# State Auditor's Office Performance Review

# K-12 Employee Health Benefits

**February 2011**

**Report No. 1004979**

Washington
Brian Sonntag
State Auditor

## Overview

Washington State provides health benefits to more than 100,000 public school employees in 295 school districts and nine educational service districts. In late 2010, the State Auditor's Office contracted with The Hay Group, actuarial experts in health benefits, to examine this system. Our study found opportunities for the state and public schools to:

- Streamline the system to improve efficiency, transparency, and stability.
- Standardize coverage levels for more affordable, quality medical benefits.
- Reduce costs by restructuring the health benefits system.

The study identifies changes that, depending on how they are structured, could save up to $180 million per biennium – enough for salaries and benefits for about 1,000 teachers.

These reforms could greatly simplify and stabilize a health benefits system that many, including state legislators and other policy-makers, find too tangled to understand. The current system:

- Includes more than 1,000 separate benefits-funding pools that pay for more than 200 different medical plans offered through 10 different insurance companies.
- Provides very uneven out-of-pocket costs for different groups of K-12 employees. About 27 percent of employees, who insure just themselves, pay no premiums at all, while those who buy family coverage pay average monthly premiums of $500.

## Background

Since 1969, the Legislature has appropriated funds to public schools to provide health benefits for their employees. In 1990 the Legislature said this funding is intended to:

- Provide access to basic coverage for school employees and their dependents while minimizing employees' out-of-pocket premium costs.
- Eliminate major differences in out-of-pocket premium expenses for employees who do and do not need coverage for dependents by pooling funds at the school district level.
- Encourage plans that promote appropriate use of health benefits without creating major barriers to receiving care.

## Study objectives and methodology

The study asked two main questions:

1. What is the current cost of public school employee health-benefits coverage and what level of benefits do the plans provide?
2. Are there opportunities to reduce current or contain future costs through alternative health care coverage? If so, how might these opportunities be realized?

### Performance review conducted under authority of I-900

We conducted this review under the authority of Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006. Specifically, the law directs the State Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs and accounts."

The law identifies several specific elements that we considered in reviewing K-12 employee health benefits, including potential cost savings, gaps or overlaps in programs or services, recommendations to change departmental roles or functions, analysis of performance data, and identification of best practices.

This review does not constitute an audit under Generally Accepted Government Auditing Standards (GAGAS). However, it was conducted in a manner consistent with the independence principles specified by GAGAS.

The State Auditor's Office worked with The Hay Group of Philadelphia to examine these questions. We developed a survey after discussing health benefits issues with staff from the Office of the Superintendent of Public Instruction, Health Care Authority, Office of the State Actuary, Legislature, public school employee unions, school district administrators and professional school associations. Hay sent the survey to all public school and educational service districts to collect information about health benefits coverage, costs, and associated district administration for 2009-10.

A total of 129 districts responded, representing 42 percent of all public K-12 districts and 68 percent of all employees— a very high response rate. The survey responses are representative of all districts and their employees. The Hay Group used actuarial methods to analyze the health benefits plans and costs.

## Current K-12 employee health benefit costs and coverage

Public school employee-health benefits totaled about $1.21 billion during the 2009-10 school year. Of that, vision and dental benefits cost $181 million (15 percent). Medical benefits cost about $1,029 million (85 percent).

**2009-10 Total Health Benefit Costs by Benefit Type (Dollars in millions)**

| Benefit Type | Cost | Percent of Total Cost |
|---|---|---|
| Dental | $155 | 13% |
| Vision | $26 | 2% |
| Medical | $1,029 | 85% |
| **TOTAL** | **$1,210** | **100%** |

**Source:** *The Hay Group based on school district surveys.*

### Funding health benefits

Districts used about $1 billion (84 percent) from state, federal and local levy funding sources to provide their employees with health benefits. The rest is paid by employees. In 2009-10, about 10.4 percent of districts' total general fund operating costs paid for employee health benefits.

In 2009-10, the state provided about $778 million (64 percent of total cost) to fund health benefits. Washington State funds public school employee health benefits on a per-full-time equivalent employee basis[1] (e.g., $745 per FTE in 2009-10). The state includes additional money for health benefits in funding formulas for specific programs such as special education and pupil transportation. About $90 million in federal and other funding (7 percent of total benefits cost) helped to pay for health benefits to employees in federally sponsored school programs, such as the school lunch program.

**2009-10 Total Health Benefit Costs by Funding Source (Dollars in millions)**

| Funding Source | Cost | Percent of Total Cost |
|---|---|---|
| State | $778 | 64% |
| Employees | $198 | 16% |
| Local Levy | $144 | 12% |
| Federal and Other | $90 | 8% |
| **TOTAL** | **$1,210** | **100%** |

**Source:** *The Hay Group and Office of the Superintendent of Public Instruction.*

For public school retirees, districts pay the Health Care Authority (HCA) an amount per current, active employee who is eligible for benefits (e.g., $59.59 per eligible employee in 2009-10). The HCA collected about $77 million from districts in 2009-10 for retiree benefits. Districts typically use local levy money to pay the HCA.

[1] *State money is allocated by formula, but the formula usually does not include all employees in a district. School districts often employ more people than the formula includes, and they make up the difference from local levy or federal money.*

Districts added about $144 million (12 percent of total benefit cost) in local-levy money to state and federal funding to provide health benefits to current employees in 2009-10. Local collective bargaining agreements determine the amount of local money a district adds. This affects employees' out-of-pocket premium costs.

Employees paid about $198 million (16 percent of total benefit costs) in premium costs in 2009-10. Of that amount, employees with plans that just cover themselves paid about 9 percent while employees with plans that cover themselves and their families paid about 42 percent of total out-of-pocket premium costs.

**Employees' Share of Total Health Benefit Costs in 2009-10 by Coverage Type (Dollars in millions)**

| Coverage Type | Total Employee Premium | Percent of Employee Premium Costs | Percent of $1.2 Billion Total Premium Cost |
|---|---|---|---|
| Employee | $18 | 9% | 1% |
| Employee & Spouse | $52 | 26% | 4% |
| Employee & Child | $46 | 23% | 4% |
| Employee & Family | $82 | 42% | 7% |
| **TOTAL** | **$198** | **100%** | **16%** |

**Source:** *The Hay Group based on school district surveys.*

The amount employees pay for their health benefits is determined by several factors that vary by collective bargaining unit:

- Local levy money that a district contributes to pay for its employees' benefits.
- The cost of premiums of the health-benefit plans (especially medical plans) available to a unit's employees.
- The amount of benefits money that employees, who are ineligible for benefits or who waive coverage, do not use. This is reallocated evenly among a unit's other employees through a process called "pooling".

## Differences in what employees pay

State law requires districts to pool benefits money. The intent of pooling is described in the 1990 law as follows:

> "The legislature also intends that school districts pool State benefit allocations so as to eliminate major differences in out-of-pocket premium expenses for employees who do and do not need coverage for dependents." (See RCW 28A.400.200, Intent.)

Just over half of K-12 employees are enrolled in plans that cover themselves only. On average, they pay about 5 percent of their total premium out-of-pocket, or about $27 per month. Employees enrolled in plans that cover themselves and their families represent about 12 percent of all employees enrolled in a plan. They pay an average of 39 percent of their total premium

out-of-pocket, or about $500 per month. This gap appears to contradict the Legislature's intent.

**Differences in What Employees Paid for Medical Benefits in 2009-10**

| Coverage Type | Percentage Enrollment | Share of Premium Paid by Employee | Average Monthly Employee Cost |
|---|---|---|---|
| Employee | 51% | 5% | $27 |
| Employee & Spouse | 12% | 31% | $327 |
| Employee & Child | 24% | 18% | $145 |
| Employee & Family | 13% | 39% | $500 |
| **TOTAL** | **100%** | **19%** | **$151** |

**Source:** *The Hay Group based on school district surveys.*

## Medical benefits coverage

While all retired public school employees have standard medical benefit plans available to them through the HCA's Public Employee Benefit Board (PEBB), active employees may choose any plans their bargaining units approve. Hay's survey indicated less than 2 percent of active employees were enrolled in a PEBB medical plan in 2009-10.

**Enrollment by Medical Provider in 2009-10**

| Medical Benefits Provider | Percent of employees covered |
|---|---|
| WEA-Premera | 55% |
| Group Health | 18% |
| Regence Blue Shield | 8% |
| Premera Blue Cross | 6% |
| Kitsap Physicians Service | 2% |
| Kaiser Permanente | 2% |
| Other (including PEBB) | 9% |
| **TOTAL** | **100%** |

**Source:** *The Hay Group based on school district surveys.*

About 55 percent of all public school employees were enrolled in the Washington Education Association's (WEA) Premera plan. These are mostly certificated employees (teachers), and are typically in WEA collective bargaining units. The remaining 45 percent of employees enrolled in medical plans are classified employees (custodians, bus drivers, food service workers, etc.). Classified employees are represented by many different bargaining units and typically enroll in coverage from plan providers other than the WEA.

### WEA rate stabilization fund

The WEA has a rate stabilization fund designed to reduce premium increases over time. Having such a fund is a common health-insurance industry practice. The fund is subject to legal restrictions and annual audits by a public accounting firm to ensure the money in the fund is used only to benefit WEA plan participants through subsidizing premiums or purchasing benefits. It may not be used for political purposes.

The WEA has a policy to maintain a balance in the stabilization fund equal to 3 to 5 percent of total premiums. However, due to a multi-year lag between management decisions and paying down the balance, the fund has had deficits as well as large surpluses over the last 20 years.

Recently, significantly lower-than-expected medical claims increased the fund balance from about $16 million (three percent of premiums) in 2005 to over $106 million (17 percent of premiums) in 2008. The balance began to decrease in 2009, and both the WEA and Hay predict that the balance will be about $22 million (2.5 percent of projected premiums) by 2013 after subsidizing premiums.

## Opportunities to improve K-12 health benefits system

The Hay Group identified three main opportunities to reform the way health care is delivered to public school employees while still providing quality affordable care. These three options are not mutually exclusive. They are related options that, taken together, could yield significantly greater savings and transparency.

1. **Streamline the system by simplifying the pooling process.** Create fewer and larger funding pools to create stability, save money through reduced administrative costs and greatly increase transparency.

2. **Standardize coverage levels for more affordable, quality medical benefits.** Provide affordable, quality care by creating standard benefit levels or "tiers." Public school employees could choose from these benefit tiers.

3. **Restructure the health benefits system.** Completely restructure the public-school employee health-benefits system. Create a separate, statewide, self-funded program with its own governing board.

### Option 1: Streamline the system

School districts use a process called "pooling" to help subsidize some employees' premium costs. The current pooling system is extremely complicated and places a significant burden on district administration. State law requires districts to pool benefits money not used by employees in a bargaining unit that are ineligible or that waive coverage, and then redistribute that money evenly among the other employees in that unit's pool to reduce their premium costs. These pools should not be confused with what insurers call "risk pools." In the K-12 system, pools are places where the money goes before it is reallocated.

There are more than 1,000 pools in the current system; some individual districts have more than a dozen. Each funding pool is unique and is shaped by

the employees' labor bargaining unit. There is no uniform approach among the local districts. More than half of the pools reallocate benefits funding multiple times per year.

Money in each funding pool is divided evenly among the enrollees in that pool. But at this point it becomes more complicated to follow the money, because each pool operates differently. Some employees have enough extra funding to buy richer benefits or have zero out-of-pocket premium costs. When this happens it is usually because the district has enough part-time, benefits-ineligible employees to fully subsidize others' coverage. Part-time employment is more common among classified employees (bus drivers, food service workers) because certificated employees (teachers) are usually full-time.

Because funding from the pools is reallocated after employees enroll in their medical plans, the employees do not know how much they will have to pay in out-of-pocket premium costs until after they have signed up for benefits. This often causes significant changes in benefits enrollment from year to year.

Hay recommends limiting the number of pools in a district to two (i.e., for certificated and classified staff) and establishing a minimum pool size. Restructuring the pooling process would:

- Increase the stability of participation rates.
- Improve administrative efficiency.
- Increase the transparency of premium costs.

### Option 2: Standardize coverage levels

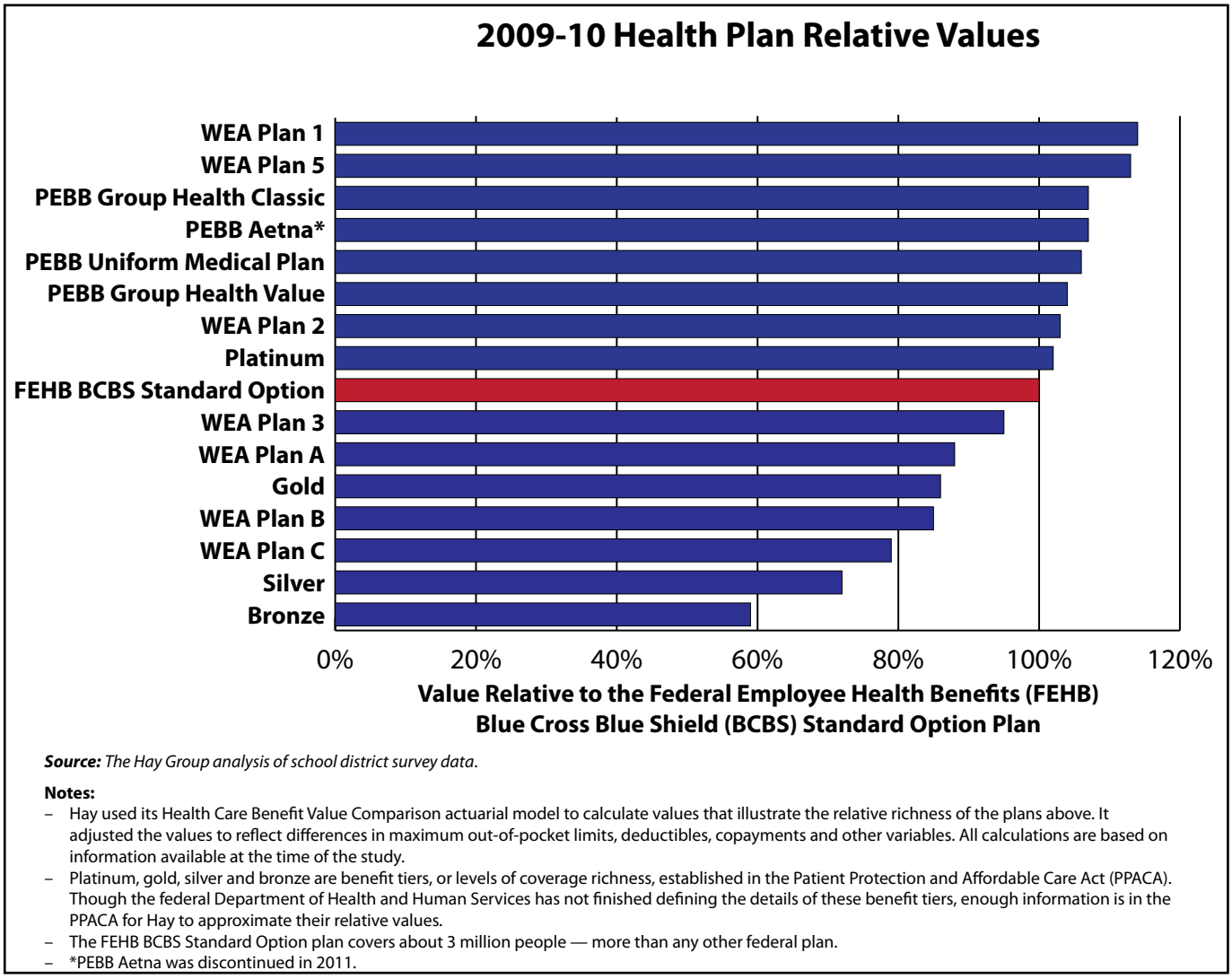
After reviewing the health benefits available to public school employees, Hay concluded that districts generally provide generous benefits. For example, Hay estimated that the two most popular WEA plans provide benefits that are up to 14 percent richer than the Federal Employee Health Benefits (FEHB) Blue Cross Blue Shield (BCBS) Standard Option plan.

**The 55% of Employees in WEA-Premera By Plan**

| WEA-Premera Plan Name | Percent of Employees Covered |
|---|---|
| WEA Select Plan 1 & 5 | 60% |
| WEA Select Plan 2 | 21% |
| WEA Select Plan 3 | 14% |
| WEA EasyChoice Plans A/B/C Combined | 6% |
| **TOTAL** | **100%** |

**Source:** *The Hay Group based on school district surveys.*

The following chart shows the relative values, or comparative richness, of the plans in PEBB, the WEA, the FEHB BCBS Standard Option Plan, and the platinum, gold, silver and bronze benefit tiers established in last year's federal health-care reform law (the Patient Protection and Affordable Care Act).




***Source:*** *The Hay Group analysis of school district survey data.*

**Notes:**

- Hay used its Health Care Benefit Value Comparison actuarial model to calculate values that illustrate the relative richness of the plans above. It adjusted the values to reflect differences in maximum out-of-pocket limits, deductibles, copayments and other variables. All calculations are based on information available at the time of the study.
- Platinum, gold, silver and bronze are benefit tiers, or levels of coverage richness, established in the Patient Protection and Affordable Care Act (PPACA). Though the federal Department of Health and Human Services has not finished defining the details of these benefit tiers, enough information is in the PPACA for Hay to approximate their relative values.
- The FEHB BCBS Standard Option plan covers about 3 million people — more than any other federal plan.
- *PEBB Aetna was discontinued in 2011.

A platinum plan will pay the most medical costs, but its premium is normally higher than for the lower tiers. About 82 percent of public school employees have plans closest to the platinum tier; 18 percent have plans closest to a gold tier. None have plans near the silver or bronze tiers.

The Hay Group estimates that if the whole public school employee health benefits system funded plans at the level of the FEHB BCBS Standard Plan, the overall savings would be about $13 million annually. Standardizing health benefits for all public school employees in alignment with the tiers of the federal health-care reform law could result in further savings as shown in the following table.

**Estimated Annual Cost Differences by Standardizing Medical Benefits for All Employees (Dollars in millions from all sources)**

| Benefit Level | Cost Savings / Increases | Percentage Cost Savings / Increases |
|---|---|---|
| PEBB[1] | **Increase $45** | **Increase 3.7%** |
| FEHB BCBS Standard Option Plan | $13 | 1.1% |
| Platinum | **Increase $7** | **Increase 0.6%** |
| Gold | $157 | 13.0% |
| Silver | $300 | 24.8% |
| Mapped to Closest Plan[2] | $28 | 2.3% |

**Source:** *The Hay Group based on school district surveys. Estimates are based on 2009-10 health benefits costs of $1.21 billion.*

[1] **"PEBB"** *represents the average level of coverage richness currently available through the PEBB program. It does not assume that the PEBB program would administer the benefits.*

[2] **"Mapped to Closest Plan"** *assumes that, if only the platinum, gold and silver tiers were available, employees would choose a plan closest to the value that they currently have. Currently, 82 percent of public school employees have benefit plans closest to the platinum tier and 18 percent have benefit plans closest to the gold tier. This would likely be the least disruptive change in benefits.*

## Option 3: Restructure the health benefits system

Hay concludes that creating a new, separate self-funded program for K-12 employees that provides standardized benefits that map most closely to current benefits could save as much as $90 million per year.

A statewide, self-funded program for public school employees, that is separate from PEBB, could be administered by the HCA or some other organization. Separating the public school employee program from the PEBB program would avoid many issues with merging the programs (e.g., differences in funding rates and benefit designs). Also, merging a larger portion of public school employees and state employee populations would not save money because economies of scale quickly decrease after insurance risk pools exceed 50,000 employees. A separate public school program could have its own governance structure, including both district management and labor representation, providing greater confidence in the new system.

**Estimated Annual Cost Savings by Restructuring**
**(Dollars in millions from all sources, based on 2009-10 health benefits costs of $1.21 billion)**

| Savings by Funding Source | Voluntary Participation[1] | Mandatory Participation[2] |
|---|---|---|
| State and federal | **$21** | **$46** |
| Local levy | **$3** | **$8** |
| Employees | **$5** | **$10** |
| **TOTAL** | **$29 (2.4%)** | **$64 (5.3%)** |

**Source:** *The Hay Group based on school district surveys. Estimates are based on 2009-10 health benefits costs of $1.21 billion.*

1. **"Voluntary Participation"** *assumes that all districts would offer plans through the statewide program along with other plans, and that about 45 percent of all employees currently covered would enroll in a plan through the statewide program. Hay believes that this is a conservative estimate.*

2. **"Mandatory Participation"** *assumes that all districts would only offer plans through the statewide program, and that 100 percent of all employees currently covered would enroll through that program.*

By just restructuring the many current public school employee health plans, the program could achieve about $29 million in annual cost savings if 45 percent of public school employees voluntarily participated in the program (a conservative estimate), and up to $64 million annually if all employees participated. Consistent eligibility and benefit management would produce other administrative efficiencies.

The combined savings from restructuring the system to either a voluntary or mandatory system and standardizing the benefits plans to match different coverage levels are reflected in the following table.

| Estimated Annual Savings or Cost Increases from Standardizing Medical Benefits and Restructuring the System (Dollars in millions from all sources) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Program Structure** | **Current Plans** | **PEBB[1]** | **FEHB** | **Platinum** | **Gold** | **Silver** | **Mapped to Closest Plan[2]** |
| Current Structure | No change | $45<br>3.7%<br>increase | $13<br>1.1% | $7<br>0.6%<br>increase | $158<br>13% | $300<br>24.8% | $28<br>2.3% |
| Voluntary[3] | $29<br>2.4% | $16<br>1.3%<br>increase | $41<br>3.4% | $22<br>1.8% | $182<br>15% | $321<br>26.5% | $56<br>4.6% |
| Mandatory[4] | $64<br>5.3% | $21<br>1.7% | $76<br>6.3% | $57<br>4.7% | $213<br>17.6% | $347<br>28.7% | $90<br>7.4% |

**Source:** *The Hay Group based on school district surveys. Estimates are based on 2009-10 health benefits costs of $1.21 billion.*

1. **"PEBB"** *represents the average level of coverage richness currently available through the PEBB program. It does not assume that the PEBB program would administer the benefits.*
2. **"Mapped to Closest Plan"** *assumes that, if only the platinum, gold and silver tiers were available, employees would choose a plan closest to the value that they currently have. Currently, 82 percent of public school employees have benefit plans closest to the platinum tier and 18 percent have benefit plans closest to the gold tier. This would be the least disruptive change in benefits.*
3. **"Voluntary participation"** *assumes that all districts would offer plans through the statewide program along with other plans, and that about 45 percent of all employees currently covered would enroll in a plan through the statewide program. Hay believes that this is a conservative estimate.*
4. **"Mandatory participation"** *assumes that all districts would only offer plans through the statewide program, and that 100 percent of all employees currently covered would enroll.*

## Implementation considerations

The Hay Group did not calculate the costs to create a statewide, self-funded plan. A fiscal note to the 2009 Senate Substitute Bill 5491 — An act relating to developing a strategy to reduce the cost of providing health benefits for K-12 employees — outlined some of the necessary implementation steps to create a statewide program. Because school district payroll systems are separate and do not talk to each other, a new IT system would need to be created to interface between the program and each district's payroll system. Staffing would be necessary to administer the statewide program. The fiscal note estimated that it would cost the Health Care Authority up to $1.5 million per year to administer the program. Finally, a substantial reserve fund would need to be established to pay insurance claims and mitigate insurance risk.

View the **full study.**

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January 31, 2011

# State of Washington

## K-12 Health Benefits Study

***Prepared by:***

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Ms. Larisa Benson
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Dear Ms. Benson:

On behalf of the Hay Group, we are pleased to present the results of our review of the current system for providing health benefits to public school employees in the State of Washington.

We find that there are substantial opportunities for streamlining the funding of these benefits. We also discuss three policy alternatives for establishing a state-wide health benefit system for school employees. These alternatives differ in the participation rules: in the first district participation would be voluntary; in the second district participation would be voluntary for current employees and mandatory for new employees; in the third district participation would be mandatory. In addition, we discuss options for standardizing the health benefits offered to school employees.

The successful and timely completion of our report depended on the generous assistance provided by your office, as well as the timely and complete responses provided by local school districts, educational service districts, and the many organizations that provided input into our study. We wish to thank all those who gave generously of their time to meet with us and provided their counsel as well as the information we used in the study, including the administrators of the many local districts who completed the health benefits study.

We would also like to acknowledge the assistance of Tova Labell, who analyzed the survey results, and Sanjit Puri ASA, who performed our actuarial modeling under our direction.

Yours truly,

Tom Wildsmith, FSA, MAAA

Adam Reese, FSA, MAAA

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## Key Findings and Policy Options

- *The system for providing health benefits to K-12 school employees in the State of Washington has been shaped by the State's constitutional commitment to providing a "basic education" and by the use of local funding pools, both of which are particular to Washington.*
- *Over half of school employees receiving health benefits are enrolled in one of the Washington Education Association plans.*
- *Employee contributions for single coverage are on average lower than is typical for other employers, while the contributions for family coverage are higher.*
- *The benefit plans for school employees are, on average, more generous than is typical for other employers.*
- *The current system for funding school employee health benefits is complex and confusing.*
- *We recommend streamlining the current funding system as a necessary precondition to any more comprehensive reform.*
- *There are significant potential savings available from standardizing the medical benefit coverage levels offered to K-12 districts and from restructuring the health benefits system by establishing a state-wide program.*
- *If a state-sponsored program for providing health benefits to school employees is established, we recommend that it be a separate program from the health plan for State employees (PEBB).*
- *One of the key design questions for any state-wide system is whether participation by local school districts would be voluntary or mandatory. A mandatory system would produce larger savings than a voluntary system, but a voluntary system would cause less disruption to existing coverage arrangements.*

## Executive Summary

The Washington State Auditor's Office (SAO) engaged Hay Group (Hay) to perform an actuarial review of the current system for providing health benefits to public school employees in the State of Washington (the State). The scope of the assignment included reviewing the benefits provided by the current system, the cost of the current system, and the opportunities available for containing or reducing future health care costs. In performing our review we surveyed local school districts around the State, interviewed representatives of key groups and organizations currently involved in the provision of health benefits to school employees, studied the legal and regulatory requirements governing the system, compared the benefits provided to those provided by other employers, and evaluated several alternatives for controlling future costs.

The constitutional commitment of the State to fund basic education has shaped the way in which health benefits for school employees are financed and provided in Washington. In particular, this commitment leads to substantial State contributions towards the cost of health benefits for "formula" school employees and the development of local funding pools. State funding for schools is based on formulas that determine the number of full-time equivalent (FTE) employees necessary to provide a "basic education" given the enrollment characteristics of each district. Almost eight out of ten school employees in the state are "formula" employees for state funding purposes. Funding for benefits provided to non-formula employees, and to supplement the benefits of formula employees, comes from local school levies and some federal sources. Funds from these sources are combined and allocated at the local school district level through one or more funding "pools" in each district.

The State provides approximately 72 percent[1] of the aggregate cost of health benefits for school employees. Most districts have more than one funding pool, and many districts have more than a half dozen local funding pools. Funding pools are generally structured around bargaining units or classes of employment. For these pools, the benefit options offered and the level of funding provided by the local school district are the subject of collective bargaining. Health benefits for retired school employees are provided through the retiree health benefit programs administered by the State of Washington's Health Care Authority (HCA) and the Public Employees' Benefits Board (PEBB) for retired State employees.[2]

The Washington Education Association (WEA) health plan has the highest enrollment of school employees. It covers more than half (55 percent) of the school employees who receive health benefits through their employment by a district. Nine out of ten school employees are covered by one of six

[1] The 72 percent that is State funded includes some federal and other funding.
[2] The primary exception is the temporary extension of coverage available to retirees under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

providers of health benefits.[3] A range of benefit options is available to local districts. In many cases, the medical coverage provided to school employees is significantly more valuable than the typical employer-sponsored health plan. For instance, we estimate that the two WEA plans with the highest enrollment both provide benefits that are approximately 13 to 14 percent more valuable than those provided by the Federal Employees Health Benefits (FEHB) Blue Cross Blue Shield (BCBS) Standard Option plan.

Over half of all State school employees (52 percent) are not required to contribute towards the cost of single coverage. In comparison, nationally, only 10 percent of employers pay the full premium for single coverage. However, almost all State school employees who choose to enroll in family coverage must contribute towards the cost, which is consistent with other employers. There are approximately 122,000 school employees, based on the number of enrollees in the pension plans covering teachers and classified employees.[4] Total spending for health benefits for all State school employees is approximately $1.21 billion, of which 72 percent is provided by the State.

The system of local funding pools that has developed is peculiar to Washington. Some districts have over a dozen funding pools and over half of the pools are recalculated two or more times per year. This system adds a significant administrative burden to local districts and makes the overall system of funding school employee benefits less transparent. The structure of State funding also contributes to a lack of transparency by allocating State funding based on the number of FTEs rather than the number of employees eligible for benefits, and providing local districts with allocations for post-retirement medical benefits that they must then remit back to the State. In addition, the use of multiple pools in most districts means that employer funding of health benefits differs for similarly situated employees in different districts, and between employee groups in the same district. To address this concern, one reform option would be to streamline the current funding system to reduce the administrative complexity and make the funding of these benefits more transparent. We discuss one such package of reforms in the body of the report.

The Patient Protection and Affordable Care Act (PPACA) established a set of four benefit tiers ("Bronze," "Silver," "Gold" and "Platinum") to be used in health insurance exchanges beginning in 2014. These tiers are intended to make choosing a health plan easier while providing for a reasonable range of benefit options. They are defined in terms of "actuarial value," and establish specific levels of coverage while allowing for meaningful varation in cost sharing and provider network options within a given benefit tier. One policy option would be to adopt, for school employees, the benefit tiers that PPACA establishes for state-based exchanges and specify that every school employee have access to at

[3] WEA, Group Health, Regence, Premera, Kitsap and Kaiser.

[4] The OSPI database has a 6 percent higher count of 129,000. For purposes of estimates of the total statewide cost, we used the pension data total employee count of 121,672.

least one benefit option in each of the four tiers. This would provide an objective standard for the range of benefit options and would simplify the comparision of those benefit options. It would also structure the benefits in a way that will become very familiar to State residents, and provide benefits that will be directly comparable to those that will be available to State residents through an exchange (beginning in 2014), though the employee contributions could vary as determined at the local school district level.

Of the 23 other states we reviewed, 21 states currently have some form of state-wide health benefits program for school employees. Six of these have a mandatory participation requirement. Establishing a state-wide health benefits program for school employees would be another policy option for the State of Washington. We discuss this option in the body of the report**.**

If a state-sponsored program for providing health benefits to school employees is established, we recommend that it be a separate program from the health plan for State employees (PEBB). There are several reasons for this. Managing the State's funding commitments is simplified if the funding for school employees and state employees is not comingled in a single insurance pool. The PEBB program is designed for the particular needs of State employees; it is likely that benefit designs and other plan features would require modification to best serve the needs of school employees.[5] A program for school employees should operate on a schedule that coordinates with the financing and enrollment schedule for local school districts. A separate pool would also allow for a separate governance structure which would provide school employees, their labor representatives and district management with greater input and confidence in the system.

One of the key design questions for any state-wide system is whether participation by local school districts would be voluntary or mandatory.[6] Voluntary participation would minimize the disruption to existing coverage arrangements, but could result in higher costs if the participating districts have, on average, older or sicker workforces. Mandatory participation would avoid the risk of higher costs associated with a voluntary system, and would guarantee a high enough enrollment level to ensure a viable insurance pool. It would also result in more near-term disruption to existing coverage arrangements.

We discuss three alternative participation rules for a state-wide school health benefits program: voluntary participation by local school districts; voluntary participation by local school districts for current employees but mandatory participation for new employees; and mandatory participation for all local school districts. To limit disruption, we would recommend that for any state-wide system, the

[5] PEBB currently covers only 2 percent of school employees receiving health benefits through a local district.
[6] Under a mandatory system, local districts would be required to provide employee health benefits through the state-wide system. Under a voluntary system, local districts would be permitted, but not required, to provide benefits through the state-wide system.

transition for groups of collectively bargained employees be tied to the timing of the next collective bargaining agreement.[7]

| Table ES-1<br>Summary of Policy Options Reviewed | | |
|---|---|---|
| **Column A<br>Funding Options** | **Column B<br>Benefit Rules** | **Column C<br>Program Structure** |
| Current Funding System | Current Rules for Benefits | No State-Sponsored System |
| | | Voluntary |
| Streamline Funding System | Adopt PPACA Benefit "Tiers" | Voluntary for current employees<br>*but*<br>Mandatory for new employees |
| | | Mandatory |

Table ES-1 provides a conceptual framework for understanding how the policy options discussed in the body of the report relate to each other. Each column shows, for completeness, maintaining the status quo as an option. These reforms could be implemented individually or together.

In column A, streamlining the funding system would modestly reduce administrative costs at the local district level, principally by reducing the administrative burden associated with the local funding pools.

In column B, there are significant potential savings available from standardizing the range of benefits offered to school employees. This would produce both winners and losers; some more generous plans would be brought down to the "Platinum" level, while some less generous plans would be raised to the "Gold" level. There would also likely be a small administrative savings because the tier system would simplify the enrollment process and reduce the amount of assistance school employees need in selecting a health plan.

In column C, significant savings are potentially available through self-funding the benefits through a state-wide system. Self-funding avoids several expenses associated with insurance, including the insurer's risk charge and state premium taxes. A mandatory system would have more than adequate

[7]See Table XI-I, Collective Bargaining Agreement Expiration Dates.

enrollment to constitute a viable self-insured risk pool. A voluntary state-wide system would need a minimum level of enrollment (5,000 employees) for self-funding to be practical. We provide specific recommendations in the body of the report concerning the organizational structure and financial management for a self-funded state-wide program.

A mandatory system would produce larger savings than a voluntary system. First, a mandatory system would generate savings on all covered school employees, while a voluntary system would most likely only include a portion of them. Second, a mandatory system would avoid the potential voluntary systems have for cost increases due to a disproportionate enrollment of higher-cost districts.

**Estimate of Costs for K-12 Health Benefits**

Table ES-2 shows the estimated costs under the voluntary and mandatory program structures. Under both program approaches, we first show the impact on the costs and payers if all of the changes in costs are shared equally, then show the impact on the State and local levy funding if there is no change in the employee contributions. In 2010 costs levels, the voluntary structure is expected to lower costs by about 2.4 percent, yielding savings of $29 million, and the mandatory structure is expected to lower costs by about 5.25 percent, yielding savings of $64 million.

Table ES-3 shows the estimated costs from the use of standardized benefit plans under PPACA. The table shows five sets of costs. The first column summarizes the information on total health benefit costs from Table ES-2 assuming that the current array of benefit plans is maintained. The next three columns show the total health benefit costs assuming that Washington school employees were provided benefits at the "Platinum," "Gold" or "Silver" levels.[8] The final column shows the total health benefit costs assuming that each current plan is mapped into the closest of the four standardized benefit tiers. The table shows that the potential savings from plan design changes are larger than from implementing either a voluntary or mandatory program structure. The table combines the effect of benefit rule changes with program structure changes. For example, the cost from adopting a standard platinum plan design for all K-12 employees is estimated at $7 million, while combining the benefit standardization at the platinum design level with a mandatory system is expected to yield savings of $64 million savings for a net $57 million of savings.

It is important to note that the savings from restructuring the system and from adopting standardized benefit plans are not directly additive. The net savings from adopting *both* a mandatory system *and* standardizing benefits at the silver level would be $347 million. Adopting only a mandatory system,

[8] We did not develop cost estimates for a system based on "Bronze" benefits. The "Bronze" tier is more representative of the level of benefits often purchased by consumers purchasing health benefits on their own through the individual health insurance market than it is of benefits typically provided by medium-to-large employers. It would also represent a greater change in benefit levels than we believe is likely to be practical in the near term.

while maintaining the current benefit options, would produce savings of $64 million. Standardizing benefits at the silver level, without changing the current structure for providing benefits, would result in savings of $300 million. Our modeling indicates that, due to interactions between the two reforms, the net savings of $347 million from adopting both a mandatory system and standardizing benefits at the silver level is less than the sum of $64 million and $300 million achieved if each reform were implemented separately.[9]

Table ES-4 shows the estimated costs from the use of the benefit plans offered by PEBB as well as the estimated savings if all employees were enrolled in a plan with benefits equivalent to the FEHB BCBS Standard Option plan. The first column summarizes the information on total health benefit costs from Table ES-2 assuming that the current array of benefit plans is maintained. The next column shows the total health benefit costs assuming that Washington school employees were enrolled in the PEBB plans in the same mix as current PEBB enrollees. The third column shows the total health benefit costs assuming that Washington school employees were enrolled in the FEHB BCBS Standard Option plan. The table combines the effect of benefit rule changes with program structure changes.

[9] Similarly, the net savings from adopting both a mandatory system and benefits at the gold level would be $213 million. Adopting only a mandatory system, while maintaining the current benefit options, would produce savings of $64 million. Standardizing benefits at the gold level, without changing the current structure for providing benefits would result in savings of $157 million. Our modeling indicates a net savings of $213 million from adopting both a mandatory system and standardizing benefits at the gold level, which is less than the sum of $64 million and $157 million achieved if each reform were implemented separately.

| Table ES-2<br>Estimated Costs in $millions | | | | | |
|---|---|---|---|---|---|
| Program Structure | Total Health Benefit Cost (A) | Employee Contributions (B) | School District Costs (C) = (A) – (B) | Pooled Levy Funds (D) | State Funding (E) = (C) – (D) |
| 1. Current Structure | $1,211 | $198 | $1,012 | $144 | $868 |
| 2. Voluntary System | $1,182 | $194 | $988 | $141 | $848 |
| ***3. Savings*** ***(savings shared by all payers)*** | ***$29*** | ***$5*** | ***$24*** | ***$3*** | ***$21*** |
| 4. Voluntary System | $1,182 | $198 | $984 | $140 | $844 |
| ***5. Savings*** ***(savings shared by State and Districts)*** | ***$29*** | ***$0*** | ***$29*** | ***$4*** | ***$25*** |
| 6. Mandatory System | $1,147 | $188 | $959 | $136 | $823 |
| ***7. Savings*** ***(savings shared by all payers)*** | ***$64*** | ***$10*** | ***$54*** | ***$8*** | ***$46*** |
| 8. Mandatory System | $1,147 | $198 | $949 | $135 | $814 |
| ***9. Savings*** ***(savings shared by State and Districts)*** | ***$64*** | ***$0*** | ***$64*** | ***$9*** | ***$55*** |

Note: Amounts may not add due to rounding.
Source: Calculations by Hay Group. See Appendix H for development of savings.

| Table ES-3<br>Estimated Savings (Costs) from Use of a Standardized Benefit Plan for all Employees<br>Amounts in $ millions | | | | | |
|---|---|---|---|---|---|
| **Program Structure \ Plan Designs** | **Current Plans** | **Platinum** | **Gold** | **Silver** | **Closest Plan** |
| 1. Current Structure | $1,211 | $1,218 | $1,053 | $911 | $1,183 |
| **Amount of savings (costs)** | | ($7) | $157 | $300 | $28 |
| 2. Voluntary System | $1,182 | $1,189 | $1,029 | $889 | $1,155 |
| **Amount of savings** | $29 | $22 | $182 | $321 | $56 |
| 3. Mandatory System | $1,147 | $1,154 | $998 | $863 | $1,121 |
| **Amount of savings** | $64 | $57 | $213 | $347 | $90 |
| Source: Calculations by Hay Group. See Appendix H for development of savings. | | | | | |

| Table ES-4<br>Estimated Savings (Costs) from Use of PEBB or FEHB Benefit Plans for all Employees<br>Amounts in $ millions | | | |
|---|---|---|---|
| **Program Structure \ Plan Designs** | **Current Plans** | **PEBB** | **FEHB BCBS Standard Option** |
| 1. Current Structure | $1,211 | $1,256 | $1,198 |
| **Amount of savings (costs)** | | ($45) | $13 |
| 2. Voluntary System | $1,182 | $1,226 | $1,169 |
| **Amount of savings (costs)** | $29 | ($16) | $41 |
| 3. Mandatory System | $1,147 | $1,190 | $1,135 |
| **Amount of savings** | $64 | $21 | $76 |
| Source: Calculations by Hay Group. See Appendix H for development of costs and savings. | | | |

## I. Study Context and Process

The delivery of employee benefits for Washington school employees has been studied periodically over the past 22 years. Health benefit studies concerning school employees were conducted in 1989 (Coopers & Lybrand), 1991 (HCA), and 2004 (OFM). The benefit program for school employees has evolved over time.

As to health benefits, the Health Care Authority (HCA) was established effective October 1, 1988 (RCW 41.05). HCA operates a number of health programs for State citizens and employees, including the Public Employees' Benefit Board (PEBB). PEBB provides a group of health plan choices for active and retired government employees. All active State employees are covered by PEBB's programs (unless they waive coverage). Local governments (including schools and tribal governments) may participate voluntarily, with PEBB as the exclusive health benefits provider for their employees. Retired employees of participating governments are also eligible to receive health benefits in retirement which are partially subsidized by the State. Effective in 1993, all retired school employees are also eligible to receive these partially subsidized health benefits, regardless of whether their school participates in the PEBB programs for active employees (RCW 28A.400.391).[10]

Over most of the past 40 years, premiums for medical coverage have grown more rapidly than general inflation. This has caused a number of economic stresses for plan sponsors, including the following:

(1) Health care benefits have become an increasing percentage of an employee's total compensation.

(2) Health care benefits have become an increasing percentage of an employer's budget.

In response, many employers have periodically reduced the overall level of health benefits provided, and/or increased the required level of employee contribution. Because many employers extend coverage to the dependents of their employees, and many families have two employed spouses, plans with more generous benefits receive a disproportionate share of dependent coverages. As a result, over time, employers have tended to reduce the subsidy provided for dependent benefits. This trend has been greatest among employers in the private sector, leading to increasing dependent coverage (and associated subsidy expense) in the public sector. This of course has further exacerbated the cost increase of health benefits in the public sector, which is particularly difficult given the decreased revenue streams governments in general and schools in particular have faced over the past few years.

[10] In 1994, legislation was enacted making participation in PEBB mandatory for K-12 districts; however, this legislation was repealed in 1995 through the action of the successor legislature. These changes occurred within the context of comprehensive reform for the entire Washington health care market, passed in 1993 but repealed in 1995.

In this environment, Hay Group has been asked to analyze alternative health care coverage models for Washington's K-12 district employees. Our approach has been to collect data through stakeholder interviews, design and administer a comprehensive survey of K-12 districts, and conduct a survey of administrative practices used by the plans and carriers currently providing the vast majority of K-12 health care coverage (WEA/Premera, PEBB, and Group Health Cooperative).

