Kansas

State Employees Health Care Commission

October 18, 2021

Meeting Materials

STATE OF KANSAS - STATE EMPLOYEES HEALTH CARE COMMISSION

AGENDA

October 18, 2021

KPERS Board Room, 611 S. Kansas Ave., Topeka, KS

Please register for the HCC Meeting at:
https://register.gotowebinar.com/register/1366862695349807627

Welcome and Introductions by Chair Burns-Wallace

1. **Approval of Minutes** ***[Action Item]*** - Secretary Burns-Wallace
    a. September 27, 2021

New Business:

2. **Rule and Regulation Change (No Wait Period) Ratification** ***[Action Item]*** **-** Secretary Burns-Wallace

Reports:

3. **Financial Report -** Segal
4. **Director Report -** Janet Stanek
5. **Follow-up Items from the 8/23/21 & 9/27/21 Meetings** - Secretary Burns-Wallace *(Previously Reported to Commissioners via email)*
    a. **PBM Audit Articles**

Discussion Items:

6. **HB2218 Review -** Secretary Burns-Wallace
7. **HCC Legal Counsel Options -** Secretary Burns-Wallace
8. **Procurement Process/Survey Results -** Secretary Burns-Wallace
9. **Wellness Program -** Secretary Burns-Wallace
10. **Schedule Next Meeting: (***After Nov. 10 in order to vote on EAC member recommendations)*

Appendix:

a) *Aetna Audit Summary*
b) *Delta Dental Audit Summary*
c) *Dependent Eligibility Verification Audit Summary*

Agenda Item #1

STATE OF KANSAS - STATE EMPLOYEES HEALTH CARE COMMISSION

MEETING MINUTES - DRAFT

September 27, 2021 - 3:00 PM

KPERS Board Room, 611 S. Kansas Ave., Topeka, KS

The Kansas - State Employees Health Care Commission (HCC) meeting was called to order on Monday, September 27, 2021, at 3:00 pm. The meeting was conducted in person at the KPERS Board Room, in Topeka, KS with a virtual video broadcast available to the public using GoTo Webinar following publication to the State of Kansas's Public Square web portal and SEHP website.

The following members were present:

- Chair DeAngela Burns-Wallace
- Commissioner Steve Dechant
- Commissioner Vicki Schmidt
- Commissioner Carolyn McGinn
- Commissioner Brenda Landwehr
- Commissioner Sandy Praeger (virtual)
- Commissioner Rebekah Gaston

The following staff were present:

- Janet Stanek, SEHP Director
- Mike Michael, SEHP Deputy Director
- Jennifer Flory, SEHP, Administrative Coordinator
- Pete Nagurny, SEHP Sr. Manager, Data & Finance
- Paul Roberts, SEHP Sr. Manager, Health Plan Operations
- Laurie Knowlton, SEHP Sr. Manager, Membership Services
- John Yeary, Department of Administration Chief Counsel
- Tracy Diel, Department of Administration, Legal Counsel

The following attended virtually:

- Courtney Fitzgerald, SEHP Marketing Manager
- Ken Vieira, Segal Consulting
- Patrick Klein, Segal Consulting
- Dr. Sadhna Paralkar, Segal Consulting
- Doug Sumner, Marathon Health
- Eric Schrumpf, Marathon Health
- Holly Martin, Marathon Health
- Jon Swartz, Marathon Health

Topic	Discussion	Action	Follow-up
Welcome and Introductions	Secretary Burns-Wallace called the meeting to order at 3:06 pm. She welcomed the commissioners and those listening in. She reminded all commissioners to please identify themselves when speaking for those listening on the phone. She recapped the purpose for the meeting, review of the Marathon Health Contract, and that it is a public meeting and is broadcast via GoTo Meeting.		
1. Approval of Minutes **a. August 23, 2021** **[Action Item]**	Secretary Burns-Wallace recapped the new format for the meeting minutes. Commissioner Schmidt suggested the following edits: Page 11 – should say Commissioner Schmidt; Page #2 – the explanation of vote should be moved to the Action column instead of the Discussion column. There was consensus expressed in respect to the new minute format and flow of information.	***Commissioner Dechant made a motion to approve the minutes for 08/23/21.*** ***1st – Commissioner Dechant*** ***2nd – Commissioner Gaston*** ***All in favor, none against, the motion passed.*** The 08/23/21 Minutes were approved with the noted edits.	It was requested to include headers on each page for future versions.

Topic	Discussion	Action	Follow-up
2. Marathon Contract Recommendation [Action Item]	Janet Stanek presented information regarding the Marathon contract. See attached materials. She noted that today's information included excerpts from Marathon's Year 2 Annual Report with current and trended data. The commission had various questions for Marathon and requested clarification on some of the metrics presented. Commissioner Schmidt expressed concern that the negotiated extension did not include any modifications to the performance guarantees, as had been her understanding from the last HCC meeting. Concern was expressed that the ability to negotiate revised performance guarantees from the vendor had been compromised. Janet Stanek noted that staff has been in discussions with Marathon regarding alternative performance guarantees and plans to make modifications should the contract be extended. Janet Stanek reviewed the current performance guarantees with the commissioners included in the materials. Commissioner Schmidt inquired about the terms of the lease for the Clinic space. Commissioner Burns-Wallace noted that Marathon would extend for 1 year and that the State would potentially look to use that space for other purposes, should the Clinic be discontinued in the future.	***Commissioner Gaston made a motion to extend the amended Marathon contract and lease for 1 year at the rate of $16.50 per square foot ($5,478 monthly cost; $65,736 annual cost) resulting in an annual savings of $301,478 as follows:*** ***Reduce the annual fee consistent with the 2020 annual fee at the cost of $2,073,048 (reduced from $2,285,526) resulting in a savings of $212,478; increase behavioral health a .5 FTE at no additional cost to the state resulting in a savings of $89,000; and expand virtual services across the state at no additional cost to the state.*** Commissioner Burns-Wallace clarified this would allows include the SEHP staff moving forward with an RFP. ***1st – Commissioner Gaston*** ***2nd – Commissioner Dechant*** ***6 in favor, 1 against. The motion passed.***	Commissioner McGinn requested that future reports that are broken out by department include the Legislative Branch individually and not combined with other departments. Commissioner Landwehr requested that future Performance Guarantees include outcomes measurements.

Topic	Discussion	Action	Follow-up
		Commissioner Schmidt voted in opposition of the motion and requested to record her explanation as being the same reason as she has stated in previous meetings where she expressed opposition to the process used by the HCC to award contracts ***The Marathon Contract was approved as presented for a one-year extension, including a one-year lease extension.***	
3. Next Meeting Agenda, October 18, 11 am	Secretary Burns-Wallace noted the next meeting is scheduled for October 18th at 11am in the KPERS Board Room. She noted that the agenda would be robust and include discussions on HB 2218 requirements, the 30-day rule and regulation change, the procurement process, HCC legal counsel options as well as standard reports, including the financial report and the Director report.		Commissioner Landwehr requested that all emails come from a single contact. Janet Stanek will be recorded as the Sender on all future HCC related communications.
4. Adjournment		***The meeting adjourned at 4:16 pm.***	

Agenda Item #2

108-1-1. Eligibility. (a) ~~General~~ Definitions. Each of the following terms, as used in this regulation, shall have the meaning specified in this subsection:

(1) "Active participant" means any person enrolled in the health care benefits program.

(2) "Child" means any of the following:

(A) A natural son or daughter of a primary participant;

(B) a lawfully adopted son or daughter of a primary participant. The term "lawfully adopted" shall include those instances in which a primary participant has filed the petition for adoption with the court, has a placement agreement for adoption, or has been granted legal custody;

(C) a stepchild of a primary participant. However, if the natural or adoptive parent of the stepchild is divorced from the primary participant, the stepchild shall no longer qualify;

(D) a child of whom the primary participant has legal custody; or

(E) a grandchild, if at least one of the following conditions is met:

(i) The primary participant has legal custody of the grandchild or has lawfully adopted the grandchild;

(ii) the grandchild lives in the home of the primary participant and is the child of a covered eligible dependent child, and the primary participant provides more than 50 percent of the support for the grandchild; or

(iii) the grandchild is the child of a covered eligible dependent child and is considered to reside with the primary participant even when the grandchild or eligible dependent child is temporarily absent due to special circumstances including education of the covered eligible

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dependent child, and the primary participant provides more than 50 percent of the support for the grandchild.

(3) "COBRA" means the consolidated omnibus budget reconciliation act, public law 99-272, as amended.

(4) "Commission" means the Kansas state employees health care commission.

(5) "Direct bill participant" means any person enrolled in the health care benefits program pursuant to subsections (d), (e), and (h).

(6) "Eligible dependent child" means any dependent child who meets one of the following criteria:

(A) The child is under 26 years of age.

(B) The child is aged 26 or older, has a permanent and total disability, and has continuously maintained group coverage as an eligible dependent child of the primary participant before attaining the age of 26. The child shall be chiefly dependent on the primary participant for support.

(7) "Health care benefits program" means the state of Kansas health care benefits program established by the commission.

(8) "Permanent and total disability" means that an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months. An individual shall not be considered to have a permanent and total disability unless that person furnishes proof of the permanent and total

disability in the form and manner, and at the times, that the health care benefits program may require.

(9) "Primary participant" means any person enrolled in the health care benefits program under subsection (b), a direct bill participant under subsection (d), or a COBRA participant.

(10) "Variable-hour employee" means any officer or employee of a state agency for whom, at the date of hire, it cannot be determined that the employee is reasonably expected to work at least 1,000 hours per year.

(b) Primary participants. Subject to the provisions of subsection (c), the classes of persons eligible to participate as primary participants in the health care benefits program shall be the following classes of persons:

(1) Any elected official of the state;

(2) any other officer or employee of a state agency who meets both of the following conditions:

(A) Is working in one or more positions that together require at least 1,000 hours of work per year; and

(B) is not a variable-hour employee;

(3) any person engaged in a postgraduate residency training program in medicine at the university of Kansas medical center or in a postgraduate residency or internship training program in veterinary medicine at Kansas state university;

(4) any person serving with the foster grandparent program;

(5) any person participating under a phased retirement agreement outlined in K.S.A. 76-746, and amendments thereto;

(6) any student employee and any adjunct professor at a state institution of higher learning if the individual works in one or more positions that together require at least 1,560 hours of work per year; and

(7) any other class of individuals approved by the Kansas state employees health care commission, within the limitations specified in K.S.A. 75-6501 et seq., and amendments thereto.

(c) ~~Waiting period~~ Eligibility upon beginning employment.

~~(1)~~ Each person who is within a class listed in paragraph (b)(1), (b)(2), (b)(3), (b)(4), (b)(6), or (b)(7) shall become eligible for enrollment in the health care benefits program ~~following completion of a 30 day waiting period beginning with~~ on the first day of work for the state of Kansas. Each person shall have 31 days after becoming eligible to elect coverage.

~~(2) The waiting period established in paragraph (c)(1) shall not apply if all of the following conditions are met:~~

~~(A) The person is returning to work for the state of Kansas or is transferring from a position that was eligible for coverage under K.A.R. 108 1 3 or K.A.R. 108 1 4.~~

~~(B) Immediately before leaving the prior position, the person was enrolled in the health care benefits program.~~

~~(C) The break in service between the prior position and the new position does not exceed the following time periods:~~

~~(i) 30 calendar days; or~~

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~~(ii) 365 calendar days, if the person was laid off, as defined in K.S.A. 75 2948 and amendments thereto~~.

~~(3) The waiting period established in paragraph (c)(1) shall not apply to any person who, on that person's first day of work for the state, is enrolled in the health care benefits program on any of the following bases:~~

~~(A) As a direct bill participant;~~

~~(B) under the continuation of benefits coverage provided under COBRA; or~~

~~(C) as a dependent of a participant in the health care benefits program~~.

~~(4) The waiting period established in paragraph (c)(1) may be waived by the commission or its designee if, within 30 days of the date of hire, the agency head or the agency head's designee certifies in writing to the commission, or its designee, that the waiver is being sought because the potential new employee is required to have health insurance as a condition of obtaining a work visa for employment in the United States~~.

(d) Classes of direct bill participants. Subject to the provisions of subsection (e), the classes of persons eligible to participate as members of the health care benefits program on a direct bill basis shall be the following:

(1) Any former elected state official;

(2) any retired state officer or employee who is eligible to receive retirement benefits under K.S.A. 74-4925, and amendments thereto, or retirement benefits administered by the Kansas public employees retirement system;

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(3) any totally disabled former state officer or employee who is receiving disability benefits administered by the Kansas public employees retirement system;

(4) any surviving spouse or dependent of a qualifying participant in the health care benefits program;

(5) any person who is in a class listed in paragraph (b)(1), (b)(2), (b)(3), (b)(4), or (b)(6) and who is lawfully on leave without pay;

(6) any blind person licensed to operate a vending facility as defined in K.S.A. 75-3338, and amendments thereto;

(7) any former "state officer," as that term is defined in K.S.A. 74-4911f and amendments thereto, who elected not to be a member of the Kansas public employees retirement system as provided in K.S.A. 74-4911f and amendments thereto; and

(8) any former state officer or employee who separated from state service when eligible to receive a retirement benefit but, in lieu of that, withdrew that individual's employee contributions from the retirement system.

(e) Conditions for direct bill participants. Each person who is within a class listed in paragraph (d)(1), (d)(2), (d)(3), (d)(4), (d)(5), (d)(7), or (d)(8) shall be eligible to participate on a direct bill basis only if the conditions of both paragraphs (e)(1) and (e)(2) are met:

(1) The person was covered by the health care benefits program on one of the following bases:

(A) The person was covered as an active participant, as a COBRA participant, or as a spouse under paragraph (g)(1) immediately before the date that person ceased to be eligible for

that type of coverage or the date the individual became newly eligible for a class listed in subsection (d).

(B) The person is the surviving spouse or eligible dependent child of a person who was enrolled as a primary participant or a direct bill participant when the primary participant died, and the surviving spouse or eligible dependent child was covered by the health care benefits program as a dependent pursuant to subsection (g) when the primary participant died.

(2) The person completes an enrollment form requesting transfer to the direct bill program and submits the form to the health care benefits program. The form shall be submitted no more than 30 days after the person ceased to be eligible for coverage.

(f) COBRA participants. Any individual with rights to extend coverage under COBRA may continue to participate in the health care benefits program, subject to the provisions of that federal law.

(g) Eligible dependent participants.

(1) Any person enrolled in the health care benefits program as a primary participant may enroll the following dependents, subject to the same conditions and limitations that apply to the primary participant:

(A) The primary participant's lawful wife or husband, as recognized by Kansas law and subject to the documentation requirements of the commission or its designee; and

(B) any of the primary participant's eligible dependent children, subject to the documentation requirements of the commission or its designee.

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(1) Except as otherwise provided in this subsection, each direct bill participant enrolled in the state health care benefits program on or after January 21, 2001, shall maintain continuous coverage in the program or shall lose eligibility to be in the state health care benefits program as a direct bill participant.

(2) Any person who discontinued direct bill coverage in the state health care benefits program before January 21, 2001, and who is not a direct bill participant on that date may return one time to the state health care benefits program if the person meets the criteria specified in subsections (d) and (e) and if that person has not previously discontinued and returned to direct bill coverage before January 21, 2001. (Authorized by K.S.A. ~~2014 Supp.~~ 75-6501 and K.S.A. 75-6510; implementing K.S.A. ~~2014 Supp.~~ 75-6501; effective, T-85-22, July 16, 1984; effective May 1, 1985; amended, T-88-64, Dec. 30, 1987; amended, T-89-12, May 1, 1988; amended, T-108-9-12-88, Sept. 12, 1988; amended Oct. 31, 1988; amended May 9, 1997; amended Jan. 21, 2001; amended Aug. 27, 2004; amended June 17, 2005; amended Jan. 6, 2006; amended July 16, 2010; amended, T-108-8-16-10, Aug. 16, 2010; amended March 11, 2011; amended Jan. 2, 2015; amended P-_____.)

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(2) An eligible dependent child who is enrolled by one primary participant shall not be eligible to be enrolled by another primary participant.

(3) An individual who is eligible to enroll as a primary participant in the health care benefits program shall be eligible to be enrolled under this subsection as a dependent in the health care benefits program, subject to the following requirements:

(A) The individual who enrolls as a dependent of a primary participant shall be the lawful spouse, as defined in paragraph (g)(1)(A).

(B) An individual who enrolls as a dependent of a primary participant shall not be eligible to be enrolled as a primary participant during that plan year.

(C) Each individual who enrolls as a dependent of a primary participant shall be subject to the copays, deductibles, coinsurance, and employer contribution levels as a dependent and not as a primary participant.

(4) The term "dependent" shall exclude any individual who is not a citizen or national of the United States, unless the individual is a resident of the United States or a country contiguous to the United States, is a member of a primary participant's household, and resides with the primary participant for more than six months of the calendar year. The dependent shall be considered to reside with the primary participant even when the dependent is temporarily absent due to special circumstances, including illness, education, business, vacation, and military service.

(h) Direct bill participants; continuous coverage provisions.

108-1-3. School district employee health care benefits plan. (a) Definitions ~~for K.A.R. 108-1-3~~. Each of the following terms, as used in this regulation, shall have the meaning specified in this subsection:

(1) "Active participant" means any person who is enrolled in the school district plan.

(2) "Child" means any of the following:

(A) A natural son or daughter of a primary participant;

(B) a lawfully adopted son or daughter of a primary participant. The term "lawfully adopted" shall include those instances in which a primary participant has filed the petition for adoption with the court, has a placement agreement for adoption, or has been granted legal custody;

(C) a stepchild of a primary participant. However, if the natural or adoptive parent of the stepchild is divorced from the primary participant, the stepchild shall no longer qualify;

(D) a child of whom the primary participant has legal custody; or

(E) a grandchild, if at least one of the following conditions is met:

(i) The primary participant has legal custody of the grandchild or has lawfully adopted the grandchild;

(ii) the grandchild lives in the home of the primary participant and is the child of a covered eligible dependent child, and the primary participant provides more than 50 percent of the support for the grandchild; or

(iii) the grandchild is the child of a covered eligible dependent child and is considered to reside with the primary participant even when the grandchild or eligible dependent child is temporarily absent due to special circumstances including education of the covered eligible

dependent child, and the primary participant provides more than 50 percent of the support for the grandchild.

(3) "COBRA" means the consolidated omnibus budget reconciliation act, public law 99-272, as amended.

(4) "Commission" means the Kansas state employees health care commission.

(5) "Direct bill participant" means any person enrolled in the school district plan pursuant to subsections (d), (e), and (h).

(6) "Eligible dependent child" means any dependent child who meets one of the following criteria:

(A) The child is under 26 years of age.

(B) The child is aged 26 or older, has a permanent and total disability, and has continuously maintained group coverage as an eligible dependent child of the primary participant before attaining the age of 26. The child shall be chiefly dependent on the primary participant for support.

(7) "Health care benefits program" means the state of Kansas health care benefits program established by the commission.

(8) "Permanent and total disability" means that an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months. An individual shall not be considered to have a permanent and total disability unless that person furnishes proof of the permanent and total disability in the form and manner, and at the times, that the health care benefits program may require.

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(9) "Primary participant" means any person enrolled in the school district plan under subsection (b), a direct bill participant under subsection (d), or a COBRA participant.

(10) "Qualified school district" means a public school district, community college, area vocational technical school, or technical college that meets the terms, conditions, limitations, exclusions, and other provisions established by the commission for participation in the school district employee health care benefits component of the health care benefits program and has entered into a written agreement with the commission to participate in the program.

(11) "School district employee" means any individual who is employed by a qualified school district and who meets the definition of employee under K.S.A. 74-4932(4), and amendments thereto, except that the following employees shall be employed in a position that requires at least 1,000 hours of work per year:

(A) Employees of community colleges; and

(B) employees of area vocational technical schools and technical colleges that are not governed by a unified school district.

For purposes of this definition, a technical college shall be a participating employer under K.S.A. 74-4931, and amendments thereto, in accordance with K.S.A. ~~72-4471~~74-32,456, and amendments thereto.

(12) "School district plan" means the school district employee health care benefits component of the health care benefits program.

(13) "Variable-hour employee" means any school district employee for whom, at the date of hire, it cannot be determined that the employee is reasonably expected to work at least 1,000 hours per year.

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(b) Primary participants. Subject to the provisions of subsection (c), each school district employee shall be eligible to participate as a primary participant in the school district plan. Eligibility and participation shall be subject to terms, conditions, limitations, exclusions, and other provisions established by the commission, including the amount and method of payment for employee and employer contributions.

(c) ~~Waiting periods~~ Eligibility upon beginning employment.

~~(1)~~ Each school district employee whose first day of work for a qualified school district is on or after the first day on which the employee's qualified school district participates in the school district plan shall become eligible for coverage ~~following completion of a 30 day waiting period beginning with~~ on the first day of work for the qualified school district. Each school district employee shall have 31 days after becoming eligible to elect coverage.

~~(2) The waiting period established in paragraph (c)(1) shall not apply if all of the following conditions are met:~~

~~(A) The person is returning to work for the qualified school district, transferring from another qualified school district, or transferring from a position that is eligible for coverage under K.A.R. 108 1 1 or K.A.R. 108 1 4.~~

~~(B) Immediately before leaving the prior position, the person was enrolled in the health care benefits program.~~

~~(C) The break in service between the prior position and the new position does not exceed the following time periods:~~

~~(i) 30 calendar days; or~~

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~~(ii) 365 calendar days, if the person was laid off in accordance with the practices of the qualified school district.~~

~~(3) The waiting period established in paragraph (c)(1) shall not apply to any person who, on that person's first day of work for the qualified school district, is enrolled in the health care benefits program on any of the following bases:~~

~~(A) As a direct bill participant;~~

~~(B) under the continuation of benefits coverage provided under COBRA; or~~

~~(C) as a dependent of a participant in the health care benefits program.~~

~~(4) The waiting period established in paragraph (c)(1) may be waived by the commission or its designee if, within 30 days of the date of hire, the chief administrative officer of the qualified school district, or the chief administrative officer's designee, certifies in writing to the commission, or its designee, that the waiver is being sought because the new employee is required to have health insurance as a condition of obtaining a work visa for employment in the United States.~~

~~(5) Each school district employee who is employed by the qualified school district immediately before the first day on which the employee's qualified school district participates in the school district plan shall be subject to transitional provisions established by the commission regarding waiting periods and the effective date on which the employee becomes eligible to participate in the school district plan.~~

(d) Classes of direct bill participants. Subject to the provisions of subsection (e), the classes of persons eligible to participate as members of the school district plan on a direct bill basis shall be the following:

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(1) Any retired school district employee who is eligible to receive retirement benefits;

(2) any totally disabled former school district employee who is receiving benefits under K.S.A. 74-4927, and amendments thereto;

(3) any surviving spouse or dependent of a primary participant in the school district plan;

(4) any person who is a school district employee and who is on approved leave without pay in accordance with the practices of the qualified school district; and

(5) any individual who was covered by the health care plan offered by the qualified school district on the day immediately before the first day on which the qualified school district participates in the school district plan, except that no individual who is an employee of the qualified school district and who does not meet the definition of school district employee in subsection (a) shall be qualified as a direct bill participant under this paragraph.

(e) Conditions for direct bill participants. Each person who is within a class listed in subsection (d) shall be eligible to participate on a direct bill basis only if the person meets both of the following conditions:

(1) The person was covered by the school district plan or the health care insurance plan offered by the qualified school district on one of the following bases:

(A) Immediately before the date the person ceased to be eligible for coverage, or for any person identified in paragraph (d)(5), immediately before the first day on which the qualified school district participates in the school district plan, the person either was covered as a primary participant under subsection (b) or was covered by the health care insurance plan offered by the employee's qualified school district.

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(B) The person is a surviving spouse or dependent of a plan participant who was enrolled as a primary participant or a direct bill participant when the primary participant died, and the surviving spouse or eligible dependent child was covered by the health care benefits program as a dependent under subsection (g) when the primary participant died.

(C) The person is a surviving spouse or dependent of a primary participant who was enrolled under the health care insurance plan offered by the participant's qualified school district when the primary participant died, and the person has maintained continuous coverage under the qualified school district's health care insurance plan before joining the health care benefits program.

(2) The person completes an enrollment form requesting transfer to the direct bill program and submits the form to the health care benefits program. The form shall be submitted no more than 30 days after the person ceased to be eligible for coverage, or in the case of any individual identified in paragraph (d)(5), no more than 30 days after the first day on which the qualified school district participates in the school district plan.

(f) COBRA participants. Any individual with rights to extend coverage under COBRA may participate in the school district plan, subject to the provisions of that federal law.

(g) Eligible dependent participants.

(1) Any person enrolled in the school district plan as a primary participant may enroll the following dependents, subject to the same conditions and limitations that apply to the primary participant:

(A) The primary participant's lawful wife or husband, as recognized by Kansas law and subject to the documentation requirements of the commission or its designee; and

(B) any of the primary participant's eligible dependent children, subject to the documentation requirements of the commission or its designee.

(2) An eligible dependent child who is enrolled by one primary participant shall not be eligible to be enrolled by another primary participant.

(3) An individual who is eligible to enroll as a primary participant in the health care benefits program shall be eligible to be enrolled under this subsection as a dependent in the health care benefits program, subject to the following requirements:

(A) The individual who enrolls as a dependent of a primary participant shall be the lawful spouse, as defined in paragraph (g)(1)(A).

(B) An individual who enrolls as a dependent of a primary participant shall not be eligible to be enrolled as a primary participant during that plan year.

(C) Each individual who enrolls as a dependent of a primary participant shall be subject to the copays, deductibles, coinsurance, and employer contribution levels as a dependent and not as a primary participant.

(4) The term "dependent" shall exclude any individual who is not a citizen or national of the United States, unless the individual is a resident of the United States or a country contiguous to the United States, is a member of a primary participant's household, and resides with the primary participant for more than six months of the calendar year. The dependent shall be considered to reside with the primary participant even when the dependent is temporarily absent due to special circumstances, including illness, education, business, vacation, and military service.

(h) Direct bill participants; continuous coverage provisions.

(1) Except as otherwise provided in this subsection, each direct bill participant enrolled in the health care benefits program on or after January 21, 2001 shall maintain continuous coverage in the program or shall lose eligibility to be in the health care benefits program as a direct bill participant.

