

State Employee Health Plan

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- Aon Hewitt, State Employee Health Plan Actuary

STATE EMPLOYEE HEALTH PLAN OVERVIEW

Previous Efficiency Initiatives

- Kansas State Employee Health Plan (SEHP):
- Evaluating the State's Pharmacy Benefit Management System – The Legislative Division of Post Audit (LPA) provided a report in February 2015 detailing SEHP's use and management of the Pharmacy Benefit Manager (PBM), CVS Caremark. The report made the following findings:
 - » The Kansas Department of Health & Environment (KDHE) does not "adequately monitor Caremark's compliance with negotiated contractual provisions."
 - » The State does not accurately monitor for "spread pricing," though the LPA's audit of the sample claims did not result in finding any spread pricing.
 - » KDHE does not appropriately monitor the PBM's compliance with pharmacy rebating requirements.
 - » There are minimal controls over the mail-order pharmacy program, although the findings indicate that SEHP participants do not heavily use the mail-order program.
- SEHP responded to the report by stating that additional controls would be implemented immediately to address the findings.
- SEHP is an extremely lean, efficient organization—the staff appears to effectively manage partnerships with vendors. In addition, the staff is cross-trained, in order to provide additional support throughout the organization, when needed.
- In addition to taking into consideration the recommendations provided by LPA, SEHP executed a three-year contract with Aon Hewitt for pharmacy benefit audit services beginning in January 2015. Hewitt will audit the PBM plan for plan years 2012-2014 and provide insight into any errors in pharmacy rebating and management. Although Hewitt does not expect this process to provide savings for the SEHP, the audit will review the overall administration and efficiency of the PBM, which could lead to identifying and potentially creating future efficiency opportunities.
- The state has begun to take action to limit the its liability as it relates to retirees. Beginning in 2016, Medicare-Eligible Retirees who want to participate in the SEHP program must elect and pay the entire cost of fully-insured Medicare Supplement plan, rather than continuing enrollment on the SEHP plan. This initiative will remove SEHP's liability for any unfunded costs realized by Medicare-

Eligible Retirees under the self-funded SEHP plan.

- The SEHP, in conjunction with the Health Care Commission (HCC) and plan actuary, evaluated efficiency and cost saving measures on an annual basis, making annual plan design changes that will further drive participant behavior. In addition, they implemented a wellness program to support member wellbeing and engagement.

BASELINE BUDGET

The State Employee Health Plan (SEHP) is a self-sustaining organization within the Kansas Department of Health & Environment (KDHE). Fees and self-generated revenues are received from state agencies and non-state employer groups that participate in the group insurance program. Premiums are collected from plan members, employees, and retirees as well as earnings of program funds. Agency and non-state employer group spend is based on the number of individuals enrolled, the plan type and tier enrollment.

State Employee Health Plan <i>(All values in 000s)</i>	FY 2012 Actual	FY 2013 Budget	FY 2014 Budget	FY 2015 Budget
Regular Pay	\$1,674,826	\$1,719,032	\$1,712,791	\$1,671,063
Other Salary	\$329,596	\$324,243	\$341,229	\$370,755
State Contribution -- Life and Health	\$289,562	\$311,880	\$302,447	\$296,003
State Contribution -- Pensions and Retirement	\$178,590	\$179,007	\$189,319	\$188,019
State (Employer) Contribution	\$179,590	\$184,696	\$178,762	\$173,131
Overtime Pay	\$15,831	\$16,433	\$17,577	\$17,762
Total Salaries and Wages	\$2,667,994	\$2,735,292	\$2,742,123	\$2,716,733
Total	\$5,335,989	\$5,470,585	\$5,484,247	\$5,433,467

BENCHMARK COMPARISONS

A&M researched a number of other state benefits departments and related health plans to generate ideas and best practices around organization structure and benefit design. A&M benchmarked SEHP program against five similar state departments:

- Arkansas Employee Benefits Division
- Colorado Division of Human Resources
- Missouri Consolidated Health Care Plan
- Nebraska Office of Administrative Services: Benefits
- South Dakota State Employee Benefits Program

ORGANIZATIONAL BENCHMARKS

In evaluating the appropriateness of the current position of the SEHP under KDHE, A&M collected information on the current organizational structure of the benchmark states.