Table I-1 lists the stakeholder groups who were interviewed between September 20 and October 12.

**Table I-1**

**Stakeholder Groups Interviewed**

| |
|---|
| Association of Washington School Principals |
| Health Care Authority |
| Legislative staff |
| Office of State Actuary |
| Office of the Superintendent of Public Instruction |
| Public School Employee Union |
| Tacoma Public Schools |
| Washington Association of School Administrators |
| Washington Association of School Business Officers |
| Washington Education Association |
| Washington State School Directors' Association |

We conducted a series of interviews with interested parties and others knowledgeable about the current system of providing health benefits to school employees in Washington. Senior Hay Group actuaries conducted the interviews; representatives of SAO staff were also present at all of the interviews. We met with representatives of State agencies, insurers, school organizations, several local school districts and the WEA and PEBB plans. During these interviews a number of common themes emerged concerning the design goals or principles that stakeholders in Washington have for the system. Some of these are already reflected in State law, others reflect a consensus among all of the stakeholders, and some reflect the point of view of a particular subset of interested parties. Among these themes are:

- Maximizing transparency
- Ensuring that school funds are not diverted to other purposes
- Preserving local input into the management of the program
- Preserving ability to bargain benefits

- Ensuring consistent treatment of school employees between districts and between job categories
- Reflecting the needs of school employees
- Controlling the cost of benefits

No one system can fully achieve all of these goals. Taken together, however, they do provide insight into the interests and concerns of the various stakeholders and the Washington-specific context for the system.

The survey of the K-12 districts was based on Hay Group's past experience in conducting these surveys, with the document customized based on information gained from the interview process and our review of Washington's current school coverages. The survey document, shown in Appendix A, was designed to capture as much information as possible with the least amount of work for district employees. Several districts volunteered to test the draft survey document, and we wish to thank those districts for their assistance in this process, including North Thurston, Sedro-Woolley, Tacoma and Tumwater. We sent the survey by email to the districts under a cover letter from the State Auditor's Office describing the overall study process. Initially due October 22, 2010, the submission deadline was extended to November 1, 2010. We accepted additional submissions through November 5 as we worked through the data validation process. The testing process identified certain areas where data collection was difficult.[11] We also wish to thank the Washington School Information Processing Cooperative (WSIPC) for its committed and timely efforts to develop data extraction tools to assist the districts in compiling the needed information and the Washington Association of School Business Officers for their insight and assistance.

Most K-12 districts have multiple bargaining groups as well as non-represented employees, and benefits often differ by group. As such, the proper unit for gathering complete information is bargaining unit by district. However, some districts have as many as 13 bargaining units.[12] We therefore restricted data collection to the three largest bargaining units in each district.

The results of this process were 129 submissions, 42% of the 304 K-12 districts and Educational Service Districts (ESDs). Of the 129 survey submissions received, 12 submissions included incomplete or inconsistent data that could not be used, resulting in 117 usable submissions. All but 2 of the 30 largest

[11] As part of the customization process, we learned that only two of the K-12 districts currently self-insure; as such, we removed questions primarily related to self-insured plans from the main survey, simplifying the response process for most districts. These questions were then compiled into a supplemental survey sent to the two self-insuring districts, also included in Appendix A.

[12] There is not a one-to-one correspondence between bargaining units and local funding pools. In responding to the Hay Group survey, one local district reported 13 funding pools and 8 bargaining units, while another local district reported 7 funding pools and 10 bargaining units.

districts responded (93%), so that the data from the responding districts represents about half of the Washington school employees. Testing of subgroups demonstrated that there was adequate representation of districts in both Eastern and Western Washington, in both rural and urban counties, and of WEA and PEBB members. Additionally, both self-insured districts responded. A summary of responding districts and the subgroup analysis is also included in Appendix A. Survey data for the dental plan survey was 55 percent of the total statewide K-12 workforce of 121,672. Survey data for the vision plan was 51 percent of the total statewide K-12 workforce. The survey data for the medical plan and employee contribution data captured information on 49,748 employees, about 45 percent of employees who elect medical coverage. The survey response rate was very high and ensures that the data is representative of the K-12 system.

As part of the survey we asked for free-form responses to the question "What aspect about the health benefits would you most like to see improved?" Those responses are provided as part of Appendix I. The most common concerne expressed was the high cost of health benefits.

The survey of administrative practices was distributed electronically to WEA, PEBB, and Group Health Cooperative, with a requested response date of November 18; follow-up telephone discussions were conducted with each organization. A copy of the survey document and a summary of the responses are also included in Appendix B.

## II. History and Background of Washington K-12 Employees' Health Care Benefits

The State has 295 school districts and 9 educational service districts, which for this report will be referred to as "K-12 districts." Educational Service Districts (ESD's), are regional administrative units created by statute that evolved from county superintendents. Health care benefits are provided within the overall funding structure for K-12 districts in Washington. Washington is unique among the states in that its Constitution declares the education of children to be "the paramount duty of the State." The overall funding structure of Washington K-12 districts is beyond the scope of this study.[13] In this report we discuss those aspects of the funding structure relevant to employee health care benefits.

The State's responsibility under the Constitution has been interpreted as requiring the State to make "ample provisions" for "basic education." Thus, the funding structure for Washington schools is that the State funds "basic education" as currently defined under the law. Additional funding comes from the federal government for various federal initiatives; and the remainder of funding for an individual district is determined by local voters through passage of a local school levy. The Budget Guide notes that the typical district receives 72% of its funding from the State, 9% from the federal government, 16% from its local levy, and 3% from reserves or other revenue sources (which includes fees for non-basic education programs, school lunch charges, revenue from other school districts, rental income, donations, and the use of reserves or fund balance). There are, however, variations among districts in levels of funding and services both because of the varying impact of federal funding and because of available funds from local levies. To illustrate, Table II-1 summarizes the variation in local school levy rates per $1,000 of assessed property value:

[13] Interested readers may review an overview for citizens (see http://www.leg.wa.gov/Senate/Committees/WM/Documents/Publications/BudgetGuides/2009/K1209.pdf), or a more detailed description (see http://www.k12.wa.us/safs/PUB/ORG/09/2009OrgFin_Final%20Copy.pdf ).

| Table II-1<br>Washington K-12 school levy funding | |
|---|---|
| **Tax rate per $1,000** | **Number of districts** |
| No Levy | 14 |
| $0.01-$1.00 | 21 |
| $1.001-$1.50 | 41 |
| $1.501-$2.00 | 35 |
| $2.001-$2.50 | 50 |
| $2.501-$3.00 | 74 |
| $3.001-$3.50 | 30 |
| $3.5001-$4.00 | 16 |
| Over $4.00 | 14 |
| TOTAL | 295 |
| Source: Byron Moore, Operating Budget Coordinator, Washington Senate Ways & Means Staff | |

When translated into a per student rate, the average per student expenditure throughout Washington is $1,771, which by district ranges from $0 (no levy) to $5,638 per student (in a small district with a significant taxable property base, the levy tax rate being approximately $1.92, which is below the State average of $2.03).

From this, it seems reasonable to conclude that there are significant funding differences in "non-basic" educational services among the districts, based on local voter decisions. There are limits on this "local control", however; the current provisions of the Levy Lid Act limit a district's levy revenue to 24 percent of its State and federal revenues (the limit applies to 205 districts; the other 90 districts are grandfathered at percentage limits ranging from 24.01% to 33.90%). This Act effectively caps the amount a local district can fund in addition to State and federal revenues.

We explore this issue in more detail below in the discussion of pooling arrangements. For now, the following viewpoint seems to be a reasonable formulation of the factors described above: (1) the State has an obligation to fund "basic education" for all of its citizens; (2) while this funding can reasonably vary between districts based on transportation requirements, special needs, and other factors not amenable to per-student reimbursement formulas, the nature of this statewide obligation would typically lead to similar funding levels for the basic education programs of all districts across the State; (3) "local control" suggests that other school district programs beyond basic education are primarily determined

locally, and as such these programs may vary significantly between the districts state-wide; and (4) funding of these other programs will primarily come from federal and local funds.

## III. Washington's K-12 District Employee Population

As with any large group, exact data counts can differ by sources due to definitional and timing issues. However, the data provided in the Washington State 2009 Actuarial Valuation Report, issued by the Office of the State Actuary in October, 2010, provides important information about K-12 employees.[14] In this section, we summarize data on State school employees taken from the Actuarial Valuation Report (AVR). We examined this data for two principal reasons. Firstly, to gain a better understanding of the school employee demographics, and secondly to assist us in extrapolating from the detailed district survey data we obtained the cost and characteristics of the districts' health care programs.

Our understanding of these results is that they are based on headcount; thus, for example, an individual working ½ of a full-time schedule (that is, 0.5 FTE) is recorded here as 1 individual rather than 0.5 as would appear in a count of FTE's. The report describes this information as "participant data used in the actuarial valuation for the plan year ending June 30, 2009."[15] Total active K-12 and ESD employment is shown as follows[16]:

**Table III-1**
**Washington Pension Enrollees**

| All Systems | PERS | TRS | | | | SERS | | | Grand Totals |
|---|---|---|---|---|---|---|---|---|---|
| | Plan 1 | Plan 1 | Plan 2 | Plan 3 | Total | Plan 2 | Plan3 | Total | |
| **1. K-12** | **2,135** | 4,974 | 9,062 | 52,676 | **66,712** | 19,469 | 31,307 | **50,776** | **119,623** |
| **2. ESD** | **63** | 22 | 59 | 207 | **288** | 728 | 970 | **1,698** | **2,049** |
| **3. Total K-12 & ESD** | **2,198** | 4,996 | 9,121 | 52,883 | **67,000** | 20,197 | 32,277 | **52,474** | **121,672** |
| **4. Non K-12 & ESD** | **8,156** | 208 | 53 | 127 | **388** | 0 | 0 | **0** | **8,544** |
| **5. Total** | **10,354** | 5,204 | 9,174 | 53,010 | **67,388** | 20,197 | 32,277 | **52,474** | **130,216** |
| **6. K-12 Enrollees as a Percent of total (3. / 5.)** | **21.2%** | **96.0%** | **99.4%** | **99.8%** | **99.4%** | **100%** | **100%** | **100%** | **93.4%** |

Source: Washington State 2009 Actuarial Valuation Report

There are other retirement plans within the Washington State system, but all K-12 and ESD active employees are covered by one of the six plans shown above. The School Employees' Retirement System (SERS) covers only classified employees. The Teachers' Retirement System (TRS) covers virtually all

[14] The complete report may be found at http://osa.leg.wa.gov/Actuarial_Services/Publications/PDF_Docs/Valuations/2009AVR.pdf.
[15] AVR page 7.
[16] AVR page 38.

K-12 certificated employees.[17] As over 98% of current school employees belong to TRS or SERS, and these plans cover almost exclusively K-12 and ESD employees, we can take information about the personnel covered by these plans as a proxy for the school employee population, with SERS representing classified employees and TRS representing certificated employees. Table III-2 provides a comparison of key statistics of the certificated and classified employee groups.[18]

**Table III-2**
**Teachers' Retirement System (TRS) and School Employees' Retirement System (SERS)**
**Membership Statistics**

| EMPLOYEES | TRS | SERS |
|---|---|---|
| Number | 67,388 | 52,474 |
| Average Age | 45.8 | 49.4 |
| Average Service | 12.7 | 9.7 |
| Average Age at Hire | 33.1 | 39.7 |
| Average Salary | $64,493 | $27,947 |
| Males | 18,971 | 11,438 |
| Females | 48,417 | 41,036 |
| **SERVICE RETIREES*** | **TRS** | **SERS** |
| Number | 36,193 | 4,208 |
| Average Age | 71.3 | 68.3 |
| Average Years Retired | 12.5 | 3.5 |
| Average Age at Retirement | 58.8 | 64.8 |
| Males | 15,441 | 1,187 |
| Females | 20,752 | 3,021 |
| Actives per Retiree | 1.86 | 12.47 |

* Does not include disabled retirees or survivors

From Table III-2 we see that each group is predominantly female. Among active employees, the average SERS employee is 3.6 years older, and was 6.6 years older at hire, than the average TRS employee. The average TRS employee has a pensionable salary of 2.3 times that of the SERS employee (this in part reflects the higher percentage of part-time employees among SERS employees). While TRS employees are 56% of total active employees shown, they are 90% of total retirees. Also, TRS employees retire on average 6 years earlier than SERS employees.

Together, these statistics portray significant differences between the certificated (TRS) and classified (SERS) employees. The certificated employees are on average younger and have longer service and

[17] There are an additional 388 members of TRS who currently work at community colleges, state agencies, or in higher education. There are 2,198 employees covered by the Public Employees' Retirement System (PERS) Plan 1, which was closed to new entrants in 1977.
[18] AVR pages 40, 41, and 93-97.

higher pay than classified employees; they are also more likely to receive pension benefits (i.e., the classified employees have higher turnover).

These factors have certain important ramifications for the cost of health benefit coverage. First, as the classified employees are on average 3.6 years older than the certificated employees, they would be expected to have higher average health claims. Second, as the classified employees have higher turnover as a group, they create more potential exposure to claims after termination (i.e., COBRA exposure) than do certificated employees. Third, because they have significantly lower average incomes, classified employees pay a significantly greater percentage of their income for coverage than do certificated employees. Fourth, as certificated employees represent a much larger percentage of retirees than they do of active employees, the retiree reimbursement amount per FTE (which the State pays to the schools and then requires the schools to pay to PEBB) constitutes a significant movement of assets paid on behalf of classified employees to subsidize the retiree health benefits of certificated retirees.

***Full-Time Employment***

As part of our analysis of the funding of K-12 employee health care benefits and the demographics of the certificated and classified groups, we examined data concerning the distribution of part-time and full-time employment. The following data was supplied to us by SAO, developed from OSPI databases:

**Table III-3**
**Washington K-12 Employment Distribution**

| Category | Certificated | Classified |
|---|---|---|
| 0.0-0.1 FTE | 0.08% | 1.17% |
| 0.1-0.2 FTE | 0.16% | 1.78% |
| 0.2-0.3 FTE | 0.35% | 3.51% |
| 0.3-0.4 FTE | 0.25% | 6.80% |
| 0.4-0.5 FTE | 0.87% | 9.05% |
| 0.5-0.6 FTE | 3.71% | 22.85% |
| 0.6-0.7 FTE | 2.33% | 15.59% |
| 0.7-0.8 FTE | 0.71% | 9.00% |
| 0.8-0.9 FTE | 2.34% | 6.46% |
| 0.9-1.0 FTE | 0.97% | 3.29% |
| 1.0+ FTE | 88.20% | 20.49% |

Source: Washington State Auditor's Office, based on OSPI databases.

From the above data, we can see that almost 90% of the certificated staff is full-time, while almost 80% of the classified staff is part-time. This has significant implications for both benefits funding (which is based on FTE's) and pooling (since employees below a certain threshold may not be eligible for benefits, so the funds allocated to the district by the State on behalf of these employees is reallocated to benefits-eligible employees).

An additional complication is the distinction between "calculated" FTE, which is typically calculated on 2,080 hours per year and is used in the above tables, and "benefits" FTE, which is used to determine benefits eligibility and is typically based on 1,440 hours per year. Thus, as an example, suppose an employee is scheduled to work 1,456 hours per year, and thus has a benefits FTE of 1.0. This person would typically be eligible for a full employer contribution based on this status. However, the State funding would be set at 0.7 FTE (1,456/2,080). The remaining contribution would need to be provided through local or federal funding, or as a result of the pooling process.

## IV. Health Plans Currently Available to K-12 Employees

The survey of K-12 districts found that coverage is obtained from a relatively small number of carriers and providers. Survey responses included both plan names (e.g., WEA Plan 1) and provider names (e.g., Premera). As these can both refer to the same benefit design, where possible the data was grouped by plan or provider. Given the variety of names provided, some WEA or PEBB enrollees may have been summarized by their provider name and not WEA or PEBB plan name.

Within some providers, we found a large variety of different benefit designs or plan names. Table IV-1 shows that the top six providers represent 90 percent of the enrollees from the survey.

**Table IV-1**
**Enrollment by Plan / Provider From Survey Responses**

| Plan / Provider | Enrollment | Percent of Total | Cumulative Percent |
|---|---|---|---|
| 1. WEA | 30,429 | 55% | 55% |
| 2. Group Health | 9,725 | 18% | 73% |
| 3. Regence | 4,267 | 8% | 80% |
| 4. Premera | 3,305 | 6% | 86% |
| 5. Kitsap | 1,354 | 2% | 89% |
| 6. Kaiser | 1,220 | 2% | 91% |

Source: Hay Group survey of K-12 School Employee Benefits.

Table IV-1 shows that 55 percent of the enrollees from the survey listed WEA as their plan. Table IV-2 shows the enrollment by plan option within WEA.

**Table IV-2**
**WEA Enrollment by Medical Plan Option**

| WEA Plan Option | Enrollment | Percent |
|---|---|---|
| WEA 1 | 10,302 | 33.9% |
| WEA 2 | 6,312 | 20.7% |
| WEA 3 | 4,236 | 13.9% |
| WEA 5 | 7,898 | 26.0% |
| WEA Easy Choice A/B/C Combined | 1,681 | 5.5% |
| Total | 30,429 | 100.0% |

Source: Hay Group survey of K-12 School Employee Benefits.

Table IV-3 shows the PEBB enrollment by plan option.

| Table IV-3<br>PEBB Enrollment by Medical Plan Option | |
|---|---|
| **PEBB Plan Option** | **Enrollment** |
| Aetna Public Employees Plan | 96 |
| Group Health Classic | 307 |
| Group Health Value | 104 |
| Uniform Medical Plan | 441 |
| Total | 948 |
| Source: Hay Group survey of K-12 School Employee Benefits. | |

PEBB covers less than 2 percent of the coverage employees

***Benefits offered through WEA***

The WEA provides coverage in 251 K-12 districts; in 206 of those districts, the WEA program is offered to all employees. In the remaining 45 districts, the WEA program does not cover all employees of the district; however, as WEA is the primary teachers' union in the State, their program covers the teachers in virtually all of these 45 districts. Extensive materials concerning the WEA program are provided in Appendix C.

The WEA medical benefit program is offered through Premera, with whom they have contracted since the 1970's. Table IV-4 shows the carriers WEA uses by benefit coverage.

| Table IV-4<br>Carriers Used by the WEA | |
|---|---|
| **Coverage** | **Carrier** |
| Medical | Premera |
| Dental / Washington Dental Service | Delta Dental & Willamette Dental |
| Vision | Premera / VSP |
| Life Insurance and AD&D | Provident Life & Accident/UNUM |
| LTD | American Fidelity |
| Source: WEA | |

The WEA programs do not offer any retiree coverage, other than COBRA. Individuals desiring coverage in retirement would participate in the PEBB plans for retirees.

The WEA Select Health program includes 7 plans – Plans 1, 2, 3 and 5 and EasyChoice plans A, B and C – using two provider networks – Foundation (Plans 5 and C) and Heritage (all other plans). The

bargaining process determines which plans a district will offer to its employees. A district might only offer WEA Plans 1, 3 and C, for example. Premium rates do not vary between participating employers, however there are two rate sets: a "Full Rate" and a "10% Discount Rate." The 10% discount is given to any group where all participating employees have their medical benefit choice limited to the WEA Select Plan(s) and at most one licensed HMO plan from one HMO carrier. The 10% discount is almost universal among participating groups. Also, each of the 7 plans includes a $20,000 decreasing term life and AD&D benefit.

Tables IV-5A and IV-5B set out the key medical plan design features of the seven plans.

**Table IV-5A**
**Key Medical Plan Design Features**

| | WEA Plan 1 | WEA Plan 2 | WEA Plan 3 | WEA Plan 5 |
|---|---|---|---|---|
| Deductible | $50 | $100 | $200 | $100 |
| Out-of-Pocket Limit | $494 | $1,475 | $2,700 | None |
| Coinsurance | 10% | 20% | 20% | 0% |
| Office Copayment | $20 | $25 | $30 | $15 |
| Hospitalization | $100 copay days 1-3 | $150 copay days 1-3 | $300 copay days 1-3 | $200 copay days 1-3 |
| Rx - Generic copay | $10 | $10 | $15 | $10 |
| Rx - Brand Preferred copay | $15 | $20 | $25 | $15 |
| Rx - Brand Non-Preferred | $30 | $35 | $40 | $30 |

Source: Hay Group review of WEA benefit plan brochures.

| Table IV-5B<br>Key Medical Plan Design Features | | | |
|---|---|---|---|
| | **WEA Plan A** | **WEA Plan B** | **WEA Plan C** |
| Deductible | $1,000 | $750 | None |
| Out-of-Pocket Limit | $5,000 | $4,000 | $7,500 |
| Coinsurance | 20% | 25% | 35% |
| Office Copayment | $15 | $20 | $35 |
| Hospitaliztion | No copay | No copay | No copay |
| Rx - Generic copay | 0% | $0 | $1 |
| Rx - Brand Preferred copay | 30% with $500 Ded. | $30 with $250 Ded. | $30 with $500 Ded. |
| Rx - Brand Non-Preferred copay | 30% with $500 Ded. | $45 with $250 Ded. | $45 with $500 Ded. |
| Source: Hay Group review of WEA benefit brochures. | | | |

***Benefits Offered through PEBB***

PEBB provides benefits in over 50 K-12 districts; the program may or may not cover all employees in a district. It is likely that in districts where PEBB is not the sole provider, the groups involved are predominantly classified employees.

PEBB offers a variety of coverages. In order of size of (total State/local) enrollment, these are: the Uniform Medical Plan, Group Health (Classic and Value plans), Kaiser (Classic and Value* plans), Aetna*, and several retiree-only plans – Premera* (Medicare Supplement plans E, J with drug coverage, and J without drug coverage) and Secure Horizons (Classic and Value plans). These plans are all offered to any employee or retiree enrolled in PEBB (provided they are eligible for the specific plan), although not all plans are offered in all counties. * Effective January, 1 2011, these plans will no longer be offered.

Table IV-6 shows the key medical plan design features for the PEBB plan options.

**Table IV-6**
**Key Medical Plan Design Features**

| | PEBB Aetna | PEBB Group Health Classic | PEBB Group Health Value | PEBB Uniform Medical Plan |
|---|---|---|---|---|
| Deductible | $250 | $250 | $350 | $250 |
| Out-of-Pocket Limit | $2,000 | $2,000 | $2,000 | $2,000 |
| Coinsurance | Copays | Copays | Copays | 15% |
| Office Copayment | $25 | $25 | $30 | 15% |
| Hospitalization | $200 copay days 1-3 | $200 copay days 1-3 | $200 copay days 1-3 | $200 copay days 1-3, +15% |
| Rx - Generic copay | $20 | $20 | 10% | 10% |
| Rx - Brand Preferred copay | $40 | $40 | 30% | 30% |
| Rx - Brand Non-Preferred copay | $60 | $60 | 50% | 50% |

Source: Washington State Health Care Authority Public Employees Benefit Board publication "Your Medical and Dental Coverage 2010" HCA 50-100 (6/10)

Additional details and analysis of the PEBB program are provided in Appendix D.

### *Dental Benefits*

Table IV-7 shows the dental plan coverages provided through WEA and PEBB.

**Table IV-7**
**Dental Plan Coverages**

| Sponsor | Benefit Plan | Deductible | Preventive Care | Basic Restorative | Major Restorative | Benefit Year Maximum |
|---|---|---|---|---|---|---|
| WEA | Plan A | None | 100% | 70-100% | 50% | $1,750/person |
| WEA | Plan B | $50 single<br>$150 family | 100% | 80% | 50% | $1,750/person |
| WEA | Plan C | None | 100% | 80% | 50% | $1,750/person |
| WEA | WDS DeltaCare | None | 100% | 100% | copayments | None |
| WEA | Willamette 1 | None | $15 Copay | $15 Copay | $50 Copay | None |
| WEA | Willamette 2 | None | $20 Copay | $20 Copay | $250 Copay | None |
| PEBB | Uniform | $50 single<br>$150 family | 100% | 80% | 50% | $1,750/person |
| PEBB | DeltaCare Willamette | None | 100% | Copayments ($10-175) | | None |

Source: 2010-2011 WEA Select Dental Program Brochure and PEBB Employee Enrollment Guide: Your Medical and Dental Coverage for 2010

Table IV-8 shows the orthodontia plan coverages

**Table IV-8**
**Orthodontia Plan Coverages**

| Sponsor | Plan | Benefit Level |
|---|---|---|
| WEA | WDS Plans | 50% to Max Lifetime max of $1,000, $1,500, or $2,000 |
| WEA | Willamette Plans | OV copayments with OOP max of $1,500, $1,650, or $2,000 |
| PEBB | Uniform | 50% of costs up to $1,750, then covered at 100% |
| PEBB | DeltaCare Willamette | Member pays up to $1,500 per case |

Source: 2010-2011 WEA Select Dental Program Brochure and PEBB Employee Enrollment Guide: Your Medical and Dental Coverage for 2010

***Benefits offered outside of PEBB or WEA***

Other than benefits offered through WEA or PEBB, the most common alternative plan is an HMO plan offered in addition to a WEA program, typically provided by Group Health Cooperative, or Kaiser in southwest Washington, as WEA allows an additional HMO program to be offered without losing the 10% WEA premium discount. As to other plans outside of WEA or PEBB, we believe that for the most part these benefits are placed by insurance brokers for the contracting school districts, and that benefit provisions vary considerably among these arrangements as benefits are typically subject to collective bargaining.

As shown in Table IV-1, Group Health has the second highest enrollment of K-12 employees. Group Health is a non-profit health care system based in Seattle and offers health plans under Group Health Cooperative and subsidiaries: Group Health Options, Inc. and KPS Health Plans. Group Health covers more than 650,000 individuals in twenty counties in Washington and two counties in northern Idaho. Group Health is a consumer-governed organization with an 11-member board of trustees who are all plan members and are elected by other members.

There are only two self-insured medical programs, in Everett and Northshore. While there is some use of self-insurance for vision and dental programs, these benefits involve low annual maximums and are a relatively small part of overall health benefit expense.

## V. Comparison of Benefit Designs to Prevailing Employer Practices

As part of our analysis of the health care benefits provided to district employees, we benchmarked both the prevalance of key plan features and the relative value of the plans compared to all employers nationwide in order to evaluate the relative richness of the plans available to district employees.

Every year, Hay Group conducts benefits surveys in order to maintain our extensive database on benefits practice and prevalence information. The Hay Benefits Prevalence Report, (Hay Prevalence Report), which has been published annually for over 40 years, details the benefits practices of organizations participating in Hay Group's annual survey. The report compares and analyzes all aspects of the employee benefit programs offered by participating employers. It reflects all facets of the U.S. economy and is one of the most comprehensive and detailed analyses of U.S. employee benefits data from for-profit, not-for-profit, and public sector employers.

The 2010 Hay Prevalence Report includes data from over 800 U.S. employers from a cross-section of the U.S. employers. Data from the Hay Prevalence Report was used as a comparison tool in our analysis for the State of Washington. Where relevant, we also indicate the prevalence of certain health plan features among "the Service Sector" responding employers. Service Sector includes employers that, similar to government and schools, provide services to the public. In general, employers in the Service Sector tend to provide better health benefits than employers in other sectors of the economy. Following is a summary of medical, prescription drug, dental, and vision benefit prevalences from the 2010 Hay Prevalence Report.

**Medical Plan Comparisons**

*Medical Plan Deductible*

Based on the 2010 Hay Prevalence Report, 67 percent of employer-offered medical plans have a flat dollar deductible, 32 percent have no deductible, and less than 1 percent vary the deductible by salary or percentage of pay.

For the plans which do have a deductible, Table V-1 shows the dollar amounts of the individual deductibles. The table shows the deductible amounts for those plans which are from the Service Sector as well as for all employers. Service Sector employers use plans with somewhat lower deductible amounts than all employers.

| Table V-1<br>Dollar Amount of Individual Flat Dollar Deductibles | | |
|---|---|---|
| **Deductible Amount** | **Service Sector** | **All Employers** |
| Less than $200 | 10% | 6% |
| $200 | 7% | 9% |
| $201-$299 | 17% | 19% |
| $300 | 13% | 13% |
| $301-$399 | 10% | 5% |
| $400 | 5% | 4% |
| $401-499 | 2% | 1% |
| $500 | 18% | 19% |
| Greater than $500 | 18% | 24% |
| Source: 2010 Hay Prevalence Report. | | |

*Medical Plan Coinsurance and Out-of-Pocket Expense Limits*

As reported in the 2010 Hay Prevalence Report, over half of the medical plans offered have an out-of-pocket limit whereby once an employee's share of coinsurance (out-of-pocket expenses) reaches a certain amount, expenses for the remainder of the year are paid at 100 percent of recognized charges. The intent is to provide a limit to employee out-of-pocket expenses in the event of "catastrophic" medical expenses.

Of the 60 percent of organizations in the Hay Prevalence Report that have individual out-of-pocket limit provisions, 51 percent initially pay benefits at 80 percent of recognized charges, 4 percent pay benefits at less than 80 percent, 6 percent pay at 85 percent, and 39 percent pay between 90 and 99 percent.

Table V-2 shows the individual out-of-pocket limits for all Hay Prevalence Report participating organizations as well as participants from the Service Sector. Service Sector employers select plans with somewhat lower out-of-pocket limits compared with all employers.

| Table V-2<br>Dollar Amount of Individual Out-of-Pocket Limits | | |
|---|---|---|
| **Out-of-Pocket Limit** | **Service Sector** | **All Employers** |
| Less than $1,000 | 10% | 7% |
| $1,000 | 14% | 11% |
| $1,001 to $1,500 | 22% | 23% |
| $1,501 to $2,000 | 33% | 25% |
| $2,001 to $3,999 | 18% | 26% |
| $4,000 or greater | 3% | 8% |
| Source: 2010 Hay Prevalence Report. | | |

**Prescription Drug Coverage**

The 2010 Hay Prevalence Report shows that all organizations provide prescriptions drug coverage. Precription drugs have been an increasingly important and expensive component of health plans. Ninety-five percent of plans cover prescription drugs under a separate plan while 5 percent cover prescription drugs under medical plan provisions.

*Copayments for Separate Prescription Drug Plans*

Eighty-six percent of the Hay Prevelance Report respondents with prescription drug plans require a copayment per prescription. Another 3 percent of respondents have an annual deductible, 5 percent do not require a copayment, and 6 percent require some other form of payment.

Table V-3 shows the copayments for generic prescriptions.

| Table V-3<br>Copayments for Prescription Drug Plans | | |
|---|---|---|
| **Copayment** | **Service Sector** | **All Employers** |
| Less than $5.00 | 3% | 2% |
| $5.00 | 16% | 15% |
| $5.01-$9.99 | 13% | 12% |
| $10.00 | 53% | 53% |
| Greater than $10.00 | 15% | 18% |
| Source: 2010 Hay Prevalence Report. | | |

Table V-4 shows the prevalence of different copayment amounts for generic drugs, brand name formulary, and brand name non-formulary prescription drugs. The most common design has copay amounts of:

- $10 for generic drugs
- $25 to $30 for brand name drugs
- $40 to $50 for brand non-formulary drugs

**Table V-4**
**Copayments for Generic and Brand Name Prescription Drugs**

| Copayment | Generic | Brand Name Formulary | Brand Name Non-Formulary |
|---|---|---|---|
| Less than $5.00 | 2% | - | - |
| $5.00 | 15% | - | - |
| $5.01 - $9.99 | 12% | - | - |
| $10.00 | 53% | 2% | 1% |
| $10.01 - $14.99 | 3% | - | 1% |
| $15.00 | 12% | 7% | 3% |
| $15.01 - $19.99 | - | - | - |
| $20.00 | 2% | 21% | 4% |
| $20.01 - $24.99 | - | 1% | - |
| $25.00 | 1% | 32% | 5% |
| $25.01 - $29.99 | - | 1% | - |
| $30.00 | - | 23% | 7% |
| $30.01 - $39.99 | - | 8% | 7% |
| $40.00 | - | 3% | 23% |
| $40.00 - $49.99 | - | - | 11% |
| $50.00 | - | 2% | 25% |
| Greater than $50 | - | - | 13% |

Source: 2010 Hay Prevalence Report.

**Dental Coverage**

Ninety-nine percent of Hay Prevalence Report participants provide dental coverage. Table V-5 shows the percentage of Recognized Charges Paid for dental benefits under plans where coverage varies by type of expense. Basic Restorative services include filings, endodontics, periodontics, and oral surgery. Major Restorative services include inlays, crowns, and dentures.

| Table V-5<br>Percentage of Recognized Charges Paid for Dental Plans where Coverage Varies by Type of Expense | | | |
|---|---|---|---|
| **Percent Paid** | **Preventive Care** | **Basic Restorative** | **Major Restorative** |
| 100 | 94% | 6% | - |
| 81-99 | 1% | 11% | 1% |
| 80 | 4% | 68% | 7% |
| 51-79 | 1% | 6% | 19% |
| 50 | - | 8% | 72% |
| Less than 50 | - | 1% | 1% |
| Source: 2010 Hay Prevalence Report. | | | |

Table V-5 shows that the most common plan design provides:

- 100 percent coverage for preventive care,
- 80 percent coverage for basic restorative, and
- 50 percent coverage for major restorative.

**Vision Coverage**

Ninety-two percent of Hay Prevalence Report survey respondents provide vision coverage to employees. Eighty-seven percent of employers provide coverage under the medical plan or through a separate plan, while 5 percent provide a discount plan only.

Table V-6 shows the types of vision services covered by vision plans.

| Table V-6<br>Types of Services Covered under Vision Care Plans | | | | | |
|---|---|---|---|---|---|
| | **Eyeglass Lenses** | **Contact Lenses** | **Routine Check-Ups** | **Frames** | **Laser Vision Correction** |
| Covered | 94% | 91% | 99% | 92% | 23% |
| Not Covered | 6% | 9% | 1% | 8% | 77% |
| Source: 2010 Hay Prevalence Report. | | | | | |

**Commentary on K-12 Health Benefits**

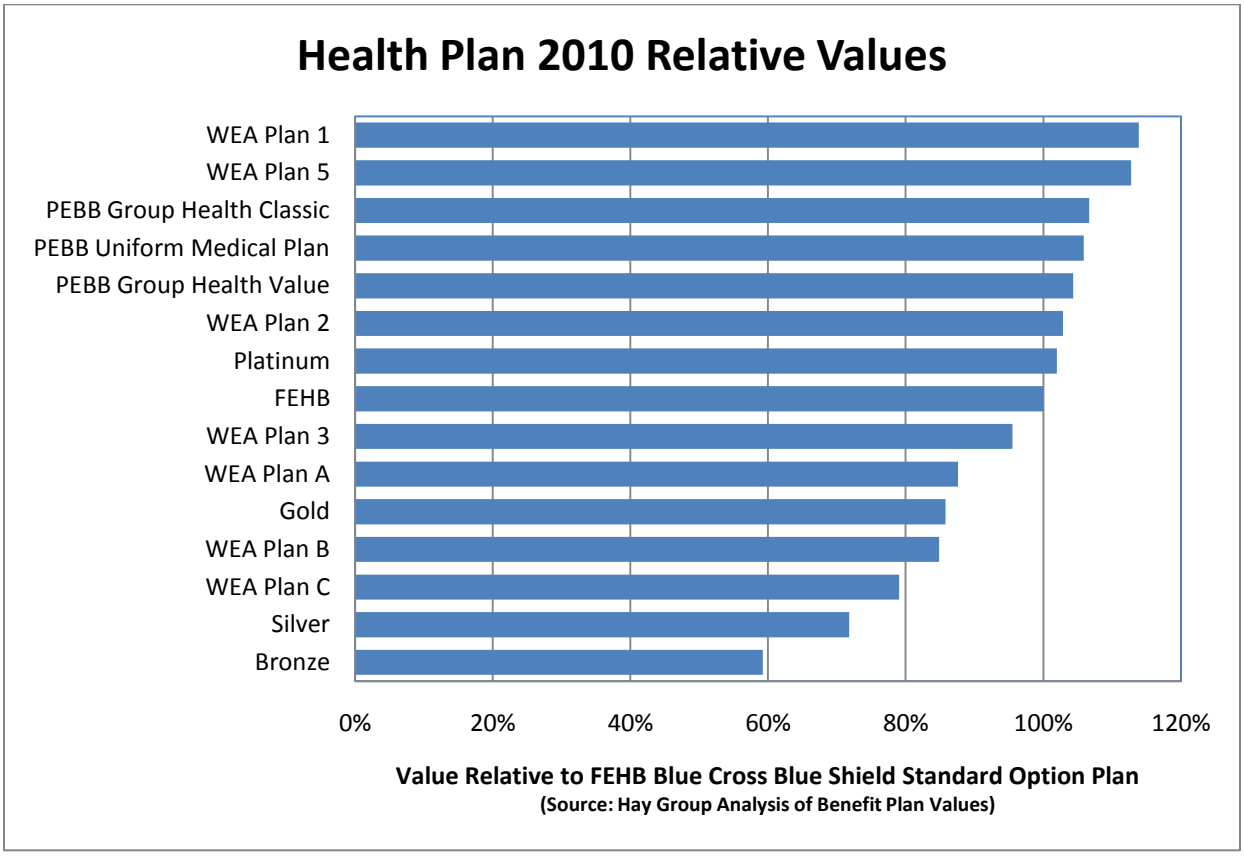
Reviewing the benefit plans provided to the State's K-12 employees and comparing them to the benefit programs provided nationwide, we observe that the medical benefit coverages provided to the State's K-12 employees are quite generous. Relative to the FEHB BCBS Standard Option plan, we found that the two top plans with the highest enrollment (WEA Plans 1 and 5) were 13-14 percent more valuable. WEA Plan 1 had the highest enrollment among all K-12 employees. Ninety-four percent of nationwide plans had a deductible larger than $200, whereas WEA Plan 1's deductible is $50. Ninety-three percent of nationwide plans had an out-of-pocket limit that was larger than $1,000, whereas WEA Plan 1's out-of-pocket limit was $494.

***Comparison of Benefit Values***

Using Hay Group's Benefit Value Comparison tool (an actuarial model[19]), we determined the relative richness of the WEA and PEBB plans. Chart V-1 ranks the health plans available to district employees and includes a benchmark plan – the Federal Employees Health Benefit (FEHB) program plan with the largest enrollment (the Blue Cross Blue Shield Standard Option plan). An explanation of Hay Group's Benefit Value Comparison Methodology is contained in Appendix J.

The comparison includes only the value for medical and prescription drug coverage. The value for dental and vision coverage was not included. Plans with higher values provide greater financial protection to enrollees through lower deductibles, copayments, and out-of-pocket limits.

**Chart V-1**




[19] See Appendix J for a description of the actuarial model and the methodology it uses for valuing and comparing health plans.

***Observations***

With respect to the relative value of the variable health plan options, the main observation we have is that the two plans with the largest enrollment, WEA Plans 1 and 5, are also the plans with the highest plan values. The combined enrollment in these plans is about 30 percent of the total K-12 enrollment, and the plans are over 13 percent more valuable than the FEHB Blue Cross Blue Shield Standard Option plan.

We also observed that several plans have a very similar value. PEBB Uniform Medical Plan, and WEA Plan 2 provide broadly equivalent value, but with quite different plan designs in terms of initial cost-sharing and annual out of pocket costs.

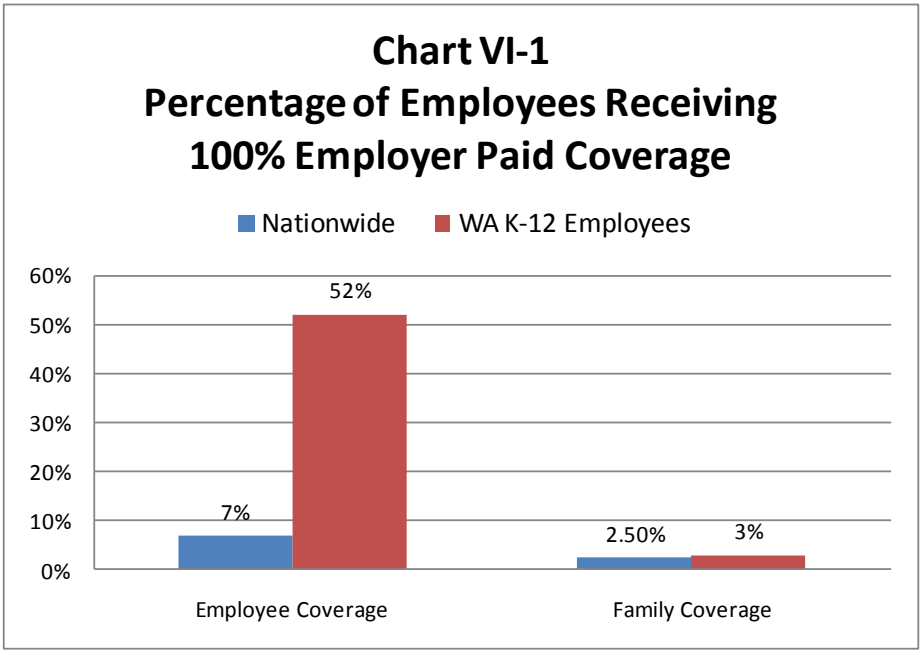
## VI. Comparison of Employee Contributions to Prevailing Employer Practices

The Hay Prevalence Report also provides information on employee contributions. Following is a summary of prevailing employer contribution practices from the 2010 Hay Prevalence Report, and a comparison of those practices to the contribution requirements for K-12 employees in Washington.

**Employee Contributions for Medical Coverage**

The data from Hay Prevalence Report shows that 7 percent of employees received fully employer-paid employee-only medical coverage. Two and a half percent of employees receive family coverage fully paid. Eleven percent of organizations report that their employee contributions vary by salary level or by years of service. Based on the Washington K-12 survey responses, we found that 52 percent of the employees have fully employer-paid policies for employee-only coverage and 3 percent of the employees have fully employer-paid policies for family coverage.

Chart VI-1 compares the prevalence of 100 percent employer-paid coverage in the State's K-12 districts (WA K-12) to Nationwide data. [20]




[20] For the WA K-12 information, the prevalence was based on number of employees from the survey. For the nationwide data the prevalence was based on the number of organizations in the Hay Prevalence Report, weighted by employees at these organizations.

The practice of paying 100% of the premium cost has become less prevalent over time. Table VI-1 shows data from the Hay Prevalence Report since 1990 and shows an almost 80% decline over the past 20 years in the number of employers that fully paid either single or family coverages.

**Table VI-1**
**HBPR Repsondents Primary Plans Paying 100% of Premium Cost**

| Year | Single Coverage | Family Coverage |
|---|---|---|
| 1990 | 49% | 25% |
| 1995 | 32% | 15% |
| 2000 | 29% | 11% |
| 2005 | 14% | 6% |
| 2010 | 10% | 4% |

Source: 2010 Hay Benefit Prevalence Report.

