2008 Annual Legislative Report

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presented to:
Kansas Legislature

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Executive Summary

The ultimate goal of the Kansas Health Policy Authority (KHPA) is to improve the health of Kansans. We stand ready to work with the Governor, Legislature, and stakeholders to focus on common sense health reform that works for Kansas.

It is critical to the success of this agency and the process of health care reform to enhance our current programs and initiatives, while creating new priorities for the future. This annual report looks back at the past year, but with an eye on the future.

This report:

- Highlights the agency achievements in 2007
- Delineates advancements in accomplishing statutory charges
- Identifies 2008 agency priorities and outlines goals for 2009

We look forward to working with Governor Kathleen Sebelius, the Legislature, and our stakeholders in developing a plan that will ensure accessible health care for Kansans and embrace the vision statement the Kansas Health Policy Authority Board has defined as important to accomplishing its mission.

-Marcia Nielsen, Ph.D, MPH, Executive Director of the Kansas Health Policy Authority

Kansas Health Policy Authority
2008 Annual Report

Vision Statement

KHPA: Coordinating health and health care for a *thriving* Kansas

Mission Statement

As expressed in KSA 2005 Supp. 75-7401, *et seq.*, the mission of Kansas Health Policy Authority (KHPA) is to develop and maintain a coordinated health policy agenda which combines the effective purchasing and administration of health care with health promotion oriented public health strategies. The powers, duties and functions of the Kansas Health Policy Authority are intended to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health services and public health programs.

The vision principles are the guiding framework of the Board and agency. Ranging from providing access to care to stewardship and education, these principles reflect the Board's application of their statutory mission to the full range of health policies within their purview. The principles will provide direction to the agency in its ongoing work and in developing new initiatives and programmatic proposals.

KHPA Board Vision Principles

Access to Care—Every Kansan should have access to patient-centered health care and public health services ensuring the right care, at the right place, and the right price. Health promotion and disease prevention should be integrated directly into these services.

Quality and Efficiency in Health Care—The delivery of care in Kansas should emphasize positive outcomes, safety, and efficiency and be based on best practices and evidence-based medicine.

Affordable and Sustainable Health Care—The financing of health care and health promotion in Kansas should be equitable, seamless, and sustainable for consumers, providers, purchasers, and government.

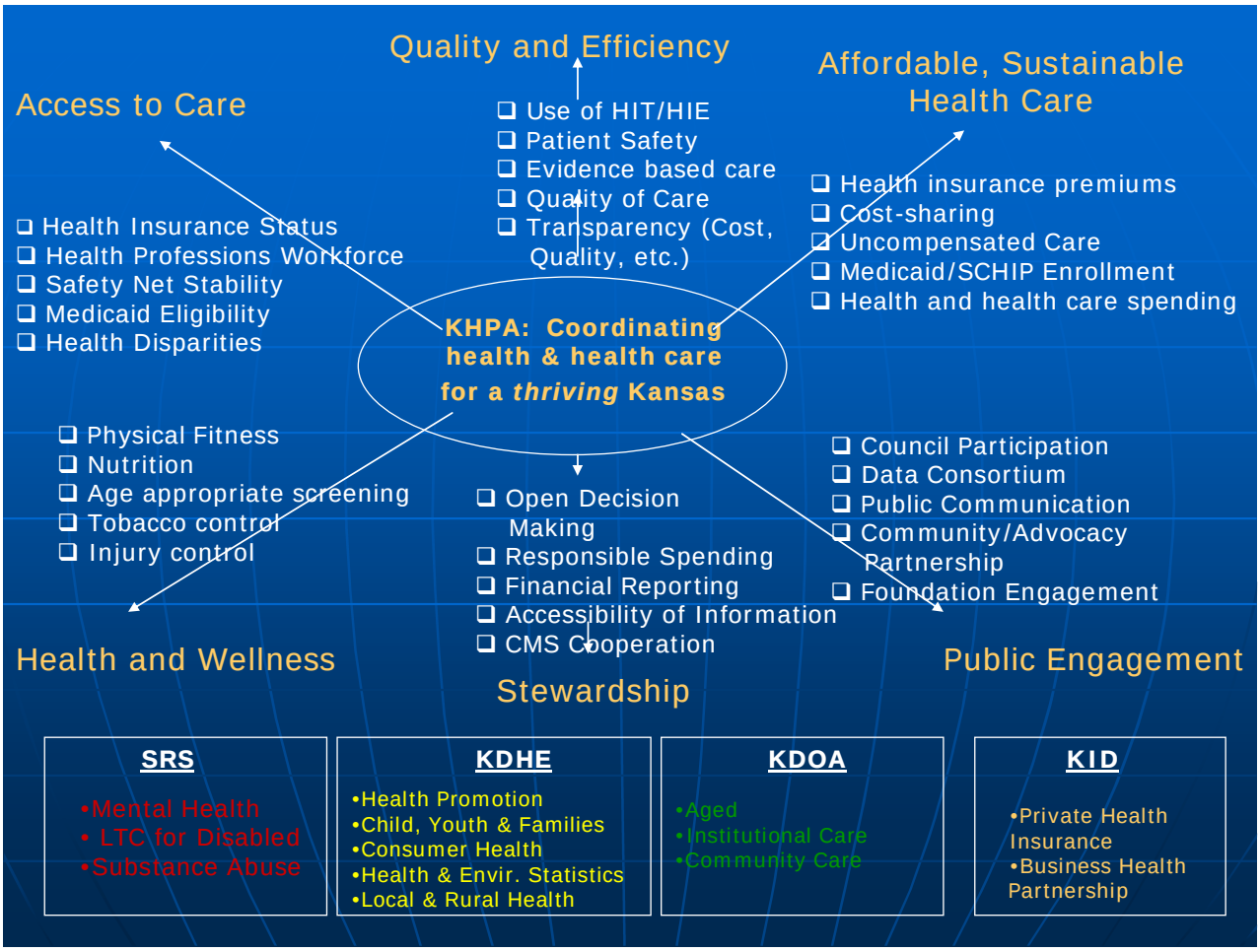
Promoting Health and Wellness—Kansans should pursue healthy lifestyles with a focus on wellness—to include physical activity, proper nutrition, and refraining from tobacco use—as well as a focus on the informed use of health services over their life course.

Stewardship—The Kansas Health Policy Authority will administer the resources entrusted to us by the citizens and the State of Kansas with the highest level of integrity, responsibility, and transparency.

Education and Engagement of the Public—Kansans should be educated about health and health care delivery to encourage public engagement in developing an improved health system for all.

Health Indicators

As required by statute, the Kansas Health Policy Authority Board developed and approved an initial set of health indicators that correlate with each vision principle. These indicators will include baseline and trend data on health care, health outcomes, healthy behaviors, KHPA operational integrity, and health costs.



History of the Kansas Health Policy Authority

The Kansas Health Policy Authority (KHPA) is charged to develop a statewide health policy agenda including health care, health promotion components, and health indicators to include baseline and trend data on health care costs.

KHPA was established on July 1, 2005, as a new agency within the Executive Branch. For one year, the immediate predecessor to the KHPA was the Division of Health Policy and Finance (DHPF) within the Department of Administration. This division was also established on July 1, 2005, within the Department of Administration, and served as the single state Medicaid agency. On July 1, 2006, DHPF was abolished, and the KHPA assumed responsibility for Medicaid, State Children's Health Insurance Program (SCHIP), State Employee Health Benefits Program, and the State Self Insurance Fund (Workers Compensation). KHPA was also designated as the single state agency responsible to the federal government for all programs receiving federal Medicaid funds. However, certain long-term care services (e.g., nursing facilities, HCBS waivers, and mental health) continue to be managed on a day-to-day basis by the Kansas Department of Aging (KDOA) and the Kansas Department of Social and Rehabilitation Services (SRS).

The KHPA is an independent state agency and is monitored and studied by the Joint Committee on Health Policy Oversight. The Kansas Health Policy Authority Board is comprised of nine voting members, who are appointed by the Governor and House and Senate leadership, and seven non-voting (ex-officio) members, who serve as a resource and support for the voting members. The appointed members will serve a four-year term, except the original members who were appointed to serve terms that vary for the first cycle.

The Executive Director of the KHPA has responsibility and statutory authority for the oversight of the Medicaid and SCHIP programs, the State Employee Health Benefits Program, State Self Insurance Fund (Workers' Compensation), and the health care data responsibilities of the former Health Care Data Governing Board.

In 2007 the KHPA was asked by the Governor and the Legislature to develop health reform options in collaboration with Kansas stakeholders. The health reform recommendations delivered to the Governor and the Legislature on November 1, 2007 were the result of deliberations of the KHPA Board, four Advisory Councils (140 members), a 22 community listening tour, and feedback from numerous stakeholder groups and other concerned citizens of Kansas. In addition, four Kansas foundations – the United Methodist Health Ministry, the Sunflower Foundation, the REACH Foundation, and the Health Care Foundation of Greater Kansas City – funded an independent actuarial and policy analysis of various health insurance models as well as the coordination of the four Advisory Councils. The health reform recommendations are summarized in appendix A of this report. The full report can be found at http://www.khpa.ks.gov .

KHPA 2007 Highlights

Strengthening Medicaid/HealthWave

- **Implemented HealthWave Contracts:** KHPA awarded two new Medicaid Managed Care Organizations (MCO) to serve our HealthWave populations which resulted in increased consumer health plan choice, with an estimated State savings of between $10 and 15 million dollars annually.
- **Resolved Center for Medicare and Medicaid Services (CMS) Audits and Deferrals:** KHPA resolved all outstanding Medicaid audit and deferral issues in the Local Educational Agencies (LEA), Targeted Case Management (TCM), and Child Welfare and Mental Health programs; KHPA is working closely with partner agencies to ensure Medicaid program integrity moving forward.
- **Managed New Citizenship Requirements**: KHPA managed and resolved the impact of new federal Medicaid Citizenship/Identification requirements, requesting and acquiring funds to increase Clearinghouse staff to reduce the number of unprocessed applications and reviews.
- **Resolved Presumptive Medical Disability Backlog**: KHPA shortened the process time and eliminated the backlog of Presumptive Medical Disability applications for consumers applying to the MediKan program.
- **Reformed Payments for Hospitals:** Working closely with the Kansas Hospital Association, hospital stakeholders, and consultants, KHPA developed a new Disproportionate Share Hospital (DSH) payment formula to maximize federal contributions to the program, treat both in-patient and outpatient care equitably, and strengthen Critical Access Hospitals (CAH).
- **Increased Dental Providers**: KHPA increased the number of dental providers serving Medicaid patients and increased the number of Medicaid consumers receiving dental services.
- **Created Program for Working Disabled Kansans**: KHPA established the Work Opportunities Reward Kansans (WORK) program which provides cash and counseling supports for working disabled Kansans.
- **Negotiated Additional Federal Dollars for Data Initiative**: KHPA negotiated an enhanced match for Data Analytic Interface (DAI) from CMS – a project to improve access to information for improved health plan management and data driven policymaking.
- **Completed National Provider Identification (NPI)**: KHPA implemented the federal NPI program. The NPI is intended to uniquely identify a health care provider in standard transactions, such as health care claims.
- **Strengthened Pilot Program for the Chronically Ill**: KHPA implemented the Enhanced Care Management Pilot Project in Sedgwick County, a community based disease management program; the pilot is currently being evaluated with future utilization dependent upon the outcome of that evaluation.
- **Strengthened Pilot Program for Health Information Technology:** KHPA piloted a shared community health record with Kansas Medicaid providers in Sedgwick County; an evaluation has been conducted to evaluate the impact of the CHR on quality of care. An additional community health record pilot in Kansas City for State Employees will begin in 2008.

- **Coordinated Data Systems**: KHPA linked the state immunization registry with the Medicaid Management Information System (MMIS) to allow for the transfer of immunization data for all eligible Medicaid beneficiaries.

State Employee Health Plan

- **Improved Health and Wellness Offerings**: The State Employee Health Benefits Program (SEHBP) developed a program to increase the promotion of health and wellness in the health benefits plan of state employees, to include access to health coaching, personal health screenings, and health education and promotion tools.
- **Provided Employees with Additional Tools and Marketing Information**: A Benefit Selector/Plan Selector Tool was made available to SEHBP eligible persons and improved marketing materials were developed.
- **Increased Support for Dependent Coverage**: The employer financial contribution for SEHBP dependent coverage was increased from 45% to 55%, making health insurance more affordable for families.
- **Improved Health Plan Benefit Design**: The SEHBP benefit design was improved to expand the focus on prevention, health and wellness with emphasis placed on tobacco cessation, obesity, and diabetes management.
- **Strengthened Financial Management**: A systematic financial reporting SEHBP mechanism to the Health Care Commission (HCC) was initiated.

Agency Infrastructure

- **Completed Agency Staffing**: KHPA received legislative approval and hired an additional 31 staff positions, primarily in the areas of finance, accounting, and oversight to support the mission of the independent agency.
- **Integrated Functions Across Agency**: KHPA integrated programs across the agency to consolidate finance, contracts, legal, operations.
- **Secured Additional Space for our Employees**: KHPA secured additional office space, outfitted it, and moved staff to the Mills Building and an expanded 10th Floor of LSOB.
- **Improved Agency Communication**: The KHPA Intranet was established for internal communications, allowing a mechanism for the posting important documents and files that need to be accessed by all KHPA staff.
- **Improved Agency Operations**: KHPA instituted several important infrastructural initiatives which improved system efficiency and effectiveness, including the establishment of new policy, procedures, and budgetary practices.

Interagency Partnerships

- **Developed Long Term Care Program**: The Long-Term Care Partnership program was jointly developed and implemented by the Kansas Insurance Department, Kansas Department on Aging and the Kansas Health Policy Authority, providing a means for individuals who have long term care partnership policies to retain more assets, based on policy benefits received, than other persons applying for Medicaid.
- **Solidified Interagency Operations:** Interagency relationships were codified by new updated interagency agreements, addressing responsibilities, duties and management of Medicaid programs that are implemented by the Kansas Department of Social and

Rehabilitative Services (SRS), the Kansas Department on Aging (KDOA) and the Kansas Juvenile Justice Authority (JJA) and are coordinated by the Kansas Health Policy Authority (KHPA).

- **Implemented CMS-required reforms**: State Plan Amendments were submitted and approved by CMS to make needed changes in the Targeted Case Management and Local Educations Agencies Medicaid programs.
- **Supported Other Agency Reform Efforts**: KHPA supported the implementation of Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP), waiver for dental coverage, and autism waiver Medicaid initiatives advanced by SRS and KDOA.

Health Reform

- **Developed Reform Recommendations**: KHPA in conjunction with the Health for All Kansas Steering Committee developed health reform recommendations aimed at increasing personal responsibility for health, paying for prevention and promoting medical homes, and improving access to affordable health insurance.
- **Solicited Significant Stakeholder Input**: KHPA convened four Advisory Councils; Provider Council, Purchaser Council, Consumer Council, and the At-Large Council which met from March through December to provide input into the development of the health reform recommendations presented to the Legislature and the Governor.
- **Met with Kansans Across the State**: KHPA convened a well attended Listening Tour in 22 communities across the state to dialog about health reform in Kansas.
- **Obtained External Funding from Kansas Foundations**: Foundation funding to support the health reform stakeholder participation and data analysis process was secured.

New Initiatives

- **Created Consumer Health Information Website – Kansas Health Online:** Health information transparency for consumers was enhanced through the establishment of a two-phase initiative that (1) collects and makes available health and health care data resources to consumers and (2) will publicize cost and health care quality information developed by the Health Data Consortium for use by purchasers and consumers.
- **Improved Agency Health Policy and Research Capacity**: KHPA added significant health policy research and analysis staff capacity and undertook the development of a data management, and policy analysis program that will promote data driven health policy decisions, improve health care efficiency, lower health care costs, and improve overall health status.
- **Convened Data Stakeholders**: KHPA convened the first meeting of the Data Consortium to provide stakeholder input on data policy and assess State's health status.
- **Developed Private Insurance Model for Low Income Kansans**: KHPA undertook the development and design of the Premium Assistance program, Kansas Healthy Choices, which will provide private health insurance for low income Kansans.
- **Established Inspector General's Office:** Legislation was passed authorizing the establishment of the Office of the Inspector General at the KHPA to provide an independent oversight body to review and investigate the performance of the KHPA's delivery of health services (KHPA Office of the Inspector General 2008 Annual Report can be found at http://www.khpa.ks.gov).

Achievement of Statutory Responsibilities

The table below describes the major statutory responsibilities of the KHPA and delineates how successful program and policy initiatives undertaken in 2007 fall under each of those major priorities.

Effective Health Care Purchasing	Health Promotion and Public Health	Coordinating Health and Health Care
Implemented Medicaid MCO Successful CMS Audit Deferral Negotiations Created Consumer Health Information Website Reformed DSH Payments Initiated financial reporting to HCC Added Benefit/Plan Selector Tool to SEHP LTC Partnership Increased dental providers and beneficiaries	Health and wellness focus for SEHP Improved benefit design for SEHP Developed health reform recommendations Solicited stakeholder input in health reform Listening tour on health reform	Managed impact of new citizenship identification requirements Shortened process time and backlog for Presumptive Medical Disability WORK program launched Completed National Provider Identification implementation Community Health Record Pilot Program Expanding Enhanced Care Management Pilot Project Linked State immunization records to MMIS Established KHPA Intranet

Transfer of Additional Health Programs

In 2008 the Kansas Health Policy Authority Board has unanimously agreed to a recommendation not to transfer any additional programs to KHPA at the beginning of FY 2009. During 2008, the Kansas Health Policy Authority will continue to find new ways to improve existing programs, establish new initiatives that accomplish the mission of the agency, and monitor activity related to the recommended health care reform recommendations presented to the legislature and the Governor in November, 2007. We intend to work with the Governor's Office, Legislature and stakeholders to provide Kansans with accessible and affordable health care.

KHPA Priorities for 2008

Agency Goal (1): To improve consumer communication and provide data rich information in order to improve health and public policy.

- Develop health care cost and quality indicators for public reporting through a rigorous public stakeholder process ("Data Consortium").
- Implement and expand the consumer health transparency project ("Kansas Health Online") to provide consumers with usable health information. This website will contain links to the health indicators selected by the Data Consortium.
- Implement the data base software manager ("Data Analytic Interface") with the goal of integrating various KHPA and other data sets to provide researchers and analysts with usable health data.
- Improve public communications for consumers in order to increase health literacy. Highlight for consumers the relationship between health care costs, health outcomes, and health behaviors.
- Educate and advocate to the public and legislature for the 21 health reform recommendations adopted by the KHPA Board on November 1, 2007.

Agency Goal (2): To strengthen and improve leadership and organizational development within the agency.

- Develop a five year integrated strategic plan for presentation and adoption by the KHPA Board.
- Develop and provide staff development and leadership opportunities to KHPA employees at all levels of the agency.
- Define "new culture" for the KHPA, focused on an *integrated* vision – across programs and departments -- of health for all Kansans.
- Improve internal and interagency communications.

