elective use of non-participating hospital). Surgical care paid at 80%.	Paid at 80% (significant reduction of benefits for elective use of non-participating hospital). Surgical care paid at 80%.	Paid at 90%. Surgical care paid at 90%.	Paid at 70% (significant reduction of benefits for elective use of non-participating hospital). Surgical care paid at 70%.	Paid at 100% after admission CP. Must use HMO Colorado hospitals. Surgical care paid at 100% for IP. Paid at 100% after office visit CP for OP care.
Paid at 80%	Paid at 80%	Paid at 90%	Paid at 70%	Paid at 100% after office visit CP.
Paid at 80%	Paid at 80%	\$12 CP for brand name, \$8 for generic.	\$12 CP for brand name, \$8 for generic.	\$5 CP for generic; \$10 for brand name.
Paid at 80% after deductible; frequency of covered visits varies with patients' age.	Paid at 80% after deductible; frequency of covered visits varies with patients' age.	Pd. at 90% after deductible; frequency of covered visits varies with patients' age.	Pd. at 70% after deductible; frequency of covered visits varies with patients' age.	\$10 CP per office visit

Covered, with Dental Maintenance Organization enrollees paid at 100% for most services. Fee-for-services enrollees pay \$50 deductible

Coverages and Benefits	Iowa BCBS Program I	Iowa BCBS Program II	Iowa BCBS Program III	HMO Iowa
Maximum Annual Out-of-Pocket Expense	\$1700 single \$3200 family	\$500 single \$500 family	\$600 single \$800 family	200% of annual premium.
Physician Selection and Prior Authorizations	No restriction on physician selection. Prior approval from BCBS required.	No restriction on physician selection. Prior approval from BCBS required.	No restriction on physician selection. Prior approval from BCBS required.	Must have a plan physician; Plan physician handles pre-approvals.
Hospital Admissions and Inpatient Services	Physician svcs: 100%, no deductible. Surgery: 100%, no deductible if approved as an IP procedure. Prior auth. required.	Physician svcs: 90%, no deductible. Surgery: 90%, no deductible if approved as an IP procedure. Prior auth. required.	Physician svcs: 80%, no deductible. 80%, no deductible if approved as an inpatient procedure. Prior auth. required.	\$50 CP/day. Prior approval required.
Outpatient Services	Mandatory for certain surgeries. Paid at 100%, no deductible.	Mandatory for certain surgeries. Paid at 90%, no deductible.	Mandatory for certain surgeries. Paid at 80%, no deductible.	\$25 CP for OP surgeries.
Prescription Drugs (outpatient unless otherwise noted)	80% after major med. deductible.	90% after "other covered svcs" deductible.	80%, no deductible.	Higher of \$5 or 25% per prescription.
Office Visits and Routine Physicals	Routine physicals not covered. Office visits paid at 80% after major med. deductible.	Limit of 1 physical/member/yr. Office visits paid at 90%, no deductible.	Limit of 1 physical/member/yr. Office visits paid at 80%, no deductible.	\$10 CP per visit
Dental	Dental is provided under a separate plan. Can use non-participating providers, but plan may not cover all charges. Max. coverage of \$750/individual/yr. No deductibles. Pay 100% for diagnostic & preventative svcs 80% for routine and restorative services; and 50% for major restorative services.			

Missouri State Medical Care Plan	Nebraska BCBS Basic	Nebraska BCBS Optional	HMO Nebraska
\$1800/individual <i>(\$300 ded + \$1500 CI)</i> \$3600/family of 2 <i>(\$600 ded + \$3000 CI)</i> \$3900/family of ≥ 3 <i>(\$900 ded + \$3000 CI)</i> (Less if use PPO)	\$2000/individual <i>(\$250 ded. + \$1750 CI)</i> \$4000/family <i>(\$500 ded. + \$3500 CI)</i>	\$1500/individual <i>(\$150 ded. + \$1350 CI)</i> \$3000/family <i>(\$300 ded. + \$2700 CI)</i>	\$500 CP for employee \$500 CP for spouse \$750 CP for children <i>(After these amts are met, the plan pays 100%.)</i>
No restriction on physician selection.	No restriction on physician selection.	No restriction on physician selection.	Must select a PCP to provide or authorize all services. PCP for all treatments or referrals.
Covers charges for daily room and board and routine nursing.	Covered subject to ded. & co-insurance.	Covered subject to ded. & co-insurance.	Covered at 80%.
Covers medical care and supplies.	Covered subject to ded. & co-insurance.	Covered subject to ded. & co-insurance.	Covered in full.
Covered subject to deductible and CI.	Covered under a drug card program—\$5 CP for generics.	Covered under a drug card program—\$5 CP for generics.	Covered in full after \$5 CP
Covered unless for preventative care.	Routine physicals are not covered. Non-routine physicals are covered subject to deductible and co-insurance.	Routine physicals are not covered. Non-routine physicals are covered subject to deductible and co-insurance.	Covered, subject to \$10 CP/office visit.
Routine dental checks, etc. are not covered.	Varying CPs for each covered procedure.	Varying CPs for each covered procedure.	Must use participating dentist; CPs for each covered procedure.

Coverages and Benefits	Oklahoma Network Provider Plan—using Network Provider	Oklahoma Network Provider Plan—using non-Network Provider
Maximum Annual Out-of-Pocket Expense	\$2300 per person for percentage co-ins; Dollar amt CPs still apply after out-of-pocket max is met.	\$300 + CPs for covered services. <i>(Effectively no out-of-pocket limit on non-Network services.)</i>
Physician Selection and Prior Authorizations	May use Network or non-Network providers, but coverage is better w/Network providers—lower or no deductibles & lower CI with Network providers	
Hospital Admissions and Inpatient Services	Subject to \$200 per confinement; other hospital svcs covered 100% after that; no deductible.	Must pay 25% of fee schedule after meeting \$300 CP. Also must pay \$300 per confinement
Outpatient Services	\$100 CP for OP surgery; covered services associated w/surgery covered at 100%, with no deductible.	\$300 deductible for OP surgery, plus 25% of fee schedule for such procedure.
Prescription Drugs (outpatient unless otherwise noted)	\$10 CP at network pharmacy. No deductible.	25% of fee sched. after \$50/CY deductible + \$3.25 dispensing fee per prescription.
Office Visits and Immunizations	Covered with \$15 CP per visit and no deductible.	Covered with \$300 CY deductible, then 25% of fee schedule.
Dental	Dental coverage is divided into 4 classes, with deductibles of \$0 - \$25 and CI of 50-100%.	Dental coverage is divided into 4 classes, with deductibles of \$0 to \$25 and CI of 50-100%.

APPENDIX B

Availability of Medical and Dental Providers in Selected Cities

This table shows the total number of primary-care doctors, dentists, and hospitals available in the eight cities examined in the audit. It further shows whether they contract with Blue Cross and Blue Shield of Kansas under the Contracting Allowance Program (CAP), and whether they contract under the Blue Select and HMO-Kansas programs.

AVAILABILITY OF MEDICAL AND DENTAL PROVIDERS IN SELECTED CITIES

City and type Insurance	# State employees	DOCTORS					DENTISTS			HOSPITALS				
		total #	# contracting	% contracting	# contracting as primary- care physicians	% primary care phy.	total #	# contracting	% contracting	total #	# contracting	% contracting	# w/managed care contract	% w/managed care contract
Topeka														
Total	7,053	68	67	98.5		72	64	88.9	2	2	100.0			
Blue Select	4,519				65	95.6						2	100.0	
HMO Kansas	2,531				34	50.0						2	100.0	
Other	3													
Wichita														
Total	2,851	206	199	96.6		165	149	90.3	4	2	50.0			
Blue Select	1,312				137	66.5						2	50.0	
HMO Kansas	277				87	42.2						2	50.0	
PPK	932													
Other	330													
Manhattan														
Total	2,594	16	16	100.0		21	21	100.0	2	2	100.0			
Blue Select	2,569				15	93.8						0	0.0	
HMO Kansas	16				0	0.0						2	100.0	
Other	9													
Pittsburg														
Total	614	11	11	100.0		8	8	100.0	1	1	100.0			
Traditional	601				N/A	N/A						N/A	N/A	
Other	13													
Salina														
Total	449	20	20	100.0		21	21	100.0	2	2	100.0			
Blue Select	256				15	75.0						0	0.0	
HMO Kansas	192				12	60.0						2	100.0	
Other	1													
Garden City														
Total	232	19	18	94.7		11	10	90.9	1	1	100.0			
Traditional	226				N/A	N/A						N/A	N/A	
Other	6													
Colby														
Total	68	3	3	100.0		3	3	100.0	1	1	100.0			
Traditional	65				N/A	N/A						N/A	N/A	
Other	3													
Liberal														
Total	66	7	6	85.7		6	6	100.0	1	1	100.0			
Blue Select	64				6	85.7						1	100.0	
Other	2													
TOTAL														
Total	13,927	350	340	97.1		307	282	91.9	14	12	85.7			
Traditional	892				N/A	N/A						N/A	N/A	
Blue Select	8,720				238	75.1						5	45.5	
HMO-Kansas	3,016				133	42.9						8	80.0	

*The following definitions apply:

Doctors - refers to doctors of medicine and osteopathy who practice general medicine, family medicine, or internal medicine.

Dentists - refers to general practice dentists.

Hospitals - refers to acute care hospitals.

Contracting - refers to contracting under the Competitive Allowance Program.

Contracting as PCPs - refers to doctors that further contract as a primary care physician under Blue Select or HMO-Kansas. (The dental program does not require patients to select a primary provider.)

Managed care contract - refers to hospitals who further contract to provide additional discounts under the Blue Select or HMO-Kansas program.

APPENDIX C

Survey of Doctors Providing Primary Care in Selected Cities

We sent surveys to a sample of 105 primary care doctors (general practice, family practice, and internal medicine) in the eight cities included in the audit. Forty-four surveys were returned, for a response rate of 41.9 percent.