(2) Any person who discontinued direct bill coverage in the health care benefits program before January 21, 2001 and who was not a direct bill participant on that date may return one time to the health care benefits program if the person meets the criteria specified in subsections (d) and (e) and if that person has not previously discontinued and returned to direct bill coverage before January 21, 2001. (Authorized by K.S.A. ~~2014 Supp.~~ 75-6501 and K.S.A. 75-6510; implementing K.S.A. ~~2014 Supp.~~ 75-6501 and K.S.A. ~~2014 Supp.~~ 75-6508; effective, T-108-9-13-99, Sept. 13, 1999; effective Feb. 4, 2000; amended July 16, 2010; amended, T-108-8-16-10, Aug. 16, 2010; amended March 11, 2011; amended Jan. 2, 2015; amended P-_____.)

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108-1-4. Local unit of government employee health care benefits plan. (a) Definitions ~~for K.A.R. 108-1-4~~. Each of the following terms, as used in this regulation, shall have the meaning specified in this subsection:

(1) "Active participant" means any person who is enrolled in the local unit plan.

(2) "Child" means any of the following:

(A) A natural son or daughter of a primary participant;

(B) a lawfully adopted son or daughter of a primary participant. The term "lawfully adopted" shall include those instances in which a primary participant has filed the petition for adoption with the court, has a placement agreement for adoption, or has been granted legal custody;

(C) a stepchild of a primary participant. However, if the natural or adoptive parent of the stepchild is divorced from the primary participant, the stepchild shall no longer qualify;

(D) a child of whom the primary participant has legal custody; or

(E) a grandchild, if at least one of the following conditions is met:

(i) The primary participant has legal custody of the grandchild or has lawfully adopted the grandchild;

(ii) the grandchild lives in the home of the primary participant and is the child of a covered eligible dependent child, and the primary participant provides more than 50 percent of the support for the grandchild; or

(iii) the grandchild is the child of a covered eligible dependent child and is considered to reside with the primary participant even when the grandchild or eligible dependent child is temporarily absent due to special circumstances including education of the covered eligible

dependent child, and the primary participant provides more than 50 percent of the support for the grandchild.

(3) "COBRA" means the consolidated omnibus budget reconciliation act, public law 99-272, as amended.

(4) "Commission" means the Kansas state employees health care commission.

(5) "Direct bill participant" means any person enrolled in the local unit plan pursuant to subsections (d), (e), and (h).

(6) "Eligible dependent child" means any dependent child who meets one of the following criteria:

(A) The child is under 26 years of age.

(B) The child is aged 26 or older, has a permanent and total disability, and has continuously maintained group coverage as an eligible dependent child of the primary participant before attaining the age of 26. The child shall be chiefly dependent on the primary participant for support.

(7) "Health care benefits program" means the state of Kansas health care benefits program established by the commission.

(8) "Local unit" means any of the following:

(A) Any county, township, or city;

(B) any community mental health center;

(C) any groundwater management district, rural water-supply district, or public wholesale water-supply district;

(D) any county extension council or extension district;

(E) any hospital established, maintained, and operated by a city of the first or second class, a county, or a hospital district in accordance with applicable law;

(F)(i) Any city, county, or township public library created under the authority of K.S.A. 12-1215 et seq., and amendments thereto;

(ii) any regional library created under the authority of K.S.A. 12-1231, and amendments thereto;

(iii) any library district created under the authority of K.S.A. 12-1236, and amendments thereto;

(iv) the Topeka and Shawnee county library district established under the authority of K.S.A. 12-1260 et seq., and amendments thereto;

(v) the Leavenworth and Leavenworth county library district established under the authority of K.S.A. ~~12 1270~~12-1276, and amendments thereto;

(vi) any public library established by a unified school district under the authority of K.S.A. ~~72 1623~~72-1418, and amendments thereto; or

(vii) any regional system of cooperating libraries established under the authority of K.S.A. 75-2547 et seq., and amendments thereto;

(G) any housing authority created pursuant to K.S.A. 17-2337 et seq., and amendments thereto;

(H) any local environmental protection program obtaining funds from the state water fund in accordance with K.S.A. 75-5657, and amendments thereto;

(I) any city-county, county, or multicounty health board or department established pursuant to K.S.A. ~~65 204 and~~ 65-205, and amendments thereto;

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(J) any nonprofit independent living agency, as defined in K.S.A. 65-5101 and amendments thereto;

(K) the Kansas guardianship program established pursuant to K.S.A. 74-9601 et seq., and amendments thereto; or

(L) any group of persons on the payroll of a county, township, city, special district or other local governmental entity, public school district, licensed child care facility operated by a not-for-profit corporation providing residential group foster care for children and receiving reimbursement for all or part of this care from the department for children and families, nonprofit community mental health center pursuant to K.S.A. 19-4001 et seq. and amendments thereto, nonprofit community facility for people with intellectual disability pursuant to K.S.A. 19-4001 et seq. and amendments thereto, or nonprofit independent living agency as defined in K.S.A. 65-5101 and amendments thereto.

(9) "Local unit employee" means any individual who meets one or more of the following criteria:

(A) The individual is an appointed or elective officer or employee of a qualified local unit whose employment is not seasonal or temporary and whose employment requires at least 1,000 hours of work per year.

(B) The individual is an appointed or elective officer or employee who is employed concurrently by two or more qualified local units in positions that involve similar or related tasks and whose combined employment by the qualified local units is not seasonal or temporary and requires at least 1,000 hours of work per year.

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(C) The individual is a member of a board of county commissioners of a county that is a qualified local unit, and the compensation paid for service on the board equals or exceeds $5,000 per year.

(D) The individual is a council member or commissioner of a city that is a qualified local unit, and the compensation paid for service as a council member or commissioner equals or exceeds $5,000 per year.

(10) "Local unit plan" means the local unit employee health care benefits component of the health care benefits program.

(11) "Permanent and total disability" means that an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months. An individual shall not be considered to have a permanent and total disability unless that person furnishes proof of the permanent and total disability in the form and manner, and at the times, that the health care benefits program may require.

(12) "Primary participant" means any person enrolled in the local unit plan under subsection (b), a direct bill participant under subsection (d), or a COBRA participant.

(13) "Qualified local unit" means a local unit that meets the terms, conditions, limitations, exclusions, and other provisions established by the commission for participation in the local unit employee health care benefits component of the health care benefits program and that has entered into a written agreement with the commission to participate in the program.

(14) "Variable-hour employee" means any local unit employee for whom, at the date of hire, it cannot be determined that the employee is reasonably expected to work at least 1,000 hours per year.

(b) Primary participants. Subject to the provisions of subsection (c), each local unit employee shall be eligible to participate as a primary participant in the local unit plan. Eligibility and participation shall be subject to terms, conditions, limitations, exclusions, and other provisions established by the commission, including the amount and method of payment for employee and employer contributions.

(c) ~~Waiting periods~~ Eligibility upon beginning employment.

~~(1)~~ Each local unit employee whose first day of work for a qualified local unit is on or after the first day on which the employee's qualified local unit participates in the local unit plan shall become eligible for coverage ~~following completion of a 30 day waiting period beginning with~~ on the first day of work for the qualified local unit. Each local unit employee shall have 31 days after becoming eligible to elect coverage.

~~(2) The waiting period established in paragraph (c)(1) shall not apply if all of the following conditions are met:~~

~~(A) The person is returning to work for the qualified local unit, is transferring from another qualified local unit under this regulation, or is transferring from a position that is eligible for coverage under K.A.R. 108 1 1 or K.A.R. 108 1 3.~~

~~(B) Immediately before leaving the prior position, the person was enrolled in the health care benefits program provided by the state of Kansas under K.A.R. 108 1 1, the school district plan under K.A.R. 108 1 3, or the qualified local unit plan under K.A.R. 108 1 4.~~

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(C) The break in service between the prior position and the new position does not exceed the following time periods:

(i) 30 calendar days; or

(ii) 365 calendar days, if the person was laid off in accordance with the practices of the prior qualified local unit.

(3) The waiting period established in paragraph (c)(1) shall not apply to any person who, on that person's first day of work for the qualified local unit, is enrolled in the local unit plan, the school district plan under K.A.R. 108 1 3, or the health care benefits plan under K.A.R. 108 1 1 on any of the following bases:

(A) As a direct bill participant;

(B) under the continuation of benefits coverage provided under COBRA; or

(C) as a dependent of a participant in the health care benefits program.

(4) The waiting period established in paragraph (c)(1) may be waived by the commission or its designee if, within 30 days of the date of hire, the chief administrative officer of the qualified local unit, or the chief administrative officer's designee, certifies in writing to the commission, or its designee, that the waiver is being sought because the new employee is required to have health insurance as a condition of obtaining a work visa for employment in the United States.

(5) Each local unit employee who is employed by the qualified local unit immediately before the first day on which the qualified local unit participates in the local unit plan shall be subject to transitional provisions established by the commission regarding waiting periods and the effective date on which the employee becomes eligible to participate in the local unit plan.

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(d) Classes of direct bill participants. Subject to the provisions of subsection (e), the classes of persons eligible to participate as members of the local unit plan on a direct bill basis shall be the following:

(1) Any retired local unit employee who meets one of the following conditions:

(A) The employee is eligible to receive retirement benefits under the Kansas public employees retirement system or the Kansas police and firemen's retirement system; or

(B) if the qualified local unit is not a participating employer under either the Kansas public employees retirement system or the Kansas police and firemen's retirement system, the employee is eligible to receive retirement benefits under the retirement plan provided by the qualified local unit;

(2) any totally disabled former local unit employee who meets one of the following conditions:

(A) The employee is receiving benefits under the Kansas public employees retirement system or the Kansas police and firemen's retirement system; or

(B) if the qualified local unit is not a participating employer under either the Kansas public employees retirement system or the Kansas police and firemen's retirement system, the employee is receiving disability benefits under the retirement or disability plan provided by the qualified local unit;

(3) any surviving spouse or dependent of a primary participant in the local unit plan;

(4) any person who is a local unit employee and who is on approved leave without pay in accordance with the practices of the qualified local unit; and

(5) any individual who was covered by the health care plan offered by the qualified local unit on the day immediately before the first day on which the qualified local unit participates in the local unit plan, except that no individual who is an employee of the qualified local unit and who does not meet the definition of local unit employee in subsection (a) shall be qualified as a direct bill participant under this paragraph.

(e) Conditions for direct bill participants. Each person who is within a class listed in subsection (d) shall be eligible to participate on a direct bill basis only if the person meets both of the following conditions:

(1) The person was covered by the local unit plan or the health care insurance plan offered by the qualified local unit on one of the following bases:

(A) Immediately before the date the person ceased to be eligible for coverage or, for any person identified in paragraph (d)(5), immediately before the first day on which the qualified local unit participates in the local unit plan, the person either was covered as a primary participant under subsection (b) or was covered by the health care insurance plan offered by the employee's qualified local unit.

(B) The person is a surviving spouse or dependent of a plan participant who was enrolled as a primary participant or a direct bill participant when the primary participant died, and the person was covered by the health care benefits program as a dependent under subsection (g) when the primary participant died.

(C) The person is a surviving spouse or dependent of a plan participant who was enrolled in the health care insurance plan offered by the participant's qualified local unit when the

participant died, and the person has maintained continuous coverage under the local unit's health care insurance plan before joining the health care benefits program.

(2) The person completes an enrollment form requesting transfer to the direct bill program and submits the form to the health care benefits program. The form shall be submitted no more than 30 days after the person ceased to be eligible for coverage or, ~~in the case of~~ for any individual identified in paragraph (d)(5), no more than 30 days after the first day on which the qualified local unit participates in the local unit plan.

(f) COBRA participants. Any individual with rights to extend coverage under COBRA may participate in the local unit plan, subject to the provisions of that federal law.

(g) Eligible dependent participants.

(1) Any person enrolled in the local unit plan under subsection (b), (d), or (f) as a primary participant may enroll the following dependents, subject to the same conditions and limitations that apply to the primary participant:

(A) The primary participant's lawful wife or husband, as recognized by Kansas law and subject to the documentation requirements of the commission or its designee; and

(B) any of the primary participant's eligible dependent children, subject to the documentation requirements of the commission or its designee.

(2) An eligible dependent child who is enrolled by one primary participant shall not be eligible to be enrolled by another primary participant in the health care benefits program.

(3) An individual who is eligible to enroll as a primary participant in the health care benefits program shall be eligible to be enrolled under this subsection as a dependent in the health care benefits program, subject to the following requirements:

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(A) The individual who enrolls as a dependent of a primary participant shall be the lawful spouse, as defined in paragraph (g)(1)(A).

(B) An individual who enrolls as a dependent of a primary participant shall not be eligible to be enrolled as a primary participant during that plan year.

(C) Each individual who enrolls as a dependent of a primary participant shall be subject to the copays, deductibles, coinsurance, and employer contribution levels as a dependent and not as a primary participant.

(4) The term "dependent" shall exclude any individual who is not a citizen or national of the United States, unless the individual is a resident of the United States or a country contiguous to the United States, is a member of a primary participant's household, and resides with the primary participant for more than six months of the calendar year. The dependent shall be considered to reside with the primary participant even when the dependent is temporarily absent due to special circumstances, including illness, education, business, vacation, and military service.

(h) Direct bill participants; continuous coverage provisions.

(1) Except as otherwise provided in this subsection, each direct bill participant enrolled in the health care benefits program shall maintain continuous coverage in the program or shall lose eligibility to be in the health care benefits program as a direct bill participant.

(2) Any person who discontinued direct bill coverage in the health care benefits program before January 21, 2001 and was not a direct bill participant on that date may return one time to the health care benefits program if the person meets the criteria specified in subsections (d) and (e) and if that person has not previously discontinued and returned to direct bill coverage before

January 21, 2001. (Authorized by K.S.A. ~~2014 Supp.~~ 75-6501 and K.S.A. 75-6510; implementing K.S.A. ~~2014 Supp.~~ 75-6501 and K.S.A. ~~2014 Supp.~~ 75-6508; effective Aug. 30, 2002; amended March 28, 2003; amended Jan. 9, 2004; amended June 18, 2004; amended March 10, 2006; amended July 17, 2009; amended July 16, 2010; amended, T-108-8-16-10, Aug. 16, 2010; amended March 11, 2011; amended Jan. 2, 2015; amended P-_____.)

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Kansas Administrative Regulations

Economic Impact Statement
For the Kansas Division of the Budget

Department of Administration	Tracy Diel	7852963011
Agency	Agency Contact	Contact Phone Number

108-1-1
K.A.R. Number(s)

Submit a hard copy of the proposed rule(s) and regulation(s) and any external documents that the proposed rule(s) and regulation(s) would adopt, along with the following to: Division of the Budget
900 SW Jackson, Room 504-N
Topeka, KS 66612

I. Brief description of the proposed rule(s) and regulation(s).

The proposed change in this regulation eliminates the 30 day waiting period for new employees to be covered by the State Employee Health Plan (SEHP) and makes coverage available from the first day of employment. K.A.R. 108-1-1 would eliminate the waiting period for new state employees.

II. Statement by the agency if the rule(s) and regulation(s) is mandated by the federal government and a statement if approach chosen to address the policy issue is different from that utilized by agencies of contiguous states or the federal government. *(If the approach is different, then include a statement of why the Kansas rule and regulation proposed is different)*

This change is not mandated by the federal government.
Our contiguous states different policies:

- For State of Missouri MCHCP plan, new employees must enroll or waive coverage through the Statewide Employee Benefit Enrollment System (SEBES) **within 31 days of hire date**. Eligibility for coverage begins the first of the month after the hire date. Coverage begins on the first day of the month on or after enrollment is completed.
- The State of Nebraska benefits start on the 1st of the month following a 30 day waiting period. Nebraska State Statute 84-1604 declares the 30 waiting period.
- Oklahoma does not have a specific waiting period for coverage. Coverage for a new employee is effective the first day of the month following their employment date or employer eligibility date. Additional information is at https://omes.ok.gov/content/eligibility.
- For the State of Colorado new employee benefits begin on the first day of the month after the month they were hired.

III. Agency analysis specifically addressing following:

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A. The extent to which the rule(s) and regulation(s) will enhance or restrict business activities and growth;

The proposed regulation change only affects the State of Kansas agencies, Regents institutions, the Legislative and Judicial branches and their covered employees that elect to purchase coverage through the SEHP. This change will enhance recruitment of quality employees by being able to offer health insurance upon employment with the State.

B. The economic effect, including a detailed quantification of implementation and compliance costs, on the specific businesses, sectors, public utility ratepayers, individuals, and local governments that would be affected by the proposed rule and regulation and on the state economy as a whole;

Segal, the health plan actuaries, have stated this change is cost neutral for the State Employee Health Plan (SEHP) as any claims incurred during the initial coverage period would be covered by the premiums paid. Implementation can be accomplished through the SEHP Membership Administrative Portal at no additional cost.

C. Businesses that would be directly affected by the proposed rule and regulation;

K.A.R. 108-1-1 would affect all State entities (state agencies, regent institutions, the judicial and legislative branches) if their new employees elect coverage under the SEHP. insurance coverage.

D. Benefits of the proposed rule(s) and regulation(s) compared to the costs;

The benefit of the change for employees and their covered dependents is immediate access to health insurance coverage from their first day of employment. This would be a positive recruitment tool for the State. This would eliminate the need of new employees having to pay for COBRA continuation coverage or the need to pay for other group health insurance premiums once their employment with the State begins.

E. Measures taken by the agency to minimize the cost and impact of the proposed rule(s) and regulation(s) on business and economic development within the State of Kansas, local government, and individuals;

This change does not affect other business or economic development within the State.

F. An estimate, expressed as a total dollar figure, of the total annual implementation and compliance costs that are reasonably expected to be incurred by or passed along to business, local governments, or members of the public.

$ $293,630.61 State Employer Premiums for KAR 108-1-1

An estimate, expressed as a total dollar figure, of the total implementation and compliance costs that are reasonably expected to be incurred by or passed along to business, local governments, or members of the public.

$$95,122.24 premiums paid by new State employees under KAR 108-1-1

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Do the above total implementation and compliance costs exceed $3.0 million over any two-year period?

YES ☐ NO ☒

Give a detailed statement of the data and methodology used in estimating the above cost estimate.

Cost to the State of Kansas for the first months premium:	Employer	Employee
Number of State Employees hired in 2019 that enrolled in the SEHP medical plan	7,441	7,441
Average monthly medical premium paid by State	$644.16	$191.89
Average monthly dental premium paid by the State	$26.68	$25.43
Average monthly premium for medical & dental premiums paid by the State	$670.84	$217.32
Number of new hires in a year that took medical	7,441	7,441
Average Employer cost	$670.84	$217.32
Estimated Employer Cost resulting from the regulation change before Employment Turnover Credit	$4,991,720.44	$1,617,078.12
Less credit for Employee Turn over		
Job is open and no new employee	7,441	7,441
Assumes 4 weeks to fill after employee leaves employment (4.25 weeks in a month)	94.12%	94.12%
Average Employer cost	$670.84	$217.32
Total Credit for turn over	$4,698,089.83	$1,521,955.88
Net cost to the state for the change to first day of hire coverage		
Estimated Total Employer Cost resulting from the regulation change	$4,991,720.44	$1,617,078.12
Total Credit for turn over (Section 3)	-4,698,089.83	-1,521,955.88
Net Cost to the state	293,630.614	$95,122.24

Prior to the submission or resubmission of the proposed rule(s) and regulation(s), did the agency hold a public hearing if the total implementation and compliance costs exceed $3.0 million over any two-year period to find that the estimated costs have been accurately determined and are necessary for achieving legislative intent? If applicable, document when the public hearing was held, those in attendance, and any pertinent information from the hearing.

YES ☐ NO ☒

G. If the proposed rule(s) and regulation(s) increases or decreases revenues of cities, counties or school districts, or imposes functions or responsibilities on cities, counties or school districts that will increase expenditures or fiscal liability, describe how the state agency consulted with the League of Kansas

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Municipalities, Kansas Association of Counties, and/or the Kansas Association of School Boards.

N/A.

H. Describe how the agency consulted and solicited information from businesses, associations, local governments, state agencies, or institutions and members of the public that may be affected by the proposed rule(s) and regulation(s).

The proposed regulation change was proposed, discussed and approved by the Kansas State Employees Health Care Commission during a public meeting. The Chair of the HCC, the Secretary of Administration proposed this rule change. The entire Commission voted at their public meeting on April 24, 2020 to pursue this change and directed to staff to begin the process to change the regulation.

I. For environmental rule(s) and regulation(s) describe the costs that would likely accrue if the proposed rule(s) and regulation(s) are not adopted, as well as the persons would bear the costs and would be affected by the failure to adopt the rule(s) and regulation(s).

N/A

I. Kansas Administrative Regulations

Economic Impact Statement
For the Kansas Division of the Budget

Department of Administration	Tracy Diel	
Agency	Agency Contact	Contact Phone Number

108-1-3

K.A.R. Number(s)

Submit a hard copy of the proposed rule(s) and regulation(s) and any external documents that the proposed rule(s) and regulation(s) would adopt, along with the following to: Division of the Budget
900 SW Jackson, Room 504-N
Topeka, KS 66612

I. Brief description of the proposed rule(s) and regulation(s).

The proposed change in this regulation eliminates the 30 day waiting period for new employees to be covered by the State Employee Health Plan (SEHP) and makes coverage available from the first day of employment. K.A. R. 108-1-3 would eliminate the waiting period for new employees of school districts covered under the SEHP.

II. Statement by the agency if the rule(s) and regulation(s) is mandated by the federal government and a statement if approach chosen to address the policy issue is different from that utilized by agencies of contiguous states or the federal government. ***(If the approach is different, then include a statement of why the Kansas rule and regulation proposed is different)***

- This change is not mandated by the federal government.

- For State of Missouri MCHCP plan, new employees must enroll or waive coverage through the Statewide Employee Benefit Enrollment System (SEBES) **within 31 days of hire date**. Eligibility for coverage begins the first of the month after the hire date. Coverage begins on the first day of the month on or after enrollment is completed.
- The State of Nebraska benefits start on the 1st of the month following a 30 day waiting period. Nebraska State Statute 84-1604 declares the 30 waiting period.
- Oklahoma does not have a specific waiting period for coverage. Coverage for a new employee is effective the first day of the month following their employment date or employer eligibility date. Additional information is at https://omes.ok.gov/content/eligibility.
- For the State of Colorado new employee benefits begin on the first day of the month after the month they were hired.

III. Agency analysis specifically addressing following:

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A. The extent to which the rule(s) and regulation(s) will enhance or restrict business activities and growth;

The proposed regulation change only affects school districts that have elected to purchase coverage as Non State Public employers through the SEHP. This change will enhance recruitment of quality employees by being able to offer health insurance upon employment with the Non State Public employer.

B. The economic effect, including a detailed quantification of implementation and compliance costs, on the specific businesses, sectors, public utility ratepayers, individuals, and local governments that would be affected by the proposed rule and regulation and on the state economy as a whole;

Segal, the health plan actuaries, have stated this change is cost neutral for the health plan as any claims incurred during the initial coverage period would be covered by the premiums paid. Implementation can be accomplished easily through the SEHP Membership Administrative Portal at no additional cost. Employers and employees would be responsible for paying the premium for the additional month of coverage.

Businesses that would be directly affected by the proposed rule and regulation;

K.A.R. 108-1-3 would affect school districts that have contracted with the State to offer the SEHP coverage to their employees as outlined in K.S.A. 75-6506 and that have been authorized to participate in the SEHP by the Health Care Commission. The group has exercised this option by contracting with the SEHP for their employees' health insurance coverage.

D. Benefits of the proposed rule(s) and regulation(s) compared to the costs;

The benefit of the change is employees and their covered dependents would be able to have health insurance coverage from their first day of employment. This would be a positive recruitment tool for the covered Non State Public Employers. This would potentially eliminate the need of prospective employees to enroll and pay for COBRA continuation coverage or other group health insurance premiums once their employment with the covered employer under the SEHP has begun.

E. Measures taken by the agency to minimize the cost and impact of the proposed rule(s) and regulation(s) on business and economic development within the State of Kansas, local government, and individuals;

This change does not affect other business or economic development within the State.

F. An estimate, expressed as a total dollar figure, of the total annual implementation and compliance costs that are reasonably expected to be incurred by or passed along to business, local governments, or members of the public.

$ 149,725.52

An estimate, expressed as a total dollar figure, of the total implementation and compliance costs that are reasonably expected to be incurred by or passed along to business, local governments, or members of the public.

$42,884.26

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Do the above total implementation and compliance costs exceed $3.0 million over any two-year period?

YES ☐ NO ☒

Give a detailed statement of the data and methodology used in estimating the above cost estimate.

School Districts		
Numbered hired in 2019 by School groups that took medical	167	167
The average medical premium paid by employer for new hire	841.15	229.59
The average dental premium paid by employer for new hire	55.41	27.20
The average Employer cost (Medical and Dental)	896.56	256.79
Estimate cost for the employer for 30 days		
Number of new hires in a year that took medical	167	167
Average Employer cost for a new hire	896.56	256.79
Total cost for 30 days	$149,725.52	$42,884.26

Prior to the submission or resubmission of the proposed rule(s) and regulation(s), did the agency hold a public hearing if the total implementation and compliance costs exceed $3.0 million over any two-year period to find that the estimated costs have been accurately determined and are necessary for achieving legislative intent? If applicable, document when the public hearing was held, those in attendance, and any pertinent information from the hearing.

YES ☐ NO ☒

G. If the proposed rule(s) and regulation(s) increases or decreases revenues of cities, counties or school districts, or imposes functions or responsibilities on cities, counties or school districts that will increase expenditures or fiscal liability, describe how the state agency consulted with the League of Kansas Municipalities, Kansas Association of Counties, and/or the Kansas Association of School Boards.

The proposed regulation change was proposed, discussed and approved by the Kansas State Employees Health Care Commission during a public meeting. The Chair of the HCC, the Secretary of Administration proposed this rule change. Non State Public Employers agree as part of their contract with the State that the Health Care Commissions shall have sole authority to determine the policies and procedures for coverage in the SEHP. The entire Commission voted at their public meeting on April 24, 2020 to pursue this change and directed to staff to begin the process of changing the regulation.

H. Describe how the agency consulted and solicited information from businesses, associations, local governments, state agencies, or institutions and members of the public that may be affected by the proposed rule(s) and regulation(s).

N/A

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I. For environmental rule(s) and regulation(s) describe the costs that would likely accrue if the proposed rule(s) and regulation(s) are not adopted, as well as the persons would bear the costs and would be affected by the failure to adopt the rule(s) and regulation(s).

N/A

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Kansas Administrative Regulations

Economic Impact Statement
For the Kansas Division of the Budget

Department of Administration	Tracy Diel	
Agency	Agency Contact	Contact Phone Number

108-1-4

K.A.R. Number(s)

Submit a hard copy of the proposed rule(s) and regulation(s) and any external documents that the proposed rule(s) and regulation(s) would adopt, along with the following to: Division of the Budget
900 SW Jackson, Room 504-N
Topeka, KS 66612

I. Brief description of the proposed rule(s) and regulation(s).

The proposed change in this regulation eliminates the 30 day waiting period for new employees to be covered by the State Employee Health Plan (SEHP) and makes coverage available from the first day of employment K.A.R. 108-1-4 would eliminate the waiting period for new employees of Non State public employers covered under the SEHP.