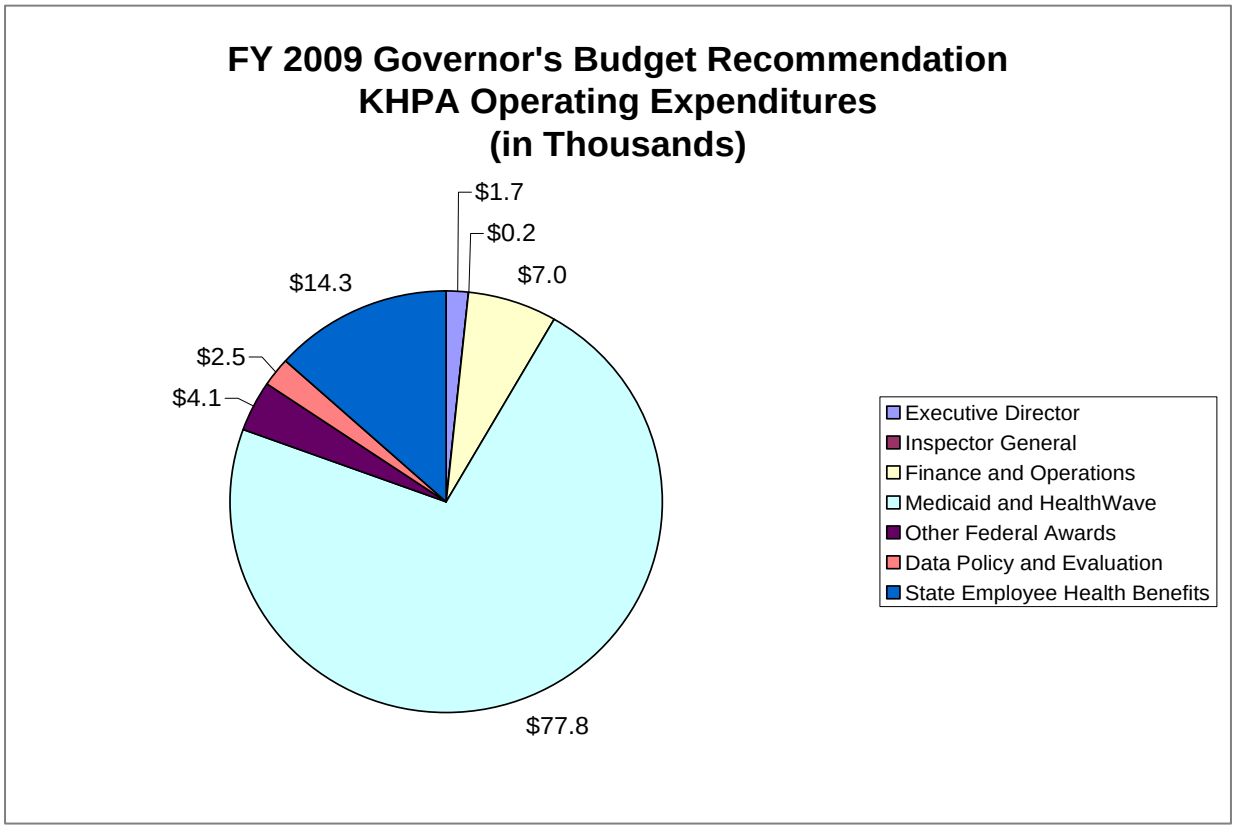
Agency Goal (3): To successfully implement new initiatives and programs, while consistently improving ongoing programs/initiatives

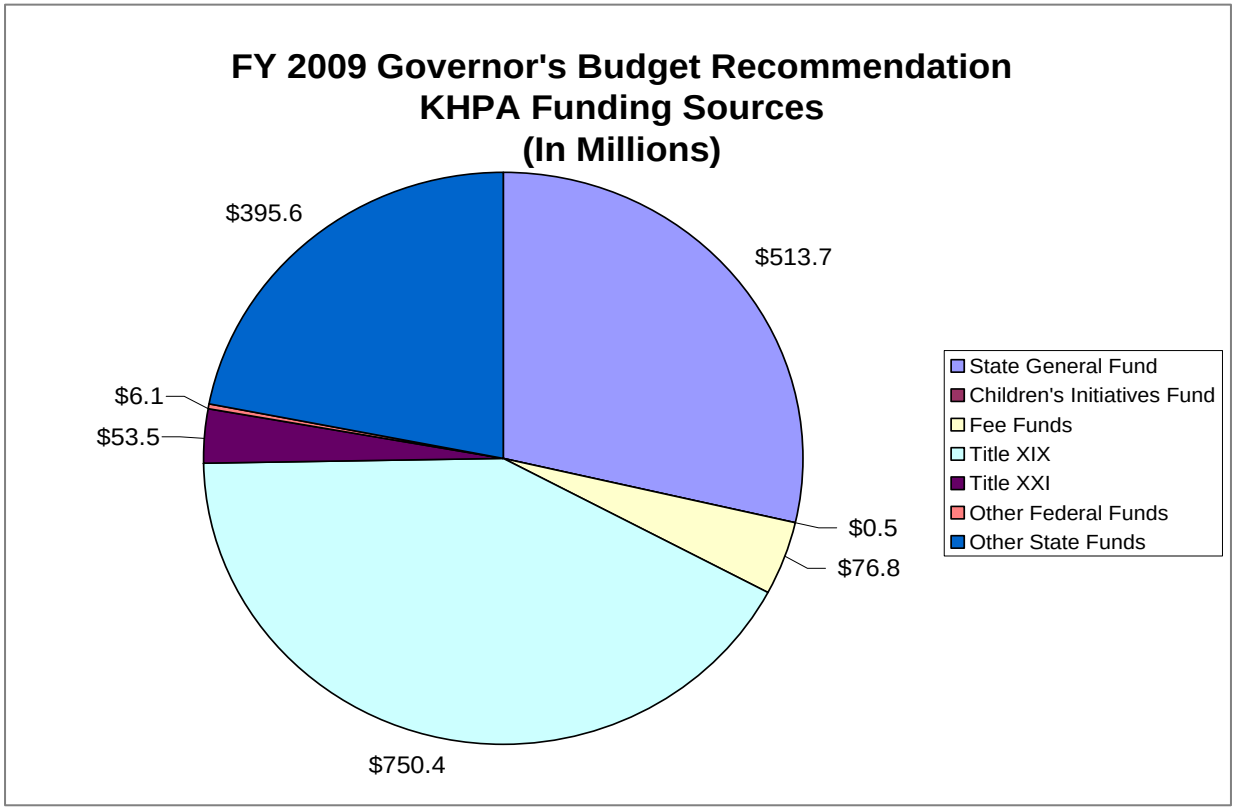
- Successfully implement the new premium assistance program as defined by SB 11 ("Kansas Healthy Choices")
- Develop and begin planning for a new eligibility and enrollment system for KHPA programs, together with the Department of Social and Rehabilitation Services.
- Analyze, develop and implement "medical home" model of coordinated, team-based, and patient-centered health care; analyze health professions workforce to support that model of care.

- Implement Phase I and II of the State Employee Health Plan wellness, which will provide significant health, wellness and prevention benefits to state employees and their dependents.
- Increase the number of insured Kansas children through aggressive targeting outreach and enrollment for those children eligible for Medicaid or HealthWave.

KHPA Statutory Responsibilities within Programs

As expressed in the Statute establishing the Kansas Health Policy Authority, the Authority is charged with three primary responsibilities; developing and maintaining a coordinated health policy agenda, engaging in effective purchasing and administration of health care, and integrating health promotion public health strategies. The KHPA programs are integral in achieving these functions and within the following program overviews specific achievements for each of those responsibilities are delineated for the Data Policy and Evaluation Division, Finance and Operations Division, Kansas Medicaid and HealthWave Division, and the State Employee Health Benefits Program Division.


FY 2009 Governor's Budget Recommendation
KHPA Operating Expenditures
(in Thousands)
$1.7
$0.2
$7.0
$14.3
$2.5
$4.1
$77.8
Executive Director
Inspector General
Finance and Operations
Medicaid and HealthWave
Other Federal Awards
Data Policy and Evaluation
State Employee Health Benefits


FY 2009 Governor's Budget Recommendation
KHPA Funding Sources
(In Millions)
$395.6
$513.7
$6.1
$53.5
$0.5
$76.8
$750.4
State General Fund
Children's Initiatives Fund
Fee Funds
Title XIX
Title XXI
Other Federal Funds
Other State Funds

Data Policy and Evaluation

KHPA is charged with the responsibility for a wide range of health and health care data including both programmatic, or administrative information as well as market-based information. The goal is to increase the quality, efficiency, and effectiveness of health services and public health programs. KHPA is specifically required to adopt health indicators and include baseline and trend data on health costs and indicators in each annual report to the Legislature.

To meet this mission, the Division of Data Policy and Evaluation consolidates data management and analysis with policy evaluation. All program data are available to analysts to assess the impact of proposed policies, forecast utilization and expenditures, and provide information to the KHPA Board, KHPA staff, and other stakeholders. This division is also responsible for ensuring the accuracy of the state employees' benefits enrollment data and options within the state personnel database and for researching new policy initiatives.

Examples of programmatic data include Medicaid and SCHIP, State Employee Health Benefits Program, and State Self-Insurance Fund (Workers' Compensation). Market-based data are inpatient hospital claims information, health care provider database, and private insurance data from the Kansas Health Insurance Information System (KHIIS).

House Substitute for Senate Bill 272, the enabling legislation for the KHPA transfers responsibility for collection and management of a wide range of data once managed by the Health Care Data Governing Board (HCDGB) to the KHPA. In addition, House Substitute for Senate Bill 577 transferred responsibility for collection of data from insurance carriers on behalf of the Commissioner of Insurance from the Kansas Department of Health and Environment (KDHE) to KHPA.

It is KHPA's responsibility to ensure the effective collection, management, use and dissemination of these data to improve decision-making in the design and financing of health care and public health and wellness policies charted by the KHPA Board. To help meet the KHPA's responsibilities, KHPA will convene and direct the Data Consortium to advise the Authority in the development of policies and bring recommendations to the KHPA for consideration.

The Data Consortium will provide recommendations and input in a number of areas:

- The KHPA's responsibilities for managing health data
- Reporting standards and requirements for non-programmatic data
- Data sharing for research, policy development and programmatic improvement
- Identifying specific topics for analysis
- Health and health care data initiatives in other organizations and agencies
- Reporting cost, quality, and other data for consumers, policymakers, and others

In order to allow KHPA staff and stakeholders to access KHPA-managed data more easily and quickly, a Data Analytic Interface (DAI) that incorporates data from the Medicaid Management Information System (MMIS), the State Employee Health Benefit Program (SEHBP) system, and the Kansas Health Insurance Information System (KHIIS) will be created. The breadth and depth

of information contained in these datasets will present an unprecedented opportunity to document, describe, analyze, and diagnose the state of health care in Kansas.

The data contained in each of the systems are:

- MMIS-medical claims data for Medicaid and SCHIP consumers representing nearly 400,000 Kansans each year.
- SEHBP- medical coverage and workers compensation claims, medical, lab results, drug and dental claims data and also member eligibility data for approximately 88,000 Kansans.
- KHIIS- detailed claims, enrollment and health plan information from 20 to 30 private insurance carriers representing several hundred thousand Kansans.

The overall goal of DAI is to take currently available data from the three systems and create a single interface for analysis. This will allow analysis based on episodes of care of individual beneficiaries, disease management, predictive modeling, and evaluative analysis to measure costs and outcome effectiveness. The DAI is being designed to use public and private data to compare the health care service and utilization patterns, and identify trends and areas for focus and improvement. KHPA will analyze these data to develop programmatic improvements in Medicaid and the State Employee Health Program, and to advance health policy for the state as a whole. The improved decision-making capability of the DAI should lead to increased productivity and more efficient use of state health care dollars in order to manage costs, quality, and access to health care programs.

The legislature provided full funding for the DAI project in its FY 2008 appropriation including for additional staff and for procurement of the system. The CMS approved the Advanced Planning Document, which budgets a 90% Federal match for the portion of the DAI dedicated to Medicaid and SCHIP data. The DAI is to be procured in fall 2008 with implementation to follow.

Programs to Support the Mission

- The **Director of the Division of Data Policy and Evaluation** promotes the collection, management, analysis, and dissemination of health data to improve decision-making by consumers, in the marketplace, and among policy makers. This includes developing a plan to maximize the effective use of health data by supporting the activities of the KHPA Data Consortium.

- The **Data Analysis Unit** establishes reimbursement rates, computes the fiscal impact of proposed policies, establishes diagnosis-related groups (DRGs) for Medicaid inpatient services, establishes capitation rates for Medicaid and SCHIP managed care, and forecasts caseloads.

- The **Data Policy and Management Unit** is responsible for management of health care professional licensure data received from eight licensing boards, hospital discharge data received from the Kansas Hospital Association (KHA), and private insurance carrier data required by the Commissioner of Insurance (known as the Kansas Health Insurance Information System-KHIIS). Fees are collected from insurance carriers to defray the cost

of accepting, storing, managing, and analyzing the KHIIS data. This unit will also manage the vendor contract for a data analytic interface.

- The **Policy Evaluation Unit** explores emerging health, health care and coverage issues; manages state and federally funded research projects; and estimates the impact of proposed coverage changes in the State Employee Health Benefits Program.

Finance & Operations

The Finance unit is charged with the preservation of the fiscal management and accurate reporting of KHPA's programs. Key finance activities include managing the budget submission and adjustment processes, accurately reporting expenditures and revenues to the federal government, prudently managing cash balances, and managing receipts and receivables. The Accounting section manages all payables processing, including reconciliation of contractor pay tapes for provider payments, managing contract encumbrances, and developing management reports to guide decision making.

The Operations unit includes Legal, Audits, Human Resources, Purchasing, Facilities and Information Technology sections – all of which are geared toward improving the efficient and effective operation of the KHPA:

- The Legal section is directed by the General Counsel and is responsible for advancing the KHPA mission through effective legal counsel and execution of specific programmatic activities, including those related to collection of third party claims (medical subrogation) as well as an Estate Recovery Unit, which recoups the costs of long term care from the estates of deceased Medicaid recipients. The section provides direct support to Workers Compensation Units for legal representation and negotiating settlements. The section also provides counsel on contracting and interpretations of federal laws, regulations and state plan issues, and helps with other risk management issues.

- The Audits Unit tracks and provides assistance with resolution of external audits, provides management consultation to improve internal processes, validates program integrity, and leads the enterprise risk management program.

- Facilities and Purchasing provides for the space and equipment needs of the policy areas within KHPA.

- Human Resources manage personnel issues, recruitment, and training for KHPA.

- Information Technology manages the computer and telecommunications infrastructure, information security, and technology projects for KHPA and direct desktop support is provided to KHPA through arrangements with the Department of Administration, with policy direction from the Chief Operating Officer.

- Medicaid Eligibility Quality Control (MEQC) will review KHPA and SRS compliance with regulations and policy governing those who are eligible for Medicaid benefits and how eligibility determinations are made.

- The KHPA Compliance Office is responsible for agency compliance with HIPAA privacy regulations and HIPAA training. Additionally, this Office ensures compliance with ADA regulations and serves as the agency contact for EEO and Freedom of Information requests under the Kansas Open Records Act.

Kansas Medicaid & HealthWave Programs

The Kansas Medicaid and HealthWave Division develops policies and administers and manages programs that fund health care services for persons who qualify for Medicaid, MediKan, and the State Children's Health Insurance Program (SCHIP). Persons served by these programs include low-income children and adults, people with disabilities, and the elderly. In addition to administering cost-effective managed care and fee-for-service purchasing systems, KHPA contracts with and oversees a fiscal agent that operates the Medicaid Management Information System (MMIS), ensures compliance with relevant federal rules and regulations, and coordinates health care purchasing and planning among various state agencies.

Kansas Medicaid & HealthWave at a Glance

Total Expenditures	$2,193,399,000
Average Monthly Consumers	288,709
Unduplicated individuals	363184
Providers	20,000
Average claims processed per day	39,000

Medicaid

Medicaid is a federal-state program that provides health and long-term care services to people with low-incomes. All states currently participate in the Medicaid program, and federal matching funds are available for the costs of these services. As a condition of state participation, each state must agree to cover certain populations (e.g., those receiving Supplemental Security Insurance benefits) and certain services (e.g., physician services). These eligibility groups and services are referred to as "mandatory" and include:

Mandatory Populations

- Children age 6 and older below 100% FPL ($17,170 a year for a family of 3)
- Children between ages 1 and 6 below 133% FPL ($22,836 a year for a family of 3)
- Parents below the state's Aid to Families with Dependent Children (AFDC) cutoffs effective July 1996
- Pregnant women and infants (ages 0-1) at or below 150% FPL ($15,755 for a family of 3)
- Elderly and disabled SSI beneficiaries
- Certain working disabled
- Medicare Buy-In groups (Qualified Medicare Beneficiaries or QMBs, Specified Low Income Medicare Beneficiaries or SLMBSs, and Qualifying Individuals or QIs)

Mandatory Acute Care Benefits

- Physician services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic-screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Family planning and supplies

- Federally-qualified health center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services

Mandatory Long-Term Care Benefits

- Institutional Services—Nursing facility (NF) services for individuals 21 or over

State Children's Health Insurance Program (SCHIP)

SCHIP is a federal-state partnership similar to Medicaid. The program was designed to provide coverage to "targeted low-income children." A "targeted low-income child" is one who resides in a family with income below 200% of FPL or whose family has an income fifty percent higher than the state's Medicaid eligibility threshold. Kansas provides free or low-cost health insurance coverage to children in this program who:

- Are under the age of nineteen;
- Do not qualify for Medicaid;
- Have family incomes under the 200% of the FPL; and
- Are eligible for state employee health insurance or covered by other private health insurance.

Nearly all health care services purchased by Medicaid and HealthWave are financed through a combination of state funds and federal matching funds authorized through Medicaid or SCHIP of the Social Security Act of 1965. Under Medicaid, the federal government provides approximately sixty percent of the cost of Medicaid services with no upper limit on what the federal government will reimburse the State. The State provides the remaining forty percent of the cost of Medicaid services. Under SCHIP, the federal government provides approximately 72 percent of the cost up to a maximum allotment, and the State provides the remaining 28 percent and any excess spent above the federal allotment.

In FY 2007, the State of Kansas spent over $1 billion purchasing health care for more than 360,000 persons through the Medicaid and HealthWave programs. It is the third largest purchaser of health care services and the largest purchaser of children's health care services in Kansas. About 64 percent of the people served were low-income children and families. Medicaid pays for nearly forty percent of the births in Kansas.

Purchasing Health Care

Health care services are purchased through both a traditional fee-for-service model and two different managed care models (HealthWave and HealthConnect). In the fee-for-service model, Medicaid consumers can receive services from any enrolled provider without having a primary care physician (PCP). In HealthConnect, services to providers are paid on a fee-for-service basis, but physicians also receive a monthly per person payment to serve as PCPs and provide a medical home for Medicaid consumers. This model is referred to as a primary care case management (PCCM) model. HealthWave, a capitated managed care program, is funded through

per member per month payments to managed care organizations (MCOs) that assume risk for health care costs of Medicaid consumers who exceed monthly capitation amounts.

The Center for Medicare and Medicaid Services (CMS) requires that Medicaid consumers have a choice of either their health plan, or a provider within a fee-for-service model. Deviations from this requirement are available only through a CMS waiver. SCHIP populations are not subject to this "freedom-of-choice" requirement, and according to state law, they must receive physical health services through a capitated managed care model. Nevertheless, KHPA provides a choice of health plans to both Medicaid and SCHIP consumers participating in the HealthWave program and generally offers a choice of providers to both its HealthConnect and HealthWave populations. Through the utilization of value-based purchasing strategies, KHPA has increased access to quality healthcare through the development of an expanded managed system of care that promotes long term health and wellness through the use of Managed Care Organizations (MCOs).

The HealthWave population consists of Temporary Assistance to Families (TAF), Poverty Level Eligibles (PLE) and SCHIP. These groups typically consist of pregnant women, children, and very low-income adults who do not qualify as chronically ill. The HealthConnect population includes these same eligible groups in those areas where HealthConnect is a choice as well as Supplemental Security Insurance eligible persons and MediKan persons. Supplemental Security Insurance eligible children, Title V children and Native Americans are exempt from automatic managed care assignment to HealthWave or HealthConnect. However, they may choose to participate. This is also true for persons in nursing homes, persons on an HCBS waiver, and those eligible under the medically needy programs. These persons are served fee-for-service and are not assigned to HealthConnect.