LEGISLATIVE DIVISION OF POST AUDIT
STATE EMPLOYEE HEALTH INSURANCE PROVIDER SURVEY

The Legislative Post Audit Committee has directed the Legislative Division of Post Audit to conduct a performance audit of the State employees' health insurance program. To learn health providers' opinions on certain issues, we are requesting that a sample of health care providers in eight cities across Kansas complete the following survey. Please take a few moments to answer the questions listed below. The survey has been designed to be non-identifiable, so please do not sign your name.

Please return the completed survey in the enclosed, self-addressed, stamped envelope no later than March 26, 1993. If you have any questions, please call Cindy Lash or Sharon Patnode at (913)296-3792.

Information About You

1. Please check all of the following that apply to you.

- 40 93.0% I am a contracting provider in the Blue Cross/Blue Shield Competitive Allowance Program.
- 35 81.4% I am a primary care physician under contract to Blue Select.
- 25 58.1% I am a primary care physician under contract to HMO-Kansas.
- 30 69.8% I contract with an insurance company or companies other than Blue Cross/Blue Shield
- 0 0.0% None of the above apply to my situation.

2. Please list all cities in which you practice: 1-Colby, 1-Garden City, 1-Liberal, 2-Manhattan, 1-Pittsburg, 2-Salina, 10-Topeka, 23-Wichita, 2-City not listed

Non-Contracting Physicians

If you are not a contracting provider, please answer questions 3 through 5, then skip to question 10.

3. Why have you not contracted with Blue Cross/Blue Shield?

- 1 33.3% I chose not to contract.
- 0 0.0% I was not offered a contract by Blue Cross/Blue Shield.
- 1 33.3% Blue Cross/Blue Shield refused to contract with me.
If Blue Cross/Blue Shield refused to contract with you,
what reason(s) did they give for the refusal.

4. Which of the following most influenced your decision not to be a Blue Cross/Blue Shield contracting provider?

- 0 0.0% Administrative paperwork required by Blue Cross/Blue Shield is too burdensome.
Comments:
- 0 0.0% I did not wish to accept Blue Cross/Blue Shield's reimbursement as payment-in-full.
Comments:
- 2 66.7% Other, please explain:

5. What would need to change to persuade you to become a contracting provider?

- 2 - If Blue Cross would contract with St. Joseph's Hospital

(OVER)

Contracting Physicians

If you contract with Blue Cross/Blue Shield, please answer questions 6 through 10.

6. What are the main advantages you have experienced from being a Blue Cross/Blue Shield contracting provider?

18 45.0% Patient pool greater

19 47.5% Quick claims payment process

7 17.5% Other, please explain:

7. What impediments or disadvantages do you see to being a Blue Cross/Blue Shield contracting provider?

17 42.5% Reimbursement limits mean lost revenue

15 37.5% Excessive administrative paperwork

12 30.0% Other, please explain:

8. How satisfied are you with the administrative efficiency of Blue Cross/Blue Shield? (For example, are claim payments made quickly?, are there minimal paperwork hassles?)

Very Satisfied

Moderately Satisfied

Dissatisfied

1

2

3

4

5

1 2.5%

8 20.0%

21 52.5%

5 12.5%

1 2.5%

9. Comparing the Blue Cross/Blue Shield claims payment process with other insurance companies' processes, would you say that Blue Cross/Blue Shield is:

11 27.5% More efficient

20 50.0% There is no difference.

1 2.5% Less efficient

5 12.5% Do not know

1 2.5% Other, please explain:

10. Do you have any suggestions for improvements the State could make to contain health insurance costs for State employees? Please provide your comments below or on additional pages.

3 - Have co-pays for every visit for HMO patients. This reduces unnecessary visits and allows every patient to own part of the responsibility for the visit.

2 - Place a greater emphasis on preventive services, and structure co-pays and reimbursement to encourage early treatment.

2 - Investigate self-insurance.

2 - Minimize the oversight of government and the insurance industry.

APPENDIX D

Survey of Dentists Providing General Care in Selected Cities

We sent surveys to a sample of 98 general practice dentists in the eight cities included in the audit. Fifty-five surveys were returned, for a response rate of 56.1 percent.

LEGISLATIVE DIVISION OF POST AUDIT
STATE EMPLOYEE HEALTH INSURANCE PROVIDER SURVEY

The Legislative Post Audit Committee has directed the Legislative Division of Post Audit to conduct a performance audit of the State employees' health insurance program. To learn health providers' opinions on certain issues, we are requesting that a sample of health care providers in eight cities across Kansas complete the following survey. Please take a few moments to answer the questions listed below. The survey has been designed to be non-identifiable, so please do not sign your name.

Please return the completed survey in the enclosed, self-addressed, stamped envelope no later than March 26, 1993. If you have any questions, please call Cindy Lash or Sharon Patnode at (913)296-3792.

Information About You

1. Please check all of the following that apply to you.
 - 44 80.0% I am a contracting provider in the Blue Cross/Blue Shield Competitive Allowance Program.
 - 28 50.9% I contract with an insurance company or companies other than Blue Cross/Blue Shield
 - 7 12.7% None of the above apply to my situation.

2. Please list all cities in which you practice: 1-Colby, 2-Garden City, 1-Liberal, 4-Manhattan, 2-Pittsburg, 5-Salina, 12-Topeka, 22-Wichita, 6-City not listed

Non-Contracting Dentists

If you are not a contracting provider, please answer questions 3 through 5, then skip to question 10.

3. Why have you not contracted with Blue Cross/Blue Shield?

- 10 90.9% I chose not to contract.
- 0 0.0% I was not offered a contract by Blue Cross/Blue Shield.
- 1 9.1% Blue Cross/Blue Shield refused to contract with me.
If Blue Cross/Blue Shield refused to contract with you,
what reason(s) did they give for the refusal.

4. Which of the following most influenced your decision not to be a Blue Cross/Blue Shield contracting provider?

- 2 18.2% Administrative paperwork required by Blue Cross/Blue Shield is too burdensome.
Comments:
- 8 72.7% I did not wish to accept Blue Cross/Blue Shield's reimbursement as payment-in-full.
Comments:
- 3 27.3% Other, please explain:

5. What would need to change to persuade you to become a contracting provider?

- 2 - Blue Cross should pay fees in full, or allow the dentist to bill the patient for the difference.
- 2 - Will never contract/will not allow insurance company to have control over fees and treatment plan
- 1 - Increase fee flexibility to pay for new procedures.

(OVER)

Contracting Dentists

If you contract with Blue Cross/Blue Shield, please answer questions 6 through 10.

6. What are the main advantages you have experienced from being a Blue Cross/Blue Shield contracting provider?

- 17 38.6% Patient pool greater
- 27 61.4% Quick claims payment process
- 16 36.4% Other, please explain:

7. What impediments or disadvantages do you see to being a Blue Cross/Blue Shield contracting provider?

- 32 72.7% Reimbursement limits mean lost revenue
- 5 11.4% Excessive administrative paperwork
- 7 15.9% Other, please explain:

8. How satisfied are you with the administrative efficiency of Blue Cross/Blue Shield? (For example, are claim payments made quickly?, are there minimal paperwork hassles?)

Very Satisfied		Moderately Satisfied		Dissatisfied	
1	2	3	4	5	
5	23	10	2	4	9.1%
11.4%	52.3%	22.7%	4.5%		

9. Comparing the Blue Cross/Blue Shield claims payment process with other insurance companies' processes, would you say that Blue Cross/Blue Shield is:

- 26 59.1% More efficient
- 12 27.3% There is no difference
- 4 9.1% Less efficient
- 0 0.0% Don't know
- 3 6.8% Other, please explain:

10. Do you have any suggestions for improvements the State could make to contain health insurance costs for State employees? Please provide your comments below or on additional pages.

- 9 - Place greater emphasis on preventive services, and structure co-pays and reimbursement to encourage early treatment.
- 3 - Give each employee a dollar amount to spend on dental care to use as the employee sees fit. This would save on administrative costs, and make the employee responsible for using the benefits.
- 2 - Investigate self-insurance
- 2 - Don't automatically give the contract to Blue Cross. Switch to a carrier that is more efficient administratively.
- 1 - Provide preventive training, such as diet counseling and analysis, exercise programs, and oral hygiene instruction.



APPENDIX E

Survey of State Employees in Selected Cities

We sent surveys to a sample of 554 State employees in the eight cities included in the audit. We received 304 usable surveys in return, for a response rate of 54.8 percent.

LEGISLATIVE DIVISION OF POST AUDIT

STATE EMPLOYEE HEALTH INSURANCE SURVEY

The Legislative Post Audit Committee has directed the Legislative Division of Post Audit to conduct a performance audit of the State employees health insurance program. To learn employees opinions on certain issues related to their health and dental insurance, we are requesting that a sample of State employees in eight cities across the State complete the following survey. Please take a few moments to answer the questions listed below. The survey has been designed to be non-identifiable, so please do not sign your name.

Please return the completed survey in the enclosed, self-addressed, stamped envelope no later than March 17, 1993. If you have any questions, please call Sharon Patnode or Cindy Lash at (913) 296-3792.

1. Which State insurance plan(s) are you currently enrolled in? (Check one)

97	32.2%	Traditional (Blue Cross)
152	50.5%	Blue Select (Blue Cross)
42	14.0%	HMO-Kansas (Blue Cross)
10	3.3%	Preferred Plus of Kansas, Inc. (HMO)

2. Are you covered by an individual plan or by a family plan?

146	48.2%	Individual
157	51.8%	Family

143	48.8%	Individual
150	51.2%	Family

3. Do you have dependents (spouse or children) who are not covered by your current State insurance plan?

121	40.1%	Yes (go to question 3a)
181	59.9%	No (go to question 4)

110	41.7%	Yes (go to question 3a)
154	58.3%	No (go to question 4)

3a. Please check the answer(s) that best describes your dependents' insurance coverage.