II. Statement by the agency if the rule(s) and regulation(s) is mandated by the federal government and a statement if approach chosen to address the policy issue is different from that utilized by agencies of contiguous states or the federal government. ***(If the approach is different, then include a statement of why the Kansas rule and regulation proposed is different)***

- This change is not mandated by the federal government.

- For State of Missouri MCHCP plan, new employees must enroll or waive coverage through the Statewide Employee Benefit Enrollment System (SEBES) **within 31 days of hire date**. Eligibility for coverage begins the first of the month after the hire date. Coverage begins on the first day of the month on or after enrollment is completed.
- The State of Nebraska benefits start on the 1st of the month following a 30 day waiting period. Nebraska State Statute 84-1604 declares the 30 waiting period.
- Oklahoma does not have a specific waiting period for coverage. Coverage for a new employee is effective the first day of the month following their employment date or employer eligibility date. Additional information is at https://omes.ok.gov/content/eligibility.
- For the State of Colorado new employee benefits begin on the first day of the month after the month they were hired.

III. Agency analysis specifically addressing following:

A. The extent to which the rule(s) and regulation(s) will enhance or restrict business activities and growth;

The proposed regulation change only affects Non State Public employers that have elected to purchase coverage as Non State Public employers through the SEHP. This change will enhance recruitment of quality employees by being able to offer health insurance upon employment with the Non State Public employer.

B. The economic effect, including a detailed quantification of implementation and compliance costs, on the specific businesses, sectors, public utility ratepayers, individuals, and local governments that would be affected by the proposed rule and regulation and on the state economy as a whole;

Segal, the health plan actuaries, have stated this change is cost neutral for the health plan as any claims incurred during the initial coverage period would be covered by the premiums paid. Implementation can be accomplished easily through the SEHP Membership Administrative Portal at no additional cost. Employers and employees would be responsible for paying the premium for the additional month of coverage.

C. Businesses that would be directly affected by the proposed rule and regulation;

K.A.R 108-1-4 would affect any eligible Non State Public employer groups as outlined in K.S.A. 75-6506 and that have been authorized to participate in the SEHP by the Health Care Commission, The group has exercised this option by contracting with the SEHP for their employees' health insurance coverage.

D. Benefits of the proposed rule(s) and regulation(s) compared to the costs;

The benefit of the change is employees and their covered dependents would be able to have health insurance coverage from their first day of employment. This would be a positive recruitment tool for the covered Non State Public Employers. This would potentially eliminate the need of prospective employees to enroll and pay for COBRA continuation coverage or other group health insurance premiums once their employment with the covered employer under the SEHP has begun.

E. Measures taken by the agency to minimize the cost and impact of the proposed rule(s) and regulation(s) on business and economic development within the State of Kansas, local government, and individuals;

This change does not affect other business or economic development within the State.

F. An estimate, expressed as a total dollar figure, of the total annual implementation and compliance costs that are reasonably expected to be incurred by or passed along to business, local governments, or members of the public.

$ 365,796.48

An estimate, expressed as a total dollar figure, of the total implementation and compliance costs that are reasonably expected to be incurred by or passed along to business, local governments, or members of the public.

$104,771.13

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Do the above total implementation and compliance costs exceed $3.0 million over any two-year period?

YES ☐ NO ☒

Give a detailed statement of the data and methodology used in estimating the above cost estimate.

Non State Public Employer		
Number of employees hired in 2019 by a Non State Public Employer that took medical	408	408
The average medical premium paid by employer for new hire	841.15	229.59
The average dental premium paid by employer for new hire	55.41	27.20
The average Employer cost (Medical and Dental)	896.56	256.79
Estimate cost for the employer for 30 days		
Number of new hires in a year that took medical	408	408
Average Employer cost for a new hire	896.56	256.79
Total cost for 30 days	$365,796.48	$104,771.13

Prior to the submission or resubmission of the proposed rule(s) and regulation(s), did the agency hold a public hearing if the total implementation and compliance costs exceed $3.0 million over any two-year period to find that the estimated costs have been accurately determined and are necessary for achieving legislative intent? If applicable, document when the public hearing was held, those in attendance, and any pertinent information from the hearing.

YES ☐ NO ☒

G. If the proposed rule(s) and regulation(s) increases or decreases revenues of cities, counties or school districts, or imposes functions or responsibilities on cities, counties or school districts that will increase expenditures or fiscal liability, describe how the state agency consulted with the League of Kansas Municipalities, Kansas Association of Counties, and/or the Kansas Association of School Boards.

The proposed regulation change was proposed, discussed and approved by the Kansas State Employees Health Care Commission during a public meeting. The Chair of the HCC, the Secretary of Administration proposed this rule change. Non State Public Employers agree as part of their contract with the State that the Health Care Commissions shall have sole authority to determine the policies and procedures for coverage in the SEHP. The entire Commission voted at their public meeting on April 24, 2020 to pursue this change and directed to staff to begin the process.

H. Describe how the agency consulted and solicited information from businesses, associations, local governments, state agencies, or institutions and members of the public that may be affected by the proposed rule(s) and regulation(s).

N/A

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I. For environmental rule(s) and regulation(s) describe the costs that would likely accrue if the proposed rule(s) and regulation(s) are not adopted, as well as the persons would bear the costs and would be affected by the failure to adopt the rule(s) and regulation(s).

N/A

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DIVISION OF THE BUDGET

Agenda Item #3

2727 Paces Ferry Road SE,
Building One, Suite 1400
Atlanta, GA 30339-4053
segalco.com

October 11, 2021

Ms. Janet Stanek
Director – State Employee Health Benefit Plan
Kansas Department of Health and Environment
Room 900-N
Landon State Office Building
Topeka, Kansas 66612

Re: Projection Summary – October 2021

Dear Ms. Stanek:

Segal Consulting ("Segal") was selected to be the Consultant and Actuary for the State Employees Health Benefit Program ("Program"). For each projection update, Segal provides a thorough analysis of the Program's financial position, including a detailed 4-year projection. This letter provides a summary of the financial updates with data through September of 2021 and key assumptions included in the projections.

Experience: January 2021 to September 2021

For the update, Segal collected the actual experience and compared it to what was projected in our initial budget. Because the projection is developed monthly, we are able to summarize the emerging experience and analyze the gain/(loss). For this update, the Program is running at a **YTD loss of $4.4M** for Calendar Year 2021. The loss grew $2.4M from last report after incorporating August and September actual results. The loss in August, driven by medical claims, outpaced the gain from September. Thru September, the Rx claims continue to show the largest deviation – a loss of $3.4M.

January 2021 to September 2021 – YTD Financials (in Millions)				
	Budgeted	**Actual**	**Gain/(Loss) $**	**Gain/(Loss) %**
Program Revenue	$361.4	$361.5	$0.1	0.0%
Medical self-insured claims*	$232.4	$234.9	$(2.5)	(1.1)%
Rx self-insured claims	$54.6	$58.0	$(3.4)	(6.2)%
Dental self-insured claims	$21.4	$19.8	$1.6	7.5%
ASO/Premium	$31.1	$31.4	$(0.3)	(1.0)%
Contract Fees/Other	$10.8	$10.8	$0	0.0%
Program Expenses	$350.3	$354.9	$(4.6)	(1.3)%
Net Income/(Loss)	$11.1	$6.6		
Reserve Balance	$80.1	$75.7	$(4.4)	
* Includes Self-Insured Claims, Health Savings and Health Reimbursement Contributions				
** Total may not fully reconcile due to some intermediate values shown rounded to 1 decimal.				

Enrollment

The YTD enrollment declined 1.0%. The following table summarizes the projected vs. actual enrollment through July. The reduced headcount does have a direct correlation to revenue and expenses; however the net impact is negligible.

Enrollment Monthly Avg.	Projected	Actual	Change in #	Change in %
Active & COBRA	37,345	36,996	(349)	-0.9%
Non-Medicare Retiree	405	382	(23)	-5.7%
Medicare Members	8,709	8,621	(88)	-1.0%
Total	46,459	45,999	(460)	-1.0%

* Totals may not fully reconcile due to some intermediate values shown rounded to the digit.

The following table shows a snapshot of the month October 2021 enrollment. This serves as the basis for future enrollment assumptions for 2021. We assume members from Plan Q migrate to Plan J starting in 2022 until actual enrollment becomes available. The financial impact is insignificant.

Contracts (October-2021)				
	Active	COBRA	Non-Medicare Retiree	Medicare Retiree
Medical				
Plan A	16,382	227	115	
Plan C	15,621	181	198	
Plan J	710	2	5	
Plan N	2,951	29	22	
Plan Q	484	2	19	
Medicare				
Aetna (MA)				821
Plan C/C Select (Supp)				7,093
Plan G/G Select (Supp)				436
Plan N (Supp)				219
Medical Total	36,148	441	359	8,569
Contracts (October-2021)				
	Active	COBRA	Non-Medicare Retiree	Medicare Retiree
Dental Total	35,722	389	627	8,084
Vision Total	30,161	341	618	4,979

Multi-Year Projection Summary

The following table summarizes the projected revenue, expense and employer/employee funding for the Program. Each update will project the year we are in, now CY 2021, and four (4) additional calendar years.

Financial Projections (in Millions) – as of September 30, 2021						
	CY 2020	**CY 2021**	**CY 2022**	**CY 2023**	**CY 2024**	**CY 2025**
Program Revenue	$482.6	$481.1	$491.5	$523.0	$561.4	$602.6
*Medical self-insured claims**	$300.9	$326.4	$334.4	$352.2	$370.0	$388.8
Rx self-Insured claims	$75.8	$81.6	$82.5	$89.6	$97.2	$105.5
Dental self-Insured claims	$22.8	$27.1	$27.8	$28.7	$29.5	$30.4
ASO/Premium	$41.8	$41.5	$42.5	$44.3	$46.2	$48.3
Contract Fees/Other	$13.8	$13.8	$13.6	$13.8	$14.0	$14.2
Program Expenses	$455.1	$490.5	$500.8	$528.6	$557.0	$587.2
Net Income/(Loss)	$27.5	$(9.3)	$(9.3)	$(5.6)	$4.4	$15.4
Reserve Balance	$69.0	$59.7	$50.4	$44.8	$49.2	$64.5
* Includes Self-Insured Claims, Health Savings and Health Reimbursement Contributions						
** Total may not fully reconcile due to some intermediate values shown rounded to 1 decimal.						

The emerging experience impacted the per capita amounts used as the basis of the projection in the follow manner:

Medical – none
Pharmacy – increase
Dental – decrease

The combined impact is minimal. Segal projects CY 2021 to end with a **reserve balance of $59.7M**, $4.9M lower than the $64.6M initial budget estimate. Furthermore, the future projected reserve balances remained comparable to those in the August report.

The plan design and funding changes approved at the June HCC meeting are incorporated in the projections above. Renewal fees for Marathon program were incorporated in the projection. The new fees are 15% lower than prior projection and effective on January 1, 2022.

The 2020 experience for medical and dental claims were significantly impacted by Covid-19. We continue adjusting the baseline claims data accordingly to prevent skewing of the future projections above. Another adjustment to the future projection is reducing CY 2021 and CY 2022 pharmacy self-insured claims to reflect the latest RFP savings shown in the assumption section.

One other assumption is the number of weekly claims payments for a given year. Most often there are 52 payments for medical and dental, however CY 2021 has 53 payments. This is reflected in the table above.

Funding and Reserves

The program has two reserves that in aggregate represent the Target Reserve Balance. The IBNR is calculated by applying 7.5% to the self-insured claims. An IBNR reserve is money set aside for the liability of outstanding self-insured claims yet to be paid. Claims fluctuation reserve is calculated by applying 5.5% to the self-insured claims. Self-Insured claims are volatile in nature so this reserve helps to provide stability against adverse claims experience. This helps give the client flexibility when making decisions regarding funding increases. Both reserves and their proportions relative to claims are common among Segal's client base.

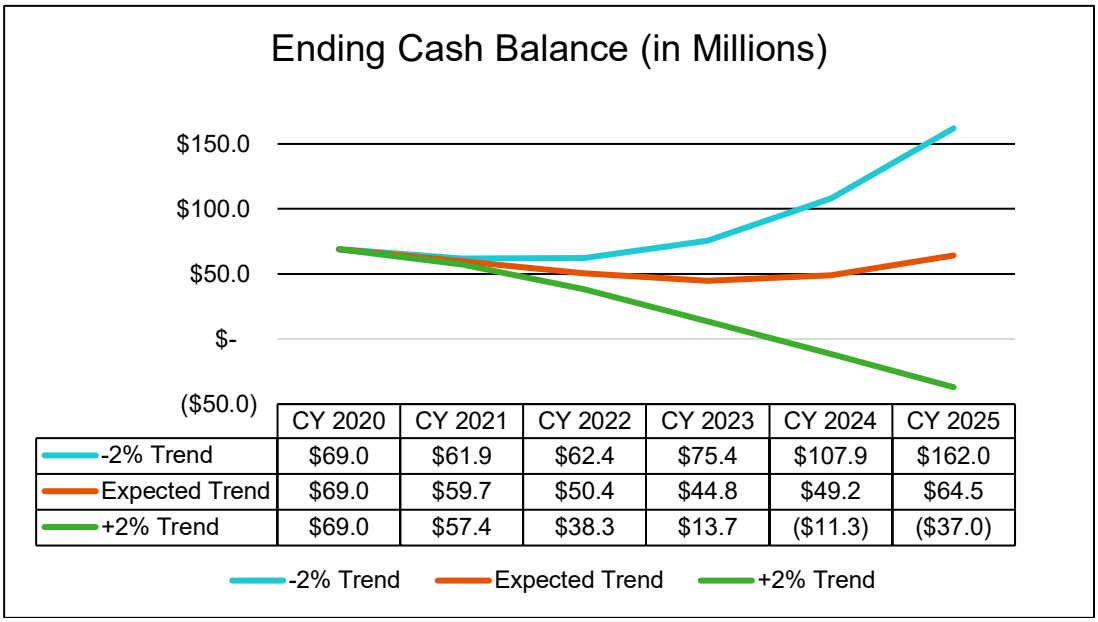
The future funding increases are shown below. Under the current financial conditions and with various benefit changes adopted in June HCC meeting, an annual increase of 7.6% is needed to maintain the Target Reserve. The funding for the program is provided by the employee and employer. The employee funding is effective January 1st each year and the employer funding is effective July 1st each year. Thus, the 7.6% increase shown in 2025 represents the employer contribution between 7/1/2025-6/30/2026, while the employee funding would be 1/1/2025-12/31/2025. This increased from 7.5%, as shown in the August 2021 report.

See the table below for the Target Reserve Balance and funding amounts:

Medical & Rx Benefit Funding in CY 2021-2025 (in Millions)					
	2021	2022	2023	2024	2025
Total Medical, Rx and Dental self-insured claims	$406.0	$416.5	$442.2	$468.5	$496.5
IBNR Claim Reserve (7.5% of self-insured claims)	$30.5	$31.2	$33.2	$35.1	$37.2
Claim Fluctuation Reserve (5.5% of self-insured claims)	$22.3	$22.9	$24.3	$25.8	$27.3
Total Target Reserves	$52.8	$54.1	$57.5	$60.9	$64.5
Reserve Balance	$59.7	$50.4	$44.8	$49.2	$64.5
Fund Balance vs. Target Surplus/(Shortfall)	$6.9	$ (3.7)	$ (12.7)	$ (11.7)	$0
Funding Rate Increase					
Employer	3.0%	5.0%	7.6%	7.6%	7.6%
Employee*	0.0%	0.0%	7.6%	7.6%	7.6%
* Spouse tier and retiree funding is -2.0% for 2021 and spouse tier is -2% for 2022					

Sensitivity Analysis

Trend is one of the most important assumptions in the projection. The following table illustrates the impact on the funds Cash Balance if trend (Medical, Pharmacy, and Dental) is 2% higher or lower than assumed:



	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
-2% Trend	$69.0	$61.9	$62.4	$75.4	$107.9	$162.0
Expected Trend	$69.0	$59.7	$50.4	$44.8	$49.2	$64.5
+2% Trend	$69.0	$57.4	$38.3	$13.7	($11.3)	($37.0)

This analysis illustrates the importance of having a reserve. If trend is 2% higher than the assumptions from 2021-2025, the cash balance will decrease to -$37.0M at the end of CY 2025, assuming the current proposed funding increases of 7.6% remain intact. In order to make up this shortfall, a funding increase of approximately 21.4% in 2026 and 2027 is necessary. This increase will allow the Reserve Balance to grow and meet the target reserve at the end of CY 2027.

Alternatively, a lower trend of 2% would provide a significant surplus and would allow lower future rate increases to balance to the target reserve.

Key Assumptions & Methodology

Claim Trends

Trend assumptions are utilized to project the annual increase in per member costs. We develop these by integrating the Program's historical performance with Segal's Annual Trend Survey. They are updated annually and reviewed with the Program. Current trend assumptions are as follows:

- Medical Self-Insured Claims: 5.5% for all years
- Pharmacy Self-Insured Claims: 8.5% for all years
- Dental Self-Insured Claims: 3.0% for all years

- Medicare Premium: Renewal for 2021 and 6.0% trend for all future years

COVID-19 Impact

The COVID-19 pandemic caused members to delay or avoid medical and dental care. This impact was initially exhibited in March-May incurred claims, and more recently in November. Adjustments were applied to the baseline Medical and Dental claims in order to normalize the baseline experience used to project future claims.

Enrollment

From current levels, no overall population growth and no plan migration are assumed.

Baseline Self-Insured Claims Cost

Baseline claims rates for both medical and pharmacy follow a similar methodology, summarized below:

- Medical claims cost is developed based on expected cost per member per month (PMPM), and accounts for some months having 5 payment weeks rather than 4. The cost is developed based on medical claims paid in the experience period and 2-month lagged enrollment data. The PMPM is adjusted to reflect historical plan changes, enrollment migration, and any known experience since the end of the data period.
- Pharmacy claims cost is developed based on expected cost per member per month (PMPM). The cost is developed based on pharmacy claims paid in the experience period with 1-month lagged enrollment data. The PMPM is adjusted to reflect historical plan changes, enrollment migration, and any known experience since the end of the data period.
- Dental claims cost is developed based on expected cost per member per month (PMPM), and accounts for some months having 5 payment weeks rather than 4. The cost is developed based on medical claims paid during the experience period with 2-month lagged enrollment data. The PMPM is adjusted to reflect historical plan changes, and any known experience since the end of the data period.
- Both Medical and Rx costs are subdivided by each plan (Plan A, C, J, N and Q) and by group (Active and Non-Medicare Retiree). Plan Q is terminated effective January 1, 2022.

Baseline claims costs are then trended and multiplied by expected enrollments and particulars for each month, populating the cash flow projection.

Prepayments

Certain university members prepay their June-Aug benefit in March-May. The prepayment of $2M per month were estimated based on prepay participants.

Adjustments from RFPs

Rx claims for 2021/2022 is adjusted to account for the expected savings of $14M/$19M yielding from improved contracts terms presented during RFP.

Funding Rates

The funding rates and member contributions for 2022 were approved by the HCC in June 2021. Future funding are set at the rate that Reserve Balance is equal to the Target Reserve at the end of 2025.

Program Actuarial Values

The Actuarial Value of the plans are used to subdivide Medical and Pharmacy cost into Plan A, C, J, N and Q. Actuarial Value of the plans were updated using the latest Optum Pricing Model and are shown in the following table.

Plan Values (without HSA/HRA funding)					
	Plan A	Plan C	Plan J	Plan N	Plan Q
2021 Plan Actuarial Value	78.2%	73.4%	78.7%	68.6%	73.5%
2022 Plan Actuarial Value	80.0%	74.7%	79.0%	68.7%	

Contract Fees

The Program provided fees for each contract fees that are consistent with their budgets. Segal received contract fees Calendar Year 2021 from the Program. Per contract costs were developed and are assumed to increase 2% annually.

Segal fees are paid from a separate fund that is used to pay for administrative costs not included in our projection. The amount paid in 2021 is $233,100 through September.

ASO Fees

The Program provided per contract BCBS, Aetna, and Delta ASO fees and per prescription Caremark ASO fees for year 2021. Caremark per prescription fees were converted to per contract fees. Per contract fees are assumed to increase 2% annually.

PCORI

ACA Reinsurance is provided by the Program. The annual fee is a nominal amount and is included with the “Contract Fees”

Wellness Participation

- HSA/HRA Rewards: 50% for 2021-2025.
- Premium Discount: 65% for 2021 and 50% for 2022-2025

Other Assumptions

There are a few other assumptions that have less impact on the plan financials that are detailed below for completeness:

- Investment Earnings are estimated at 0.05% of the annual cash balance
- Coverage Tier Factor: Factors are reviewed periodically. Current factors were developed based on 2016-2017 experience.
  - Medical Plan A: 1.00/2.11/1.57/3.15 for Employee Only/Employee + Spouse/Employee + Child(ren)/Employee + Family
  - Medical Plan C-Q: 1.00/2.11/1.57/3.15 for Employee Only/Employee + Spouse/Employee + Child(ren)/Employee + Family
  - Dental: 1.00/2.10/2.44/3. 58 for Employee Only/Employee + Spouse/Employee + Child(ren)/Employee + Family
- Reserve Percentage:
  - IBNR Self-Insured Claims Reserve is 7.5% of Medical, Rx and Dental claims
  - Self-Insured Claims Fluctuation Reserve is 5.5% of Medical, Rx and Dental claims

Certification

The projections in this report are estimates of future costs and are based on unaudited information available to Segal consulting at the time the projections were made. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, changes in group demographics, overall inflation rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period is extended.

By signing below, I certify that I am a qualified actuary by education and experience to evaluate health reserves and funding practices. I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and certify that all analysis was conducted in accordance with all applicable Actuarial Standards of Practice. All sections of this report are considered an integral part of the actuarial opinion.

Kenneth C. Vieira, FSA, FCA, MAAA
Senior Vice President

Patrick Klein, FSA, MAAA
Vice President

Kansas State Employees Health Care Commission
Mutli Year Projection
Assumption Summary

Trend Assumptions	2020	2021	2022	2023	2024	2025
Interest Rate on Fund Balance	0.05%	0.05%	0.05%	0.05%	0.05%	0.05%
Admin/Contract Fee Trend/Vision Trend	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Medical claim trend rate	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%
Prescription drug claim trend rate	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Dental claim trend rate	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Medicare Advantage trend rate	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%
Funding Rate Assumptions						
Medical						
Employer % Change (eff. July 1)				☑	☑	☑
Employee	4.5%	3.0%	5.0%	7.6%	7.6%	7.6%
Employee + Spouse	4.5%	3.0%	5.0%	7.6%	7.6%	7.6%
Employee + Child(ren)	4.5%	3.0%	5.0%	7.6%	7.6%	7.6%
Employee + Family	4.5%	3.0%	5.0%	7.6%	7.6%	7.6%
Employee % Change (fee. Jan 1)				☑	☑	☑
Employee	0.0%	0.0%	0.0%	7.6%	7.6%	7.6%
Employee + Spouse	-6.0%	-2.0%	-2.0%	7.6%	7.6%	7.6%
Employee + Child(ren)	0.0%	0.0%	0.0%	7.6%	7.6%	7.6%
Employee + Family	-6.0%	-2.0%	-2.0%	7.6%	7.6%	7.6%
Non-Medicare Retiree Contrib % Change (eff. Jan 1)						
Employee	-6.0%	-2.0%	0.0%	7.6%	7.6%	7.6%
Employee + Spouse	-6.0%	-2.0%	-2.0%	7.6%	7.6%	7.6%
Employee + Child(ren)	-6.0%	-2.0%	0.0%	7.6%	7.6%	7.6%
Employee + Family	-6.0%	-2.0%	-2.0%	7.6%	7.6%	7.6%
Dental						
Employer % increase (eff. July 1)	3.2%	3.3%	3.3%	3.3%	3.3%	3.3%
Employee tier contribution % (eff. Jan 1)	3.2%	3.3%	3.3%	3.3%	3.3%	3.3%
Dependent tier contribution % (eff. Jan 1)	3.2%	3.3%	3.3%	3.3%	3.3%	3.3%
Wellness Assumptions						
Earned HSA/HRA Contribution ($500/$1,000)	65%	50%	50%	50%	50%	50%
Wellness Contribution Credit $40 per month	50%	65%	50%	50%	50%	50%
Current Reserve Targets						
IBNR Claim Reserve (% of claims)	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
Claim Fluctuation Reserve (% of claims)	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%

Kansas State Employees Health Care Commission
2021 Variance Report
Budget vs. Actual