Within the broad population of children and low-income families, there is a great deal of overlap and movement between those eligible for Medicaid and those eligible for SCHIP. Due to the age-related eligibility requirements, about a quarter of families with a child in SCHIP also have a child in Medicaid. Because economic and family circumstances often change, the majority of families enrolled in SCHIP have previously been enrolled in Medicaid. This overlap between the low-income children and families enrolled in Medicaid and SCHIP helps motivate the provision of care through a singular, integrated program for this population, called HealthWave.

HealthWave

During FY 2002, the marketing of the Medicaid capitated managed care program was combined with the SCHIP program to provide one seamless managed care option for families called HealthWave. Combining these two programs into one managed care option has provided eligible children and families with more uniform and seamless physical health coverage, regardless of which federal government program funds the coverage. As of July 2007, a total of 151,304 persons, 114,700 in Title XIX (Medicaid) and 36,604 in Title XXI (SCHIP) were enrolled in HealthWave.

Managed Care Organizations (MCOs) provide health insurance coverage for those consumers eligible for HealthWave. The responsibilities of the MCO may range from utilization management services to the actual provision of the services through its own organization or provider network. Reimbursement for these services is paid on a capitated per member per month basis. Consumers enrolled in HealthWave are given the opportunity to select a primary

care physician to coordinate their health care service needs. If they do not elect to make this choice, the MCOs assign a primary care physician in their area. KHPA emphasizes access to care, provider participation, and the quality of care provided to its HealthWave populations through contractual requirements and standards with its MCOs. A specific emphasis is placed on the development of a managed system of care that promotes long-term health and wellness.

As of January 1, 2007, KHPA expanded the HealthWave program by contracting with two physical health managed care organizations, Unicare Health Plan of Kansas and Children's Mercy Family Health Partners (CMFHP). Cenpatico Behavioral Health is the MCO providing mental health services to consumers who are SCHIP eligible. Since July 1, 2006, dental services have been provided through a streamlined dental fee-for-service program that is identical in service delivery, coverage and payment for all populations through Electronic Data System, the state's Medicaid Fiscal Agent.

HealthConnect

For those persons not covered by HealthWave or in the traditional fee-for-service program, KHPA provides health coverage through the Primary Care Case Management (PCCM) model called HealthConnect. Many of the individuals in this portion of the Medicaid program are frail elderly or have disabilities, and by federal rule, they cannot be served by a managed care program.

As of July 2007, there were 24,794 persons served by HealthConnect. This model provides preventive and primary medical services and refers individuals to specialists when necessary. The individual may select any PCCM who is enrolled in the HealthConnect program. They may choose from a physician, an Advanced Registered Nurse Practitioner (ARNP), a physician's assistant (PA), or health clinic to act in this capacity. The HealthConnect provider receives a case management fee of $2 per member per month and services are reimbursed on a fee-for-service basis. Dental services may be accessed through any provider who accepts Medicaid enrollees. Effective July 1, 2007, mental health and substance abuse services were contracted to managed care organizations. Kansas Health Solutions covers mental health care and Value Options covers the substance abuse services. Kansans eligible for these health coverage options include those eligible for Temporary Assistance to Families program (TAF); people enrolled in the Supplemental Security Income (SSI) program, General Assistance (GA) program, and Poverty Level Eligible (PLE) individuals.

Fee-For-Service

For those persons not covered by HealthWave or HealthConnect Kansas, the KHPA provides health coverage on a fee-for-service basis. Many of the individuals in this portion of the Medicaid program are frail elderly, or have disabilities, and by Federal law cannot be served by a capitated managed care program.

Kansas Healthy Choices

Although children in Kansas are eligible for Medicaid and/or State Children's Health Insurance Program up to 200 percent of the federal poverty level (FPL), Kansas currently has one of the lowest rates of Medicaid eligibility in the nation for poor parents (less than 37 percent of the FPL). In 2006, 37% of the Federal Poverty Level was $3,626 for a single person; $4,884 for a family of two; $6,142 for a family of three; and $8,658 for a family of four.

Senate Bill 11 authorized KHPA to pursue development of a premium assistance program for an expanded group of low income parents and their families.

Kansas Healthy Choices uses state and federal funds to subsidize the purchase of private health insurance, either through an employer sponsored plan or through a state procured private health insurance plan. Kansas Healthy Choices takes advantage of the Deficit Reduction Act (DRA) flexibility that allows a state to create in a state plan program a bridge between public financing and private health insurance for families that will, in all likelihood, remain in a publicly-financed program for only a brief period of time. A number of states are moving towards a more flexible model of assistance that encourages low-income families to participate in private health insurance coverage, addresses and manages crowd-out directly, and achieves cost savings by bringing in employer contributions to help offset costs. Kansas' program represents an innovative use of DRA flexibility to address the needs of low-income parents and their families. Kansas Healthy Choices will be phased in over four years, with a "legislative trigger" to evaluate the program and ensure that adequate funding is available.

Medicaid Quality Program

A coordinated and integrated plan for quality oversight, management, and performance measurement is the overall objective for quality in Medicaid and will eventually encompass the State Employee Health Benefits Program. The program will provide oversight of the managed care plans and Fee-for-Service (FFS) performance. KHPA program managers, with the input and guidance of the Assistant Director for Quality Management, will monitor for compliance with contractual requirements which include meeting the federal CMS expectations regarding deliverables' timeliness, accuracy, and quality.

The measurement of quality in health care delivery encompasses evidence-based practice, existing measures from accepted organizations and sources such as HEDIS, AHRQ, and others. The Assistant Director consults with program managers in developing sound evaluation measures for program innovations and pilot studies with the objectives of providing high levels of care in the most cost-effective manner while maintaining the respect and dignity of the individual recipient.

Programs to support the mission

- *Drug Utilization Review Program.* The Omnibus Budget Reconciliation Act of 1990 (OBRA) required each state's Medicaid program to establish a Drug Utilization Review (DUR) program for outpatient drugs that retrospectively reviews drug utilization patterns. The information then is used to educate prescribers and pharmacists about drug utilization trends and improve safety and quality of care. This education is provided through patient profile reviews, population-based interventions, academic detailing visits and a quarterly newsletter.

  By Kansas Law, the DUR Board is comprised of four physicians, four pharmacists and one mid-level practitioner. The Board is responsible for making recommendations to the Medicaid program regarding drug therapy issues.

- *Preferred Drug List (PDL).* KHPA created a preferred drug list (PDL) to promote quality, clinically appropriate utilization of pharmaceuticals in a cost-effective manner. A Preferred Drug List Advisory Board, composed of practicing physicians and pharmacists, provides extensive clinical review of drug products for consideration of inclusion on the PDL. The Advisory Board is not provided with Medicaid's drug cost information to ensure that their review and recommendations are based solely on clinical evidence. Medicaid staff then takes the PDL Board's clinical decision and incorporates cost information to make a recommendation for inclusion on the Medicaid PDL. These recommendations are then taken to the Drug Utilization Review Board for review and approval in accordance with K.S.A. 39-7,118. The drugs that are placed on prior authorization go through the rules and regulations process, and there is a 30-day public comment period before the prior authorization is effective.

- *Estate Recovery.* The Estate Recovery Program recovers medical care cost from the estates of certain deceased Medicaid persons. The Estate Recovery Unit (ERU) has recouped approximately $52 million from 23,390 cases since the program began July 1, 1992 through fiscal year 2007. The State of Kansas retains approximately forty percent of all monies recovered.

  Under 42 U.S.C. 1396p, KHPA is allowed to establish a claim for Medicaid on persons who, prior to their death, have received medical assistance from age 55 and older or who are in a long-term care facility regardless of age. The claim is based on the medical assistance a consumer has received on and after July 1, 1992. The ERU mainly recovers through probate actions and family agreements. If there is a surviving spouse, surviving child under the age of 21 years, blind or permanently disabled according to Social Security criteria, the unit does not pursue a claim at that time. A claim can be filed upon the death of the surviving spouse.

  The medical assistance claim is a first class demand with priority being granted to reasonable funeral expenses within the class. At present, no liens are filed against the property of a person or spouse in order to establish a claim prior to death. The claim is filed against property still available at the time of death. Beginning July 1, 2004, ERU was given increased authority to recover property through liens and expanded court actions involving an expanded definition of a probate estate.

During FY 2007, KHPA entered into a contract with Health Management Systems (HMS) for estate recovery services. Since April 1, 2007, the start of the contract, through November 2007, HMS has recovered $455,903 from 332 cases.

- *Medical subrogation and third party liability.* The medical subrogation and third party liability programs enhance Medicaid's position as payer of last resort. Medical subrogation is authorized by K.S.A. 39-719a. When medical assistance has been paid and a third party becomes legally liable for the payment of those same medical expenses, the Medicaid program may recover the amount of medical expenses it paid to the recipient. Federal law and regulations require states to assure that Medicaid recipients utilize all other resources available to pay for medical care before turning to Medicaid. Accordingly, the third party liability program (TPL) identifies and seeks reimbursement from private health insurance, employment-related health insurance, medical support from absent parents, automobile insurance, court judgments or settlements from a liability insurer, state worker's compensation, first party probate recovery and other federal programs such as Tricare, veterans benefits, or Medicare.[1]

PMDT

- **Presumptive Medical Disability (PMD)** is a process where KHPA provides disability determinations for people seeking disability-based Medicaid coverage and General Assistance (GA)/MediKan coverage. A two-tier evaluation for benefits is used. First the person is evaluated using Medicaid standards. Second, if these standards are not met, the person is evaluated under MediKan standards. Because MediKan and the GA cash program continue to be linked, persons meeting PMD criteria may also receive GA cash. The process is referred to as "presumptive," because the determination provides applicants, who meet PMD criteria, full Medicaid coverage and is completed prior to the Social Security Administration (SSA) decision. This provides some beneficiaries earlier access to full Medicaid coverage and permits the State to receive federal matching funds prior to the final SSA disability decision. (MediKan is not matched with federal funds.) New applicants who do not meet Medicaid or MediKan criteria are also not eligible for GA cash. Current GA/MediKan recipients continue to receive cash and MediKan benefits provided that current GA/MediKan program requirements are met.
- During 2007, the average time to make a disability decision greatly decreased, largely through the additional efforts and staffing provided through the 2007 legislatures additional appropriation. In December 2006, the average time to make a decision was 99 days. In October 2007, that time had reduced to an average of 24 days. The average time it takes to complete a scheduled telephone consultation with an applicant went from 75 days in February, to 8 days in October.

[1] Pursuant to K.S.A. 39-709c Medicaid expenditures are noted elsewhere in this report. For FY 2006, total recoveries from the Estate Recovery Program were: $4,502,592; total recoveries from the Medical Subrogation Program were: $1,457,617.92; total recoveries from the Third Party Liability Program were: $354,314,282.20. There is only one legislative item contemplated for these programs in 2007, a bill to enhance third party liability efforts will be introduced as required by the Deficit Reduction Act. The bill expands the definition of potential third party payers and lengthens the time for collection.

- KHPA, SRS, and the Department of Corrections (KDOC) collaborated to implement a pre-release program in an effort to reduce recidivism. Traditionally, when inmates are released from jail or prison, they are given gate money and released. Very little is done to help them integrate back into the community. KDOC is working to help inmates develop support networks prior to release. That can mean identifying those who may be disabled and getting them enrolled in GA and Medicaid or MediKan. Through the pre-release program, we can have all of the paperwork completed and benefits ready to start, for those who are eligible, on the day of release.

Working Healthy

- Working Healthy is the Ticket-toWork or Buy-in program for the State of Kansas. This program focuses on those individuals who are considered disabled according to SSA standards, but who want to integrate back into a competitive work environment. In many cases, the only way these individuals can be employed is if they are able to continue their Medicaid coverage. Yet, without the Working Healthy program, going back to work would often result in the loss of Medicaid eligibility. Hence, most people who would want to work and are capable of working, would choose not to. Through Working Healthy, these working disabled can still participate in the Medicaid program, but pay a premium for their health coverage. Since its inception, other programs to assist the working disabled have been added.

- KHPA implemented a new program for people with cognitive and physical disabilities who are eligible to enroll in Working Healthy. Titled Work Opportunities Reward Kansans (WORK), the program was implemented on July 1, 2007. *WORK* provides an assessment to determine the need for services, personal assistance services, assistive technology and home modifications, and Independent Living Counseling, to assist persons who need these services to live and work in their communities.

- WORK, which was among the first four Flexible Benefit Packages approved by CMS under the Deficit Reduction Act, employs a "cash and counseling" model. "Cash and counseling" is designed to provide individuals with disabilities optimum control of their lives by allowing them to obtain personal assistance services in alternative ways that meet their unique needs. Allowing consumers to manage their own funds, either directly or via a fiscal intermediary, also encourages them to purchase services in the most cost-effective and innovative manner. Previously available only as an 1115 waiver, WORK is the first instance of "cash and counseling" being used as a State plan option.

- KHPA was awarded its third Medicaid Infrastructure Grant in January 2007 by the Center for Medicare and Medicaid Services (CMS). The first year grant award was for one million dollars. CMS allowed states that have developed effective Medicaid Buy-In programs to progress to the second tier of funding to "build comprehensive approaches to removing employment barriers by forming linkages between Medicaid services and other non-Medicaid programs". Such infrastructure development is expected to support the goal of removing barriers to employment, and create lasting improvements, by expanding the capacity of the state to support individuals with disabilities who wish to work. It is the hope of CMS that competitive employment of people with disabilities will be embraced as an executive and legislative priority for the state. Pending approval by CMS

of a comprehensive strategic plan, the grant will continue through 2011, with award amounts varying each year based on Medicaid Buy-In expenditures for the previous year.

- Partnering with the Kansas Health Insurance Association (KHIA) and the University of Kansas, KHPA continues its Demonstration to Maintain Independence and Employment (DMIE). One of four demonstrations awarded by CMS, KHPA received $21,312,114.00 through September 2009 to conduct a study to determine whether the provision of intensive health care and support services to individuals with severe medical conditions will forestall the loss of employment and potential entrance into the Social Security system. Early findings from the study indicate that participants experience a large range of potentially disabling conditions, including cancers, diabetes, mental illnesses, back pain/spinal disorders, neurological impairments, and cardiovascular and respiratory conditions. Even though these individuals are insured, many report having delayed or avoided treatment due to costs. Historically, those leaving the KHIA plan have transitioned to federal disability programs at a rate eight times that of the general population.

New citizenship guidelines for applicants of Medicaid and SCHIP programs

A year has passed since the new federal citizenship requirements went into effect on July 1, 2006, which mandated that all Medicaid applicants provide adequate documentation of citizenship and identification. The requirement of additional documentation for each and every applicant significantly altered the normal processes to apply for medical benefits. Each person applying for benefits is now required to submit either one primary document verifying citizenship and identity such as a passport or certificate of naturalization, or two secondary documents, one verifying citizenship, such as a birth certificate and one verifying identity, such as a driver's license or school ID card. For example, in the past, an applicant with two children would submit an application on their own behalf and on behalf of their two children, and the necessary income verification documentation. Under the new rules, the same family now submits all of the same documents plus they need to submit an additional six documents -- two citizenship/identity documents per person.

At the beginning the applicants were confused by what it was they were being asked to verify and what documents they needed to provide. As a result, more cases were pended because of missing documentation, and in turn, this generated more customer service phone calls and significantly strained many other processes and systems. The sheer volume of physical documents that are routinely received by the Clearinghouse has more than doubled since the implementation of this requirement. Each of these documents must be verified, processed and stored for future reference. As a result, the average amount of time it takes to complete the processing of a family's application has increased.

The first year of this requirement has been the most difficult, because each month this past year the Clearinghouse has been conducting verifications for not only the average 4,100 monthly new applicants, but also for the average 5,300 current beneficiaries who are scheduled for their annual eligibility review. After the verification was performed for all current beneficiaries, the information has been kept on file for future access at the next review time and the requirements now only affect new applicants.

This new mandate impacted beneficiaries in many way resulting in an original drop in caseload of about 20,000 people between June 2006 and October 2006. Many of those who lost coverage eventually regained coverage once they gathered and provided the necessary documentation. They, however, experienced a gap in coverage that we know proved to be significant for some. KHPA put in place measures to deal with some of these issues. To compensate for the significant impact the new requirements had on KHPA's ability to process applications and reviews, we reallocated some resources within our existing contract with MAXIMUS. However, reallocation was not sufficient to remedy the situation. As a result, KHPA made a supplemental request to fund additional staff for the Clearinghouse for FY 2007. The request was approved by the legislature. The additional funds allocated to KHPA by the legislature were used to add 13 contract staff and 4 state staff. All staff was on board by the first week of July 2007. We are continuing to reallocate resources as needed and we are continuing to use overtime to supplement the newly allocated funds. Since the addition of the new resources, KHPA has made significant progress in reducing the number of unprocessed applications and reviews. Beginning February 2007 we had reached a peak of 15,000 applications and reviews which were received and remained unprocessed. Of those, the total number of applications which were over 25 days old was 4,729 and the total number of reviews which were over 25 days old was 3,280.

For the months of February through the end of December, 2007, we received an additional 45,157 applications and 58,173 reviews to process for an impressive total of 103,330 requests for medical assistance. In spite of the large number of additional requests, as of the end of December, the total number of unprocessed applications and reviews has been reduced to 3,774. The total number of applications over 25 days old has dropped to 121 and the total number of reviews over 25 days old has dropped to 155. We are expecting the number of applications and reviews over 25 days to remain the same. KHPA keeps applications and reviews open as long as the beneficiary communicates their interest in completing the process by providing the necessary documentation.

	Unprocessed applications and reviews in house	Applications over 25 days old	Reviews over 25 days old
Feb 2007	15,000	4,729	3,280
Sept 26, 2007	6,399	982	887
Oct 31, 2007	5,971	685	200
November 30, 2007	6,007	296	519
December 31, 2007	3,774	121	155

Outreach efforts continue

Identifying uninsured families has long been a goal of Kansas, and increasing the presence of workers at key locations throughout the community will elevate the awareness of the opportunity for coverage. As families obtain coverage, they are more likely to access preventive medicine, including well child visits, immunizations, and dental care.

In 2008, KHPA expects to implement the online screening tool which will allow for the expansion of presumptive eligibility (PE) determinations, where clinical personnel are able to do an initial eligibility determination, followed up by a full determination done by eligibility staff. We currently have three PE sites and anticipate expanding by five additional sites in 2008.

In addition, KHPA will work with outreach organizations such as the Sunflower Foundation to empower other organizations to assist families with the application process. We also expect to partner with schools in identifying children who may be eligible for health care coverage and assistance with enrolling those children and potentially their families.

Included in the KHPA health reform proposals is a goal to enroll an additional 20,000 children into Medicaid, HealthWave, or Kansas Healthy Choices within the next three years. In order to achieve this, KHPA plans to offer grants that will allow community partners to hire some additional staff dedicated to outreach to low income, uninsured children and their families.

KHPA Pilot Projects

Enhanced Care Management (ECM) is a pilot project which began service delivery in March 2006 and was developed to identify and provide enhanced administrative and health care services to eligible Medicaid recipients in Sedgwick County who have multiple chronic health conditions and probable or predictable high future health care costs. The design of the ECM pilot is unique in its approach to connecting providers and beneficiaries through community resources; and the design is closely aligned with chronic disease management models. Service delivery is community based and culturally appropriate with the goal of connecting beneficiaries to social and health care already available in the community. Eligible Medicaid beneficiaries are invited to receive services; participation is strictly voluntary. The goal of the ECM project is to provide a holistic approach which focuses on assisting clients in accessing resources in the community which will improve their health conditions. There are approximately 200 individuals who are served from this project.