For plans that require contributions, the nationwide average employee contribution for employee-only coverage is 20.4 percent and the average employee contribution for family coverage is 25.3 percent. Contributions as a percentage of total premium cost for employee and family medical coverage are shown in tables VI-2 and VI-3 respectively, and are compared to the employee contributions paid by Washington K-12 employees.

Table VI-2 compares nationwide contribution rates to Washington State K-12 employee-only contribution rates for Employee Medical Coverage for those plans that require contributions.

**Table VI-2**
**Employees' Contribution for Employee-Only Medical Coverage for Plans that Require Contributions**

| Percent of Total Cost | Nationwide | WA K-12 Employees |
|---|---|---|
| Less than 5 | 3% | 40% |
| 5 to 9.9 | 10% | 33% |
| 10 to 14.9 | 18% | 10% |
| 15 to 19.9 | 18% | 8% |
| 20 to 24.9 | 22% | 0% |
| 25 to 29.9 | 12% | 2% |
| 30 to 39.9 | 10% | 2% |
| 40 to 49.9 | 5% | 1% |
| 50 to 99.9 | 2% | 4% |

Source: 2010 Hay Benefit Prevalence Report.

As indicated in the above Table, 13 times more K-12 employees pay less that 5 percent for employee-only coverage than the national average, and 90 percent of the K-12 employees pay less than the national average for employee-only coverage.

Table VI-3 compares nationwide contribution rates to State K-12 employee contribution rates for Family Medical Coverage for those plans that require contributions.

**Table VI-3**

**Employees' Contribution for Family Medical Coverage for Plans that Require Contributions**

| Percent of Total Cost | Nationwide | WA K-12 Employees |
|---|---|---|
| Less than 10 | 7% | 7% |
| 10 to 14.9 | 10% | 7% |
| 15 to 19.9 | 18% | 1% |
| 20 to 24.9 | 20% | 6% |
| 25 to 29.9 | 14% | 6% |
| 30 to 39.9 | 20% | 18% |
| 40 to 49.9 | 6% | 25% |
| 50 to 99.9 | 5% | 30% |

Source: 2010 Hay Benefit Prevalence Report.

In contrast, Washington K-12 employees generally pay much more for family coverage than those who elect single coverage, and many pay more than the national average (25.3%). As indicated in Table V1-3, significantly fewer Washington K-12 employees pay 10-30 pecent of the family premium than employees nationwide. But interestingly, more than half of the Washington K-12 employees pay 40 percent or more of the cost for family coverage.

**Contribution Rates by Tiers**

WEA and most other plans use tiered rates where the amount of the premium relates to the cost of the coverage. Under this rating structure the cost for family coverage is typically 2.1 to 2.4 times the cost for single coverage.

PEBB plans use a consolidated premium rate structure, where the cost of family coverage is 1.1 to 1.3 times the rate for single coverage.

Due to the differences in rating structures, a school district with a large number of employees requiring family coverage will find the PEBB rating structure costs less than the WEA rating structure.

**Commentary on K-12 Employee Contributions**

Reviewing the contributions made by K-12 employees for health benefits and comparing them to the prevailing employer practices nationwide, we observe:

- **The employer cost-sharing is quite generous for employee-only coverage**. For single coverage, over 50 percent of employees have the full cost paid by their school district and of those who do pay a portion of the cost, 73 percent pay less than 10 percent of the premium. Nationwide, only 7 percent of employees receive medical coverage fully paid and of those that share the cost, only 13 percent of employers require less than 10 percent of the premium.
- **Employer support for family coverage is less generous than nationwide.** For family coverage, only 3 percent of employees have the full cost paid by their school district and of those who do pay a portion of the cost, only 21 percent pay less than 25 percent of the premium. Nationwide, 2.5 percent of employees receive family medical coverage fully paid and of those that share the cost, 55 percent of employers require less than 25 percent of the premium.
- **Some employees are accessing the K-12 health benefits for family coverage**. Ten percent of employees with spousal or family coverage are paying the full incremental cost for their dependents (i.e. they receive no subsidy or financial support from the school district other than for their employee coverage). Of the employees who elect employee plus child(ren) coverage, 8 percent of the employees are paying the full cost for their children's coverage.

## VII. Funding Sources and Mechanisms

The State provides certain funding to the schools from the State budget. The monthly allocation was $745 per eligible FTE for FY 2009/10. This amount increased to $768 per eligible FTE for FY 2010/11, an increase of 3.1%.[21] Each district must also remit to the State's Health Care Authority (HCA) $62.48 per FTE[22] for 2010/11 for retiree medical coverage (up from $59.59 for 2009/10), as all retirees are eligible for subsidized coverage in retirement provided by HCA through PEBB. This amount is determined annually by HCA in consultation with an independent actuary, and increased by 4.9% for the FY 2010/11 fiscal year.

The State determines eligibility for funding by FTE's using a formula mostly based on the number of students in the district. Districts typically have total FTE's in excess of the formula-based number, often as much as 20% or more above the number. Thus, the FTE's reimbursed by the State are known as "formula" FTE's, and the additional district staff is known as "staff over formula."

***Use of Pooling at the District Level***

Revised Washington Code (RCW) 28A.400.280 mandates the use of pools at the district level to redistribute unused State allocations for employee benefits among the district's employees. The intent of pooling is described in the 1990 law as follows**:**

> "The legislature recognizes the rising costs of health insurance premiums for school employees, and the increasing need to ensure effective use of State benefit dollars to obtain basic coverage for employees and their dependents. In school districts that do not pool benefit allocations among employees, increases in premium rates create particular hardships for employees with families. For many of these employees, the increases translate directly into larger payroll deductions simply to maintain basic benefits."
>
> "The goal of this act is to provide access for school employees to basic coverage, including coverage for dependents, while minimizing employees' out-of-pocket premium costs. Unnecessary utilization of medical services can contribute to rising health insurance costs. Therefore, the legislature intends to encourage plans that promote appropriate utilization without creating major barriers to access to care. The legislature also intends that school districts pool State benefit allocations so as to eliminate major differences in out-of-pocket premium expenses for employees who do and do not need coverage for dependents" (RCW 28A.400.200).

[21] See ESSB 6444 Sections 504(2) and 903(1)(a).
[22] Full-time employees and eligible part-time employees; see ESSB 6444 Section 903(1)(a)

The relevant provisions of 28A.400.280 provide as follows:

*(1) Except as provided in subsection (2) of this section, school districts may provide employer fringe benefit contributions after October1, 1990, only for basic benefits. However, school districts may continue payments under contracts with employees or benefit providers in effect on April 13, 1990, until the contract expires.*

*(2) School districts may provide employer contributions after October 1, 1990, for optional benefit plans, in addition to basic benefits, only for employees included in pooling arrangements under this subsection. Optional benefit plans may not include employee beneficiary accounts that can be liquidated by the employee on termination of employment. Optional benefit plans may be offered only if*

*(a) The school district pools benefit allocations among employees using a pooling arrangements that includes at least one employee bargaining unit and/or all non-bargaining group employees;*

*(b) Each full-time employee included in the pooling arrangement is offered basic benefits, including coverage for dependents, without a payroll deduction for premium charges;*

*(c) Each full-time employee included in the pooling arrangement, regardless of the number of dependents receiving basic coverage, received the same additional employer contribution for other coverage or optional benefits; and*

*(d) For part-time employees included in the pooling arrangement, participation in optional benefit plans shall be governed by the same eligibility criteria and/or proration of employer contributions used for allocations for basic benefits.*

*(3) Savings accruing to school districts due to limitation on benefit options under this section shall be pooled and made available by the districts to reduce out-of-pocket premium expenses for employees needing basic coverage for dependents. School districts are not intended to divert state benefit allocations for other purposes.*

However simple the original intent may have been, pooling is very complex in practice. There are five Basic Benefits: life, long-term disability, vision, dental, and medical. Bargaining determines which of the five benefits are offered to employees. (This determination can be different for different bargaining units of the district, and a district may have many bargaining units – 3 or 4 is common, but 6 is not unusual, and a district may have as many as 15.)

The first 4 Basic Benefits (life, LTD, vision and dental), if offered, are typically funded at 100%, as required by either law or the insurance carrier. The medical benefit then becomes the "balancing" item, with employee contributions often required. Employees may elect single coverage, coverage for their spouse and/or other dependents, or decline coverage.

State funds placed in the pool come from an employee's waiver of medical coverage, or from allocations for part-time employees who are not eligible for benefits. As an example of the second situation, recall that the State's allocation is based on formula FTE's. Suppose that benefit eligibility is set at 0.5 FTE, and a part-time employee has a position defined as 0.3 FTE. The district will receive a 0.3 FTE allocation for that employee, who is not eligible for benefits, so that allocation would go into the pool.

Each full-time employee in the pool receives the same allocation from the pool regardless of whether they cover dependents, and part-time employees receive a pro-rata allocation based on the portion of FTE which they work.

Bargaining units often prefer a separate pool for their covered employees in order that reallocated funds from their bargaining unit are allocated to employees in their unit. So, a district with 11 bargaining units may have 11 pools. Because some classifications of employees include many more part-timers than others, these separate pools often lead to disparate employer funding of employee groups within the district. For example, suppose a food service operation has 15 employees, 12 of whom work part-time at 0.3 FTE and 3 of whom are full-time. If these are all formula employees, the State's allocation is for 12 x 0.3 + 3 = 6.6 FTE's. As there are only 3 employees eligible for benefits, they each receive a State allocation of 2.2 FTE; their benefits may therefore be fully employer-paid, while teachers in the district, in a separate pool with few part-time employees, may each be making significant employee contributions for coverage. Also, while there are typically more certificated than classified employees in a district, the certificated employees (teachers) are more likely to bargain as one group; thus, the multiple pools tend to represent a fragmentation of classified employees.

Another problem can occur with enrollments over time. This is because employees sign up for benefits without knowing what their employee contribution will be, since the pooling calculations are done after employees enroll so that funds for any employees waiving coverage can be reallocated. For example, suppose a bargaining unit has 5 full-time employees and 15 employees working 0.5 FTE. All are eligible for benefits. The State allocation, if all are formula employees, is 5 + 0.5 x 15 = 12.5 FTE. In Year 1, only the 5 FTE sign up for benefits, receive an allocation of 12.5/5 = 2.5 FTE, and their benefits are fully paid. Hearing this, in year 2 all 15 part-timers also sign up, causing their allocation to each be 0.5 FTE, and they now owe substantial monthly premiums for their coverage, which they cannot afford. So in year 3, the part-timers drop coverage, and the 5 FTE now again receive health benefits fully paid for by the employer. Clearly this is a less than transparent approach.

Table VII-1 shows the summary of the pools from our survey of districts. Of the 117 respondents, 95 included information on pooling, with three districts reporting more than 13 pools, and an average of more than 4 pools per school district that uses a pool.

**Table VII-1**
**Survey Data on the Number of Funding Pools per District**

| Number of Pools A | Number of Districts B | Total Number of Pools C = A x B |
|---|---|---|
| 0 | 22 | 0 |
| 1 | 12 | 12 |
| 2 | 13 | 26 |
| 3 | 18 | 54 |
| 4 | 15 | 60 |
| 5 | 13 | 65 |
| 6 | 5 | 30 |
| 7 | 8 | 56 |
| 8 | 4 | 32 |
| 9 | 2 | 18 |
| 10 | 1 | 10 |
| 11 | 1 | 11 |
| 12 | 0 | 0 |
| 13 | 0 | 0 |
| 14 | 2 | 28 |
| 15 | 1 | 15 |
| Total | 117 | 417 |
| | | |
| Number of Districts with a Pool | | 95 |
| Percentage of Districts with a Pool | | 81.2% |

Source: Hay Group survey of K-12 School Employee Benefits.

The survey also requested information on how frequently the pools are calculated. For this information we sought data on the three largest pools in the district. We found that over half of the pools were recalculated two or more times per year, with 13 percent recalculated four or more times per year.

| Table VII-2<br>Count of Times a Year the Largest Pool is Recalculated | | |
|---|---|---|
| **Frequency of Calculation** | **Number of Pools** | **Percent of Total** |
| Once | 107 | 45% |
| Two or Three Times per Year | 101 | 42% |
| Four or More Times per Year | 31 | 13% |
| Total | 239 | 100% |
| Source: Hay Group survey of K-12 School Employee Benefits. | | |

To summarize the concerns about pooling identified in the preceding discussion:

- pooling is complex in practice and requires a material effort to manage;
- the current structure encourages the formation of multiple pools at the district level;
- employees sign up for benefits without knowing what their employee contribution will be, as pooling is completed after sign-up is complete; and
- this structure can produce significant disparities in employer funding per covered employee between different pools at the same district, or even within the same pool over time.

***Retiree Benefits***

Other than continued post-employment health care coverage required under federal law (COBRA), virtually all K-12 retired employees receiving health benefits do so through the HCA and PEBB.

HCA operates two health insurance pools within PEBB involving subsidized benefits to government retirees. The "Non-Medicare" pool provides health insurance to individuals under age 65, including all active employees and pre-65 retirees, and their dependents under age 65. Because the retirees may purchase coverage at the same rate charged active employees, this is a favorable price relative to the age-rated premium which would apply to these retirees, and so these retirees receive an "implicit subsidy" of their health care coverage.

The "Medicare" health insurance pool provides health insurance to individuals age 65 and over, including retirees and their Medicare-eligible dependents; the retirees receive an "explicit subsidy" of their premiums of 50% of the premium up to $182.89 monthly (for 2011, unchanged from 2010 and 2009). An individual can retire and defer participation in the retiree health insurance program, so long as

they maintain appropriate health insurance in the interim. There are no time limits on participation; employers can join or depart PEBB annually.[23]

We understand that virtually all K-12 District retirees are in PEBB. WEA discontinued its retiree program effective October 1, 2007. As summarized in Table VII-3, below, and detailed in Appendix D, the PEBB statistics for school and non-school retirees are quite similar, even though PEBB has few active school employees.

**Table VII-3**
**Characteristics of K-12 and non-School Populations**

| | K-12 | Other |
|---|---|---|
| 1. Non-Medicare | 4,011 | 5,269 |
| 2. Medicare eligible retirees | 22,170 | 22,109 |
| 3. Total retirees | 26,181 | 27,378 |
| 4. Active employees | 109,766 | 101,608 |
| 5. Retirees per 100 active employees | 23.9 | 26.9 |

Source: Washington State Health Care Authority: PEBB Enrollment Report for June 2010 Coverage

These ratios of retirees to actives are important because they are an indicator of the per-capita cost of retiree benefits. It is likely that the ratios of retirees to active employees will increase over the next few years as large numbers of Baby Boomers retire. The funding of retiree benefits through assessments on active employees is therefore of concern over this period. Over the past three years, the explicit retiree subsidy has remained constant as a dollar amount. It is likely there will be additional pressure to either reduce the retiree subsidy or increase active contributions at a rate faster than medical trend. This will put further pressure on the State.[24]

***Funding of Retiree Benefits***

Essentially all retiree health benefits for K-12 district employees are paid through PEBB (the primary exception is that retirees may choose COBRA coverage from their active employee coverage before electing PEBB retiree coverage), even though over 97% of active K-12 employees are not covered by

[23] Local and tribal governments must apply for participation; if accepted, they pay the same rates as other participants, but they may be rejected if their participation is deemed to be potentially harmful to the pool. Schools (including the K-12 districts) are automatically accepted.
[24] A fuller treatment of the issues surrounding the funding of retiree medical costs is beyond the scope of this report.

PEBB health benefits. Funding of health benefits is not divided between active and retiree groups for PEBB; that is, a combined fund is used to pay premium/claims expenses for both groups, as well as administrative costs. The sources of funding for the active and retiree groups include employer and participant (i.e., covered employees and retirees) premium payments. Employer funding differs among the following employers (here, "participating" refers to whether or not the group participates in PEBB for its active employees):

(1) State government (participating for all covered employees);
(2) Participating K-12 districts;
(3) Participating local governments;
(4) Non-participating local governments; and
(5) Non-participating K-12 districts.

Groups 1, 2, and 5 (that is, the State and all K-12 districts) receive health benefit funding from the State; while local governments (groups 3 and 4) do not. The funding level for FY 2011 is $850 monthly per eligible State employee (up from $745 in FY 2010; ESSB 6444 section 906(1)(a)) and $768 monthly per K-12 district school FTE (also up from $745 in FY 2010; ESSB 6444 section 504(2)).[25]

The contributions of covered employees and retirees are paid to the combined fund. For employers participating in PEBB for active employees (groups 1, 2 and 3), premium payments are based on active employees. The employer premium payments are as follows: (1) the State contributes only the $850 mentioned above; (2) the participating K-12 districts contribute from the $768 State funding mentioned above, and may contribute additional local funds; (3) the participating local governments contribute based on the individual plan premiums and enrollments under PEBB; (4) the non-participating local governments do not receive State funding and have no rights to coverage under PEBB, so their health insurance arrangements are completely independent from the State and PEBB; and (5) the non-participating K-12 districts make independent arrangements for their health coverage, using the $768 State allocation and perhaps additional local funds. However, their retirees have the right to participate in the PEBB pools, and receive the same (implicit or explicit) subsidies as other participating retirees. In recognition of these rights, non-participating schools pay PEBB $62.48 (effective September 1, 2010; ESSB 6444 section 906(3)(a)) monthly for each full-time and eligible part-time employee.[26] These payments are called a "retiree remittance" in the law, although districts often refer to these payments as

[25] Effective January 1, 2010, tribal governments are allowed to participate in PEBB, with the same charge structure as local governments.
[26] See ESSB 6444, Section 906(3).

the "carveout" or "clawback."[27] The districts' health insurance arrangements may include alternative coverage for retirees, but currently this is quite rare (primarily COBRA coverage as mentioned above.

For fiscal year 2010, the remittance calculation valued the explicit subsidy at $108 million and the implicit subsidy at $50.5 million. The values of the explicit and implicit subsidy were very similar for the prior fiscal year, $106 million and $51 million, respectively.

Amounts charged by PEBB for coverage are not necessarily matched to State funding, and may be above or below the funding. For example, two years ago, to spend down a surplus in the PEBB account, the monthly State reimbursement was $732 while the PEBB charge was $561; the districts keep the surplus reimbursement. For fiscal year 2010/11, the monthly funding rate is $768 while the PEBB charge is $850; the district (or the employees) must make up the difference.

As to the PEBB rate structure, it involves both composite and tiered rates. The composite rate is a flat charge per active member, while the tiered rate is by member but depends on the level of coverage elected. New local and tribal government PEBB members must accept a tiered rate structure, while there are grandfathered local governments with a composite rate structure. New school PEBB members must accept a composite rate structure, while there are grandfathered schools with a tiered rate structure.

[27] The use of the term "carveout" to describe the Washington State retiree remittance should not be confused with the use of the term "carve-out" in the context of a health benefit program to describe the removal of a specific benefit from the contract with the primary health plan so that the coverage may be negotiated separately, usually with a specialty vendor or network.

## VIII. How Much Does Washington State Spend on Health Care Benefits?

Using enrollment and premium data collected from the surveys we built a model to estimate how much the State spends on health care benefits for K-12 employees. The model has four components:

1) Enrollment and cost data for dental coverage
2) Enrollment and cost data for vision coverage
3) Enrollment, cost, and employee contribution data for medical coverage and
4) Local levy funds for the school district pools

For the State-wide costs, we extrapolated from the district-provided survey data, using the State's pension data, to produce costs assuming the State count of 121,672 employees.[28] For dental and vision benefits, all employees are covered. For the medical plan costs, as not all employees are covered, we used a 10 percent lower employee count of 105,505. Separate survey tables were used to collect information on dental, vision, and medical benefits. Each of the data sets was validated resulting in slightly different survey counts for medical, dental, and vision coverages.

For dental coverage, Table VIII-1 shows the verified dental data and the factor used to extrapolate the survey results to representative total costs for the State.

**Table VIII-1**
**Estimate of Cost for Dental Coverage**

| | Employee Enrollment | Employee & Spouse/Domestic Partner | Employee & Children | Employee & Family | Total |
|---|---|---|---|---|---|
| 1. Count | 3,282 | 1,622 | 956 | 61,600 | 67,460 |
| 2. Monthly | $231,377 | $103,058 | $64,988 | $6,761,911 | $7,161,334 |
| 3. Annual Cost | | | | | $85,936,008 |
| 4. Statewide Employee Count | | | | | 121,672 |
| 5. Extrapolation factor (4. Divided by 1.) | | | | | 1.80 |
| 6. Estimated total Statewide cost for dental coverage (3. Times 5.) | | | | | $154,995,641 |

Source: Hay Group Analysis

For vision coverage, Table VIII-2 shows the verified vision data and the factor used to extrapolate the survey results to representative total costs for the State.

[28] We believe it is reasonable to assume that school employees who are eligible for retirement benefits are also eligible for health benefits.

| Table VIII-2<br>Estimate of Cost for Vision Coverage | | | | | |
|---|---|---|---|---|---|
| | Employee Enrollment | Employee & Spouse/Domestic Partner | Employee & Children | Employee & Family | Total |
| 1. Count | 3,159 | 1,208 | 667 | 57,540 | 62,574 |
| 2. Monthly | $26,179 | $5,164 | $3,184 | $1,105,187 | $1,139,713 |
| 3. Annual Cost | $13,676,560 | $13,676,560 | $13,676,560 | $13,676,560 | $13,676,560 |
| 4. Statewide Employee Count | | | | | 121,672 |
| 5. Extrapolation factor (4. Divided by 1.) | | | | | 1.94 |
| 6. Estimated total Statewide cost for vision coverage (3. Times 5.) | | | | | $26,593,383 |
| Source: Hay Group Analysis | | | | | |

For medical coverage, Table VIII-3 shows the aggregate data from the medical coverage survey after validation. Some of the survey responses were excluded as the data was not reasonable, or was not specific (e.g. "employee contribution rates vary by group"). We compared the extrapolated total medical cost from the medical data before validating for employee contributions to the extrapolated total from Table VIII-3 and found the two amounts differed by less than 0.5 percent. We are therefore confident that the results from extrapolating the tabulation of the 49,748 enrollees in the medical survey data set are fully representative of the State's districts.

| Table VIII-3<br>Estimate Cost for Medical Coverage | | | | |
|---|---|---|---|---|
| Coverage Tier | Count | Total Medical Cost | Employee Contributions | School District Costs |
| 1. Employee | 25,453 | $14,905,250 | $685,096 | $14,220,154 |
| 2. Employee & Spouse | 6,013 | $6,260,645 | $1,963,242 | $4,297,404 |
| 3. Employee & Child | 12,036 | $9,755,997 | $1,740,002 | $8,015,994 |
| 4. Employee & Family | 6,246 | $8,035,293 | $3,122,850 | $4,912,443 |
| 5. Total | 49,748 | 38,957,186 | 7,511,190 | 31,445,995 |
| 6. Annual Cost (5. x 12) | | $467,486,228 | $90,134,282 | $377,351,946 |
| 7. Extrapolation Factor | 2.20 | | | |
| 8. Estimated Statewide | 109,505 | $1,029,026,010 | $198,402,681 | $830,623,329 |
| Source: Hay Group Analysis | | | | |

Table VIII-4 shows the estimated total State cost for K-12 employee health care benefits. The 2010 cost is estimated at $1.21 billion. Thirteen percent of the cost is attributable to dental benefits, 2 percent to vision benefits, and 85 percent to medical benefits.

**Table VIII-4**
**Estimate of State Health Care Costs**

| Benefit | 2010 Cost | Percent of Total Cost |
|---|---|---|
| 1. Dental | $154,995,651 | 13% |
| 2. Vision | $26,593,383 | 2% |
| 3. Medical | $1,029,026,010 | 85% |
| **4. Total (1. + 2. + 3.)** | **$1,210,615,044** | **100%** |

Source: Hay Group Analysis

Table VIII-5 shows the source of the funding. Of the $1.21 billion total cost, 16 percent is funded through employee contributions, and 84 percent is funded by the school districts. About one seventh of the school district funding comes from local levy funds, which equates to 12 percent of the total cost. The balance, 72 percent of the total cost, is derived from State funding.

**Table VIII-5**
**Estimate of State Health Care Costs**

| Benefit | 2010 Cost | Percent of Total Cost |
|---|---|---|
| 1. Total | $1,210,615,044 | 100% |
| 2. Employee Contributions | $198,402,681 | 16% |
| 3. School District Cost (1. – 2.) | $1,012,212,363 | 84% |
| 5. Pooled Levy Funds | $143,914,317 | 12% |
| 5. State Funding (3. – 4.) | $868,298,047 | 72% |

Source: Hay Group Analysis

## IX. School Employee Health Care Benefits in Other States

For this report we examined how 23 other states structure the provision of health care benefits to their public school employees. As indicated in Table IX-1, below, and as further detailed in Appendix G (containing summaries of the health care programs for these states), only six states, the nearest and most recent being in Oregon, mandate that their public school employees participate in a state-wide health plan, including Texas, which requires participation for school districts with fewer than 500 employees. The politics of local control often limit initiatives to mandate a state-wide program. States with mandatory programs, in our view, tend to do a good job of controlling costs when there is a strong legislature or board that effectively controls costs and adjusts benefits and providers when it is necessary or advantageous. The mere existence of a state-wide plan – whether voluntary or mandatory – does not, in and of itself, ensure cost-effective delivery of health care benefits. For example, Kentucky, in 2005, in the face of a 52 percent premium increase for its voluntary plan, restructured its voluntary plan.

Of the 23 states surveyed, 15 of them provide school districts some type of voluntary participation in a state-wide health plan. Of those 15, 10 states offer state-sponsored plans, 2 offer union-sponsored plans, and 4 states offer management-sponsored plans.[29]

Of the two states surveyed that have no state-wide health care plans for school employees, Maryland school districts operate on a county basis and tend to be very large and therefore can obtain economies of scale. Ohio has studied the issue of a state-wide program, but has yet to enact one. In Nevada, although a state-sponsored plan is available, because the school districts are organized on a county basis, few school districts elect to participate in the state-sponsored plan.

Our conclusions from the state survey are that mandatory state-wide programs offer the best opportunity to control health care cost, and the critical differences between large voluntary programs and mandatory programs is greater equity across the state in mandatory plans and greater potential for large-scale cost-effective plan administration, and the elimination of much of the marketing overhead that is inherent in any competitive market environment.

As indicated above, further details about the 23 states surveyed can be found in Appendix G.

[29] In Wyoming, both the school board association and the union offer state-wide plans.

| Table IX-1<br>Summary of School Health Plan Design for School Employees by State | | | |
|---|---|---|---|
| **State** | **Mandatory Participation in a Statewide Health Plan** | **Voluntary Participation in a Statewide Health Plan** | **No Statewide Health Plan for School Employees** |
| Alaska | | Membership | |
| Arizona | | Membership (Union) | |
| California | | X (School Board Association) | |
| Colorado | | X (State Plan) | |
| Delaware | X | | |
| Georgia | | X (State Plan) | |
| Idaho | | X (State Plan) | |
| Illinois | | X (State Plan) | |
| Kentucky | | X (State Plan) | |
| Louisiana | | X (State Plan) | |
| Maryland | | | X |
| Minnesota | | X (State Plan) | |
| Nevada | | X (State Municipal Leagues) | |
| New Jersey | | X (Separate State Plan for School Districts) | |
| New Mexico | X | | |
| New York | | X (State Plan) | |
| North Carolina | X | | |
| Ohio | | | X |
| Oregon | X | | |
| South Carolina | X | | |
| Texas | For Districts with Fewer than 500 Employees | For Districts with More than 500 Employees (State Plan) | |
| Utah | | X (State Plan) | |
| Wyoming | | Membership (School Board Association or Union) | |
| Source: Hay Group review of current state mechanisms for providing health benefits to school employees. | | | |

"Membership" means membership in sponsoring organization is required.

## X. Policy Options for Restructuring the Current System

We have examined a wide range of policy options for health benefits for school employees. In this section, we provide a range of options which we believe will improve benefit delivery for Washington K-12 district employees. First, however, we present some general observations.

***State-wide*** – We first note that there are a variety of factors which favor state-wide approaches. First, funding of health benefits is provided on a uniform state-wide basis by the State government. Second, the nature of insurance is to provide more efficiency when a larger group is involved, as this provides a larger group over which to spread coverage risks and administrative charges. Third, policy at the State level has focused on access to coverage, and so state-wide solutions are more likely to provide relatively equal access to coverage.

***Regional*** – Regional solutions make sense where there is a significant difference in conditions. In Washington, the western portion of the State is more urban and densely populated than the eastern portion of the State. This difference in conditions suggests that there may be different access to care and different pricing for that care in these two regions. Despite the substantial differences between the eastern and western regions of the State, as explained in further detail below, our review has indicated that these differences are not significant enough at this time to justify regional solutions. [30]

To investigate the nature of this issue in Washington, we looked at individual insurance products offered by the two largest "Blue" organizations operating in Washington, Premera and Regence, to understand the regional rating considerations employed by these two insurers. For each insurer, we looked at two individual insurance products and compared the October 1, 2010, rates at ages 20 and 50 (male non-smokers) for 4 cities in the 4 "corners" of the State – Seattle (King County; NW); Vancouver (Clark County; SW); Spokane (Spokane County; NE); and Walla Walla (Walla Walla County; SE).

[30] For example, the extension of the health plan for State of California employees to the employees of local governments (including school districts) illustrates a situation where regional rates are not only appropriate but desirable. The rates for State employees are the same statewide, entirely appropriate for a single employer. When the plan was extended to local governments, however, the significant difference in health care costs between Northern and Southern California (in excess of 20%) meant that state-wide rates were in general overpriced for Southern California governments and underpriced for Northern California governments, thus discouraging the first group from joining while encouraging the second. As participation in the state plan was voluntary, this situation would lead to primarily Northern California governments joining, forcing the rates for the local plan higher than the state rates to cover the increased expense; this in turn would further discourage lower cost employers from joining as they could obtain coverage less expensively in the marketplace. The local government portion of the program therefore moved to 4 and then 5 rate categories (by county, the 4 categories may be loosely described as Southern California urban, Southern California rural, Bay Area (urban) and Northern California (rural); the 5th category was carved away from the Bay Area grouping, and is the Sacramento vicinity rate group.

For Premera, we examined the Heritage Value Plus 30 (a PPO with a $2500 deductible and 30% co-pay) and the Heritage Protector Plus 20 (a PPO with a $1000 deductible and 20% co-pay). Neither plan offered coverage in Vancouver; the rates were identical in the other three cities. Clearly, Premera has chosen not to rate these products regionally.

For Regence, we examined the Evolve – Core (a PPO with a $2500 deductible and 30% co-pay) and the Evolve – Plus (a PPO with a $2500 deductible and 20% co-pay). Setting the Seattle rates for each age and product at 100%, the regional rate differences used by Regence are shown in the following table:

**Table X-1**

| City | Evolve – Core | | Evolve – Plus | |
|---|---|---|---|---|
| | Age 20 | Age 50 | Age 20 | Age 50 |
| Seattle | 100% | 100% | 100% | 100% |
| Vancouver | 122% | 122% | 125% | 125% |
| Spokane | 106% | 106% | 106% | 106% |
| Walla Walla | 100% | 100% | 100% | 100% |

Source: Hay Group review of Regence premium rates.

We see that Seattle has the lowest rates in the State; Walla Walla has identical rates; Spokane has slightly higher rates; and Vancouver has significantly higher rates. From this we would conclude that only the Vancouver area shows significant experience differences from the rest of the State, reflected in Regence's higher rates for the area and Premera's decision not to write coverage in the area. As Vancouver is a suburb of Portland, Oregon, claims experience in Vancouver is significantly affected by the health care delivery environment in Portland. As the Vancouver area represents a relatively small percentage of the State's population, increased rates for this area would not significantly affect rates for the remainder of the State. We see no compelling argument for regional rating or development of separate regional programs.

***By Job Category*** – We note that the circumstances of certificated and classified employees tend to be somewhat different in all districts throughout the State. These two groups generally have differing pay levels and working conditions. A greater percentage of classified employees are part-time, particularly certain categories such as food service and transportation employees. Eligibility rates are lower for classified employees than for certificated employees. As roughly half of all school employees fall into each group, thus forming two groups of approximately 50,000 employees each, differing solutions for

the two groups is feasible because each group is sufficiently sizable to gain the advantages afforded large health benefits groups.

***Should Health Benefits for School Employees be Identical to Those for State Employees***? Health plan benefit designs generally differ among employers, for a variety of reasons. Employers commonly ask these questions, and of course differing answers lead to different plan designs:

a) What is the nature of the employee group (e.g., age, marital status, number of dependents, longevity with the employer, location)?

b) What are the competitive issues in attracting and retaining employees (e.g., competing employers, skill/training of employees)?

c) What health programs are available in the local insurance market?

d) What can the employer and employees afford (e.g., range of plan choices, employee/employer contribution levels)?

e) What benefits have traditionally been offered to employees?

f) What are the collective bargaining objectives and priorities for each different employee group?

Even within a given employer, different employee groups may have different health benefits. All of the factors listed above can indicate different needs among the different employee groups, and therefore different design results.

In health insurance, size matters: as an insured group covers more individuals, its claims experience is more predictable and less variable, so the group is more financially efficient – the plan design applies to more people, as do fixed costs, and risk charges can be reduced. These cost and stability factors argue for standardized plan design. However, past a certain size, the marginal gains in efficiency through increasing size become less. At perhaps 2,000 lives, the health care benefits group is large enough to safely self-insure; one 40,000 life group is barely more efficient than two 20,000 life groups.

In Washington, the approximately 110,000 State employees have a standardized package of benefits provided through the HCA and PEBB. There is a standard employer contribution ($850 per employee for fiscal year 2010-11). The PEBB program also covers (participation is voluntary) some local government employees (approximately 12,000) and a few K-12 employees (approximately 1,000). It also is the nearly exclusive source of retiree medical benefits for State and K-12 employees

(approximately 26,000 State, 27,000 K-12, and 1,000 local government retirees). The active plan design was designed with State employees in mind.

How do active school employees fit into this picture? The factors a) through f) listed above suggest the following reasons why benefits should differ between the two groups:

a) School employees differ from State employees in their group characteristics.

b) School employees, particularly teachers, have different skill/training and different competing employers than do State employees

c) State employees are restricted to PEBB coverage while school districts have generally chosen to participate in programs other than PEBB (e.g., the WEA plans).

d) Pay structures differ between State and school employees, as do part-time employment levels. Benefit funding differs significantly; while the State has a fixed-dollar contribution per State employee to PEBB, it has a different dollar level per FTE (not the same as per employee), and it covers only "formula" FTE's; federal and local levy funds cover the remaining expense, and these amounts differ significantly on a per employee basis between the various school districts.

e) Traditional offerings have been different (PEBB vs. non-State, insured benefits)

f) State employees cannot bargain health benefit designs and features, while school employees do, often with multiple bargaining groups in each district.

Additionally, while the State has a constitutional duty to provide ample funding for basic education, school employees are local government employees, and local control is a meaningful guiding principle.

***Policy Options*** – Given the observations provided above, we evaluated a series of policy options for restructuring the system for providing employee health benefits to K-12 school employees in Washington. The options fall into three general categories:

1. Streamlining funding of school employees' health benefits
2. Standardizing medical coverage levels offered to districts
3. Restructuring the health benefits system by establishing a state-wide program, with
    a. Voluntary participation by districts

b. Voluntary participation by districts for current employees with mandatory participation for new employees or

c. Mandatory participation for all districts

Funding simplification would be an important first step to take before adopting a more ambitious restructuring such as establishing standard benefit coverage levels or restructuring the health benefits system by establishing a state-wide program with voluntary or mandatory district participation.

**Option 1: Streamline the Funding System**

The current system of funding benefits for school employees has evolved over time. Streamlining the funding system would reduce the complexity of the system and better align it to serve the current needs of the State. It would also provide an important foundation for any potential consolidation of the system. We would recommend a package of funding reforms that would include:

Ensuring the Stability of Funding Pools

Funding pools provide a mechanism for ensuring that State contributions towards benefits that go unused when an employee declines coverage are used to benefit other school employees. When a funding pool has a very small number of employees, however, the sharing of State contributions can result in employee costs that vary significantly from year to year depending on the participation level among eligible employees. Since the employee cost affects contribution levels, this can lead to a feedback loop where both participation and cost levels are unstable from year to year.

We would recommend restructuring the local funding pools to ensure that they are more stable. There are at least two alternatives that could be used. The first would be to establish a minimum size – measured in the number of *eligible* employees rather than the total number of employees – for a local funding pool which did not cover all employees. The second would be to limit a local district to no more than two funding pools: one for certificated employees, and another one for classified employees. It would also be possible to adopt both ideas.

For example, suppose that the minimum pool size was established at 50 employees and also the two-pool maximum was adopted. Based on the data in Table VII-1, which shows that there are 417 pools from 117 districts reporting this data, we estimate there are as many as 1,200 individual pools among the 295 districts and 9 ESD's; the two-pool maximum would limit this number to 608. The 50-life minimum would restrict districts with fewer than 100 employees to one pool, and would reduce the maximum number of pools to under 500. Further, we understand that some larger districts already restrict their pooling activity to one pool, so in practice the actual operating pools would presumably be lower than

500. We understand the "one pool" approach to be based on the philosophy of equal treatment of all employees within the district.

The lack of financial reserves and small size contribute to instability of funding pools. Encouraging, or requiring, that each funding pool incorporate a trust fund that could be used to spread costs among years would be another way to increase the stability of participation rates and employee contribution levels.

Aligning State Funding with Employee Eligibility

Currently State funding is tied to the number of full-time equivalent employees, and not the number of employees who are eligible for coverage. As a result, the funding provided per eligible employee can vary significantly between types of employee and bargaining units depending on the percentage of employees in each group who are eligible for benefits. We would recommend basing funding on the number of eligible employees, rather than the number of full-time equivalents. This would better target State funding to the employees receiving benefits, and would ensure that workers would not be disadvantaged simply because they belong to bargaining units or classes of employees with high eligibility levels.

To implement this approach, a State standard for benefit eligibility should be established. A 0.5 FTE minimum eligibility rule seems to be a common standard state-wide, and we would therefore suggest that as the rule for State funding purposes. Districts would be free to offer broader eligibility, as some currently do; they would need to bargain or grant relaxed eligibility locally, and fund it from local levies or federal funds.

We would also recommend prorating the State funding for part-time employees . This is broadly consistent with the current FTE-based funding formula, since under the current system two half-time employees result in the same State funding allocation as one full-time employee.

For this package of reforms, we assume that the funding for eligible employees will be tied to the current limit on the number of State-funded (formula) full-time equivalents. One approach would be to base the benefits allocation on the number of eligible employees, but cap it at the number of formula positions. In that case these changes would result in a reduction in total State funding for school benefits unless the funding amount per FTE were adjusted, because positions under 0.5 FTE would be reduced from partial to no funding. However, it would also be possible to make this change on a budget neutral basis. To do this, the per capita amount should be re-based to reflect the number of eligible employees rather than the number of FTE's.

In revising the structure of the State funding allocations, one potential goal might be making the State allocation more directly comparable to the funding provided for State employees. The relationship

between funding for school employees and State employees was referenced by all of the stakeholder groups we interviewed. One advantage of aligning the funding to simplify this comparison is that it would improve the transparency of the system. A disadvantage is that it might create an expectation of equal funding per employee which might not be appropriate given differences in the demographics and health status of the two groups, and differences in the labor market for State workers and school employees.

The current State funding allocation of a fixed dollar amount per-FTE was described in many of our stakeholder interviews as creating the expectation that each full-time employee has an "entitlement" to that allocation. As a result, it effectively establishes a benchmark for the benefits contribution that districts must provide for "staff over formula" out of local levies or federal funds. This is, however, consistent with the State's overall approach to providing school funding; if salaries for "staff over formula" must be funded from local and/or federal funds, it is consistent for their benefit funding to come from the same source.

Reform Retiree Medical "Remittance" System

State contributions for retiree medical benefits for school employees are currently funneled through local school districts. The local districts, however, have no direct involvement in providing these retiree benefits, and simply remit the funds back to the State. This system is unnecessarily complex. Most school districts and ESDs pay the retiree remittance monthly; others pay bi-monthly or quarterly. The HCA does not invoice the school districts or ESDs for the remittance amount due. The HCA does not know how much each school district and ESD owes in remittance and therefore cannot verify that each school district and ESD remits the correct amount.

We would recommend that State contributions to PEBB for retiree medical benefits be sent directly to PEBB, and that any adjustments necessary be made to local districts' funding authority to make this change revenue neutral at the district level.

**Option 2: Standardizing Medical Coverage Levels for K-12 Employees**

PPACA established a set of benefit tiers to be used in health insurance exchanges beginning in 2014. These tiers are intended to make choosing a health plan easier while providing for a reasonable range of benefit options. They are defined in terms of "actuarial value," and establish specific levels of coverage while allowing for meaningful varation in cost sharing and provider network options within a given benefit tier. The actuarial value of a plan, as defined by PPACA, is a way of measuring the value of the benefits provided. It represents the average percentage of allowed medical costs that would be paid by the plan, assuming a specified standard enrollee population. It does not include premium costs, and represents an average value – the percentage payout for any particular enrollee may be very different

from the actuarial value of a plan. The four benefit tiers for state health insurance exchanges under PPACA are:

**Table X-2**
**PPACA Benefit Plan Tiers**

| Benefit Tier | Actuarial Value |
|---|---|
| Platinum | 90% |
| Gold | 80% |
| Silver | 70% |
| Bronze | 60% |
| Source: PPACA | |

While the final rules for calculating actuarial value have not yet been issued by the Department of Health and Human Services, we would recommend that consideration be given to:

1) Adopting the benefit rules PPACA establishes for state-based exchanges; and

2) Specifying that at least one benefit option must be available in each tier.

This would provide an objective standard for the range of benefit options to be provided and would simplify the comparison of benefit options. It would also structure the benefits in a way that would become very familiar to State residents, and provide benefits that would be directly comparable to those that will be available to State residents through an exchange.[31]

The actuarial value standard used by PPACA to define benefit tiers specifies an overall level of coverage, but allows for a significant amount of variation in the mix of cost-sharing provisions such as deductibles, co-payments and coinsurance used to achieve that coverage level. Table X-3 shows four plans designed to illustrate the four benefit tiers defined by PPACA. The Federal Employees Health Benefit Plan (FEHB) Blue Cross Blue Shield Standard Option plan is included as a point of comparison.[32] The Standard Option has the highest enrollment of any plan within the FEHB program.

[31] PPACA also provides a catastrophic benefit option for individuals under age 30; however, it is only available in the individual market. We would not recommend including this option in a State-sponsored plan for school employees. Because it is an employment based system, with a significant employer contribution fund available through the State and local districts, the need for an option below the "bronze" level is reduced.