State	Location
Arkansas	Department of Finance & Administration
Colorado	Department of Personnel & Administration
Missouri	Standalone State Entity
Nebraska	Department of Administrative Services
South Dakota	Bureau of Human Resources

PLAN DESIGN BENCHMARKS

The following chart indicates the current medical plans offered by the benchmark states. All states currently offer a Health Savings Account (HSA) plan option, though only two of the states provide employer/state funding to that HSA account on behalf of employees.

State	Carrier	Type	Deductible	ER/State HSA Contribution
Arkansas	Arkansas	HSA	\$4,350/\$8,500	None
	BCBS	HSA	\$2,000/\$3,000	None
	Qualchoice	PPO	\$1,000/\$2,000	N/A
Colorado	UHC	HSA	\$1,500/\$3,000	None
		HSA	\$1,500/\$3,000	N/A
	Kaiser	PPO	\$1,500/\$3,000 \$750/\$1,500	None N/a
Missouri	UMR	HSA	\$1,650/\$3,300	\$300/\$600
		PPO	\$600/\$1,200	N/A
		PPO	\$300/\$600	N/A
Nebraska	UHC	HSA	\$2,600/\$5,300	None
		PPO	\$1,000/\$2,000	N/A
		PPO	\$600/\$1,200	N/A
South Dakota	Dakota Care	HSA	\$1,800/\$3,600	\$300/\$600
		PPO	\$1,250/\$3,125	N/A
		PPO	\$750/\$1,875	N/A

SUMMARY

A&M's approach to the SEHP recommendations focused on furthering the Health Care Commission's health plan initiatives, cost reduction, and the alignment of an administrative structure that would allow the SEHP to function more effectively.

All opportunities included within this section are medium to long-term opportunities. The assessment team worked collaboratively with SEHP staff and health plan actuary, Aon Hewitt, to develop these recommendations, which address plan design, administrative efficiency, and leveraged solutions to generate savings in the next five years.

It is expected that most of these recommendations can be executed without statute or regulatory chang-

es; however, we have also included a number of recommendations that may require Governor approval or regulatory changes.

RECOMMENDATIONS

Recommendation #1 – Execute Opportunities for Cost Savings through Plan Design Changes

Over the past several years, the State Employee Health Plan has taken steps to lessen the rising cost of healthcare through plan design changes. However, there are opportunities to further reduce the cost of benefits through strategic plan design changes, and the implementation of a population health management program. Specifically, the SEHP should consider:

- Total Replacement Consumer Driven Health Plan** – The state can improve overall consumer engagement in healthcare choices and reduce costs by offering "Plan C," the Consumer Driven Health Plan, with Health Savings Account (HSA) or Health Reimbursement Account (HRA). Additionally, the state should reduce employer contributions to \$500 for single and \$1,250 for family, in order to reduce employer cost and move toward similar state benchmark HSA contribution amounts. This change in the employer contribution will bring the actuarial value (or overall value of benefits paid by the plan) to approximately the equivalent of the actuarial value of the current Plan A. The total replacement Consumer Driven Health Plan would result in savings to the SEHP

Rec #	Recommendation Name	Target Savings and Revenue Estimate					Total
		FY17	FY18	FY19	FY20	FY21	
1	Execute on opportunities for cost savings through plan design changes	\$13,750	\$27,500	\$27,500	\$27,500	\$27,500	\$123,750
2	Implement Retiree Exchange Platform	\$5,750	\$12,000	\$12,936	\$13,945	\$15,033	\$59,664
3	Increase organizational efficiency of SEHP	\$165	\$165	\$165	\$165	\$165	\$825
SEHP Total		\$19,665	\$39,665	\$40,601	\$41,610	\$42,698	\$184,239

of approximately \$12.5 million to \$15 million in FY17.