Community Health Record (CHR) is a pilot project which engages select managed care organizations and an information technology company to deploy CHR technology to Medicaid managed care providers in Sedgwick County. The health record is built on administrative claims data and provides clinicians electronic access to claimed medical visits, procedures, diagnoses, medications, immunizations, and lead screening data. The CHR pilot contains an e-Prescribing component that provides a drug interaction and contraindication tool. The prescriber may access formulary information and has the capacity to submit prescriptions to pharmacies electronically. The goal of the CHR pilot was to assess the value that health information exchange (HIE) could offer to Medicaid providers and beneficiaries. The CHR pilot was launched in February 2006 with 20 Medicaid provider sites participating, with over 5,000 unduplicated Medicaid beneficiaries' records accessed by 215 CHR providers in Sedgwick County. The State Employee Health Plan currently is initiating participation in an employer-based community health record in the Kansas City area, which is home to about 11,000 state employees. The vendor and system would mimic those available in the current CHR pilot, with the addition of member access to their information.

Medical Assistance Expenditures

Title XIX Medicaid	FY 2007 Actual	FY 2008 Revised	FY 2009 Gov Recommendation
Expenditures	1,136,526,943	1,177,528,010	1,222,607,000
Persons Served Each Month	249,966	256,158	256,158

Title XXI HealthWave	FY 2007 Actual	FY 2008 Revised	FY 2009 Gov Recommendation
Expenditures	61,058,264	67,493,338	67,493,338
Persons Served Each Month	35,610	36,604	36,604

MediKan	FY 2007 Actual	FY 2008 Revised	FY 2009 Gov Recommendation
Expenditures	23,321,000	19,472,000	19,472,000
Persons Served Each Month	4,434	3,181	3,181

Medical Assistance Revenue Sources

	FY 2007 Actual	FY 2008 Revised	FY 2009 Gov Recommendation
State General Fund	461,195,711	439,918,393	482,997,383
Children's Initiative Fund	3,000,000	5,000,000	-
Medical Programs Fee Fund	45,772,019	53,500,000	38,500,000
Health Care Access Improvement Fund	36,770,860	36,990,236	36,990,236
Title XIX Medicaid	628,705,112	678,133,159	700,133,159
Title XXI HealthWave	43,149,754	48,574,955	48,574,955
Other Federal Funds	2,312,751	2,376,605	2,376,605

State Employee Health Benefits Program

The State Employee Health Benefits Program Division:

- Manages and administers medical, prescription drug, dental and vision insurance contracts for State and covered Non State employees and their dependents;
- Manages the HealthQuest and wellness programs;
- Manages and administers the State Self Insurance Fund (Workers Compensation);
- Oversees the Customer Service Unit which provides an integrated approach—regardless of program—to health care consumers for solving or avoiding problems related to eligibility, enrollment, coverage or payment issues, and providing for improved access to information.
- Implements programs to improve the health and wellness of covered State and Non State members through:
    - Providing enhanced preventive care benefits in the State Employee Health Benefits plans;
    - Promote proper prescription drug usage through Caremark's Adherence to Care program;
    - Disease Management programs;
    - Offering a Health Risk Assessment and Health Risk Screening;
    - Providing Health Coaching;
    - Providing Healthy Weight telephonic courses; and
    - Partnering with other state agencies to coordinate health and wellness statewide.

State Employee Benefits Program at a Glance

State Employees	35,369
Non-State employees	5,157
Dependents	37,022
Retirees	10,472
COBRA	165
Total Individuals Covered	88,185

The State Employee Health Benefits Program administers health insurance contracts for state employees and their dependents. Oversight of the State Employee Health Benefits Program is done by the State Employees' Health Care Commission (HCC), which was statutorily created in 1984 through the enactment of K.S.A. 75-6501, *et seq*, to "develop and provide for the implementation and administration of a state healthcare benefits program."

Over the years, the number of contracts and types of people covered by the program has expanded. Beneficiaries receiving health insurance services through the program include active, retired, disabled State employees and their dependents, people on leave without pay, elected officials, blind vending facility operators, and employees of school districts, community colleges and other educational entities. The local government employer components include cities, counties, townships, community mental health centers, groundwater management districts, rural water supply districts, public wholesale water supply districts, county extension councils and extension districts and public hospitals. There has been steady growth in the Non State entities.

Health Plan Enrollment

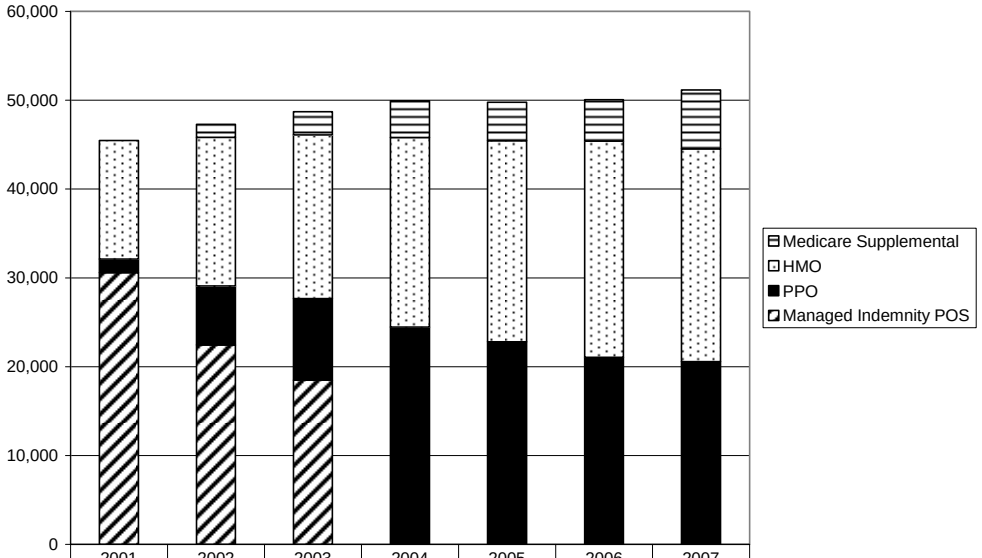
Total plan enrollment in the State Employee Health Benefits Program is 51,163 contracts and 88,185 covered lives. In plan year 2007, 93 percent of eligible employees were enrolled. Of those, 56 percent carried single coverage and 44 percent provided coverage for their dependents.

There are 90 Non State group employers participating with 5,157 contracts. The majority of the Non State entities are schools and municipalities. The Non State group employers include 33 school districts; 39 cities, counties or townships; and 18 other local units such as a hospital, mental health center, libraries and extensions. The number of participants in the Non State groups range from 1 to 584. Only 5 groups have more than 200 and 13 have between 100 and 200 employees.

In addition to the active employees, KHPA provides coverage for nearly 10,000 retirees and former employees living in all states and some abroad.

Participation in the plans include active employees, retirees, employees receiving long-term disability payments, employees on leave without pay, Non State employer groups, qualified beneficiaries on COBRA, as well as other individuals identified on K.A.R. 108-1-1, K.A.R. 108-1-3, and K.A.R. 108-1-4. On June 30, 2006, at the end of FY 2006, there were 51,163 contracts covering 88,185 lives. The contracts included:

Number of Contracts by Plan Type



	2001	2002	2003	2004	2005	2006	2007
Medicare Supplemental		1,442	2,599	4,120	4,342	4,660	6,632
HMO	13,362	16,751	18,419	21,344	22,634	24,370	23,969
PPO	1,526	6,660	9,218	24,467	22,805	21,040	20,562
Managed Indemnity POS	30,590	22,430	18,463				

Health Plans

Medical. For PY 2007, all participants have a choice of preferred provider organizations (PPOs) and, where available, a Health Maintenance Organization (HMO) option as well. For plan year 2007, 61 percent of State of Kansas active participants chose an HMO. Retirees who are Medicare eligible also can enroll in a self-funded Medicare Supplement Plan or one of two Medicare Advantage Plans offered by Coventry. Retirees have the same choices of health plans. Approximately $110.7 million was spent in 2007 on medical claims and ASO fees for the self-funded plans administered by Blue Cross Blue Shield and about $136.4 million in premiums for the fully insured plans and ASO fees for the self-funded plans.

Prescription Drugs. Prescription drugs are carved out of the health plans and are self-funded. They are administered by Caremark, a pharmacy benefits manager. The plan design includes a tiered coinsurance program with a separate copayment for special case medications and discounts for lifestyle drugs. The generic dispensing rate for the state employee plan has grown to about 60.3 percent. Annual claims cost for 2007 was $48.5 million not including SilverScript. The SilverScript Part D plan was a new option for our Medicare eligible members in 2007 with an annual cost of $9.2 million.

Dental. The dental component is a self-funded plan administered by Delta Dental of Kansas. Dental coverage is provided by the employer for employees at no cost, and it is optional for dependents. In 2007, $18.5 million was paid in claims.

Vision. Two voluntary vision plans are offered to employees from Superior Vision. There are 8,370 State of Kansas employees enrolled in the basic plan and 15,397 enrolled in the enhanced plan. The vision premiums are entirely employee-paid.

Adherence to Care. The Adherence to Care solution is Caremark's multi-dimensional participant-centric approach to medication therapy compliance. The program gathers plan participant data, identifies influencing factors for participants, stratifies intervention pathways specific to plan participants, and intervenes with personalized care. The Adherence to Care program can provide significant value to plan participants by developing individualized care plans that empower the plan participant. Ensuring proper adherence to medication therapy is a key component to controlling total healthcare costs.

CustomCare Retail. The Caremark CustomCare Retail program takes retrospective standard drug utilization review to a more detailed level in an effort to improve outcomes and provide savings. CustomCare Retail identifies plan participants who may be at risk for drug interactions or drug-induced disease conditions by using retrospective claims analysis and system-driven edits. The CustomCare Retail program also identifies appropriate opportunities to simplify therapies and minimize unnecessary prescriptions.

The CustomCare programs evaluate the appropriateness of therapy from a variety of perspectives, with the focus on ensuring safety and efficacy first, and reducing unnecessary cost, second. The clinical pharmacists review each flagged profile based on:

- Product Selection
- Dosage
- Quantity

- Duration

Iscribe. iScribe is the Caremark ePrescribing tool, that allows Physicians to electronically, via the internet or PDAs, submit plan participant prescriptions and renewals to mail and/or retail pharmacies, easily access patient prescription history, universal formularies, and generic formulary alternatives. As part of the State Employee Health Benefits Program contract with Caremark, 25 providers will be given a PDA, software, printer and support to be able to set up e-prescribing in their office at no cost to them. Caremark is currently in the process of contacting providers about participating.

Disease management. Disease management programs currently offered by the State Employee Health Benefits Program are through the contracted health and prescription drug plans/vendors and include coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD). Participation and results are tracked and monitored by the health plans and results are reported to the contract management team.

Health and Wellness SEHBP Program

Employee Health and Wellness. HealthQuest was instituted in 1988 to provide wellness programs with the goal of improving employee health and reducing health care costs. Programs have included periodic health risk appraisals and screening, disease management, employee assistance counseling and referrals, life coaching, healthy weight classes, wellness newsletter and a health blog, as well as wellness presentations for employee groups across Kansas.

In August, HealthQuest began working with Health Dialog, to prepare for a January 2008 launch of the new programs. Pre-launch activities included the following: Established cross-functional teams (HealthQuest, SEHBP, Health Dialog, Thomson, and DISC) to plan and prepare for 2008 launch. These teams included: data, website, communications/marketing, process integration, incentive determination, onsite screening, reporting/program measurement, and telephony.

New HealthQuest Offerings in 2008

Kansas Health Policy Authority will be adding many *new* programs to the HealthQuest offerings that focus on health wellness initiatives and preventive care. These program enhancements will officially begin in January 2008. Plan members will receive a letter from the Governor and the KHPA Executive Director along with a promotional flier describing the new programs.

New HealthQuest program components will include a new complimentary Health Coaching service, onsite health screening events, as well as a $50 gift card incentive to increase participation.

Health Coaching Service

Through this service plan members will be able to talk by phone with a Health Coach anytime, 24/7. Health Coaches are specially trained professionals (such as nurses, respiratory therapists, or dietitians) who can help answer any health questions participants may have concerning their health or their family's health. Health Coaches can also provide support and information to help participants manage ongoing conditions such as diabetes, heart disease and asthma. When participants call a Health Coach, they receive the following:

- Personal education and support
- Health information that is provided 24/7
- Questions to discuss with their doctor
- Educational materials mailed to their home
- Support from a personal Healthy Lifestyle Coach for nutrition, tobacco cessation, stress management, weight management and more.

Statewide Health Screening Events

As part of the commitment to help participants' lead healthier lifestyles, the HealthQuest program will also offer onsite health screenings during company time in 37 cities (53 sites) across the state.

The program starts in January 2008 and includes the following tests: total cholesterol, HDL, LDL, triglycerides, glucose, blood pressure, measured height, weight and BMI calculation.

Personal Health Assessment (PHA) and $50 Gift Card

The online Personal Health Assessment helps participants get an accurate picture of their current health status and take an active role in managing their health and well-being. Participants who complete the PHA will receive a $50 gift card.

Personal Health Coaching

After completion of the screening and PHA, participants will have an opportunity to work with a health coach to design and implement their own personal health action plan.

Quarterly Dialog Planning (QDP) will be held to review progress to date and adjust future activities so that program outcomes are reached.

Legislative Fitness Day for legislators and their staff and the Governor and her staff. The new HealthQuest program will launch January 15 on Legislative Fitness Day. Events will include onsite health screening, access to the online Personal Health Assessment, health coaching, and mini health fair activities.

State Self Insurance Fund (Workers Compensation)

The Workers Compensation program for state employees is called the State Self Insurance Fund (SSIF). The SSIF is funded by agency rates based on experience rating. The rates are developed by an actuarial service using three years of claims experience, payroll and caps on expenses, and are currently approved by the Department of Administration and published by the Division of Budget.

The SSIF processes and manages claims for injuries that arise out of and in the course of work. There is unlimited medical compensation to treat the injury. Additionally, compensation is made for loss of time, permanent impairment or death. Medical payments are based on a fee schedule developed by the Workers Compensation Division of the Kansas Department of Labor. A third-party medical review service is utilized to review claims for medical appropriateness and pricing. On average, 345 accident reports are received monthly. In FY 2007, the SSIF spent over $17.4 million on compensation, with about 61 percent for medical services and 39 percent for loss time compensation.

Future Initiatives and Strategies

The following information details future initiatives and strategies the HCC is either researching or considering.

Medical. The current medical contracts with Blue Cross Blue Shield of Kansas, Coventry Health Care of Kansas and Preferred Health Systems will expire December 31, 2008. A request for proposals will be issued in early 2008.

A review of the current plan designs will be undertaken for PY 2009 for possible redesign. For PY 2008 less than 700 employees selected the Plan B plan design, therefore the Plan B program will be evaluated to provide employees benefit alternatives. The Qualified High Deductible Health Plan (QHDHP) with Health Savings Account (HSA) will also be evaluated for potential redesign as enrollment in this program remains low with less than 200 members enrolled for 2008. The limited enrollment in the QHDHP does not present adverse selection issues however changes in the plan will need to be monitored to determine if “anti-selection” presents an issue.

Prescription Drug. The current progressive five-tiered plan design encourages and provides an incentive to use generic and preferred brand drugs to maximize plan and member savings. The introduction of a number of generic alternatives for blockbuster drugs over the last few years has provided members with increase opportunity for member and plan cost savings. Additional blockbuster generics are expected in the next few years. The plan will continue to look for opportunities to promote generic use among members.

Dental Plan. Plan design considerations will continue to focus on encouraging and supporting preventive care activities of plan members. Currently the dental plan is only available as part of the medical/prescription/dental plan. The HCC has requested further study into allowing direct bill members to elect the dental plan separately from the medical options.

Stop Loss. Claims and utilization data continue to be monitored very closely to determine any future need for stop loss insurance. Should the claims analysis system indicate unpredictable

variability in the group experience, stop loss coverage may be considered to protect the stability of the plan.

Health and Prevention Programs. Continued consumer education and health promotion are keys to lowering healthcare costs for the long term. More emphasis is being directed at promoting health and individual responsibility by providing programs that give members tools, such as health coaching, information on treatment and options to better promote their own health and wellness.

CareEntrust Pilot Program. This is a regional health information organization whose purpose is to facilitate the creation of an electronic community health record (CHR) in the 15-county Kansas City Metropolitan Statistical Area (KCMSA). The KCMSA is comprised of the Kansas Counties of Jackson, Jefferson, Osage, Leavenworth, Wyandotte, Johnson, Miami, Linn, and Franklin and the Missouri counties of Clinton, Caldwell, Ray, Clay, Platte, Jackson, Lafayette, Cass, and Bates. The goal of the CHR is to bring medical information to the point of care to facilitate and improve healthcare treatment in the community. The CHR would be a community resource with a mission to maximize health and improve quality and efficiency.

Member Engagement. Promotion of member engagement will be emphasized so that members are engaged in improving their health and making wise choices in the medical plan utilization, thus playing an active role in encouraging healthy behaviors and prevention. The enrollment materials, both printed and internet-based have been revised to provide members with better plan design information and decision making tools. The Plan Select online decision tool was added to assist State employees in health plan selection. The HCC continues to look to the EAC, as well as other focused member groups for ideas and support for changes in the health plan.

Conclusion

As the leading state agency on health, health care, and health policy, we are committed to ensuring Kansans have access to quality, affordable, and sustainable health care. The Kansas Health Policy Authority's Annual Legislative Report provides a snapshot of important work we continue to accomplish at this agency. It also has demonstrated the upcoming challenges and goals of 2008. We will continue to provide this report to the Legislature on a yearly basis, and look forward to working with them to ensure this agency is meeting the mission the Legislature entrusted to us.