	Jan-2021			Feb-2021			Mar-2021		
	Initial Budget	Actual	$ Difference	Initial Budget	Actual	$ Difference	Initial Budget	Actual	$ Difference
Revenue									
State ER	28,744,403	28,733,664	(10,739)	23,647,629	23,714,813	67,184	25,601,915	25,617,711	15,796
State EE	6,157,161	6,328,100	170,938	6,157,161	6,325,625	168,464	6,758,056	6,927,834	169,777
Non-State ER	4,147,621	4,076,201	(71,420)	4,147,621	3,988,817	(158,804)	4,147,621	4,040,496	(107,125)
Non-State EE	883,154	969,645	86,491	883,154	992,863	109,709	883,154	961,759	78,605
Direct Bill	2,718,167	2,533,497	(184,670)	2,718,167	3,304,012	585,845	2,718,167	2,750,806	32,639
COBRA	299,802	564,425	264,623	299,802	291,966	(7,835)	299,802	310,332	10,530
Voluntary Benefit	300,000	318,396	18,396	300,000	329,161	29,161	300,000	349,147	49,147
Interest/Other	2,876	163,637	160,761	2,876	25,785	22,909	2,876	14,617	11,741
Total	**43,253,184**	**43,687,565**	**434,381**	**38,156,410**	**38,973,043**	**816,633**	**40,711,591**	**40,972,701**	**261,110**
Expenses									
Medical Claims	28,224,565	29,725,597	1,501,031	20,045,819	19,518,449	(527,371)	18,718,241	18,680,292	(37,949)
Rx Claims	6,483,960	6,678,443	194,483	5,706,022	5,698,280	(7,742)	5,164,462	5,901,241	736,779
Dental Claims	2,711,699	2,546,137	(165,562)	2,173,541	2,055,366	(118,175)	2,185,707	1,995,447	(190,260)
Health Savings ER	5,248,454	5,229,271	(19,183)	890,107	817,955	(72,152)	918,508	808,873	(109,636)
ASO/Premium	3,460,586	3,366,860	(93,726)	3,460,586	3,546,961	86,375	3,460,586	3,469,248	8,662
Voluntary Benefit	300,000	318,396	18,396	300,000	329,161	29,161	300,000	349,147	49,147
Onsite Clinic (Marathon)	200,000	181,300	(18,700)	200,000	18,995	(181,005)	200,000	180,159	(19,841)
Other Contract Fees/Flex	443,667	358,847	(84,819)	443,667	784,231	340,564	1,828,169	559,691	(1,268,478)
PCORI	-	-	-	-	-	-	-	-	-
Total	**47,072,931**	**48,404,853**	**1,331,921**	**33,219,742**	**32,769,398**	**(450,344)**	**32,775,674**	**31,944,098**	**(831,576)**
Net Cash Flow	**(3,819,747)**	**(4,717,288)**	**(897,541)**	**4,936,667**	**6,203,645**	**1,266,977**	**7,935,916**	**9,028,603**	**1,092,687**
Beginning Balance	69,021,173	69,021,173	-	65,201,426	64,303,885	(897,541)	70,138,093	70,507,530	369,437
Ending Balance	65,201,426	64,303,885	(897,541)	70,138,093	70,507,530	369,437	78,074,010	79,536,133	1,462,124
Enrollment (Subscriber)									
Active	37,002	37,002	-	37,002	36,901	(101)	37,002	36,898	(104)
COBRA	343	343	-	343	379	36	343	390	47
Non-Medicare Retiree	405	405	-	405	402	(3)	405	395	(10)
Medicare Retiree	8,709	8,709	-	8,709	8,667	(42)	8,709	8,638	(71)
Total	46,459	46,459	-	46,459	46,349	(110)	46,459	46,321	(138)
Revenue PEPM	931	940	9	821	841	20	876	885	8
Expenses PEPM	1,013	1,042	29	715	707	(8)	705	690	(16)

** Segal fees are paid out of a separate fund and total $233,100 through September. Note this fund is used to pay for administrative costs not included in our projection.*

Kansas State Employees Health Care Commission
2021 Variance Report
Budget vs. Actual

	Apr-2021			May-2021			Jun-2021		
	Initial Budget	Actual	$ Difference	Initial Budget	Actual	$ Difference	Initial Budget	Actual	$ Difference
Revenue									
State ER	30,698,689	30,667,989	(30,700)	25,601,915	25,561,270	(40,645)	21,693,343	21,546,172	(147,172)
State EE	6,758,056	6,915,377	157,320	6,758,056	7,049,437	291,381	5,556,266	5,640,965	84,699
Non-State ER	4,147,621	4,072,145	(75,477)	4,147,621	4,042,777	(104,844)	4,147,621	4,062,458	(85,163)
Non-State EE	883,154	969,650	86,496	883,154	976,785	93,631	883,154	963,858	80,704
Direct Bill	2,718,167	2,744,757	26,590	2,718,167	2,725,067	6,900	2,718,167	2,708,520	(9,647)
COBRA	299,802	298,143	(1,659)	299,802	308,260	8,459	299,802	298,911	(891)
Voluntary Benefit	300,000	349,341	49,341	300,000	183,463	(116,537)	300,000	324,588	24,588
Interest/Other	2,876	9,451	6,575	2,876	7,275	4,399	2,876	12,448	9,572
Total	**45,808,365**	**46,026,852**	**218,487**	**40,711,591**	**40,854,335**	**142,744**	**35,601,229**	**35,557,919**	**(43,310)**
Expenses									
Medical Claims	27,788,717	26,327,720	(1,460,997)	19,544,439	19,651,794	107,355	19,705,573	20,941,237	1,235,664
Rx Claims	5,564,076	7,061,874	1,497,798	5,965,453	5,498,609	(466,844)	5,711,374	6,571,089	859,715
Dental Claims	2,738,872	2,625,735	(113,137)	2,196,501	2,083,765	(112,736)	2,201,919	2,084,833	(117,086)
Health Savings ER	5,930,079	6,171,461	241,382	833,305	1,325,855	492,549	804,904	716,341	(88,563)
ASO/Premium	3,460,586	3,496,322	35,736	3,460,586	3,480,825	20,239	3,460,586	3,534,034	73,447
Voluntary Benefit	300,000	349,341	49,341	300,000	183,463	(116,537)	300,000	324,588	24,588
Onsite Clinic (Marathon)	200,000	180,606	(19,394)	200,000	189,668	(10,332)	200,000	186,529	(13,471)
Other Contract Fees/Flex	891,410	1,640,308	748,898	443,667	847,403	403,736	711,468	461,990	(249,479)
PCORI	-	-	-	-	-	-	-	-	-
Total	**46,873,740**	**47,853,367**	**979,627**	**32,943,951**	**33,261,381**	**317,430**	**33,095,825**	**34,820,639**	**1,724,815**
Net Cash Flow	**(1,065,375)**	**(1,826,515)**	**(761,140)**	**7,767,639**	**7,592,953**	**(174,686)**	**2,505,404**	**737,280**	**(1,768,125)**
Beginning Balance	78,074,010	79,536,133	1,462,124	77,008,635	77,709,618	700,983	84,776,274	85,302,571	526,297
Ending Balance	77,008,635	77,709,618	700,983	84,776,274	85,302,571	526,297	87,281,679	86,039,851	(1,241,827)
Enrollment (Subscriber)									
Active	37,002	36,884	(118)	37,002	36,762	(240)	37,002	36,562	(440)
COBRA	343	387	44	343	394	51	343	395	52
Non-Medicare Retiree	405	386	(19)	405	375	(30)	405	363	(42)
Medicare Retiree	8,709	8,617	(92)	8,709	8,596	(113)	8,709	8,592	(117)
Total	46,459	46,274	(185)	46,459	46,127	(332)	46,459	45,912	(547)
Revenue PEPM	986	995	9	876	886	9	766	774	8
Expenses PEPM	1,009	1,034	25	709	721	12	712	758	46

Kansas State Employees Health Care Commission
2021 Variance Report
Budget vs. Actual

	Jul-2021			Aug-2021			Sep-2021		
	Initial Budget	Actual	$ Difference	Initial Budget	Actual	$ Difference	Initial Budget	Actual	$ Difference
Revenue									
State ER	27,559,809	26,850,343	(709,466)	22,463,035	21,969,951	(493,083)	24,417,320	23,790,053	(627,267)
State EE	5,556,266	5,450,190	(106,076)	5,556,266	5,592,644	36,377	6,157,161	6,184,655	27,494
Non-State ER	4,274,872	4,186,588	(88,283)	4,274,872	4,201,241	(73,631)	4,274,872	4,155,989	(118,883)
Non-State EE	883,154	951,715	68,561	883,154	967,092	83,938	883,154	962,833	79,679
Direct Bill	2,718,167	2,725,491	7,324	2,718,167	2,714,111	(4,056)	2,718,167	2,703,088	(15,079)
COBRA	299,802	315,900	16,098	299,802	314,797	14,995	299,802	315,390	15,588
Voluntary Benefit	300,000	439,098	139,098	300,000	300,740	740	300,000	327,560	27,560
Interest/Other	2,876	5,077	2,201	2,876	15,686	12,810	2,876	5,102	2,226
Total	**41,594,945**	**40,924,402**	**(670,543)**	**36,498,171**	**36,076,262**	**(421,910)**	**39,053,352**	**38,444,669**	**(608,683)**
Expenses									
Medical Claims	28,583,731	28,759,223	175,493	23,386,807	25,609,458	2,222,651	24,620,717	23,618,420	(1,002,297)
Rx Claims	5,862,660	6,386,441	523,781	6,698,304	6,614,302	(84,002)	7,425,480	7,610,188	184,708
Dental Claims	2,759,186	2,499,847	(259,339)	2,212,793	2,082,732	(130,061)	2,218,250	1,815,651	(402,599)
Health Savings ER	5,816,475	5,798,870	(17,605)	691,300	570,028	(121,272)	662,899	632,517	(30,381)
ASO/Premium	3,460,586	3,565,821	105,235	3,460,586	3,513,813	53,227	3,460,586	3,401,921	(58,665)
Voluntary Benefit	300,000	439,098	139,098	300,000	300,740	740	300,000	327,560	27,560
Onsite Clinic (Marathon)	200,000	189,518	(10,482)	200,000	210,173	10,173	200,000	187,847	(12,153)
Other Contract Fees/Flex	443,667	600,862	157,195	443,667	388,305	(55,362)	443,667	528,638	84,972
PCORI	163,699	164,593	894	-	-	-	-	-	-
Total	**47,590,004**	**48,404,273**	**814,269**	**37,393,457**	**39,289,551**	**1,896,094**	**39,331,599**	**38,122,743**	**(1,208,856)**
Net Cash Flow	**(5,995,059)**	**(7,479,871)**	**(1,484,813)**	**(895,285)**	**(3,213,289)**	**(2,318,004)**	**(278,247)**	**321,926**	**600,173**
Beginning Balance	87,281,679	86,039,851	(1,241,827)	81,286,620	78,559,980	(2,726,640)	80,391,335	75,346,690	(5,044,644)
Ending Balance	81,286,620	78,559,980	(2,726,640)	80,391,335	75,346,690	(5,044,644)	80,113,088	75,668,616	(4,444,471)
Enrollment (Subscriber)									
Active	37,002	36,239	(763)	37,002	36,180	(822)	37,002	35,991	(1,011)
COBRA	343	387	44	343	429	86	343	439	96
Non-Medicare Retiree	405	382	(23)	405	372	(33)	405	359	(46)
Medicare Retiree	8,709	8,598	(111)	8,709	8,585	(124)	8,709	8,586	(123)
Total	46,459	45,606	(853)	46,459	45,566	(893)	46,459	45,375	(1,084)
Revenue PEPM	895	897	2	786	792	6	841	847	7
Expenses PEPM	1,024	1,061	37	805	862	57	847	840	(6)

Kansas State Employees Health Care Commission
2021 Variance Report
Budget vs. Actual

	Oct-2021			Nov-2021			Dec-2021		
	Initial Budget	Budget	$ Difference	Initial Budget	Budget	$ Difference	Initial Budget	Budget	$ Difference
Revenue									
State ER	29,514,094	28,699,540	(814,554)	24,417,320	23,756,385	(660,936)	24,417,320	23,756,385	(660,936)
State EE	6,157,161	5,991,624	(165,538)	6,157,161	5,991,624	(165,538)	6,157,161	5,991,624	(165,538)
Non-State ER	4,274,872	4,281,394	6,522	4,274,872	4,281,394	6,522	4,274,872	4,281,394	6,522
Non-State EE	883,154	878,898	(4,256)	883,154	878,898	(4,256)	883,154	878,898	(4,256)
Direct Bill	2,718,167	2,631,897	(86,270)	2,718,167	2,631,897	(86,270)	2,718,167	2,631,897	(86,270)
COBRA	299,802	383,084	83,282	299,802	383,084	83,282	299,802	383,084	83,282
Voluntary Benefit	300,000	300,000	-	300,000	300,000	-	300,000	300,000	-
Interest/Other	2,876	2,876	-	2,876	2,876	-	2,876	2,876	-
Total	**44,150,126**	**43,169,312**	**(980,814)**	**39,053,352**	**38,226,156**	**(827,196)**	**39,053,352**	**38,226,156**	**(827,196)**
Expenses									
Medical Claims	29,726,628	29,321,172	(405,456)	25,602,480	25,138,156	(464,324)	30,446,575	29,985,346	(461,229)
Rx Claims	7,514,833	7,523,337	8,504	8,020,730	8,029,807	9,077	8,020,927	8,030,004	9,077
Dental Claims	2,779,652	2,626,432	(153,220)	2,229,206	2,097,215	(131,991)	2,793,379	2,633,943	(159,436)
Health Savings ER	5,731,272	5,564,781	(166,491)	719,701	704,644	(15,057)	776,503	759,990	(16,514)
ASO/Premium	3,460,586	3,390,398	(70,188)	3,460,586	3,390,398	(70,188)	3,460,586	3,390,398	(70,188)
Voluntary Benefit	300,000	300,000	-	300,000	300,000	-	300,000	300,000	-
Onsite Clinic (Marathon)	200,000	200,000	-	200,000	200,000	-	200,000	200,000	-
Other Contract Fees/Flex	443,667	443,667	-	643,619	643,619	-	443,667	443,667	-
PCORI	-	-	-	-	-	-	-	-	-
Total	**50,156,637**	**49,369,787**	**(786,850)**	**41,176,321**	**40,503,838**	**(672,483)**	**46,441,637**	**45,743,348**	**(698,289)**
Net Cash Flow	**(6,006,511)**	**(6,200,475)**	**(193,964)**	**(2,122,969)**	**(2,277,682)**	**(154,713)**	**(7,388,285)**	**(7,517,191)**	**(128,906)**
Beginning Balance	80,113,088	75,668,616	(4,444,472)	74,106,577	69,468,142	(4,638,436)	71,983,608	67,190,460	(4,793,149)
Ending Balance	74,106,577	69,468,142	(4,638,436)	71,983,608	67,190,460	(4,793,149)	64,595,323	59,673,268	(4,922,055)
Enrollment (Subscriber)									
Active	37,002	36,148	(854)	37,002	36,148	(854)	37,002	36,148	(854)
COBRA	343	441	98	343	441	98	343	441	98
Non-Medicare Retiree	405	359	(46)	405	359	(46)	405	359	(46)
Medicare Retiree	8,709	8,569	(140)	8,709	8,569	(140)	8,709	8,569	(140)
Total	46,459	45,517	(942)	46,459	45,517	(942)	46,459	45,517	(942)
Revenue PEPM	950	948	(2)	841	840	(1)	841	840	(1)
Expenses PEPM	1,080	1,085	5	886	890	4	1,000	1,005	5

Kansas State Employees Health Care Commission
2021 Variance Report
Budget vs. Actual

	Jan-2021 - Sep-2021			Jan-Dec 2021			
	Initial Budget	Actual	$ Difference	Initial Budget	Actual/Budget	$ Difference	% Difference
Revenue							
State ER	230,428,058	228,451,966	(1,976,092)	308,776,794	304,664,276	(4,112,517)	-1.3%
State EE	55,414,452	56,414,826	1,000,374	73,885,936	74,389,697	503,761	0.7%
Non-State ER	37,710,342	36,826,712	(883,630)	50,534,957	49,670,895	(864,062)	-1.7%
Non-State EE	7,948,385	8,716,200	767,815	10,597,846	11,352,893	755,047	7.1%
Direct Bill	24,463,504	24,909,350	445,846	32,618,005	32,805,040	187,035	0.6%
COBRA	2,698,214	3,018,123	319,908	3,597,619	4,167,373	569,754	15.8%
Voluntary Benefit	2,700,000	2,921,493	221,493	3,600,000	3,821,493	221,493	6.2%
Interest/Other	25,883	259,077	233,194	34,511	267,705	233,194	675.7%
Total	**361,388,838**	**361,517,747**	**128,910**	**483,645,668**	**481,139,372**	**(2,506,296)**	**-0.5%**
Expenses							
Medical Claims	210,618,609	212,832,190	2,213,581	296,394,291	297,276,864	882,573	0.3%
Rx Claims	54,581,790	58,020,468	3,438,678	78,138,280	81,603,615	3,465,335	4.4%
Dental Claims	21,398,470	19,789,514	(1,608,956)	29,200,706	27,147,104	(2,053,602)	-7.0%
Health Savings ER	21,796,032	22,071,171	275,138	29,023,508	29,100,585	77,076	0.3%
ASO/Premium	31,145,275	31,375,805	230,530	41,527,033	41,547,000	19,967	0.0%
Voluntary Benefit	2,700,000	2,921,493	221,493	3,600,000	3,821,493	221,493	6.2%
Onsite Clinic (Marathon)	1,800,000	1,524,795	(275,205)	2,400,000	2,124,795	(275,205)	-11.5%
Other Contract Fees/Flex	6,093,048	6,170,276	77,228	7,624,000	7,701,228	77,228	1.0%
PCORI	163,699	164,593	894	163,699	164,593	894	0.5%
Total	**350,296,923**	**354,870,304**	**4,573,381**	**488,071,518**	**490,487,277**	**2,415,759**	**0.5%**
Net Cash Flow	**11,091,915**	**6,647,443**	**(4,444,471)**	**(4,425,850)**	**(9,347,905)**	**(4,922,055)**	
Beginning Balance	69,021,173	69,021,173	-	69,021,173	69,021,173	-	
Ending Balance	80,113,088	75,668,616	(4,444,471)	64,595,323	59,673,269	(4,922,055)	
Enrollment (Subscriber)							
Active	37,002	36,602	(400)	37,002	36,489	(513)	-1.4%
COBRA	343	394	51	343	406	63	18.2%
Non-Medicare Retiree	405	382	(23)	405	376	(29)	-7.1%
Medicare Retiree	8,709	8,621	(88)	8,709	8,608	(101)	-1.2%
Total	46,459	45,999	(460)	46,459	45,878	(581)	-1.2%
Revenue PEPM	864	873	9	868	874	6	0.7%
Expenses PEPM	838	857	19	875	891	15	1.8%

Kansas State Employees Health Care Commission
Data Through September 2021
Multi Year Projection

	2021 Actual/Projected	2022 Projected	2023 Projected	2024 Projected	2025 Projected
Revenue					
State ER	$ 304,664,276	$ 312,402,763	$ 331,961,353	$ 356,817,026	$ 383,541,997
State EE	$ 74,389,697	$ 74,243,290	$ 79,890,126	$ 85,948,851	$ 92,450,223
Non-State ER	$ 49,670,895	$ 52,659,072	$ 55,940,951	$ 60,101,136	$ 64,572,304
Non-State EE	$ 11,352,893	$ 10,831,324	$ 11,653,757	$ 12,536,466	$ 13,483,959
Direct Bill	$ 32,805,040	$ 33,124,715	$ 35,042,272	$ 37,075,441	$ 39,231,382
COBRA	$ 4,167,373	$ 4,580,951	$ 4,913,180	$ 5,270,140	$ 5,653,692
Voluntary Benefit	$ 3,821,493	$ 3,600,000	$ 3,600,000	$ 3,600,000	$ 3,600,000
Interest/Other	$ 267,705	$ 29,837	$ 25,180	$ 22,404	$ 24,587
Total	$ 481,139,372	$ 491,471,952	$ 523,026,819	$ 561,371,463	$ 602,558,145
Expenses					
Medical Claims	$ 297,276,864	$ 306,145,791	$ 323,926,218	$ 341,742,160	$ 360,537,979
Rx Claims	$ 81,603,615	$ 82,484,721	$ 89,630,554	$ 97,249,152	$ 105,515,329
Dental Claims	$ 27,147,104	$ 27,832,975	$ 28,667,964	$ 29,528,003	$ 30,413,843
Health Savings ER	$ 29,100,585	$ 28,228,347	$ 28,228,347	$ 28,228,347	$ 28,228,347
ASO/Premium	$ 41,547,000	$ 42,473,421	$ 44,302,640	$ 46,227,228	$ 48,252,620
Voluntary Benefit	$ 3,821,493	$ 3,600,000	$ 3,600,000	$ 3,600,000	$ 3,600,000
Onsite Clinic (Marathon)	$ 2,124,795	$ 2,073,048	$ 2,114,509	$ 2,156,799	$ 2,199,935
Other Contract Fees/Flex	$ 7,701,228	$ 7,776,480	$ 7,932,010	$ 8,090,650	$ 8,252,463
PCORI	$ 164,593	$ 170,633	$ 176,896	$ 183,388	$ 190,118
Total	$ 490,487,277	$ 500,785,416	$ 528,579,138	$ 557,005,727	$ 587,190,635
Net Cash Flow	$ (9,347,905)	$ (9,313,464)	$ (5,552,318)	$ 4,365,737	$ 15,367,510
Beginning Balance	$ 69,021,170	$ 59,673,266	$ 50,359,801	$ 44,807,483	$ 49,173,220
Ending Balance	**$ 59,673,266**	**$ 50,359,801**	**$ 44,807,483**	**$ 49,173,220**	**$ 64,540,730**
Target Reserve	**$ 52,783,585.78**	**$ 54,140,253**	**$ 57,489,216**	**$ 60,907,511**	**$ 64,540,730**
Fund Balance vs. Target Surplus/(Shortfall)	**$ 6,889,680**	**$ (3,780,452)**	**$ (12,681,733)**	**$ (11,734,291)**	**$ 0**
Enrollment (Subscriber)					
Active	36,489	36,148	36,148	36,148	36,148
COBRA	406	441	441	441	441
Non-Medicare Retiree	376	359	359	359	359
Medicare Retiree	8,608	8,569	8,569	8,569	8,569
Total	45,878	45,517	45,517	45,517	45,517
Revenue PEPM	$ 874	$ 900	$ 958	$ 1,028	$ 1,103
Expenses PEPM	$ 891	$ 917	$ 968	$ 1,020	$ 1,075

Kansas State Employees Health Care Commission
Data Through September 2021
Projected 2023 Contribution Rates

	Plan A	Plan C	Plan J	Plan N	Dental
State Active Employers (Including HSA/HRA Amount) - Effective 7/1/2023					
Full Time					
Employee	$ 711.29	$ 711.29	$ 711.29	$ 711.29	$ 24.99
Employee + Spouse	$ 1,042.18	$ 1,042.18	$ 1,042.18	$ 1,042.18	$ 41.87
Employee + Child(ren)	$ 1,042.18	$ 1,042.18	$ 1,042.18	$ 1,042.18	$ 41.87
Employee + Family	$ 1,042.18	$ 1,042.18	$ 1,042.18	$ 1,042.18	$ 41.87
Part-Time					
Employee	$ 569.25	$ 569.25	$ 569.25	$ 569.25	$ 14.53
Employee + Spouse	$ 829.32	$ 829.32	$ 829.32	$ 829.32	$ 29.27
Employee + Child(ren)	$ 829.32	$ 829.32	$ 829.32	$ 829.32	$ 29.27
Employee + Family	$ 829.32	$ 829.32	$ 829.32	$ 829.32	$ 29.27
HealthyKids Full-time					
Child(ren)	$ 1,107.89	$ 1,107.89	$ 1,107.89	$ 1,107.89	$ 41.87
Family	$ 1,107.89	$ 1,107.89	$ 1,107.89	$ 1,107.89	$ 41.87
HealthyKids Part-time					
Child(ren)	$ 883.89	$ 883.89	$ 883.89	$ 883.89	$ 29.27
Family	$ 883.89	$ 883.89	$ 883.89	$ 883.89	$ 29.27
State Active Employees					
Full Time					
Employee	$ 85.86	$ 75.74	$ 113.10	$ 50.03	$ 13.83
Employee + Spouse	$ 510.57	$ 266.16	$ 330.05	$ 181.40	$ 33.77
Employee + Child(ren)	$ 272.34	$ 139.91	$ 196.40	$ 94.51	$ 29.78
Employee + Family	$ 893.87	$ 448.29	$ 565.48	$ 323.14	$ 49.79
Part-Time					
Employee	$ 248.92	$ 113.23	$ 141.16	$ 74.80	$ 24.95
Employee + Spouse	$ 761.66	$ 340.42	$ 386.81	$ 232.03	$ 50.10
Employee + Child(ren)	$ 430.84	$ 190.05	$ 234.12	$ 128.36	$ 45.03
Employee + Family	$ 1,208.62	$ 540.63	$ 644.71	$ 389.65	$ 70.37
HealthyKids Full-time					
Child(ren)	$ 178.21	$ 106.24	$ 171.11	$ 71.79	$ 17.36
Family	$ 668.25	$ 410.01	$ 532.62	$ 295.53	$ 37.30
HealthyKids Part-time					
Child(ren)	$ 178.21	$ 106.24	$ 171.11	$ 71.79	$ 17.36
Family	$ 668.25	$ 410.01	$ 532.62	$ 295.53	$ 37.30

Kansas State Employees Health Care Commission
Data Through September 2021
Projected 2023 Contribution Rates

	Plan A	Plan C	Plan J	Plan N	Dental
Non-State Active Employer (Including HSA/HRA Amount) - Effective 7/1/2023					
Full Time					
Employee	$ 848.27	$ 848.27	$ 848.27	$ 848.27	$ 54.05
Employee + Spouse	$ 1,488.94	$ 1,488.94	$ 1,488.94	$ 1,488.94	$ 92.05
Employee + Child(ren)	$ 1,488.94	$ 1,488.94	$ 1,488.94	$ 1,488.94	$ 92.05
Employee + Family	$ 1,488.94	$ 1,488.94	$ 1,488.94	$ 1,488.94	$ 92.05
Part-Time					
Employee	$ 663.07	$ 663.07	$ 663.07	$ 663.07	$ 40.88
Employee + Spouse	$ 1,166.66	$ 1,166.66	$ 1,166.66	$ 1,166.66	$ 69.55
Employee + Child(ren)	$ 1,166.66	$ 1,166.66	$ 1,166.66	$ 1,166.66	$ 69.55
Employee + Family	$ 1,166.66	$ 1,166.66	$ 1,166.66	$ 1,166.66	$ 69.55
Non-State Active Employees					
Full Time					
Employee	$ 88.46	$ 76.09	$ 120.42	$ 53.49	$ 13.89
Employee + Spouse	$ 514.85	$ 282.08	$ 351.80	$ 194.70	$ 33.87
Employee + Child(ren)	$ 276.04	$ 147.06	$ 209.33	$ 101.31	$ 29.89
Employee + Family	$ 919.11	$ 485.80	$ 602.99	$ 347.11	$ 49.87
Part-Time					
Employee	$ 266.50	$ 118.37	$ 150.22	$ 79.98	$ 25.03
Employee + Spouse	$ 801.62	$ 366.46	$ 412.27	$ 249.03	$ 50.20
Employee + Child(ren)	$ 450.64	$ 201.97	$ 249.46	$ 137.61	$ 45.16
Employee + Family	$ 1,280.15	$ 584.27	$ 687.47	$ 418.57	$ 70.48
State COBRA					
Employee	$ 734.64	$ 610.01	$ 739.57	$ 629.51	$ 55.12
Employee + Spouse	$ 1,491.42	$ 1,085.28	$ 1,262.48	$ 1,054.85	$ 92.71
Employee + Child(ren)	$ 1,246.29	$ 928.31	$ 1,145.97	$ 962.02	$ 88.60
Employee + Family	$ 1,882.40	$ 1,271.06	$ 1,502.62	$ 1,199.41	$ 109.02
Non-State COBRA					
Employee	$ 870.38	$ 743.44	$ 880.11	$ 766.12	$ 68.26
Employee + Spouse	$ 1,921.10	$ 1,526.85	$ 1,709.99	$ 1,493.73	$ 126.38
Employee + Child(ren)	$ 1,684.06	$ 1,369.59	$ 1,593.15	$ 1,402.95	$ 122.33
Employee + Family	$ 2,333.46	$ 1,734.64	$ 1,966.20	$ 1,649.18	$ 142.71
Non-Medicare Retirees					
Employee	$ 1,031.37	$ 761.34	$ 841.96	$ 733.58	$ 41.31
Employee + Spouse	$ 2,106.36	$ 1,608.31	$ 1,706.40	$ 1,495.36	$ 94.04
Employee + Child(ren)	$ 1,844.80	$ 1,388.15	$ 1,480.33	$ 1,328.79	$ 104.56
Employee + Family	$ 3,001.78	$ 2,351.99	$ 2,557.43	$ 2,139.99	$ 167.84
Medicare Retirees					
Individual					$ 41.31