65	54.2%	Covered by spouse's insurance
37	30.8%	Covered by other insurance carrier
18	15.0%	Do not have health insurance

53	46.1%	Covered by spouse's insurance
20	17.4%	Covered by other insurance carrier
42	36.5%	Do not have dental insurance

3b. Why are your dependents not covered under your State insurance?

53	40.5%	Spouse's insurance less costly or better benefits
45	34.4%	State premiums too high for dependents
33	25.2%	Other, please explain:

42	38.2%	Spouse's insurance less costly or better benefits
43	39.1%	State premiums too high for dependents
25	22.7%	Other, please explain:

(OVER)

4. Depending where you live, you may not have access to all the insurance plans listed on the other side. Please check the one answer that best describes your opinion concerning this issue.

- 172 55.7% I am satisfied with the State health insurance plans available in my area
- 30 9.7% I would like access to the Traditional plan
- 6 1.9% I would like access to Blue Select
- 30 9.7% I would like access to an HMO
- 62 20.1% I do not know enough about the other plans to comment

5. Under your State health and dental insurance plans, are you satisfied with the available choices for:

	Yes	No	If no, please indicate your reason:
Doctors	233 77.7%	67 22.3%	30 44.8% The doctor I prefer does not participate in the State insurance plans
			32 47.8% Not enough doctors in my community participate in the State insurance plans
			14 20.9% Other, please explain:
Dentists	244 81.1%	57 18.9%	29 50.9% The dentist I prefer does not participate in the State insurance plans
			24 42.1% Not enough dentists in my community participate in the State insurance plans
			8 14.0% Other, please explain:
Hospitals	263 88.6%	34 11.4%	16 47.1% The hospital I prefer does not participate in the State insurance plans
			12 35.3% Not enough hospitals in my community participate in the State insurance plans
			10 29.4% Other, please explain:

DEMOGRAPHIC INFORMATION

Annual Salary Range:

32	10.5%	Less than \$17,000
151	49.7%	\$17,001 to \$29,999
114	37.5%	\$30,000 or more
7	2.3%	Not reported

City in which you work:

34	11.2%	Colby	31	10.2%	Pittsburg
30	9.8%	Garden City	35	11.5%	Salina
37	12.2%	Liberal	63	20.7%	Topeka
37	12.2%	Manhattan	37	12.2%	Wichita

APPENDIX F

Survey of Hospitals in Selected Cities

We sent surveys to the 14 acute care hospitals operating in the eight cities included in the audit. Eleven surveys were returned, for a response rate of 78.6 percent.

LEGISLATIVE DIVISION OF POST AUDIT
STATE EMPLOYEE HEALTH INSURANCE PROVIDER SURVEY

The Legislative Post Audit Committee has directed the Legislative Division of Post Audit to conduct a performance audit of the State employees' health insurance program. To learn health providers' opinions on certain issues, we are requesting that a sample of health care providers in eight cities across Kansas complete the following survey. Please take a few moments to answer the questions listed below.

Please return the completed survey in the enclosed, self-addressed, stamped envelope no later than March 17, 1993. If you have any questions, please call Cindy Lash or Sharon Patnode at (913)296-3792.

Information About Your Hospital

1. Please check all of the following that apply to you.

- 9 32.1% My hospital is a contracting provider in the Blue Cross/Blue Shield Competitive Allowance Program.
- 6 21.4% My hospital is under contract to Blue Select.
- 5 17.9% My hospital is under contract to HMO-Kansas.
- 8 28.6% My hospital contracts with an insurance company or companies other than Blue Cross/Blue Shield
- 0 0.0% None of the above apply to my hospital.

2. City in which hospital located: 1-Colby, 1-Liberal, 1-Manhattan, 1-Pittsburg, 1-Salina, 2-Topeka, 4-Wichita.

Non-Contracting Hospitals

If yours is not a contracting hospital, please answer questions 3 through 5, then skip to question 10.

3. Why have you not contracted with Blue Cross/Blue Shield?

- 1 50.0% Hospital chose not to contract.
- 1 50.0% Hospital was not offered a contract.
- 0 0.0% Blue Cross/Blue Shield refused to contract with this hospital.

If Blue Cross/Blue Shield refused to contract with your hospital, what reason(s) did they give for the refusal.

4. Which of the following most influenced your decision not to be a Blue Cross/Blue Shield contracting provider?

- 0 0.0% Administrative paperwork required by Blue Cross/Blue Shield is too burdensome.

Comments: _____

- 0 0.0% Did not wish to accept Blue Cross/Blue Shield reimbursement as payment-in-full.

Comments: _____

- 2 100.0% Other, please explain: - the contract was a poor contract
- previous contract terminated, new contract not offered

5. What would need to change to persuade your hospital to become a contracting provider?

- would need to be offered a contract
- would need to offer contracts to all three major hospitals in Wichita

(OVER)

Contracting Hospitals

If your hospital contracts with Blue Cross/Blue Shield, please answer questions 6 through 10.

6. What are the main advantages you have experienced from being a Blue Cross/Blue Shield contracting hospital?

- 4 44.4% Patient pool greater
- 5 55.5% Quick claims payment process
- 1 11.1% Other, please explain: _____

7. What impediments or disadvantages do you see to being a Blue Cross/Blue Shield contracting hospital?

- 6 66.7% Reimbursement limits mean lost revenue
- 1 11.1% Excessive administrative paperwork
- 2 22.2% Other, please explain: _____

8. How satisfied are you with the administrative efficiency of Blue Cross/Blue Shield? (For example, are claim payments made quickly?, are there minimal paperwork hassles?)

Very Satisfied		Moderately Satisfied		Dissatisfied	
1	2	3	4	5	
1 11.1%	4 44.4%	3 33.3%	1 11.1%	0 0.0%	

Comments:

9. Comparing the Blue Cross/Blue Shield claims payment process with other insurance companies' processes, would you say that Blue Cross/Blue Shield is:

- 7 77.8% More efficient
- 2 22.2% There is no difference.
- 0 0.0% Less efficient
- 0 0.0% Do not know
- 0 0.0% Other, please explain: _____

10. Do you have any suggestions for improvements the State may make to contain health insurance costs for State employees? Please provide your comments below or on additional pages.

- 2 - There should be a greater emphasis on preventive services, with co-pays and reimbursement structured to encourage early treatment.
- 2 - Decrease administration and reviews.
- 2 - Maintain a reliable utilization review program
- 1 - Investigate self-insurance

APPENDIX G

Recomputation of 1993 Blue Select and Traditional Premiums Separating Regents' Agencies and Non-Regents' Agencies into Two Groups

The attachments were provided by Blue Cross and Blue Shield and show the recalculated Blue Select and Traditional premiums for the 1993 plan year for Regents' agencies and non-Regents' agencies if the groups had been separated during that year. The attachments also include the documentation, claims, premiums, and explanations for the recalculations.

State of Kansas Health Rates*
Recalculated to separate Board of Regents agencies
from the rest of the State
(This includes early retirees)

Category	Overall 1993 Health Rates	Board of Regents Agencies "Rates"	Chg from Overall "Rates"	Non-Board of Regents Agencies "Rates"	Chg from Overall "Rates"
Employee only	184.29	151.37	-18%	209.33	+14%
Employee/Spouse	394.82	324.30	-18%	448.46	+14%
Employee/Child(ren)	296.46	243.50	-18%	336.74	+14%
Full Family	494.98	406.56	-18%	562.23	+14%

* Excludes drugs and dental

Note: These rates assume the same retention and aggregate settlement for the total State of Kansas Employee group as is currently in place.

3/31/93

Explanation of Incurred and Projected Claims Expense

- Line #3** Claims Expense incurred 1/1/91 through 5/31/92 as paid through 5/31/92.
- Line #4:** Line #3 plus an estimate for claims incurred but unpaid as of 5/31/92. (Calculated as 51% of claims incurred and paid in the latest 5 months of 1/1/91 - 5/31/92.) This factor is based on historical experience of the State Employee group and varies depending upon the length of the period for which the unpaid is estimated; the shorter the period, the higher the ratio of unpaid claims expense.
- Line #5:** Line #4 adjusted by seasonality of 2.0% (for latest 5 months only) and projected to 1993 using cost and utilization trends of about 15% annually. Based on historical experience of the State Employee group the first 5 months of the calendar year are seasonally low and need to be increased by 2.0% in order to reflect the average level of claims expense. The trend of 15% annually reflects our estimate of both the increase in the utilization of health services and the increase in the cost of those services from the base period to 1993.