[32] Regulations specifying the method for calculating actuarial values have not yet been issued. Details of the method, such as the standardized enrollee population to be assumed in estimating medical spending and plan benefit payments, will have a material effect on the actuarial value calculated for a given plan, and thus on the plans that can be offered in each benefit tier.

| Table X-3<br>Illustrative Plan Design Features | | | | | |
|---|---|---|---|---|---|
| | Platinum | Gold | Silver | Bronze | FEHB BCBS Standard Option Plan |
| Deductible | $300 | $800 | $1,900 | $3,000 | $300 |
| Out-of-Pocket Limit | $3,000 | $5,000 | $6,000 | $8,000 | $5,000 |
| Coinsurance | 10% | 20% | 35% | 40% | 15% |
| Office Copayment | $20 | $35 | $50 | $90 | $20 |
| Hospitalization per admission copay | $200 | $300 | $600 | $1,000 | $200 |
| Hospitalization coverage after copay | 90% | 80% | 65% | 60% | 100% |
| Rx - Generic copay | $15 | $20 | $20 | $30 | 20% |
| Rx - Brand Preferred copay | $25 | $40 | $50 | $70 | 30% |
| Rx - Brand Non-Preferred copay | $40 | $50 | $60 | $100 | 30% |
| Source: Hay Group analysis of prevailing benefit designs and actuarial values using the 2010 Hay Benefit Prevalence Report and the Health Care Benefit Value Comparison (HCBVC) model. | | | | | |

Using Hay Group's Health Care Benefit Value Comparison (HCBVC) actuarial model to develop Benefit Value Comparison (BVC) values, we quantified the relative values for the WEA and PEBB plans as well as the FEHB Blue Cross Blue Shield Standard Option plan and the illustrative "Platinum", "Gold", "Silver", and "Bronze" plans shown above.

Table X-4 shows (in descending value) the relative benefit values for the plans. We determined the relative benefit values (BVC values) using the HCBVC model. The BVC method, using the HCBVC

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The potential effect of this may be illustrated by comparing the actuarial values different actuarial firms have estimated for the FEHB Blue Cross Blue Shield Standard Option. The Congressional Research Service (CRS) estimated, based on actuarial work performed by Watson Wyatt Worldwide, that the Standard Option has an actuarial value of 87 percent (Chris L. Peterson, *Setting and Valuing Health Insurance Benefits*, Congressional Research Service, April 6, 2009 http://assets.opencrs.com/rpts/R40491_20090406.pdf). Hay Group estimates the actuarial value of the Standard Option to be approximately 89 percent. Actuaries with Milliman, Inc. have estimated the actuarial value of the Standard Option to be 83 percent (Thomas D. Snook, Robert H. Dobson and Ronald G. Harris, *Understanding Healthcare Plan Costs and Complexities*, Milliman, Inc., June 2009, http://publications.milliman.com/research/health-rr/pdfs/understanding-healthcare-plan-costs-rr06-15-09.pdf). The Congressional Budget Office (CBO) has estimated that employer-sponsored health plans average, under current law, an actuarial value of 88 percent (Douglas W. Elmendorf, *An Analysis of Premiums Under the Chairman's Mark of the America's Healthy Future Act*, Letter to the Honorable Max Baucus, Congressional Budget Office, September 22, 2009, http://www.cbo.gov/doc.cfm?index=10618). Both the CRS and Milliman papers provide estimated actuarial values for multiple plans, and may be used as points of comparison for the illustrative plans shown in Table X-4. For a consumer perspective, see Lynn Quincy, *What will an "Actuarial Value" Standard Mean for Consumers?*, Consumers Union, December 2009, http://prescriptionforchange.org/pdf/Act%20Value%20Dec%202009.pdf.

model, enables us to compare the relative value of the benefits packages by controlling for extrinsic differences in plans, such as demographics and funding methods that distort the direct comparisons of premiums. In other words, the BVC method evaluates the *relative* cost of each benefit package, assuming the same group of enrollees and funding method for each. The BVC values shown in Table X-4 represent relative plan values, which include the value of benefits provided and the savings produced by using a negotiated provider network. Consequently, the BVC value of a PPO or POS plan will be lower than a fee-for-service (FFS) plan with exactly the same benefits. Thus, because of network discounts, moving from a FFS plan to a PPO plan will often result in both lower costs and reduced patient cost sharing. Because the purpose of this analysis was to focus on the design of the benefits provided to school employees, and not to evaluate the price competitiveness of the various insurers currently serving local districts in Washington, we used the same network discount assumptions for all plans in order to ensure that we were measuring differences in design, rather than differences in network efficiency.

**Table X-4**

| Plan | BVC Value | Value Relative to FEHB BCBS Standard Option Plan |
|---|---|---|
| WEA Plan 1 | 6,086 | 114% |
| WEA Plan 5 | 6,024 | 113% |
| PEBB Group Health Classic | 5,701 | 107% |
| PEBB Aetna | 5,701 | 107% |
| PEBB Uniform Medical Plan | 5,658 | 106% |
| PEBB Group Health Value | 5,575 | 104% |
| WEA Plan 2 | 5,497 | 103% |
| Platinum | 5,448 | 102% |
| FEHB BCBS Standard Option | 5,343 | 100% |
| WEA Plan 3 | 5,102 | 95% |
| WEA Plan A | 4,681 | 88% |
| Gold | 4,584 | 86% |
| WEA Plan B | 4,534 | 85% |
| WEA Plan C | 4,225 | 79% |
| Silver | 3,835 | 72% |
| Bronze | 3,166 | 59% |

Source: Hay Group analysis using the HCBVC model.

Table X-5 shows the actuarial value for the plans. The Department of Health and Human Services has not yet issued final regulations on the methodology for determining actuarial value. For the purposes of

this report, the actuarial value has been determined as the aggregate portion of incurred plan expenses that are paid by the plan after reflecting plan deductibles, copayments, and coinsurance payments.

| Table X-5 | | |
|---|---|---|
| Plan | HCBVC Value | Actuarial Value |
| WEA Plan 1 | 6,086 | 97% |
| WEA Plan 5 | 6,024 | 95% |
| PEBB Aetna | 5,701 | 93% |
| PEBB Group Health Classic | 5,701 | 93% |
| PEBB Uniform Medical Plan | 5,658 | 93% |
| PEBB Group Health Value | 5,575 | 92% |
| WEA Plan 2 | 5,497 | 91% |
| Platinum | 5,448 | 90% |
| FEHB BCBS Standard Option | 5,343 | 89% |
| WEA Plan 3 | 5,102 | 86% |
| WEA Plan A | 4,681 | 80% |
| Gold | 4,584 | 80% |
| WEA Plan B | 4,534 | 79% |
| WEA Plans ABC | 4,480 | 78% |
| WEA Plan C | 4,225 | 74% |
| Silver | 3,835 | 70% |
| Bronze | 3,166 | 60% |
| Source: Calculations by Hay Group | | |

While they are correlated, there is no direct linear relationship between actuarial values and premiums. Plans with higher actuarial values often use more restrictive provider networks and more medical management than do plans with lower actuarial values. Differences in financing methods and administrative costs affect premiums, but not acturial values.[33] In addition, the cost-sharing provisions of a health plan affect patient behavior. While a plan with an actuarial value of 100 percent might appear to be only modestly more valuable than a plan with an actuarial value of 90 percent, it would represent a "free plan" under which patients would receive health care with no out-of-pocket cost to themselves. Patient use of health care will increase significantly under a free plan, leading to a much greater

[33] A study of individual market plans in California found "that two plans might have very similar actuarial values but very different premiums." Roland McDevitt, *Actuarial Value: A Method for Comparing Health Plan Benefits*, prepared for the California Health Care Foundation by Watson Wyatt Worldwide, October 2008, page 7 (http://www.chcf.org/~/media/Files/PDF/H/PDF%20HealthPlanActuarialValue.pdf).

difference in cost between a 90 percent plan and a 100 percent plan than a simple comparison of the actuarial values might suggest.

Table X-6 shows the enrollment by benefit level after "mapping" from the current plan to the plan closest in value.[34] We estimate that most employees would enroll in the Platinum tier with about 18 percent enrolling in the Gold tier.

**TABLE X-6**
**Enrollment by Benefit Level after Mapping to the Closest Benefit Level**

| Platinum | Gold | Silver | Bronze |
|---|---|---|---|
| 82% | 18% | 0% | 0% |

Source: Hay Group analysis.

"Actuarial value," as defined by PPACA, is a general measure of how much of an enrollee's medical bills will be paid by the plan, and how much will be paid by the beneficiary through cost sharing provisions such as deductibles, coinsurance and co-payments. Out-of-pocket premiums are also an important consideration for employees, and are not captured in the actuarial value. While the relationship is not linear, in general plans with higher acturial values will also have higher premiums. Moving to a plan with a higher actuarial value generally means higher premiums, but lower out-of-pocket spending for health care. Conversely, moving to a plan with a lower actuarial value generally means lower premiums, but higher out-of-pocket spending for health care. From a design standpoint, patient cost sharing through deductibles, coinsurance and co-payments may be seen as one tool to control unnecessary use of health care by giving patients a financial incentive to be prudent purchasers of health care. Thus, higher cost sharing may be seen as an alternative to managed care techniques, such as limited provider networks and referral requirements, for controling health care costs. Not surprisingly, HMO plans have traditionally offered benefits with higher actuarial values, while PPO and indemnity plans have traditionally offered benefits with lower actuarial values.

Impact of Standardized Health Benefit Plans

All certificated participate in TRS and have the same retirement benefit plan, and similarly all classified employees participate in SERS and have the same retirement benefit plan. Using a standard benefit package (or much reduced set of standardized benefit plans) greatly improves the efficiency for administering health plans. We therefore evaluated the cost impact if a standardized benefit plan were provided to all district employees. Table X-7 shows the savings (or cost increase) associated with the

[34] For this purpose, "closest in value" means the plan with the BVC value closest to the current plan.

change from the current array of different medical benefits to a common medical benefit level. In the table below, no changes were anticipated in the dental and vision coverages or costs.

Table X-7 shows the total State-wide health care costs, and total savings (or cost increase), if all employees were enrolled in the same medical benefit design. [35]

- If all employees were enrolled in the Platinum plan design, we estimate that this would result in an aggregate cost increase of $7 million.
- If all employees were enrolled in the Gold plan design, we estimate that this would result in aggregate savings of $157 million.
- If all employees were enrolled in the Silver plan design, we estimate that this would result in aggregate savings of $300 million.
- If all employees were enrolled in a plan comparable in value to the FEHB Blue Cross Blue Shield Standard Option plan, we estimate that this would result in aggregate savings of $13 million.
- If all employees were enrolled in plans comparable in value to the PEBB plans, we estimate that this would result in aggregate cost increase of $45 million.

**Table X-7**
**Estimated Savings (Costs) from Use of a Standardized Benefit Plan for all Employees**
**Amounts in $ millions**

| Medical Benefit Design | Platinum | Gold | Silver | FEHB | PEBB | Map to Closest |
|---|---|---|---|---|---|---|
| 1. Dental | $155 | $155 | $155 | $155 | $155 | $155 |
| 2. Vision | $27 | $27 | $27 | $27 | $27 | $27 |
| 3. Medical | $1,036 | $872 | $729 | $1,016 | $1,074 | $1,001 |
| 4. Total (1. + 2. + 3.) | $1,218 | $1,053 | $911 | $1,198 | $1,256 | $1,183 |
| 5. Savings (costs) | ($7) | $157 | $300 | $13 | ($45) | $35 |
| 6. Costs as a percent of current | 101% | 87% | 75% | 99% | 104% | 97% |

Source: Hay Group analysis.

[35] We did not develop cost estimates for a system based on "Bronze" benefits. The "Bronze" tier is more representative of the level of benefits often purchased by consumers purchasing health benefits on their own through the individual health insurance market than it is of benefits typically provided by medium-to-large employers. It would also represent a greater change in benefit levels than we believe is likely to be practical in the near term.

Table X-8 shows the magnitude of the change in the value of the benefits. Table X-8 illustrates the potential impact on the employees.

| TABLE X-8<br>Change in Benefit Value Compared to Current Level | | | | | | |
|---|---|---|---|---|---|---|
| Change in Benefit Value Compared to Current Level | Percentage of Washington State K-12 Employees | | | | | |
| | All in Platinum | All in Gold | All in Silver | Map to Closest | All in FEHB | All in PEBB |
| Decrease in benefits of more than 12.5% | 0% | 59% | 85% | 0% | 0% | 0% |
| Decrease of 7.5% to 12.5% | 47% | 22% | 15% | 47% | 47% | 0% |
| Decrease of 2.5% to 7.5% | 1% | 0% | 0% | 32% | 13% | 47% |
| Less than 2.5% change | 11% | 3% | 0% | 14% | 0% | 2% |
| Increase of 2.5% to 7.5% | 22% | 15% | 0% | 7% | 22% | 11% |
| Increase of 7.5% to 12.5% | 0% | 0% | 0% | 0% | 0% | 22% |
| Increase of more than 12.5% | 18% | 0% | 0% | 0% | 18% | 18% |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |
| Source: Hay Group analysis. | | | | | | |

Column (1) of Table X-8 shows that if all employees were enrolled in the Platinum plan, this would result in:

- a decrease in benefit value of between 7.5% and 12.5% for 47 percent of the employees,
- a decrease in benefit value of between 2.5% and 7.5% for 1 percent of the employees,
- a change in benefit value of less than 2.5% for 11 percent of the employees,
- an increase in benefit value of between 2.5% and 7.5% for 22 percent of the employees, and
- an increase in benefit value of more than 12.5% for 18 percent of the employees

If the State were to provide four plan designs (Platinum, Gold, Silver, and Bronze) and School districts and employees elected plans closest in value to their current plan (as indicated in column (4) of Table X-6 above), this would result in:

- a decrease in benefit value of between 7.5% and 12.5% for 47 percent of the employees,
- a decrease in benefit value of between 2.5% and 7.5% for 32 percent of the employees,
- a change in benefit value of less than 2.5% for 14 percent of the employees, and
- an increase in benefit value of between 2.5% and 7.5% for 7 percent of the employees.

**Option 3: Restructure the Health Benefits System**

In addition to rationalizing the funding structure, the State may also want to consider establishing a state-wide, self-funded plan for school employees. A key design decision for any such program is whether participation by local school districts is voluntary or mandatory. We will discuss three alternative sets of participation rules below. There are, however, a number of design considerations that are common to any such program.

State-Managed Program Parallel to but Separate from PEBB

There are several reasons that a state-wide health benefits program for State school employees should be separate from the existing PEBB program:

- Managing the State funding commitments to both school employees and State employees will be simplified if the funding for the two groups is not comingled in a single insurance pool.
- The PEBB program is designed for the particular needs of State employees and their dependents; it is likely that benefit designs and other plan features may require modification to best serve the needs of school employees.
- A separate pool will allow the program for school employees to operate on a schedule that coordinates with the financing and enrollment schedule for local school districts.
- Separating the programs will allow for a separate governance structure for the school employees plan, which will provide school employees, their labor representatives and district management with greater transparency and confidence in the system.

Program Managed by the Same State Staff Managing the PEBB Program

While the benefits program for State school employees should be separate from the existing PEBB program, there are several reasons that it should be managed by the same State staff who are responsible for the operation of the PEBB program:

- They have experience running a similar program.
- There are efficiencies to be gained by using the same administrative and accounting processes.
- It creates the potential for negotiating both programs together in order to obtain more favorable agreements with health plans.

Joint Labor/Management Board of Trustees

The governance structure of a state-wide health plan is a critical factor for ensuring that it keeps up to date with the needs of the State, districts, and school employees and their representatives. It also is likely to be a crucial factor in determining how well a State-wide school employees program is accepted

by school employees and districts. We would recommend a board of directors with equal labor and management representation. We would also recommend the inclusion of two public representatives, one with expertise in public health and one with expertise in health care financing, and consideration should be given to making the State insurance commissioner an ex officio member. We would recommend that the board be given authority over the design of the benefit packages offered, the number and structure of the enrollment tiers, and the premiums charged to participating local districts.

Financial Management

We recommend that the progam be self-funded. As noted above, the target population is large enough for a self-insured pool to be viable, and self-funding can reduce the cost of coverage. In particular, self-funding will eliminate premium taxes and the insurer's "risk charge." Both are relatively small percentages of the overall health insurance premium, but for a group this size the aggregate dollar amount is material. We note that while eliminating State premium taxes will directly reduce the cost of providing health benefits to school employees, it will result in a corresponding loss in State revenue from such premium taxes. The use of those revenues, and the impact of their loss on other functions of State government, is outside the scope of this study.

Explicit requirements should be established for managing the pool on a financially sound basis. These requirements should include, at a minimum, audited finacial statements and appropriate reserves for Incurred but Not Reported (IBNR) claims.

Consideration Should be Given to Establishing a Separate Retiree Pool or Pools

At the same time that a separate program is established for school employees, we would recommend that consideration be given to separating the retiree medical pool from the current PEBB pool. The result would be one insurance pool for active State employees (and their dependents), a second insurance pool for active school employees (and their dependents) and a third insurance pool for retired State and school employees (and their dependents). This would ensure that the costs and funding for each of these groups is clearly recognized and distinguished.

Several considerations would suggest establishing two retiree pools – one for State retirees and one for school retirees– with the school retiree pool managed by the same board responsible for the pool for active school employees. This would avoid commingling the funding for school retirees with that for State retirees, as well as providing a more accurate picture of the cost of post-retirement benefits for each group. It would also provide the flexibility to offer school retirees the same benefit options available to active school employees.

Considerations Regarding the State "Level of Effort" for School Employees

Providing school employee benefits through a State program will make comparisons between the school plan and the plan for State employees inevitable. State and school employees are likely to have unique needs, leading to different design decisions for each program. As a result, comparability is likely achievable only on the funding side. If the State determines that making the programs for school employees and State employees directly comparable is an important design goal, then we believe the most natural point of comparison is the level of State funding provided per eligible employee or, if enrollment levels are dramatically different, the level of State funding per enrolled employee. Setting the State funding level for school employees equal to that for State employees would guarantee a basic equivalence while allowing for benefit designs tailored to the needs of each employee population. If this approach were taken, an important design question would be whether or not the State funding level should be adjusted for the demographics and health status of the two populations. Making such an adjustment would complicate the system and could be viewed as unfair by the younger/healthier group. On the other hand, not adjusting for demographics and health status could be viewed as unfair by the older/less healthy group. Further research would be needed to explore the impact of these alternatives or some middle ground.

Participation Requirements

The two most significant challenges facing a voluntary program are ensuring that the necessary overall enrollment level will be reached and avoiding the potential for attracting only high-cost groups of enrollees. The benefits of consolidation depend on establishing a large enough risk pool for self-insurance to be a viable option. To achieve the greatest savings, the pool should have the critical mass to ensure effective bargaining power with health plans, and to minimize the need for purchasing reinsurance protection. In addition, it is important to avoid adverse selection against the risk pool (the potential for districts with higher costs to participate while districts with lower costs stay out of the pool).[36]

**Option 3a: Voluntary Participation by Local Districts**

A voluntary option would allow each district to decide whether or not to participate in the state-administered program. There are important limitations to this approach. A mandatory system directly addresses both of these issues by ensuring adequate enrollment levels and avoiding adverse selection. Voluntary systems generally do not have the same savings potential as mandatory systems, and a larger contingency reserve would likely be needed if participation were voluntary.

[36] Two ways of minimizing the risk of adverse selection in a voluntary plan are: (1) establishing demographic participation standards, and (2) requiring rate adjustments when groups deviate substantially from underwriting norms.

Any voluntary system must be carefully constructed to ensure that it will attract sufficient enrollment to create a viable insurance pool. It should also include design features that minimize the potential for adverse selection. These might include requiring that districts joining the state-wide system must remain in it for a minimum of two years and requiring that if a district offers the State plan to some employees that it must offer it to all employees (subject to timing constraints imposed by the expiration of existing collective bargaining agreements). Such measures must be carefully balanced, however, to avoid unduly discouraging participation.

Adverse selection increases the cost of coverage within a voluntary plan, which leads to reduced participation and thus indirectly lower savings. However, if all local school districts choose the most economically effective approach to providing the benefits, then the additonal cost of participation in the plan due to adverse selection does not directly increase the overall cost of providing health benefits to school employees. For instance, if some districts have lower than average medical costs and stay out of the voluntary system, then the total medical cost for all school systems will not change. However, the cost of coverage for those districts that do participate will be increased. If this leads to reduced participation, then the percentage of overall school employee health coverage that is provided through a more cost-effective program will be reduced, leading to lower savings.

**Option 3b: Mandatory Participation for New Employees**

This option would give local districts the option of participating in the State-administered plans for current employees, but would also require that all future newly hired school employees participate in the state-wide system. This approach would help reduce the potential for adverse selection implicit in Option 2a, and would provide for a gradual and orderly transition to a fully consolidated state-wide system for all school employees. However, this option creates a two-tiered system that divides employees by date of hire.

**Option 3c: Mandatory State-Wide System for All Districts**

This option would require participation by all local school districts. The benefits of consolidation depend on establishing a large enough risk pool for self-insurance to be a viable option. To achieve the greatest savings, the pool should have the critical mass to ensure effective bargaining power with health provider networks and administrators, and to minimize the need for purchasing reinsurance protection.[37] In addition, it is important to avoid adverse selection against the risk pool (the potential for districts with higher costs to participate while districts with lower costs stay out of the pool). Mandatory participation has the greatest potential for cost savings, but would also present many stakeholders in the current system with the most rapid and significant changes. The participation requirement would be tied to the

[37] It is possible that reinsurance would be advisable in initial years until claims and participation stabilize.

expiration of current collective bargaining agreements (see Table XI-1) in order to avoid disrupting existing coverage arrangements.

**Estimated Impact of the Policy Options**

Table 9 shows the combined savings from standardized benefit plans (i.e. utilizing the savings identified in Table X-7) and a statewide system (either voluntary or mandatory).

**Table X-9**
**Estimated Savings from Use of a Standardized Benefit Plan for all Employees**
**Amounts in $ millions**

| Program Structure \ Plan Designs | Current Plans | Platinum | Gold | Silver | Map to Closest Plan |
|---|---|---|---|---|---|
| 1. Current Structure | $1,211 | $1,218 | $1,053 | $911 | $1,183 |
| 2. **Amount of savings** | | ($7) | $157 | $300 | $28 |
| 3. Voluntary System | $1,182 | $1,189 | $1,029 | $889 | $1,155 |
| **4. Amount of savings** | $29 | $22 | $182 | $321 | $56 |
| 5. Mandatory System | $1,147 | $1,154 | $998 | $863 | $1,121 |
| **6. Amount of savings** | $64 | $57 | $213 | $347 | $90 |

Source: Calculations by Hay Group

Table X-10 shows the combined savings (cost increases) from standardized benefit plans offered by PEBB (i.e. utilizing the savings identified in Table X-7) and a statewide system (either voluntary or mandatory) as well as the estimated savings if employees enrolled in a plan with benefits equivalent to those provided by the Federal Employees Health Benefit (FEHB) Blue Cross Blue Shield (BCBS) Standard Option plan.

| Table X-10<br>Estimated Savings Compared to PEBB or FEHB Benefits for All Employees<br>Amounts in $ millions | | | |
|---|---|---|---|
| Program Structure \ Plan Designs | Current Plans | PEBB | FEHB BCBS Standard Option |
| 1. Current Structure | $1,211 | $1,256 | $1,198 |
| **2. Amount of savings (costs)** | | ($45) | $13 |
| 3. Voluntary System | $1,182 | $1,226 | $1,169 |
| **4. Amount of savings (costs)** | $29 | ($16) | $41 |
| 5. Mandatory System | $1,147 | $1,190 | $1,135 |
| **6. Amount of savings** | $64 | $21 | $76 |
| Source: Calculations by Hay Group | | | |

**Other Policy Considerations**

Impact of Health Insurance Market Reform

PPACA represents a fundamental restructuring of the health insurance market, especially for small groups and individuals purchasing coverage on their own. The most significant market changes do not occur until 2014, when the new market rules are fully implemented and the health insurance exchanges begin operation. PPACA establishes a "pay or play" system to encourage employers to continue offering employee health benefits. The presence of guaranteed access to individually purchased coverage, in combination with significant subsidies to low-income individuals purchasing through an insurance exchange, has the potential to significantly change the way workers view employer-sponsored health benefits.

We believe it is premature to make any decision in anticipation of these changes. We would recommend a review in 2016 to determine how well the exchanges are functioning and whether there has been any material change in the value school employees place on the health benefits they receive.

Excise Tax on High-Cost Health Plans

PPACA imposes a 40 percent excise tax on the excess benefit from a high-cost employer-sponsored health benefit plans (so-called "Cadillac" Plans) beginning in 2018.[38] The tax will reduce the cost-effectiveness of any plan of benefits that falls above the threshold. If a State-sponsored plan is established, the benefit options should be reviewed in 2016 or 2017 to determine which, if any, are likely to be subject to the tax. If any are, they should be reviewed to determine what design changes may be necessary to avoid triggering the excise tax.

## XI. Implementation Issues

If Washington State were to mandate that all K-12 employees be required to participate in a single state-wide health plan, we recommend that the school districts be permitted to phase into the plan not later than upon the expiration of their current collective bargaining agreements. If the plan rates and benefits were attractive enough, some labor and management groups might reopen contract negotiations to permit early transition into the state-wide Plan.

Subject to further legal analysis the State might be able to preempt the collective bargaining process and enact a law that would require all school districts to participate in a state-wide plan by some specific date, without regard to the desires of the bargaining parties. However, for political and practical reasons we recommend that any mandatory participation or similar types of change be phased in, by requiring transition to the state-wide system by the later of: (a) three years after enactment, or (b) the expiration of the collective bargaining agreement in effect as of the effective date of the authorizing statute. A gradual transition will permit a more orderly start-up of the state-wide plan. However, the state-wide savings that could be realized would not be fully achieved until the expiration of all agreements.

Table XI-1 shows the year of expiration of collective bargaining agreements in our survey. By the end of 2014, 99 percent of the agreements will have expired.

**Table XI-1**
**Analysis of End of Bargaining Agreements**

| Year Agreement Ends | Number of Collective Bargaining Agreements | Cumulative Percentage |
|---|---|---|
| 2010 | 23 | 8.1% |
| 2011 | 136 | 55.8% |
| 2012 | 61 | 77.2% |
| 2013 | 53 | 95.8% |
| 2014 | 9 | 98.9% |
| 2015 | 2 | 99.6% |
| 2016 | 1 | 100.0% |
| Total | 285 | |

Source: Hay Group survey of K-12 School Employee Benefits.

In some cases, it may not be possible to terminate the existing health plan contract without significant penalties. For example, there may be an experience rating deficit for the plan that the insurer would have recovered through additional charges if the plan had continued past the end of the existing

collective bargaining agreement. Therefore, the law might allow some additional time to shut-down existing arrangements past the end of the collective bargaining agreement in unusual circumstances.

If the state-wide plan were to be voluntary, then there would not have to be any participation deadlines, since each school district could choose to participate, or decline to participate on a time schedule that best meets its current health insurance and their current collective bargaining arrangements. A secondary issue in a voluntary arrangement is to what extent, if any, school districts may leave the state-wide plan and later return. Our review of other states with voluntary participation indicates a range of answers from not permitting school districts to opt out, to requiring a minimum exclusion period such as three years, to unlimited ability to leave and return to the state-wide plan.

**Implementation Steps**

The first step would be to develop legislation implementing the state-wide plan. The legislation should establish the administrative structure necessary to implement the plan and contain other authority necessary to the successful implementation of the plan. If, for instance, participation were mandatory, the legislation would need to include the conditions under which school districts would have to join the plan. We recommend that the legislation be silent on exact specifications of the plan such as deductibles, co-payments, or types of plans that would have to be covered. Health insurance and delivery systems are very dynamic and the best practices today, *e.g.*, negotiation through Pharmacy Benefit Managers (PBMs) for prescription drugs, could well change to a neutral or even detrimental requirement in the future. The Federal Employees Health Benefits Program has successfully met arising challenges for almost a half century because the requirements of the legislation are very broad.

We would strongly recommend that the funding system be reformed as a preparatory step if the State decides to implement a state-wide plan.

We recommend that the state-wide system be administered by either HCA or a new state agency. We do not think that the health plan for state employees should be expanded to include school district employees because of the different funding mechanisms, the inherent differences in the populations, differences in the health care needs of each population, and the differences in customer service needs.

After passage of the legislation, the organization responsible for implementation (HCA, or a new state agency) will study how best to implement the legislation on a timely basis. These considerations will include the following:

- How best to contract with school districts to provide the health insurance to their employees.
- When and how to enroll eligible employees and permit changes after the first enrollment.

- The most effective approach for contracting with health-care providers and insurers to deliver the best benefits at the lowest possible cost.
- The organizational changes needed to implement the new state-wide plan including staffing, space, and computer systems.
- How to determine and charge the premiums paid by the school districts' employees.
- The range of health plan choices to be provided and the design of each of the choices.

The administrating organization would then prepare a timetable for implementation. The timetable should conform to any requirements in the enabling legislation.

The administrating organization would then negotiate agreements with the school districts that would be required to, or chose to, participate in the first year of the plan. These agreements would include the employees to be covered, the options selected by the school district, and the financial arrangements between the organization and the school district. The administrator would determine the date of entry of each school district into the state-wide plan based on provisions in the law and such considerations as collective bargaining and the financial position with current health insurer.

The administrating organization would negotiate coverage with health care providers and insurers throughout the State of Washington and also contract with a national network to provide coverage for employees traveling outside Washington. The goal of the negotiations would be to provide the best health care to individuals at the lowest price with the health care providers and insurers.

The administrating organization would then prepare the description of the plans available to employees in each school district and distribute that information to the individuals in sufficient time to make an educated choice of health plan for the first year.

The administrator would provide a system for the potential enrollees to make a timely decision on choice of health plan. The system would be the data base used to (1) prepare bills for school districts, (2) confirm enrollment for coverage, and (3) confirm eligibility for claims payments.

During the design period, the administrator would have put into place the organization needed to effectively administer the program. A large part of this organization would have to be in place well before the first enrollment date. The organization would have to include at a minimum:

- An enrollment verification and processing division.
- A claims administration division.
- A division to monitor and audit the contracts with the health care providers and insurers.

- A call center to handle calls from enrollees, school districts, and providers.
- An executive director's office to manage the system.

If the administration builds on the existing infrastructure in HCA, the start-up costs would be materially lower.

## XII. Plan Administration

The key drivers of a plan's costs are the level of the benefits, the cost or level of charges for the covered benefits (*i.e.*, how much hospitals, doctors, and other care providers are paid), the utilization of those benefits by plan members (*i.e.*, the frequency and intensity of illness, disease, injury, and visits to care providers), and the non-benefit costs that are required to administer the plan (*e.g.*, costs of claims processing). While plan design does influence utilization, once the plan of benefits is determined, the primary driver of the total plan cost is effective administration and management of the plan. Hence, one of the most controllable elements of health care costs are the administrative costs. Also effective plan administration is essential to providing benefits effectively and is critical for customer satisfaction.

To evaluate the effectiveness of plan administration we analyzed the administrative practices currently used by the largest providers of health care to the school districts. In order to gather information on current administrative practices and cost controls we sent questionnaires to WEA, PEBB, Group Health Cooperative, and Regence. As of the date this report was issued, we had received responses from PEBB, Group Health Cooperative, and WEA (Premera). Through a series of interviews with the various stakeholders and the responses to the questionnaire, we learned that there are substantial differences in how benefits are administered. Thus, for a given set of benefits, the system-wide cost could be reduced by applying a uniform set of administration procedures, and the cost further optimized by using best practices for plan administration.

***System-wide Plan Administration***

If Washington State were to establish a state-wide health system for K-12 employees, we recommend that the administration of the system adopt the following best practices.

***Eligibility***

The system should maintain its own eligibility database, interface with the personnel system for school district employees, and manage eligibility records on spouses and dependents. There should be a common definition of coverage, with frequent feeds of eligibility changes to the various health plans. As a self-funded plan, the plan's costs can be controlled by effective eligibility management. Best practices eligibility management would include the following procedures:

- Daily eligibility updates should be sent to carriers. Carriers would then be held financially accountable for services provided to ineligible members after a 48-hour grace period.
- Spousal eligibility should be determined only after the plan receives positive certification of marriage.

- Dependent eligibility should be determined upon receipt of a birth certificate or proof of adoption, as applicable.

***Large Case Management***

As a significant portion of a health plan's total expenditure is routinely incurred by a small portion of the membership, effective large case management is a major contributor to total health plan cost control. Effective large case management includes early identification of large cases, periodic review of the patient's care and future needs, evaluation of alternative care options, and access to centers of excellence for transplants and other high-cost and high-risk procedures.

***Alternative Care Options***

Alternative care options provide needed care in settings that may provide more appropriate care at lesser cost than hospitals. These options include long term acute care facilities, non-hospital residential physical rehabilitation facilities for medical conditions and residential facilities for substance abuse and mental health conditions.

***Transplants***

Transplant services are among the highest cost services, providing life-saving and life-extending care to a relatively few members. A state-wide program can negotiate with centers of excellence in tranplants and establish consistent protocols for transplant coverage.

***Carve-outs***

An effective cost management approach that has been implemented by large employer groups is to "carve-out" specific benefits from the health plan and separately negotiate the coverage.[39] The most common benefits that are managed through a carve-out arrangement are:

- Prescription drugs
- Mental health and substance abuse
- Imaging
- Durable medical equipment
- Chiropractic care

[39] The use of the term "carve-out" in the context of managing a health benefit plan to describe this approach to negotiating a specific benefit should not be confused with the use of the term "carveout" to describe the Washington State retiree remittance.

- Transplants

Of these possible carve-out benefits, prescription drugs represent the largest portion of benefit costs. Pooling all the pharmacy claims into a single contract has several advantages. First, it ensures benefit comparability across all medical delivery systems. Second, it facilitates ease of communication to members with the introduction of new drugs and changes in generic status. Third, it makes it possible for the plan to periodically negotiate with national pharmacy benefit managers and obtain the best possible price and service arrangements.

Similarly, carving out the mental health and substance abuse benefits and contracting with a national (or state-wide) firm specializing in this care can improve care and significantly lower costs.

The plan's size will also enable it to write contracts with durable medical equipment providers on very favorable terms.

***Disease Management***

Disease management programs provide additional services and targeted interventions to individuals who have diseases or conditions that can benefit from behavioral modification. We found that there was a wide range of DM services that are provided to school employees. As most of the school employees are covered by Premera, these DM services are provided on a consistent basis.

Emerging best practices have shown that adding resources for employees and dependents with chronic diseases, to help them manage their health, can result in improved outcomes and cost savings that more than offset the cost of the additional resources. Disease management program outcomes include a slowing down of disease progression, reduction in hospitalization, less frequent use of emergency rooms and fewer urgent doctor visits, as well as a reduction in work days missed. Currently, insurers that have disease management programs usually target those individuals whose prior claim histories indicates that they have health problems (or health risk factors indicating impending health problems) that can be improved or mitigated by disease management. School district employees can be expected to remain covered for life: either by the active school employees' health plan or by the retired school employees' health plan. Therefore a state-wide health care system's disease management program could be expanded to cover both high and low severity individuals, with the expectation that the mitigation of health problems will not only reduce lifetime health care costs, but equally importantly, it will improve and prolong the life of covered individuals.

A self-funded plan could analyze the population data on prevalence of diseases among the covered employees and use that information to identify and implement programs that would be both cost-effective and broadly used.

***Claims Audits***

Claims audits are thorough reviews of a sample of a plan sponsor's claims. The purpose of the audit is to verify whether the contract provisions are being administered appropriately.

***Prescription Drug Claims Audits***

These audits check the contract terms against actual charges and are more readily performed on the full set of claims rather than a sample.

***Mental Health and Substance Abuse***

Treatment of nervous and mental problems, and treatment of substance abuse, have been historically high-cost services, with little effective control, particularly in light of the wide range of possible treatments and treatment settings. To ensure proper care and control costs plans need utilization review and case management of these types of cases.

***Contract Negotiations and Provisions***

The best practices would take full advantage of the size of the school district employees' health system, leveraging the system's purchasing power to obtain favorable contract provisions and member service guarantees. These contract provisions could include:

- Establishing a "most favored nation" clause in all vendor contracts. This would require the vendors to certify and guarantee that the fees charged are equal to or less than those charged to any similarly situated customer. If the vendor subsequently offers lower fees to any other customer, the vendor would have to reimburse the plan for the difference. To enforce this provision, the plan would require the vendor's senior financial manager to certify annually that fees charged to the plan are in compliance with this clause.

- The contract provisions would require a 100% cost and eligibility match before it will authorize the payment of carrier invoices. If the invoice includes claims for an ineligible person, the plan would not pay the invoice until the claims are removed and a new invoice submitted. If the invoice total dollar amount does not match the sum of the individual details on the claims tape, the plan would not pay the invoice until charges are reconciled.
- As a self-funded plan, negotiate provider access fees and administration charges as per contract (or per covered life) amounts to more accurately reflect actual utilization.

### *Coordination of Benefits*

As a self-funded plan, it would be cost-effective to employ specialized staff to supplement the efforts of the claims administrator's Coordination of Benefits staff and conduct research on Medicare Secondary Payer notices as well as subrogation for Workers' Compensation and automobile insurance claims.

## XIII. Actuarial Certification

This report presents the findings from an investigation of the health benefits for K-12 school district employees of the State of Washington.

In this study, Hay Group has used a variety of data collection techniques, including: in-person meetings with several dozen individuals who are intimately involved with health benefit coverage of Washington K-12 district employees; a review of documents and data sets found on public web sites or provided by the State Auditor's Office or interviewees; and two comprehensive, standardized surveys, one of the districts themselves and another of the major insurers providing this coverage. Analysis has been conducted by a team of Hay Group employees led by three senior actuaries. Each section of the report was prepared by at least one of the actuaries and independently reviewed by one or more of the other actuaries. Hay Group has considerable past experience in studies of health benefit coverage for schools, and in the types of surveys conducted for this study. We have not found any significant inconsistencies in the various groups of data collected during this study.

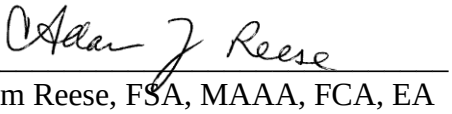
Our analysis of the effect of moving to standardized benefit designs incorporates benefit standards established by the recently enacted federal health care reform law. Not all of the regulations implementing these reforms have yet been issued, which creates some uncertainty. In our report we identify those aspects of our analysis that may be affected by the lack of final regulations.

The analyses shown in this report are based on reasonable actuarial assumptions. However, a different set of results could also be considered reasonable. The reason for this is that actuarial standards of practice describe a "best-estimate range" for each assumption, rather than a single best-estimate value. Thus, reasonable results differing from those presented in this report could have been developed by selecting different points within the best-estimate ranges for various assumptions.

Given the large survey sample size collected from K-12 school districts, we are confident that the overall results of this study are professionally rigorous and results are reasonable and appropriate.

The actuaries certifying to this investigation are members of the American Academy of Actuaries and other professional actuarial organizations, and meet the General Qualification Standards of the American Academy of Actuaries for purposes of issuing Statements of Actuarial Opinion.

Respectfully submitted,
Hay Group
January 31, 2011

By 
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# Glossary

**Actuarial Value** - A method for measuring the value to an average enrollee of the benefits provided by a health benefits plan. It represents the average percentage of allowed medical costs that would be paid by the plan, assuming a specified standard enrollee population. It does not include premium costs, and represents an average value; the percentage payout for any particular enrollee may be very different from the actuarial value of a plan.

**Adverse Selection (Anti-Selection) -** The tendency of individuals with a higher probability of incurring claims (high risk) to select the maximum amount of insurance protection, while those with lower probability elect lower levels of, or defer, coverage.

**Administrative Services Only (ASO) Contract -** Contract with an insurance company or health plan to provide self-funded benefits to an employer or other plan sponsor. An ASO contract is not an insurance policy, because the health plan does not take any insurance risk, but only administers benefits funded by the health plan sponsor. In this case, the health plan administrator takes the role of a third-party administrator (TPA).

**Hay Benefit Value Comparison (BVC) method** - A proprietary method for comparing the value of compare the relative value of employee benefit packages by placing them on a "common cost" basis that assumes both a common enrollee population and a common funding method. This approach eliminates extraneous factors that complicate a direct comparison of premiums or plan costs, such as differences between funding methods, enrollee demographics and administrative overhead.

**Carve-Out -** Removing a specific benefit from the contract with the primary health plan and negotiating the coverage separately, usually with a specialty vendor or network. For instance, prescription drug coverage is often purchased separately on a self-funded basis from a specialized pharmacy benefit manager. It should not be confused with the term "carveout" (defined below) which is sometimes used to describe the Washington State retiree remittance.

**Carveout** – A term sometimes used to describe the Washington State retiree remittance. It should not be confused with the term "carve-out" (defined above) which describes one approach for managing the cost of specific benefits.

**Case Management -** A process which focuses on coordinating a number of services required by severely ill or injured participants to ensure that provided services are appropriate, timely, thorough yet non-redundant and cost effective.

**Centers of Excellence (COE) -** Medical facilities that contract with a health plan to provide medical care for specific types of high cost services, such as transplants or cancer treatment. Centers of excellence are selected based on outcomes and cost effectiveness, and typically perform a large number of procedures with highly favorable outcomes and low incidents of adverse results.

**COBRA –** Combined Omnibus Budget Reconciliation Act of 1985

**Coinsurance -** A common provision of health care plans in which the covered individual and the insurer or plan sponsor share in a specified ratio of health care expenses (*e.g.*, 80% paid by plan, 20% paid by participant). In a PPO or POS plan, the ratio usually favors the covered individual when the costs are incurred with providers who are part of the PPO or part of a specified network (*e.g.*, 100% coverage within the PPO or network and 70% coinsurance ratio for providers outside the PPO or network).

**Contributory Benefit Plan -** A program in which the employee contributes part (or all) of the cost, and any remainder is covered by the employer.

**Coordination of Benefits (COB) -** A provision of a group health plan that eliminates duplicate payments from multiple carriers and prevents an employee from collecting more than 100 percent of the charges for the same medical expense. The provision also designates the sequence in which primary and secondary coverage will be paid when an individual is covered under two plans.

**Co-Payments -** Payments which are required to be made by covered participants on a per service basis (*e.g.*; $20 co-pay per physician visit). Co-payments are commonly used to discourage inappropriate utilization and to help finance health care plans.

**Deductible -** The amount paid by an employee for covered expenses in a group health plan before the plan pays benefits. A typical plan would follow a calendar year schedule and specify an individual deductible and a higher family deductible.