Kansas State Employees Health Care Commission
Revenue/Expense Category Definitions

Revenue	
State ER	Contributions, including HSA/HRA funded by State employers, for their employees' medical, Rx, dental benefits and other program expenses. State employers fund HSA/HRA quarterly in the first month of each quarter.
State EE	Contributions funded by State active participants for their medical, Rx, dental, vision benefits and other program expenses
Non-State ER	Contributions, including HSA/HRA funded by Non-State employers, for their employees' medical, Rx, dental benefits and other program expenses. Non-State employers fund HSA/HRA monthly.
Non-State EE	Contributions funded by Non-State active participants for their medical, Rx, dental, vision benefits and other program expenses
Direct Bill	Contributions funded by State and Non-State retirees for medical, Rx, dental and vision benefits
COBRA	Contributions funded by State and Non-State COBRA participants for their medical, Rx, dental and vision benefits
Voluntary Benefit	Premium paid to Chubb (long-term care) and Metlife/Hartford (accident, critical illness, and hospital indemnity)
Interest/Other	Interest earned on account balance and miscellaneous revenue
Expenses	
Expenses	Weekly claims billed by Aetna and BCBS who administer the self-insured medical plans for the active and non-Medicare groups
Medical Claims	Semi-monthly claims billed by Caremark who administers the self-insured pharmacy plans for the active and non-Medicare groups
Rx Claims	Weekly claims billed by Delta who administer the self-insured dental plans for the active and retiree groups
Dental Claims	Expenses of HSA/HRA funded by employers for Plan C, J, N and Q participations. Base HSA/HRA for State employees are funded quarterly, and Base HSA/HRA for Non-State are funded monthly. Earned HSA/HRA are funded whenever employees are enrolled in required wellness activities.
Health Savings ER	Fully Insured premiums. This includes Medicare Advantage for Medicare retirees and Vision for active and retiree groups.
ASO/Premium	Administrative fees paid for Aetna, BCBS, Caremark and Delta services
Voluntary Benefit	Premium paid to Chubb (long-term care) and Metlife/Hartford (accident, critical illness, and hospital indemnity)
Onsite Clinic (Marathon)	Marathon program
Other Contract Fees/Flex	Fees paid to outside vendors such as Cerner (Wellness Program), Holmes Murphy (Weight Loss Program), iTEDIUM (ITS Web Hosting Enrollment), Compsych (Employee Assistant Program) and CTI/Sagebrush (SEHP Audit), NueSynergy, Salaries and Wages to maintain Flex account etc.
PCORI	Fees paid to the Patient Centered Outcomes Research Institute created under Healthcare Reform
Target Reserve	
IBNR Claim Reserve	Reserves to pay for Incurred But Not Report medical, pharmacy and dental claims
Claim Fluctuation Reserve	Reserves to pay for unexpected high volume medical, Rx and dental claims
Revenue PEPM	Per Employee Per Month Revenue
Expenses PEPM	Per Employee Per Month Expenses

Agenda Item #4

Kansas
Department of Administration
State Employee Health Plan

SEHP Director Report

HCC Meeting

October 18, 2021

Key Activities

- Marathon Contract Amendment and Related Activities
- Open Enrollment
  - Started 10/1/21
- Retiree Open Enrollment
  - Started 10/15/21
- New vendor transition
  - Avēsis, MetLife, CobraGuard
- Wellness Program RFP Development
- EAC Collaboration

SEHP Audits

Aetna

- Complete (see appendix)

Delta Dental

- Complete (see appendix)

Dependent Eligibility Verification

- Complete (see appendix)

CVS/Caremark

- Initial data dump from Caremark was received by Sagebrush. The onsite review of the manufacturer rebates agreements is scheduled.

BCBSKS

- Sagebrush is finishing up the first draft of their report.

Premium Reconciliation

- In progress

Wellness Program

- In progress

Completed Audits: *Findings Summary*

- Aetna
- Delta Dental
- Dependent Eligibility Verification

Aetna Audit

- The statistical sample revealed $130,239.20 in overpayments. Of this amount, Aetna previously recovered, prior to the preparation of this report, $113,737.71. These amounts were previously credited to SEHP.
  - Aetna recovered the remaining amounts. Paid to the SEHP via check.
- The electronic testing identified $35,715.46 in overpayments. Aetna previously recovered, prior to the preparation of this report, $29,064.07; these amounts were previously credited to SEHP.
  - Of the remaining balance, $167.01 cannot be recovered because of the age of the claim or because the amount is under the threshold for recovery.
  - Aetna recovered the remaining amounts. Paid to SEHP via check.
- Check received on 9/23/2021.

Delta Dental Audit

- The project results indicate that Delta Dental's performance relative to claims accuracy and timeliness and operational efficiency is within acceptable standards and guidelines.
- Sagebrush's overall conclusion based on the results of the claim reviews, the observations during the onsite review and the analysis of the administrative questionnaire is that Delta Dental claims operations appear to be appropriate and efficient.
- Delta Dental reviewed potential exceptions with a total paid amount of $8,492.16. Of this amount, $3,669.66 has been previously credited on the State's Group Patient Payment Report.
  - Check received from Delta on 9/16/21.
- Delta dental disagreed with the findings for $2,572.70. The SEHP has reviewed Delta Dental's explanation on these exceptions and accepted their position. Delta Dental will not recover payment on claims for which they disagree to an error. Although, a claim for $115.00 was refunded and will be credited on the State's Group Patient Payment report.

Dependent Eligibility Verification Audit

- Total Employees Covering Dependent(s) Selected for Audit: 200
- Total Employees Successfully Completing Audit: 172
- Total Employees Submitting No Documentation: 6
- Total Employees Submitting Incomplete Documentation: 0
- Total Number of Employees Found to have an Undisclosed Divorce: 0
- Total Dependents to be Removed from Coverage: 28

Other Updates

Avēsis (new vision vendor)

- As of 10/7/21, Avēsis has added 70 provider locations to their existing 204 locations.
- In active discussions with an additional 205 providers.
- Did not meet their 10/1/21 recruitment goal of 85% resulting in a $35,000 performance guarantee refund to the plan.
- As of 10/6/21, they are at 54%. Their experience in contracting with vendors is consistent with previous vendor transitions.

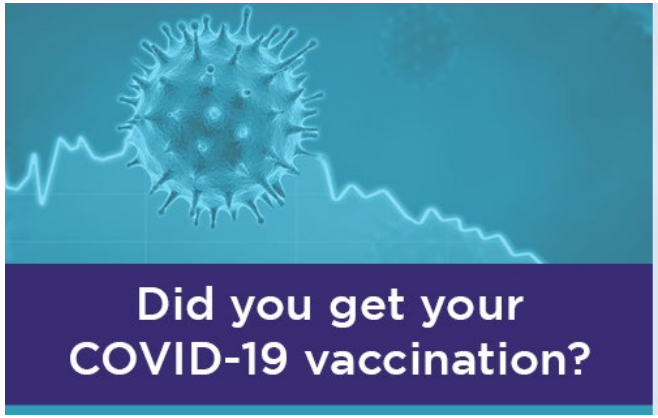
No Surprise Act

- Some components have been delayed and others will go into effect 1/1/22.
- The SEHP continues to work with Segal and our payors on a compliance plan to address any items that impact the plan and our members.

COVID Vaccine Incentive

HealthQuest Credits

- 13,581 members credited as of 10/04/21
  - 11,165 (47%) registered employees
  - 1,966 (46%) registered spouses



- Total HQ Membership = 28,081 (23,799 employees – 4,282 spouses)
- Total Employees & Spouses eligible for the HealthQuest program = 51,074
- Since June 18, there have been 397 newly activated HealthQuest members who have received their credits (340 employees; 57 spouses)

Kansas Business Group on Health: *Cancer Care Strategy Project*

- In the Summer of 2020, the National Alliance, launched a series of employer roundtables to discuss ways to enhance an employer's cancer care strategy. Three employer learning modules were developed by Dr. Chuck Cutler and William Rosenberg along with a multi-stakeholder advisory committee. The learning modules covered the patient journey and include the following areas: (1) Prevention & Preliminary Diagnosis, (2) Diagnosis, Treatment Planning & Care and (3) Survivorship, Surveillance & Back to Work.

- This project consists of presenting these 3 learning modules to the participating employers. The commitment is three 2-hour (or possibly one 2-hour meeting and one 3-to-4-hour meeting) virtual meetings along with a survey at the end of the project.

- The SEHP is participating in this initiative in a continued effort to network, learn and share information with other Kansas businesses.

Agenda Item #5

Health Care Commission Follow-up

08/23/2021 Meeting

Kansas
Department of Administration
Health Care Commission

8/23/21 HCC Follow-up Items

- Get a copy of the EAC Survey results from last fall (McGinn)
  - Sent to new Commissioners 8/25/21
- Provide the number of COVID tests performed by the Health Center to the Commission (Schmidt) June 2020 – Aug. 2021
  - In-house rapid testing: 718
  - Lab Ordered testing: 659
    - If a member tested negative with a rapid test but had symptoms, the standard of care was to follow up with a lab test to verify the patient's status.
- Bring a recommendation to the Commission at a future meeting regarding adolescent bariatric surgery. Please include the requirements of pre- and post-surgery support. (Burns-Wallace)
  - Noted; will be brought forward before end of Plan Year 2021.
- Procurement: Come back to Commissioners with a set of questions or a survey to get feedback: a list of clarifications and/or a list of changes to be considered to prepare for the next stage of the conversation (Burns-Wallace)
  - Survey sent to all Commissioners 8/30/21
  - Responses included in meeting materials
- Reach out to the AG's office regarding available services and inquire as to what services they are currently providing for other boards and commissions (Landwehr)
  - Completed by Tracy Diel, DofA Legal Counsel; Provided in the following slides

Historic/Current Legal Counsel Use by the SEHP (Option 1)

The SEHP has worked under various agencies in the past (Department of Administration, Kansas Department of Health and Environment, Kansas Health Policy Authority). Legal counsel for any matter has been handled by the respective agencies' legal counsel and at times, DofA legal counsel for services such as:

RFP Development	Contract Negotiations	HIPAA (PHI) counsel
Open Records Requests	Development of/Changes to Legislation	Media Inquiry Responses
Lawsuits	Bid Protest Responses	Legislative Research
Counsel on Federal and State Legislation Compliance	Assistance with contracting and collaborating with outside specialty legal counsel, as needed	

ATTORNEY GENERAL'S OFFICE LEGAL SERVICES (OPTION 2)

- The AG's LOGiC Division provides legal services to 29 different agencies, boards and commissions throughout state government.
- There are three (3) basic categories which define how legal services are provided:
  - Situations based upon statutory requirements. (ie State Fire Marshall's Office)
  - Situations based upon a yearly contract between the entity and the AG's office
  - Situations based upon an hourly rate being charged by the AG's office
- The AG's Office works with the requesting entity to assess their needs and determine if a contract or hourly rate would be appropriate. The hourly rate is $100 per hour. (This is equivalent to the amount paid for contract legal services by the Board of Indigent Defense Services--BIDS)
- When an attorney from LOGiC is participating in the agency meeting, they are not providing advice from or speaking on behalf of the Attorney General. They are acting in a capacity for the agency, board or commission they are advising.

LOGiC DIVISION SERVICES

- Attend Scheduled Meetings
- Prepare motions for upcoming meetings based upon the agenda (i.e., Executive Sessions, Delegated authority)
- Participate in Executive Sessions
- Review meeting minutes
- When appropriate, response to legal questions raised in meetings, or bring the questions back to be answered after they have been researched.
- Contracting—involvement in this process varies by agency
- LOGiC Division counsel does not get involved in the agency process for the formulating and the drafting of regulations and statutes to be proposed.

Outside Legal Counsel (Option 3)

- If the HCC would like to hire outside counsel, this service would not be exempt from the procurement process under KSA 75-6504.
- The HCC would be responsible for complying with the Professional Services Sunshine Act (KSA 75-37,130 et seq.) in acquiring legal services.
- Department of Administration legal counsel has contacted five (5) Boards and Commissions who have outside legal counsel from private law firms who all pay $150 per hour for the legal services they are provided.

Kansas audited its $80 million CVS prescription plan, but it's still shrouded in mystery

KCUR | By Celia Llopis-Jepsen

Published October 1, 2021 at 5:42 AM CDT

Carlos Moreno / KCUR 89.3

Kansas doesn't dig in to find out.

Editor's note: This article is about Kansas' audit of drug spending related to its state employee health plan. You can read more about the state's redactions of that audit here.

TOPEKA, Kansas — Kansas paid auditors $100,000 to dig into the more than $160 million it spent in 2018 and 2019 on prescription drugs for state employees, retirees and their families.

But experts who follow the pharmaceutical industry say the resulting 16-page report doesn't tell Kansas whether the health plan — or rather, the taxpayers and public employees who fund it — got a bargain or got gouged.

Nor does it reveal what role CVS, which manages the health plan's drug benefits and was the audit's focus, plays in either keeping down or inflating costs.

The audit "was poorly structured and poorly performed," New Jersey attorney Linda Cahn, CEO of Pharmacy Benefit Consultants said in an email. Her firm helps public and private health plans avoid contract loopholes that lead to overcharges on drugs. "It does not provide Kansas — or its taxpayers — with the information needed to evaluate just how much money the State wasted."

Cahn spent more than a decade litigating pharmacy benefit issues and has reviewed hundreds of drug spending contracts like the one Kansas signed with CVS.

Both she and 3 Axis Advisors, a consulting group that investigates prescription drug costs, said the state health plan may have lost millions to ambiguous provisions in its CVS contract.

Antonio Ciaccia, president of 3 Axis Advisors, said even the largest of public and private employers often don't know how to ask the right questions about the complex world of prescription drug deals.

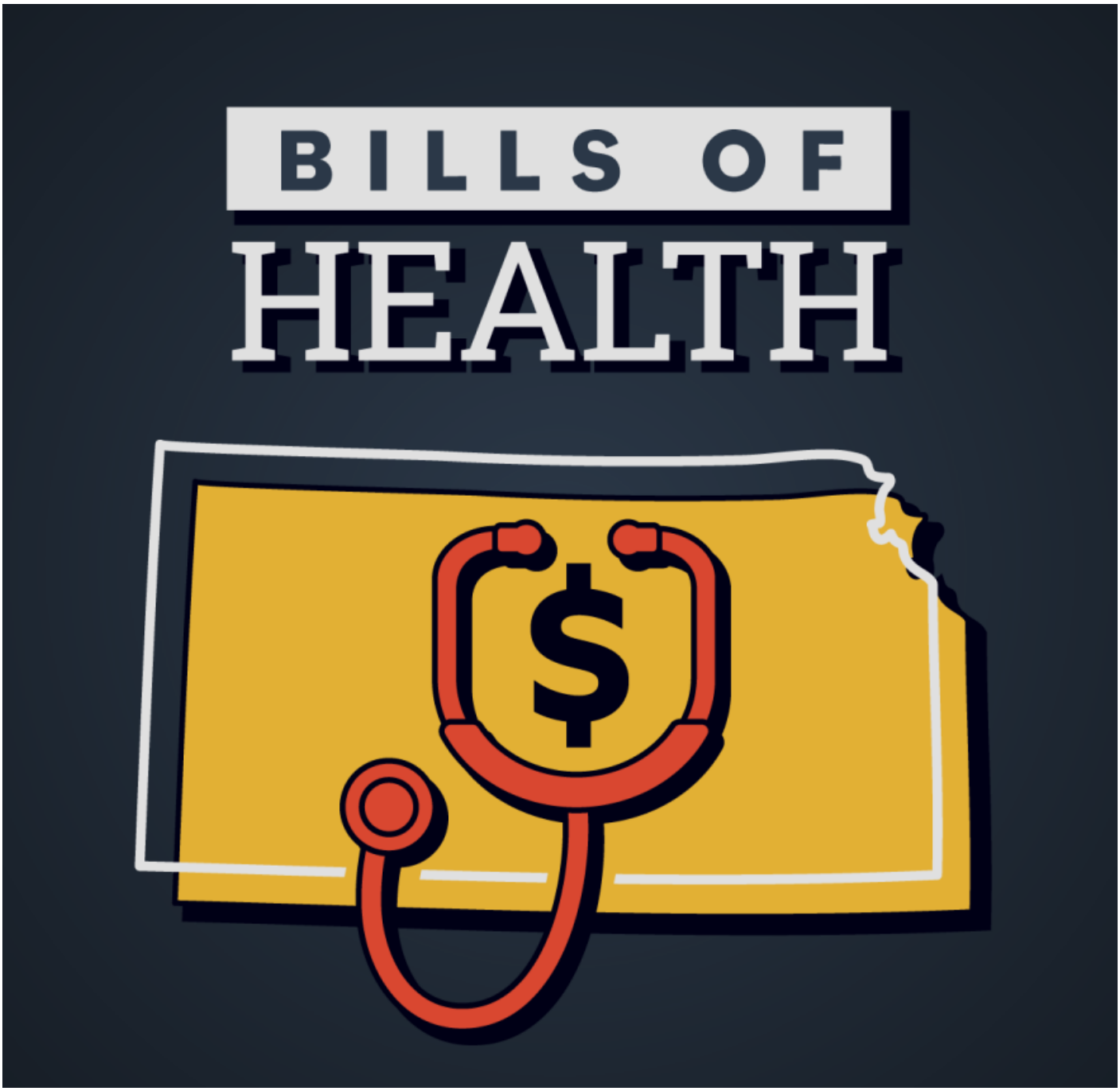
What they end up with are audits that "leave everything on the cutting room floor that you actually need."

"Some of the biggest companies in the world are getting taken advantage of," said

state. “You have an incredibly opaque and complex system … There's so many opportunities to exploit that complexity.”

By the time Ohio finished digging into the matter, it discovered more than $200 million in Medicaid spending had gone into a byzantine profit model run by the administrative middlemen.

It effectively fired the middlemen companies involved, sued one of them and got an $88 million settlement this summer.



And yet Ohio audited only a slice of what it should have, experts say, leaving unknown the full taxpayer-funded profits that middlemen took home. And that holds lessons for Kansas. Not just for its state health plan, but for its cities, counties, school districts and private employers.

Clear, thorough audits are intended to expose things like overcharges and to keep contractors honest.

In the complex business of managing prescription drugs, the stakes of those audits become even greater.

The opaqueness is compounded by how Kansas, CVS and the auditor handled inquiries from the Kansas News Service.

First, the Kansas Department of Administration redacted large swaths of the audit, saying it needed to protect trade secrets. (Lawyers who reviewed the botched redactions for the Kansas News Service disagree.)

Then the department declined an interview request, saying in an email, “the audit speaks for itself.”

CVS also declined an interview. “We would refer any questions you may have to our client, the state of Kansas,” a spokesman said by email.

And the auditor, PillarRx, said it can’t discuss its findings or even the thoroughness or quality of its work without permission from CVS — the company whose work it was paid to watchdog — and Kansas. A company vice president said her hands are tied “because of our confidentiality statements” with both parties.

PillarRx’s report found more than $1 million in overcharges that CVS paid back, but otherwise concludes that CVS largely handled the health plan’s money appropriately.

The audit conclusion is written by CVS, not the auditor. In it, the company promises to address co-pay issues related to four claims.

After that, “it is our view that we are in compliance with the contract and plan design, and there are no additional material financial discrepancies related to the findings.”

“I’ve never heard of the entity being audited having the privilege of writing their own conclusions to the audit,” he said.

Cahn said Kansas should demand to see any confidentiality agreements between PillarRx and CVS. Such agreements often limit what financial documents the auditors get to review in the first place, she said, and how much detail the auditors get to disclose to their clients. They can also grant the company under audit the right to review all drafts and preliminary findings before they reach the client. The state should demand to see all earlier drafts, she said.

“The State should also require PillarRx to provide it with all exchanges that PillarRx had with (CVS) Caremark,” Cahn said, “concerning its audit, and its draft audit reports.”

A quick primer on pharmacy middlemen

The Kansas audit homes in on the same obscure but important part of the drug supply chain that Ohio looked at — the administrators called pharmacy benefit managers.

These middlemen typically negotiate prices with pharmacies, determine what drugs a health plan should cover and process the actual claims. Health plans would struggle to get that done on their own.

So the administrators handle the money flow. They pay the drugstores. And they collect the rebates that drugmakers offer as incentives to include specific medications in their coverage.

It’s lucrative work that sometimes pulls in more money than drugmakers and insurers earn.

Three of the nation’s wealthiest corporations control most of the market: Express Scripts, CVS Caremark and OptumRx.

CVS ranks No. 4 on the Fortune 500. UnitedHealth Group (which owns OptumRx) ranks No. 5. Cigna (which controls Express Scripts) ranks No. 13.

As Fortune magazine wrote, “The company climbed more than 50 spots on the Fortune 500 after completing its merger with pharmacy benefits manager Express Scripts.” It

enjoyed “skyrocketing” revenues, and all that pharmacy benefit manager business kept Cigna healthy during the pandemic.

Independent and small-chain pharmacies generally stand at odds with the pharmacy benefit managers that control payments from health plans. That tension has magnified over the years as the corporations that do this administrative work merged with drug stores and insurance companies.

CVS Health, for example, not only owns its ubiquitous drugstore chain, but also functions as an insurance company (Aetna) and a pharmacy benefit manager.

It is the pharmacy benefit manager for the Kansas employee health plan. The plan covers about 80,000 public employees, retirees and dependents. It spends about $80 million on drugs annually.

A consultant told the Kansas Department of Administration that CVS’ latest contract would save the health plan tens of millions of dollars over a three-year period.

But pharmacy middlemen have faced increasing scrutiny over how they contribute to the incredibly high prices that Americans pay for prescriptions. Americans pay more than twice as much as people in other developed countries.

Employers, meanwhile, struggle to see where the money goes, because the middlemen they hire consider vital details of their financial arrangements with drugmakers and pharmacies to be proprietary and even trade secrets.

CVS 'underperforming' its contract

In 2015, auditors who work for the Kansas Legislature found state officials weren't checking up on CVS Caremark.

The state effectively took CVS at its word that the company handles claims correctly, doesn't steer employees toward pricey medications, and doesn't increase costs by pocketing money from drugmakers.

The legislative auditors urged a change, and the state agreed. So then-Gov. Sam Brownback's administration contracted with an external auditor, which subcontracted with another (PillarRx) to conduct regular checks.

The 2018-2019 audit is a 16-page report. The auditors also gave state officials a shorter, 10-page version of the 16-page report. The state redacted large swaths of the audit before giving the full report to the Kansas News Service. But it botched the redactions, so some of the obscured details were ultimately still readable.

A four-page written response from CVS to the auditors is also attached to the audit, which the state blacked out in full.

The audit reveals that the state employee plan didn't always get the discounts and fees it had been promised.

On that point, the auditors said CVS was "underperforming" its contract with Kansas.

They concluded the company owed about $1.2 million, but that it had already identified

amount by the time the audit was completed. It agreed to pay back the rest after the audit.

Meanwhile, PillarRx found no evidence that CVS mishandled payments to pharmacies.

Nor did PillarRx find evidence that CVS took any money from drugmakers that should have gone toward keeping down the costs of the health plan.

Audits and researchers in other states have found middlemen using both strategies to fatten their profits.

Kansas Attorney General Derek Schmidt's office may be investigating similar questions. It has hired the law firm that helped Ohio and another state, Mississippi, land their recent settlements against a pharmacy benefit manager for allegedly overcharging Medicaid.

Concerns about the audit

The Kansas audit says it was designed to check whether CVS complied with its written promises to the state.

Experts say that's not how to audit PBMs. Health plans should ask auditors to dig much deeper into where the money went.

"When the assessment of the issue is, 'Did you achieve these contract requirements?'" pharmacist Ben Link said, "it's kind of like having the answer key to the test before you take the test."

Link previously worked for pharmacy benefit managers, where he helped them manage public health plans. He joined 3 Axis Advisors in 2019.

For example, the audit concludes that CVS handed over money from drugmakers as required by its contract. Yet a provision in the contract allowed the company to keep "administrative fees" equaling up to 4% of the manufacturer list prices for all the medications that Kansas employees and retirees picked up.

So how much did CVS keep? Figuring that out requires detailed claim information.

But Link offered a rough estimate based on Kansas' brand-name drug spending — a critical component of the calculation — that the fees could add up to $2.5 million for 2018 and 2019 combined.

That revenue from drugmakers comes on top of the money that Kansas already agreed to pay CVS for its services, such as the 90 cents it got for every prescription that got filled.

The National Academy for State Health Policy recommends writing tight contracts that put a stop to pharmacy benefit managers pocketing drugmaker money in any form, including money labeled with a wide variety of terms such as "administrative fees."

Squeezing the balloon

Kansas contractually agreed to use auditors mutually approved by CVS.

The academy's recommendations — drawn from the experiences of several states that have wrestled aggressively with the pharmacy benefit sector — also say states need to ditch deals that give the pharmacy benefit managers sway over who audits them.

"That's dangerous," law professor Erin Fuse Brown said. "The (pharmacy benefit) market is extremely consolidated. ... So you could imagine that (pharmacy benefit managers) have their preferred auditors."

Fuse Brown didn't review the Kansas contract and audit. But she is director of the Center for Law, Health and Society at Georgia State University, and helped the academy write model contract terms for states to use.

Trying to rein in the profits that pharmacy middlemen take home is like squeezing a water balloon, she said. Press their profits in one area, and the revenues simply shift somewhere else.

"There are lots of different places where (they) can suck out a little bit of revenue here and there," she said. "And that can add up to a great deal of cost."

Based on PillarRx's audit of CVS, Ciaccia and Link couldn't tell whether CVS treats non-CVS pharmacies fairly.

“That would be almost impossible to derive based on the analysis,” Ciaccia said. “It would take a much more granular look.”