Exhibit A

3/31/93

State of Kansas Employee Group

	Overall Health Data	Employee Only Board of Regents Agency Data	Non-Board of Regents Agency Data
1. Actual Income 1/1/91 - 5/31/92	70,465,247	31,707,027	38,758,220
2. Income adjusted to 1992 rate level	70,043,119	31,520,864	38,522,255
3. Total Claims Expense for the period 1/1/91 - 5/31/92 as paid through 5/31/92	49,912,552	17,719,960	32,192,592
4. Estimated Incurred Claims Expense for the period 1/1/91 - 5/31/92	55,842,323	20,250,462	35,591,861
Total Projected Claims Expense	72,404,332	26,143,985	46,260,347
6. Projected loss ratio at 1992 rate	103.37	82.94	120.09
7. Projected utilization per contract month (Line #6 x 1992 employee rate) 1992 Rate = \$160.81	\$166.23	\$133.38	\$193.12
8. Loss ratio factor	0.935	0.935	0.935
9. Rounded rate (Line #7 / Line #8)	\$177.79	\$142.65	\$206.55
10. Adjusted rates to produce the same total income reflecting previously established relationships between contract types (Empl, Sp, Children)	\$184.29	\$151.37	\$209.33

- Note 1) The above data excludes dental and drugs
 2) Early retiree experience has been allocated between Regents and Non-Regents
 3) These rates assume the same retention and aggregate settlement for the total State of Kansas Employee group as is currently in place

Exhibit B

State of Kansas Employee Group

3/31/93

	Overall Health Data	Spouse Only Board of Regents Agency Data	Non-Board of Regents Agency Data
1. Actual Income 1/1/91 - 5/31/92	26,093,047	10,124,185	15,968,862
2. Income adjusted to 1992 rate level	25,976,689	10,081,497	15,895,192
3. Total Claims Expense for the period 1/1/91 - 5/31/92 as paid through 5/31/92	18,555,864	6,165,775	12,390,089
4. Estimated Incurred Claims Expense for the period 1/1/91 - 5/31/92	20,614,744	7,016,511	13,598,233
Total Projected Claims Expense	26,767,278	9,066,243	17,701,035
6. Projected loss ratio at 1992 rate	103.04	89.93	111.36
7. Projected utilization per contract month (Line #6 x 1992 employee rate) 1992 Rate = \$176.59	\$181.96	\$158.81	\$196.65
8. Loss ratio factor	0.935	0.935	0.935
9. Rounded rate (Line #7 / Line #8)	\$194.61	\$169.85	\$210.32
10. Adjusted rates to produce the same total income reflecting previously established relationships between contract types (Empl, Sp, Children)			
a) 2-party spouse	\$210.53	\$172.93	\$239.13
b) family spouse	\$198.52	\$163.06	\$225.49

- Note 1) The above data excludes dental and drugs
 2) Early retiree experience has been allocated between Regents and Non-Regents
 3) These rates assume the same retention and aggregate settlement for the total
 State of Kansas Employee group as is currently in place

Exhibit C

3/31/93

State of Kansas Employee Group

	Overall Health Data	Child(ren) Only Board of Regents Agency Data	Non-Board of Regents Agency Data
1. Actual Income 1/1/91 - 5/31/92	13,727,253	5,835,614	7,891,639
2. Income adjusted to 1992 rate level	13,647,273	5,801,510	7,845,763
3. Total Claims Expense for the period 1/1/91 - 5/31/92 as paid through 5/31/92	13,877,868	4,846,214	9,031,654
4. Estimated Incurred Claims Expense for the period 1/1/91 - 5/31/92	15,479,596	5,499,196	9,980,400
Total Projected Claims Expense	20,083,045	7,109,752	12,973,293
6. Projected loss ratio at 1992 rate	147.16	122.55	165.35
7. Projected utilization per contract month (Line #6 x 1992 employee rate) 1992 Rate = \$97.88	\$144.04	\$119.95	\$161.84
8. Loss ratio factor	0.935	0.935	0.935
9. Rounded rate (Line #7 / Line #8)	\$154.05	\$128.29	\$173.09
10. Adjusted rates to produce the same total income reflecting previously established relationships between contract types (Empl, Sp, Children)	\$112.17	\$92.13	\$127.41

- Note 1) The above data excludes dental and drugs
 2) Early retiree experience has been allocated between Regents and Non-Regents
 3) These rates assume the same retention and aggregate settlement for the total State of Kansas Employee group as is currently in place

APPENDIX H

Agency Responses

On May 10, 1993, we provided copies of the draft audit to officials of the Kansas Health Care Commission and Blue Cross and Blue Shield of Kansas. Responses from the Commission and Blue Cross are in this Appendix.

We made several changes to the wording of this report based on the two responses. The Health Care Commission expressed concerns that comparing Kansas' multi-tier premium structure with other states may be unfair. We reviewed information provided to us by the other states and found that all states, except Iowa, had a multi-tier premium structure, and we concluded that making the comparisons as we did in the report would not portray Kansas' premiums unfairly. Accordingly, we did not make any changes to the premium comparisons in the report.

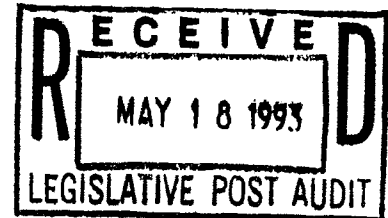


**KANSAS STATE EMPLOYEES
HEALTH CARE COMMISSION**

COMMISSIONERS:
Robert C. Harder, Chairman
Ron Todd
Susan M. Seitsam

Dave Charay,
Benefits Administrator

May 17, 1993



Ms. Barbara Hinton
Legislative Post Audit Committee
Merchants Bank Tower
800 S.W. Jackson, Suite 1200
Topeka, Kansas 66612-2212

RE: Performance of Audit Report Reviewing the Process for
Providing Health Insurance Benefits for State Employees

Dear Ms. Hinton:

Thank you for giving me the opportunity to review your report before the final copy is prepared. Overall, the report is well prepared. However, there appears to be a few areas of the report in which there appears to be a misunderstanding or difference of opinion.

1. We have clarified the role of the consultant and given the Health Benefits Administrator guidelines to follow using the services of the consultant. Enclosed for the Committee's review is the revised Health Care Commission policy.
2. The chart on page 9 and the text on pages 9 and 10 may be misleading in that they do not mention that participants and dependents covered by Blue Cross increased significantly from 30,836 in December of 1989 to 35,012 in December of 1992.
3. On page 9, second paragraph, last sentence, you discuss comparing the cost of two levels of coverage. This comparison results in an unfair comparison with the cost of four levels of coverage. To make a fair comparison, the rates of those states who have two tiers should be compared to a composite of the rates paid by all full time State of Kansas employees or Employee and Spouse, Employee and Children and Employee and Family Coverage. Blue Cross recalculated the rates for the State of Kansas group on a two tier basis and the family rate would have been reduced by over \$70 a month. Attached is a letter from Blue Cross depicting these rates.
4. On page 21, Prudential is quoted as stating the State did not support the DMO option as the company had hoped. In addition, the State did not support a "well-designed enrollment process". It was Prudential's failure to contract with DMO

dentists in areas where the State had large concentrations of state employees and an insufficient number of DMO dentist that contributed to Prudential failure to enroll a higher number of employees into their DMO dental plan. For example, there was only one DMO dentist in Lawrence. In Manhattan, Prudential wasn't able to contract with any DMO dentists. Prudential also declined to conduct a "full open enrollment" and elected to enroll employees directly by phone.

5. On page 23, seventh paragraph, the Administrator is quoted as stating the plan needed only two or three months of premium in reserves, or about \$1.5 million in order to self insure. It is not clear that this figure only relates to self-insuring the dental plan. A much greater amount would be needed if the medical and drug plans were also self-insured.
6. On page 29 and 31, Post Audit Report addresses the issue of the reserve balances, 31 million to date, and questioning whether the premiums are set too high. In preparing rates for the following plan year, projections are based on claims experience, the previous plan year and the current year to date. Premium rate projections do not take into account the migration that will occur. If many employees enrolled in the HMOs migrated to the indemnity plan, the amount of premiums dollars returned to the state could be higher than anticipated since the better risk usually enroll in HMO plans. These reserves are then used to reduce the state's cost in funding the health plan the following year. If these reserves had not been available, more of the plan cost would have been passed on to the employees.

It is also important how the reserves are used. In the mid-1980's the State used all reserves available to reduce premiums one year. The next year, 1988, they not only had to make up for the amounts that had been coming from reserves, but also faced a sizable increase in premiums.

7. On page 30, subparagraph (e) the audit report states that in 1992, \$2.7 million in left over premiums were used for 1992. Normally composite rates are set for agencies on a fiscal year basis. In the first six months of fiscal year 1992 which occurred in 1991, agencies had paid composite rates higher than was necessary. During the last six months of the fiscal year the agencies paid less than what was needed. The excess from the first part of the fiscal year was used to make up for the deficit in the last half of the year as was planned.

Ms. Barbara Hinton
May 17, 1993
Page 3

If you have any questions, please call me or the Administrator.

Sincerely,



Robert C. Harder
Chairman, Health Care Commission

RCH/DC:bcl

cc: Susan M. Seltsam
Ron Todd
Judy B. Rickerson
R. E. Roberts
Dave Charay



Department of Health and Environment

Robert C. Harder, Secretary
(913) 296-0461

May 14, 1993

Dave Charay
Health Benefits Administrator
State Employees Health Care Commission
900 SW Jackson
Topeka, KS 66612

Dear Mr. Charay:

I am following up on the Legislative Post Audit report dated May 10, 1993.

To address the issues outlined on page 28 regarding the inappropriate use of our consultant, I am implementing a new plan for the utilization of a consultant.

I will expect the in-house staff to draft and prepare the kinds of letters and memos outlined on page 28. My expectation is that the consultant will be used as an individual to provide expert advice concerning health benefit packages generally. I will expect the consultant to be used to critique the total program, both from a financial and program standpoint.

Because I expect this kind of work will continue to be around contract time, I am further requiring that each request for payment to the consultant be approved by the Chairman of the Commission.

If you have any questions, please let me hear from you.

Sincerely,

A handwritten signature in cursive script that reads "Robert C. Harder".

Robert C. Harder
Secretary

pc: Susan Seltsam
Richard Todd
Richard Roberts
Judy Rickerson

**Blue Cross
Blue Shield**
of Kansas



1133 S.W. Topeka Boulevard
Topeka, Kansas 66629-0001

Local Corporate Phone # -
(913) 291-7000
Corporate Toll-Free # -
(800) 432-0218

May 12, 1993

Mr. Dave Charay
Health Benefits Manager
Kansas Health Care Commission
Landon State Office Building
900 S.W. Jackson, Room 553-S
Topeka, Kansas 66612-1251

Dear Dave:

Below are the rates we talked about on the phone this morning. The rates below are an attempt to get a comparable family rate for the 1993 rates. We have computed these rates by compositing the two-party and family rates based on the first quarter contract counts. These are for under 65 rates and would reflect the compositing of all the contracts with multiple members.