-*Marcia Nielsen, Ph.D, MPH, Executive Director of the Kansas Health Policy Authority*

Appendix A

Kansas Health Policy Authority Board

Health Reform Recommendations

UPDATED

January 10, 2008

PREPARED BY:

KHPA
Kansas Health Policy Authority
Coordinating health & health care for a thriving Kansas

EXECUTIVE SUMMARY

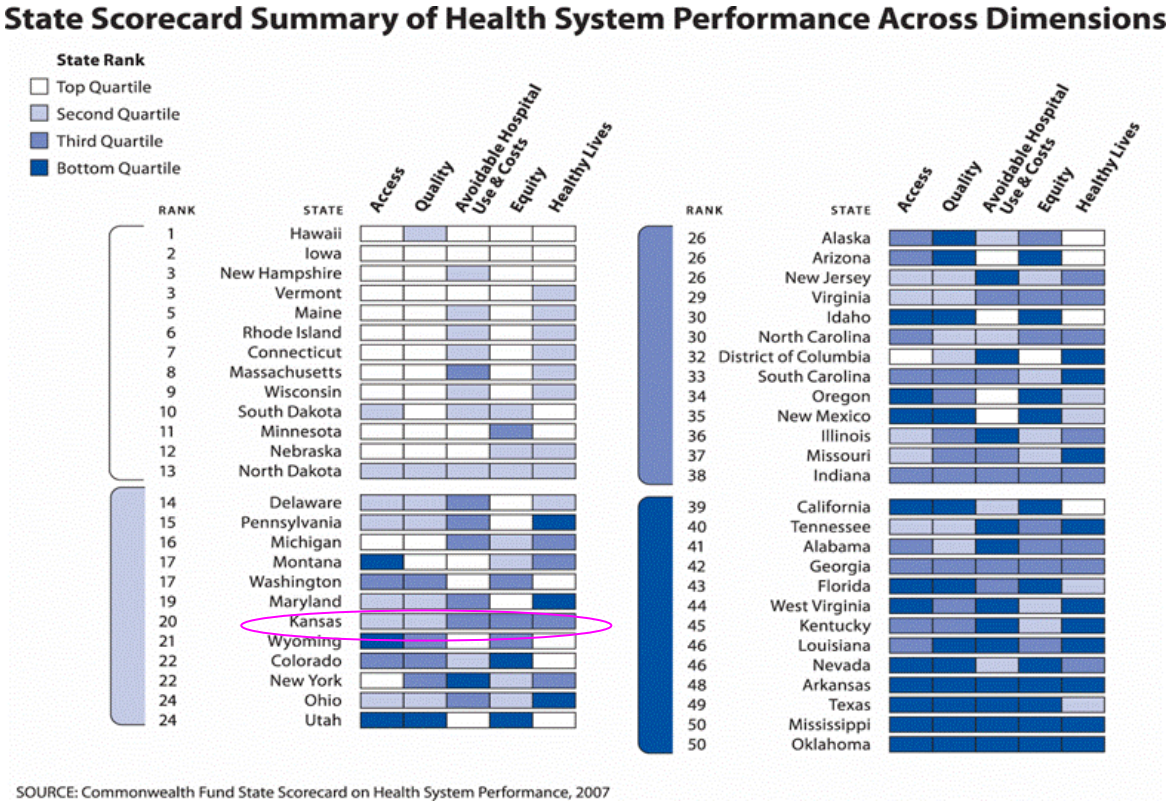
BACKGROUND

The current health system in Kansas and the nation face many challenges. Health care costs continue to rise at an unsustainable rate, the health system is inefficient and fragmented, and the health status of many Kansans is at risk. From the perspective of health system performance, Kansas currently ranks 20th in the nation[1] – we can and should do better (Figure 1). The goals of the health reform recommendations described in this report are twofold: 1) to begin the *transformation* of our underlying health system in order to address the staggering rise in health care costs and chronic disease, as well as the underinvestment in the coordination of health care; and 2) to provide Kansans in need with affordable access to health insurance. Taken together, these reforms lay out a meaningful first step on the road to improve the health of Kansans, and we respectfully submit them to the Governor and Legislature for their consideration.

These health reform recommendations were requested by both the Governor and the Legislature. During the 2007 legislative session, the Kansas Legislature passed House Substitute for Senate Bill 11 (SB 11), which included a number of health reform initiatives. This Bill passed unanimously by both the House and Senate, and was signed into law by the Governor. In addition to creating a new "Premium Assistance program" to expand access to private health insurance, the Bill directed the Kansas Health Policy Authority (KHPA) to develop health reform options in collaboration with Kansas stakeholders.

The health reform recommendations described herein are the result of deliberations of the KHPA Board, four Advisory Councils (140 members), a 22 community listening tour, and feedback from numerous stakeholder groups and other concerned citizens of Kansas – over 1,000 Kansans provided us with their advice and suggestions. In addition, four Kansas foundations – the United Methodist Health Ministry, the Sunflower Foundation, the REACH Foundation, and the Health Care Foundation of Greater Kansas City – funded an independent actuarial and policy analysis of various health insurance models as well as the coordination of the four Advisory Councils. The modeling was instrumental in the development of the health insurance recommendations offered by the KHPA Board, and a separate document describing these models is available through the United Methodist Health Ministry Fund (www.healthfund.org).

Figure 1



*For more information about the Study, go to http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551

These health reform recommendations represent just one of the many chapters required to write the story of improved health and health care in Kansas. Ultimately, the solution for our fragmented health system requires leadership at the federal level. However, the state of Kansas should debate and embrace reform solutions that can help our citizens right now. Additional policy issues – such as health professions workforce development, and a focus on the safety and quality of care – must also be addressed in subsequent health reform proposals over the course of the coming months and years.

PRIORITIES

Kansas established three priorities for health reform:

1) ***Promoting Personal Responsibility*** – for healthy behaviors, informed use of health care services, and sharing financial responsibility for the cost of health care;
2) ***Promoting Medical Homes and Paying for Prevention*** – to improve the coordination of health care services, prevent disease before it starts, and contain the rising costs of health care; and
3) P***roviding and Protecting Affordable Health Insurance –*** to help those Kansans most in need gain access to affordable health insurance.

The combination of these health reforms helps to improve the health status of Kansans, begins to contain the rising cost of health care in our state, and improves access to affordable health insurance.

The table below outlines the reform priorities recommended by the KHPA Board on November 1, 2007. Those policy initiatives identified as high priority are marked by an asterisk.

SUMMARY OF REFORM RECOMMENDATIONS

Promoting Personal Responsibility (P1)		
Policy Option	**Population Served**	**Estimated Cost**
Improve Health Behaviors . Encourage healthy behaviors by individuals, in families, communities, schools, and workplaces. **(Policies listed under P2)**		
Informed Use of Health Services		
***P1 (1) Transparency for Consumers: Health Care Cost & Quality Transparency Project** . Collect and publicize Kansas specific health care quality and cost information measures which will be developed for use by purchasers and consumers	All Kansans with access to the Internet (or access to public libraries)	$200,000 State General Fund (SGF) for Phase II of the Transparency project
***P1 (2) Promote Health Literacy.** Provide payment incentives to Medicaid/HealthWave providers who adopt health literacy in their practice settings	Medicaid/HealthWave enrollees under care of these providers	$280,000 All Funds (AF) $140,000 SGF for pilot program with Medicaid/ HealthWave providers
Shared Financial Responsibility . Asking all Kansans to contribute to the cost of health care. ***(Policies listed under P3)***		
Estimated Costs for P1	**$480,000 AF $340,000 SGF**	

Promoting Medical Homes and Paying for Prevention (P2)		
Policy Option	**Population Served**	**Estimated Cost**
Promoting Medical Homes		
***P2 (1)Define Medical Home** . Develop statutory/regulatory definition of medical home for state -funded health programs – Medicaid, HealthWave, State Employee Health Plan (SEHP)	Beneficiaries of state -funded health care plans	Planning process should incur minimal costs to KHPA
***P2 (2) An Analysis of and Increase in Medicaid Provider Reimbursement.** Increased Medicaid/HealthWave reimbursement for primary care and prevention services	Beneficiaries and providers in Medicaid and HealthWave programs	$10 million AF; $4 million SGF
P2 (3) Implement Statewide Community Health Record (CHR). Design statewide CHR to promote efficiency, coordination, and exchange of health information for state -funded health programs (Medicaid, HealthWave, SEHP)	Beneficiaries of state -funded health care plans	$1.8 million AF; $892,460 SGF
P2 (4) Promote Insurance Card Standardization. Promote and adopt recommendations from Advanced ID Card Project for state -funded health programs	Kansans who qualify/enrolled in state -funded health care plans	$172,000 AF; $86,000 SGF
Paying for Prevention: Healthy Behaviors in Families/Communities		
***P2 (5) Increase Tobacco User Fee.** Institute an increase in the tobacco user fee $.50 per pack of cigarettes, and an increase in the tax rate of other tobacco products to 57% of wholesale price.	Total Kansas population	Provides revenues of $61.57 million. Dept of Revenue estimate 12/07
***P2 (6) Statewide Restriction on Smoking in Public Places.** Enact statewide smoking ban in public places, couples with Governor's Executive Order requiring state agencies to hold meetings in smoke -free facilities	1.4 million working adults in Kansas	No cost to the state; limited evidence of other cost implications
***P2 (7) Partner with Community Organizations.** Expand the volume of community -based health and wellness programs through partnerships between state agencies and community organizations	All residents and visitors to state of Kansas	Costs dependent upon scope of project (number of organizations)
Paying for Prevention: Healthy Behaviors in Schools		
***P2 (8) Include Commissioner of Education on KHPA Board.** Expand the KHPA Board to include an ex -officio seat for the Kansas Commissioner of Education	Kansas school children	No cost
***P2 (9) Collect Information on Health/Fitness of Kansas School Children.** Support the establishment of a state- based surveillance system to monitor trends of overweight, obesity, and fitness status on all public school-aged children in Kansas	Kansas school children K -12; for 2006 -07 year, there were 465,135 enrolled K-12 students	Schools would incur some indirect costs for staff training and body mass index (BMI) measurement

Promoting Medical Homes and Paying for Prevention (P2) (continued)		
Policy Option	**Population Served**	**Estimated Cost**
Paying for Prevention: Healthy Behaviors in Schools		
***P2 (10) Promote Healthy Food Choices in Schools.** Adopt policies that encourage Kansas school children to select healthy food choices by competitively pricing and marketing these foods and restricting access to foods with little or no nutritional value	Kansas school children K-12; for 2006-07 year, there were 465,135 enrolled K-12 students	Depending on pricing policies, implementation of this initiative may reduce or increase the revenue generated
***P2 (11) Increase Physical Fitness and School Health Programs** . Strengthen physical education (PE) requirements and expand Coordinated School Health (CSH) programs	465,135 enrolled K-12 students	$8,500 per participating school. KDHE has requested $1.8 million SGF for the CSH program for participation of 100 districts
Paying for Prevention: Healthy Behaviors in Workplace		
***P2 (12) Wellness Grant Program for Small Business.** Develop a community grant program to provide technical assistance and start-up funds to small businesses to assist them in the development of workplace wellness programs	Kansas employees of small firms	$100,000 SGF for pilot project
***P2 (13) Healthier Food Options for State Employees.** Expand healthy food choices in state agency cafeterias and vending machines	Approximately 45,000 state employees	Costs depend on contract negotiations and pricing policies
Paying for Prevention: Additional Prevention Options		
***P2 (14) Provide Dental Care for Pregnant Women.** Include coverage of dental health services for pregnant women in the Kansas Medicaid program	6,600 Pregnant women enrolled in Medicaid	$1.3 million AF; $524,000 SGF
***P2 (15) Improve Tobacco Cessation within Medicaid.** Improve access to Tobacco Cessation programs in the KMedicaid program to reduce tobacco use, improve health outcomes, and decrease health care costs	Approximately 84,000 Medicaid beneficiaries who smoke	$500,000 AF; $200,000 SGF for an annual cost
***P2 (16) Expand Cancer Screenings.** Increase screenings for breast, cervical, prostate, and colon cancer through expansion of the Early Detection Works (EDW) program	7,500 women (for Breast/Cervical screenings); 6,100 men (for prostate cancer screening); and 12,000 Kansans (for colorectal cancer screenings)	KDHE has requested $6.7 million SGF for cost of expansion of all three cancer screenings
Estimated Costs for P2	**$22.4 million AF $14.3 million SGF**	

Providing and Protecting Affordable Health Insurance (P3)		
Policy Option	**Population Served**	**Estimated Cost**
P3 (1) Access to Care for Kansas Children and Young Adults		
• Aggressive targeting and enrollment of children eligible for Medicaid and HealthWave • Include specific targets and timelines for improved enrollment. Inability to meet targets will "trigger" additional action by the KHPA, to include the consideration of mandating that all children in Kansas have health insurance • Allow parents to keep young adults (through age 25 years) on their family insurance plan • Develop Young Adult policies with limited benefit package and lower premiums	Estimated 20,000 Medicaid/HealthWave eligible Estimated 15,000 young adults	$22 million AF $14 million SGF
P3 (2) Expanding Insurance for Low-Income Kansans*		
• Expansion population for the Premium Assistance program ♦ Adults (without children) earning up to $10,210 annually[100% federal poverty level (FPL)]	Estimated 39,000 low income Kansas adults	$119 million AF $ 56 million SGF
P3 (3) Affordable Coverage for Small Businesses		
• Encourage Section 125 plans (develop Section 125 "toolkits") and education campaign for tax-preferred health insurance premiums • Develop a "voluntary health insurance clearinghouse" to provide on-line information about health insurance and Section 125 plans for small businesses and their employees • Add sole proprietors and reinsurance to the very small group market (VSG: one to ten employees). Stabilize and lower health insurance rates for the smallest (and newest) businesses: obtain grant funding for further analysis • Pilot projects – support grant program in the Department of Commerce for small business health insurance innovations	Estimated 12,000 small business owners and their employees (***Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above. Practically, however, at the program level, the State of Kansas will not change the State's Disproportionate Share Hospital reimbursement methodology.)	-$5 million AF*** $1 million SGF
Estimated Costs for P3 Cost of all 3 policy options is:		**$136 million AF** **$ 71 million SGF**
Total Costs		**$158.9 million AF**** **$ 85.7 million SGF** ****(includes federal matching dollars)**

Two additional components of health reform, separate from the policies listed here, are being submitted to the Governor and Legislature as part of the KHPA budget. Funding for each is essential as the "building blocks" of health reform: 1) **Premium Assistance. As designed in SB 11, this request asks for a $5.037 million enhancement ($12.075 AF) for the Premium Assistance program in FY2009; these funds will health insurance to parents of children eligible for Medicaid who earn less than 50% of the FPL (approximately $10,000 for a family of four); and 2) **Web-Based Enrollment System**. The KHPA budget asks for a $4 million enhancement for FY2009 ($8 million AF) to implement a new electronic eligibility system that can support premium assistance, enhanced outreach, and program participation through web-based enrollment.

Appendix B

KANSAS STATE EMPLOYEES

HEALTH CARE COMMISSION

ANNUAL REPORT

2007

PLAN YEAR

Kansas State Employees Health Care Commission
2007 Annual Report

Table of Contents

EXECUTIVE SUMMARY

- The HCC approved significant changes to the state employee health plan for 2008 to lower administrative costs, revamp the SEHP's overall approach to wellness and prevention, lower premium contribution requirements for families, and provide greater choice of health plans for employees across the state.
    - All health plans shifted to self-funded status to lower administrative costs.
    - A major health and wellness initiative was set to begin January 2008, strengthening the HealthQuest program by offering healthy lifestyle programs, a personal health assessment, and health screenings.
    - The gatekeeper component of the HMO was eliminated, while costs for preventive services were lowered, providing significant new incentives for health-improving and health –preserving investments in preventive care.
    - The employer contribution for dependent coverage was raised from 45% of an average premium to 55%, following an increase just two years ago from the longstanding contribution rate of 35%.
    - The SEHP moved to statewide health plan options so that all members have access to the same health plan choices and low cost plan options.

- Changes in benefits and improvements in the enrollment process contributed to a significant increase in active participation in the open enrollment process for plan year (i.e., calendar year) 2008. KHPA staff visited 32 cities around the state and presented to over 8,000 employees – double the attendance of the prior year. Approximately 26,612 members, or 81% of eligible employees, utilized the Web based system to make elections for their 2008 SEHP coverage, a significant increase over previous years.

- Important plan changes implemented in 2007 include the application of manufacturer rebates for prescription drugs at the point of sale, giving employees an immediate share of those savings rather than crediting rebates to the SEHP after the purchase. A competitive re-bid of the pharmacy benefit contract yielded a lower overall negotiated price for drugs, generating approximately $8 million dollars in savings during 2007 The generic dispensing rate also continued to increase, further limiting cost growth.

- The HCC extended the HealthyKIDS pilot program (for the children of State employees only), implemented in 2006, through at least 2008. The program provides an employer contribution of 90% towards the cost of children's health insurance premiums for low income families. There are currently 1,373 employees enrolled covering over 3,200 dependents.

- The HCC completed its year by receiving for the first time a quarterly financial report from KHPA summarizing plan revenue, plan expenses, and both current and projected balances in SEHP funds. Based on staff projections and the opinion of SEHP actuaries, KHPA reported the fund to be in good financial standing with adequate resources and reserves to support and sustain the plan improvements adopted for 2008.

BACKGROUND

The Kansas State Employees Health Care Commission (HCC) was created by the 1984 Legislature through the enactment of K.S.A. 75-6501 et. seq.… to "develop and provide for the implementation and administration of a State health care benefits program. . . It may provide benefits for persons qualified to participate in the program for hospitalization, medical services, surgical services, non-medical remedial care and treatment rendered in accordance with a religious method of health and other health services." Under K.S.A. 75-6504, the HCC is authorized to "negotiate and enter into contracts with qualified insurers, health maintenance organizations and other contracting parties for the purpose of establishing the State health care benefits program."

The HCC is composed of five members and met seven (7) times during 2007. The Secretary of Administration and Commissioner of Insurance serve as members of the HCC as mandated by statute, while the Governor appoints the other three members. The statute requires one member to be a representative of the general public, one member to be a current State employee in the classified service, and one member to be a retired State employee from the classified service. The Secretary of Administration, Duane Goossen, serves as the Health Care Commission chair. The State employee in classified service position is currently vacant. Present members are:

Duane Goossen, Chair and Secretary of Administration
Connie Hafenstine, retiree from the classified service
Sandy Praeger, Commissioner of Insurance
John Staton, representative from the general public

The Segal Company provided actuarial and consulting services to the HCC beginning in 2000 through May 2007. Mercer Health and Benefits took over actuarial and consulting services beginning in May 2007.

An Employee Advisory Committee (EAC) assists the HCC. It is composed of 21 members, 18 of whom are active employees and three who participate through Direct Bill. Members are selected on the basis of geographic location, agency, gender, age, and plan participation in order to assure a balanced membership representing a broad range of employee and Direct Bill member interests. Each member serves a three-year term. (Exhibit A) The EAC met four (4) times during 2007.

The State Employee Health Plan (SEHP) is administered by the Kansas Health Policy Authority (KHPA), which is charged with coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies. The Director of the State Employee Health Benefits Plan (SEHBP) reports to the Executive Director and Deputy Director of KHPA and is responsible for bringing recommendations for the design of the SEHP to the Health Care Commission, and with carrying out the operation of the SEHP according to HCC policy. KHPA staff prepared this report.

I. SUMMARY OF CHANGES AND OTHER ACTIVITIES IN PLAN YEAR 2007

This section provides a summary of improvements, changes, and other activities in the SEHP that occurred or took effect in the 2007 plan year (i.e., calendar year 2007). The summary includes a record of the HCC's contracting activities during the year and an overview of the enrollment trends during 2007. A summary of the SEHP's financial experience during 2007 is included in Section IV of this report.

Health Plan Design

A number of important plan changes took effect in 2007 which lowered costs and improved benefits. Relationships with the three medical benefit plans – Blue Cross Blue Shield of Kansas (BCBSKS), Preferred Health System (PHS) and Coventry – continued unchanged in 2007, the second in the HCC's three-year contract with each carrier. Specific changes are highlighted below.

Changes in medical benefits

Two important improvements in health benefits were implemented in 2007, beginning with the inclusion of one routine age-appropriate colonoscopy per person per lifetime as a no-cost preventive care benefit in the HMO and PPO plans. In addition, the state plan began supplementing employee contributions with its own contribution to the Health Savings Account for all participating in the Qualified High Deductible Health Plan (QHDHP).