Organizations such as the ERISA Industry Committee and the National Conference of State Legislatures have turned to Ciaccia to help educate private employers and state policymakers on where the money goes.

Cahn, the industry consultant, questioned sample sizes. The number of drugmakers and pharmacies included in the review. The lack of investigation into CVS’ definition of terms such as “generic” and “specialty drug,” and how this relates to its guarantees.

She pointed to a section that says PillarRx “requested reports from CVS to substantiate their performance levels … to determine if CVS had performed at the minimum level required to avoid paying a penalty to the State.”

“This is ludicrous,” Cahn said. “This is like asking a Fox to report on whether it ate the chickens in the chicken coop.”

The National Academy for State Health Policy proposes strengthening contracts to ensure health plans can conduct aggressive audits and checks that go beyond measuring contract compliance.

“Let’s say the state negotiated a not-so-strong contract on its own behalf,” Fuse Brown said. “It’s paying too much … and passing a lot of those costs on to the state employees.”

“You wouldn’t necessarily pick up on that if you were just doing an audit of whether or not the PBM lived up to the contract terms,” she said.

Celia Llopis-Jepsen reports on consumer health for the Kansas News Service. You can follow her on Twitter @celia_LJ or email her at celia (at) kcur (dot) org.

The Kansas News Service is a collaboration of KCUR, Kansas Public Radio, KMUW and High Plains Public Radio focused on health, the social determinants of health and their connection to public policy.

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Celia Llopis-Jepsen

I'm inspired to write about how we can all live healthier, happier lives. That means stories about preventive care and societal changes that can beat back disease and chronic conditions so we make fewer trips to the doctor in the first place. And when people do have to go to the doctor, I want to give them tools to find and afford the right care. I'm also interested in what it's like for employers trying to build high-quality health plans that don't break the bank. Email me at celia@kcur.org.

See stories by Celia Llopis-Jepsen

Kansas Hid Parts of a $100,000 Audit of Drug Spending. Experts Say State Went Too Far

(Photo by Carlos Moreno, KCUR)

Friday, October 1st, 2021, by Kansas News Service

By Celia Llopis-Jepsen, Kansas News Service

Editor's note: This article is about Kansas' decision to redact a recent report on drug spending related to its state employee health plan. You can read more detail about the content of the redacted report here.

TOPEKA, Kansas — Kansas blacked out large swaths of an audit on prescription drug spending in response to a public records request.

But because the state botched its redactions, leaving much of the concealed text accessible, the Kansas News Service was able to show several lawyers what the state intended to obscure.

Those experts consider it highly likely that many of the redactions weren't allowed under state law. That's particularly the case because so many of the details appear in other public documents, including on the state's own website.

That undermines the Kansas Department of Administration's argument that it needed to redact the $100,000 watchdog report on how one of the wealthiest companies in the nation — CVS — handles prescription drug coverage for Kansas employees**,** their families and retirees.

The agency said it needed to protect trade secrets.

But the redacted details go to the heart of the state health plan, such as how many prescriptions it covered in 2018 and 2019.

"There is no strong argument in my mind for why those specific pieces of data are trade secrets," said Amy Kristin Sanders, a University of Texas-Austin professor of journalism and law.

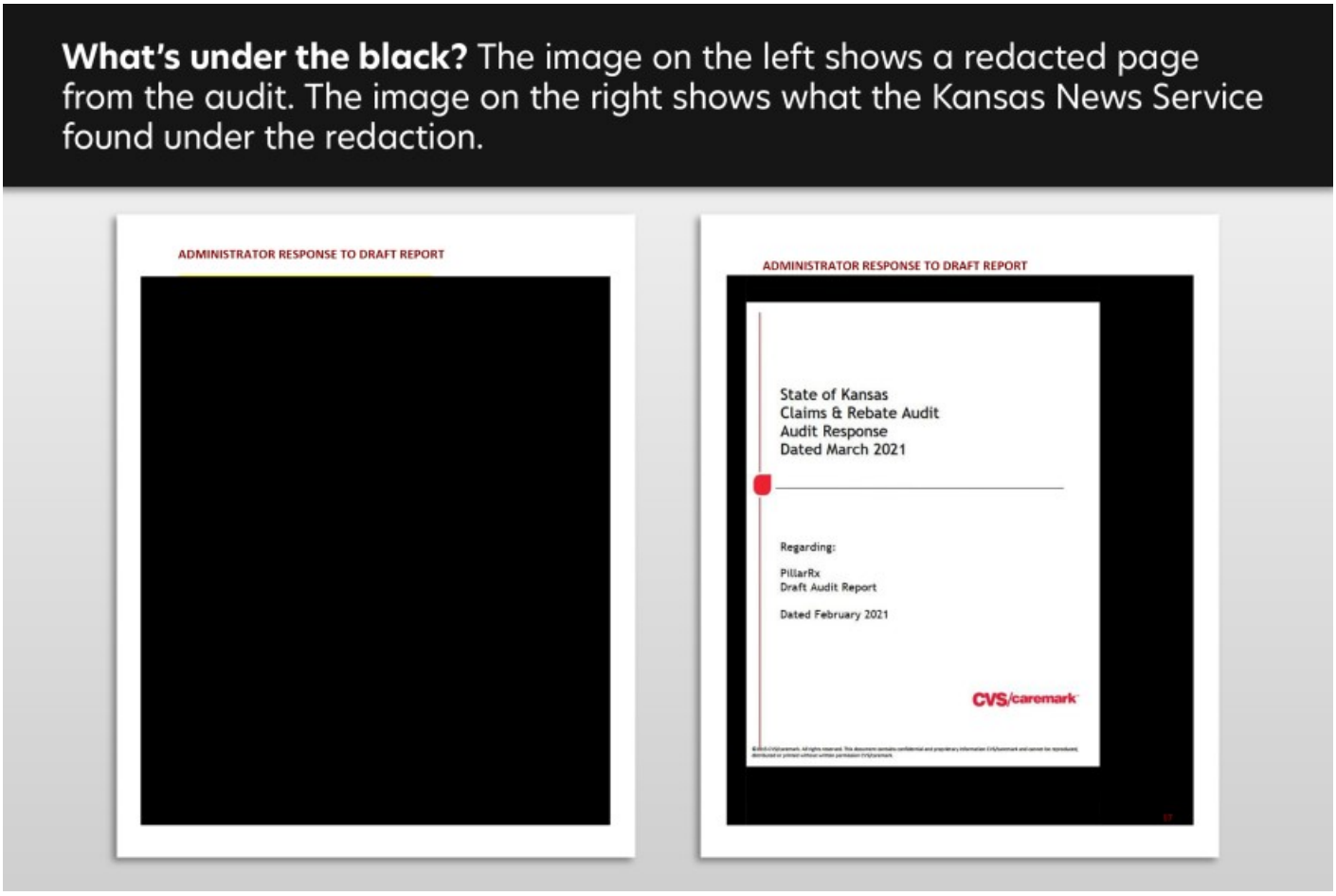
She studies government transparency in situations where private corporations are involved in public work.

Sanders and other lawyers reviewed the document and the legal justification for redaction provided by the Department of Administration. They found the state's logic weak.

"Across almost all 50 states," she said, "'Let's just cite something and hope it scares the requester off' … is a universal approach to dealing with public records requests."

The Kansas Department of Administration declined the Kansas News Service's request to interview the agency's attorney about the redactions.

What's under the black? The image on the left shows a redacted page from the audit. The image on the right shows what the Kansas News Service found under the redaction.



An image shows portions of the redacted document, and the content that the Kansas News Service found beneath the black box.

‘Orwellian’ implications

The Kansas Department of Administration struck whole paragraphs, charts and even entire pages from the report, which includes a 16-page audit and four-page response from CVS.

“Given what I saw,” said Mike Kautsch, professor emeritus of the University of Kansas School of Law, “it would really be hard to justify (the redactions) under the Kansas trade secret law.”

“My guess is that the audit in question here probably could have been disclosed without any redactions,” he said, “or with very few.”

The Department of Administration redacted the number of prescriptions covered over a two-year period — just over 2 million.

And it hid fee details, such as the 45 cents Kansas agreed to pay pharmacies each time an employee picked up a prescription in 2019.

“This is so Orwellian,” said John Francis, an antitrust attorney and professor of health law at the University of Colorado.

If states could shield their spending from public scrutiny simply by running it through a third-party auditor that considers its work confidential, Francis said, that would give them an easy cloak for all government business.

“This would allow every state agency to create a trade secret out of *all* information,” he said. “It gives them an opportunity to make otherwise non-confidential information, confidential.”

Francis isn’t licensed to practice law in Kansas. Rather, he based his analysis on Colorado trade secret law and says the Kansas trade secret law is almost word-for-word identical.

The auditor, PillarRx, labeled its report “proprietary and confidential” and for the state’s “internal” use only.

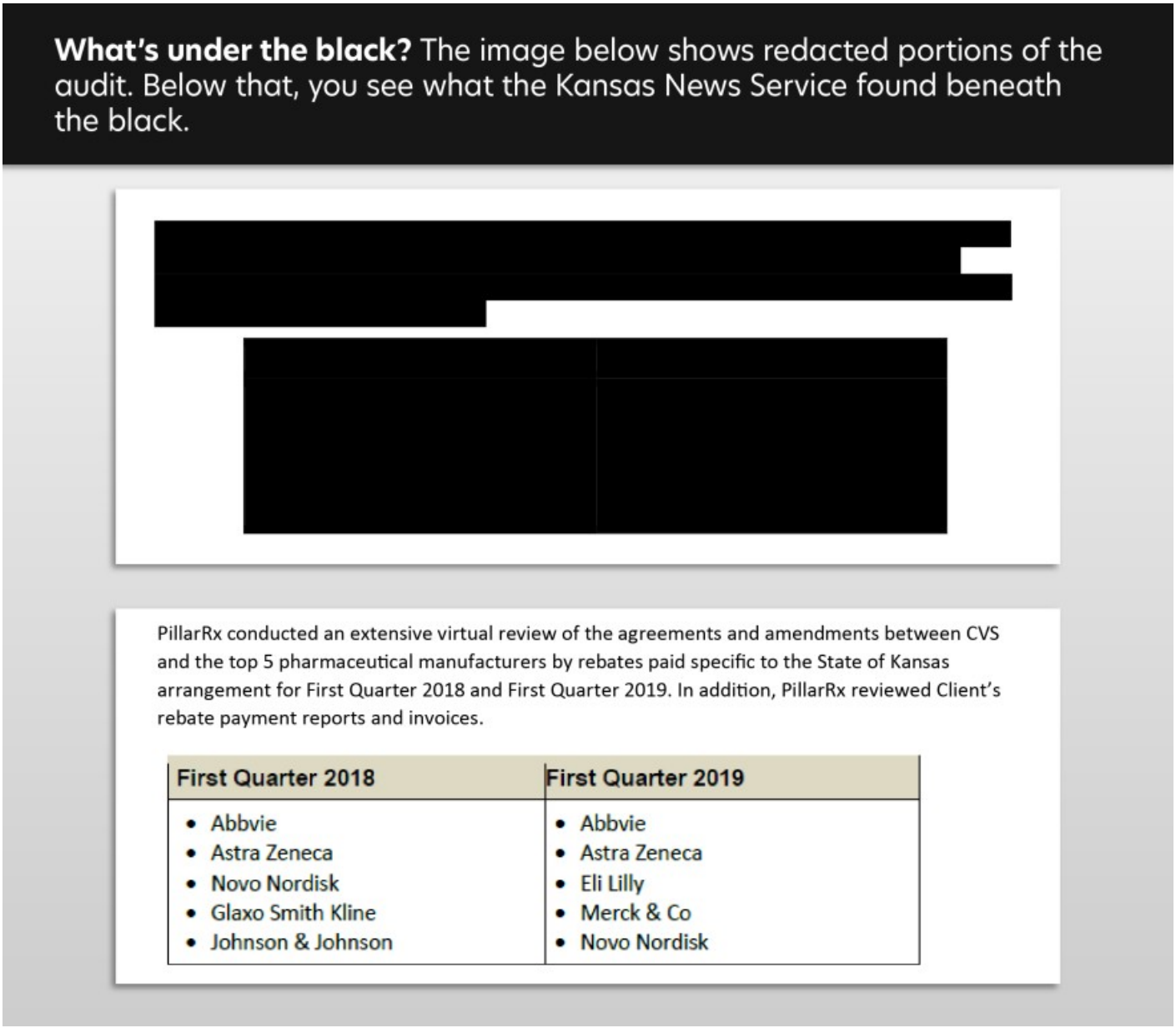
Pharmaceutical industry in focus

The audit offers a mixed picture of CVS’ work for Kansas. It concludes CVS largely handled the Kansas state employee plan’s money appropriately, but didn’t always deliver on contracted discounts and fees. Auditors say it overcharged the health plan by about $1.2 million in 2018 and 2019 combined. CVS repaid almost all of that before the audit was completed, and was anticipated to pay back the rest after the audit.

The state health plan is funded by taxpayers and the people it covers. It spends about $80 million a year on prescription drugs. And that doesn’t include the more than $20 million that the employees and retirees shell out directly in coinsurance.

Legal experts say that by deciding to cloak much of the audit, Kansas put industry secrecy ahead of the public’s right to know about government business and how their tax dollars are spent, and employees’ right to know whether they pay too much**.**

CVS functions as the state health plan’s pharmacy benefit manager — a kind of pharmacy middleman that has come under scrutiny in recent years by Congress, state attorneys general and state lawmakers probing the nation’s high drug costs.



An image shows redacted portions of the audit.

Americans pay more than twice as much as people in other developed countries for their medications, with little understanding of where the money goes.

Government agencies should give particular weight to the clear public interest involved in shedding light on the industry, Francis said.

"And that means the less redactions and the more information out there, the better for everyone," he said.

"This is bipartisan — both the Trump administration and the Biden administration have tried hard to improve health care transparency," he said. "Almost anyone who looks seriously at health care reform would consider transparency of this kind of information to be critically important."

Parts of the redacted audit remain inaccessible to the Kansas News Service, and conceal from public view details of PillarRx's assessment of how CVS spends tax dollars.

What's a trade secret?

Many of the pricing and other details in the 2018-2019 audit that Kansas argues are trade secrets appear in an audit summary that it provided to the Kansas News Service in August. It handed over the summary without redactions, and the summary also appears on the state's website unredacted.

The same pricing specifics are also revealed in CVS contract documents obtained through an open records request.

And the same details appear in PillarRx's previous work — its 2017 audit — which the state also posted unredacted to its website.

Under state law, though, the definition of "trade secret" hinges on secrecy. If there hasn't been a substantial effort to keep information secret, it doesn't fit the legal definition of a trade secret.

Trade secrets also need to be something valuable — think, the recipe for Coca Cola — that a company cashes in on by keeping it hidden from competitors.

But the lawyers who reviewed Kansas' redactions struggled to see why many of the details should be treated like a heavily branded and protected soda formula.

For instance, Kansas blacked out the names of seven major drugmakers (Abbvie, AstraZeneca, Novo Nordisk, GlaxoSmithKline, Johnson & Johnson, Eli Lilly and Merck & Co.) whose interactions with CVS were scrutinized to ensure CVS hadn't profited inappropriately from them.

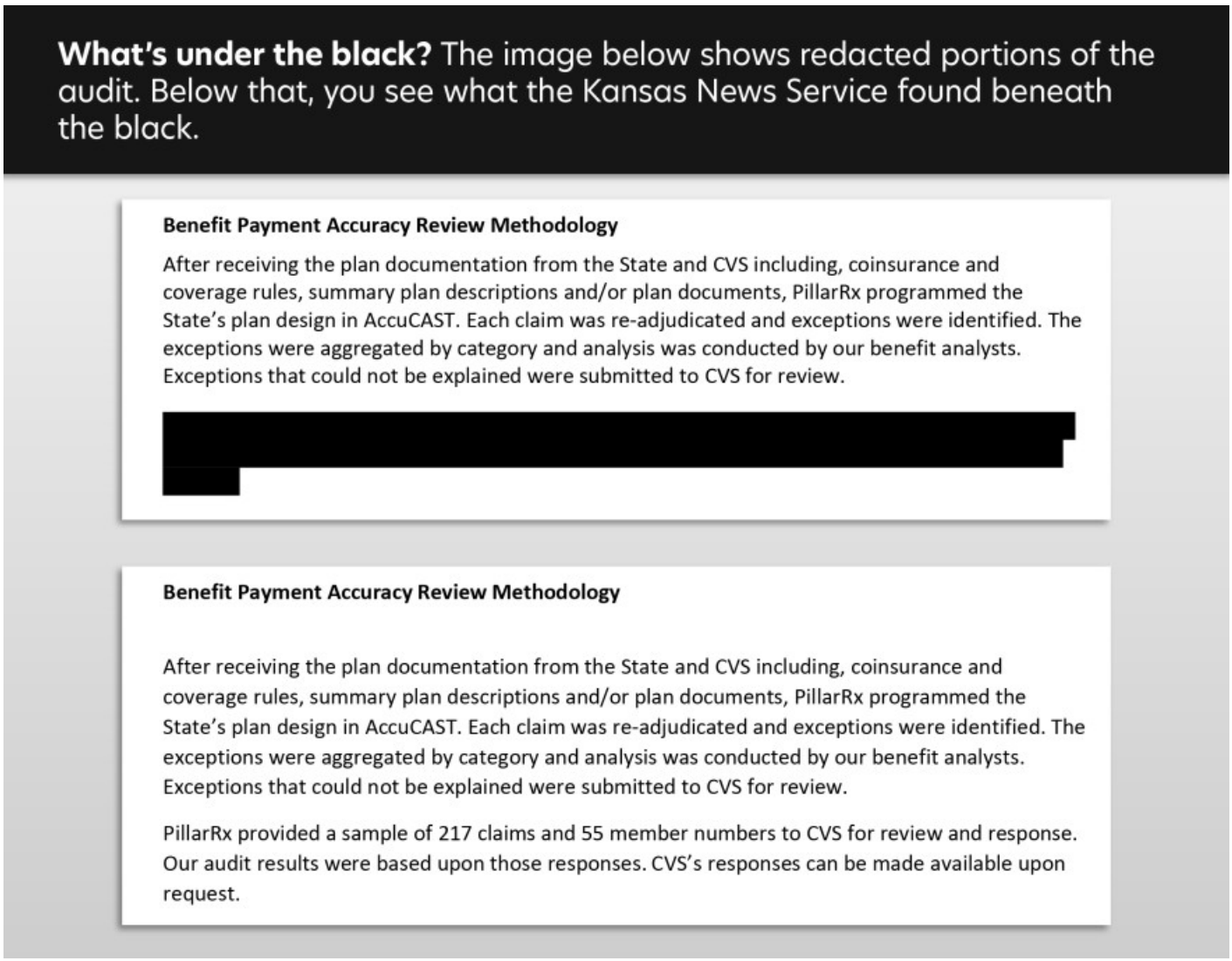
And it blacked out the identities of 10 pharmacies included in the audit.

"I don't think that's a trade secret," Sanders said. "We deserve to know whose contracts you reviewed."

The redactions also concealed sample sizes related to various portions of the audit, including the number of claims PillarRx used to check CVS' payments to pharmacies.

The audit concludes CVS stuck to the letter of its contract with Kansas when dealing with the manufacturers. And that its payments to pharmacies were appropriate.

However, pharmacy benefit experts question the quality of the audit.



redactions_3-.jpg

Here are a few more examples of redactions:

- Kansas concealed the number of pharmacies that auditors included in their probe.
- Kansas concealed discounts promised by CVS, such as 17% off of retail brands.
- And it redacted method details that shed light on how auditors checked whether CVS had handled claims and charges appropriately.

The negotiated discount rates, the dispensing fees and the identities of manufacturers are among the details that appear in the unredacted audit summary provided back in August. And the same level of detail appears unredacted in the 2017 audit.
In one instance, the state blacked out a paragraph reflecting concern from pharmacists about payments from CVS. The redacted note reads:

"It is to be noted that a couple pharmacies made comments that the reimbursement amount that they received, while it was accurate based on the adjudication of the claim, was less that (sic) what they expected it to be based on their own independent pharmacy research based on the tools they had available to them."

The Department of Administration also withheld the audit's supplementary exhibits, even though the Kansas News Service submitted an open records request for all attachments and addendums.

1980s AG opinion

Asked to justify its redactions, the Kansas Department of Administration first cited two entire state laws — "the Kansas Uniform Trade Secret Act (K.S.A. 60-3320 et seq) and the Kansas Open Records Act (K.S.A. 45-215 et seq)" — but would not explain which particular portions applied.

But legal experts say the state can't deny records without specific reasons any more than a court can declare an action unconstitutional without pointing to a specific part of the Constitution.

Pressed for its legal reasoning, Kansas responded with citations that included an entire page of statutory definitions — without clarifying which it believed were relevant.

That raised eyebrows among law professors interviewed by the Kansas News Service.

"An agency that decides not to fully disclose a record really has a burden" to get specific, Kautsch said.

The agency also cited a provision of the Kansas law that governs court proceedings, but he struggled to see why the provision would apply.

The Kansas trade secret law dates to 1981, and it didn't take long before questions arose about what the government could hide from public view under the new law.

In 1988, Kansas Attorney General Robert Stephan tackled that question in the context of public meetings. He issued an opinion clarifying that public bodies couldn't simply retreat behind closed doors each time they wanted to discuss matters involving private companies.

At the time, an economic development commission in Geary County wanted to talk privately about businesses considering relocating to the area, and about possible financial incentives and local wages.

"We believe these items do not qualify" as trade secrets that justify shutting out the public, the attorney general wrote. He made clear the commission must think carefully whenever it's tempted to retreat from public scrutiny.

"When in doubt," the attorney general's opinion says, "members of the Commission should remember that exceptions to the open meetings law are interpreted narrowly."

Gov. Laura Kelly's office didn't respond to a request for comment on the redactions.

The Kansas Department of Administration's decision to redact so much of PillarRx's audit makes it hard for journalists and the public to scrutinize the work of the auditors and CVS, Sanders said.

"It's not enough for a state to hire the auditor of its choice to sign off and say everything is OK," she said. "There needs to be some ability to replicate this audit or to be able to look at the steps taken in this audit and make sure that all of the i's are dotted and all the t's are crossed."

-30-

Celia Llopis-Jepsen reports on consumer health for the Kansas News Service. Follow her on Twitter @celia_LJ. The Kansas News Service is a collaboration of Kansas Public Radio, KCUR, KMUW and High Plains Public Radio -focused on health, the social determinants of health and their connection to public policy. Kansas News Service stories and photos may be republished by news media at no cost with proper attribution and a link to ksnewsservice.org.

Agenda Item #6

HOUSE BILL No. 2218

AN ACT concerning the Kansas state employees health care commission; changing membership thereon; providing responsibility to balance the healthcare needs of state employees with the financial impact on the state; requiring reports to the legislature on current and projected reserve balances in the state healthcare benefits program; amending K.S.A. 75-6501, 75-6502 and 75-6509 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 75-6501 is hereby amended to read as follows: 75-6501. (a) Within the limits of appropriations made or available therefor and subject to the provisions of appropriation acts relating thereto, the Kansas state employees health care commission shall develop and provide for the implementation and administration of a state health care benefits program. *The state employees health care commission shall balance the healthcare needs of state employees at an affordable cost to the employees with the financial impact on the state.*

(b) (1) Subject to the provisions of paragraph (2), the state health care benefits program may provide benefits for persons qualified to participate in the program for hospitalization, medical services, surgical services, nonmedical remedial care and treatment rendered in accordance with a religious method of healing and other health services. The program may include such provisions as are established by the Kansas state employees health care commission, including, but not limited to, qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits by reason of termination of employment or other change of status, leaves of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

(2) The state health care benefits program shall provide the benefits and services required by K.S.A. 75-6524, and amendments thereto.

(c) The Kansas state employees health care commission shall designate by rules and regulations those persons who are qualified to participate in the state health care benefits program, including active and retired public officers and employees and their dependents as defined by rules and regulations of the commission. Such rules and regulations shall not apply to students attending a state educational institution as defined in K.S.A. 76-711, and amendments thereto, who are covered by insurance contracts entered into by the board of regents pursuant to K.S.A. 75-4101, and amendments thereto. In designating persons qualified to participate in the state health care benefits program, the commission may establish such conditions, restrictions, limitations and exclusions as the commission deems reasonable. Such conditions, restrictions, limitations and exclusions shall include the conditions contained in K.S.A. 75-6506(d), and amendments thereto. Each person who was formerly elected or appointed and qualified to an elective state office and who was covered immediately preceding the date such person ceased to hold such office by the provisions of group health insurance or a health maintenance organization plan under the law in effect prior to August 1, 1984, or the state health care benefits program in effect after that date, shall continue to be qualified to participate in the state health care benefits program and shall pay the cost of participation in the program as established and in accordance with the procedures prescribed by the commission if such person chooses to participate therein.

(d) (1) Commencing with the 2009 plan year that begins January 1, 2009, if a state employee elects the high deductible health plan and health savings account, the state's employer contribution shall equal the state's contribution to any other health benefit plan offered by the state. The cost savings to the state for the high deductible health plan shall be deposited monthly into the employee's health savings account up to the maximum annual amount allowed pursuant to 26 U.S.C. § 223(d), as amended, for as long as the employee participates in the high deductible plan.

(2) If the employee had not previously participated in the state

health benefits plan, the employer shall calculate the average savings to the employer of the high deductible plan compared to the other available plans and contribute that amount monthly to the employee's health savings account up to the maximum annual amount allowed pursuant to 26 U.S.C. § 223(d), as amended.

(3) The employer shall allow additional voluntary contributions by the employee to their health savings account by payroll deduction up to the maximum annual amount allowed pursuant to 26 U.S.C. § 223(d), as amended.

(e) The commission shall have no authority to assess charges for employer contributions under the student health care benefits component of the state health care benefits program for persons who are covered by insurance contracts entered into by the board of regents pursuant to K.S.A. 75-4101, and amendments thereto.

(f) Nothing in this act shall be construed to permit the Kansas state employees health care commission to discontinue the student health care benefits component of the state health care benefits program until the state board of regents has contracts in effect that provide student coverage pursuant to the authority granted therefor in K.S.A. 75-4101, and amendments thereto.

(g) (1) On and after July 1, 2018, the commission shall designate claimants, as defined in K.S.A. 2020 Supp. 60-5004, and amendments thereto, as qualified to participate in the state health care benefits program. The commission shall implement this subsection in accordance with applicable federal law, including, but not limited to, the employee retirement income security act of 1974 and any regulations issued by the United States department of the treasury.