The family health rate would be \$426.39.

The family drug rate would be \$51.45.

The family dental rate would be \$22.04.

These rates are for comparative purposes to other programs that would be on a single/family rate structure instead of the four rate structure of the State.

I hope this information is helpful to you.

Sincerely,

Donald R. Lynn
Vice President, Finance

DRL/pw

1992 AND 1993
CONTRACT FOR DENTAL BENEFITS

THIS CONTRACT is entered into by and between the Kansas State Employees Health Care (hereinafter referred to as the "Commission") and the Prudential Insurance Company of American (hereinafter referred to as the "Carrier").

The Carrier agrees to provide services, benefits and coverage in accordance with the Commission's Request for Proposal HCC-92 and the following:

1. Benefits. Dental coverage for eligible State officers, employees and retirees as provided in Exhibit A.
2. Rates. Rates for the dental coverage are based upon the following monthly cost per enrolled subscriber:

Calendar Year 1992:

Subscriber	\$ 8.37
Additional Cost For:	
Spouse	9.49
Child	5.20
Family	12.94
Medicare as Primary	5.21

Calendar Year 1993:

Carrier will provide the Commission proposed calendar year 1993 rates no later than July 10, 1992 and guarantees that such rates will not exceed the following:

Subscriber	\$9.20
Additional Cost For	
Spouse	10.44
Child	5.72
Family	14.23
Medicare as Primary	5.73

3. DMO Network. (a) Carrier agrees to actively recruit additional DMO providers for the DMO network to produce the following minimum results:

County	Number of State Plan Subscribers DMO Providers Will Accept	Minimum Number of DMO Dentists
Barton	400	1
Cowley	1,000	2 (including 1 in Winfield)
Crawford	800	1 (in Pittsburgh)
Douglas	3,800	5 (including 4 in Lawrence)
Ellis	800	1 (in Hays)
Johnson	2,400	N/A
Kansas City, MO	990	N/A
Labette	625	1 (in Parsons)
Leavenworth	800	2
Lyon	800	1 (in Emporia)
Miami	600	1 (in Osawatomie)
Pawnee	650	1 (in Larned)
Reno	800	1 (in Hutchinson)
Riley	3,100	5 (including 3 in Manhattan)
Saline	500	1 (in Salina)
Sedgwick	2,500	N/A
Shawnee	7,500	12
Wyandotte	1,800	3

On December 30, 1991, Carrier will provide the State a listing showing DMO providers, the number of State plan subscribers that they are willing to accept and designate the providers' county and city of practice.

(b) If Carrier has not met the goals set forth in (a) above for Shawnee County (both as to number of State plan subscribers and minimum number of DMO dentists) or has not met such goal for 14 of the 17 other counties (both as to number of State plan subscribers and minimum number of DMO dentists in the counties and cities designated) by December 31, 1991, Carrier shall not be entitled to any reimbursement of unamortized start-up expenses, pursuant to Section 14.

4. Contract Modifications. It is agreed that this contract shall be for a period of twenty four months, beginning

January 1, 1992. This contract may be extended or amended under such terms and conditions as both parties may agree to in writing.

5. Payments. Premiums will be payable monthly, subject to a grace period of 45 days which shall be allowed the Commission for payment thereunder. For premiums due after this agreement has been executed, the failure to pay premiums timely shall make the Commission liable for interest in accordance with the Kansas Prompt Payment Act. Failure of Commission to timely pay premiums when due shall allow Carrier to cancel this contract by giving written notice of proposed cancellation and a period of 15 days to cure its failure to pay. Carrier shall be entitled to prorata premiums up to the effective date of cancellation. The State will include a remittance tape which will allow for reconciliation.
6. HMO Subscribers. Carrier agrees to provide dental coverage to HMO subscribers at the same premium and subject to the same conditions as apply to all other participating subscribers.
7. Coverages. Carrier agrees to provide to State of Kansas Employee Health Insurance coverage for newborns and adopted children in accordance with K.S.A. 1990 Supp. 40-2,102 and amendments thereto.
8. COBRA. Carrier will be responsible for billing and collecting 102% or 150% of premiums from employees and other qualified beneficiaries who continue insurance coverage under COBRA. Carrier shall remit to the Commission at least quarterly the additional 2% to cover administrative costs. For extended continuation of coverage required by the Omnibus Budget Reconciliation Act of 1989, during coverage from the 19th through the 29th month, individuals will be required to pay 150% of the premium required of active participates. In such instances an amount equal to 50% of the normal premium will be remitted by Carrier to the Commission as a special administrative expense. Commission acknowledges that Carrier is utilizing Prudential Service Bureau, Inc. for COBRA administration.
9. Refunds. When warranted, on a case-by-case basis, the Commission will require Carrier to make payment directly to subscriber for duplicate premium payments.
10. Information Dissemination. Carrier will print and distribute materials related to the 1992 contract in quantities sufficient to provide the same to all eligible subscribers; make slides or tapes as requested for

presentation to state employees; meet with employees and distribute informational brochures during open enrollment in October, 1991. Carrier will give each subscriber an individual certificate. It will describe the subscriber's coverage under the contract. It will include: (1) to whom carrier pays benefits, (2) any protection and rights when the insurance ends and (3) claim rights and requirements

11. Reports. The Commission shall have access to information owned by Carrier relevant to the insurance program for State employees, such information to include information relating to individual providers including provider fees and charges, procedure and service information by provider, and specific complete claims information; provided however, that such claims information shall not in any event include diagnostic information which is personally identifiable to a specific employee or dependent. The types of reports available to the Commission shall include claim payment summaries, claims analysis by coverage and service, claims analysis, utilization analysis reports, COBRA continuation reports, monthly income/expense reports, and annual utilization reports. The above listing suggests the interests of the Commission, but does not preclude requests for additional information as pertinent to the operation of the program. The Carrier also shall be obligated to furnish to the Commission reports, in addition to the above, of a type for which existing computer programs of the Carrier are utilized. The Commission may request other types of reports which the Carrier will be required to furnish on the condition that the Commission first agrees to reimburse the Carrier for the costs of furnishing such reports. Attached hereto as Exhibit B is a list of required reports the Carrier must furnish without cost to the Commission as of the dates specified therein. The Commission will be damaged by late delivery of such reports, and the Carrier and the Commission hereby agree that such damage, difficult to ascertain with precision, shall be liquidated at the rate of \$1,000 for each report which is delivered to the Commission more than ten Carrier working days after such due dates; provided, however, that any delays due to the Commission's action or insurrection, riot, strike, or acts of god shall not result in any payment of such liquidated damages by the Carrier. Information required by this section pertains to the traditional portion of the plan.

A list of the reports produced by software programs used by the Carrier in connection with the plan, together with

a designation for the holder of the copyrights to such programs, will also be provided to the Commission upon request with the Commission agreeing to reimburse the Carrier for the cost of furnishing such additional reports. Nothing herein shall be construed to require the Carrier to provide access to or make available to the Commission such software programs.

12. Contractual Provision Attachment. The provisions of the Contractual Provisions Attachment (DA-146a), which is attached hereto, are hereby incorporated by reference; the reference to "current fiscal year" in Paragraph 3 thereof refers to the state's fiscal year that ends June 30, 1992.
13. RFP And Response. This agreement is subject to provisions of the Commission's Request for Proposal and the Carrier's response thereto which is incorporated herein by reference unless any such provision is contrary to or at variance with this contract including Exhibits, in which case this contract shall take precedence.
14. Cancellation. The Commission reserves the right to cancel the contract at any time by giving at least 90 day advanced notice. Subject to the provisions of Section 3, the Commission agrees to reimburse Carrier its unamortized start-up expenses of up to \$100,000, from the time cancellation is effective, in the event the Commission cancels the contract effective on or before December 31, 1992. Carrier will provide an itemization of unamortized start-up costs and other data requested by the Commission to support any request for reimbursement pursuant to this section. Carrier has the right to cancel this contract at any time upon giving the Commission 6 months written notice of cancellation.
15. Dividends Carrier will determine the share, if any, of its divisible surplus allocable to this contract as of each contract anniversary, if the contract stays in force by the payment of all premiums to that date. The share will be credited to the contract as a dividend as of that rate.
16. Group Insurance Contract. Attached hereto and incorporated by reference is Exhibit C (The Prudential Group Insurance Contract, Group Contract No. G-88500).

Any conflict or variance between Exhibit C and this Contract for Dental Benefits (including Exhibit A and B) shall be governed by this Contract for Dental Benefits.

Conflicts or variances of documents shall be governed by the following order of priority:

- A. This Contract for Dental Benefits.
- B. Exhibit A - State of Kansas Freedom of Choice Dental Plan.
- C. Exhibit B - Reporting Requirements.
- D. Exhibit C - Prudential Group Insurance Contract.
- E. Exhibit D - COBRA Responsibilities.

PRUDENTIAL INSURANCE COMPANY
OF AMERICA

KANSAS STATE EMPLOYEES HEALTH
CARE COMMISSION

By: *Neil Puzon*
Title *ASSISTANT SECRETARY*

By: *Robert G. Hader*
Chairman

Date: *March 16, 1992*

Date: *3/20/92*

3639L

**Blue Cross
Blue Shield**
of Kansas

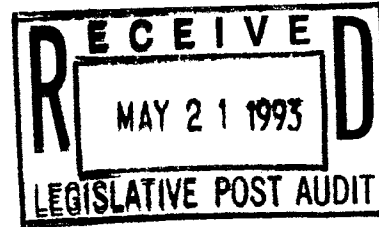


1133 S.W. Topeka Boulevard
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(913) 291-7000
Corporate 800 Number -
(800) 432-0216

May 20, 1993

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



Dear Ms. Hinton:

Thank you for the opportunity to respond to the completed audit report, Reviewing the Process for Providing Health Insurance for State Employees. You asked that I specifically address any recommendations contained in the report. I have no comments regarding the recommendation. I do have some general comments to make on behalf of Blue Cross and Blue Shield of Kansas.