**Disease Management (DM) –** Disease management refers to the process of identifying health plan enrollees with particular health conditions or risk factors, then assisting those enrollees in managing their conditions to delay the onset or slow the progression of disease.

**Durable Medical Equipment (DME) -** Medical equipment, such as a hospital bed, wheelchair, or oxygen equipment that may be prescribed by a physician and that has an extended useful life.

**ESD** – Educational Service Districts are regional administrative units created by statute that evolved from county superintendents. There are currently nine ESDs in Washington.

**Experience Rating -** A premium based on the anticipated claims experience of, or utilization of service, by a contract group according to its age, sex, and any other attributes expected to affect its health service utilization. Such a premium is subject to periodic adjustment, generally on an annual basis, in line with actual claims or utilization experience.

**FEHB** – Federal Employee Health Benefits (FEHB) Program. This is the health benefits program for federal workers.

**Fee-for-Service Plan (FFS) -** A traditional plan which provides for each reimbursement for designated covered health care services on a fee-for-service basis, with no provider network or negotiated discounts.

**Formulary -** A list of preferred medications within a prescription drug plan that have been chosen by the pharmacy benefits manager (PBM). Typically, formularies are developed to steer plan participants (through lower co-pays) and their physicians to cost effective or discounted drug alternatives.

**FTE** – Full Time Equivalents.

**Funding Pool** – A mechanism mandated by Revised Code of Washington (RCW) 28A.400.280 for redistributing at the local school district level any unused State allocations for employee benefits among the district's employees.

**Gatekeeper -** Usually a primary care physician, who is responsible for directing the patient's care. To receive full benefits, participants must be referred to other medical specialists by their gatekeeper physician. This type of physician generally is found in HMOs and Point-of-Service (POS) networks.

**HBPR** – Hay Benefits Prevalence Report.

**Hay Health Care Benefit Value Comparison (HCBVC) model** – A proprietary actuarial model used to estimate the relative value of health benefit packages. It is one of the primary tools used by Hay Group in applying the Benefit Value Comparison (BVC) method to health benefit programs.

**HCA** – Health Care Authority.

**Health Maintenance Organization (HMO) -** A pre-paid medical group practice plan that provides a comprehensive predetermined medical care benefit. In order for an individual's health care costs to be paid, the individual must utilize services from the specified HMO network of providers. A participant's care is monitored and controlled by a selected primary care physician who is accountable for the total health services of the participant, arranges referrals and supervises other care, such as specialist services and hospitalization.

**Health Reimbursement Account (HRA) -** A tax free employer funded account that provides employees with medical care expense reimbursements. These accounts allow unused funds within the account to be carried forward to future years. HRAs are typically provided with high deductible medical plans.

**Health Risk Appraisal -** A method of appraising the health status of a plan participant, generally via a health questionnaire and basic health measurements.

**Health Savings Account (HSA) -** A pre-tax account that is funded by employees and/or employers to cover employees' out-of-pocket expenses. These accounts require an employee to be enrolled in a qualified high deductible plan. Unused funds in the HSA may be carried forward to future years.

**Indemnity Plan -** A traditional plan which provides for each reimbursement for designated covered health care services on a fee-for-service basis, with no provider network or negotiated discounts.

**Levy Lid -** A statutory limit on the local levy, expressed as a percentage, for a school district. The levy lid effectively caps the amount of revenue a local district can raise to supplement State and federal funds.

**Managed Care -** Control of utilization, costs, quality and claims, using a variety of cost containment methods, including pre-certification and case management. The primary goal is to deliver cost-effective health care without sacrificing quality or access.

**Maximum Benefit -** The maximum amount that a health care plan will pay on behalf of a covered participant during that individual's lifetime.

**National Committee for Quality Assurance (NCQA) -** A non-profit organization that accredits managed care organizations. The accrediting process evaluates organizations against a specific set of standards.

**OFM** – Office of Financial Management.

**OIC** – Office of Insurance Commissioner.

**Out-of-Pocket Limit -** The maximum amount of out-of-pocket health care expenses that a participant is responsible for during a plan year. Every dollar spent on health care after this amount is generally reimbursed in full.

**PEBB** – Public Employees' Benefits Board.

**Pharmacy Benefit Manager (PBM) -** An organization that administers prescription drug benefits. PBMs can be stand alone organizations or part of the carrier that handles the medical benefits. Typically, PBMs negotiate deeper prescription drug discounts, use lists of preferred drugs called a "formulary," and coordinate and monitor patients' prescription drug utilization thus reducing dangerous drug interactions and in other ways enhancing patient care.

**Point-of-Service Plan (POS) -** A type of managed care system that combines features of indemnity plans and HMOs and uses in-network and out-of-network features. A gatekeeper is used to direct an individual to medical care within the network. The covered participant also has the option to received care from any out-of-network provider. If care is received out-of-network, the participant will pay higher co-payments and/or deductibles.

**PPACA** – Patient Protection and Affordable Care Act.

**Precertification/Predetermination -** An administrative procedure whereby a health care provider submits a treatment plan to a third party, such as a case manager, before treatment is started. The third party reviews the treatment plan, indicating the patient's eligibility, covered services, amounts payable, application of appropriate deductibles and co-payments and plan maximums.

**Point-of-Service Plan (POS) -** A type of managed care system that combines features of indemnity plans and HMOs and uses in-network and out-of-network features. A gatekeeper is used to direct an individual to medical care within the network. The covered participant also has the option to received care from any out-of-network provider. If care is received out-of-network, the participant will pay higher co-payments and/or deductibles.

**Preferred Provider Organization (PPO) -** A group of hospitals and physicians that contract on a fee-for-services basis with employers, insurance companies and other third party administrators, to provide comprehensive medical service. Providers exchange discounted services for increased volume. Participants' out-of-pocket costs are usually lower than under a traditional fee-for-service or indemnity plan. If the network-based health plan has gatekeeper/primary physician requirements, it is not a PPO plan, but a Point of Service (POS) plan.

**Provider Network** - Health care providers that have a contractual relationship with a health plan to provide care to the plan's enrollees. Network contracts define the payments the health plan will make to the providers for services rendered to enrollees. They also typically include provisions designed to ensure the quality and cost-effectiveness of care.

**RCW** – Revised Code of Washington.

**SAO** – State Auditor's Office (of Washington State).

**Self-administered Plan -** Refers to a benefit plan in which the company assumes responsibility for full administration of the plan, including claims administration.

**Self-funding -** A benefit plan funding method in which the employer carries the risk for any claims. The employer may contract with a third party administrator to pay claims in its behalf, or may develop its own department to administer the program.

**SERS** – School Employees' Retirement System.

**Stop-loss provision -** A provision in a self-funded plan that is designed to limit an employer's risk of losses to a specific amount. If claim costs (for a month or year or per claim) exceed a predetermined level, an insurance carrier will cover the excess amount.

**TRS** – Teachers' Retirement System.

**Third Party Administrator (TPA) -** In a health benefit plan, the person or organization with responsibility for plan administration, including claims payment.

**Voluntary Employees' Beneficiary Association (VEBA) -** A tax-exempt trust established to fund employee welfare benefits other than pensions. Also known as 501(c)(9) trusts, after the section of the Internal Revenue Code authorizing their tax exemption.

**WAC** – Washington Administrative Code.

**WEA** – Washington Education Association.

**WSIPC** – Washington School Information Processing Cooperative.

# Appendices

**Appendix A –** Survey Documents and Summary of Survey Responses

**Appendix B –** Administrative Practices Survey & Summary of Responses

**Appendix C –** WEA Submitted Materials & Hay Group Commentary

**Appendix D –** PEBB Materials and Analysis

**Appendix E –** Relevant Washington Laws and Regulations

**Appendix F –** Group Health Insurance Principles

**Appendix G –** Survey of 23 State Programs for the Provision of Health Care Benefits to Public School Employees

**Appendix H –** Actuarial Savings Assumptions

**Appendix I –** Free-form Survey Responses to the Question: "What aspect about the health benefits would you most like to see improved?"

**Appendix J** – Benefit Value Comparison Methodology

# Appendix A

## Survey Documents

## Summary of Survey Responses

## Washington State

## K-12 Health Benefits Survey

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Completed by: **Name:**

**Phone:**

**Title:**

**District School Code:**

**County:** Choose an item

What is the name of your School District/Educational Service District: (Please select from one of the drop down lists)

A through H: Choose an item

I through O: Choose an item

P through Z: Choose an item

**Address:**

**City, State, & Zip:**

**Fax:**

**E-mail:**

Complete data submission due by **October 22, 2010**

*- No individual school district data will be released –*

Please Send Completed Surveys to:


Tova Labell
Hay Group, Inc
4301 N. Fairfax Drive, Suite 600
Arlington, VA 22203
FAX: (703) 841-3108
Email:
Tova.Labell@haygroup.com

## General Instructions

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- In addition to the information that will be collected through this survey, we may also need copies of the health benefit plans' employee handbooks or other detailed plan descriptions. We already have detailed descriptions of the WEA and PEBB plans; these need not be submitted. If material is outdated, please make handwritten corrections or provide supplemental explanations.
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Arlington, VA 22203

**Districts Participating in WEA or PEBB Plans**

The survey has been designed to incorporate common plans in drop-down menus, allowing you to complete your responses for these plans more easily.

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**Point-of-Service (POS)** – a medical plan that allows the individual to decide between a network of gatekeeper managed care providers or a PPO with higher employee copayments each time service is provided.

**Pooling –** the state requirement that certain funds allocated to employee benefits be pooled and redistributed to covered employees with the goal of minimizing out-of-pocket premium expense for their coverage and their dependents' coverage.

## Part A

**1. For each of your three largest bargaining units, please provide a list of all comprehensive group medical plans that your school district offered in the 2009/2010 school year. In determining the largest bargaining units, please include units covering all types of school employees (e.g., including instructional staff, instructional aides, administrative staff, support staff, others). You may provide the information in the table below or in a separate attachment.**

**If the monthly payroll deduction for comprehensive group medical coverage is the same for all bargaining units, please fill out the table on the next page and then proceed to question 2. If the monthly payroll deduction for comprehensive group medical coverage varies between bargaining units, please complete all three of the tables which follow, one for each of your three largest bargaining units.**

**Enter the name of the health plan in the leftmost column titled "Insurer/Plan Name". If the plan is a WEA or PEBB plan, select from the drop down list, otherwise, type the name of the plan below the drop down list, next to the word "Other".**

**In the column labeled "Type", specify the plan type (HMO, PPO, POS, FFS, Other) by selecting one of the choices from the drop down list.**

| Comprehensive Group Medical Plans<br>All bargaining units/employee groups? ☐ Yes ☐ No (If "No", please enter the name of the bargaining unit ) | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | ***Enrollment**** | | | | ***Total Monthly Premium**** | | | | ***Monthly Employee Payroll Deduction*** ** | | | |
| *Insurer/Plan Name* | *Type* | *Employee* | *Employee + Sp. or D.P.* | *Employee + Children* | *Family* | *Employee* | *Employee + Sp. or DP* | *Employee + Children* | *Family* | *Employee* | *Employee + Sp or DP* | *Employee + Children* | *Family* |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |

*** If the group uses composite rather than tiered rates, please show enrollment and premium data in the "Family" column of each section**

**** Payroll deduction for an FTE for comprehensive group medical coverage (compute after pooling dollars are applied; do not include voluntary coverages); in computing the employee contribution, assume the most common dental plan and vision plan elected in the district**

| Comprehensive Group Medical Plans<br>Name of the bargaining unit | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | ***Enrollment**** | | | | ***Total Monthly Premium**** | | | | ***Monthly Employee Payroll Deduction*** | | | |
| *Insurer/Plan Name* | *Type* | *Employee* | *Employee + Sp. or D.P.* | *Employee + Children* | *Family* | *Employee* | *Employee + Sp. or DP* | *Employee + Children* | *Family* | *Employee* | *Employee + Sp or DP* | *Employee + Children* | *Family* |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |

*** If the group uses composite rather than tiered rates, please show enrollment and premium data in the "Family" column of each section**

**** Payroll deduction for an FTE for comprehensive group medical coverage (compute after pooling dollars are applied; do not include voluntary coverages); in computing the employee contribution, assume the most common dental plan and vision plan elected in the district**

| Comprehensive Group Medical Plans<br>Name of the bargaining unit | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | ***Enrollment**** | | | | ***Total Monthly Premium**** | | | | ***Monthly Employee Payroll Deduction*** | | | |
| *Insurer/Plan Name* | *Type* | *Employee* | *Employee + Sp. or D.P.* | *Employee + Children* | *Family* | *Employee* | *Employee + Sp. or DP* | *Employee + Children* | *Family* | *Employee* | *Employee + Sp or DP* | *Employee + Children* | *Family* |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |
| ☐ Select<br>☐ *Other:* | Select | | | | | | | | | | | | |

*** If the group uses composite rather than tiered rates, please show enrollment and premium data in the "Family" column of each section**

**** Payroll deduction for an FTE for comprehensive group medical coverage (compute after pooling dollars are applied; do not include voluntary coverages); in computing the employee contribution, assume the most common dental plan and vision plan elected in the district**

**2. Please provide a list of all the Dental and Vision plans that your school district offered in the 2009/2010 school year to any of your public school employees (e.g. including, instructional staff, instructional aides, administrative staff, support staff, others). You may provide the information in the table below or in a separate attachment. If the group uses composite rather than tiered rates, please show enrollment and premium data in the "Family" column of each section.**

**Enter the name of the plan in the column labeled "Name of Plan". If the plan is a WEA or PEBB dental plan, select from the drop down list on the first box titled "Name of Plan", otherwise, select "other".**

**Dental Plans**
**Under the column labeled "Type", select the plan type (FFS, Dental HMO, Other) from the drop down list.**

| | | *Enrollment* | | | | *Total Monthly Premium* | | | |
|---|---|---|---|---|---|---|---|---|---|
| *Name of Plan (e.g., WDS)* | *Type* | *Employee* | *Employee + Sp. or D.P.* | *Employee + Children* | *Family* | *Employee* | *Employee + Sp. or DP* | *Employee + Children* | *Family* |
| Select | Select | | | | | | | | |
| Select | Select | | | | | | | | |
| Select | Select | | | | | | | | |
| Select | Select | | | | | | | | |
| Select | Select | | | | | | | | |
| Select | Select | | | | | | | | |
| Select | Select | | | | | | | | |
| Select | Select | | | | | | | | |
| Select | Select | | | | | | | | |

**If your dental benefit is not 100% employer-paid, check here ☐ and indicate the average percentage of total premium paid by an employee for employee-only coverage here ____ % (must be between 1% and 100%).**

**Vision Plans**

| | *Enrollment* | | | | *Total Monthly Premium* | | | |
|---|---|---|---|---|---|---|---|---|
| *Name of Plan (e.g., VSP)* | *Employee* | *Employee + Sp. or D.P.* | *Employee + Children* | *Family* | *Employee* | *Employee + Sp. or DP* | *Employee + Children* | *Family* |
| | | | | | | | | |
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**If your vision benefit is not 100% employer-paid, check here ☐ and indicate the average percentage of total premium paid by an employee for employee-only coverage here ____ % (must be between 1% and 100%).**

**3. Total Expenditures**

**a) For FY 2009/2010, did your district allocate at least $685.41 ($745 - $59.59) to eligible FTE's in the district for health benefits?**

☐ **Yes (the surveyors understand that this typically means that the state funds cover only state-funded (formula) positions, and that the district provides an equivalent amount for staff over formula through local levy or federal funds; if that is not the case, please describe under the "No" box in the space provided)**

☐ **No (please describe )**

**b) For a recent month, what was:**

1) **The total employer contribution for health benefits made by the district?**
2) **The total employee contribution for health benefits?**
3) **The total paid premium for health benefits? (equals 1 + 2)**

**(Include all sources of funding – state, federal, and local. Please use the most recent month in FY 2009/2010 for which data is available; for some districts, that could be the most recent month in which the pool was calculated, perhaps as far back as October 2009)**

**c) Does the district provide a full benefit funding allocation for employees above a certain full-time equivalent (FTE), or prorate the benefit funding allocation based on the employee's full-time equivalent?**

☐ **Provide full benefit allocation above FTE**
☐ **Prorate benefit funding allocation based on FTE**
**If benefit funding allocation is prorated by FTE, how many hours is a full FTE for certificated and classified employees?**
**Hours/day certificated**
**Hours/day classified**
☐ **Other method (please describe )**

**4. Pooling**

**4.1 How many separate benefit pools exist for your School District/Educational Service District? If none, skip to question 5.**

**4.2 For each separate pool, please provide the following information:**

| Group Covered by Pool | FTE Equivalent Units in Pool for Funding Purposes | Number of Employees in Pool for Benefit Coverage | Funds in Excess of $685 per FTE per Month Contributed to Pool | |
|---|---|---|---|---|
| | | | Per Employee per Month (or) | Annual Total Dollars for the Pool |
| | | | | |
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**4.3 How many times per year are the 3 largest pools recalculated?**

| | Pool Name | | | |
|---|---|---|---|---|
| 1. | _____ | ☐ Once | ☐ Two or three times per year | ☐ Four or more times per year |
| 2. | _____ | ☐ Once | ☐ Two or three times per year | ☐ Four or more times per year |
| 3. | _____ | ☐ Once | ☐ Two or three times per year | ☐ Four or more times per year |

**4.4 Are there any groups in the district that do not participate in a pool?**

☐ No
☐ Yes Number of employees not in a pool
Number of FTE equivalents not in a pool

**(These answers will help address how many part-time employees are not participating in a pool)**

**4.5 The largest classified pool above is**

**For this pool, do classified employees get a full FTE benefits allocation even if they are less than full time?**
☐ No
☐ Yes Lowest portion of FTE qualifying for full allocation (for example, 0.6 FTE) FTE
What is the lowest portion of FTE qualifying for benefits (for example, 0.5 FTE)?

**5. Who is eligible to enroll in the health care plans (Medical, Dental, and Vision) regardless of who pays all or part of the premium? Enter the information in the spaces provided.**

| Comprehensive Group Medical Plans | Enter Hours or Days as Applicable for An Employee to be Eligible for Coverage | | Percent of Workers Who Do Not Qualify |
|---|---|---|---|
| Employee Classification | Hours per Day | Days per year | |
| Certified Instructional Staff | | | |
| Other Educational Support Staff (technology, security) | | | |
| Administrative Staff (executive/ administrator) | | | |
| Clerical Staff | | | |
| Transportation staff | | | |
| Food Service staff | | | |
| Custodial / Maintenance Staff | | | |
| Others Please Specify. | | | |

**6. Who is eligible to enroll in the Dental plans, regardless of who pays all or part of the premium? Enter the information in the spaces provided. If you do not have a dental plan, skip to question 7.**

| Dental Plans | Enter Hours or Days as Applicable for An Employee to be Eligible for Coverage | | Percent of Workers Who Do Not Qualify |
|---|---|---|---|
| Employee Classification | Hours per Day | Days per year | |
| Certified Instructional Staff | | | |
| Other Educational Support Staff (technology, security) | | | |
| Administrative Staff (executive/ administrator) | | | |
| Clerical Staff | | | |
| Transportation staff | | | |
| Food Service staff | | | |
| Custodial / Maintenance Staff | | | |
| Others Please Specify. | | | |

**7. Who is eligible to enroll in the Vision plans, regardless of who pays all or part of the premium? Enter the information in the spaces provided. If you do not have a vision plan, skip to question 8.**

| Vision Plans | Enter Hours or Days as Applicable for An Employee to be Eligible for Coverage | | Percent of Workers Who Do Not Qualify |
|---|---|---|---|
| Employee Classification | Hours per Day | Days per year | |
| Certified Instructional Staff | | | |
| Other Educational Support Staff (technology, security) | | | |
| Administrative Staff (executive/ administrator) | | | |
| Clerical Staff | | | |
| Transportation staff | | | |
| Food Service staff | | | |
| Custodial / Maintenance Staff | | | |
| Others Please Specify. | | | |

## PART B

**Please answer questions in Part B using the primary health plan; that is, the Comprehensive Group Medical Plan with the highest enrollment, as entered on pages 4 through 6. (See your answer to Question 1.)**

**8. What is the name of the primary health plan with the highest enrollment?**

_____

**9. Who handles the claims administration for the plan?**

| | Medical | Dental | Vision |
|---|---|---|---|
| Not offered | ☐ | ☐ | ☐ |
| WEA Plan | ☐ | ☐ | ☐ |
| PEBB | ☐ | ☐ | ☐ |
| Other Insurance Carrier | ☐ | ☐ | ☐ |
| HMO | ☐ | ☐ | ☐ |
| TPA / self-administered | ☐ | ☐ | ☐ |
| Other Union / Taft-Hartley Plan | ☐ | ☐ | ☐ |

## PART C

**10. Does your organization allow employees to enroll their spouses in your medical plan even if the spouse could have medical coverage through his/her own employer?**

☐ **Yes, with no penalty**
☐ **Yes, although additional premium is imposed as a penalty**
☐ **No, does not allow it**

**11. Do you use the services of a health insurance consultant/broker for the purpose of assisting you in obtaining health care benefits?**

☐ **Yes**
☐ **No**

**12. Please describe the services your broker provides in regards to your health care plans.**

**13. If the health benefits are subject to collective bargaining, what is the date of the next Collective Bargaining Agreement?**

| Group | Next Agreement Date |
|---|---|
| | |
| | |
| | |
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| | |

**14. Do employees in your school district participate in (select from the drop down lists):**

| | |
|---|---|
| **a. Health Fairs** | Select |
| **b. Wellness Programs** | Select |
| **c. Health Risk Assessments** | Select |

**15. What aspect about the health benefits would you most like to see improved?**

**16. Would you like to receive a copy of the participants report? (The participants report will provide a summary of the answers received from responding districts to the questions above).**

Select

**Please Send Completed Surveys to:**

By email: Tova.Labell@haygroup.com
By fax: (703) 841-3108
Or by mail to:

Tova Labell
Hay Group, Inc.
4301 N. Fairfax Drive, Suite 600
Arlington, VA 22203

## Surveys are due October 22, 2010

**Washington State**

**K-12 Health Benefits Survey**

# Addendum for Self-Insured Districts

Completed by: **Name:**

**Phone:**

**Title:**

**District School Code:**

**County:** Choose an item

What is the name of your School District/Educational Service District: (Please select from one of the drop down lists)

A through H: Choose an item

I through O: Choose an item

P through Z: Choose an item

**Address:**

**City, State, & Zip:**

**Fax:**

**E-mail:**

Complete data submission due by **October 22, 2010**

*- No individual school district data will be released –*

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**Point-of-Service (POS)** – a medical plan that allows the individual to decide between a network of gatekeeper managed care providers or a PPO with higher employee copayments each time service is provided.

**Pooling –** the state requirement that certain funds allocated to employee benefits be pooled and redistributed to covered employees with the goal of minimizing out-of-pocket premium expense for their coverage and their dependents' coverage.

**Your Primary Health Plan is the Medical Plan with the highest enrollment.**

**1. What is the name of the primary health plan?**

**2. Who administers the primary health plan?**

| | Medical | Prescription | Dental | Vision |
|---|---|---|---|---|
| Not offered | ☐ | ☐ | ☐ | ☐ |
| Premera | ☐ | ☐ | ☐ | ☐ |
| Other Third Party Administrator | ☐ | ☐ | ☐ | ☐ |
| HMO | ☐ | ☐ | ☐ | ☐ |
| In-house/self-administered | ☐ | ☐ | ☐ | ☐ |

**3. If you have a self-insured health plan, please provide the following information.**

| | Current Plan year | Last Year |
|---|---|---|
| **Individual Stop Loss** | | |
| Individual Stop Loss Level (e.g., $50,000) | | |
| **Monthly Premium** for Individual Stop Loss | | |
| On a per employee basis *or* | | |
| On a per covered life basis | | |
| **Aggregate Stop Loss** | | |
| Aggregate Level (e.g., 125%) | | |
| **Monthly Premium** for Aggregate Stop Loss | | |
| On a per employee basis *or* | | |
| On a per covered life basis | | |

## ***Prescription Drug Coverage***

**4. Does your prescription plan utilize a formulary? If no, skip to question 8.**

**Definitions:**
**Formulary** - a list of drugs selected by a health plan identified as safe, effective and lower cost than non-formulary drugs.
**Open Formulary** – coverage provided for all drugs
**Closed Formulary** – non-formulary drugs are not covered by the health plan

☐ Yes
☐ No

**5. If your health plan uses a formulary, is it an open formulary or a closed formulary?**

☐ Open
☐ Closed

**6. Does you prescription drug program include a mail order plan? If no, skip to question 8.**

☐ Yes, mail order in addition to retail
☐ Yes, mail order only
☐ No mail order plan

**7. If mail order plan is offered, is it mandatory for maintenance (long term) prescriptions?**

☐ Yes, mandatory for maintenance prescriptions
☐ No

## *Mental Health and Substance Abuse Care*

**8. Do you have a stand alone or carved-out mental health plan (not an Employee Assistance Program)? (that is, a mental health plan in which mental health services are covered under a separate contract by a specialty vendor instead of under regular medical covered services)**

☐ Yes, inpatient only
☐ Yes, outpatient only
☐ Yes, both
☐ Yes, other -
☐ Not a carved-out benefit

## *Case Management*

**Catastrophic case management** involves active management of medical services for very ill persons with the objective of facilitating hospital discharge, thus enabling patients to receive lower cost care in an extended care facility or home health care program.

**Disease management** attempts to minimize the costs associated with conditions such as asthma, diabetes, hypertension, and high risk pregnancies to name a few.

**9. Does your school district sponsor a case management program for your health plan?**

☐ Yes
☐ No **If no, please skip to question 12.**

**10. Does your organization's case management program include:**

| | Yes | No |
|---|---|---|
| Large Case Management | ☐ | ☐ |
| Psychiatric Care Management | ☐ | ☐ |
| Specific Disease Management | ☐ | ☐ |

**11. Who administers your case management programs? (Check all that apply)**

☐ Insurance company
☐ Third-party administrator
☐ Self-administered
☐ Other, Please Specify

## ***General Questions about Self-insuring***

12. Approximately what year did the district begin self-insuring? _____
13. Why did the district choose to self-insure? (Check all that apply)

- ☐ We expected to save money because of our workforce characteristics
- ☐ We wanted to control the plan design locally
- ☐ It was important for philosophical/historical reasons
- ☐ It was important for political reasons

Please explain your answer

_____

_____

14. Do you intend to continue self-insuring?

- ☐ Yes
- ☐ No

Why or why not?

- ☐ Self-insurance saves us money
- ☐ Self-insurance allows us to retain certain plan features.
- ☐ Right now, an insured program would be less expensive
- ☐ We can no longer support the risk of loss associated with self-insurance

**Please Send Completed Your Survey Addendum to:**

By email: Tova.Labell@haygroup.com
By fax: (703) 841-3108
Or by mail to:

Tova Labell
Hay Group, Inc.
4301 N. Fairfax Drive, Suite 600
Arlington, VA 22203

**Surveys are due October 22, 2010**

K-12 DISTRICTS RESPONDING TO SAO/HAY SURVEY
(A legend describing the table headings appears at the end of the table)

| District | FTE's | Res FTE's | Urban | Rural | West | East | PEBB Res |
|---|---|---|---|---|---|---|---|
| Seattle | 4914.31 | 4914.31 | 1 | 0 | 1 | 0 | 0 |
| Tacoma | 3144.15 | 3144.15 | 1 | 0 | 1 | 0 | 0 |
| Spokane | 3087.10 | 3087.10 | 1 | 0 | 0 | 1 | 0 |
| Kent | 2592.42 | 2592.42 | 1 | 0 | 1 | 0 | 0 |
| Vancouver | 2260.02 | 2260.02 | 1 | 0 | 1 | 0 | 0 |
| | | | | | | | |
| Federal Way | 2206.69 | 2206.69 | 1 | 0 | 1 | 0 | 0 |
| Lake Washington | 2194.50 | 2194.50 | 1 | 0 | 1 | 0 | 0 |
| Puyallup | 1968.26 | 1968.26 | 1 | 0 | 1 | 0 | 0 |
| Edmonds | 1924.59 | 1924.59 | 1 | 0 | 1 | 0 | 0 |
| Highline | 1817.94 | 1817.94 | 1 | 0 | 1 | 0 | 0 |
| | | | | | | | |
| Northshore | 1770.34 | 1770.34 | 1 | 0 | 1 | 0 | 0 |
| Bethel | 1729.07 | 1729.07 | 1 | 0 | 1 | 0 | 0 |
| Everett | 1712.85 | 1712.85 | 1 | 0 | 1 | 0 | 0 |
| Bellevue | 1705.17 | 1705.17 | 1 | 0 | 1 | 0 | 1 |
| Issaquah | 1496.49 | 1496.49 | 1 | 0 | 1 | 0 | 0 |
| | | | | | | | |
| Kennewick | 1483.52 | 1483.52 | 1 | 0 | 0 | 1 | 0 |
| Pasco | 1405.88 | 1405.88 | 0 | 1 | 0 | 1 | 0 |
| Auburn | 1394.56 | 1394.56 | 1 | 0 | 1 | 0 | 0 |
| Renton | 1393.41 | 1393.41 | 1 | 0 | 1 | 0 | 0 |
| North Thurston | 1358.70 | 1358.70 | 1 | 0 | 1 | 0 | 0 |
| | | | | | | | |
| Clover Park | 1310.08 | 1310.08 | 1 | 0 | 1 | 0 | 0 |
| Mukilteo | 1302.87 | 1302.87 | 1 | 0 | 1 | 0 | 0 |
| Central Valley | 1264.11 | 1264.11 | 1 | 0 | 0 | 1 | 0 |
| Central Kitsap | 1255.89 | 1255.89 | 1 | 0 | 1 | 0 | 0 |
| Battle Ground | 1175.24 | 1175.24 | 1 | 0 | 1 | 0 | 0 |
| | | | | | | | |
| Marysville | 1081.20 | 1081.20 | 1 | 0 | 1 | 0 | 0 |
| Richland | 1011.55 | 1011.55 | 1 | 0 | 0 | 1 | 0 |
| Bellingham | 1002.67 | 1002.67 | 0 | 1 | 1 | 0 | 0 |
| Snohomish | 841.79 | 841.79 | 1 | 0 | 1 | 0 | 0 |
| Sumner | 815.96 | 815.96 | 1 | 0 | 1 | 0 | 0 |
| | | | | | | | |
| Franklin Pierce | 768.07 | 768.07 | 1 | 0 | 1 | 0 | 0 |
| North Kitsap | 686.43 | 686.43 | 1 | 0 | 1 | 0 | 0 |
| Lake Stevens | 683.35 | 683.35 | 1 | 0 | 1 | 0 | 0 |
| Walla Walla | 646.62 | 646.62 | 0 | 1 | 0 | 1 | 0 |
| Tumwater | 635.27 | 635.27 | 1 | 0 | 1 | 0 | 0 |

| District | FTE's | Res FTE's | Urban | Rural | West | East | PEBB Res |
|---|---|---|---|---|---|---|---|
| Oak Harbor | 535.88 | 535.88 | 1 | 0 | 1 | 0 | 0 |
| Eastmont | 509.97 | 509.97 | 0 | 1 | 0 | 1 | 0 |
| Bremerton | 508.19 | 508.19 | 1 | 0 | 1 | 0 | 0 |
| University Place | 508.11 | 508.11 | 1 | 0 | 1 | 0 | 0 |
| Shelton | 463.49 | 463.49 | 0 | 1 | 1 | 0 | 0 |
| Enumclaw | 446.06 | 446.06 | 1 | 0 | 1 | 0 | 0 |
| Sedro Woolley | 423.85 | 423.85 | 0 | 1 | 1 | 0 | 1 |
| ESD 112 | 416.03 | 416.03 | 1 | 0 | 1 | 0 | 0 |
| White River | 383.30 | 383.30 | 1 | 0 | 1 | 0 | 0 |
| Aberdeen | 381.01 | 381.01 | 0 | 1 | 1 | 0 | 0 |
| Wapato | 363.94 | 363.94 | 0 | 1 | 0 | 1 | 0 |
| Othello | 353.44 | 353.44 | 0 | 1 | 0 | 1 | 0 |
| Grandview | 337.69 | 337.69 | 0 | 1 | 0 | 1 | 0 |
| Steilacoom Hist. | 308.79 | 308.79 | 1 | 0 | 1 | 0 | 0 |
| ESD 121 | 304.58 | 304.58 | 1 | 0 | 1 | 0 | 0 |
| Riverview | 303.60 | 303.60 | 1 | 0 | 1 | 0 | 0 |
| Quincy | 288.94 | 288.94 | 0 | 1 | 0 | 1 | 1 |
| ESD 113 | 283.36 | 283.36 | 1 | 0 | 1 | 0 | 1 |
| Tukwila | 269.54 | 269.54 | 1 | 0 | 1 | 0 | 0 |
| Lynden | 258.90 | 258.90 | 0 | 1 | 1 | 0 | 0 |
| Anacortes | 252.25 | 252.25 | 0 | 1 | 1 | 0 | 1 |
| Deer Park | 250.24 | 250.24 | 1 | 0 | 0 | 1 | 0 |
| Lakewood | 239.33 | 239.33 | 1 | 0 | 1 | 0 | 0 |
| North Mason | 229.29 | 229.29 | 0 | 1 | 1 | 0 | 0 |
| Ephrata | 221.30 | 221.30 | 0 | 1 | 0 | 1 | 1 |
| Blaine | 219.00 | 219.00 | 0 | 1 | 1 | 0 | 0 |
| Rochester | 217.98 | 217.98 | 1 | 0 | 1 | 0 | 0 |
| North Franklin | 217.38 | 217.38 | 0 | 1 | 0 | 1 | 0 |
| Pullman | 213.79 | 213.79 | 0 | 1 | 0 | 1 | 0 |
| Medical Lake | 207.22 | 207.22 | 1 | 0 | 0 | 1 | 0 |
| Orting | 201.72 | 201.72 | 1 | 0 | 1 | 0 | 0 |
| Eatonville | 200.75 | 200.75 | 1 | 0 | 1 | 0 | 0 |
| Nooksack Valley | 188.93 | 188.93 | 0 | 1 | 1 | 0 | 0 |
| South Whidbey | 173.82 | 173.82 | 1 | 0 | 1 | 0 | 0 |
| Riverside | 171.17 | 171.17 | 1 | 0 | 0 | 1 | 0 |
| Nine Mile Falls | 158.51 | 158.51 | 1 | 0 | 0 | 1 | 0 |
| ESD 189 | 148.05 | 148.05 | 0 | 1 | 1 | 0 | 1 |
| Ridgefield | 148.03 | 148.03 | 1 | 0 | 1 | 0 | 0 |

| District | FTE's | Res FTE's | Urban | Rural | West | East | PEBB Res |
|---|---|---|---|---|---|---|---|
| Vashon Island | 144.89 | 144.89 | 1 | 0 | 1 | 0 | 0 |
| ESD 114 | 141.14 | 141.14 | 1 | 0 | 1 | 0 | 0 |
| | | | | | | | |
| Castle Rock | 140.67 | 140.67 | 0 | 1 | 1 | 0 | 0 |
| Tenino | 132.47 | 132.47 | 1 | 0 | 1 | 0 | 0 |
| Okanogan | 122.37 | 122.37 | 0 | 1 | 0 | 1 | 1 |
| ESD 101 | 120.26 | 120.26 | 1 | 0 | 0 | 1 | 1 |
| Chimacum | 117.36 | 117.36 | 0 | 1 | 1 | 0 | 1 |
| | | | | | | | |
| Tonasket | 114.35 | 114.35 | 0 | 1 | 0 | 1 | 0 |
| Goldendale | 113.83 | 113.83 | 0 | 1 | 0 | 1 | 0 |
| Warden | 108.04 | 108.04 | 0 | 1 | 0 | 1 | 1 |
| Brewster | 105.56 | 105.56 | 0 | 1 | 0 | 1 | 0 |
| Chewelah | 99.71 | 99.71 | 0 | 1 | 0 | 1 | 0 |
| | | | | | | | |
| Coupeville | 94.03 | 94.03 | 1 | 0 | 1 | 0 | 0 |
| Freeman | 91.70 | 91.70 | 1 | 0 | 0 | 1 | 0 |
| Onalaska | 85.45 | 85.45 | 0 | 1 | 1 | 0 | 0 |
| ESD 171 | 83.75 | 83.75 | 0 | 1 | 0 | 1 | 1 |
| Concrete | 80.89 | 80.89 | 0 | 1 | 1 | 0 | 0 |
| | | | | | | | |
| North Beach | 77.56 | 77.56 | 0 | 1 | 1 | 0 | 0 |
| Kalama | 74.62 | 74.62 | 0 | 1 | 1 | 0 | 0 |
| Raymond | 71.87 | 71.87 | 0 | 1 | 1 | 0 | 0 |
| Napavine | 71.14 | 71.14 | 0 | 1 | 1 | 0 | 0 |
| Asotin-Anatone | 69.43 | 69.43 | 0 | 1 | 0 | 1 | 1 |
| | | | | | | | |
| Mossyrock | 67.29 | 67.29 | 0 | 1 | 1 | 0 | 0 |
| Toutle Lake | 65.99 | 65.99 | 0 | 1 | 1 | 0 | 0 |
| Griffin | 64.37 | 64.37 | 1 | 0 | 1 | 0 | 0 |
| Soap Lake | 57.25 | 57.25 | 0 | 1 | 0 | 1 | 0 |
| White Pass | 54.37 | 54.37 | 0 | 1 | 1 | 0 | 0 |
| | | | | | | | |
| Dayton | 52.75 | 52.75 | 0 | 1 | 0 | 1 | 0 |
| Adna | 52.14 | 52.14 | 0 | 1 | 1 | 0 | 0 |
| Willapa Valley | 47.20 | 47.20 | 0 | 1 | 1 | 0 | 0 |
| Naselle Grays Riv | 44.29 | 44.29 | 0 | 1 | 1 | 0 | 0 |
| Conway | 43.62 | 43.62 | 0 | 1 | 1 | 0 | 0 |
| | | | | | | | |
| Entiat | 41.78 | 41.78 | 0 | 1 | 0 | 1 | 1 |
| Cusick | 41.48 | 41.48 | 0 | 1 | 0 | 1 | 1 |
| Oakville | 35.47 | 35.47 | 0 | 1 | 1 | 0 | 0 |
| Wilbur | 35.02 | 35.02 | 0 | 1 | 0 | 1 | 1 |
| Odessa | 33.19 | 33.19 | 0 | 1 | 0 | 1 | 1 |
| | | | | | | | |
| Crescent | 32.60 | 32.60 | 0 | 1 | 1 | 0 | 0 |

| District | FTE's | Res FTE's | Urban | Rural | West | East | PEBB Res |
|---|---|---|---|---|---|---|---|
| Orondo | 30.34 | 30.34 | 0 | 1 | 0 | 1 | 0 |
| Coulee/Hartline | 28.69 | 28.69 | 0 | 1 | 0 | 1 | 1 |
| Lacrosse Joint | 25.72 | 25.72 | 0 | 1 | 0 | 1 | 1 |
| Oakesdale | 24.04 | 24.04 | 0 | 1 | 0 | 1 | 1 |
| | | | | | | | |
| Klickitat | 21.65 | 21.65 | 0 | 1 | 0 | 1 | 0 |
| Mansfield | 21.07 | 21.07 | 0 | 1 | 0 | 1 | 1 |
| Almira | 20.13 | 20.13 | 0 | 1 | 0 | 1 | 1 |
| Wishram | 19.35 | 19.35 | 0 | 1 | 0 | 1 | 0 |
| Paterson | 15.99 | 15.99 | 1 | 0 | 0 | 1 | 0 |
| | | | | | | | |
| Boistfort | 11.88 | 11.88 | 0 | 1 | 1 | 0 | 0 |
| Keller | 9.58 | 9.58 | 0 | 1 | 0 | 1 | 0 |
| Orchard Prairie | 7.70 | 7.70 | 1 | 0 | 0 | 1 | 1 |
| Steptoe | 7.19 | 7.19 | 0 | 1 | 0 | 1 | 1 |
| Great Northern | 5.35 | 5.35 | 1 | 0 | 0 | 1 | 0 |
| | | | | | | | |
| Star | 5.04 | 5.04 | 0 | 1 | 0 | 1 | 0 |
| Evaline | 4.67 | 4.67 | 0 | 1 | 1 | 0 | 0 |
| Evergreen (Stev) | 4.24 | 4.24 | 0 | 1 | 0 | 1 | 0 |
| Benge | 3.44 | 3.44 | 0 | 1 | 0 | 1 | 0 |
| | | | | | | | |
| **TOTALS** | | **70644.52** | **63** | **66** | **79** | **50** | **24** |
| **PERCENT OF RESPONDERS (129)** | | | **48.84%** | **51.16%** | **61.24%** | **38.76%** | |

**Legend for Table Headings**

**FTE's** – Full-time equivalent employees. FTE measures the amount of time an employee works: full-time is 1.0, half-time is 0.5, etc.

**Res** – Responding districts, or responders.

**Urban/Rural** – Is based on the county where the district is located; urban counties defined as having a population density greater than the state average of 101.18 persons per square mile in 2010. The following 9 counties would be considered urban: Benton (101.52); Clark (693.39); Island (389.09); King (909.39); Kitsap (627.06); Pierce (485.19); Snohomish (340.39); Spokane (266.67); Thurston (347.17). All other districts have fewer than 100 persons per square mile and should be considered rural. This is consistent with the definition used in certain Washington legislation; see http://www.ofm.wa.gov/pop/popden/rural.asp .

**West/East** – Is based on the county where the district is located, based roughly on a north-south line running along the Cascade Mountains.

**PEBB** – Responses were received from 24 of the 52 districts (46%) with one or more bargaining units participating in PEBB.