- Population Health Management** – The SEHP member population is relatively stable and credible, and as such, long-term savings can be realized through claims management and risk reduction—achieved by the monitoring and management of individual healthcare outcomes, otherwise known as Population Health Management. SEHP has leveraged the Truven Health Analytics technology through partnership with Medicaid. Truven is a powerful population health management analytics tool. Some analytics are being performed; however, it would be beneficial to incorporate a clinical perspective to the data. This can be achieved without additional cost through the current Third Party Administrator (TPA) or for objectivity, through the hiring of a consultant. Although we believe additional savings are achievable, a full review of the SEHP claims is needed to provide an estimate. No savings estimate for this sub-recommendation is included in figures shown.

Background and Findings

- The current deductible for Plan C is \$2,750 for single coverage and \$5,500 for family coverage.
- The state and participating Non-State Employers provide \$1,500 or \$2,250 contribution to individuals enrolled in the HSA/HRA plan in employee only or employee family, respectively. This contribution is embedded in the monthly rate charged to each agency.
- State benchmarks indicate that most states sponsor high deductible health plans with HSAs (five out of five benchmark states sponsor these plans). Two states sponsoring these plans provide a small employer contribution to the HSA, while the other three benchmark states provide no contribution at all.
- The current actuarial value of Plan A is approximately 77 percent while the current actuarial value of Plan C is approximately 89 percent, when considering all employer contributions. This means that on average, Plan A covers 77 percent of the cost of covered benefits, while Plan C currently covers 89 percent of the cost of covered benefits. The recommended change would bring

the total replacement plan to an actuarial value similar to that of the current Plan A.

- The state is currently providing a premium discount of \$480/year for participation in the wellness program. This will decrease to \$240/year in 2016. Participation in the program is satisfied by a participant obtaining 30 credits through activities including:
 - » Biometric Screening
 - » Preventive Exams
 - » Tobacco Cessation Program
 - » Wellness Challenges
 - » Virtual Health Coaching, etc.
- SEHP currently uses the data analytics software from Truven Health Analytics to collect all claims data. However, according to SEHP staff, no population health management program is in place and health data is not being actively monitored.
- Variations to this recommended plan design could also produce similar results. i.e. more than one high deductible plan offering. Additional plan design variations would require additional in-depth actuarial analysis.

Recommendation #1 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
\$13,750	\$27,500	\$27,500	\$27,500	\$27,500

Key Assumptions

- Estimates assume the current contribution structure (employer vs. employee contribution amounts) remains the same as 2016 levels.
- All estimates are derived using 2016 benefit plan design and contribution levels, and do not take into consideration any planned changes for 2017.
- Savings assume that SEHP's membership count and tier enrollment remains relatively consistent with current levels.
- Estimates are based on the average of the high and low range of savings values.
- Since the state currently contracts with Truven, we have assumed there would be no initial capi-

tal required to implement the population health management program. Additionally, the state can leverage on-staff physicians at the carriers to analyze the data and drive the population health programs.

Critical Steps to Implement

The critical steps necessary to complete the implementation of the plan design recommendations include:

- Projections will need to be maintained by SEHP actuary to update strategy for 2017 Plan Year for any deviation in plan claims experience.
- Recommendations will need to follow the Kansas Health Care Commission process for ultimate approval.
- The SEHP should develop a communication campaign regarding plan changes and provide education to all SEHP participants regarding Consumer Driven Health Plans.
- Population Health Management program and internal program managers must be designated by SEHP staff. Clinical expertise should be engaged either through TPA or consultant.

To realize savings as soon as possible, this recommendation should be implemented for the next SEHP plan year, beginning January 1, 2017.

Recommendation #2 – Implement Retiree Exchange Platform

Per Statute, Kansas provides pre-65 and post-65 retirees access to the SEHP. The state has tried to limit the liability for these retirees by requiring all Medicare-Eligible Retirees to join a fully-insured Medicare supplement plan effective January 1, 2016; however, a Governmental Accounting Standards Board (GASB) liability remains. In order to remove the liability for future payments and reduce the current retiree subsidy, Kansas should:

- **Implement Retiree Exchange Platform** – Retiree specific platforms provide pre-65 and post-65 retirees with a choice of healthcare plans and provider networks. These platforms also provide the retiree with additional resources targeted to the specific needs of retirees. Moving the Kansas retirees to an exchange platform would increase

retiree choice of plans and networks while removing SEHP's current subsidy and GASB liability for future payments for pre-65 retirees. Savings to the SEHP fund from removing the current retiree liability are estimated at \$5.75 million for the last six months of FY17. The full year of savings will be realized in FY18, with an estimated savings of \$12 million.