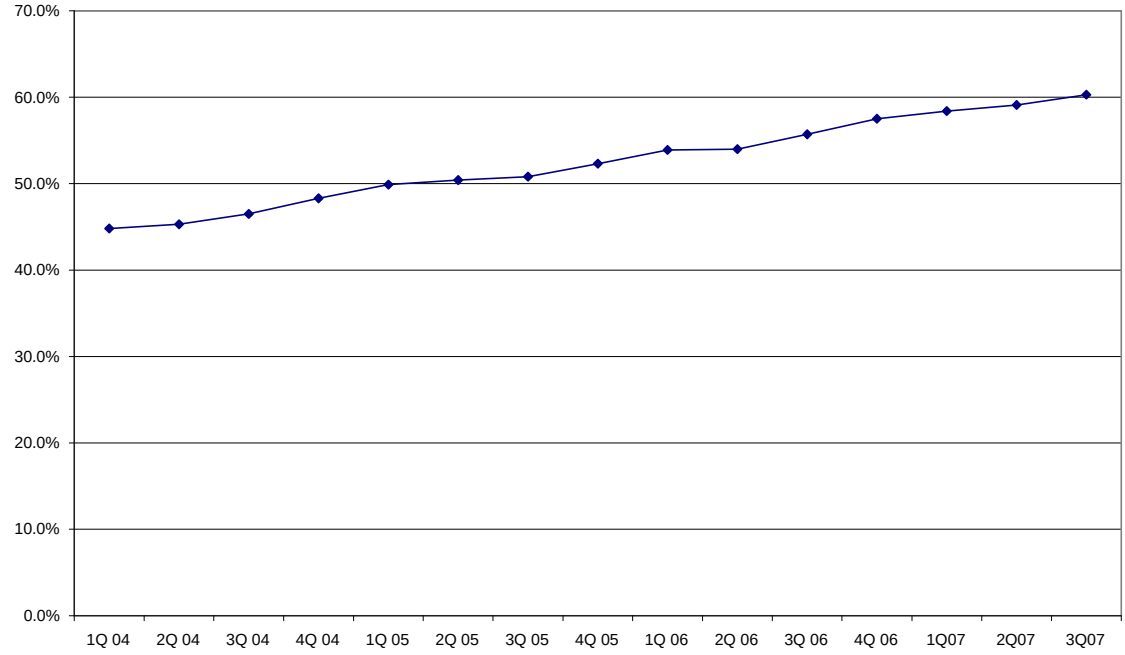
Changes in Prescription Drug Benefits

Under the new pharmacy contract for 2007, won again by Caremark, the state received increased discounts on prescription drug prices, yielding estimated annual savings to employees and the state of approximately $8 million dollars. Another important change was to begin applying manufacturer rebates for prescription drugs at the point of sale, giving employees an immediate share of those savings rather than crediting rebates to the SEHP after the purchase. Now, when a member purchases a rebate-eligible drug, the estimated rebate amount is deducted from the allowed amount for the medication before the percentage coinsurance is applied, yielding shared savings for both the member and the SEHP.

The HCC continued its multi-tiered coinsurance plan design that encourages and rewards cost-effective consumer purchasing. The overall prescription drug trend of the plan remains favorable as compared to national trends. Through proactive plan management, increased consumer awareness and the introduction of several new generic products, the generic dispensing rate increased from 55.7% in PY 2006 to 60.3% in 2007 (see Figure 1).

For Direct Bill members with Medicare, 2007 was the first year that members could elect to purchase the Kansas Senior Plan C Medicare Supplement plan with the SilverScript Part D prescription drug coverage. Members still had the option to purchase Kansas Senior Plan C without drug coverage if they preferred. Of those enrolled in Senior Plan C, 3,834 members elected to take the SilverScript Part D drug plan and 2,349 elected to purchase drug coverage from another source.

Figure 1
Generic Dispensing Rate Per Quarter



Changes in Dental Benefits

Coverage for composite (white) resin restorations for posterior teeth was added for 2007 in addition to the coverage for amalgams (silver) restorations. Composite resin fillings were already available for anterior teeth.

Limited coverage was also added for dental implants to allow the member more flexibility in restoration treatment options. Coverage is equal to what would have been provided for the least expensive alternative treatment, which is a three (3) unit bridge.

Recontracting for the Lab card

For the 2007 plan year, the State continued its contract with Quest Diagnostics (formerly LabOne) as a specialty vendor for the Kansas Choice and Coventry PPO plans. Lab card provides members with high quality outpatient lab services covered by the medical plan at 100% with neither copay nor deductible. Each month about 6% of the eligible members use the Lab card program. For 2007, over 70,893 services were completed in 2007 with an estimated savings to employees and the state of $881,056.

On April 19, 2007 the HCC released Requests for Proposal (RFP) 10125 to obtain competitive proposals from qualified vendors for a lab card program. The preferred lab benefit provides discount lab services to the plan members with no cost sharing. Two (2) bids were received in response to the RFP. The HCC award a three (3) year contract to Quest Diagnostics (Lab One).

<u>Long Term Care Insurance</u>

The SEHP's contract with MedAmerica for long term care insurance expired

March 31, 2006. MedAmerica provided notification in February 2006 that they did not wish to extend the contract beyond its original term. The reason given was that despite marketing efforts, enrollment remained flat with 701 enrollments. Individuals who are enrolled in this program were allowed to maintain their coverage; however no new enrollments were taken after March 31, 2006.

The HCC released RFP 10197 on February 16, 2007 to obtain competitive proposals from qualified vendors for a voluntary group long term care (LTC) program. This was the second attempt to obtain a long term care program. No qualified bids were received.

Participation

Active state employee contracts increased by 519 contracts from January 2007 to January 2008 (1.4 %), while covered dependents increased by 1,320 (3.5 %). The direct bill program saw a decrease of 70 covered members (-.6 %) between January 2007 and January 2008. [See Exhibit B for more detailed accounting of SEHP enrollment]

Interest and enrollment of Non State groups, consisting of school districts, municipalities, and public hospitals, continued to grow in 2007. As of January 2008, 95 groups will be enrolled in the Non State plan with 6318 contracts, representing 12% of total enrollment, an increase of 3 groups and 732 contracts (about 11.9 %) over January 2007.

Claims Analysis System

To monitor health plan performance throughout the year, manage program costs, and evaluate health plan options, SEHP staff have access to a web-based decision support system that enables multi-level access to the administrative records generated by employee health care claims.

The SEHP continued to build on the capacity of the system to support data-driven management. In the first quarter of 2007 a new data feed from Caremark was added to our database to capture the prescription drug data from the Silverscript plan offered to Medicare eligible retirees. In the second quarter of 2007 lab results data from Quest Diagnostics were added to help identify, monitor, and manage members who are living with chronic conditions. In the third quarter of 2007 we added the National Provider Identifier (NPI) field from all our vendors to the database.

In addition, the SEHP conducted a number of targeted internal analyses to identify opportunities for potential cost-savings and other program improvements, including: data comparing medical and pharmacy costs and utilization for employees with and without preventive dental services; costs and utilization for active members with low back pain; costs and prevalence of chronic kidney disease compared to market; emergency room use analysis; and, an analysis on the health status of the population in the SEHP using relative risk scores to identify potential improvements in service delivery.

HealthQuest

Since it was established in 1998, the HealthQuest Program has developed considerable employee trust and participation in a range of programs that encourage healthy lifestyles. The program received a comprehensive review in 2007 to develop a new package of incentives and services promoting employee health, wellness, and preventive care. Consistent with the KHPA's statutory charge to coordinate a statewide health policy agenda incorporating effective purchasing with health promotion strategies, the review was designed to create through HealthQuest an overall wellness program that will serve as a model for other employers and health care purchasers across the state.

To help design this initiative, the state plan KHPA released RFP 10300 on March 15, 2007 to obtain competitive proposals from qualified vendors for a prime integrator to offer personal health assessments, health screenings, health coaching, disease management, and other services supporting a health lifestyle. The vendor selected in the process would partner with KHPA to develop the "next generation" health management and productivity initiative. Twenty-one (21) bids were received. The HCC awarded a three year contract to Health Dialog.

In August, HealthQuest began working with Health Dialog to prepare for a January 2008 launch of the new programs. The program kicks off during Legislative Fitness Day 2008, with health screenings followed by health coaches providing legislators and staff with health improvement information.

The HCC also released RFP 10586 on July 2, 2007 to obtain competitive proposals from qualified vendors for a pilot weight loss program. This pilot program was to establish a weight loss program for state employees in the Capital Complex. Three (3) bids were received in response to the RFP however the decision was made not to pursue a contract at this time.

Audit, Oversight, and Plan Management

Beginning in 2007, KHPA contracted with a single actuarial vendor for Medicaid, the SEHP, and the State Self Insurance Fund (state employee workers compensation program), providing a single point of contact to consider options for coordinated purchasing, and to support overall health reform options that may involve multiple programs administered (or proposed to be administered) by KHPA. Examples include the development of options and estimates for the premium assistance program included in SB11, the health reform legislation passed in May 2006, which explicitly ties benefits required by the Center for Medicare and Medicaid Services (CMS) for expansion populations to the actuarial value of the SEHP.

Recognizing the need for increased oversight of SEHP spending, the plan approved a number of audits designed to increase the programmatic effectiveness and fiscal integrity. The HCC released RFP 10126 on March 29, 2007 to obtain competitive proposals from qualified Vendors for a complete audit of self funded medical, dental and prescription drug plans. Nine (9) bids were received in response to the RFP. The HCC awarded a two (2) year contract to Claim Technologies Incorporated (CTI). The HCC also released RFP 10127 on April 5, 2007 to obtain competitive proposals from qualified vendors for an eligibility audit of the employees and

dependents in both State and Non State groups. Five (5) bids were received. The HCC awarded a contract to Claim Technologies Incorporated (CTI) for the project. However, KHPA staff put a temporary hold on this initiative to consider alternative methods of working with human resource staff and employees to ensure appropriate enrollment of qualified dependents. KHPA will present the HCC with options in 2008 before proceeding with this initiative.

II. SUMMARY OF CHANGES IN PLAN YEAR 2008

This section includes a summary of health plan improvements developed and approved in 2007 for implementation in plan year 2008, which began January 1, 2008. As a package, the changes to be made in 2008 represent a significant step forward in employee benefits, lowering administrative costs and employee contributions, improving benefits to emphasize prevention and wellness, and revamping health plan options to provide better choices to employees across the state. The comprehensive set of reforms to the HealthQuest program are highlighted separately in Section III. The projected impact of these plan changes on SEHP finances in 2008 and in future years is summarized in Section IV of this report.

Health Plan Design

Beginning in 2008, the HCC approved an initiative to self-insure all employee benefits. This means that the state employee plan will no longer purchase insurance products from carriers, but rather purchase administrative services (e.g., claims administration) and access to a contracted provider network. Prior to 2008, only one medical plan (Kansas Choice) was self-funded. Given the strong funding balances in the employee health fund (see section IV), KHPA staff determined that additional protection from financial loss was unnecessary, and recommended the move to self-funding to save the costs associated with the purchase of insurance. Most large employers/purchasers in Kansas and across the United States self-insure benefits for their employees. Self-funding is designed to give the State more flexibility in the benefit design, improve cash flow, simplify the health plan rebidding process and reduce State expenditures for vendor margins, contingency charges, profits and taxes.

The Commission also approved changes to move away from the traditional HMO model and to develop instead a plan that encourage appropriate use of care through incentives emphasizing preventive care and the concept of a primary care medical home. This is also consistent with other large purchasers of health care plans. The new plan designs more closely resemble PPO, and so the plan labels were switched from “HMO” and “PPO” to “Plan A” and “Plan B,” respectively. The lifetime benefit cap of two (2) million dollars was removed from both Plan A and Plan B.

The following vendors will continue to provide administrative and network services for the SEHP:

- Blue Cross Blue Shield of Kansas (Plan A and Plan B)
- Coventry Health Care of Kansas (Plan A, Plan B and the QHDHP)
- Preferred Health Systems (Plan A and Plan B)

The Coventry and PHS plans were moved to broader networks, thus allowing the expansion of these plans on a statewide basis. This is intended to increase competition among the carriers and ultimately provide better pricing for the State. It also expands coverage options for many State employees.

Medicare Options for Direct Bill (retiree members)

Medicare eligible members have access to the plans listed above except the QHDHP. Medicare eligible direct bill members also have programs designed to compliment their Medicare coverage. For 2008, we are offering the Coventry Advantra Freedom Private Fee for Service program with or without the Medicare Part D drug coverage. This will allow members greater flexibility in selecting the Medicare Part D drug plan that best meets their pharmacy needs.. The Advantra Freedom Private Fee for Service program is a Medicare Part C Advantage plan available nationwide.

Changes in medical benefits

Numerous changes are to be implemented in 2008 reflecting a shift from a focus on health care to a focus on wellness. The desired outcome is to engage members in their own health, promote the use of preventive services, foster tobacco control, provide options to address obesity and promote compliance with prescription drug usage. The following benefit changes are to be implemented in 2008:

Providing plan choice to employees and their dependents continues to be highly valued. Changes in benefit design between Plan A and Plan B reflect the first year of plan design improvements to emphasize preventive care and the concept of a primary care medical home. In future years, it is the goal of the KHPA to work closely with the HCC to ensure significant high quality plan choices are available.

Plan A

Network Benefits

- Removed Primary Care Physician referral requirement.
- The primary care physician benefit was replaced by the Primary Care Medical Home Office Visit and is subject to $20 office visit copay.
- The Specialist office visit copay was increased from $30 to $40.
- Expanded the preventive care benefit coverage for medically appropriate colonoscopy screenings and removed the routine diagnosis requirement and the lifetime limit of one.
- Expanded the preventive care benefit coverage for medically appropriate mammography screenings for both routine and medically necessary screening and removed the annual limit of one.
- Remove the age limit on 100% coverage of immunizations to include all age appropriate immunizations.
- Expanded the coverage for Dietician visits from only those diagnosed with diabetes to cover all medical diagnosis. Care is subject to a 10% coinsurance.
- Removed the Inpatient Services copay of $200, but maintained 10% coinsurance.
- Removed the Outpatient Surgery copay of $100.
- Removed the Major Diagnostic tests copay of $100.
- Removed inpatient copay of $200 on inpatient rehabilitation services
- Increased the Emergency Room copay from $75 to $100 per visit.
- To encourage the use of appropriate and cost effective treatment, the cap of $5,000 was removed from Home Health Services.
- To better meet the needs of the terminally ill, the $7,500 Hospice Care cap was removed and a time limit on services of 6 months was added.
- Removed the office visit copay from Allergy Testing.

- The office visit copay requirement has been removed to encourage compliance with allergy shots and antigen administration.
- To provide parity on mental health conditions the inpatient copay of $200 was removed along with the 60 day limit on treatment. For office visits the benefit was designed to match the primary care medical home benefit provided for medical care.
- Alcohol and Chemical Dependency
    - Inpatient Care – inpatient copay was removed the 10% coinsurance applies.
    - Outpatient Care – no change in payment however both network and non network services will count toward first 25 visits.
- To encourage members to use their primary care medical home the Urgent Care Center benefit was changed to a $20 copay plus 10% coinsurance instead of a $30 copay.

Plan A

Non Network Benefit

- Plan A did not previously offer coverage for out of network benefits. To encourage members to use network providers, the plan has added an annual deductible of $500 per person and $1,500 per family and care is subject to 50% coinsurance to a max of $3,650 per person and $7.300 per family. The following copays also apply to services:
    - Inpatient Services copay $600
    - Emergency Room copay $200
    - Mental Health Inpatient copay $600 and 60 day limit on services.

Plan B

Network Benefits

- The primary care physician benefit was replaced by the Primary Care Medical Home Office Visit, which is subject to $20 office visit copay.
- The Specialist office visit copay was increased from $30 to $40.
- Removed the $450 maximum allowance on Preventive Care Services.
- Expanded the preventive care benefit coverage for medically appropriate colonoscopy screenings and removed the routine diagnosis requirement and the lifetime limit of one.
- Expanded the preventive care benefit coverage for medically appropriate mammography screenings for both routine and medically necessary screening and removed the annual limit of one.
- Remove the age limit on 100% coverage of immunizations to include all age appropriate immunizations.
- Expanded the coverage for Dietician visits from only those diagnosed with diabetes to cover all medical diagnosis. Care is subject to a 10% coinsurance.
- Removed the Inpatient Services copay of $300.
- To encourage the use of appropriate and cost effective treatment, the cap of $5,000 was removed from Home Health Services.
- To better meet the needs of the terminally ill, the $7,500 Hospice Care cap was removed and a time limit on services of 6 months was added.

- The office visit copay requirement has been removed to encourage compliance with allergy shots and antigen administration.
- To provide parity on mental health conditions the inpatient copay of $200 was removed along with the 60 day limit on treatment. For office visits the benefit was designed to match the primary care medical home benefit provided for medical care.

Rehabilitation Services

  - Inpatient – removed inpatient copay of $300.
- Alcohol and Chemical Dependency
  - Inpatient Care – inpatient copay was removed.
- To encourage members to use their primary care medical home the Urgent Care Center benefit was changed to a $20 copay plus 35% coinsurance instead of a $30 copay.

Plan B

Non Network Benefit

- Alcohol and Chemical Dependency Inpatient copay $100 instead of $600.

Qualified High Deductible Health Plan (QHDHP)

No changes were made to the Qualified High Deductible Health Plan (QHDHP) plan design for 2008.

Changes in Prescription Drug Benefits

Improvements in the prescription drug plan in 2008 were also focused on preventive care and wellness. Non-compliance by diabetics and asthmatics with prescription drug therapy increases health risks and plan expenses for preventable complications and emergency room visits. To promote adherence with diabetic and asthma drug therapies the Commission voted to lower the member's out of pocket expense for medications to 10% (to a maximum of $10) for generic drugs and 20% (to a maximum of $20) for preferred brand name drugs. Lowering the member cost for these medications should remove a barrier to drug therapy compliance and ultimately lower plan cost for complications and emergency room visits.

To promote member wellness, coverage of up to $300 per member per year was added for prescription tobacco control products. Coverage was also added for prescription weight loss medications. In prior plan years these items were only available for a discount under the lifestyle benefit.

The prescription drug program in 2008 also includes two value-added services from the contracted benefits manager, Caremark. The first, Adherence to Care, is a participant-centric approach to medication therapy compliance. The program gathers plan participant data, identifies influencing factors for participants, stratifies intervention pathways specific to plan participants, and intervenes with personalized care including individualized care plans that help to ensure proper adherence to medication therapy. The second, CustomCare, relies on automated reviews of drug utilization to improve outcomes and provide savings by identifying plan participants who may be at risk for drug interactions or drug-induced disease conditions, or who may otherwise benefit from a simpler or reduced drug regimen.

Employer Contribution and Rates

Reflecting the strong finances of the state employee plan, and the desire to place employee benefits more in line with other major employers, the HCC approved an increase in the state contribution towards the cost of dependent coverage from the 2006-7 average of 45% to an average of 55%. The State contribution of 95% of the cost of employee-only coverage remains unchanged.

Changes in health plan options also introduced opportunities for member savings. By moving to a Preferred Provider Organization (PPO) plan design for benefits, reflected in both Plan A and Plan B, the State was able to extend all health plan options statewide, making the lowest cost plans available to all state employees. Under the new set of plan offerings, all options are available statewide and nationwide eliminating the need for multiple rate structures for different areas of the state. All employees in the same salary tier have the same plan options and pay the same premium rate regardless of where they live.

The HCC determined to continue in 2008 the HealthyKIDS pilot program that helps eligible lower-income State employees with premium costs for children. The program covers children who meet the income guidelines for the state's HealthWave program (i.e., a family income below 200% of the Federal poverty level), but who are prohibited from enrolling in HealthWave by Federal rules that are designed to prevent States from shifting insurance benefits onto the Federally-subsidized HealthWave program. For HealthyKids families, the state covers 90 percent of the premium (instead of the typical 55 percent average) and the employee pays only 10 percent for their eligible dependent children. In 2007, over 3,200 children participate in the health care plan through HealthyKids.

Open Enrollment

Employee participation in open enrollment activities for the 2008 plan year increased significantly over previous years, demonstrating interest in the wide range of changes and improvements to the SEHP. Open Enrollment for active employees was held from October 1 - October 31, 2007. Ninety-one (91) Open Enrollment meetings were held for employees in thirty-two (32) cities. Staff estimates that approximately 8,800 employees attended these meetings.