Comparison of Premiums

There are several issues which need to be taken into account when comparing health care plans and associated premiums. It is difficult to compare benefits from Plan to Plan due to the variations in deductibles and coinsurance as well as the covered benefits.

It is difficult and possibly not appropriate to compare fully insured plan premiums to those of self^o funded plans. In the self funded situation you need to know if the premiums are based on a cash basis or if there is a run out period as well as what kind of a benefit period settlement is applicable. The age of the insured in the group is a big factor because the higher the utilization the higher the rate must be for that given benefit package. The rate structure used in developing the rates can vary from plan to plan. The following are possible rate structures; (1) insured, and family; (2) insured, insured and spouse, and family; (3) insured, insured and dependent, insured and spouse, and family. The rating structure have a direct impact on the premiums calculated. These factors can make it difficult to compare health care plans.

In reviewing the benefits of the surrounding states it appears the Kansas employees have richer benefits. Thus you would expect the rates to be higher.

87.

Wichita Hospital Agreement

The last paragraph in the section entitled, "Except in Wichita, State Employees had access to all acute-care hospitals in the cities we reviewed" states, "Although this contractual arrangement may be beneficial for the State in the short-term, it raises questions about whether, in the long run, it could lead to a situation that would be financially disadvantageous for the State". Blue Cross and Blue Shield of Kansas contracts with two of the four acute care hospitals in Wichita.

The current Preferred Health Care (PHC) and Preferred Plus of Kansas (PPK) agreement, between two Wichita hospitals, is having an equal or greater impact in the Wichita situation than that of Blue Cross and Blue Shield of Kansas. To further support this point is the fact that St. Francis owns physician practices which represent approximately 50 physicians in the Wichita area and continues to purchase practices. We don't feel our hospital agreement is having an adverse impact in the Wichita area.

The State of Kansas Employee Group Settlement Arrangement

Blue Cross and Blue Shield of Kansas and the State Employee Group have an 85/15 split premium arrangement. That is, each month the State is billed for 100% of the total monthly premium, but the State actually remits only 85% of that premium. The remaining 15% is held in reserve by the State to be used to cover claims expense if needed.

Within one month of the end of the contract period, a first settlement is made with the State. At that time any additional money required to cover estimated ultimate claims expense is requested by Blue Cross and Blue Shield from the State's reserves.

After six months of claims expense run out on that contract period a second estimated settlement is made. At this time additional monies may be called for from the State. Or, if less money is required than was originally anticipated, a refund may be made to the State.

After 18 months of claims expense run out on that contract period a final settlement is made. If additional money is required and there are still funds in the State's reserves, it is remitted to Blue Cross and Blue Shield at that time. If no funds remain in the reserves, Blue Cross and Blue Shield is liable for the expense and cannot charge the State for the additional expense. That is, at no time is the State liable for more than 100% of the billed premiums plus interest earned on reserves. If less money was required

than was previously received from the State, a refund will be made to the State.

The State has the benefit of being able to keep the premiums if claims are less than expected, while still having the protection of not having the liability for expenses if claims run higher than expected (see exhibit A).

In addition, interest is earned on money in excess of claims and administrative expense, and is the property of the State of Kansas.

Self Insuring

The subject of self insuring is outside the scope of this review as both the Legislative Post Audit Staff and I understand. Thus, they did not look at the ramifications of the State self insuring, although it was mentioned because the Health Care Commission has discussed the issue in the past. Several places in the report self insuring is noted and in one of the conclusions it states, "The Commission has chosen to keep the State's insurance plans fully-insured in the past, but if its intention to self-insure the dental plan in 1994 is realized, it will begin to have the information necessary to determine whether it would be cost beneficial to self-insure the health plan as well". As I mentioned above there are factors which need to be taken into account when dealing with self-insured programs.

Currently the State has the best of both a self insured and insured financial arrangement, because there is a settlement as discussed above. The state does not have a stop loss insurance premium to pay and it's liability is limited to the amount of 100% premium allocated to the health care plan including drugs and dental benefits when covered by Blue Cross and Blue Shield.

In conclusion, we feel the Legislative Post Audit Staff has fairly reported the results of the review. We appreciate the opportunity to participate in this audit activity.

Sincerely,



Thomas L. Miller
President and CEO

Premiums, Claims, Administrative Fees,
and Claims and Fees as a Percent of Premiums
for the Blue Select and Traditional Plans
(includes Dental and Drugs)
Plan Years 1989 - 1992

<u>Year</u>	<u>Total Premiums (100%)</u>	<u>(c) Actual Collected Premiums</u>	<u>Total Claims</u>	<u>Administrative Fee</u>	<u>Claims and Administrative Fees as a % of 100% Premiums</u>	<u>Claims and Administrative Fees as a % of Actual Premiums</u>
1989	\$70,074,818	\$64,510,118	\$59,674,956	\$4,835,162	92%	100%
1990	\$89,982,974	\$77,074,508	\$70,955,666	\$6,118,842	86%	100%
1991	\$105,159,319	\$89,402,152 (a)	\$83,087,502 (a)	\$6,314,650	85%	100%
1992	\$101,710,151	\$97,651,906 (b)	\$91,008,300 (b)	\$6,643,606	96%	100%

(a) The Health Benefits Administration estimated this figure because all claims for 1991 will not be finally settled until July 1993.

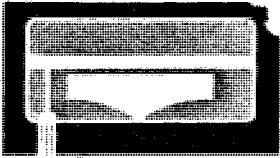
(b) The Health Benefits Administration estimated this figure because all claims for 1992 will not be finally settled until July 1994.

(c) Actual Collected Premiums exclude interest income credit.

Appendix I

Other Responses

At the June 7, 1993, Legislative Post Audit Committee meeting, members requested that this report be sent to several organizations, who were invited to respond to the report. Those organizations were the Board of Regents, Kansas Association of Public Employees, and the presidents and faculty chairpersons of all Regents' institutions. The Board of Regents and the University of Kansas provided the attached responses.



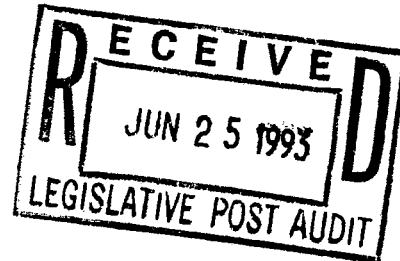
KANSAS BOARD OF REGENTS

700 SW HARRISON • SUITE 1410 • TOPEKA, KS 66603-3760

GENERAL ADMINISTRATION - 913 296-3421 • STUDENT ASSISTANCE - 913 296-3517 • FAX 913 296-0983

June 25, 1993

Ms. Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
Merchants Bank Tower
800 S.W. Jackson, Suite 1200
Topeka, KS 66612-2212



In Re: Reviewing the Process for Providing Health Insurance Benefits for State Employees

Dear Post Auditor Hinton:

Thank you for your letter of June 9, 1993. The Board of Regents and the Regents Institutions certainly appreciate your consideration and interest in providing an opportunity for commentary and input.

Clearly, the availability and provision of health insurance protection to the employees of the state of Kansas is a matter of significant concern. The dilemmas posed by increasing costs and increasing needs are real.

As you are aware, the Kansas State University Faculty Senate has devoted considerable staff time to employee benefit issues, including the provision of adequate and affordable health insurance. Representatives of Kansas State University (Director of Human Resource Services Alonzo White and faculty members Brad Fenwick, John Havlin and Aruna Mitchie) have reviewed the above-referenced June 1993 Post Audit Report and, as a result, have prepared a response. I believe that the concerns expressed by their response to the Post Audit Report would be shared by employee representatives of our other campuses; I am therefore forwarding it to you under cover of this letter.

On behalf of the almost 18,000 dedicated employees of the Regents system, I again express my appreciation for your consideration of this issue. I am certain that representatives of our universities would be most willing to meet with you and your staff, the Post-Audit Committee and/or the State Employee Health Care Commission to continue dialogue and discussion on this topic.

Ms. Barbara J. Hinton

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June 25, 1993

The employee benefits currently provided and the work of the State Employee Health Care Commission and its staff are certainly appreciated. However, perhaps the posing of difficult questions can lead to improvements and greater satisfaction.

Sincerely,



Stanley Z. Koplik
Executive Director

SZK:bf

cc: Members, Kansas Board of Regents, w/attachment
Council of Presidents, w/attachment
Council of Faculty Senate Presidents, w/attachment
Alonzo H. White
John Havlin
Aruna Mitchie
Ted D. Ayres

- I. How do the health care benefits and costs for State employees compare to those in other states?

Conclusion: Kansas' health-care coverage compares favorably with the other states that were reviewed.

This does not appear to be accurate. Based on the data in the report, health-care coverage in Kansas is significantly less than the other States that were examined. The report notes that "Kansas' dental plan ... provides significantly lower coverage than the remaining four states" (page 13) and four States provide 90/10% co-insurance for inpatient services while Kansas is 80/20% (page 12). There are numerous other examples where the employees of the other States have better benefits than the employees of Kansas. Items like the a maximum lifetime payout of \$1 million dollars per person in Kansas were not included in the report.

Importantly, even with reduced benefits the cost of health-care coverage in Kansas is significantly higher for both the employee and the State of Kansas (pages 13,14).

Conclusion: Kansas' State employees paid among the lowest in maximum annual out-of-pocket costs.

Again, this conclusion is contrary to the data in the report. State employees with full-family coverage pay the *highest* maximum annual out-of-pocket costs for health care premiums (page 17, graph 2). As well, average claims experience of \$1301 (page 41, non Regents' Agencies) would indicate that most employees are not approaching the maximum out of pocket expenses. Higher maximum out of pockets limits - passed on as savings on employee premiums - could significantly reduce employee actual expenses.