Background and Findings

- Per 2012 Kansas Statute 12-5040¹, all local governments providing employer sponsored health care must extend the offer of coverage to pre-65 retirees. Employers may require retirees to pay up to 125 percent of the cost for similarly situated employees.
- The State Employee Health Plan allows retirees, their spouses, and survivors access to the medical and dental plans sponsored by the SEHP.
- Beginning in 2016, SEHP will require all Medicare-Eligible Retirees (post-65) to participate in the fully-insured Medicare plans.
- All pre-65 retirees will continue to have the option to continue participation in the SEHP self-funded plans in FY16. Although retirees are required to pay their "full cost of coverage," the SEHP fund is paying for any claims in excess of the premium collected.
- Pre-65 retirees will experience a 22.5 percent increase in their required contributions beginning in 2016 as an attempt by the SEHP to more accurately charge retirees for their full cost of coverage.
- In 2016, pre-65 retiree contributions for the BCBS KS plans are as follows:
 - » Plan A: \$638.08 for single, \$1,895.02 for family
 - » Plan C: \$471.02 for single, \$1,484.80 for family
- Premium amounts for 2016 Aetna pre-65 retirees are slightly higher than BCBS contribution

¹ http://kslegislature.org/li_2012/m/statute/012_000_0000_chapter/012_050_0000_article/012_050_0040_section/012_050_0040_k.pdf

amounts.

- The average employer contribution on retiree specific exchanges are \$100 per retiree per month.
- In 2016, an average participant contribution for single coverage under a “Gold” plan, or a plan with 80 percent actuarial value, ranged from \$500 to \$700 per month for a 55 year old in Topeka Kansas. Actual contributions are determined based on the plan elected and participant age, gender and dependents covered.
- GASB requires all governmental entities sponsoring Other Postemployment Benefits (OPEB) to accrue for the obligations under the plan².
- Despite moving the Medicare-Eligible Retirees to a fully-insured platform, SEHP continues to have a GASB liability for those current and future pre-65 retirees.
- Approximately 50 percent of all active employees and 22 percent of their spouses who retire and meet the eligibility criteria will participate in the plan, according to the 2015 Actuarial Report for GASB OPEB Valuation provided by the SEHP actuary, Hewitt.

Recommendation #2 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
\$5,750	\$12,000	\$12,936	\$13,945	\$15,033

Key Assumptions

- Estimate of savings do not consider any changes to retiree contributions from the CY2016 levels
- Estimates are based on the average of the high and low range of savings values
- Savings assume current retiree claims experience remains stable and increases with 7.8 percent

2 Other Postemployment Benefits: A Plain-Language Summary of GASB Statements No. 43 and No. 45. (n.d.). Retrieved December 2, 2015, from http://www.gasb.org/cs/ContentServer?c=Document_C&pagename=GASB/Document_C/GASBDocumentPage&cid=1176156714369

trend, as estimated by the 2016 Segal Health Plan Cost Trend Survey³

- Savings assume retirees will to an exchange platform for January 1, 2017 and the SEHP will realize savings for the last six months of FY17

Critical Steps to Implement

The critical steps necessary to complete the implementation of the plan design recommendations include:

- Issuance of a Request For Proposal (RFP) for the retiree exchange platform
- Oversight and monitoring by SEHP staff of the awarded vendor
- Ample communication plan and timeline for all retirees to successfully understand new options through the exchange
- Transfer all current retiree members to the exchange platform
- Change KS Statue 12-5040 to indicate that employers can make a group health plan available, or a plan of similar design, network, and cost

The expected time to implement this recommendation is 12 months and changes can become effective the beginning of the 2017 plan year (January 1, 2017). In the event that an RFP is needed for the retiree exchange, it can be completed in advance, before the 2017 plan year for a January 1, 2017 effective date.