# Appendix B

# Administrative Practices Survey

# &

# Summary of Responses

| Operational Area | PEBB | PREMERA | GROUP HEALTH |
|---|---|---|---|
| **Contract negotiations** | | | |
| Do you have a "most favored nation" price guarantee? If so, what is the smallest size plan that would be eligible for the guarantee? | No | Premera does not employ any contract terms that prohibit a contracting party from offering another party a lower price than Premera's. | The only plan that currently has such a provision is the Federal Employee Health Plan. They have close to 50,000 members. They audit two accounts of similar product, financing arrangement and size each year. |
| For your pharmacy program, please describe your approach for maximizing the savings through negotiation of discounts, rebates, etc. | Our contract contains a guaranteed maximum discount off of AWP. The contractor is at risk for costs above the guarantee. Our contract is a "pass-through" contract so the Plan keeps 100% of benefits if costs are below guarantee. Rebates are negotiated by contractor as well. We require contractor to negotiate rebates specific to our plan whenever possible, we also keep 100% of rebates, manufacturer admin fees etc. | Premera approaches the goal of managing pharmacy cost trends by maintaining a strong pharmacy network, promoting appropriate utilization of medications, and providing actionable information for consumers. Pharmacy savings are maximized through the maintenance and utilization of the extensive pharmacy network available to enrollees. The pharmacy network is provided in partnership with their pharmacy benefit manager, Medco Health Solutions (Medco) and is designed for clients, such as WEA, who require a wide range of pharmacy choice while maintaining competitive discounts. In order to maximize discounts, network pharmacies must accept "lesser of" pricing – the lower of usual and customary, MAC, or network reimbursement rate.<br><br>Formulary compliance can have an impact on maximizing rebates. Network pharmacies support the formulary program by informing enrollees when a non-preferred brand drug has been prescribed; pharmacies use best efforts to contact the prescribing physician to educate them that a non-preferred brand has been prescribed and see if either a generic or preferred brand could be dispensed instead. Premera partners with Medco to deliver | Group Health receives rebates from manufactures based on formulary status and utilization of some pharmaceuticals applicable in both Group Health's Group Model delivery system and Netwrok Model delivery system. These rebates are received between 4 months and 18 months after an applicable medication is dispensed. Rebates are considered in determining Group Health's pharmaceutical expenses and resulting premium trends and development |

| Operational Area | PEBB | PREMERA | GROUP HEALTH |
|---|---|---|---|
| | | pharmacy benefits. In addition, they develop and administer their own formulary. A best-practice model is used that incorporates clinical evidence, pharmaceutical outcomes and cost-effectiveness analysis (when available) to promote preferred drugs that offer value and support member health.<br>WEA receives 100% of Premera's guaranteed rebate amount per brand prescription from Medco. The rebate amount is based on WEA's actual member pharmacy utilization and applied as a credit to claims in the annual accounting for each contract period.<br>**Pharmacy and Therapeutic Committee**<br>Premera's Pharmacy and Therapeutic (P&T) Committee meets six times per year to weigh evidence as presented by our clinical pharmacy staff. It consists of seven physicians, three pharmacists and one lay member from the community. All physicians, and all but one pharmacist, actively see patients on at least a part-time basis. They are professional opinion leaders and several are faculty at the University of Washington. As members of the P&T Committee resign, they are replaced with specialists who are not only familiar with traditional medicines, but who also bring a strong knowledge of new biotech drugs. While Premera pharmacists prepare and participate in P&T meetings, no Premera employee has voting power. The Committee has final authority to determine which drugs will be preferred.<br><br>This method of formulary development provides a high degree of transparency since medications are evaluated and selected through a process outside of typical corporate structure. | |

| Operational Area | PEBB | PREMERA | GROUP HEALTH |
|---|---|---|---|
| **Benefit carve-outs** | | | |
| Are any of the coverages "carved-out" and managed by a specialty organization? (e.g. behavioral health, durable medical equipment) | Yes | No. | No |
| If, yes, please list which coverages | Prescription Drug retail and mail order coverage is carved out and managed by separate Pharmacy Third Party Administrators. | N/A | N/A |
| If yes, how often are the carved-out benefits bid to ensure competitiveness? | The pharmacy benefit is re-bid every 5-7 years. | N/A | N/A |
| **Eligibility management** | | | |
| How frequently are eligibility updates sent to carriers? | Daily | Participating school districts send applications and terminations throughout the month and updates are made to Premera's system daily. Weekly updates are sent to Washington Dental Service (WDS) for WEA's dental plan and VSP, the administrator for four of the vision plans. | At least monthly |
| What arrangements are in place to confirm eligibility for spouses and dependents? | In 2010, PEBB did a Dependent Verification project in which all enrollees were required to verify their dependents' eligibility for coverage. From 2010 onward, enrollees are required to verify new dependents' eligibility prior to enrollment. | As the entity with the most accurate information, the districts have responsibility for doing the initial review of specific eligibility parameters, and for following bargaining agreements within their districts.<br>Premera checks each application it receives for any differences in a name, address and dependent information (i.e., date of birth, newly adopted dependents which require certification | Spouse and dependent eligibility audit is the responsibility of the employer. |

| Operational Area | PEBB | PREMERA | GROUP HEALTH |
|---|---|---|---|
| | PEBB also has a data sharing agreement with Vital Statistics for verifying marriages and marriage dissolutions. | and legal review and approval, etc.).<br><br>If there is a difference from what appears in the system, the district is contacted. If there is a concern about the information that has been received, the billing department forwards the issue to the WEA Service team. They conduct additional research and the outcome is documented.<br><br>Premera sends notification of termination to overage dependents 90 days prior to the 26th birthday. The overage dependent eligibility is terminated at the end of the month in which the 26th birthday occurs.<br><br>Requests for overage disabled dependent certification is reviewed and approved (or denied) through Premera Care Management. Certifications are either temporary or permanent, depending on the specific situation. | |
| **Coordination of benefits** | | | |
| Please describe your coordination of benefits management processes (subrogation, Workers Comp, Medicare Secondary payer, other plans, etc). | Effective 1/1/2011 UMP will administer non-duplication of benefits for its non-Medicare product and Standard COB for its Medicare product. | The coordination of benefits process for WEA Select Medical Plan is as follows:<br><br>• Upon receipt of Other Health Insurance information (OHI), the membership file is updated<br><br>• Premera uses a subsidiary called Calypso that provides custom tools and services to detect, recover and prevent claims overpayments, including subrogation. The following month after receipt of OHI Calypso generates a report which identifies enrollees where PBC coverage is now secondary<br><br>• All claims are reviewed for potential overpayments | For quicker processing of claims, Group Health Cooperative expects its providers to determine primary/secondary coverage and bill accordingly with the information/EOB from the primary carrier attached or data indicated on the claim form per community standard practice. GHC reimburses providers according to their contracted terms rather than their billed charges. Claims Administration COB staff contact the other plan to verify primary/secondary status prior to entering COB information into our system. This assures we have the most current information for our members. |

| Operational Area | PEBB | PREMERA | GROUP HEALTH |
|---|---|---|---|
| | | • Overpayment requests are sent to payees<br><br>An overview of the processes for subrogation and Worker's Compensation cases are as follows:<br><br>• Premera Operations identifies subrogation-related claims. This is based on accident-related diagnosis codes and/or whether the claim was billed with accident/worker's compensation indicators to determine if an incident questionnaire should be sent. Once a questionnaire is returned, the items are sent to Calypso. The questionnaire is reviewed to determine if subrogation/worker's compensation applies.<br><br>The claims and eligibility system is updated accordingly.<br><br>For Medicare, Premera conducts a monthly eligibility exchange with Medicare to determine who is eligible for that coverage. Reports are generated to update Premera's files with the correct order of liability. Otherwise, claims that are received with Medicare information are investigated if that information has not already been loaded. | With respect to the administration of COB, we follow the Insurance Commissioner Office WAC regulations for COB in the state of Washington to determine whether other benefits are payable.<br><br>Procedures are in place to have other insurance investigation occur anytime there is an indication of a change in status with the other carrier. |
| Please describe the level of savings achieved in recent years. | Non-Duplication of Benefits 2011 Savings Projection: $1 - $3M | For the WEA Select Medical Plans, the level of savings from other sources (Amounts From Other Sources[AFOS] such as Coordination of Benefits) are:<br><br>• CY 2009: $8.8M or $6.42 PMPM<br>• CY 2008: $8.7M or $6.34 PMPM<br>• CY 2007: $7.9M or $5.90 PMPM | |
| **Case management** | | | |
| Please describe your case management | Case management is administered for enrollees | The WEA Select Medical Plan includes | Group Health offers case management services to members who experience a |

| Operational Area | PEBB | PREMERA | GROUP HEALTH |
|---|---|---|---|
| programs. What triggers a claim or member for large case management involvement? | with serious, complex, or difficult health care. The member works with a nurse case manager who assists the member in finding health care providers and services appropriate for their treatment. When preauthorization is requested for a condition that may benefit from case management services or the plan receives a claim for services indicating complex health needs, the Third Party Administrator's case management staff contacts the member to discuss options. | numerous care/case management programs through Premera Blue Cross, as well as several other cost management programs. A brief description of each of these programs is noted below:<br><br>The purpose of the Care Management Program is to provide the right health management services at the right time and in the right combination to assure timely medical intervention and facilitate access to appropriate clinical care.<br><br>Care Management has a comprehensive suite of programs that help enrollees take a more active role in managing their overall health and to assist physicians in providing the highest quality care. To facilitate patient-provider healthcare decisions, Care Management acts as a resource to support those decisions with information and data. Patients are assisted with catastrophic/chronic diseases and injuries across the continuum of their healthcare needs. These range from outpatient or inpatient utilization review to medical case management, behavioral health management and NurseLine telephonic advice.<br><br>**Clinical Review**<br><br>Whenever an enrollee needs hospitalization, surgery, complex medical procedures or supplies, the WEA plan encourages the enrollee's doctor or hospital to contact the plan first.<br><br>Each request triggers a review by care management staff to verify benefits and eligibility on selected procedures. There is a potential for medical necessity review as needed per clinical edit. Through this clinical review, coverage can | critical event or diagnosis requiring timely coordination of care and services. This includes members with complex medical needs. Case Management that is provided during an episode of care is referred to as Episodic Case Management. Patients who require coordination between settings of care and enhanced care plan coordination are provided Complex Case Management. Case managers evaluate the needs of the patient, develop a care management plan with the patient, and document activities to achieve the personal case management plan goals.<br><br>Group Health utilizes several methods to identify candidates for case management.<br><br>Member self-referral<br><br>Physician referral<br><br>Predictive modeling<br><br>Referred by other clinical staff - DM, UM, Discharge planner, Appeals department<br><br>Claims and encounter data<br><br>Pharmacy data<br><br>Hospital discharge data<br><br>Group Health's Case Management |

| Operational Area | PEBB | PREMERA | GROUP HEALTH |
|---|---|---|---|
| | | be confirmed prior to treatment.<br><br>**Benefit Advisory**<br><br>Benefit advisory reviews are usually conducted before a service occurs. The reviewer determines whether a service is medically necessary and that the enrollee has benefits available. If a benefit advisory is not requested in advance, a retrospective clinical review is conducted upon billing to determine medical necessity and to ensure that medical costs are applied to the appropriate benefit.<br><br>**Complex Case Management**<br><br>Premera's case management program is fully-accredited by URAC. The program is further distinguished by the fact that all Case Managers are certified.<br><br>Premera Case Managers help WEA Select enrollees and their provider coordinate the sometimes complex maze of services and processes that patients and families with chronic diseases or traumatic injuries face. The case manager, attending physician and enrollee work together as a team and identify potential hospital needs and facilitate access to those services before the enrollee is admitted to the hospital.<br><br>In the event of a discharge from a hospital stay, the case manager contacts enrollees to identify any post-hospital needs to facilitate recovery and prevent readmission by implementing necessary interventions. On an ongoing basis, case managers oversee all aspects of the care continuum, including care in a skilled nursing facility, ongoing durable medical equipment and home care.<br><br>Case Managers typically work within the Plan's | programs differ from our competitors in that they are provided internally by Group Health staff and are integrated with the overall delivery of care. |

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| | | benefits to provide alternative services that result in cost savings and increased enrollee satisfaction. Case managers work outside benefit structure in cases where an out-of-contract solution results in a better clinical outcome and cost savings to the Plan.<br><br>Management of specialty areas includes organ transplantation, oncology, pediatrics, neonatology, rehabilitation, and catastrophic case management.<br><br>Case management activities are performed on an ongoing basis, conducted by registered nurse case managers, MSWs (professionals with a master's degree in Social Work) and other care management staff whose responsibilities are under the direction of a medical director. Regular census meetings, facilitated by the medical director and team leader, assure that enrollees receiving case management services are appropriately and effectively managed.<br><br>**Identification of Candidates for Case Management**<br><br>1. Enrollees are identified for case management when there is a potentially measurable opportunity to improve the coordination of their care, develop treatment plans and improve quality and efficiency. Premera's case management system identifies enrollees based on risk and clinical indicators. Triggers may include specific computerized trigger diagnoses; length of stay; readmissions; emergency room utilization; claims screening/dollar thresholds; pharmacy data; physician encounter data by diagnosis; physician referral; member referral; health risk appraisal/questionnaire; | |

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| | | and psychosocial indicators.<br><br>Case management provides continual, real-time data updates because it is integrated with the claims system. Rules built into the system are constantly scanning for enrollees who might benefit from case management services.<br><br>The daily inventory of claims is analyzed against a set of customized criteria (i.e., specific diagnoses, claim amounts, inpatient hospital stay, etc.) to identify candidates for case management. The system assigns enrollees an overall risk score, based on medical history, diagnosed conditions, treatments and prescription medications, which helps to identify potential candidates. The system uses case management software which integrates claims analysis capabilities and tools to assist case managers in improving health outcomes. Specifically, it allows review of an enrollee's short-term situation and long-term health trends, to identify and assist with treatment and benefits which will ultimately achieve better outcomes.<br><br>2. For early identification, Premera also uses the Care Compass service, which is an integrated program that proactively identifies and reaches out to enrollees who typically would not fall under the umbrella of case management but would benefit from improved care coordination. This program is specifically designed to increase enrollee engagement in health improvement opportunities, provide support for illness or recovery, and integrate existing services and programs with key areas of focus in | |

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| | | preadmission screening, discharge planning and readmission prevention.<br>3. Additional information sources used to identify potential case management referrals include self-referral, referrals from other departments within Premera such as customer service, and referrals from outside sources such as a family member, physician or vendor partner. Anyone can initiate a referral to our Case Management program by simply filling out a referral form located at www.premera.com, and faxing it to the identified number on the form.<br><br>**Behavioral Health Case Management**<br>The Behavioral Health program focuses on utilization management including inpatient admission and concurrent review of facility based care. Medical necessity review is conducted for selective outpatient care.<br>Comprehensive case management focuses on clinically complex cases and/or high dollar cases.<br>The program includes coordination between behavioral health and clinical nurse case managers when indicated.<br><br>**Other Care Management Programs**<br>**High Risk Obstetrics Program**<br>High risk obstetric enrollees are assisted by Case Managers who have extensive experience with conditions including pre-labor, diabetes, and high blood pressure.<br>Case Managers work collaboratively with | |

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| | | physicians to encourage proactive identification of high risk enrollees and offer them early case management services to help prevent potential complications resulting in additional medical costs.<br><br>**Pediatric Specialty Programs**<br><br>Case managers, who have extensive experience in pediatrics, assist in the case management of these enrollees by assisting in coordinating care with any state or local programs available to parents of children with special needs.<br><br>**Breast and Lung Cancer Specialty Program**<br><br>Dedicated oncology trained nurses assist enrollees and their family to manage their condition by coordinating care among multiple providers. They provide coaching about self-management skills to assist them with their difficult condition and answer questions about health care services. | |
| What aspects of your programs differentiate you from your competitors? | | **Premera Case Management Differentiators:**<br><br>1. **Accreditation** – Premera's Case Management program is fully-accredited by URAC.<br><br>2. **Certifications** – All Premera case managers are required to be certified within two years of their hire date.<br><br>3. **Integration** – Premera's Case Management system is fully integrated with the claims system. This allows for continuous, real-time updates and identification of enrollees with the greatest need for case management | |

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| | | intervention on a daily basis.<br><br>4. **ROI** – Premera's Integrated Health Management return on investment ranges from 2:1 to 8:1 depending on the intervention and measurement period, according to standard methodologies.<br><br>5. **Cost** – Case management savings per episode average $11,300 during the first 90 days (Premera Book of Business through January 2010).<br><br>**Enrollee Experience** – The most recent Premera survey indicated that 95% of enrollees who received case management were satisfied or extremely satisfied with the program (average of 2009 enrollee satisfaction survey results, % of rating at 7+ on scale of 1 – 10). | |
| What alternative care options are available with standard approval, and what options require plan sponsor approval? | Services provided by naturopathic physicians are covered in the same way as or other providers. Limited Acupuncture and Massage Therapy services are covered and do not require Plan Sponsor approval. | Alternative care options are offered via the Case Management program when clinically appropriate and cost-effective. No plan sponsor approval is required. | Under most group plans, coverage is allowed for services provided by alternative care providers for members who meet established clinical review criteria adopted by Group Health and who are in plans for which these benefits apply.<br><br>Clinical Review Criteria vary for each Alternative Care specialty, but the condition must have been present for a given period of time and the pain and functional limitations caused by the condition must have failed to respond to usual medical management (i.e. physical therapy and/or drug management). |

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| **Disease management** | | | |
| Please describe your disease management programs, including the specific diseases and impact conditions that are covered. | UMP is transitioning to a new Third Party Administrator, effective 1/1/2011. Specific disease management programs have not been identified at this time. | Premera's Disease Management program is focused on assisting enrollees with chronic conditions to manage their health by providing education, self-care skills and regular contact with a clinician to provide person-to-person support. The program is designed to treat the "whole person" and not just the identified condition. The program is accredited by URAC (Utilization Review Accreditation Commission), the National Committee for Quality Assurance (NCQA), the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and has been reviewed by Johns Hopkins University Outcomes Verification Program.<br><br>Here is what the program does and how it differs from other programs:<br><br>• Early ID – Participants with diabetes and/or heart disease who may benefit from disease management services are identified in approximately 10 – 14 days, instead of the industry average of 90 – 120 days. This means that enrollees who are newly diagnosed or have been prescribed a new treatment regimen are identified quickly. This positively affects their health status, while reducing or controlling overall healthcare costs.<br><br>• Targeted Follow-up – All program participants receive follow-up care. Clinicians work to improve patient compliance with accepted standards of care, provide education and drive behavior changes that result in better health outcomes and lower healthcare costs. In fact, the program does not assume that an enrollee's health remains | Group Health offers specific programs for patients with Chronic Obstructive Pulmonary Disease (COPD), Asthma, Diabetes, Depression, HIV/AIDS, Coronary Artery Disease (CAD), and Congestive Heart Failure (CHF), and the co-morbid conditions frequently associated with them, including chronic pain, obesity, depression, renal failure, and hypertension.<br><br>Specialized care teams coordinate this care with primary care teams.<br><br>Programs are managed both internally and through vendor partners. |

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| | | constant; participants are consistently re-evaluated in order to provide them with the right level of care and information at the right time.<br>• 100% Annual Depression Screening – The program assesses all participants for depression on an annual basis.<br>The Disease Management program is developed and administered in partnership with Healthways, Inc., one of the nation's largest and most experienced disease management companies with more than 20 years of experience. They are a leading provider of disease management services and manage more than two million lives. Premera has partnered with Healthways for the following reasons:<br>• Use of an "opt-out" engagement model, ensuring maximum participation. Approximately three to four percent of identified disease management candidates opt not to participate. Other programs require potential participants to opt in, which reduces participation.<br>• All participants receive a welcome call, are screened annually for depression and assigned a risk level which ensures the right frequency of intervention to match their particular health status (i.e., the higher the level, the greater frequency of calls from a nurse.)<br>• Integration of the program with Premera's pharmacy partner to analyze pharmacy claims data on a daily basis and identify participants new to a treatment regimen or diagnosis. This fast identification process detects candidates quickly, enabling a nurse | |

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| | | to contact enrollees shortly after the change in regimen or diagnosis, when they are more receptive to coaching.<br>• Premera's disease management program services are managed in the Pacific Northwest (Bellevue, Washington).<br>**Covered Diseases and Impact Conditions**<br>In partnership with Healthways, the disease management program provides services for Diabetes, Congestive Heart Failure and Coronary Artery Disease. Services are based on nationally-recognized, evidence-based guidelines with major objectives as follows:<br>• Improve member health status and outcomes<br>• Enhance patient satisfaction with the overall care experience<br>• Improve physician satisfaction<br>• Reduce total health care costs<br>*Diabetes*<br>• Slow disease progression<br>• Educate employers and enrollees about self-management<br>• Assist in enrollee decision-making<br>• Improve enrollees' quality of life through support and goal setting<br>• Reduce risk of acute exacerbation and death<br>*Congestive Heart Failure/Coronary Artery Disease*<br>• Prevent re-infarction | |

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| | | • Prevent development of heart failure or new episodes of worsening heart failure<br>• Assist in member decision-making<br>• Prevent repeat interventions (angioplasty or heart surgery)<br><br>WEA has participated on Premera's formal disease management program since its inception. After a multi-year evaluation, WEA made the decision to discontinue the program in its current form effective October 1, 2010. All current disease management program participants have been invited to join the health management program outside of its normal qualification period, including health coaching. The health management program does not replace the disease management program; however, participants will have access to important tools and resources to assist them with their chronic disease. WEA will continue to monitor and evaluate Premera's disease management program offering, as well as other programs for potential inclusion in the future. | |
| What metrics are used to determine the return on investment on the disease management program? | N/A | Premera calculates financial savings for the disease management programs as follows:<br><br>**Base Period**<br>1. The measurement period is defined. The first reporting period is typically the first year of program operations.<br>2. On-going during the program year, participants are identified for the program in the same manner used to identify base period enrollees.<br>3. Member months are calculated for non-diseased | Group Health uses HEDIS and non-HEDIS clinical measures to determine the effectiveness of the disease management programs. |

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| | | and diseased enrollees.<br>4. For each member month, total healthcare costs are calculated for non-diseased and diseased enrollees. Total healthcare costs include medical and pharmacy claims.<br>5. The trend adjustment factor is determined. This captures all changes between the base period and the reporting period other than those due to the impact of the Disease Management program.<br>• The total health care costs of all non-diseased enrollees in the base period are calculated and divided by the corresponding member months for those enrollees.<br>• The total health care costs of all non-diseased enrollees in the reporting period are calculated and divided by the corresponding member months for those enrollees.<br>6. These are divided to determine the **Trend Adjustment Factor.**<br>7. Trended base period costs are calculated.<br>• The total health care costs of all diseased enrollees in the base and reporting periods are calculated and divided by the corresponding member months for those enrollees.<br>• The adjustment factor is applied to the diseased member base period costs, which are measured as per disease member per month, or PDMPM. This is the **Trend Adjusted Base Period Cost** for the diseased population.<br>8. The adjusted base period is compared to the reporting period. The difference is the **Gross** | |

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| | | **Savings PDMPM**.<br>9. Any fees paid for the reporting period are subtracted from the Gross Savings. The difference is the **Net Savings PDMPM.**<br>10. Gross Savings are divided by program fees. The result is the **Return on Investment (ROI)**. | |
| **Medical necessity verification** | | | |
| How do you define medical necessity? What resources are used to determine medical necessity? | **Medically Necessary** or **Medical Necessity** means health care services or supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:<br>* In accordance with generally accepted standards of medical practice.<br>* Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.<br>* Not primarily for the convenience of the patient, physician or other health care standards of medical practice.<br>* Clinically appropriate, in | Medical necessity is defined by the group contract:<br>**Medically Necessary** Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:<br>• In accordance with generally accepted standards of medical practice;<br>• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and<br>• Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.<br>For these purposes, "generally accepted standards of medical practice" means standards | Medical necessity is defined in the member contracts. In addition we use a combination of criteria developed by GH and Milliman Care Guidelines to review coverage requests for medical necessity. |

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| | terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.<br>* Not primarily for the convenience of the patient, physician or other health care that patient's illness, injury or disease.<br><br>For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of physicians and other health care providers practicing in relevant clinical areas and any other relevant factors. | that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.<br><br>Resources used to determine medical necessity include review of appropriate medical and scientific literature by plan medical staff, and where necessary, same-specialty review by independent medical review organizations. | |
| How frequently are hospital claims audits conducted? | Hospital Claims Audits are performed on a routine basis by the UMP's Third Party Administrator's Corporate Audit Team & approximately every 5 years by the Washington State Office of Insurance Commissioner. Hospital claim audits are also | Calypso audits both professional and institutional claims on a daily basis.<br><br>• Internal and external overpayment leads come into Calypso. In addition Calypso runs over 250 payment rules and ad-hoc reports to identify any potential violations. | !00% of institutional claims are audited prepayment. In addition to the prepayment audit , institutional claims are also included in the random performance audits that are performed weekly. |

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| | periodically performed by the HCA. | • Calypso also has a Hospital Bill Audit and Hospital Credit Balance Program, which consist of on-site hospital claim and financial review. Criteria are extensive and reviews are conducted monthly. All of Premera's participating hospitals are included. | |
| How frequently are pharmacy claims audited? | Our PBM audits approximately 3% of the pharmacy claims annually. | On behalf of WEA Select and all clients, Premera performs audits of Medco at least once each contract period. These audits ensure the performance of discounts and contracts for all customers, including review of manufacturer agreements with Medco that have a direct impact on manufacturer rebates. | Pharmacy claims are adjudicated by a third party administrator, MedImpact. MedImpact has audits conducted twice yearly by an individual audit firm the reports of which Group Health views . Group Health also monitors MedImpact's performance in a number of ways including internal audit reviewing our processes related to monitoring oversight<br><br>Commercial and Medicare Part D pharmacy claims are audited quarterly by MedImpact<br><br>Group Health's Medicare Part D pharmacy claims are also audited by Burchfield on an annual Basis. |
| Do you have programs for plan members to conduct Explanation of Benefit (EOB) claim reviews? If so, please describe the incentives. | No | Enrollees can call Customer Service if they have questions regarding EOB messages.<br>• In some instances, the issue may be education about why the provider has billed for a service, and the enrollee may be asked to contact the provider's billing staff to resolve it. If this is not resolved to the | |

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| | | enrollee's satisfaction, Provider Relations contacts the provider for clarification and/or resolution.<br>• If it appears that the disputed item on the EOB is considered to be deliberate, the issue will be turned over to the Special Investigations Unit to determine whether a fraud has been perpetrated.<br>In addition, enrollees have access to the appeals process if they don't agree with the decision or information communicated by the EOB. This includes Premera internal appeals, and the WEA Select independent claim appeal process. | |
| **Collections** | | | |
| What resources are used to manage collections of ineligible and unauthorized claims (i.e. how many FTE equivalents are assigned to this role)? | Management of collections of ineligible and unauthorized claims is the responsibility of the PEBB's contracted Third Party Administrators. | The Calypso Recovery team has five Customer Service Representatives and three Recovery Specialists assigned to this role. These representatives are responsible for all Premera recoveries, and are not allocated to any specific line of business. | |
| How does the level of collections compare to the internal staff costs or external charges? | N/A<br>No internal staff dedicated to this effort. | Currently, Calypso's recovery rate is 88% recovery within 120 days of discovery for all of Premera lines of business. | |
| **Other** | | Wellness Programs – The WEA Health Management Program, administered by WebMD, is designed to provide enrollees with tools and resources to assist them in making healthier choices. Participation in the program is voluntary; however, a small financial incentive is offered to encourage participation. The plan just completed its 3rd year, and participation has increased dramatically each year, with thousands of | |

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| | | enrollees taking advantage of this program.<br><br>An annual promotional campaign encourages enrollees to take an online health assessment during the qualification period (February 1 through April 11). Enrollees who might benefit from telephonic coaching are identified at that time.<br><br>In an effort to further engage enrollees in their health, WEA will offer biometric screening as a pilot to a limited number of participating school districts in 2011. | |

In regard to the survey responses which follow, Regence was a later addition to the carriers and programs asked to complete the survey document; although their response arrived after the completion of these materials, we have included their response separately. Like all of the responses shown, the complete unedited response is included in this appendix.

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| **Contract negotiations** | |
| Do you have a "most favored nation" price guarantee? If so, what is the smallest size plan that would be eligible for the guarantee? | No, Regence does not have a "most favored nation" price guarantee. |
| For your pharmacy program, please describe your approach for maximizing the savings through negotiation of discounts, rebates, etc. | RegenceRx offers a very effective rebate program. We contract directly with manufacturers and focus on keeping overall net costs down by promoting generics and lower costs brands. RegenceRx has a demonstrated track record for influencing physician prescribing, medication preferences by members, and market share. Because of this track record, pharmaceutical manufacturers award the best discounts and rebates to RegenceRx.<br><br>With our approach, RegenceRx rebate yields have increased by 25 - 40% compared to the national PBM methodologies, while delivering trends below national averages.<br><br><u>Rebate Return to Client</u><br><br>RegenceRx will return the negotiated contractual amount of the collected rebate to the client depending on the fee schedule chosen. Please see Administrative and Other Fees and Charges section of this RFP.<br><br>The rebate dollars would be based on actual utilization of the client. (The client's rebate dollars would be calculated using the number of tablets, capsules, and other units that the members used of the rebated medications.) Rebate dollars collected are generally credited monthly. However, RegenceRx would be happy to discuss other options.<br><br><u>Efficient Processing</u><br><br>RegenceRx invoices pharmaceutical manufacturers for rebates at the end of each quarter. We receive rebates from most manufacturers within three to five months after the end of the submitted quarter. After receipt of the rebate from the manufacturer, RegenceRx would split out the rebate dollars according to our |

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| | contract with the client.<br><br>Our rebate operations are audited by both our internal audit department, as well as by pharmaceutical manufacturers. These audits have validated that our operations are accurate, thorough, and meet our contractual obligations. Pharmaceutical manufacturers have commended RegenceRx for the accuracy of processing and submitting rebate claims.<br><br><u>Savings</u><br><br>RegenceRx does not guarantee rebates because these guarantees lend to incentives for PBMs to increase utilization and costs. With generic medications costing an average of $19.00 per prescription, while brands cost $105.00 per prescription (plan paid), RegenceRx makes it a priority to promote generic products whenever possible. Rebate guarantees only give incentives to PBMs to promote high cost brands, rather than generics, which results in higher overall costs.<br><br>Additionally, many medications with the highest available rebates are the highest cost brands. Even with the high rebate, the high cost brands end up costing more than a lower cost brand with a modest rebate.<br><br><u>Yields</u><br><br>After focusing on lowest product cost, RegenceRx rebate yields, for commercial business, range from $2.50 to $3.00 per claim (average of all retail and mail order prescriptions), depending on utilization mix. This high return is achieved without higher cost medications on the PML/formulary. We ensure rebates are true savings, not a case where more money is paid to get money back. |
| **Benefit carve-outs** | |
| Are any of the coverages “carved-out” and managed by a specialty organization? (e.g. behavioral health, durable medical equipment) | Our benefit plans are integrated plans that include behavioral health, durable medical equipment and are in full compliance with state and federal requirements. |
| If, yes, please list which coverages | Not applicable. |
| If yes, how often are the carved-out benefits bid to ensure competitiveness? | Not applicable. |

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| **Eligibility management** | |
| How frequently are eligibility updates sent to carriers? | We have the ability to process ANSI 834 files. The frequency of file submission is at the discretion of the group, though most clients choose to send change files either daily or weekly. Our system is set up to run batch files on a daily basis so if you elect to send daily change files, they will be processed upon receipt. Change files automatically update the Regence eligibility system with add, change, or termination events as indicated by the file.<br><br>Regence also accepts periodic audit or reconciliation files. These files do not update our system. We perform a comparison of audit file data to production membership data and provide a discrepancy report to the group. Most clients submit monthly or quarterly audit files.<br><br>If electronic eligibility is desired in a Non-ANSI 834 format, consensus on the format needs to be agreed upon first to ensure automation.<br><br>Regence has the ability to accept eligibility in additional formats such as enrollment application or spread sheet submissions. |
| What arrangements are in place to confirm eligibility for spouses and dependents? | Regence requires notification either by marriage certificate or legal documentation for adopted or legal wards of the Plan participants. |
| **Coordination of benefits** | In compliance with the Patient Protection and Affordable Care Act (PPACA), Regence no longer requires student status confirmation. Dependents may be covered under a Group plan up to the age of 26 regardless of marital or student status. |
| Please describe your coordination of benefits management processes (subrogation, Workers Comp, Medicare Secondary payer, other plans, etc). | |
| Please describe the level of savings achieved in recent years. | Members are required to list any other coverage on their open enrollment application. Information is updated as needed. Each member has an internal coordination of benefits file that lists other insurance information and which coverage is primary. Any spouse's or ex-spouse's coverage is captured on this file for any covered |

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| | members. This information is updated initially from the application form, and then updated as needed. Any conflicting information received on claims also generates a new questionnaire. Benefits are calculated to ensure that our payment of the balance is not more than what we would pay as a prime carrier. Regence applies the standard coordination of benefits rules for all claims consistent with state regulations. Dual coverage information is supplied by the member at time of enrollment and entered into our claims payment system and COB file. Claims are processed on the primary policy and then captured on a daily report for processing on the secondary policy by a claims analyst.<br><br>If there is no other indication of other insurance coverage listed on an application, Regence pays as the primary carrier. However, we do have the capability of changing this process to meet your needs.<br><br>For self-insured groups, either standard coordination of benefit (COB) guidelines or maintenance of benefits (MOB) guidelines can be followed. |
| **Case management** | We do not track the percentage of claims that are subrogated, however, we do track how much we recover in subrogated cases overall:<br>• 0.70% of claims expenses incurred for 2007<br>• 0.96% of claims expenses incurred for 2008<br>• 0.81% of claims expenses incurred for 2009<br>Definition: Subrogation is the contractual right held by health care payors to recover paid medical claims when another party is liable for the injuries of their health plan members. |
| Please describe your case management programs. What triggers a claim or member for large case management involvement? | |
| What aspects of your programs differentiate you from your competitors? | Regence Case Management is an internally administered advocacy program targeting members who are experiencing complex or catastrophic health conditions, as well as those at high risk for future high-cost events. Our case managers provide evidence-based interventions, care coordination and decision support tools aimed at helping members navigate the complex |

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| | health care system and make informed decisions that ensures the delivery of the right care, in the right place, at the right time. The result is the best health outcomes for our members while increasing cost savings for employers.<br><br>Regence uses Impact Pro™ predictive modeling software to identify members at significant risk for future use of services, a key advantage of our program. While these members are not generating high-dollar claims today, behaviors like using multiple providers, obtaining multiple prescription medications and visiting emergency rooms are among a number of indicators of increased risk for future use of services. We also use routine reporting on utilization and incurred expense to identify high-cost cases. Referrals are also used to identify members including self referrals and family, customer service, provider and staff referrals. Current reporting criteria for identification of cases includes:<br><br>• Claims – Allowed amounts over $25,000 or anticipated services and/or cumulative claims (allowable charges) in excess of $100,000 per calendar year<br><br>• Diagnosis – Spinal cord injury; extensive burns; newborns with congenital anomalies, severe respiratory distress or complications of prematurity; newly diagnosed malignant neoplasms; organ transplants or ventricular assist device; ventilator dependency; multiple/severe trauma; end-of-life<br><br>• Overutilization trends – Two or more hospital admits in a three-month period for the same condition<br><br>Regence can also develop special data mining queries based on the employer group's utilization patterns to identify members for case management. |
| What alternative care options are available with standard approval, and what options require plan sponsor approval? | Our alternative benefit policy allows coverage for services or supplies that are not otherwise covered under the member's contract when specific criteria are met. We may approve coverage under a different benefit of the member's contract after case management evaluation and analysis if the member's contract includes an appropriate benefits management provision.<br><br>In order to meet required criteria, the alternative benefit must be:<br><br>• Medically necessary |

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| | • Intended to treat an illness or injury that is life-threatening, significantly impairs or limits bodily function, or causes severe and debilitating pain<br>• A replacement for a covered and available benefit that could be approved as medically necessary based on the member's current clinical condition<br>• Less costly than the coverable benefit being replaced, and the net medical cost savings must be specific and measurable, not theoretical<br>• At least as effective as the benefit being replaced<br>If all of the above criteria are met, the case manager must clearly document how the requested alternative benefit meets the criteria, including a financial analysis of the amount of the expected cost savings, and obtain supervisor and medical director approval for coverage. |
| **Disease management** | |
| Please describe your disease management programs, including the specific diseases and impact conditions that are covered. | Regence Disease Management is designed to improve the quality of life for participants with one or more chronic conditions, increase the participant's ability to self-manage the condition, and reduce the overall financial burden to both The employee group and the participant. Regence Disease Management targets participants with the following conditions:<br>• Diabetes – Associated with an increased risk for many serious and sometimes life-threatening complications.<br>• Asthma – One of the most common diseases in the U.S., asthma is becoming increasingly prevalent in both adults and children.<br>• Chronic obstructive pulmonary disease (COPD) – A chronic lung disease that includes two main illnesses: chronic bronchitis and emphysema.<br>• Congestive heart failure (CHF) – A leading cause of hospitalization in certain age groups.<br>• Coronary artery disease (CAD) – The leading cause of death and premature permanent disability for men and women in the U.S.<br>• Depression – A state of low mood or inactivity impacting an estimated 12 million Americans. |

| Operational Area | REGENCE |
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| | Regence uses a predictive modeling tool to proactively identify members appropriate for disease management intervention. This tool allows us to leverage historical information about a participant's past care to identify immediate and actionable intervention opportunities. We can identify which participants appear to lack the appropriate care for their condition and identify potential health care problems before they occur.<br><br>While members are not outreached directly for chemical dependency and depression due to the associated significant social stigma of targeting those members, our clinical team screens for these conditions with each member encounter. Our behavioral health programs are highly integrated into the medical and pharmacy programs that make up our overall care management model, providing a whole-person approach that views your employees and their families as people, not as conditions or diseases.<br><br>We proactively seek to engage all members who meet program inclusion criteria. This is a key advantage of our program. Participation in the Regence Disease Management programs is voluntary and confidential. Members may notify Regence if they do not wish to participate. Members identified as high risk receive a phone call by a nurse and may also opt in to receive ongoing telephone assistance in managing their condition. |
| What metrics are used to determine the return on investment on the disease management program? | Our programs focus on long-term strategy and condition-specific management. However, we do evaluate defined outcome measures in order to gauge the performance of our programs. These measures include clinical outcomes such as improved drug compliance and adherence to recommended tests, program participation rates, improvement in absenteeism and productivity levels, and member satisfaction with the programs. In addition to the reporting above, a return on investment (ROI) calculation is available for certain groups. |
| **Medical necessity verification** | |
| How do you define medical necessity? What resources are used to determine medical necessity? | Unless the member's contract defines medical necessity otherwise, medical necessity means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating illness, injury, disease or its symptoms, and that are:<br><br>• In accordance with generally accepted |

| Operational Area | REGENCE |
|---|---|
| | standards of medical practice. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.<br>• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and<br>• Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.<br>Regence follows an evidence-based process for determining medical necessity as described above using published medical policy, established guidelines, and research of issues not addressed in medical policy. The final decision on whether a service or supply is medically necessary or a contract benefit rests with a medical director, and may be appealed using the provider appeal process. |
| How frequently are hospital claims audits conducted? | |
| How frequently are pharmacy claims audited? | Regence's hospital auditing department performs reviews prior to service delivery and prior to payment to evaluate all questionable and high-cost claims for proper coding, along with some components related to medical necessity. Regence's multi-disciplinary reimbursement advisory team, which includes physicians (MDs), registered nurses, certified coders and medical analysts, also reviews claims (inpatient hospital, physician and other) for valid coding. Medical necessity determinations are primarily handled through our pre-authorization, notification, concurrent and retrospective review processes designed to ensure coverage of appropriate, medically necessary services, which include review of admissions and/or length of stay, but if these programs haven't reviewed the case, the |

| Operational Area | REGENCE |
|---|---|
| | Payment Review team will review it when the claim comes in.<br><br>In 2009 Regence reported nearly $11.6 million in savings for all post-service activities. Regence can also provide aggregate savings due to care management interventions, such as utilization and case management activities. |
| Do you have programs for plan members to conduct Explanation of Benefit (EOB) claim reviews? If so, please describe the incentives. | RegenceRx uses ACS-Heritage, an independent firm, to audit 100% of our prescription claims provided through network and non-network pharmacies. ACS-Heritage has been in the business of medical claims and database management for over 29 years. Our benchmarking process calculates an array of statistics for each pharmacy. Based on results, further auditing procedures are employed. Pharmacies that fall outside the norm are selected for desk audits or depending upon the issues may be audited on-site. |
| **Collections** | All Regence members have the right to appeal our decisions. When a denial occurs at the preauthorization/care management level, reconsiderations are addressed directly in Medical Affairs. The response time for expedited appeals is 72 hours. |
| What resources are used to manage collections of ineligible and unauthorized claims (i.e. how many FTE equivalents are assigned to this role)? | |
| How does the level of collections compare to the internal staff costs or external charges? | Regence employs approximately 22 full time analysts manage collections. |
| **Other** | We utilize both external and internal resources in the collection process. We are more successful with collections handled by internal staff than external resources. |

# Appendix C

# WEA Submitted Materials

# &

# Hay Group Commentary

# School District Size / Enrollment Statistics

## School Districts by Total Number of Employees[1]

| # of School District Employees | # of Districts | % of Total | # of Districts in Category | % of Total |
|---|---|---|---|---|
| 2,000+ | 15 | 5.1% | 68 | 23% |
| 1,500-1,999 | 11 | 3.7% | | |
| 1,000-1,499 | 12 | 4.1% | | |
| 500-999 | 30 | 10.1% | | |
| 200-499 | 53 | 18.0% | 109 | 37% |
| 100-199 | 56 | 19.0% | | |
| 50-99 | 38 | 12.9% | 118 | 40% |
| Less than 50 | 80 | 27.1% | | |
| Total Districts | 295 | 100.0% | | |

| **NUMBER OF SCHOOL DISTRICTS . . .** | | |
|---|---|---|
| Statewide | **295** | |
| • That **do not** offer any of the WEA Select Medical Plans | **44** | ~15% of 295 |
| • That **offer** the WEA Select Medical Plans – of those: | **251** | ~85% of 295 |
| ▪ Participate on **full rates** | **25** | ~10% of 251 |
| ▪ At least 1 employee group participates on the 10% discount rates | **226** | ~90% of 251 |
| – All employee groups participate on the 10% discount rates | **181** | ~80% of 226 |
| – Offer an *HMO* | **115** | ~51% of 226 |
| ▪ Some but not all employee groups offer the WEA Select Medical Plan | **36** | ~14% of 251 |
| – In which the Administrator and/or Non-Rep employee groups do not offer the WEA plans | **9** | ~4% of 251 |

**Note:** There are 9 ESD and WSIPC Groups that participate in some or all of the WEA Select Medical Plans.

# Number of Participating Groups
# Based Upon Number of Enrolled Subscribers[2]

| # of Enrolled Subscribers | # of Districts | % of Total | # of Districts in Category | % of Total |
|---|---|---|---|---|
| 2,000+ | 3 | 1.2% | 37 | 14.7% |
| 1,500-1,999 | 4 | 1.6% | | |
| 1,000-1,499 | 11 | 4.4% | | |
| 500-999 | 19 | 7.6% | | |
| 200-499 | 45 | 17.9% | 77 | 30.7% |
| 100-199 | 32 | 12.7% | | |
| 50-99 | 42 | 16.7% | 137 | 54.6% |
| Less than 50 | 95 | 37.9% | | |
| Total Participating Districts | 251 | 100.0% | | |

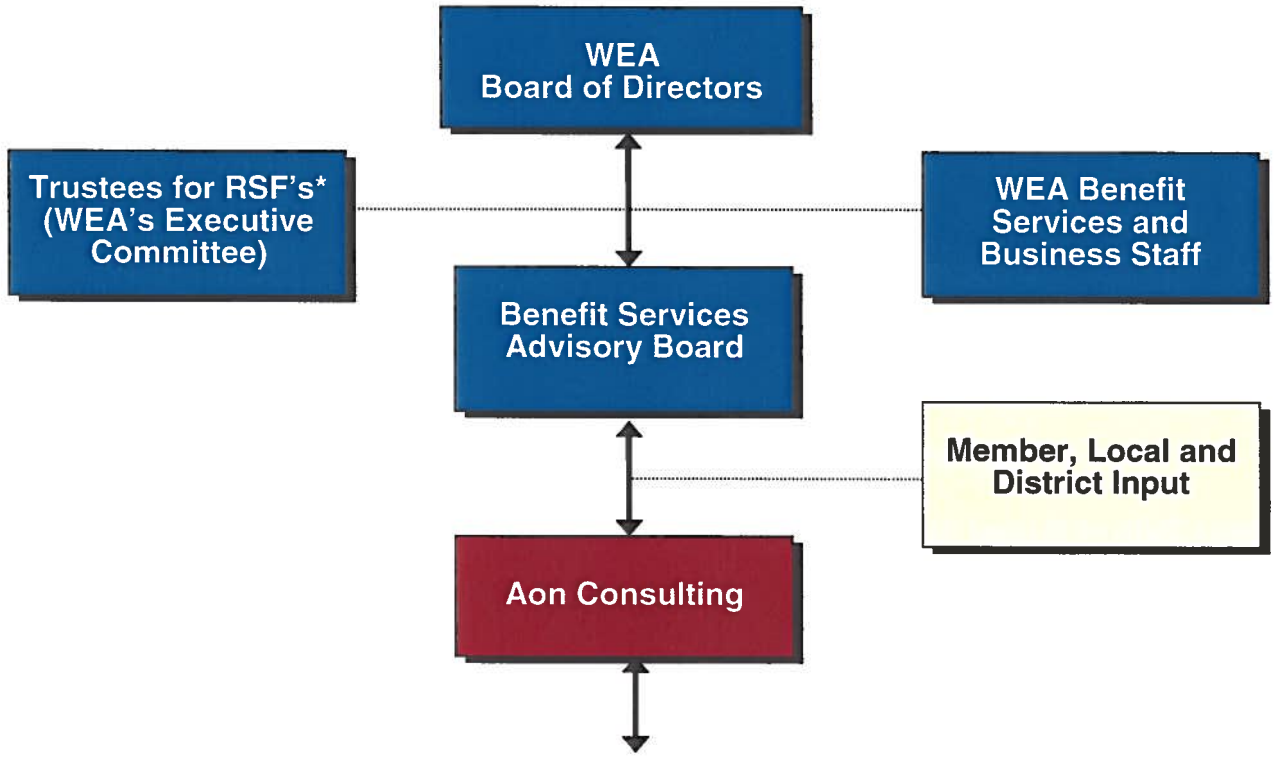
(1) Data based on School District Personnel Summary Reports for the 2009-10 school year; Office of the Superintendent of Public Instruction website.