(2) A claimant shall have 31 calendar days from the date of judgment entered pursuant to K.S.A. 2020 Supp. 60-5004, and amendments thereto, to complete or decline enrollment in the state health care benefits program. A claimant shall be qualified to participate in the state health care benefits program for the remainder of the plan year when judgment is entered pursuant to K.S.A. 2020 Supp. 60-5004, and amendments thereto, and for the next ensuing plan year. A claimant shall not be qualified to elect a high-deductible health plan and health savings account under the state health care benefits program.

(3) Costs of premiums under the state health care benefits program for a claimant shall be paid from the tort claims fund established by K.S.A. 75-6117, and amendments thereto, and shall not be charged to the claimant. A claimant shall be responsible to pay any applicable copayments, deductibles and other related costs under the state health care benefits program.

(4) A claimant may elect to include the claimant's dependents under the state health care benefits program. For any covered dependents, the claimant shall be responsible to pay the costs of premiums, copayments, deductibles and other related costs under the state health care benefits program.

(5) The secretary of health and environment or the secretary's designee shall provide assistance to a claimant to obtain and maintain coverage under the state health care benefits program pursuant to this subsection, including: Enrollment; maintenance of related records; and other assistance as may be required or incidental to implement this subsection.

Sec. 2. K.S.A. 75-6502 is hereby amended to read as follows: 75-6502. (a) There is hereby established the Kansas state employees health care commission which is composed of ~~five~~ *seven* members as follows: (1) The commissioner of insurance; (2) the secretary of administration; (3) a current state employee ~~in the classified service under the Kansas civil service act~~ *who is currently enrolled in the state healthcare benefits program group health insurance medical plan*, appointed by the governor; (4) a person who retired from a position in ~~the classified service under the Kansas civil service act~~ *state service and who is currently enrolled in the state healthcare benefits program group health insurance medical plan*, appointed by the governor; ~~and~~ (5) a

representative of the general public, appointed by the governor*; (6) a member of the senate ways and means committee, appointed by the president of the senate; and (7) a member of the house of representatives appropriations committee, appointed by the speaker of the house of representatives*. A state officer or employee may not be appointed as the member representative of the general public.

(b) Each member appointed under this section by the governor shall serve at the pleasure of the governor. *The member appointed by the president of the senate shall serve at the pleasure of the president of the senate, and the member appointed by the speaker of the house of representatives shall serve at the pleasure of the speaker of the house of representatives.* Not more than ~~three~~ *five* members of the commission shall be members of the same political party.

(c) The chairperson of the commission shall be designated by the governor. The commission shall meet at least once each calendar quarter and at such other times as may be required on call of the chairperson or any three members thereof.

(d) A quorum of the Kansas state employees health care commission shall be ~~three~~ *four*. All actions of the commission shall be taken by a majority of all of the members of the commission.

(e) Members of the Kansas state employees health care commission attending meetings of such commission, or attending a subcommittee meeting thereof authorized by such commission, shall be paid compensation, subsistence allowances, mileage and other expenses as provided in K.S.A. 75-3223*,* and amendments thereto.

Sec. 3. K.S.A. 75-6509 is hereby amended to read as follows: 75-6509. Commencing with the regular session of the legislature in 1985 and with each regular session of the legislature thereafter, the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, on the day the governor's budget report is submitted to the legislature, recommendations with respect to the state health care benefits program together with estimates of the cost of the program proposed by the commission, including a five-year projection of the cost of the program, and the estimated cost of admitting each entity pursuant to ~~subsection (c) of~~ K.S.A. 75-6506*(c)*, and amendments thereto. *The recommendations shall include a report on the current and projected reserve balance, including as a percentage of total plan expenses. For any reserve balance over 10% of the average plan expenses for the immediately preceding three plan years, the commission shall provide recommendations for reducing reserves by minimizing increases to employee contributions or cost-sharing requirements.* Together with the recommendations submitted, the commission shall include alternatives for cost containment and benefit coverage for qualified persons for both the proposed program and the five-year projected program. The commission shall also submit any recommendations for legislation with respect to the state health care benefits program.

Sec. 4. K.S.A. 75-6501, 75-6502 and 75-6509 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

I hereby certify that the above BILL originated in the HOUSE, and was adopted by that body

_____

HOUSE adopted
Conference Committee Report_____

_____
Speaker of the House.

_____
Chief Clerk of the House.

Passed the SENATE
as amended _____

SENATE adopted
Conference Committee Report_____

_____
President of the Senate.

_____
Secretary of the Senate.

APPROVED _____

_____
Governor.

Agenda Item #7

Agenda Item #8

HCC PROCUREMENT PROCESS SURVEY

The survey was separated into sections to correspond with the particular stage of the procurement process. HCC members were asked to provide any edits or suggestions for each stage in the process. 4 responses were received.

Sections:

1. Bid Development (Items 1-4)

Comments:

- Item 2 refers to contracts being time-dependent - It seems that we continue to struggle, not having enough time to consider, review and make final decisions. At the same time, we bring some of that on ourselves. I think it is a combination of setting reasonable initiation of process time frames and the HCC/Commissioners abiding by and doing the work necessary to complete contract reviews/approval/decision in a timely fashion as well.

- It would be helpful for me to understand more about which SEHP contracts are not subject to state procurement guidelines. Could staff provide a list of current projects and note which are subject to state procurement guidelines and which are not? I think it would also be helpful to see a side-by-side comparison of the SEHP procurement process next to the state guidelines for procurement processes

2. Bid Posting & Follow-Up (Items (5-6)

Comments:

- I suggest that comments be shared with all the Commissioners for their awareness and that action taken (incorporated in full or partially, not incorporated, etc.) also be shared with the Commissioners.

3. Bid Response Preparation (Items 7-12)

Comments:

- I have a question related to item 10 -- do state procurement guidelines require the OPC to continue as the single point of contact between the time the bid event closes, and award decisions are made?

4. Recommendation Development (Items 13-16)

Comments:

- item 16 - referencing my comments to item 2 above, this may be the point where there is enough time built in that if a contract raises issues which require more information, clarification, etc. and approval is not forthcoming that the time exists for another later meeting to occur for final approval.

5. HCC Contract Approval Process (Item 17)

Comments:

- Add some clarification regarding SEHP staff's ability or inability to share any bidders' proposal details with the other bidders.
- 1st word is 'if' - suggest striking 'if' and replace it with the word 'when'

6. Bid Protest Process (Item 18)

Comments:

- Just to make sure I understand: the protest decision is made solely by the HCC Chair and does not involve the remaining Commissioners?

SUPPLEMENT TO PROCUREMENT PROCESS SURVEY

September 10, 2021

Secretary Burns-Wallace,

On behalf of Commissioner Vicki Schmidt, please see the attached redlined and commented document that sets forth in more detail suggestions on the procurement process that the Health Care Commission ("HCC") will adopt. This supplements Commissioner Schmidt's responses to the electronic survey.

Collectively, the statutes governing the HCC give significant flexibility to the HCC to effectively develop, implement, and administer a state health care benefits program. K.S.A. 75-6501 directs that the HCC shall develop and provide for the implementation and administration of a state health care benefits program. K.S.A. 75-6504, in turn, permits the HCC to enter into contracts to facilitate the health care benefits program. Subsection (d) of 75-6504 clearly exempts the HCC from many of the State's procurement statutes, including K.S.A. 75-3738 to 75-3740, inclusive.

Commissioner Schmidt believes there are four main items that should be addressed in any procurement process that the HCC adopts. First, HCC commissioners should be involved in the decision to put out a request for proposal or invitation to bid and to the specifications and deliverables. As we have seen in recent HCC meetings, there is significant disagreement between the commissioners as to the effectiveness of certain contractors and as to the need for certain programs to be offered. Prior to releasing an RFP, the HCC should have input and decision-making authority over the overall need for the services to be solicited. Along the same lines, the HCC commissioners should have input and decision-making authority on matters such as to the bid specifications. Currently, commissioners are given the specifications, usually from a prior bid event, and asked to provide feedback. But then there is no further communication on the feedback that is given. While it is helpful to receive the draft as a starting point, the commissioners should have final review of the specifications before they are publicized. HCC commissioners should also be afforded the opportunity to ask questions of bidders. HCC commissioners should also have a say in the election process and evaluative criteria that will be used for each bid event.

Second, the HCC commissioners should have full access to all information pertaining to potential contracts the HCC might award. For example, the HCC commissioners must be able to review all of the submitted bids, and all of the materials within each submitted bid, not just summaries compiled by SEHP staff. HCC commissioners should have the opportunity to ask questions of bidders.

Third, HCC commissioners should be afforded the opportunity to negotiate with bidders. The commissioners each bring unique backgrounds, experience, and expertise to the HCC. These qualities will benefit the members the HCC serve as we expect the gravitas of one or more commissioners on the negotiating team would add strength to the state's position in negotiating.

Fourth, the HCC should either establish a formal protest procedure or make the contract award voted on by the HCC final and appealable pursuant to the Kansas Judicial Review Act. Each option has merit, but the process should be formalized and decided on by the HCC after discussion.

Thank you for beginning the conversation on developing and voting on a procurement process for the HCC. The document presented was a good start, and with further input by HCC commissioners and a formal vote on the final process, the HCC will be in a much better position.

Justin L. McFarland

General Counsel

Kansas Insurance Department

Vicki Schmidt, Commissioner

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STATE EMPLOYEE HEALTH PLAN

PROCUREMENT PROCESS DRAFT OUTLINE

1. The SEHP follows the core requirements (principles) utilized by the Office of Procurement and Contracts (OPC). The Bid Guidelines for State Agencies is a document created by OPC, which sets forth the state procurement process and the statutory authority for this process found primarily in KSA 75-3739 – 75-3740 and KSA 75-37,102. However, KSA 75-6504 provides certain contracts entered into by the HCC are not subject to the provisions of KSA 75-3738 – 75-3740. This permits the HCC to utilize its own procurement procedure.

    - Bid Events are publicly posted and published by OPC on behalf of the SEHP/HCC and follows the statutory requirements utilized by OPC found in KSA 75-3739 (b) and KSA 75-37,102 (d).
    - SEHP ensures the bidding process is open and permits fair competition among bidders.
    - All vendors are provided the same opportunity to submit bid responses to the bid event.
    - All bid responses are evaluated to determine best value for the state and SEHP members based upon performance, cost and disruption factors [1]

2. Many SEHP contracts are time dependent on the Open Enrollment process and need to be coordinated with the plan insurance carriers and incorporated into various information system and communication builds ahead of the annual October 1st Open Enrollment start process. The SEHP adheres to a strict timeline in this regard.

3. OPC will determine if a dedicated Procurement Officer is needed to work with the SEHP staff on any aspects related to the bid document, including the initial development of the bid specifications and timeline to be used in the Request for Proposal (RFP) process.

4. The specifications for the bid event will be developed by SEHP program staff, and may include legal counsel, consultants working with SEHP and the OPC as needed [2] Once a draft RFP bid document has been developed, it will be electronically provided to the Health Care Commission (HCC) Commissioners for review and comment ahead of being provided to OPC for posting on the website and publishing. The Commissioners will provide their input to SEHP staff in the time period provided. The time period for review will not be less than one (1) week. This bid document as it is being developed and reviewed is not considered a public document and is not subject to disclosure under KSA 45-221 (a) (27). It should not be shared with anyone who is not affiliated with the SEHP, HCC or OPC.

5. SEHP staff will review the comments received from HCC Commissioners, utilizing the OPC and any consultants who may be involved. Changes will be made where appropriate, or a response provided when required to the respective Commissioner(s). [3]

6. Final specifications and bid documents are sent from the SEHP to OPC as they utilize OPC to post the SEHP bid event. OPC will then prepare the document for posting on the public website and for publishing. OPC has public posting capabilities through the SMART system consistent

Summary of Comments on SEHP Procurement Process_9.10.21_ (002).pdf

Page: 1

Number: 1 Author: Justin L. McFarland [KID] Date: 8/20/2021 10:50:00 AM

Why is this the exclusive criteria? The HCC commissioner should have a say into the evaluative criteria.

Number: 2 Author: Justin L. McFarland [KID] Date: 8/20/2021 10:51:00 AM

The HCC should be involved in determining:
Overall need to hire contractor(s)
Requirements and performance outcomes
Evaluation criteria

Number: 3 Author: Justin L. McFarland [KID] Date: 8/20/2021 10:53:00 AM

Who determines appropriateness? This seemingly undercuts the HCC authority. “Changes will be made based upon the HCC direction and final specifications will be provided to HCC for review before publication.”

with KSA 75-3739 and a bidder registration capability to notify potential bidders of any potential bid event. If SEHP has potential bidders it wants contacted about the bid event, SEHP can provide the contact information to the OPC Procurement Officer, who will contact the potential bidder to make them aware of the bid event and ask them to become a registered bidder in the State's procurement system.

7. The Procurement Officer assigned by OPC for the bid event is responsible for responding to all questions/comments from potential bidders until the bid event closes and all bids received are turned over to the SEHP staff. Amendments to the RFP, if necessary, will be routed through the OPC Procurement Officer for posting in accordance with the rules of the OPC. All questions posed by bidders and answers to questions will come through the OPC Procurement Officer. The OPC Procurement Officer will coordinate responses with the SEHP point of contact. This will ensure all potential bidders receive the same information and will have an equal opportunity to respond to the bid event.

8. The SEHP Administrative Coordinator is the designated point person for bid events for the SEHP division. This is consistent with the guidelines followed by OPC to ensure transparency of the process and the potential bidders are receiving the same information. The SEHP Administrative Coordinator works with the OPC Procurement Officer. This includes from the time the bid event is posted on the public website and published according to state statute until the bid event closes. This allows for the same information to be provided to all potential bidders. All questions and contacts by any potential bidder(s) are required by the rules of the bid event to go through the OPC Procurement Officer. It is the OPC Procurement Officer who contacts the SEHP Administrative Coordinator to obtain the requested information for the bidders. Failure to follow this process by any potential bidder could result in their bid submission being disqualified from consideration. The SEHP Administrative Coordinator, upon being contacted by the OPC Procurement Officer, will contact the appropriate individual(s) within SEHP to obtain the information needed to answer the bidder's inquiry during the time period the bid event is open. The OPC Procurement Officer will then take the information provided and will post an amendment to the bid event on the public website for anyone interested in the bid event to see and read. Any amendment becomes a part of the bid event documents. Registered bidders receive an email notification directing them to the website to see any posted amendment.

9. The SEHP Administrative Coordinator is responsible for overseeing the procurement process for all potential bid events within SEHP including:

   - Corresponding with the Office of Procurement and Contracts and the specific procurement officer handling the bid event.
   - Notifying the Office of Procurement and Contracts of all forthcoming, pending, and "in process" bid events/RFPs and their respective timelines.
   - Coordinating with legal counsel and any consultant assisting with the evaluation of the bid responses.
   - Coordinating with the different internal points of review within the SEHP to answer bidder questions.

Page: 2

Number: 1 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:11:00 PM
Not necessary.

Number: 2 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:12:00 PM
I assume this also means if the HCC wants potential bidders, the Commissioners can send that on, too?

Number: 3 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:13:00 PM
This is not clear. Who provides the content of the answers? But see #8
What rules of the OPC govern amendments?
The HCC should have a say in amendments?

Number: 4 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:23:00 PM
This is good idea.

Number: 5 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:23:00 PM
HCC should be able to decide this instead of a generic reference to “according to state statute”

10. OPC Procurement will be the single point of contact for all potential bidders and vendors once the bid event is posted. OPC will receive and track all questions, answers and bid responses submitted for the bid event from the posting of the bid event until the bid event closes. Copies of all bids received by OPC and determined to be eligible by OPC are forwarded from the OPC Procurement Officer to the SEHP Administrative Coordinator after the bid closing deadline. Once the bid responses have been received by the SEHP Administrative Coordinator from the OPC Procurement Officer, all future contact regarding the bid will go through the SEHP Administrative Coordinator. This includes vendors who failed to respond to the bid event or whose bid responses were found to be ineligible to be considered for the contract award.

11. In conjunction with the Director, SEHP, the SEHP Administrative Coordinator is responsible for coordinating SEHP staff review of the bid proposals received in response to the bid event and obtaining any additional information needed form the bidders. In addition to the senior leadership team, legal counsel, contracted vendor resources (as needed), staff included in these reviews include subject matter experts, staff responsible for the contract administration, and financial management staff.

12. Following its review of the bid responses, the SEHP staff determines which vendors should be contacted to set up information/negotiation sessions. This does not mean all bids received will be involved in these sessions. In accordance with NSA 75-6504 (b), a minimum of three vendor bids are selected. It can be more than three bids, if there are more than three submissions. It can be less than three bids, if only one or two bid responses are received in response to the bid event.

13. An SEHP team, consisting of the Director, legal counsel, relevant Management Team members, and staff, and when appropriate and necessary, the Actuarial and Consulting Vendor or other consultant, holds negotiation/information gathering sessions with bidders.

14. The SEHP Director is designated as the Chief Negotiator for the SEHP/SOK with SEHP staff involved in formulating the negotiation/information session questions. This is consistent with the process used by OPC.

15. Following the negotiation/information sessions, the SEHP will request bidders provide responses to any questions which have arisen during the process, along with a best and final offer to the SEHP. The final submissions from the bidders will be reviewed by SEHP staff and legal counsel, and any follow-up and clarifications will be requested from the bidders.

16. After the SEHP staff reviews all the information submitted by the bidders and does a comparison of pre-established criteria used in the selection process, such as cost of services, experience, capacity to provide the requested services, customer service etc., the SEHP staff will make a recommendation to the HCC for approval at its next available meeting date or special meeting date, if necessary.

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Number: 1 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:26:00 PM
Which leadership team?

Number: 2 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:26:00 PM
Notably absent are HCC commissioners

Number: 3 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:29:00 PM
The HCC should see the bids prior to this.

Number: 4 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:30:00 PM
Once again, no HCC member is listed. HCC commissioners should be part of the negotiations.

Number: 5 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:33:00 PM
See comment above regarding evaluation criteria. HCC commissioners should have an opportunity to select the criteria and evaluate the bids based upon that criteria.

17. If the HCC approves of the contract award recommendation by a majority vote of the HCC members in an open meeting held in accordance with the Kansas Open Meeting Act, a contract will be forwarded to the vendor being awarded the contact for signature.

18. The SEHP closely follows the OPC's Bid Protest Process as outlined below:

a. The protest shall be made in writing to, and received by, the Director, State Employee Health Plan (SEHP) within **thirty (30) calendar days** after the date of the event which gives rise to the vendor's protest. The Director, SEHP shall not accept any protest more than thirty (30) days after the date of the contract award or renewal.

b. The written protest shall include the following:

- The name and address of the protesting vendor;
- Appropriate identification of the procurement by bid or contract number;
- A statement of the specific reasons for the protest; and
- Supporting exhibits, evidence, or documents, unless they are not available within the filing time, in which case the expected availability date shall be indicated.

c. If a protest has been filed before an award or renewal has been made, no contract shall be awarded or renewed until the protest has been heard, unless it is determined by Chairperson, Health Care Commission the immediate award of the contract is necessary to protect State interest.

d. A protest decision shall be made by the Chairperson, Health Care Commission as soon as possible after receiving all relevant, requested information. The decision of the Chairperson, Health Care Commission is final and there is no further administrative appeal process. The Chairperson, Health Care Commission is the state agency officer to receive service of a petition for judicial review on behalf of the Health Care Commission (HCC) and SEHP.

e. To maintain the integrity of the procurement process, the HCC/SEHP shall not grant waivers for, or hear protests concerning, the following omissions:

- Failure to properly complete the bid form;
- Failure to submit the bid to the Office of Procurement and Contracts by the due date or time;
- Failure to provide samples, descriptive literature, or other required documents by the bid deadline or other specified time; or
- Failure to provide a required bid deposit or performance bond by the specified date or time.

Number: 1 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:33:00 PM
Alternatively the HCC makes a decision, and the aggrieved bidder's remedy is to file a petition for judicial review pursuant to the Kansas Judicial Review Act.

Number: 2 Author: Justin L. McFarland [KID] Date: 8/22/2021 7:34:00 PM
HCC has not delegated this authority to the chairperson. As this could be construed as agency action pursuant to the KJRA, it needs to be made by the agency, i.e., the HCC.

STATE EMPLOYEE HEALTH PLAN

PROCUREMENT PROCESS DRAFT OUTLINE

Original Document presented to the HCC
at the August 23rd meeting.

Bid Development

1. The SEHP follows the core requirements (principles) utilized by the Office of Procurement and Contracts (OPC). The Bid Guidelines for State Agencies is a document created by OPC, which sets forth the state procurement process and the statutory authority for this process found primarily in KSA 75-3739 – 75-3740 and KSA 75-37,102. However, KSA 75-6504 provides certain contracts entered into by the HCC are not subject to the provisions of KSA 75-3739 – 75-3740. This permits the HCC to utilize its own procurement procedure, while incorporating many of the rules and procedures followed by OPC.

    - Bid Events are publicly posted and published by OPC on behalf of the SEHP/HCC and follows the statutory requirements utilized by OPC found in KSA 75-3739 (b) and KSA 75-37,102 (d).
    - SEHP ensures the bidding process is open and permits fair competition among bidders.
    - All vendors are provided the same opportunity to submit bid responses to the bid event.
    - All bid responses are evaluated to determine best value for the state and SEHP members based upon performance, cost and disruption factors

2. Many SEHP contracts are time dependent on the Open Enrollment process and need to be coordinated with the plan insurance carriers and incorporated into various information system and communication builds ahead of the annual October 1st Open Enrollment start process. The SEHP adheres to a strict timeline in this regard.

3. OPC will determine if a dedicated Procurement Officer is needed to work with the SEHP staff on any aspects related to the bid document, including the initial development of the bid specifications and timeline to be used in the Request for Proposal (RFP) process.

4. The specifications for the bid event will be developed by SEHP program staff, and may include legal counsel, consultants working with SEHP and the OPC as needed Once a draft RFP bid document has been developed, it will be electronically provided to the Health Care Commission (HCC) Commissioners for review and comment ahead of being provided to OPC for posting on the website and publishing. The Commissioners will provide their input to SEHP staff in the time period provided. The time period for review will not be less than one (1) week. This bid document as it is being developed and reviewed is not considered a public document and is not subject to disclosure under KSA 45-221 (a) (27). It should not be shared with anyone who is not affiliated with the SEHP, HCC or OPC.

Bid Posting & Follow-Up

5. SEHP staff will review the comments received from HCC Commissioners, utilizing the OPC and any consultants who may be involved. Changes will be made where appropriate, or a response provided when required to the respective Commissioner(s).

6. Final specifications and bid documents are sent from the SEHP to OPC as they utilize OPC to post the SEHP bid event. OPC will then prepare the document for posting on the public website and for publishing. OPC has public posting capabilities through the SMART system consistent with KSA 75-3739 and a bidder registration capability to notify potential bidders of any potential bid event. If SEHP has potential bidders it wants contacted about the bid event, SEHP can provide the contact information to the OPC Procurement Officer, who will contact the potential bidder to make them aware of the bid event and ask them to become a registered bidder in the State's procurement system.

Bid Response Preparation

7. The Procurement Officer assigned by OPC for the bid event is responsible for responding to all questions/comments from potential bidders until the bid event closes and all bids received are turned over to the SEHP staff. Amendments to the RFP, if necessary, will be routed through the OPC Procurement Officer for posting in accordance with the rules of the OPC. All questions posed by bidders and answers to questions will come through the OPC Procurement Officer. The OPC Procurement Officer will coordinate responses with the SEHP point of contact. This will ensure all potential bidders receive the same information and will have an equal opportunity to respond to the bid event.

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Recommendation Development

13. An SEHP team, consisting of the Director, legal counsel, relevant Management Team members, and staff, and when appropriate and necessary, the Actuarial and Consulting Vendor or other consultant, holds negotiation/information gathering sessions with bidders.

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HCC Contract Approval Process

17. If the HCC approves of the contract award recommendation by a majority vote of the HCC members in an open meeting held in accordance with the Kansas Open Meeting Act, a contract will be forwarded to the vendor being awarded the contact for signature.

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- Failure to submit the bid to the Office of Procurement and Contracts by the due date or time;
- Failure to provide samples, descriptive literature, or other required documents by the bid deadline or other specified time; or
- Failure to provide a required bid deposit or performance bond by the specified date or time.

Agenda Item #9

APPENDIX – a

Medical Administration Audit of Aetna

Executive Summary

September 15, 2021

Prepared for
The State Employee Health Plan
State of Kansas

Submitted by:
Sagebrush Analytic Solutions
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Sagebrush Analytic

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Exhibits

Executive Summary

Sagebrush Analytic Solutions LLC (Sagebrush) was engaged by The State Employee Health Plan (SEHP), State of Kansas (SOK), to review and evaluate the medical claims processing services provided on behalf of the SEHP employee benefit plan by Aetna for calendar year 2020.

The State Employee Health Plan (SEHP) currently offers five self-insured medical plan designs, Plan A, Plan C, Plan J, Plan N, and Plan Q, administered by Aetna and Blue Cross Blue Shield of Kansas (BCBSKS). The plans cover more than 83,000 active participants, early retirees, and their dependents.

The purpose of the audit is to verify that Aetna is administering the benefit provisions as intended. The audit is designed to evaluate overall claims processing accuracy and efficiency and identify opportunities for improved administration.

In addition to conducting a statistical audit to verify administrative accuracy, SEHP engaged Sagebrush to:

- Electronically compare claims to eligibility data to identify any payment for ineligible participants; and
- Interrogate 100% of the claims data electronically for potential errors, such as duplicate payments and clinical edits.
- Interrogate 100% of the claims data electronically to verify that plan provisions were administered properly. Tests would include deductible, copayments, and plan limitations and exclusions.

Due to COVID19, Sagebrush conducted the review of claims remotely starting on May 3, 2021 and ending on May 7, 2021. During this review, the audit team tested a statistical sample of 250 medical claims for financial and processing accuracy. The claims were tested for eligibility, timeliness, payment accuracy and adherence to plan benefits and administration procedures. The sample was selected from the population of 59,789 SEHP medical claims, totaling $14,578,992.73. processed between January 1, 2020 and December 31, 2020.

Based on Sagebrush's review of the claims data, contracts, and other documents and information provided for audit, Aetna administered the medical benefits within the scope of the contract with SEHP during the 2020 calendar year. However, the audit revealed opportunities for improved administration of eligibility updates, coordination of benefits processes, and processing time that Aetna and SEHP, collaboratively, have resolved. The following summary provides an overview of the audit findings, including both statistical and focused electronic testing. The detailed audit results are discussed in the body of the report.