During Open Enrollment, approximately 26,612 employees or eighty one (81) percent of eligible employees utilized the Web-based open enrollment system to make elections for their 2008 SEHP coverage. KanElect Flexible spending accounts require an annual election to participate, and 8,225 employees elected medical accounts and 1,015 elected dependent care accounts, a 11.3 % and 11.7 % increase, respectively over levels of participation in 2007.

To facilitate more informed choices by employees, the HCC released RFP 10436 on May 4, 2007 to obtain competitive proposals from qualified vendors for an online Benefit Calculator (Employee Decision Making tool). Four (4) bids were received in response to the RFP. Subsequent to negotiations, the HCC awarded a three (3) year contract to Asparity Decision Solutions. Asparity's Plan Select online decision support tool was implemented in 2007. Plan Select is designed to assist employees in making health plan decisions. Employees answer a

series of questions about factors related to the health plan options. Based upon their answers, the health plan options are scored. In addition, a benefit calculator is included for determining health spending accounts (HSA) and health care flexible spending accounts (FSA) contributions. Over 8,000 employees took advantage of the new Plan Select tool.

Planned Changes to the Claims Analysis System

The contract with Thomsom Medstat for the claims analysis system will be expiring in 2008. Working with other KHPA programs under the leadership of the Director of Data Policy and Evaluation, a joint re-procurement of a health data analytic tool is underway. The new procurement for a Data Analytic Interface (DAI) will facilitate better coordination of data and analysis with KHPA programs such as Medicaid and Healthwave, and with major datasets managed by the KHPA, in particular the Kansas Health Insurance Information System, which includes comprehensive plan and health claims data for privately insured Kansans. The information contained in these datasets presents an unprecedented opportunity to document, describe, analyze, and diagnose the state of health care in Kansas.

The overall goal is to take currently available data from the three systems and create an analysis workshop. This will allow comparative analysis based on episodes of care of individual beneficiaries, disease management, predictive modeling, evaluative analysis, etc, to measure costs and outcome effectiveness. The improved decision-analytic capability of the DAI should lead to increased productivity and more efficient use of state health care dollars in order to manage costs, quality, and access to health care programs. The Legislature provided full funding for the DAI project in its FY 2008 appropriation including funds for additional staff and for procurement of the system.

Project Update**:** The RFP was issued on July 25, 2007. Bids closed on October 25, 2007. The anticipated contract execution start date is March 2008. The anticipated completion time is one year.

Health Information Exchange

One of KHPA's core purposes is to use its purchasing power to lead the way in market reforms that enhance quality, lower costs, and improve efficiency. Market experts predict that increasing provider and member access to existing health information (such as detailed records of each health claim), could transform the marketplace, improving patient awareness, lowering costs, and significantly increasing the effectiveness and timeliness of patient care. The SEHP, in conjunction with the Mid-America Coalition on Health Care, will be participating on a pilot basis in the CareEntrust health information exchange (HIE), a not-for-profit, Kansas City employer-based initiative located in the Kansas City. The pilot program will begin April 1, 2008 and will initially be limited to members in the metropolitan Kansas City area.

A CareEntrust Health Record collects and organizes health care visit information including medication and lab data to create a secure repository for much of what a health care provider needs to know in order to effectively treat their patients. The CareEntrust Health Record will offer members immediate and secure access to their own own health information, and through provider access across multiple locations, will facilitate communication and enhance

coordination among health care providers. The goals of the CareEntrust Health Record is to increase member access to their health information, to prevent adverse drug events and medication overdoses by offering the most up-to-date information, and to eliminate redundant procedures and unnecessary hospital admissions, and aid in the delivery of coordinated, hassle-free care.

III. PROGRAM HIGHLIGHT: BUILDING A MODEL WELLNESS PROGRAM THROUGH HEALTHQUEST

KHPA initiated a comprehensive review of the HealthQuest program in 2007 to develop a new package of incentives and services promoting employee health, wellness, and preventive care. Consistent with the KHPA's statutory charge to coordinate a statewide health policy agenda incorporating effective purchasing with health promotion strategies, the review was designed to create through HealthQuest a health and wellness program that will serve as a model for other employers and health care purchasers across the state. The new program was to be implemented in January 2008, beginning with an introductory letter from the Governor and the KHPA Executive Director and a promotional flier describing the programs. New HealthQuest program components will include Healthy Lifestyle tools, health screening events, Personal Health Assessment (PHA) as well as a $50 gift card incentive to increase participation.

Health Lifestyle Program

Through this program plan members will be able to talk by phone with a health coach twenty-four hours a day. Health coaches are specially trained professionals (such as nurses, respiratory therapists, or dietitians) who can help answer any health questions participants may have concerning their health or their family's health. Members communicate with their own health coach who can also provide support and information to help participants manage ongoing conditions such as diabetes, heart disease and asthma. When participants call a health coach, they receive the following:

- Personal education and support
- Health information that is provided 24/7
- Questions to discuss with their doctor
- Educational materials mailed to their home, at no cost to them
- Support from a personal coach for nutrition, tobacco cessation, stress management, weight management and more.

Statewide Health Screening Events

As part of the commitment to help participants' lead healthier lifestyles, the HealthQuest program will also offer onsite health screenings during company time in 37 cities (53 sites) across the state. The program starts in January, 2008 and includes the following tests: total cholesterol, HDL, LDL, triglycerides, and glucose, blood pressure, measured height and weight and BMI calculation

Personal Health Assessment (PHA) and $50 Gift Card

The online Personal Health Assessment helps participants get an accurate picture of their current health status and take an active role in managing their health and well-being. Participants who complete the PHA will receive a $50 gift card.

Personal Health Coaching

Participants will have an opportunity to work with a health coach to design and implement their own personal health action plan. Health Coaches will encourage but not require members to utilize the health screening and the Personal health Assessment tools.

Legislative Fitness Day

The new HealthQuest program will officially be launched on January 15, designated as Legislative Fitness Day for legislators, the Governor, and their staffs. Events will include onsite health screening, access to the online Personal Health Assessment, health coaching, and mini health fair activities. In 2008, over three quarters (76%) of Kansas State legislators are participants in the State Employee Health Plan.

IV. FINANCING

The HCC completed its year by receiving for the first time a quarterly financial report from KHPA summarizing plan revenue, plan expenses, and both current and projected balances in SEHP funds. Based on staff projections, and the opinion of SEHP actuaries, KHPA reported the fund to be in strong financial standing with adequate resources and reserves to support and sustain the plan improvements adopted for Plan Year 2008. This section summarizes the financial status of the state employee plan, including a discussion of funding balances, revenue, and expenses.

Beginning Balance

The beginning balances shown at the top of Table 1 and Table 2 indicate the total amounts of cash in the various funds available to the SEHP. Funds available to the SEHP are referred to as the "Plan Reserve," and the beginning balance of the plan reserve represents the funds available at the beginning of each year. The beginning balances in these funds totaled $72.9 million in FY 2000 (Table 1).

Available monies for plan expenses are managed in two funds. One fund is a dedicated, interest bearing reserve that totals approximately $11.0 million called "Reserve". This fund was created by the 1993 contract with Blue Cross and Blue Shield of Kansas to provide a reserve for self funded claims payments. The fund has continued to exist and grows by interest compounded within the Pooled Money Investment Board monthly. Interest earned on the Reserve Balance is estimated at 5%. Given the shift to self-fund all SEHP offerings, it is expected that by 2015, the plan will earn interest on all the Plan Reserves.

The second fund called "Remittance to Providers" (Table 1 and Table 2) represents moneys remaining from payroll collections (employees and State agencies), direct billed contributions from retirees and COBRA continuers and Non State group contributions. These have been reported as incurred expenditures that would be paid to the health insurance carriers for health claims.

Plan Revenues

Plan revenues are the amount of money received from contributions by State Agencies, Non State employers, and employees, plus interest earned by the plan. Past experience with fund balances, revenues, and expenses are represented in an historical chart (Figure 3) based upon fiscal years running from July 1 to June 30, since data by plan year is unavailable for those years. Projected balances, revenues, and expenses are based upon plan years running from January 1 to December 31. The Plan Revenues future projection (Table 2) is based upon a health cost trend rate of 6.5% plus an additional cost trend of 1%. The employer and agency contributions will be adjusted on the first of July each year starting July 1, 2009. The employee contributions are expected to adjust January 1 of each year starting January 1, 2009.
Due to the sound financial position of the SEHP for FY 2006, contributions were frozen for agencies and employees. This locked in the amount of agency revenue coming into the plan. The employee contributions decreased in plan year 2006 related to two changes. First, the Health

Care Commission (HCC) increased the subsidy for dependent insurance from 35% to 45%. Second, the HCC also developed a program to reduce the cost of dependant coverage for employees with family incomes under 200.0 percent of the federal poverty level. The HealthyKids program increased the state contribution for dependent coverage to 90.0 percent for children.

The projections shown on Table 2 incorporate the estimated impacts of contribution rates and benefit design changes going into effect for plan year 2008, as described above, including the increased employer contribution for dependents, the shift in enrollment to Plan A in 2008, and the projected rebalancing of enrollments between Plans A and B beginning in 2009, a shift that will depend on future changes in the plan options.

Plan Expenses

Plan Expenses are payments for medical, dental, and drug claims that have been paid by the plan. The historical plan expenses (Table 1) represent actual experience, whereas projected plan expenses (Table 2) are estimates reflecting a long-run industry standard 6.5% managed health care cost trend. The plan (Table 2) is expected to have a $15.2 million cash flow savings in 2008 due to the one-time claims lag associated with the shift to self-funding. The projection also assumes a rebalance of enrollments between Plans A and B beginning in 2009, a shift that will depend on future changes in the plan options.

The total annualized cost of the Kansas SEHP for Plan Year 2007 was approximately $328,388,000. This is 3.14% higher than the Plan Year 2006 cost of $318,870,000. The annual total cost estimate is revised each year as more recent claims experience is collected. Of the $328.4 million cost of the SEHP, $204.1 million represents current estimated expenditures of the state, while $124.3 million represents cost-sharing responsibilities of members.

Claim Payments Per Member

The claim payments per member per month (Exhibit E) increased 7.3% from 3rd quarter 2007 as compared to 3rd quarter 2006. The increase in cost for 2007 may be attributable in part to the continuing impact of plan design changes such as increased dependent contribution from 35% to 45%, increased preventive care coverage from $300 to $450 and included colonoscopy screenings. The active State employees' claim payments actually increased 12.3% while the Non State employees' claim payments decreased 8.4% when comparing 3rd quarter 2007 to 3rd quarter 2006.

Administration

Administration is the cost to maintain the program including salaries, consulting fees, wellness programs and other expenses. It is assumed in the projections that costs will grow 2% annually. SEHP administrative costs represent less than 1% of health plan expenditures.

Plan Reserves

The Plan Reserve (at the end of the year) is a target minimum reserve amount to cover unexpected future SEHP expenditures should they (temporarily) exceed revenue. In effect, Plan Reserves represent the capitalization required to self-insure for all covered health care expenses. Reserves held by the SEHP are analyzed periodically to ensure they are adequate to cover:

- Incurred But Not Reported (IBNR) claim liability, i.e., the cost of medical care delivered but not yet billed to the SEHP. These bills would continue to arrive at the plan for payment even if, for some unforeseen reason, benefits and associated premium revenue were terminated; and
- unexpected contingencies such as a spike in health care costs that arrives before plan revenues can be adjusted upward.

Table 1 and Figure 2 show SEHP balances, revenues, and expenditures from state Fiscal Year 2000 through 2006. By the end of FY 2006, the fund balances grew to $193.2 million, more than a 250 percent increase from FY1999. These reserves reflect actual historical experience as reported in the Statewide Cost Allocation Plan documents for each state fiscal year, and the single state financial audit reports for those years. This growth in the balances is due to several factors in the plan design. During fiscal years 2004 and 2005, agency and employee contributions were increased. At the same time claims experience within the plan remained essentially flat, at least in part due to reductions in the benefit design. In FY 2005 alone, the SEHP collected $82.3 million more than needed to fund expenditures. That amount was added to the beginning balance of $40.4 million. As Table 1 indicates, fund balances continued to rise into FY 2007.

Table 2 shows the projected target reserve for each year based upon a function of Plan Revenue, Plan Expenses, and health cost trend. KHPA's funding objective in managing the SEHP over the long term is to have a target reserve equal to the actuarially-calculated IBNR, plus a reasonable contingency to account for unforeseen and unexpected growth in health costs that could arrive before plan revenue could be adjusted. The target reserve will be adjusted for health cost trend over time. KHPA's actuarial consultant, Mercer, estimates the IBNR health claims in Plan Year 2008 to be $38 million, or about a month and a half of plan expense, and estimates a reasonable contingency of an additional $15 million. The total target reserve for Plan Year 2008 will be $53 million (Table 2).

Target reserves are projected to rise slowly over time with health costs and plan enrollment, while fund balances are expected to fall gradually. Based on a set of assumptions that take into account expected health costs, plan management, and future revenues, total plan reserves are expected to fall gradually over the next several years until they meet the target level.

Summary:

The 2007 plan year for the State Employee Health Plan was a significant one, with a renewed focus on health and wellness, lower premium contribution requirements for families, and lower prescription drug costs for plan participants. In 2008, the KHPA and the HCC will continue to focus on sound financial management of the SEHP, utilizing new data and analytic

capacity with the goal of increased productivity and more efficient use of state health care dollars in order to manage costs, quality and access to health care programs.

Table 1

History of State Employee Health Benefit Plan Revenues, Expenditures, and Balances

FY 2000 - FY 2007

	FISCAL YEAR							
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
REMITTANCE & RESERVE FUND								
Begin Balance:								
Reserve Fund	39,055,152	39,050,785	29,254,282	14,559,934	9,746,634	9,855,595	10,052,400	10,448,122
Remittance to Providers	33,820,241	11,377,641	6,168,315	9,861,330	26,375,054	41,708,702	116,675,422	184,644,833
Total Beginning Balance	72,875,393	50,428,426	35,422,597	24,421,264	36,121,689	51,564,296	126,727,822	195,092,955
Revenue:								
Agency Contributions	100,256,898	109,024,449	120,769,023	149,696,356	165,754,879	200,726,104	200,135,310	200,097,943
Participant Contributions	77,990,593	88,115,037	93,669,556	114,148,567	148,602,336	163,984,990	139,570,611	152,247,492
Other - rebates, penalties, etc.	5,685,582	11,465,252	18,180,611	7,797,556	5,100,207	1,753,813	25,229,868	3,375,997
Total Revenue	183,933,073	208,604,738	232,619,190	271,642,479	319,457,422	366,464,907	364,935,789	355,721,432
Reserve Fund Interest/Transfers	-4,367	-9,796,503	-14,694,348	-4,813,300	108,960	196,805	395,722	541,431
Expenses:								
Premiums, Claims & ASO Payments	205,888,527	213,380,912	228,294,048	254,741,000	303,877,757	291,258,566	296,727,928	332,269,898
Other Payments or IBNR	487,145	433,153	632,127	387,755	246,017	239,621	238,450	22,693,738
Total Expenses	206,375,672	213,814,065	228,926,175	255,128,755	304,123,774	291,498,187	296,966,378	354,963,636
End Balance:								
Reserve Fund	39,050,785	29,254,282	14,559,934	9,746,634	9,855,595	10,052,400	10,448,122	10,989,553
Remittance to Providers	11,377,641	6,168,315	9,861,330	26,375,054	41,708,702	116,675,422	184,644,833	185,402,628
End Balance	**50,428,426**	**35,422,597**	**24,421,264**	**36,121,689**	**51,564,296**	**126,727,822**	**195,092,955**	**196,392,181**
ADMINISTRATION								
Begin Balance:	1,484,187	2,201,536	2,936,054	3,237,339	756,276	405,462	858,454	1,611,873
Revenues:								
Cafeteria Fund	2,167,608	2,157,519	1,943,524	183,936	2,018,370	2,009,650	2,012,839	2,035,464
Wellness Fund	617,147	617,149	579,952	-253	528,004	576,924	605,259	645,828
Total Revenues	2,784,755	2,774,668	2,523,477	183,683	2,546,375	2,586,574	2,618,098	2,681,292
Expenses:								
Total Admin Expenses	2,067,406	2,040,150	2,222,192	2,664,746	2,897,189	2,133,582	1,864,679	2,319,404
Ending Balance	2,201,536	2,936,054	3,237,339	756,276	405,462	858,454	1,611,873	1,973,761

Figure 2

History of State Employee Health Benefit Plan Revenues and Expenditures

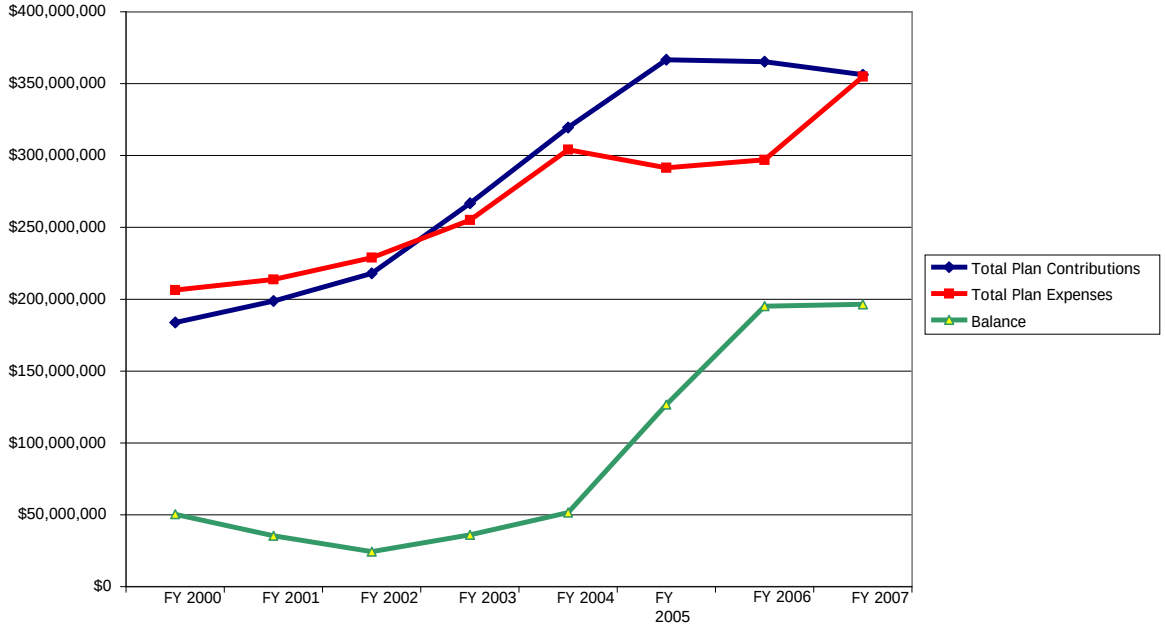


Table 2

Kansas Health Policy Authority

State Employee Health Benefit Plan Reserve Projections

Medical, Pharmacy, Dental and Vision Benefits

Plan Year	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Available Funds												
Reserve earning interest	10,714,669	11,271,959	11,835,557	12,427,335	13,048,702	13,701,137	14,386,193	15,105,503	83,315,136	80,308,327	81,624,539	88,137,583
Remittance to Providers	181,155,339	212,433,760	199,272,078	164,680,804	134,411,940	110,162,126	92,903,166	78,506,581	0	0	0	0
Beginning Available Balance	191,870,008	223,705,719	211,107,635	177,108,139	147,460,642	123,863,263	107,289,359	93,612,084	83,315,136	80,308,327	81,624,539	88,137,583
Total Employer Contributions	228,000,000	228,000,000	236,467,485	254,031,387	272,899,868	293,169,828	314,945,364	338,338,303	363,468,780	390,465,853	419,468,166	448,609,462
Total Participant Contributions	124,264,612	102,366,612	109,970,013	118,138,166	126,913,018	136,339,632	146,466,419	157,345,386	169,032,400	181,587,481	195,075,106	207,754,988
Total Contributions	352,264,612	330,366,612	346,437,498	372,169,552	399,812,886	429,509,460	461,411,783	495,683,688	532,501,180	572,053,334	614,543,272	656,364,450
Total Plan Expenses	320,986,191	343,528,293	381,028,771	402,438,417	424,062,700	446,768,420	475,808,368	506,735,911	539,673,746	574,752,539	612,111,454	651,898,699
Interest on Reserve Fund	557,290	563,598	591,778	621,367	652,435	685,057	719,310	755,275	4,165,757	4,015,416	4,081,227	4,406,879
Ending Available Balance (Reserve Ending Balance)	**223,705,719**	**211,107,635**	**177,108,139**	**147,460,642**	**123,863,263**	**107,289,359**	**93,612,084**	**83,315,136**	**80,308,327**	**81,624,539**	**88,137,583**	**97,010,213**
Target Reserve	47,766,530	53,383,000	56,701,574	59,887,582	63,105,530	66,484,409	70,805,896	75,408,279	80,309,817	85,529,955	91,089,402	97,010,213
ADMINISTRATION (Cafeteria and Wellness Fund)												
Beginning Balance	1,171,749	1,251,032	1,367,955	1,957,224	2,288,292	2,476,871	2,581,458	2,605,327	2,551,302	2,421,799	2,218,863	1,955,758
Revenues												
Cafeteria	2,454,977	2,454,977	2,454,977	2,479,527	2,498,123	2,511,863	2,525,678	2,539,569	2,553,537	2,567,581	2,593,257	2,619,190
Wellness	766,988	766,988	766,988	536,892	429,513	386,562	347,906	313,115	281,804	253,623	228,261	205,435
Total Revenues	3,221,965	3,221,965	3,221,965	3,016,418	2,927,637	2,898,425	2,873,584	2,852,685	2,835,341	2,821,205	2,821,518	2,824,625
Administrative Costs	3,142,682	3,105,042	2,632,696	2,685,350	2,739,057	2,793,838	2,849,715	2,906,709	2,964,844	3,024,141	3,084,623	3,146,316
End Balance	1,251,032	1,367,955	1,957,224	2,288,292	2,476,871	2,581,458	2,605,327	2,551,302	2,421,799	2,218,863	1,955,758	1,634,067