Recommendation #3 – Increase Organizational Efficiency of the SEHP

The State Employee Health Plan is currently running an efficient organization with the lean staff it employs. However, SEHP can increase administrative efficiencies and reduce duplicative effort through a realignment of the organization and member requirements for State Employers and Non-State Employers.

- **Reposition the SEHP under the Kansas Department of Administration** – The SEHP is cur-

3 2016 Segal Health Plan Cost Trend Survey. (2015). Retrieved November 27, 2015, from <https://www.segalco.com/media/2139/me-trend-survey-2016.pdf>

rently housed in the Division of Health Care Finance, within the Kansas Department of Health & Environment (KDHE). The current employment structure of the SEHP staff creates a misalignment of priorities due to the differing role of the Department of Administration (DOA) and the KDHE, within the Kansas Government. It is recommended that the plan transition into an ancillary agency of the DOA responsible for managing the administration of the benefit program available to state employees, retirees, and their dependents, as well as employees of certain other government entities. This structure would allow for better coordination and communication between the DOA and SEHP.

- **Streamline Payroll Deduction File Requirements** – To better utilize SEHP staff, decrease enrollment and deduction errors, and increase administrative efficiency, the state should require all state universities, or “regents,” to employ the payroll system used by the DOA. This could provide the SEHP approximately \$165,000 in savings annually, for time lost, cash outlays for system updates to accommodate regent changes, and cost for potential payroll errors.

Background and Findings

- Based on state benchmarks, state health plans are typically structured within the Department of Administration (DOA), or another state agency that handles Human Resource functions.
- Effective July 1, 2011, the staff that administers the SEHP became part of the Division of Health Care Finance (DHCF) within the KDHE. The Director of the State Employee Health Benefits Program reports to the Director of the DHCF.
- The Health Care Commission (HCC) was developed by Kansas’s statute in 1984. The HCC is comprised of five members—the Secretary of Administration, Commissioner of Insurance, and three members appointed by the Governor. The statute requires one member to be a representative of the general public, one a current state employee in classified service, and one a retired state employee from the classified service.
- Per statute, the HCC, headed by the Secretary of the Department of Administration (DOA), has the authority to make any changes to the administra-

tion and implementation of the State Employee Health Plan.

- The SEHP produces one payroll deduction file for the DOA and seven other payroll deduction files for the various regents across the state. This results in multiple additional checks and balances working with each of the various regents. Additionally this poses inefficiencies, as the SEHP must:
 - » Produce the files earlier than necessary or appropriate.

Recommendation #3 - (dollars in 000's)				
<u>FY17</u>	<u>FY18</u>	<u>FY19</u>	<u>FY20</u>	<u>FY21</u>
\$165	\$165	\$165	\$165	\$165

- » Work with each regent to reconcile any payroll file issues.
- » Accommodate limited reporting from the regents—not all reports that are provided by DOA are available with the regents payroll systems.
- » Reconcile the regent payroll files after the payroll calculation cycle and subsequent payroll file creation cycle are both closed, causing a lag in reporting and increase in potential for error.

Key Assumptions

- The Governor and DOA would grant SEHP the authority to reorganize its structure.
- SEHP staff developed saving estimates from streamlining the payroll deduction files.
- Savings estimates do not account for any investment cost that would be incurred through the purchase of new payroll systems.
- Savings will be realized when the payroll systems are consolidated and the number of payroll deduction files provided reduces to one.

Critical Steps to Implement

The critical steps necessary to complete the administrative recommendations include:

- Request approval from the Governor to realign SEHP under the DOA

- Make appropriate administrative changes to reflect SEHP staff employment by DOA
- Implement standardized payroll system for all regents
- Train regent employees on payroll deduction file requirements

The expected time to implement this recommendation is six to twelve months for the regents to adopt the state payroll system. The recommendation is not expected to require statutory or regulatory changes; however, it may require newly established statutory requirements to impose the requirement upon the regents.