Exhibit 1: Summary of Audit Findings

Finding	Description	Impact
Statistical Audit	The statistical sample revealed $130,239.20 in overpayments in the sample of 250 claims tested.	• Aetna disagrees with one overpayment, in the amount of $12.09. SEHP has reviewed Aetna's explanation and accepted their position. This amount is not shown in the $130,239.20 total. • The total overpayments of $130,239.20 does not include four underpayments identified in the sample, totaling ($1,057.15). • Aetna previously recovered and credited SEHP $113,737.71. • Aetna is in process of recovering the remaining amounts that will be paid to SEHP via check.
Focused Electronic Testing	The electronic testing identified $35,715.46 in overpayments.	• Aetna previously recovered and credited SEHP for $29,064.07. • $167.01 of the remaining balance cannot be recovered because of the age of the claim or because the amount is under the threshold for recovery. • Aetna is in process of recovering the remaining amounts that will be paid to SEHP via check.
TOTAL IMPACT		• Total overpayments paid/to be paid to SEHP: $165,954.66 • Less total overpayments previously credited to SEHP: $142,801.78 • Equals total remaining overpayments to be recovered and paid to SEHP less $167.01 uncollectible: $22,985.87

Summary of Statistical Sample Review Results

The statistical sample review identified seventeen (17) errors. Aetna agreed with all errors, except one, for which Sagebrush and Aetna agree to disagree. There were sixteen (16) payment errors with a net overpayment amount of $129,194.14 and one (1) processing or non-payment error.

Considering the sixteen (16) payment errors identified in the sample, the overall financial accuracy of the claims administered by Aetna in 2020 is 95.14%. The calculated payment or dollar accuracy from the audit is 99.37%. The calculated procedural accuracy is 98.15%.

The following exhibits summarizes the 17 errors identified in the 250-claim statistical sample by root cause and error amount.

Exhibit 2: Summary of Statistical Sample Errors

Root Cause Type	Description	# of Errors	Net Amount of Error Corrected/To Be Corrected[1]
Coordination of Benefits	Claim did not coordinate benefits with the primary insurance	4	$10,388.00
Ineligible Participant	Services were paid after the participant's termination date. (Aetna subsequently reversed these claims after the study period, in 2021).	7	$113,732.71
Incorrect Fee Allowed	The allowed fees were calculated incorrectly.	3	($1,029.77)
Benefits Applied Incorrectly[1]	Deductibles and/or coinsurance not applied correctly to claim. Aetna disagrees with one of the errors, totaling $12.09 (Not included in To Be Corrected).	2	($27.38)
Clinical Edits Not Applied	When a surgery includes multiple operative procedures, the primary procedure is allowed 100% of the fee for that procedure and the allowed amounts for other secondary and tertiary procedures are reduced per American Medical Association guidelines and Aetna policy. Procedures were not reduced.	1	$6,118.49
Total Net		17	$129,206.23

[1] Excludes overpaid amount of $12.09 on Sample 59 to which Aetna disagreed. The SEHP reviewed Aetna's explanation of the claim handling and accepted Aetna's explanation.

Exhibit 3: Number of Statistical Errors by Root Cause Type

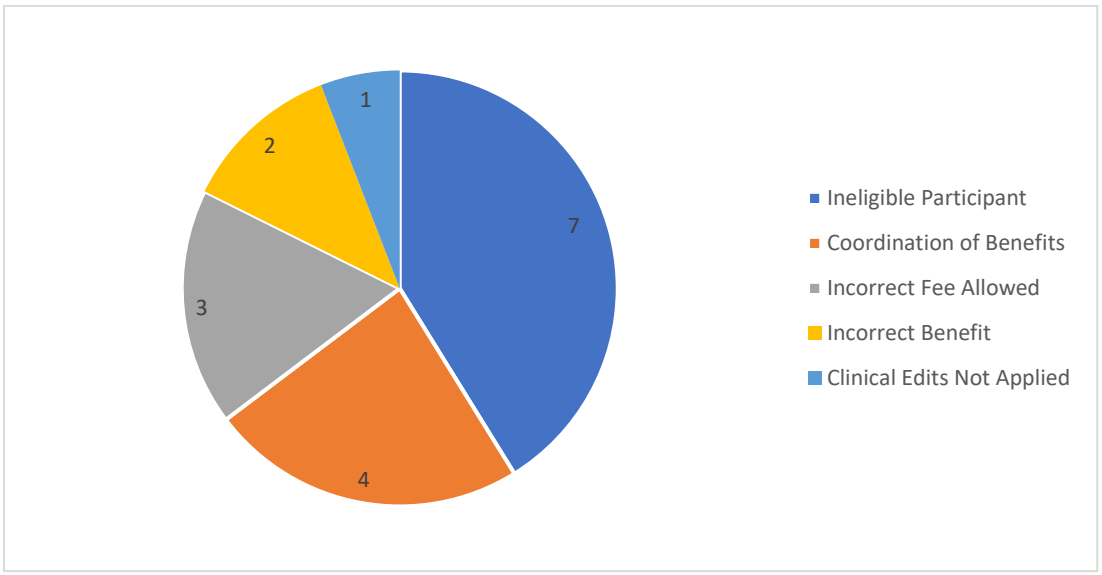
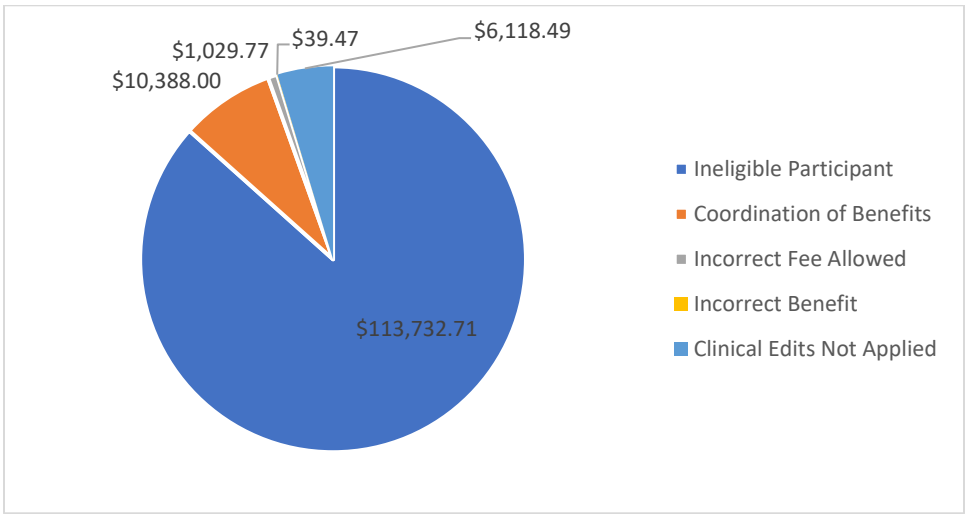


Exhibit 4: Value of Statistical Errors by Root Cause Type



Conclusion

The sample revealed errors resulting from manual processes and manual overrides of system edits for coordination of benefits, pricing, and clinical edits. Additionally, the sample findings were impacted significantly by the payment of seven sampled claims for termed participants.

Summary of Focused Electronic Testing Results

In addition to the statistical claim review, Sagebrush electronically tested 100% of the claims data to identify potential duplicate claim payments, analyzed medical claim payments utilizing clinical editing software, identified participants with claim payments after coverage terminated, and tested specific benefit provisions and exclusions. The chart below is a summary of the testing that was completed.

Exhibit 5: Electronic Testing Summary

Test	Description	Findings	Net Amount of Error Corrected/To Be Corrected
Clinical Edits			
Multiple Procedures, Incidental, and Mutually Exclusive Procedures	Electronically apply clinical edits to claims data to identify claims where unbundling edits have not been applied	●	$0.00
Assistant Surgeon Not Allowed	Identify claims where payment was made on a procedure that the American Medical Association states an assistant at surgery is not necessary or recommended	●	$0.00
Visits in the Global Surgical Period	Identify instances where a provider billed an evaluation and management service during the global post-operative period. When the diagnosis submitted on these claims is the same or related to the diagnosis submitted for the operative procedure, the services are considered post-op visits and should be included in the fee that was paid for the surgery and not separately reimbursed.	●	$0.00
Benefit Provisions			
Deductible – Coinsurance test	Identify the participants that appear to have incorrect deductible and coinsurance amounts applied	●	$0.00
Benefit Limitations/Exclusions			
Cosmetic Procedures	Identify claims for surgical procedures that could be considered cosmetic and not medically necessary.	●	$0.00
Bariatric Services	Identify claims for Bariatric services that do not meet the criteria outlined by the plan.	●	$0.00
TMJ	Medical, surgical or dental treatment or services related to the treatment of temporomandibular joint (jaw hinge) disease (TMJ) is not covered.	●	$0.00
Routine Foot Care	Is not a covered service unless Medically Necessary for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity, and except as specifically provided for a diabetic Participant	●	$0.00
Massage Therapy	General exclusion per the summary of plan description.	●	$0.00
Routine Hearing Test	Routine hearing test is covered once per plan year	●	$0.00

Test	Description	Findings	Net Amount of Error Corrected/To Be Corrected
Acupuncture	Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not covered.	🟢	$0.00
Dental Services	Treatment of teeth or supporting structures is not covered, except as specified in the Dental Services and the Transplant within the Covered Service Section provided under the terms of the Plan.	🟢	$0.00
Other			
Claims Paid for Ineligibles[2]	Electronically compare claims data to eligibility data to identify claims payments on behalf of ineligible participants	🟡	$35,604.88
Duplicate Payments	Electronically test claims data for duplicate payments for the same service for the same participant	🟢	$37.04

Exhibit 2 Key:

🟢 Aetna has adequate system edits/controls in place for this test.
🟡 Opportunities for improvement exist for System edits and/or processes for this test.
🔴 Less than satisfactory, needs immediate action

Conclusion

Aetna's systems are accurately programmed for the State's benefit plans and include adequate controls for clinical edits and duplicate payments. Sagebrush notes, as revealed in the statistic sample, that system edits may be manually overridden.

The audit revealed opportunities to improve processes for intake and implementation of eligibility information for terminated participants. Aetna and SEHP, collaboratively, have resolved these issues.

[2] Exhibit 5 is the total findings identified by Sagebrush. When Sagebrush provided Aetna the list of claims paid to ineligibles, Aetna identified an additional overpayment of $72.54, resulting in total overpayments for ineligibles and duplicate payments combined of $35,715.46.

Summary of Turnaround Time Testing Results

The following exhibit presents the findings of turnaround time, or time taken to process each claim, for the entire population of medical claims processed by Aetna in 2020.

Exhibit 6: Turnaround Time

Business Days	# of Claims	% of Claim Population	Cumulative # of Claims	Cumulative % of Population
0 - 10 days	51,071	94.6%	51,071	94.6%
11 - 14 days	436	0.8%	51,507	95.4%
15 - 30 days	514	1.0%	52,021	96.4%
> 30 days	1,948	3.6%	53,969	100.0%
Total	53,969	100.0%		

The findings are that Aetna processed 95.4% of all claims within 14 business days of receipt and 96.4% of claims within thirty (30) days. Aetna strives to process 95% of claims within fourteen (14) and 99% within thirty (30) business days.

Conclusion

Aetna processed 95.0% of all claims in fourteen days but did not process 99.0% within 30 days.

Recommendations

Eligibility Processing

Aetna receives five files daily from SEHP, one for each plan, containing eligibility changes that are worked daily by Aetna. Also, Aetna receives a full eligibility file from SEHP on a monthly basis, used to create an exceptions report that is worked collaboratively by Aetna and SEHP.

The monthly report was not retrieved by Aetna from the SOK FTP site for a number of months in 2020. Aetna and SEHP collaborated and determined that there had been a change to the naming convention for the monthly file and, as a result, the Aetna program for downloading the monthly file was not sweeping the monthly file to the Aetna servers. SOK reports communicating the file name change; Aetna did not track or report whether the name change was initially not updated or, perhaps, not updated correctly. Without the monthly file, the exceptions report was not generated and eligibility process errors were not corrected on a timely basis in 2020. The program has been

corrected, and the monthly file is being retrieved, and the monthly exceptions report work has resumed.

Multiple reasons exist for errors in the processing of the daily files that create the exceptions identified through the monthly reporting process. The reasons include daily files that are intended for Aetna but not received/retrieved and, previously, were assumed to indicate that there were no changes that day for one or more of the five plans.

Through the process of correcting the sweep for the monthly file, Aetna and SEHP implemented a process to ensure all intended daily files are received by Aetna. A daily courtesy email is sent to the Eligibility Analyst and the Account Manager listing the files transmitted that day. The Analyst and Manager compare the list to files and contact SEHP to correct for any missing files.

These corrections and enhancements to the controls on the processing of eligibility updates were completed in February 2021.

Findings

The statistical sample revealed $130,239.20 in overpayments. Of this amount, Aetna previously recovered, prior to the preparation of this report, $113,737.71; these amounts were previously credited to SEHP. Aetna is in process of recovering the remaining amounts that will be paid to SEHP via check.

The electronic testing identified $35,715.46 in overpayments. Aetna previously recovered, prior to the preparation of this report, $29,064.07; these amounts were previously credited to SEHP. $167.01 of the remaining balance cannot be recovered because of the age of the claim or because the amount is under the threshold for recovery. Aetna is in process of recovering the remaining amounts that will be paid to SEHP via check.

APPENDIX – b

Dental Administration Audit of Delta Dental of Kansas

Summary of Audit

September 15, 2021

Prepared for
The State Employee Health Plan
State of Kansas

Submitted by:
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Tables

Executive Summary

Sagebrush Analytic Solutions LLC (Sagebrush) was engaged by The State Employee Health Plan (SEHP), State of Kansas (SOK), to review and evaluate the dental claims processing services provided on behalf of the SEHP employee benefit plan by Delta Dental of Kansas (DDKS) for calendar year 2020.

SEHP directed Sagebrush to conduct an audit of the administration of the dental benefits to determine overall claims processing accuracy and efficiency, and to identify opportunities for improved administration.

In addition to conducting a statistical audit to verify administrative accuracy, Sagebrush conducted the following tests:

- Review of a sample of dental claims to the corresponding provider contracts;
- Determine the value, if any, of claims paid for ineligible participants;
- Interrogate the claims data electronically for clinical edits (procedure codes), duplicate payments and specific plan provisions and exclusions; and
- Verify the payments to providers and corresponding draw from the SEHP funds.

Due to COVID-19, Sagebrush conducted the review of claims remotely starting on April 26, 2021 and ending on April 30, 2021. During this review, the audit team tested a statistical sample of 250 dental claims for financial and processing accuracy. The claims were tested for eligibility, timeliness, payment accuracy and adherence to plan benefits and administration procedures. The sample was selected from the population of 145,601 SEHP dental claims, totaling $23,201,559.63. processed between January 1, 2020 and December 31, 2020.

Based on Sagebrush's review of the claims data, contracts, and other documents and information provided for audit, DDKS administered the dental benefits within the scope of the contract with SEHP during the 2020 calendar year. The following summary provides an overview of the audit findings along with Sagebrush's observations and recommendations. The complete audit results are discussed in the body of the report.

Summary of Findings

Dental Statistical Sample Review

The statistical review of 250 sampled claims identified one (1) payment error. DDKS agreed with the error.

Considering the one (1) payment error identified in the sample, the overall financial accuracy of the claims administered by DDKS in 2020 is 99.91%. The calculated payment or dollar accuracy from the audit is 99.92%. The calculated procedural accuracy is 100.00%.

Incorrect Benefit:

There was one (1) claim with incorrect benefits paid. The claim resulted in a net overpayment of $175.70.

Sample #242 – SEHP's plan of benefits states that implant or major restoration is paid at 50% of the allowable fee for the enhanced benefit. The enhanced benefit applies if there is an exam or cleaning within 12 months of the date of service of the implant or major restoration.

This claim did not qualify for the enhanced benefit and should have paid at the lower benefit of 40% of the allowable expense.

DDKS Response: Processing error. DDKS completed research and discovered one other claim that processed incorrectly (2 0267 006 50) and as a result overpaid by $176.10. *DDKS to issue a Guarantee of Service Excellence (GOSE) payment for both claims totaling $351.80 via check to SEHP.*

Focused Review Results

In addition to the statistical claim review, Sagebrush electronically tested the claims data to identify potential duplicate claim payments, analyzed dental claim payments utilizing clinical editing software, identified participants with claim payments after coverage terminated, and tested specific benefit provisions and exclusions. The chart below is a summary of the testing that was completed.

Table 1: Electronic Testing Summary

Test	Description	Purpose
Frequency edits, e.g., more than 2 prophylaxes in a year.	Identify members with services that exceed the frequency limit per plan year, e.g. more than 2 prophylaxes in a year.	Ensure that DDKS has the plan benefits configured correctly in the claim system.
Billing more than one one-surface filling on a tooth (instead of using the code for 2 surfaces).	Identify claims where a provider billed for 2 one-surface fillings on the same tooth on the same date	Ensure DDKS is applying clinical editing software to the SEHP claims in accordance with DDKS policies and within industry norms.
Provider billed for excessive number of patients seen in one day.	Electronically identify providers that appear to have treated an excessive number of patients (more than 12) in one day.	To test for fraudulent billing activity by a provider.
Claims Paid for Ineligible Members	Electronically compare claims data to eligibility data to identify claims payments on behalf of ineligible participants	• Verify system edits for eligibility • Identify opportunities to improve eligibility process for SEHP and Delta Dental • Identify claims to be recovered
Duplicate Payments	Electronically test claims data for duplicate payments for the same service for the same participant	• Verify system edits for duplicates • Identify claims to be recovered

Sagebrush reviewed the electronic results and provided DDKS with a file of 50 potentially erroneous claims. DDKS reviewed the claims and provided a response with additional documentation to support each position.

Exceeds Frequency Limitations

Sagebrush electronically tested the paid claims data to identify any members that had more than two (2) dental cleanings or periodontal maintenance services in the plan year. There were eight (8) claims included in the file of 50 claims sent to Delta Dental, with a potential net overpayment of $907.99.

- Of the eight (8) claims, DDKS disagreed with five (5) stating “through DDKS' plan year closing process procedural checks were conducted any deviations from policy discovered were evaluated and where necessary adjustments/refunds were completed according to evaluation. Therefore, a refund was requested from the provider on 1/13/2021. $452.99 has been previously recovered.”

- DDKS disagreed with (2) claims with a total paid amount of $232.00 stating ‘per SOK exception, this member is allowed cleanings every 3 months because of health conditions.”

- DDKS agreed with one (1) claim with a paid amount of $68.00 which was submitted as a child prophylaxis in error. DDKS has agreed to request a refund from the provider for the total claim payment of $223.00.

One-surface Filling vs. Two-surface Filling

Sagebrush identified twelve (12) claims with a net paid amount of $1,304 in our review where it appeared that the provider had billed for more than one one-surface filling for the same tooth on the same date of service.

DDKS disagreed with the $1,304.00 identified stating that DDKS policy states that the buccal or lingual surface is considered a separate restoration when submitted as a one surface filling when it does not connect to the other filling being completed on the same day. When the Client contract is silent, DDKS follows DDKS Plans Association processing policy which states "A separate benefit may be allowed for a non- contiguous restoration on the buccal or lingual surface of the same tooth."

According to the DDKS policy, there are no exceptions for multiple one-surface fillings.

Provider Billing for Excessive Patients Seen in One Day

Sagebrush tested the paid claims data to identify possible provider fraud where the provider appeared to have treated an excessive number of patients in one day.

Based on our review, we did not identify any instances of provider billing fraud. A Dental Hygienist usually sees the patients for cleanings, while the services, such as fillings, root canals, etc. are performed by the Dentist.

Claims Paid for Ineligible Members

Sagebrush ran the eligibility file that we received from the State of Kansas against the paid claims data provided by DDKS to identify claims paid for members that were no longer eligible for coverage. Sagebrush included fifteen (15) members with paid claims totaling $3,949.27 in the 50 potential exceptions sent to DDKS resulting from electronic focused testing.

- DDKS agreed with seven (7) of the members with an overpaid amount of $2193.57.

- DDKS disagreed with one (1) member with claims totaling $279.80 was previously covered under his wife but now has his own policy. These claims appeared to have been paid prior to the effective date of coverage.

- DDKS disagreed with claims totaling $388.40 stating that they had active coverage. Either the member was not on the eligibility file received from the SOK or they were terminated in the dental system on the same date as the service.

- One claim in the amount of $123.00 was previously recovered during the audit period.

- DDKS disagreed with two (2) members with claims totaling $308.00 stating that the electronic eligibility files received from the SOK never indicated a termination date for these members. Since the member was not present on the open enrollment file received in December, coverage was terminated effective 1/1/2021; the start of the new plan year.

  Sagebrush believes the member should have been terminated effective 12-1-2020, since they were not shown on the open enrollment file in December.

Sagebrush believes there was a miscommunication issue with the termination dates being sent to Delta Dental on the electronic eligibility files. For example, a file sent to Delta Dental dated 10-6-2020 included a member that was listed with a termination date effective 10-1-2020. SEHP meant that the member's last day of coverage was 9-30-2020 and that the member was terminated effective 10-1-2020. Delta Dental interpreted the date on the file to be the termination date, which gave the member coverage until 11:59 pm on 10-1-2020.

On August 8, 2021, Delta Dental added logic to subtract one day from the termination date sent over on the eligibility files in order to reflect the same final date of coverage as intended by SEHP. Overall, SEHP and Delta Dental have a good process in place for keeping eligibility updated.

Duplicate Payments

Duplicate payments - Sagebrush's review of the potential duplicate payments identified fifteen (15) possible errors resulting in an overpaid amount of $1,888.30.

- DDKS agreed to five (5) of the errors totaling $1,153.00.

- Four (4) of the claims, totaling $359.60, had been previously recovered during the audit period.

- Five (5) claims were previously identified as overpayments by DDKS and the net overpayment of $315.20 has been requested from the providers of service. Once the money is returned, the SOK account will be credited for the overpaid amount.

- DDKS disagreed with one (1) claim, totaling $60.50, stating an appeal was received

with additional documentation. A consultant reviewed the documentation and approved the additional unit of anesthesia because of necessity.

Delta Dental has system edits in place to identify duplicate payments. Any errors identified have been addressed with the claim processors through additional training.

Claim Turnaround Time

The following table represents the TAT statistics for the Delta Dental claim population for claims incurred and processed during the period January 1, 2020 through December 31, 2020.

Table 2: Claim Population Turnaround Time for Calendar Year 2020

Business Days	Number of Claims	Percentage of Population	Cumulative Calendar Days	Cumulative Number of Claims
0 - 10 days	139,530	95.8%	139,530	95.8%
11 - 14 days	3,582	2.5%	143,112	98.3%
15 - 30 days	1,793	1.2%	144,905	99.5%
> 30 days	696	0.5%	145,601	100.0%
Total	145,601	100%		

The analysis indicates that Delta Dental processed 95.8% of all claims within 14 business days of receipt and 99.5% of claims within thirty (30) days. The calculation is based on business days, Monday through Friday. Sagebrush did not remove any holidays.

Conclusion

The project results indicate that Delta Dental's performance relative to claims accuracy and timeliness and operational efficiency is within acceptable standards and guidelines. Sagebrush's overall conclusion based on the results of the claim reviews, the observations during the onsite review and the analysis of the administrative questionnaire is that Delta Dental claims operations appear to be appropriate and efficient.

Delta Dental reviewed potential exceptions with a total paid amount of $8,492.16. Of this amount, $3,669.66 has been previously credited on the State's Group Patient Payment Report and $2,249.80 will be paid via check to SEHP.

Delta dental disagreed with the findings for $2,572.70. Delta Dental will not recover payment on claims for which they disagree to an error. Although, a claim for $115.00 was refunded and will be credited on the State's Group Patient Payment report.

APPENDIX – c

Dependent Eligibility Verification Audit

Executive Summary

July 21, 2021

Prepared for
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State of Kansas

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Exhibits

Executive Summary

Sagebrush Analytic Solutions LLC (Sagebrush) was engaged by The State Employee Health Plan (SEHP), State of Kansas (SOK), to conduct the annual dependent eligibility verification audit for calendar year 2020.

Sagebrush's role in the audit included:

1. Assisting the State in developing communications to employees relative to the collection of documentation for the audit.
2. Collecting and reviewing documentation needed to verify the eligibility of covered dependents of employees selected for audit.
3. Checking through the Kansas District Court Records online for unreported divorces*,
4. Producing reports that will provide the following information:
    a. A final list identifying those employees who successfully submitted documentation to verify dependents,
    b. A final list of those employees who failed to submit the required documentation,
    c. A final list of dependents to be disenrolled.

Summary of Results

Total Employees Covering Dependent(s) Selected for Audit:	200
Total Employees Successfully Completing Audit:	172
Total Employees Submitting No Documentation:	6
Total Employees Submitting Incomplete Documentation:	0
Total Number of Employees Found to have an Undisclosed Divorce:	0
Total Dependents to be Removed from Coverage:	28

*Note: The Kansas State online database is not yet fully implemented as of the writing of this report. Only 8 judicial districts out of 31 are currently included online as a part of the Kansas eCourt System. Of the 200 selected samples, 31 of the samples fall within judicial districts currently in the eCourt System. An online search of the eCourt System was performed by Sagebrush for each of these samples.

Recommendations

Education

Sagebrush recommends that SOK educate employees about the State's fiduciary responsibility to all of its employees to control costs of the health plan, as well as the direct financial benefits to all covered State employees achieved by reducing the number of ineligible dependents.

Records Management

If not already in place, establish a searchable database recording the documents SEHP has on file for each employee's dependent(s). It should also be noted on the database dependents who should be excluded from the universe of potential dependent auditees based on documents already on file, such as a national letter mandating coverage for the child, or other documents such as guardianship, custody, adoption, etc. If an employee is the natural parent of a dependent, that dependent should be removed from the potential universe of auditees until the dependent's 26^{th} birthday.

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Communication

A preparatory memo, perhaps in an eye-catching poster format, could be posted a month or so in advance on department bulletin boards and in breakrooms, etc. notifying employees of the upcoming annual DEVA.

Disabled Dependents

Based on feedback from employees with disabled dependent children, the Permanent Totally Disabled Dependent Child Application should establish duration of the disability and the child's prognosis. Based upon on the advice of qualified physicians, the SEHP should establish guidelines for dependents whose disability is permanent. Once the determination of permanent disability has been made, the dependent should be removed from the universe of potential auditees. These dependents could be reassessed every five or ten years or at another appropriate interval. Other dependents whose condition may change could be audited on a more frequent schedule.

Exhibits

Exhibit 1: Excel spreadsheet of audit results

TAB I:	List of Employees with Dependents to be Removed
TAB II:	List of Employees Who Successfully Completed Audit
TAB III	List of Employees Who Submitted No Documentation