Conclusion: The high health insurance premiums in Kansas is because Kansas' State employees have among the lowest in maximum annual out-of-pocket costs. There is a trade-off between premium level and out-of-pocket costs for employees.

Given Kansas' employees in fact pay the highest maximum annual out-of-pocket costs, no trade-off exists (page 17).

Careful analysis of the health-care plans in the other States refute the supposition of an inverse relationship between premiums and maximum annual out-of-pocket costs. For example, the report suggests that Iowa is perhaps the best State to compare with Kansas as it is the only other State in the comparison group that is fully insured (page 21). Like Kansas, Blue Cross (of Iowa) was the only bidder in Iowa, nevertheless Iowa employees have significantly better benefits (pages 12, 46, 48) while at the same time pay significantly lower premiums (page 14). In contrast to the contention of a trade-off, Iowa and its' employees also have the lowest maximum out-of-pocket expenses (page 17).

Maximum annual out-of-pocket cost is not a valid way of evaluating benefits to costs. Such a benefit is of value only if the employee reaches this ceiling. Do more Kansas' employees reach the maximum cost limit than employees of the other States?

A more valid comparison is the average out-of-pocket costs (not maximum) per percipient, including premiums plus all co-payments and deductibles. No data are provided for actual out-of-pocket expenses. What is the average out-of-pocket costs for the employees of Kansas in comparison to the employees of the other States?

II. What steps does the State Employees Health Care Commission take to ensure that the health care coverage provides reasonable benefits at the lowest cost?

Conclusion: The Health Care Commission has taken steps to ensure reasonable benefits at the lowest cost.

This conclusion is contradicted by the data provided in the report. If the HCC is doing a good job, why are costs and benefits in Kansas short of those provided in what the report terms as "comparable states"? As well, why do we have the administrator contracting out the portion of his job which seems to be accomplished?

It must be noted that the HCC must bear the ultimate responsibility for the program and administration. The fact that there seems to be sufficient reserve to self insure and contain costs must be a matter of question. Why hasn't this been done, yet? The data from other states demonstrate that additional flexibility and cost containment is possible.

The advisory committee to the HCC is, obviously, uninvolved and not regularly consulted in decisions made by the HCC. Although there are many state employees with knowledge of, and an interest in, health care, they are not consulted or involved.

The HCC needs to be restructured, along with the duties and direction of the administrator. If Kansas is to be well served by large pool of dollars being expended through the HCC, there must be a proactive - rather than defensive and reactive - posture on the part of the HCC and the administrator.

The audit report (page 24) indicates several problems with the HCC. Although there is an advisory committee, they were evidently left out of the Request for Proposal process as it was "too late for the Commission to incorporate any of the Advisory Committee's suggestions". Although there are many valid survey instruments available to gather employee feedback on benefits and other issues, the HCC and the administrator chose to float an unscientific, badly worded and confusing survey to agency heads.

Perhaps the most obvious indicator of problems within the HCC is the noted decision (page 24, paragraph 4) that state employees should not be allowed the option of a lower cost plan with lower benefits (presumably higher deductibles and out of pocket expenses). This was

based on a, "concern ...that lower paid employees would be attracted by the lower premiums, but could experience financial disaster if they had significant medical problems". What is obviously indicated is that state employees are not intelligent enough to choose the most cost effective manner to fund their own medical expenses. This attitude also indicates a lack of understanding of how the medical reimbursement account (Kanelect) can be used in tandem with a health insurance plan for predictable medical expenses. This may be due to the fact (as noted) that Kanelect is administered by the Division of Personnel Services.

Subsidization of Full-Family Coverage:

(Page 7)... "the State began to subsidize full-family coverage for the Traditional and Blue Select plans to draw employees with dependents back into these plans from health maintenance organizations."

The effect of this action has been significantly higher rate increases for the HMO plans than the Traditional and Blue Select plans (page 7). This action undermined HMO programs and participation in these programs has declined sharply. In effect, the Health Care Commission penalizes participation in preventative medicine programs and healthy lifestyles.

What advantage did the State or its employees receive in underwriting a shift of the number of it's employees away for HMO's to the more expensive Traditional and Blue Select coverage plans?

Seeing that the profit margin for HMO plans are significantly less than the Traditional and Blue Select plans, did this actions benefit Blue Cross/Blue Shield at the expense of both the employee and the State?

If the goal was to provide more affordable coverage for dependents of employees, then why not subsidize the HMO plans as well?

Establishment of a Reserve Fund:

Do the other states, especially Iowa have a reserve fund? Could a reserve fund, which is used to smooth out rate increases, reduce the pain of the a rate increase thereby allowing rates to increases faster. What is the rate increase history of the other States?

Although the report talks about the reserve fund, it does not approach the issue of a difference in published employer contribution rates vs the rates actually charged. In 1992, the published employer premium rate was \$274 per month. The rate actually charged/collected was 225.19 (212.58 was the published and charged employee portion). According to David Charay (see attached), the discrepancy was due to premium reserves being used to reduce the employer premium. Why weren't employee premiums reduced, as well? Did not employee paid premium contribute to the reserve?

The net effect is that employees pay/fund a much greater share of total premium than is reflected in the published rates and in the legislative post audit report. This discrepancy needs to be reviewed and corrected.

Of what value is the reserve fund if it is not used to self insure or to reduce overall premium levels?

III. Do all State employees have equal access to the benefits provided by the State's health insurance plan?

Conclusion: State employees do not have equal access to benefits.

We agree, however, the report fails to note that because of the actions of the Health Care Commission in terms of subsidizing full-family coverage for the Traditional and Blue Select plans for dependent care, access to HMO programs has declined significantly.

Equal access to benefits should be a matter of concern only in that all state employees should be afforded opportunity to cost effective and sound medical care. The state HCC cannot dictate or control much of the decision making of the state health care industry. As such, it should limit its parameters to those areas where control is achievable.

IV. What would the impact be on State employee health insurance costs if the Regents' institutions became separate group?

Conclusion: If Regents' employees were to become a separate group that groups rates would decline by 18 percent but rates for the other State employees would increase by 14 percent.

Why should there be a problem in identifying Regents' employees in the HMO-Kansas plan? (page 40) This data is reported to the State by each of the Regents institutions.

The audit only compares the effect of separate groups using estimates provided by Blue Cross/Blue Shield. It fails to account for the possibility that because the size of the coverage groups would be reduce by 50% and the characteristics of the participates would be more similar in each group, it is likely that additional bids would be received. More bids would inherently provide more competition and perhaps be more cost effective.

Many States insure these two groups separately. Why?

Why are Regents' employee claims experience \$400 per person per year less than the other State employees? (page 41)

It is an accepted practice to match risk and benefit utilization with premiums. Failing to do this in effect remove incentives to reduce risks and minimize benefit utilization. Why has the Health Care Commission failed to recognize this principle and pushed for "cafeteria" type benefit programs as are common in other States?

COMMENTS:

1. State Employees Health Care Commission

The Commission has been ineffective and unresponsive. It's working relationship with Blue Cross/Blue Shield may be limiting. The Commission should be restructured to include employees and administrative personnel from other State agencies. The Commission should not have to rely on Blue Cross/Blue Shield for all its data and cost projections.

2. Consultant for the Health Care Commission

Further study/investigation needs to be conducted. For example, why is the consultant the "lead" negotiator of the health care contract? What are the duties of the consultant vs those of Dave Charay? What has been the historical and current relationship between the consultant and BC/BS? Does the consultant do consulting work for BC/BS? Did the consultant have a voice in hiring Dave Charay? What does the former administrator add that the current administrator does not already have or should have? Why was an independent insurance broker with experience with other states program not hired as the consultant?

3. HMO Costs vs Traditional and Managed Care Costs

According to the report of HMO coverage for employee-only as well as full-family has increased at a significantly higher rate (150%) than increases in the cost of Traditional and Blue Select programs (page 7). In the case of full-family coverage, this appears to be because the State chose to subsidized full-family coverage for the Traditional and Blue Select plans. What was the basis for the increases in the employee-only coverage?

If the goal was to keep the cost of dependent coverage as low as possible, why was a subsidy not provided for dependents in the HMO programs? The overall cost of HMO coverage is significantly less than either the Traditional or Blue Select programs. Are the Traditional and Blue Select programs more profitable for Blue Cross/Blue Shield than the HMO programs?

4. Premium vs Maximum Out of Pocket Costs

Does Iowa invalidate the conclusion of the report that there is a relationship between high premiums and low potential maximum out-of-pocket expenses?

Caps on maximum amount of coverage for an individual employee? Is this, in effect, a stop-loss system for Blue Cross/Blue Shield.

Their conclusion was that health care coverage (premiums) was the highest of any other state. This was in part due to having lower maximum out-of-pocket costs. However, the chart on page 17 clearly shows that maximum out-of-pocket costs are the highest for full family coverage. (We are the lowest only for single coverage). This clearly contradicts the statement by Thomas Miller, CEO of BC/BS (pg. 87).

5. Benefits Cost Structure

The structure of Kansas health care benefits - higher premiums with low out of pocket co-insurance, deductibles and payments limits - is advantageous only to those persons who are consistently high users of health care. In fact, this structure encourages and incentives indiscriminate use of health care services.

With no front end deductibles and 80/20 coverage based on a discounted rate, neither physician nor patient are incentivized to change behavior. Front end deductibles, higher co-payments and maximum out of pockets could sharply reduce premium. Each dollar decrease in premium that is added to maximum out pocket expenses represents savings - except to those who need to expend it as health care cost dollars.