(2) Data for the WEA Select Medical Plan participation are based on the 2009-10 enrollment numbers.

# WEA Select Plans

## Part I—WEA Decision Tree

**WEA = Policyholder (Benefit & Rate Decision Maker)**




### Experience Rated Plans with RSFs*

| | |
|---|---|
| • Medical | Premera Blue Cross |
| • Core Dental | Washington Dental Service |
| • Vision | Premera Blue Cross and VSP |
| • Voluntary and Group Life | Unum |
| • Voluntary and Group Disability | American Fidelity Assurance Company |

### Other Sponsored Plans

| | |
|---|---|
| • Managed Dental Care | Willamette Dental of Washington, Inc. and Washington Dental Service |
| • Long Term Care | Premera Blue Cross |
| • Accidental Death & Dismemberment | American Fidelity Assurance Company |
| • Employee Assistance Program | OptumHealth Behavioral Solutions |
| • Section 125 Program | American Fidelity Assurance Company |

* RSF = Rate Stabilization Fund

# WEA Select Plans

## Part II—Annual Accounting

This accounting is performed separately for each plan:

| | | | |
|---|---|---|---|
| **Total annual premium for all WEA statewide plan participants:** | | | $_____ |
| **Minus Claims and Expenses** | | | |
| Claims | $_____ | | |
| IBNR Reserve Adjustments* | _____ | | |
| Retention (Expense Factor) | _____ | | |
| State Premium Tax | _____ | | |
| Total Claims & Expenses | | | _____ |
| **Equals Gain or (Loss) for year** | | = | $_____ |

**IBNR = claims that are incurred, but not yet reported.*

### RSF Position

All accountings are maintained on a cumulative basis; i.e., gains and losses for each year are carried forward to a cumulative gain/loss position, as outlined below.

When there is a cumulative gain position, the excess funds are transferred to the WEA Rate Stabilization Fund Trust. The trust is an IRS Filed 501(c) (9) trust, currently invested at US Bank. These funds, by contract, can only be used to benefit plan participants. Examples would be to purchase new benefits, or to help offset future rates.

When there is a cumulative loss, it is reflected as a cumulative deficit carry-forward, and must be offset by future gains prior to any cumulative gain "refunds" to the Rate Stabilization Fund Trust.

| | |
|---|---|
| **Prior RSF Balance** | $_____ |
| **Plus or Minus Plan Year End Gain or (Loss)** | _____ |
| **Equals New RSF Cumulative Position** | $_____ |

# WEA Select Plans

## Part III—Program Structure

### I. Accountability

All WEA Select plans are monitored closely by the WEA's Benefit Services Advisory Board and Board of Directors. The Advisory Board meets throughout the year to evaluate plans, research renewal alternatives, and direct any plan bids that may be in progress. All final rates, benefits, and criteria for plan offerings must be approved each year by the Advisory Board and Board of Directors.

Both the Advisory Board and Board of Directors welcome input from districts, locals and individual members throughout the state regarding suggested benefit enhancements and additional programs to research. In fact, over the years many of the significant benefit changes on both the medical and dental plans have been made following input from districts/locals.

### II. Policyholder/Contract

The contracts for the WEA Select plans are between the Washington Education Association and the chosen vendor. The contract effective date is from October 1 to September 30 of each year. All rates and benefits must be approved each year by the WEA Benefit Services Advisory Board and Board of Directors. Plan renewals are usually finalized by June of each year, and are communicated well in advance of the new school year. Once renewal rates and benefits are approved, they are effective October 1, and guaranteed for 12 months, unless there is a significant change in coverage mandated by state, federal or other legislative body which would impact the program.

### III. Financials

The WEA Select Medical, Dental, Vision, Life and Disability plans are purely experience-rated plans with complete retention accounting, spreading the claims exposure over all covered K-12 employees statewide. Experience is maintained on a freestanding basis for each of these plans.

Year-end gains or losses are carried forward on a cumulative basis, resulting in increased plan stability. If cumulative claims experience is good, a "dividend" would refunded into an account known as the Rate Stabilization Fund Trust through US Bank. WEA's Board Executive Committee, a subset of the full Board, are the designated Trustees for this 501 (c) (9) trust account. This fund can be only used to benefit plan participants by buying improved benefits, or helping to reduce rates in the

future. Conversely, cumulative deficits are also carried forward and must be offset prior to any dividends being available.

Experience information such as premium, claims, retention, etc., is maintained on a statewide basis, and is not tracked or broken down by specific bargaining units or districts. Rather, each local/district has the advantage of blending their experience into a much larger pool of school employees—thereby softening a particular local/district's utilization peaks and valleys. Additionally, the statewide plan is able to access the most cost-effective retention (expense) factor with the insurance company due to the large number of participants sharing fixed expenses.

## IV. Flexibility/Choice

One of the basic foundations, which WEA sought for all their programs, is built-in flexibility for each local/district. Recognizing that the members of different bargaining units within a school district may have different needs, the WEA plans were set up to accommodate those decisions.

Within each school district, a particular bargaining unit can choose their own specific WEA dental/orthodontia, vision, medical, life or LTD plan, regardless of which programs or specific plans are chosen by other locals/employee classifications within the district (subject to proposal underwriting guidelines).

WEA
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# WEA Select Health Benefit Plans
# Context Surrounding WEA's Rate Stabilization Funds

There are ~100,000 K-12 employees in 296 school districts in Washington State. Each year, employee/bargaining groups and school districts have the choice of which type of benefit plans they would like to offer to their employees/members. This includes the PEBB plan, school district sponsored (non-WEA) plans, and the WEA sponsored plan.

Specifically, the WEA Select Medical Plan is offered in 88% of the school districts and currently provides health benefits to ~65,000 covered employees and ~118,000 total plan participants. The dental covers in excess of 80,000 employees and the vision plan covers ~43,000 employees. (Note: WEA also sponsors group disability, life, and some voluntary programs.)

**WEA Select Plan Rates**

The rates for each WEA Select Plan (medical, dental, etc.) are based solely on the claims experience of the participants of that plan. For example, the rates for each medical plan option are based on the claims experience of the entire group of medical plan participants – only. The same holds true for the dental plan, vision plan, etc. The annual process of setting rates is independent and irrespective of state funding.

**Development of the Rate Stabilization Fund**

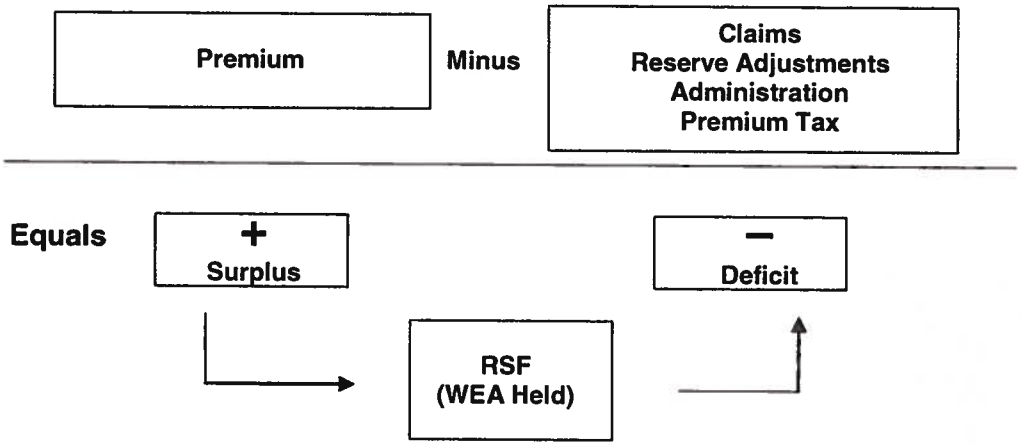
Over 15 years ago, WEA worked with attorneys from McKenzie Rothwell Barlow & Korpi, P.S. (www.mrbklaw.com) to establish IRS regulated 501(c)(9) trust account for each of the WEA plans noted below. A separate Rate Stabilization Fund (RSF) trust account is included with each of these plans. Funds cannot be co-mingled between the trust accounts.

- Medical
- Dental
- Vision
- Group & Voluntary Disability
- Group & Voluntary Life

**Rate Stabilization Fund – Here's How it Works**

At the end of every plan year a separate annual accounting is performed for each of these plans, as follows:

**Annual Year-End Accounting**



All accountings are maintained on a cumulative basis, i.e., gains and losses for each year are carried forward to a cumulative gain/loss position. As illustrated on the previous page, WEA negotiated with each of their endorsed insurance companies to refund to the WEA's RSF Trust 100% of premiums in excess of claims and administrative expenses. And conversely, when there is a year-end loss, funds are transferred to the insurance company to cover the loss.

In the event there is no money in the RSF, and the claims and administrative expenses exceed premium, by contract the insurance company must continue to pay claims, and carry the deficit on their books. Any deficit remains until it can be offset by future gains – prior to any refunds back to the RSF Trust.

**What the Rate Stabilization Fund Can/Cannot Be Used For**

When there is a cumulative gain position, the excess funds are transferred to the WEA RSF Trust, currently held at US Bank. **By contract, these funds can only be used to benefit plan participants — usually through subsidizing premiums, or purchasing additional/enhanced benefits.** These funds can never be used for political action activity. Further, any interest or investment income is reinvested and stays within the trust. The IRS code does allow for the expenses directly related to the plan to be paid out of the RSF. This includes fiduciary premiums and claim appeal expenses. Additionally, the RSF trust accounts are audited annually by the public accounting firm Tremper and Company (tremperco.com).

Information about IRS regulations related to the use of these funds can be found at:
www.irs.gov/pub/irs-tege/eotopics82.pdf.

**Advantage of WEA Financial Provisions**

In many ways the WEA Select Plan's operate as if they are self-insured plans. However, by allowing the plan to carry forward a deficit, the WEA plan includes a feature that is even more advantageous than being self-insured. A self-insured plan would need to make up any deficit between claims and premium immediately, either from a pre-funded reserve account, or a mid-year rate increase.

**WEA's Management & Strategic Goals**

WEA's Board Executive Committee, a subset of the Board, are the trustees for the RSF trust accounts. They work closely with WEA's Chief Financial Officer to oversee the trust accounts, and approve any use of RSF dollars (i.e., approve premium subsidies). WEA's goal is to hold at least a claims margin, which is a "hedge" factor, in the RSF, rather than loading it into the rates. This amount ranges from 3-5% of premium, depending on the plan. Secondarily, their goal is to use any positive RSF balance to lessen needed premium increases over a 2-4 year time frame.

Over the course of the past 15 years, the RSF balances have varied greatly, with the medical RSF having experienced several years in a deficit position. Only over the past few years has there been a positive balance, which is currently being used to mitigate rate increases through premium subsidies. This purposeful and measured approach to plan management has resulted in premium increases on the medical plan of less than 10% in all but one of the past 8 years.

## WEA Select Medical Plan
### 5-Year Rate Change History

| Plan Year | Billed Rate Change | Rate Subsidy | Benefit Changes |
|---|---|---|---|
| **2010-11** | 13.30% | 2.30% | Enhancements |
| **2009-10** | 7.40% | 2.50% | New Plans Offered |
| **2008-09** | 7.25% | 2.50% | Enhancements |
| **2007-08** | 3.60% | 1.09% | Enhancements |
| **2006-07** | 8.37% | - | Enhancements |
| | **5-Year Average** | **7.98%** | |

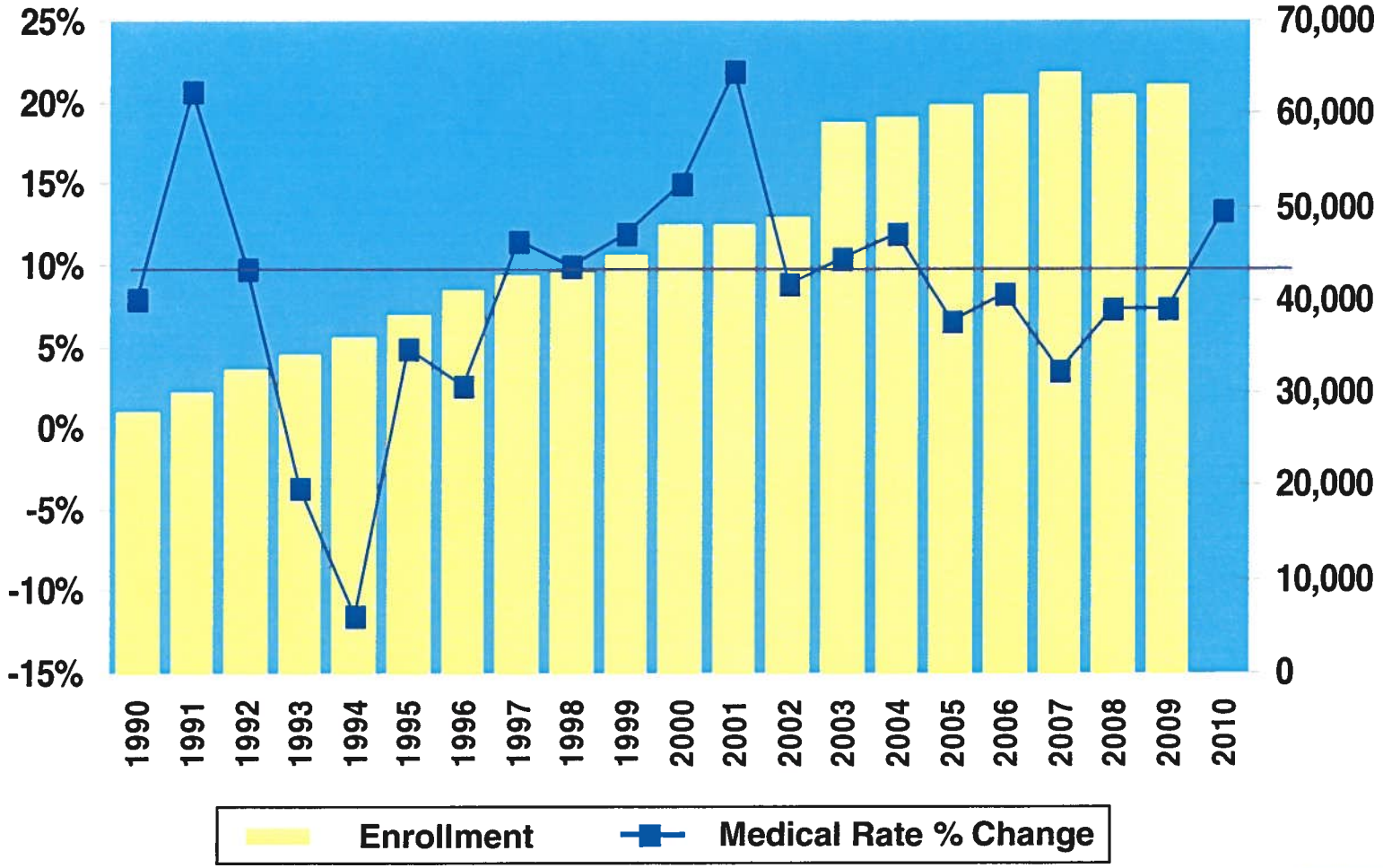
## WEA Select Dental Plan
### 5-Year Rate Change History

| Plan Year | Billed Rate Change | Rate Subsidy | Benefit Changes |
|---|---|---|---|
| **2010-11** | -2.55% | 1.40% | Enhancements |
| **2009-10** | 5.55% | 2.50% | No Change |
| **2008-09** | 0.00% | 2.69% | No Change |
| **2007-08** | 0.00% | 0.00% | Enhancements |
| **2006-07** | 0.00% | 0.00% | No Change |
| | **5-Year Average** | **0.60%** | |

## WEA Select Vision Plan
### 5-Year Rate Change History

| Plan Year | Billed Rate Change | Rate Subsidy | Benefit Changes |
|---|---|---|---|
| **2010-11** | -1.00% | 3.30% | No Change |
| **2009-10** | -7.20% | 0.00% | No Change |
| **2008-09** | 0.00% | 2.30% | No Change |
| **2007-08** | 2.50% | 1.10% | Enhancement |
| **2006-07** | 2.10% | 0.00% | No Change |
| | **5-Year Average** | **-0.72%** | |

# WEA Select Medical Plan
# Billed Rates and Enrollment History

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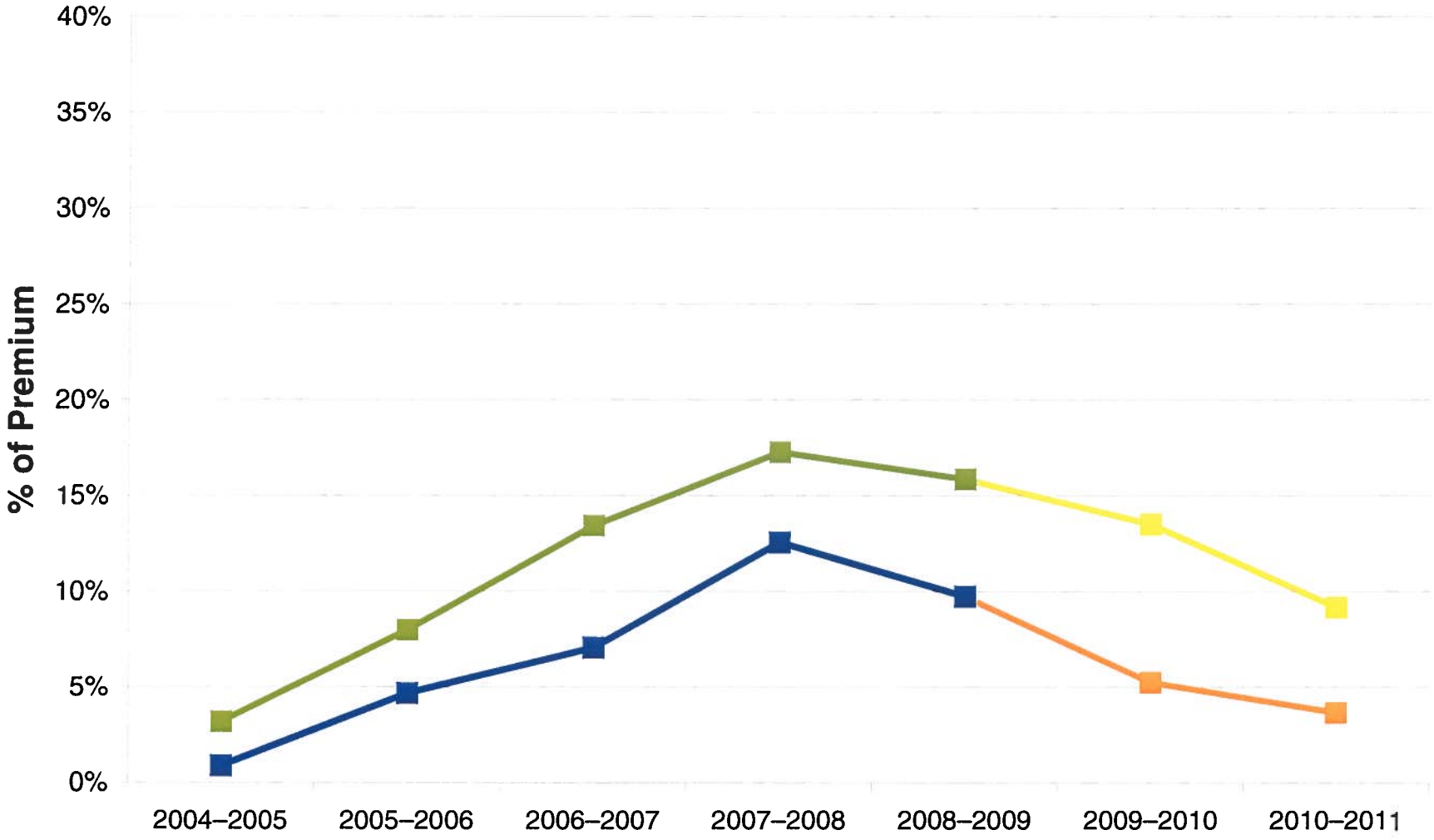
*Confidential Plan Information*



WEA WASHINGTON EDUCATION ASSOCIATION SELECT

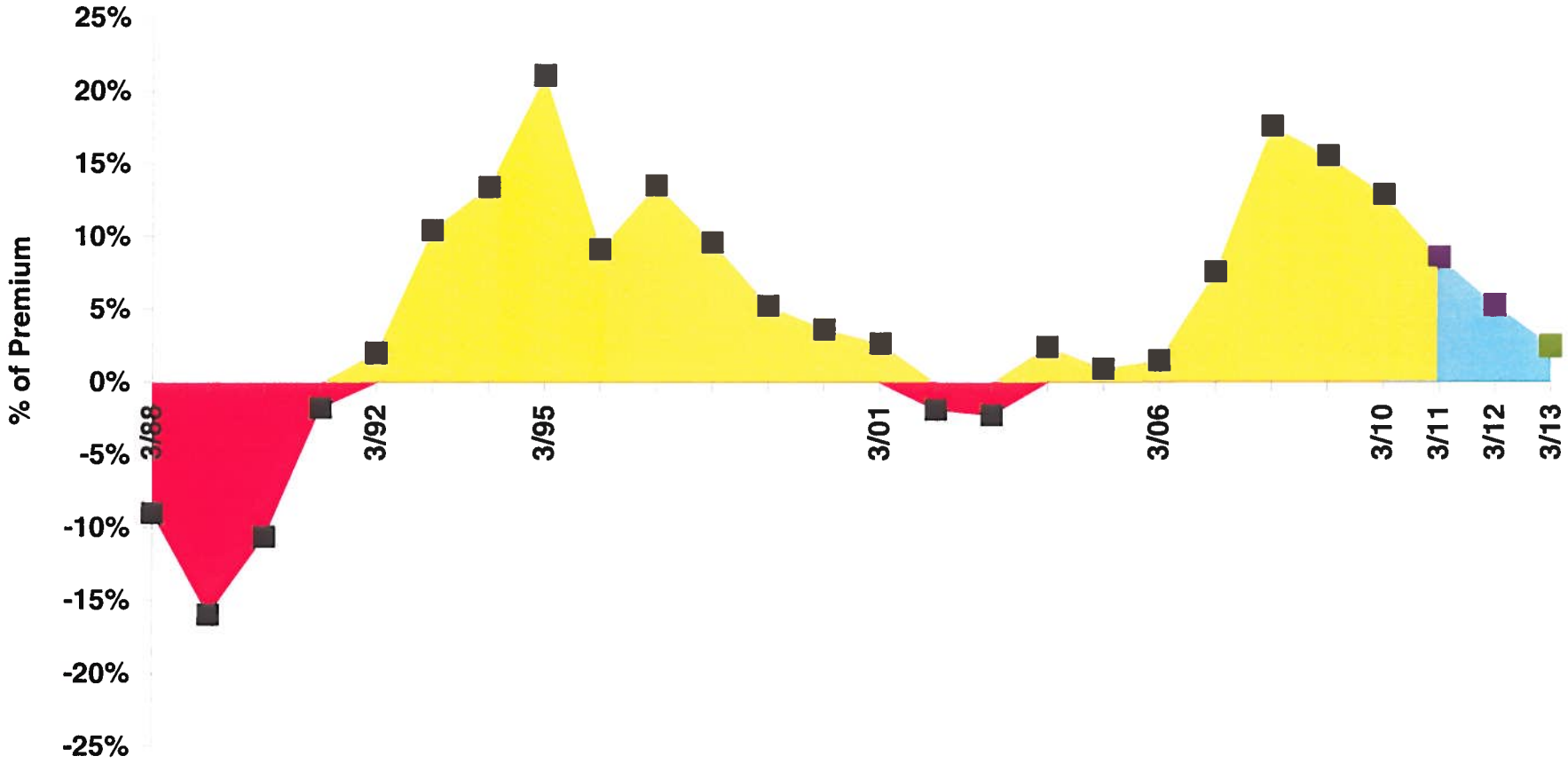
Confidential Financial Information for Plan Fiduciaries

## WEA Select Plan Historical Balance
## RSF Cumulative and Unencumbered Balance



Confidential Financial Information for Plan Fiduciaries

## WEA Select Medical Plan Historical Balance
## RSF Cumulative Balance



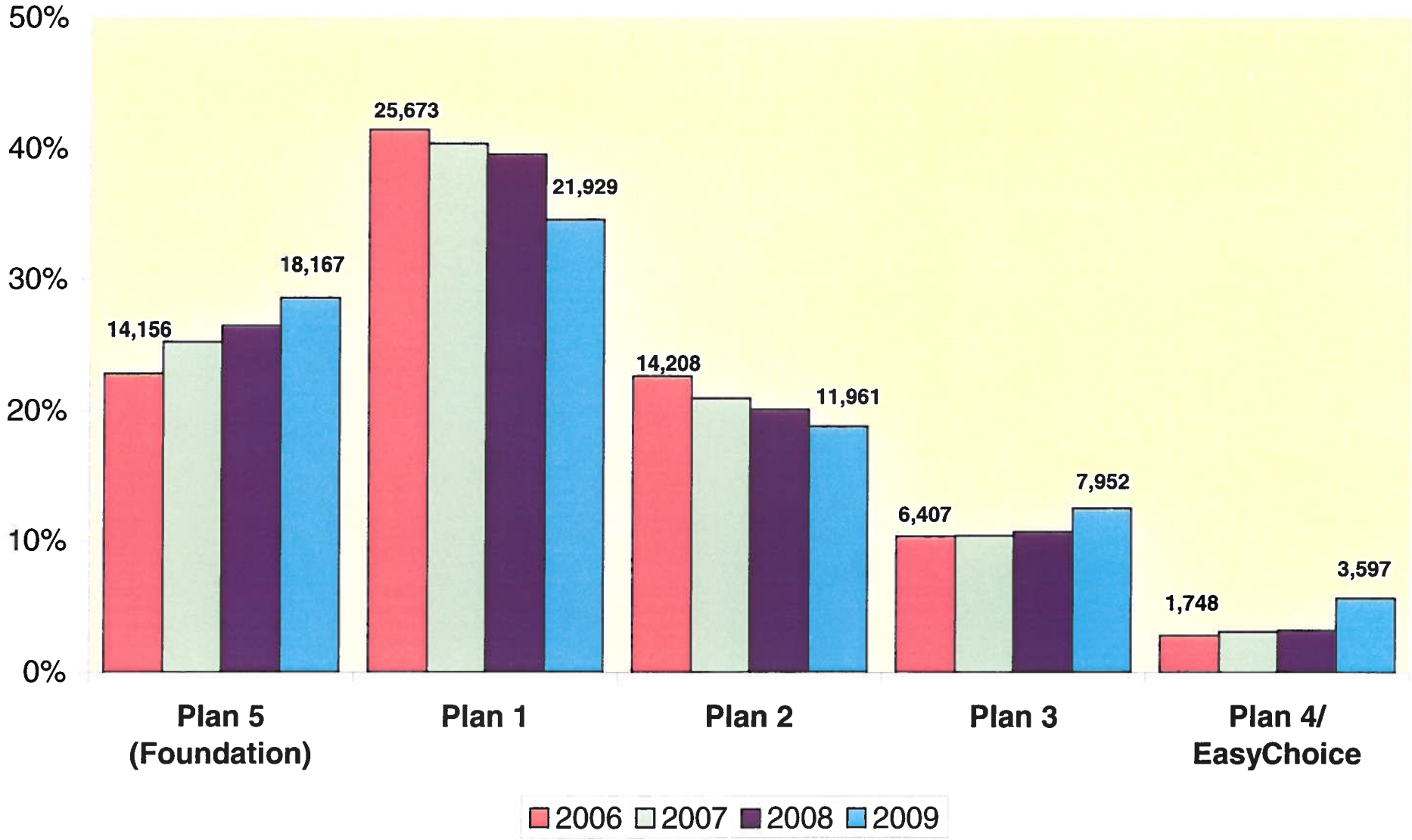

- Positive Balance
- Negative Balance
- Projected Balance
- Actual Balance Prior to Encumbrances for Margin, Rate Subsidies, etc.
- Projected Balance Based on Specific Action Taken by WEA Board
- Projected Balance Based on 3 Year Spend Strategy
  *(subject to trends, market conditions, etc.)*

Due to the unpredictable nature of claims experience, and the overall size of WEA's sponsored programs, the balance of WEA's Rate Stabilization Funds (RSF) has fluctuated over the years. For example, the Medical plan was in a deficit position for several years in the late 1980's – early 1990's, as well as 2002 - 2004. It is commonly recognizes that claim activity may vary from actuarial forecasts, resulting in gains (refunds) or losses beyond what is originally projected. WEA's philosophy is to have at least enough funds in the trust account for a margin, if at all possible, so that the margin does not have to be loaded into premium rates. In times when the remaining balance exceeds margin, a 3-5 year strategy for premium subsidies is utilized – thereby keeping funds available to mitigate future rate increases and/or purchase benefits such as WEA's Health Risk (wellness) Management Program.

There is almost a 2 year lag period between the date the WEA Board takes action to "encumber" funds to subsidize premiums, and the actual transfer of funds. For instance, when the Board approved a premium subsidy in June 2009, it was for the October 1, 2009 – September 2010 plan year. The transfer of funds will not occur until March/April 2011, after the annual accounting has been completed. The 990 for the RSF reflects the actual balance in the Trust at the end of the fiscal year reported. The balance will include gains (refunds) from the final result of actions from 2 plan years ago and will not reflect WEA Board action to encumber funds for rate subsidies for that current calendar plan year. With that in mind, the attached charts reflect the expected future RSF balance for the next three plan years based on specific action already taken by the WEA Board of Directors.

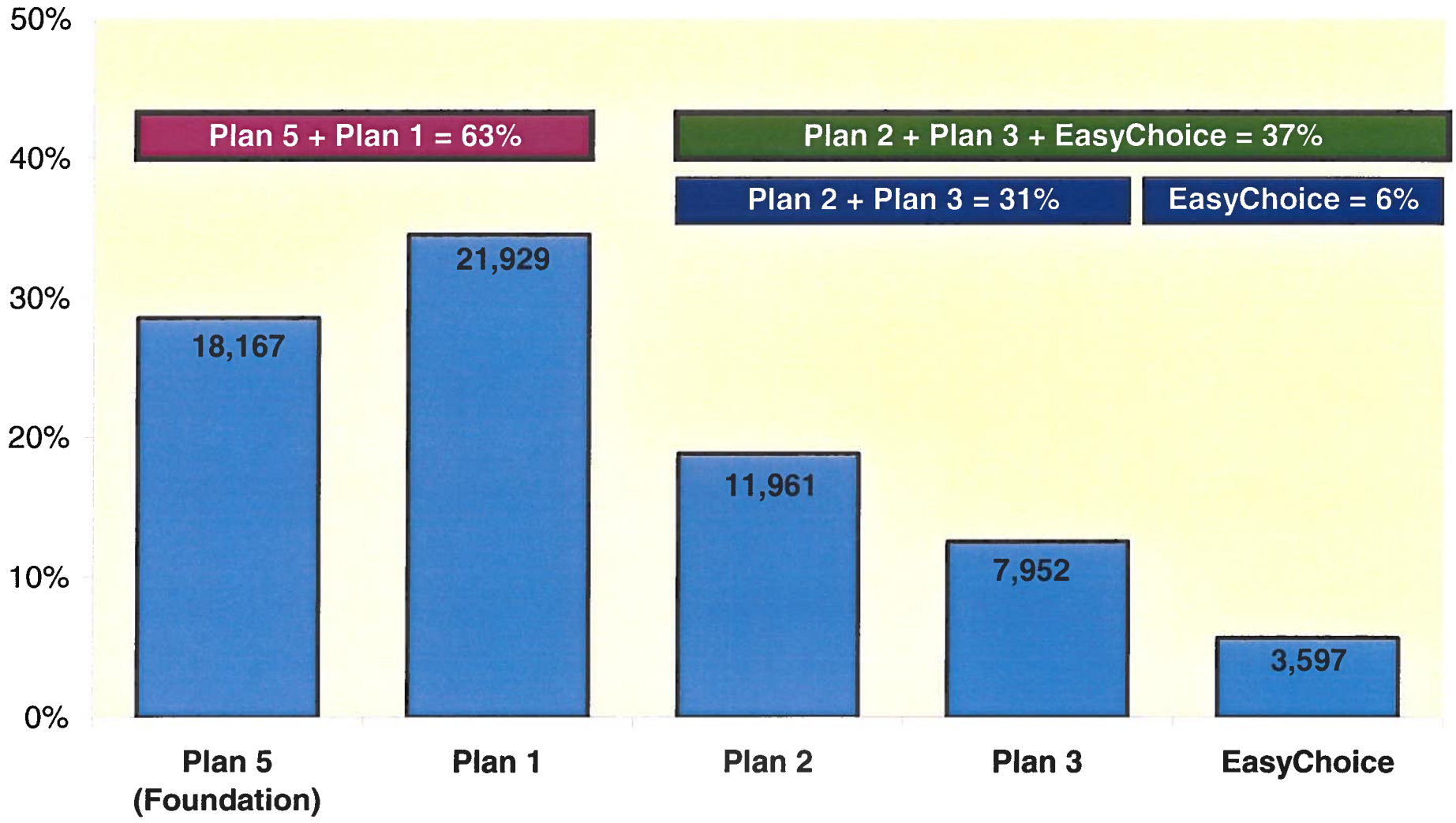
# WEA Select Medical Plan

## % of Total Enrollment By Plan (Employees)



# WEA Select Medical Plan

## % of Total Enrollment by Plan



# Primary Education Case Study — Innovative Lower Cost Plan Design

1. How to drive behavior, and not just with price?
2. How to introduce a higher deductible/lower cost approach?
3. How to ease district funding pressures?
4. How to reduce monthly OOP premium costs for Employees?
5. How to encourage use of preventive and wellness benefits?