Figure 3
State Employee Health Benefit Plan Ending Reserve Balance

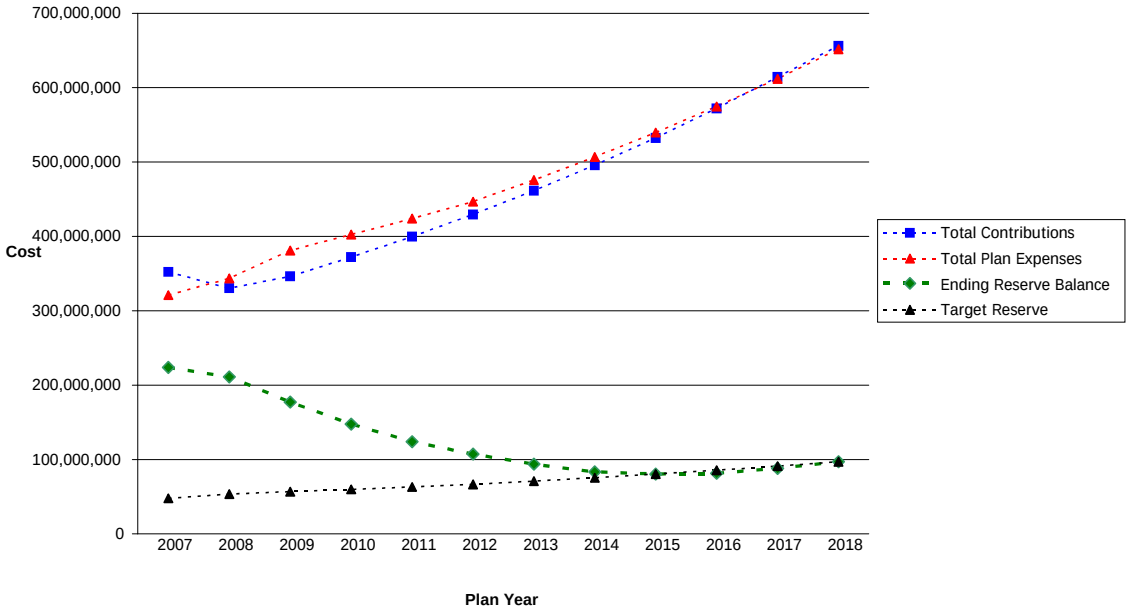


Exhibit A
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Exhibit B
STATE OF KANSAS

2007 GROUP HEALTH INSURANCE ENROLLMENT
BY TYPE OF PARTICIPANT

Grand Total Covered Lives (State & Non-State Active, Direct Bill, & COBRA)					
Type of Participant	Jan-07	Apr-07	Jul-07	Oct-07	Average
Active State Employees	35,627	35,523	35,101	35,219	35,368
Active State EE Dependents	31,136	31,137	31,028	31,106	31,102
Total Covered Lives	**66,763**	**66,660**	**66,129**	**66,325**	**66,469**
Direct Bill State Retirees	10,101	10,041	10,113	10,157	10,103
Direct Bill State Ret Dependents	905	901	881	850	884
Total Covered Lives	**11,006**	**10,942**	**10,994**	**11,007**	**10,987**
COBRA State Participants	123	127	157	168	144
COBRA State Dependents	70	49	55	56	58
Total Covered Lives	**193**	**176**	**212**	**224**	**201**
Active Educational Employees	3,467	3,491	3,409	3,274	3,410
Active Educational EE Dependents	2,650	2,679	2,641	2,628	2,650
Total Covered Lives	**6,117**	**6,170**	**6,050**	**5,902**	**6,060**
Direct Bill Educational Retirees	313	302	310	344	317
Direct Bill Educational Ret Dependents	69	64	65	76	69
Total Covered Lives	**382**	**366**	**375**	**420**	**386**
COBRA Educational Participants	12	11	14	22	15
COBRA Educational Dependents	7	5	5	9	7
Total Covered Lives	**19**	**16**	**19**	**31**	**21**
Active Local Units of Government Employees	1,754	1,769	1,733	1,729	1,746
Active Local Units of Govt EE Dependents	2,070	2,072	2,048	2,085	2,069
Total Covered Lives	**3,824**	**3,841**	**3,781**	**3,814**	**3,815**
Direct Bill Local Units of Government Employees	49	50	54	53	52
Direct Bill Local Units of Govt EE Dependents	9	8	10	4	8
Total Covered Lives	**58**	**58**	**64**	**57**	**59**
COBRA Local Units of Government Employees	5	6	9	6	7
COBRA Local Units of Govt EE Dependents	0	0	2	1	1
Total Covered Lives	**5**	**6**	**11**	**7**	**7**
Grand Total Covered Lives	**88,367**	**88,235**	**87,635**	**87,787**	**88,006**

Exhibit C
State of Kansas Employee Health Plan
Average Members by Population Group
Reflects dependents on medical coverage

Population Group	QTR 3 2006	QTR 4 2006	QTR 1 2007	QTR 2 2007	QTR 3 2007	% Change from prior year
Active State of Kansas	64,841	65,579	66,570	66,553	65,862	1.6%
Other Public Employees	10,658	10,707	9,903	9,953	9,714	-8.9%
COBRA Continuees	303	233	206	230	271	-10.7%
Retired Employees	11,622	11,549	11,343	11,328	11,405	-1.9%
Total All Groups	87,424	88,068	88,022	88,064	87,252	-0.2%
Prior Year Total All Groups	86,663	86,847	87,880	88,166	87,424	0.9%
Percent change	0.9%	1.4%	0.2%	-0.1%	-0.2%	

Reflects covered participants and dependents
Retroactive enrollment changes are not reflected

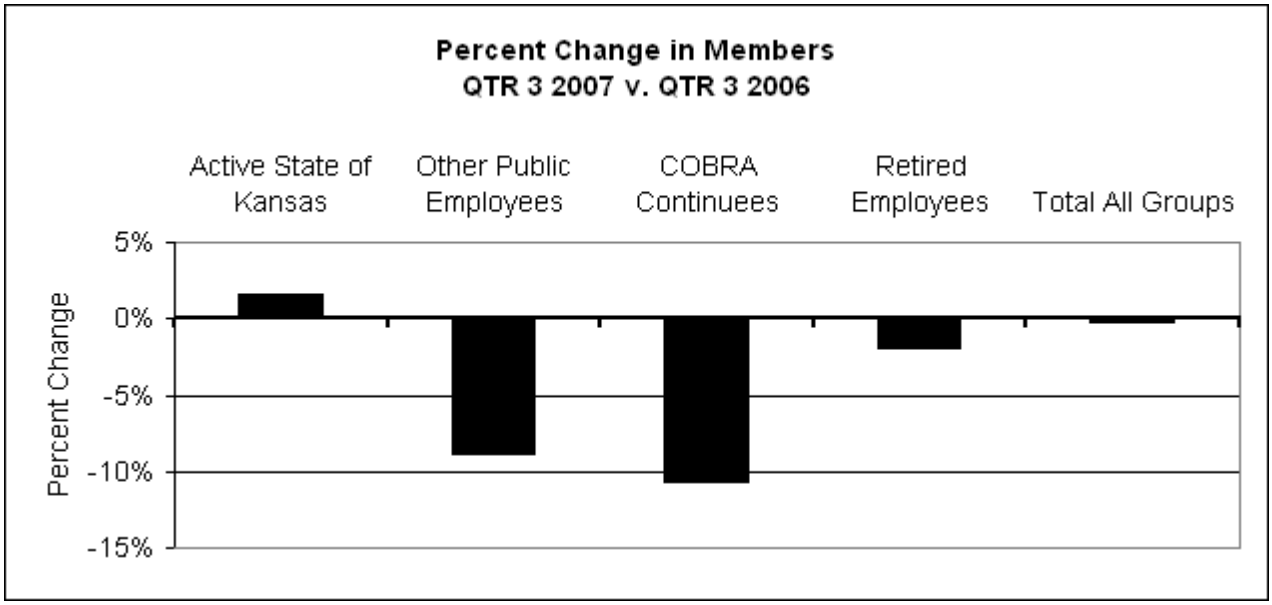

Exhibit D

State of Kansas Employee Health Plan

Claim Payments Per Member Per Month by Population Group

Population Group	QTR 3 2006	QTR 4 2006	QTR 1 2007	QTR 2 2007	QTR 3 2007	% Change from prior year
Active State of Kansas	$235	$248	$264	$258	$264	12.3%
Other Public Employees	$246	$235	$244	$241	$225	-8.4%
COBRA Continuees	$720	$692	$749	$520	$820	13.9%
Retired Employees	$357	$339	$353	$353	$348	-2.5%
Total All Groups	$254	$259	$274	$268	$272	7.3%
Prior Year Total All Groups	$234	$233	$264	$260	$254	8.4%
Percent Change	8.4%	11.3%	3.8%	3.1%	7.3%	

Reflects covered participants and dependents.
Claims payments include medical, dental and prescription drug.
Claims payments do not include capitated claims, administrative fees or premium amounts.

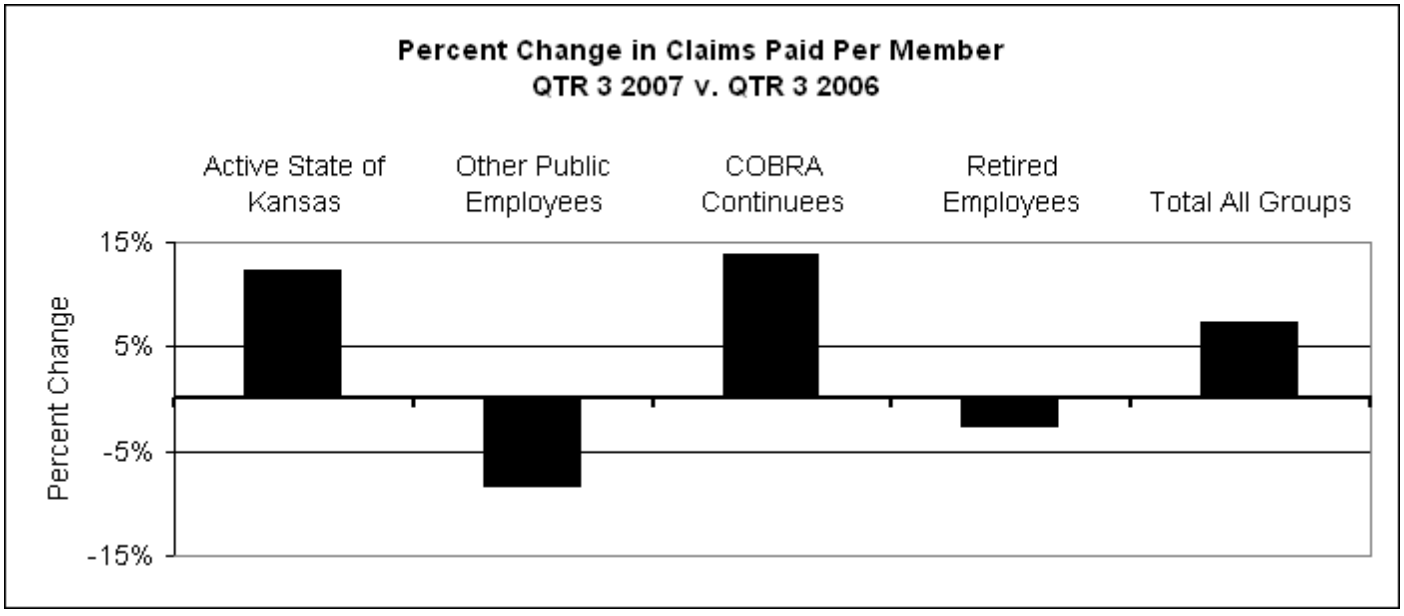

Exhibit E
State of Kansas Employee Health Plan
Total Claim Payments by Population Group

Population Group	QTR 3 2006	QTR 4 2006	QTR 1 2007	QTR 2 2007	QTR 3 2007	% Change from prior year
Active State of Kansas	$47,543,928	$50,817,079	$54,748,444	$53,506,218	$54,213,642	14.0%
Other Public Employees	$8,448,063	$8,152,289	$7,795,407	$7,714,344	$7,000,228	-17.1%
COBRA Continuees	$695,424	$526,176	$502,777	$380,944	$708,446	1.9%
Retired Employees	$12,455,892	$11,785,065	$12,055,990	$12,040,906	$11,943,917	-4.1%
Total All Groups	$69,143,307	$71,280,609	$75,102,618	$73,642,412	$73,866,233	6.8%
Prior Year Total All Groups	$63,379,132	$63,302,364	$72,417,130	$71,666,584	$69,259,150	9.3%
Percent Change	9.1%	12.6%	3.7%	2.8%	6.7%	

Reflects covered participants and dependents.
Claims payments include medical, dental and prescription drug.
Claims payments do not include capitated claims, administrative fees or premium amounts.

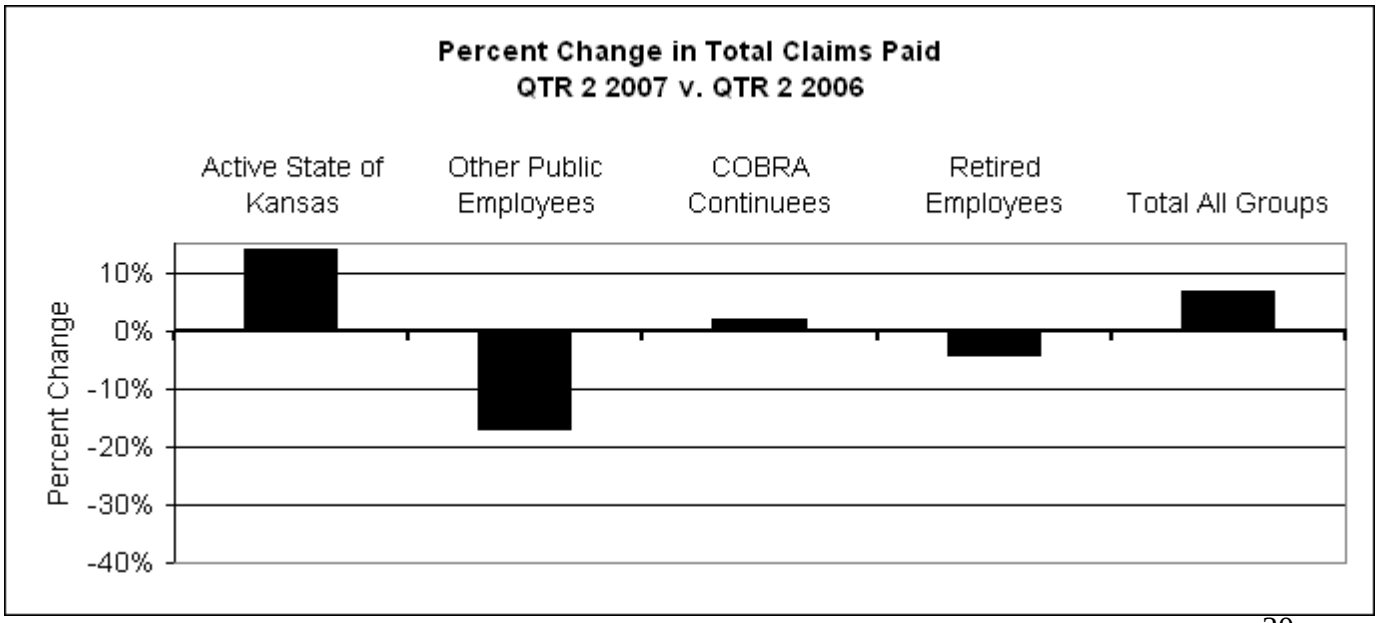

Exhibit F
2007 State of Kansas Annual Report

Kansas State Employees Health Care Commission
2007 Comparison of Actual to projected
Health Plan Costs (Unaudited)

			Actual 2007 Year-To-Date	Annualized[1]
1.	**2007 Projected Total Cost**			$345,907,000
2.	**2007 Actual Total Cost**			
	a.	Kansas Choice Self-Insured Claims	$88,802,000	$106,562,000
	b.	Kansas Senior Plan C Self-Insured Claims	$1,151,000	$1,381,000
	c.	Caremark/Silverscript Rx Claims	$46,220,000	$55,464,000
	d.	Delta Dental Claims	$17,222,000	$20,666,000
	e.	Superior Vision Premiums	$2,828,000	$3,394,000
	f.	Insured HMO/PPO Premiums	$108,728,000	$130,474,000
	g.	ASO/Other Administrative Fees	$8,706,000	$10,447,000
	Total		$273,657,000	$328,388,000
3.	**2007 Employee, COBRA, Direct Bill Contributions**			$124,265,000
4.	**2007 State Cost**			
	a.	Projected		$208,541,000
	b.	Actual [2. - 3.]		$204,123,000
	c.	% Difference [4b./4a. -1]		-2.1%

1. These values were developed by annualizing data through October 2007. Intra-year trend, deductible leveraging, and migration were not considered. Data has not been audited further.