6. Health Care Survey

The Commission sponsored a survey which purported to ask if employees would be willing to consider lower premiums with higher maximums. The way in which the question was couched was negative. Without proper sensitization to this method of funding health care costs, employees cannot but respond in a negative manner. If employees were asked if maximum out of pocket were increased by 100/yr., with a decrease of 100/yr. in premium - they might have said yes. This is not to suggest that there is a one to one relationship between premium and maximum out of pocket dollars. Rather, it suggests that there are ways to educate employees to plan design and funding issues in a manner that is positive and more likely to elicit their cooperation.

7. Deductibles in PPO's

Page 4 states that, "we call the Traditional and the Blue Select self referral coverages "conventional care" because they contain deductibles and co-insurance provisions not generally found in managed care programs such as health maintenance organizations and the Blue Select primary care option." According to the 1992 Foster Higgins Health Care Benefits Survey report, 69% of employers (public and private) require deductibles for in-network Preferred Provider Organization (PPO) services. Blue Select is a PPO.

SUGGESTED AREAS REQUIRING ADDITIONAL STUDY:

1. Do the other states, especially Iowa have a reserve fund? Could a reserve fund which is used to smooth out rate increases, in effect reduce the pain of the a rate increase. Thus, allowing rates to increases faster. What is the rate increase history of the other states?
2. What has been the comparative rate of premium increases since 1988 between the states surveyed?

3. What are the comparative total actual premium + out-of-pocket costs for employees in each state of the comparison? (Only the maximum out-of-pocket costs were considered. No data are provided for actual out-of-pocket expenses.) The difference in maximum and actual is the only reason why total premiums are the most expensive of the comparison group.
5. Why does BC/BS not want to provide HMO or other effective individual incentives to reduce health care costs (ie. live healthier). We conclude their motive is entirely profit driven. The State of Kansas should insist on and develop individual incentives to live healthier. If BCBS wont participate, then competitive bidding may force them to.
6. What are the caps or maximum claim limits for the other states? Kansas has a maximum \$1,000,000 cap, which was greatly decreased from previous years (ie. significant loss in benefit, while health care costs still increased).
7. What would the be the impact on a 'Regents only' health plan (costs + benefits) if a 'Regents only' and other agency employees plans were competitively bid? The audit only compares a BC/BS estimate. With greatly reduced participants in each group more companies would provide bids and, thus, the process is inherently more competitive and perhaps more cost effective. Conclusion #4 (this conclusion ignores competitive bid effect on increased cost to other employees)

Most states find it cost effective to insure the two groups separately - why?

The audit report states that the Commission never has allowed one group of state employees to benefit at the expense of the others. The conclusion of costs that are -18% for 'Regents only' and +14% other employees is completely erroneous without actually bidding both groups.

Why are Regents claims experience \$400 per person per year less than other employees?

Given that the average claims per person is \$911 for Regent's agencies and 1,301 for the others, what percentage of the employees ever have the opportunity to use this benefit of lower maximum annual costs? How does this percentage compare to the other states? What is the comparison of average (not potential maximum) Out-of-Pocket costs per year in Kansas and the other States?

STATE OF KANSAS



**KANSAS STATE EMPLOYEES
HEALTH CARE COMMISSION**

COMMISSIONERS:
Robert C. Harder, Chairman
Ron Todd
Susan M. Sellsam

Dave Charay,
Benefits Administrator

December 2, 1992

John L. Havlin, Ph.D., Chairman
Faculty Salaries and Fringe Benefits Committee
Department of Agronomy
Crop, Soil, and Range Sciences
Throckmorton Hall
Manhattan, Kansas 66506-5501

RE: University Health Insurance Premium
for Full Time Employees

Dear Dr. Havlin:

This letter will confirm our recent telephone conversation regarding Kansas State's health insurance contribution for full time employees.

It is my understanding that the premium of \$274 shown on page 18, table 9, for Kansas State University under the column, University Pays, in the Annual Report on the Status of Faculty Salaries and Fringe Benefits at Kansas State University represents the cost for a full time employee who has selected family medical coverage and earns a salary of \$30,000 or more. I was asked to investigate the discrepancy between the composite rate charged to the University (In the 1992 fiscal year it was \$180.00 for a full time employee and \$45.19 for a full time dependent) and the \$274.00 shown in the Group Health Insurance Benefit Options pamphlet issued to employees.

The \$274.00 shown in the group health insurance options pamphlet represent the actual state cost for a full time employee who selects family coverage and who earn a salary of \$30,000 or more. The composite rate charged to the University of \$225.19 for health, dental and drugs (\$180.00 for a full time employee and \$45.19 for a full time dependent) for family coverage represents the reduced charge to the University after the Health Care Commission has reduced the premium for State agencies by using available medical claims reserves to lower the composite rate.

As I explained to your committee last Friday, the State of Kansas has a financial arrangement with Blue Cross of Kansas that allows the State to retain 15% of the monthly premium which the State invests in government securities to earn interest income. After

John L. Havlin, Ph.D., Chairman
December 2, 1992
Page Two

the end of the plan year, there is an eighteen month claims run out period in which Blue Cross has the right to use the money if the premiums paid by the State of Kansas during the year are not sufficient to settle all of the run out claims and administrative cost. For example, the State of Kansas was able to retain approximately \$13,500,000 million dollars from the premium reserves for the 1990 plan year. Preliminary estimates indicate that the State will be able to retain about \$14,500,000 million dollars for the 1991 plan year. All reserve money retained by the State is used to pay future plan costs.

Dr. Havlin, I hope this information satisfactorily explains the reason for the difference between the composite rate charged to Kansas State University and the amount shown in the Group Health Insurance Benefit Options pamphlet issued to employees at Kansas State University that you shared with me.

I look forward to receiving the information the Committee will provide me to begin the study in comparing health care benefits and costs in Kansas with selected States and Universities. If you have any questions regarding this letter or about the study, please call me at 913-296-7483.

Sincerely,

Dave Charay
Dave Charay
Health Benefits Administrator

DC:bcl

cc: Representative Sheila Hochhauser
Robert C. Harder
Susan Seltsam
Alonzo White

The University of Kansas

University Governance
Senate Executive Committee
Faculty Executive Committee
Judicial Board



August 16, 1993

Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
Merchants Bank Tower
800 S. W. Jackson, Suite 1200
Topeka, Kansas 66612-2212

Dear Ms. Hinton:

I am writing in response to the June, 1993, report of the Legislative Post Audit Committee which reviewed the process for providing health insurance benefits for state employees. Unfortunately, because I was out of the United States this summer, it was impossible for me to react to the report within the June 25 time frame. However, I have read the report and consulted over the past few days with several knowledgeable colleagues. I hope that these remarks about a few aspects of the report will be of some help.

First of all, it is gratifying to see that a performance audit was done. Health insurance is a necessity for state employees, and it is vital that they receive the best coverage possible for the dollars expended the State and by themselves. It would be highly desirable if an audit could be done on a yearly basis.

However, the conclusion that, "... Kansas' health-care coverage compares favorably with the other states we reviewed" does not really seem to be justified by the data presented in the report itself. The statement seems to be based on the potential "out-of-pocket" costs to the employee, but the actual cost to the employee would have much more pertinent. The employee-paid cost of premiums is higher for Kansas employees than those in the other states studied, and these are costs that employees must pay. "Potential" costs are speculative. Real costs need to be studied. It is unfair to compare "real" costs such as premiums with "potential" costs such as potential out-of-pocket costs. The report argues that the tradeoff that affects state employees is higher premiums in exchange for low out-of-pocket costs.

In addition, the report states "Kansas' State employees appear to be paying higher premiums, at least in part, to keep annual out-of-pocket expenditures down." The report goes on . . . "By raising the annual deductibles and coinsurance, it seems likely that the State could lower its total premium costs." (p. 18) Both assumptions are highly suspect. Has it really been the express policy of the Health Care Commission to pay higher premiums in exchange for lower out-of-pocket costs? It is much more likely that the current arrangement has evolved without any express purpose whatsoever. Moreover, is Legislative Post Audit suggesting that if the State were to raise deductibles and coinsurance, premiums would decrease? There is a considerable amount of evidence to suggest that raising cost-sharing may affect access but does not necessarily affect premiums. Increased cost-sharing would limit access to those employees with the least resources and often the greatest need. The analysis may be helped by separating premiums from costs.

A disturbing fact brought out in the report is that the Employee Advisory Committee seems to have been bypassed in providing feedback about employee preferences on health insurance options. This is not acceptable practice. Sufficient time must be allowed for employee representatives to be properly consulted. Agency heads do not represent employee views, and questionnaires administered by agency heads cannot be depended on to provide unbiased information.

If a group comprised of the Regents' institutions could be insured at a lower cost, it is not at all clear to employees of those institutions that this is not the correct and fairest step to take. The reasons given for failing to regard Regents' employees as a separate group are not convincing.

More effective steps must be taken to make sure that the bidding procedures for the state health insurance contracts attract more bidders. It is clear from the report itself that the lowest bidder does not always get the contract; the reasons for this are not clear and persuasive. The bidding procedures, even when they attract more bidders, appear to reflect a flaw in the Health Care Commission's bidding process that the report does not address. For all intents and purposes, there is only one bidder for the State contract and when other firms bid--even when their bid is lower--there is only one firm that proposes all that the Commission finds acceptable. We suggest that the only way to achieve greater flexibility and efficiency is for the Commission and State to consider another means of insuring. Self-insurance offers some options. It is the principal means for insurance, as

Page 3
Barbara J. Hinton

the report points out, for almost every other state in the region. In a State like Kansas, the idea of competitive bidding is somewhat hollow when there is only one statewide insurance firm.

Again, the information provided by the report was very welcome and useful. It is our hope that the practice will continue.

Sincerely yours,



Dick B. Tracy, Ph. D.
Faculty Benefits Committee

cc: Robert Friauf, T. P. Srinivasan, Raymond Davis, Jackie McClain