## Solution: 3 Options → 1 Rate

| Target Group | Active, Healthier People | Families | More "experienced" workers, with some health issues |
|---|---|---|---|
| **Deductible** | Highest ($1,000) | Moderate ($750) | Low ($0) |
| **Copays** | Lowest | Moderate | Highest |
| **Value Added "extras"** | $1,000 for lab & x-ray | Lowest RX deductible and Out of Pocket Maximum | Colonoscopies and hearing exams/hardware in full |

All 3 Plan Options Have:

- No deductibles for office visits, preventive care, and generic prescription drugs
- Generic drugs are covered in full

## WEA Select EasyChoice Plan

**All Options Have...**

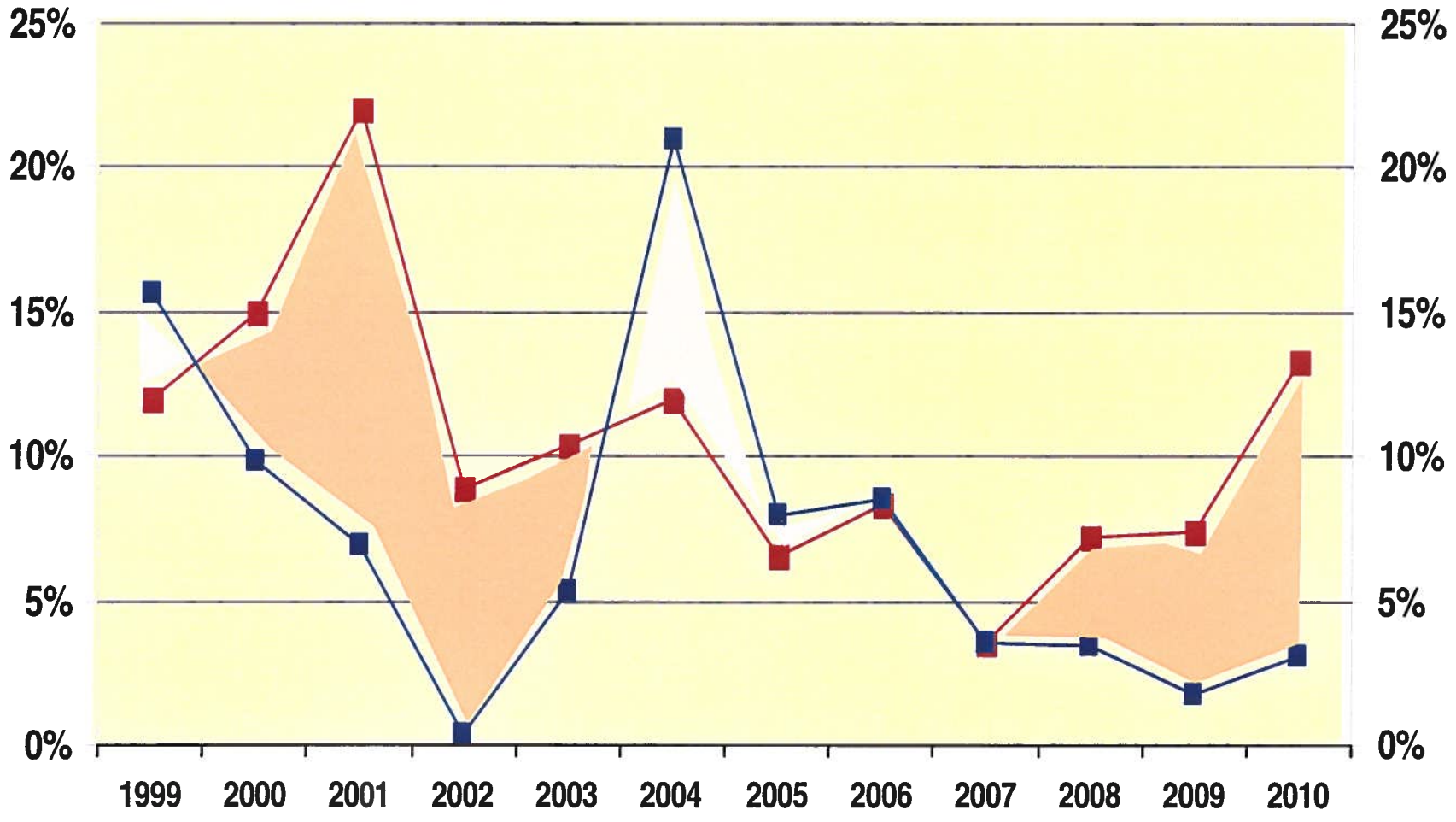
- Regardless of which EasyChoice option is chosen, all options have the same monthly premium rate
- No Deductibles for office visits, preventive care, and generic prescription drugs
- Comprehensive preventive care – including exams, screenings, and immunizations, paid in full in-network
- Generic drugs are covered in full

| | Option A | Option B | Option C |
|---|---|---|---|
| **Target Individual** | This option may be more appealing to "very active" individuals who rarely use brand name prescription drugs, and will likely utilize some diagnostic lab and x-ray services. | This option may be more appealing to families (and individuals) who use some brand name prescriptions, and still want protection from catastrophic illnesses. | This option may be more appealing to individuals that are generally healthy, use some brand name prescriptions, are interested in benefits such as hearing and colonoscopies and are more comfortable with higher financial exposure. |
| **Key Features** | **Key features for option A include:**<br>• The highest deductible ($1,000);<br>• The lowest office visit copayment ($15) and coinsurance levels (20%);<br>• First $1,000 of diagnostic lab and x-ray are covered in full, not subject to the deductible;<br>• Brand name drugs covered at 30%, after a $500 prescription drug deductible; and<br>• Lower rehabilitation limits (30 outpatient visits and 30 inpatient days). | **Key features for option B include:**<br>• A moderate deductible ($750);<br>• Moderate office visit copayments ($30) and coinsurance levels (25%);<br>• Brand name drugs are covered with a flat copayment;<br>• Lowest prescription drug deductible ($250); and<br>• Lowest out of pocket maximums. ($4,000 individual/$12,000 family). | **Key features for option C include:**<br>• No deductible for in-network services;<br>• Highest office visit copayment ($35) and coinsurance levels (35%);<br>• Brand name drugs covered with a flat copayment, after a $500 prescription drug deductible;<br>• Colonoscopies covered in full when provided by an in-network provider; and<br>• Coverage for hearing exams and hardware. |

# State Fringe Benefit Allocation Increase

| Plan Year | % of Increase |
|---|---|
| 2004-05 | +21.0% |
| 2005-06 | +8.0% |
| 2006-07 | +8.5% |
| 2007-08 | +3.6% |
| 2008-09 | +3.5% |
| 2009-10 | +1.8% |
| 2010-11 | +3.1% |

# WEA Select Medical Plan
# Billed Rates and State Benefit Funding

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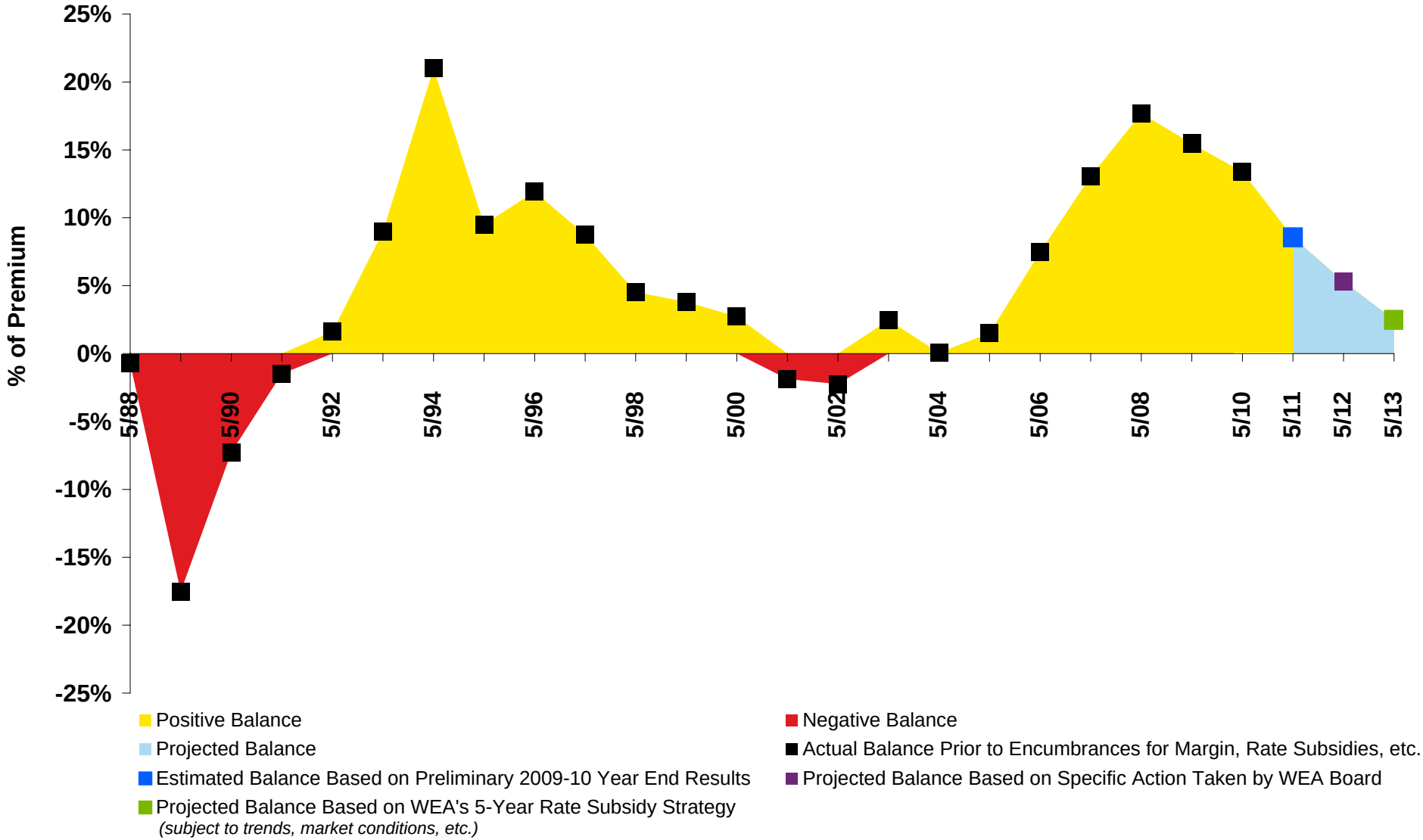
WEA WASHINGTON EDUCATION ASSOCIATION SELECT

| WEA Rate Stabilization Fund (RSF) 10-Year History | | | | | Medical Plan/RSF | |
|---|---|---|---|---|---|---|
| Fiscal Year | RSF Balance for All Plans (as of 9/30) | RSF Balance for All Plans as % of Premium (as of 9/30) | Annual Premium for All Plans (as of 9/30) | Annual Increase (Includes enrollment growth and premium changes, if any) | WEA Select Medical Plan Enrollment | Medical Plan RSF Balance as % of Premium (as of 5/1) |
| 1997 | $27,512,293 | 12.9% | $213,413,849 | | 42,700 | 8.75% |
| 1998 | $20,678,707 | 9.2% | $224,126,432 | 5.0% | 42,735 | 4.53% |
| 1999 | $13,378,146 | 5.2% | $255,568,376 | 14.0% | 42,904 | 3.82% |
| 2000 | $12,275,982 | 4.4% | $277,724,841 | 8.7% | 44,669 | 2.72% |
| 2001 | $11,267,450 | 3.5% | $323,439,776 | 16.5% | 48,059 | -1.87% |
| 2002 | $13,836,661 | 3.8% | $360,357,553 | 11.4% | 46,709 | -2.25% |
| 2003 | $19,109,084 | 5.0% | $379,753,111 | 5.4% | 48,250 | 2.46% |
| 2004 | $10,602,473 | 2.4% | $447,447,211 | 17.8% | 54,991 | 0.07% |
| 2005 | $16,173,383 | 3.2% | $503,842,733 | 12.6% | 57,755 | 1.51% |
| 2006 | $43,745,995 | 8.0% | $547,050,321 | 8.6% | 61,058 | 7.49% |
| 2007 | $79,279,147 | 13.4% | $590,229,123 | 7.9% | 61,882 | 13.06% |

**Confidential Financial Information for Plan Fiduciaries**

## WEA Select Medical Plan
## Historical RSF Cumulative Balance



# Explanation for the Increase in WEA's RSF Balance

Due to the unpredictable nature of claims experience, and the overall size of WEA's sponsored programs, the balance in their Rate Stabilization Funds (RSF) has fluctuated over the years. It is commonly recognized that claim activity may vary from actuarial forecasts, resulting in gains (refunds) or losses beyond what is originally projected. These gains/losses affect the balance in the RSF, resulting in positive or negative (deficit) balances. For example, the medical plan was in a deficit position for several years in the late 1980's – early 1990's, as well as 2001 - 2003.

WEA's philosophy is to have at least enough money in their RSF for a claims margin, if at all possible, so that the margin does not have to be loaded into premium rates. In times when the remaining RSF balance exceeds margin, a 3-5 year strategy for premium subsidies is utilized to mitigate future rate increases and/or fund benefits (e.g. WEA's Health Risk Management Program).

The WEA Select Medical Plan experienced an anomaly spanning nearly 3 plan years (2004-05, 2005-06, 2006-07). During this time period the claims experience and resulting monthly trends were consistently lower than what was projected based on historical claims experience; as well as compared to local, regional, and national trends/models.

Rates have generally been set based on the most recent available experience and a review of trends in WEA's own claims history. Entering the 2004 calendar year, WEA's claims had demonstrated much higher trend rates than had been observed elsewhere in the marketplace. These were built into future year's premiums, and with the ongoing growth in enrollment, a conservative approach to rating was recommended. However, trends then began to fluctuate within lower ranges throughout the mid-2000's – which was reflected in WEA's lower claims experience. This resulted in 3 years of annual gains in the medical plan, ranging from 4% to 6% of premium each year.

From an RSF perspective -- the high claims activity leading into 2004 had generated plan losses, resulting in a deficit position in the RSF. Gains in the subsequent years, as described above, led to a positive RSF balance. Over time, WEA's strategy has been to target an appropriate RSF balance by using available funds beyond margin for plan enhancements and mitigating future rate increases.

## Hay Group Commentary on WEA Submitted Materials

The preceding pages in Appendix C were provided by WEA at a meeting with representatives of the State Auditor's Office and Hay Group on October 12, 2010. As there is substantial interest in the details of the WEA program, we have included all analytic information provided in hard copy by WEA at that meeting; we have chosen not to include other provided hard copy not relevant to plan operations. This information is included in our report with this context:

(a) This information was volunteered at the meeting by WEA; as such, they selected its content and format;

(b) While the information provided is consistent with independent general information Hay Group has gathered, we do not have access to sufficient information to verify the accuracy of the information provided by WEA; we also have no information calling this information into question; and

(c) We have reviewed the information provided and we include additional commentary based on that information below, which is intended to assist the reader in interpreting the WEA materials.

We very much appreciate the cooperation we have received from WEA and Aon Hewitt Consulting in the development of this analysis.

Page C-WEA-1: The upper table indicates that 59% of the K-12 districts have less than 200 employees. The lower table shows that the majority of districts (226 of 295, or 77%) have WEA medical coverage with at most one additional option of HMO coverage (111 of the 226 offer WEA medical plans exclusively; this interpretation of the chart wqas verified in a subsequent telephone call with Aon Hewitt Consulting). This information is reorganized in Chart C-1 following this page.

Page C-WEA-2: Note that this table is based on enrolled subscribers, not employees, so is not directly comparable to the table on the previous page.

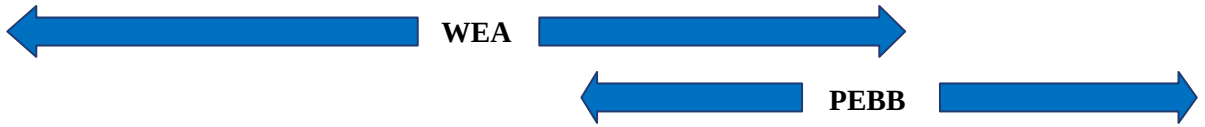
Pages C-WEA-3 through 6 provide WEA's description of its decision-making and program structure.

Pages C-WEA-7 and 8 provide WEA's description of the operational structure and legal environment surrounding the Rate Stabilization Fund (RSF). As to the uses and limitations on

## Chart C-1

## Medical Plans Offered to Washington K-12 Employees

| | | | | |
|---|---|---|---|---|
| **Number of Districts** | 111 | 115 | 25 | 44 |
| **Details of WEA Offering** | All District Employees Offered Only WEA Select Medical Plans | All District Employees Offered WEA Select Medical Plans + HMO | Some or All District employees Offered WEA – More Choices Than 1 HMO | WEA Plans Not Offered |
| **WEA 10% Discount Applied** | Yes | Yes | No | N/A |
| **Other Offerings** | No; WEA Only | One HMO – Predominant Offering is Group Health Cooperative | HMO's & Other Plans | |
| | | | PEBB may be offered | |



use of the RSF, while Hay Group does not practice law or provide legal opinions, the comments in this section are consistent with our understanding of the typical operation of this type of fund.

Page C-WEA-9: While the 5 Year Averages shown appear under the Rate Subsidy column, in each case they represent the average for the preceding column, the Billed Rate Change. Our understanding is that the Rate Subsidies shown each year were paid from the Rate Stabilization Fund for the coverage shown. We have not reviewed in detail the changes discussed in the Benefit Changes column, but in general would be more comfortable with the phrase "Plan Design Changes" in place of "Enhancements" wherever it appears. The "New Plans Offered" for the 2009-10 medical plans were lower cost programs (EasyChoice) described on pages C-WEA-16 and 17. As plan design changes were introduced in each of the 5 years shown for the medical programs, it is difficult to compare the annual rate changes with general medical cost inflation or PEBB rate changes without more analysis – specifically, the effect on claims of each of the design changes introduced.

Page C-WEA-10: Note that the scale on the left side of the graph applies to "Medical Rate % Change", which in turn appears to match the "Billed Rate Change" data for the medical plan on the previous page (Aon Hewitt subsequently informed Hay Group that these items do match). The scale on the right applies to the enrollment statistics, which indicates that there were just over 30,000 enrollees in 1991, and that enrollment trended steadily upward until 2007, when it reached approximately 65,000 employees. There is no particular connection between the data in the two charts overlaid on this page; we understand that WEA overlaid the data charts to demonstrate that their program has grown over time without regard to whether rates increases were relatively high or low in the preceding year.

Page C-WEA-11: "Encumbered" balances are calculated by deducting amounts committed by the WEA Board from the RSF (see page C-WEA-3, which also lists the plans contributing to the RSF) to future payments such as premium subsidies; thus, these future commitments (as well as expected future experience gains or losses) are the basis for the projected reduced balances for 2009-2010 and 2010-2011. The timing of "encumberment" is discussed on page C-WEA-13.

Pages C-WEA-12 and 13: Note that this chart relates to the medical plan's RSF, not the overall RSF, so this information is not directly comparable to financial information for the overall RSF. For example, while the medical RSF shows a negative balance for years 2001 and 2002, the overall RSF had a positive balance during htis period. WEA/Aon provided a later revision of the chart on page C-WEA-12; the revised chart is shown on page C-WEA-21.

Pages C-WEA-14 and 15: The first chart shows the enrollment in the various WEA medical plans between 2006 and 2009. Enrollment figures shown total to 62,192 for 2006 and 63,606 for 2009, which is consistent with the second chart and the enrollment chart on page C-WEA-10.

Pages C-WEA-16 and 17: These pages describe the design structure, intended goals, and target subscribers for the WEA EasyChoice plans.

Pages C-WEA-18 and 19: These pages show the growth in the State's benefit allocation for a K-12 FTE over the the past 11 years and the current fiscal year; the data in the first chart correspond to the "State Benefit Funding % Change" on the second page. The "Medical Rate % Change" in the second chart corresponds to the data shown on page C-WEA-19.

After the submission of the materials shown above, WEA (through Aon Hewitt) submitted additional material to Hay Group on November 5, 2010, shown on the following 3 pages:

Page C-WEA-20 provides additional statistics on the total RSF and the portion of the RSF related to the medical plan. The "RSF Balance" data corresponds to Form 990 data we had previously retrieved for years 1999 through 2007

Page C-WEA-21 presents a revised version of page C-WEA-12.

Page C-WEA-22 provides additional explanation from WEA of the behavior of the RSF (rate stabilization fund), in particular for the years after 2003.

## Additional Hay Group Analysis of WEA Program

There is considerable interest in the financial operation of the WEA program. With that in mind, Hay Group has developed a model of the financial operations of the WEA program over time in order to replace speculation concerning the program with professional estimates. We appreciate the information provided by WEA, which together with publicly available information is the basis of the model.

Results are summarized in the following table. Bolded entries represent data supplied by WEA, primarily through the materials shown previously in this section, with the exception of the bolded entries in the column "RSF Balance - $millions", which were taken from IRS Forms 990, publicly available forms filed annually by WEA.

In the table headings, "RSF" refers to the Rate Stabilization Fund, monies held in the trust by WEA which have come from prior operational gains of the plan (that is, an excess of premiums

collected over claims and other plan expenses). The monies in the RSF come from all plans that the WEA operates, although as the medical plans have the largest total dollar volume of premium, they would be expected to be the largest contributor to fund results over time. Results for 2010 and later reflect WEA projections about the expected effect on the RSF of financial commitments (premium subsidies) already put in place by the WEA Board. Thus, in the second column, "RSF Balance as % of Premium", the figures for 2010 through 2013 come from these WEA estimates. The bolded data is from the WEA chart on page C-WEA-11. The years 1997 through 2004 are calculated as the ratio of the bolded entries in the next two columns. The estimates for years before 1997 are taken from the last column (which is the RSF medical balance as a percentage of medical premiums as of May 1 of each year, in turn taken from the WEA chart shown on page C-WEA-21), as we felt this was the best available estimator among available data.

In the third column, estimates for years before 1997 are calculated as the product of the numbers in the second and fourth columns. Estimates for this period in the fourth column are created by discounting the 1997 amount by 8% annually, as shown in the fifth column. The sixth column is intended as an estimate of WEA's total market share; the entries for 1997 through 2007 were calculated based on a comparison of the WEA enrollment data on page C-WEA-20 with school employee population data shown on the OSPI website. Entires for other years are trended from the 1997-2007 data. The seventh column is then calculated as column 4 divided by column 6; column 8 is then calculated from column 7.

## Model of WEA Rate Stabilization Fund, Total WEA Premium, and Total K-12 Premium

| Year | RSF Balance as % of Prem (as of 3/1) | RSF Balance $millions (as of 9/30) | Total WEA Prem ($m) (as of 9/30) | Annual Increase | Coverage % | Total WA Prem ($m) | Prem. Growth % | RSF **Med.** Bal. as % of Prem (as of 5/1) |
|---|---|---|---|---|---|---|---|---|
| 1988 | -0.006 | -0.640560 | 106.760058 | 1.08 | 0.37 | 288.540696 | | **-0.006** |
| 1989 | -0.173 | -19.947049 | 115.300862 | 1.08 | 0.38 | 303.4233214 | 5.16% | **-0.173** |
| 1990 | -0.069 | -8.592220 | 124.524931 | 1.08 | 0.39 | 319.2946951 | 5.23% | **-0.069** |
| 1991 | -0.013 | -1.748330 | 134.486926 | 1.08 | 0.4 | 336.217314 | 5.30% | **-0.013** |
| 1992 | 0.015 | 0.167591 | 145.245880 | 1.08 | 0.41 | 354.258243 | 5.37% | **0.015** |
| 1993 | 0.092 | 14.431631 | 156.865550 | 1.08 | 0.42 | 373.4894048 | 5.43% | **0.092** |
| 1994 | 0.206 | 34.899448 | 169.414794 | 1.08 | 0.43 | 393.9878931 | 5.49% | **0.206** |
| 1995 | 0.094 | 17.198990 | 182.967978 | 1.08 | 0.44 | 415.8363126 | 5.55% | **0.094** |
| 1996 | 0.113 | 22.329412 | 197.605416 | 1.08 | 0.45 | 439.1231461 | 5.60% | **0.113** |
| 1997 | 0.088 | **27.512293** | **213.413849** | 1.08 | 0.46 | 463.94315 | 5.65% | **0.088** |
| 1998 | 0.045 | **20.678070** | **224.126432** | | 0.47 | 476.8647489 | 2.79% | **0.045** |
| 1999 | 0.038 | **13.378146** | **255.568376** | | 0.47 | 543.7625021 | 14.03% | **0.038** |
| 2000 | 0.044 | **12.275982** | **277.724841** | | 0.48 | 578.5934188 | 6.41% | **0.027** |
| 2001 | 0.035 | **11.267450** | **323.439776** | | 0.5 | 646.879552 | 11.80% | **-0.019** |
| 2002 | 0.038 | **13.836661** | **360.357553** | | 0.48 | 750.7449021 | 16.06% | **-0.023** |
| 2003 | 0.050 | **19.109084** | **379.753111** | | 0.48 | 791.1523146 | 5.38% | **0.025** |
| 2004 | 0.024 | **10.602473** | **447.447211** | | 0.54 | 828.6059463 | 4.73% | **0.001** |
| 2005 | **0.030** | **16.173383** | **503.842733** | | 0.57 | 883.9346193 | 6.68% | **0.015** |
| 2006 | **0.078** | **43.745995** | **547.050321** | | 0.59 | 927.2039339 | 4.90% | **0.075** |
| 2007 | **0.131** | **79.279147** | **590.229123** | | 0.6 | 983.715205 | 6.09% | **0.131** |
| 2008 | **0.174** | **106.330450** | 611.094540 | | 0.61 | 1001.794328 | 1.84% | **0.176** |
| 2009 | **0.160** | **104.798522** | 654.990763 | | 0.62 | 1056.436714 | 5.45% | **0.152** |
| 2010 | 0.131 | 92.668093 | 707.390024 | 1.08 | 0.63 | 1122.841307 | 6.29% | 0.129 |
| 2011 | 0.085 | 64.938404 | 763.981225 | 1.08 | 0.64 | 1193.720665 | 6.31% | 0.083 |
| 2012 | 0.051 | 42.080086 | 825.099723 | 1.08 | 0.65 | 1269.38419 | 6.34% | 0.051 |
| 2013 | 0.025 | 22.277693 | 891.107701 | 1.08 | 0.66 | 1350.163184 | 6.36% | 0.025 |

Avg. '92-'13
35.908137

The following pages provide material selected by Hay Group from the website of the Washington State Office of the Insurance Commissioner. The next page provides instructions on accessing the public records on the site. The following pages are extracted from a WEA/Premera filing initially received by OIC on November 14, 2007 (according to the site) and stamped 08202008 (presumably August 20, 2008); the filing contains a letter dated August 15, 2008 indicating actions taken by OIC. The document may be retrieved from its OIC Tracker ID, 179199.

The document group is 566 pages long. The pages shown were extracted from the images between pages 22 and 41 of the document

Accessing the OIC Public Disclosure Web site:

Go to www.insurance.wa.gov

On the left side bar, Click on Public Disclosure, then Click Rates & Forms Filing

After reading the Disclaimer, Check the box *I Agree to the terms*, and Click Continue

Select the Tracker ID Lookup Tab

Refer to the list of filings OIC has provided (the Tracker ID is listed in the left hand column)

Enter the OIC Tracker ID number and Click on Search

To view the documents, Click on the document icon under the Download column, then click open

*Please note: The documents are scanned TIFF images*

If you have difficulties viewing the documents or need to save them, please refer to the Help option at the top of the Online Rates and Forms Filing Search screen. A user manual will display for your use.

If you still have difficulties, please contact the public records office at (360) 725-7003 or email at pdr@oic.wa.gov.

08202008

PREMERA BLUE CROSS

# CONVENTIONAL FUNDING ARRANGEMENT AGREEMENT

**to the Group Health Care Contract between**

**PREMERA BLUE CROSS**

**(hereinafter also referred to as "we," "us," or "our")**

**AND**

**WASHINGTON EDUCATION ASSOCIATION**

**(hereinafter called the WEA)**

**Effective Date: October 1, 2007**

This Funding Arrangement Agreement is part of Contract Form Nos. 1223W, 1223X, and 1223Y effective October 1, 2007 and includes the following Premera Blue Cross Group Numbers:

| | | |
|---|---|---|
| Group No. | 100000008 Series | Select Medical Plan 1 (Actives) |
| Group No. | 100000008 Series | Select Medical Plan 2 (Actives) |
| Group No. | 100000008 Series | Select Medical Plan 3 (Actives) |
| Group No. | 100000008 Series | Select Medical Plan 4-500 (Actives) |
| Group No. | 100000008 Series | Select Medical Plan 4-750 (Actives) |
| Group No. | 100000008 Series | Select Medical Plan 5 (Actives) |
| Group No. | 100000008 Series | Select Retirees Medical Plan |

All Medical Plan Group Numbers listed above shall be pooled together for establishment of contractual rates, pooling of experience, billing, establishment of the Rate Stabilization Reserve, and accountings.

## I. DEFINITIONS

For purposes of this funding arrangement portion of the Contract, the following definitions apply:

A Contract Period

The term "Contract Period" means the period from 12:01 a.m. on October 1, 2007 to midnight on September 30, 2008.

B Contractual Rate

The term "Contractual Rate" means the monthly Subscription Charge rate established by us as consideration for the medical benefits offered in the Select Medical Plans. It does not include fees for the Automatic Payroll Authorization (APA) revenue collecting system, charges for life insurance benefits provided by another carrier, or any other miscellaneous charges that may be billed by the APA system.

C. Contractual Revenue

The term "Contractual Revenue" means the total of the Contractual Rate for each rate classification multiplied by the number of employees in each such classification for each month in the Contract Period.

D. Enrollee

The term "Enrollee" means any subscriber, member, employee, former employee, spouse, former spouse, dependent, former dependent, beneficiary or any other individual who may be entitled to benefits under the terms of the Contract.

E. Grace Period

The term "Grace Period" means:

Up to ten (10) days from the due date (as specified in III.A.) during which the Participating Employer Unit may make the required payment and the contract will not be terminated for nonpayment.

F. Incurred But Not Reported (IBNR) Reserves

The term "Incurred But Not Reported (IBNR) Reserves" means the reserves established from the Contractual Revenue for claims incurred during the Contract Period, but not paid during the Contract Period.

G. Incurred Claims

The term "Incurred Claims" means the sum of:

1. the claims paid during the Contract Period; less
2. the WEA share of the Prescription Drug Volume Discount Program savings; plus
3. the BlueCard Program Access Fees (see Access Fees under Section VI., Other Provisions, Subsection 2.); less
4. the IBNR Reserves from the previous contract period; plus
5. the IBNR Reserves for the current Contract Period.

H. Paid Claims

The term "Paid Claims" means all payments made by us during the Contract Period for benefits.

I. Participating Employer Unit

The term "Participating Employer Unit" means a bargaining unit or other bona fide employee classification of an eligible employer or school district which has elected to offer this plan on an equal access basis with any other group medical plans offered to any of its eligible employees.

J. Plan

The term "Plan" means the group health plan established and maintained for employees of eligible employers or school districts by the WEA which is funded all or in part through this Funding Arrangement Agreement.

K. Rate Stabilization Fund

The term "Rate Stabilization Fund" means the amount of identified gain from prior contract periods or the current Contract Period which is held by the WEA and/or Premera Blue Cross, at the WEA's discretion, to offset any cumulative loss in accordance with Section IV. The Rate Stabilization Fund balance includes credits for interest earned and debits for claim review and trust expenses. Administration of the Rate Stabilization Fund is addressed in the Rate Stabilization Fund Agreement set forth in Attachment A.

L. Financial Provisions

The term "Financial Provisions" means the amounts retained by us for Retention, Brokerage, Risk and Contingency, and Premium Tax. The specific charges for these are outlined in Attachment B.

M. WEA, the

The term "the WEA" means the Washington Education Association.

## II. CONTRACTUAL RATES (MONTHLY SUBSCRIPTION CHARGES)

A. Contractual Rates

The monthly Contractual Rates for the Contract Period are as follows:

**Contract No. Select Medical Plan 1**

| | Full Rate | 10% Discount Rate |
|---|---|---|
| Rate Classification | Contractual Rate | Contractual Rate |
| Employee | $608.11 | $549.46 |
| Employee & Spouse | $1,158.56 | $1,069.11 |
| Employee, Spouse & Children | $1,430.16 | $1,289.11 |
| Employee & Children | $852.86 | $769.46 |

**Contract No. Select Medical Plan 2**

| | Full Rate | 10% Discount Rate |
|---|---|---|
| Rate Classification | Contractual Rate | Contractual Rate |
| Employee | $531.61 | $480.56 |
| Employee & Spouse | $1,033.81 | $932.36 |
| Employee, Spouse & Children | $1,246.41 | $1,123.81 |
| Employee & Children | $744.21 | $672.01 |

**Contract No. Select Medical Plan 3**

| | Full Rate | 10% Discount Rate |
|---|---|---|
| Rate Classification | Contractual Rate | Contractual Rate |
| Employee | $475.76 | $429.71 |
| Employee & Spouse | $924.86 | $834.11 |
| Employee, Spouse & Children | $1,115.11 | $1,005.46 |
| Employee & Children | $666.01 | $601.06 |

**Contract No. Select Medical Plan 4-500**

| | Full Rate | 10% Discount Rate |
|---|---|---|
| Rate Classification | Contractual Rate | Contractual Rate |
| Employee | $439.26 | $396.91 |
| Employee & Spouse | $854.21 | $770.31 |
| Employee, Spouse & Children | $1,029.91 | $928.41 |
| Employee & Children | $614.96 | $555.01 |

**Contract No. Select Medical Plan 4-750**

| | Full Rate | 10% Discount Rate |
|---|---|---|
| Rate Classification | Contractual Rate | Contractual Rate |
| Employee | $425.71 | $384.61 |
| Employee & Spouse | $827.81 | $746.56 |
| Employee, Spouse & Children | $998.06 | $899.81 |
| Employee & Children | $595.91 | $537.91 |

**Contract No. Select Medical Plan 5**

| | Full Rate | 10% Discount Rate |
|---|---|---|
| Rate Classification | Contractual Rate | Contractual Rate |
| Employee | $547.86 | $492.76 |
| Employee & Spouse | $1,112.21 | $1,001.31 |
| Employee, Spouse & Children | $1,345.86 | $1,211.66 |
| Employee & Children | $781.51 | $703.16 |

**Contract No. Select Retiree Medical Plan**

| Rate Classification | Contractual Rate |
|---|---|
| Retiree Eligible For Medicare | $507.96 |
| Spouse Eligible For Medicare | $507.60 |

B. Rate Determination on Select Medical Plan 1, Select Medical Plan 2, Select Medical Plan 3, Select Medical Plan 4-500, Select Medical Plan 4-750 and Select Medical Plan 5

The WEA Select Medical Plan 1, Select Medical Plan 2, Select Medical Plan 3, Select Medical Plan 4-500, Select Medical Plan 4-750 and Select Medical Plan 5 rates are determined per Participating Employer Unit. The rules for rate determination are as follows:

Full Rates

WEA Select Medical Plan 1, WEA Select Medical Plan 2, WEA Select Medical Plan 3, WEA Select Medical Plan 4-500, Select Medical Plan 4-750 and Select Medical Plan 5 are offered at full rates in a Participating Employer Unit where one or more non-WEA medical plans are also available for enrollment.

10% Discount Rates

The Participating Employer Unit may qualify for a 10% discount under the following conditions:

The Participating Employer Unit offers only the WEA Select Medical Plan 1, WEA Select Medical Plan 2, WEA Select Medical Plan 3, WEA Select Medical Plan 4-500, Select Medical Plan 4-750 and/or Select Medical Plan 5 and no more than one HMO option. Note: Participating Employer Units offering Point-of-Service or other plans, which are not filed and approved as HMOs by the Office of the Insurance Commissioner, do not qualify for the 10 percent discount.

A Participation Agreement (copy attached) must be submitted each year by a school district for its Participating Employer Units to qualify for a discount. The discount will be effective October 1 or on the first billing after the application is approved, whichever is later.

We must be notified by a participating Employer Unit of any change in plan offerings available to employees. The discount will be terminated at any point during the year if it is determined that the Participating Employer Unit no longer qualifies for the discount. Retroactive contractual rates will be due if a Participating Employer Unit continues to remit the discounted rate after it ceases to meet the discount requirements.

No retroactive contractual rate credits will be made for the discount for any months prior to application and approval.

C. Composite Rates for Select Medical Plan 1, Select Medical Plan 2, Select Medical Plan 3, Select Medical Plan 4-500, Select Medical Plan 4-750 and Select Medical Plan 5

A Composite Rate on Select Medical Plan 1, Select Medical Plan 2, Select Medical Plan 3, Select Medical Plan 4-500, Select Medical Plan 4-750 and/or Select Medical Plan 5 will be provided to a Participating Employer Unit, at the Participating Employer Unit's request. The composite rate is developed by us based on demographics of the Participating Employer Unit, subject to the following:

1. The Participating Employer Unit must have 25 or more subscribers enrolled on a WEA Select Medical Plan (1, 2, 3, 4-500, 4-750, or 5).

2. 100% of the "full-time employees" must be enrolled as a subscriber on a group medical plan available to them through the Participating Employer Unit. Only employees providing written waiver of coverage to the Participating Employer Unit (due to group coverage elsewhere) can be excluded from this 100% participation requirement.

3. All medical plans available to the employees in the Participating Employer Unit must use composite rates.

4. The district pays the total composite medical contractual rates for all full-time employees (or mandatory payroll deductions are required in combination with district funds).

5. "Full-time employees" may be defined by each Participating Employer Unit. If, for example, .5 FTE is considered full-time for purpose of benefits, then all employees working .5 or more must participate and employees working less than .5 will not be eligible for participation on the composite rate.

6. Employees that work less than "full-time," as defined by the Participating Employer Unit, may participate in the plan if the employer makes a contribution towards their fringe benefits. They will be billed however, on the four-tier rate structure as set forth in this Agreement.

D. Select Retiree Medical Plan

The Select Retiree Medical Plan has been continued for Medicare-eligible retired staff of the Washington Education Association only.

E. Adjustments to Contractual Rates

The Contractual Rates set forth in II A. above will remain in effect until the end of the Contract Period, and during any extension thereof granted by us, or until the Contract is terminated, if earlier, with the following exceptions:

1. Should any federal, state or local authority mandate a material change in benefits, or procedure, or impose or change a tax or assessment on Premera Blue Cross or the WEA during the Contract Period or any extension of the Contract Period, whether by statute, regulation, interpretation or otherwise, we may then adjust the Contractual Rates at any time to offset the effect on its revenue.

2. We may increase the Contractual Rates during the Contract Period by giving ninety (90) days advance written notice to the Group or its agents if we determine that the basis upon which it assumed the risk is materially changed due to:

   a. A benefit change requested by the Group.

PREMERA | BLUE CROSS

# ATTACHMENT A
# WEA SELECT PREMERA BLUE CROSS MEDICAL PLANS
# RATE STABILIZATION FUND AGREEMENT

WHEREAS the Washington Education Association (WEA) and Premera Blue Cross are presently, and have been since 1961, the contract holder and underwriter respectively, of the WEA Select Medical Plans which currently provides hospital, medical and surgical benefits to WEA participants; and

WHEREAS most all of such participants are either members of or represented by the WEA which provides various promotional, enrollment, educational, claims and administrative services for the benefit of the WEA Select Medical Plan and its participants; and

WHEREAS the WEA and Premera Blue Cross acknowledge the need to provide protection to participants against benefit reductions that may be required due to unfavorable claims experience or increases in benefit costs that may occur without the ability to pass such increases on to participating school districts; and

WHEREAS the WEA and Premera Blue Cross further acknowledge that the nature of current participant interests in the reserves of the WEA Select Premera Blue Cross Medical Plans is equitable; that such interests are not related to either length of WEA Select Medical Plan's participation or the amount of contributions that have been paid to the WEA Select Premera Blue Cross Medical Plans; that the interests of new participants are coextensive with the interests of the oldest participants in a group that is ever changing with the result that participants leaving the WEA Select Premera Blue Cross Medical Plans cease to have an interest in the reserves and participants entering the WEA Select Premera Blue Cross Medical Plans accede to the benefit of reserves developed by the experience of their predecessors;

**RATE STABILIZATION FUND AGREEMENT** *(Continued)*

NOW, therefore, it is hereby agreed as follows:

1. The Rate Stabilization Fund (Fund) shall be that amount of money plus earned interest that has accumulated during the years when the WEA Select Premera Blue Cross Medical Plans claims experience has generated a refund less payments made from the Fund to Premera Blue Cross.
2. The refund to the Fund shall be calculated by Premera Blue Cross for the previous contract year and shall be the difference between Subscription Charges paid and the cost of incurred claims and administrative expenses. A report of the WEA Select Premera Blue Cross Medical Plans experience and the refund shall be provided to the WEA within 100 days after the close of the contract year.
3. The WEA shall hold the Fund in trust and invest it in accordance with the general criteria set forth in RCW 11.100.020 or any successor statute. Interest earned on the assets of the Fund shall be credited to it and charges against the Fund shall be debited from it.
4. During a contract year when the WEA Select Premera Blue Cross Medical Plans experience has generated a deficit, the WEA agrees to use the Fund to pay to Premera Blue Cross the amount of the deficit for that contract year including any prior carry forward losses up to but not to exceed the total amount of the Fund. Such payment shall be made within thirty-one (31) days of notice from Premera Blue Cross or one hundred twenty (120) days after the close of the contract year generating the deficit whichever is later.
5. The WEA may, at its discretion, agree to transfer all or a portion of the Fund to Premera Blue Cross, in order to reduce the Subscription Charges or to purchase additional Premera Blue Cross Medical Plan benefits for the new contract year, or to otherwise benefit the Premera Blue Cross Medical Plan participants.
6. The Fund is for the benefit of current Select Premera Blue Cross Medical Plans participants. The interest of such participants is unrelated to the length of their participation. The interests of new participants in the Fund is the same as the interests of participants who have participated in the WEA Select Premera Blue Cross Medical Plans for longer periods. Participants who cease participation in the WEA Select Premera Blue Cross Medical Plans cease having an interest in the Fund and new participants acquire an interest in the Fund. The WEA and Premera Blue Cross acknowledge these principles and agree that they are equitable.

**RATE STABILIZATION FUND AGREEMENT** *(Continued)*

7. In the event the Contracts governing the WEA Select Premera Blue Cross Medical Plans are terminated by either party, any balance in the Rate Stabilization Fund after the satisfaction of liabilities attributable to the Fund shall be utilized for the exclusive benefit of WEA Select Premera Blue Cross Medical Plan participants and their beneficiaries as determined by the WEA.

8. In the event a participating school district or WEA affiliate or group thereof shall cease its participation in the WEA Select Premera Blue Cross Medical Plans, there shall be no division or allocation of any monies or assets of the WEA Select Premera Blue Cross Medical Plans or Fund.

This Agreement shall supersede all previous agreements on the same subject including the Letter of Understanding executed by the WEA and Premera Blue Cross on May 2, 1978 and May 3, 1978, respectively, and the Rate Stabilization Fund Agreement executed by the WEA and Premera Blue Cross on March 24, 1981 and March 25, 1981 respectively and shall remain in effect until terminated by either party upon thirty (30) days written notice preceding the end of a contract year (September 30).

**PREMERA BLUE CROSS**

H. R. Brereton Barlow

President and Chief Executive Officer

Date:

**WASHINGTON EDUCATION ASSOCIATION**

*Signature on File*
Name/Title:

Date:

*Signature on File*
Name/Title:

Date:

PREMERA | BLUE CROSS

# ATTACHMENT B

to the Conventional Funding Arrangement Agreement

between

PREMERA BLUE CROSS

AND

WASHINGTON EDUCATION ASSOCIATION

Financial Provisions

| | |
|---|---|
| **Retention:** | Guaranteed at $19.42 per member per month |
| **Risk and Contingency:** | 0.25% of contractual revenue |
| **Brokerage:** | $1.26 per employee per month |
| **Premium Tax:** | 2.0% of taxable premium |
| **WA High Risk Pool:** | $1.97 per medical member per month |

PREMERA | BLUE CROSS

# ATTACHMENT C

**to the Conventional Funding Arrangement Agreement**

**between**

**PREMERA BLUE CROSS**

**AND**

**WASHINGTON EDUCATION ASSOCIATION**

The Contractual Rates effective October 1, 2007 are based on the following:

Number of Medical Enrollees:

| Employee | Spouse | Children |
|---|---|---|
| 61,831 | 13,171 | 36,485 |

## Hay Group Commentary on Data from OIC Website

Attachment B to the WEA/Premera contract provides information on non-claims charges which Premera makes under the contract. Attachment C provides information on enrollees under the contract which in turn allows estimates of these non-claims charges:

"Retention: Guaranteed at $19.42 per member per month"

Medical enrollees = 61,831 + 13,171 + 36,485 = 111,487
If members equals enrollees, 19.42 x 111,487 x 12 = $25,980,930 $25,980,930

"Risk and Contingency: 0.25% of contractual revenue"

From the rate and enrollment data, we roughly estimate premium income for the WEA medical programs to Premera at $540 million.
0.25% x $500 million = $1,350,000 1,350,000

"Brokerage: $1.26 per employee per month"

$1.26 x 61,831 x 12 = $934,885 934,885

"Premium Tax: 2.0% of taxable premium"

2.0% x $540 million = $10,800,000 10,800,000

"WA High Risk Pool: $1.97 per medical member per month"

$1.97 x 111,487 x 12 = $2,635,553 2,635,553

Total estimated non-claims charges made by Premera under this contract: $41,701,368

As a percentage of premium: $41,701,368 / $540,000,000 = 7.72%

(Note: Subtracting the premium tax leaves total non-claims charges at 5.72%, which is consistent with WEA's statements to Hay Group that total administrative charges under this program have been at or below 6% for the past several years.)

# Appendix D

# PEBB Materials and Analysis

Washington State Health Care Authority
PEBB Enrollment Report for June 2010 Coverage
Report 1: Total Member Summary

| Medical Plan | ACTIVE | | | RETIREE | | | OTHER | | Total Members |
|---|---|---|---|---|---|---|---|---|---|
| | K-12 | PEBB | Political Subs | K-12 | PEBB | Political Subs | COBRA | LWOP/RIF | |
| Aetna Public Employees Plan | 514 | 13,018 | 4,759 | 1,304 | 616 | 86 | 175 | 66 | 20,538 |
| Group Health Classic | 706 | 34,526 | 3,919 | 6,782 | 8,676 | 337 | 146 | 109 | 55,201 |
| Group Health Value | 797 | 43,945 | 2,910 | 1,309 | 1,645 | 92 | 159 | 104 | 50,961 |
| Kaiser Permanente Classic | 26 | 4,070 | 217 | 1,411 | 737 | 17 | 24 | 15 | 6,517 |
| Kaiser Permanente Value | 3 | 525 | 9 | 123 | 45 | 0 | 10 | 2 | 717 |
| No Plan Selected | 0 | 181 | 0 | 0 | 0 | 0 | 0 | 0 | 181 |
| Premera Blue Cross Medicare Supplement E | 0 | 0 | 0 | 1,675 | 848 | 21 | 1 | 0 | 2,545 |
| Premera Blue Cross Medicare Supplement F | 0 | 0 | 0 | 6 | 2 | 0 | 0 | 0 | 8 |
| Premera Blue Cross Medicare Supplement J With Prescription | 0 | 0 | 0 | 1,134 | 236 | 16 | 0 | 0 | 1,386 |
| Premera Blue Cross Medicare Supplement J Without Prescription | 0 | 0 | 0 | 2,748 | 721 | 46 | 2 | 0 | 3,517 |
| Secure Horizons Classic | 0 | 0 | 0 | 1,317 | 1,137 | 19 | 0 | 0 | 2,473 |
| Secure Horizons Value | 0 | 0 | 0 | 95 | 71 | 0 | 0 | 0 | 166 |
| Uniform Medical Plan | 3,138 | 130,593 | 10,931 | 21,290 | 22,224 | 1,019 | 1,092 | 453 | 190,740 |
| Total: | 5,184 | 226,858 | 22,745 | 39,194 | 36,958 | 1,653 | 1,609 | 749 | 334,950 |

| | ACTIVE | | RETIREE | | COBRA | | LWOP/RIF | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Members | HMO% | Members | HMO% | Members | HMO% | Members | HMO% | Members | HMO% |
| HMO | 91,653 | 35.97% | 31,266 | 40.19% | 342 | 21.26% | 230 | 30.71% | 123,491 | 36.87% |
| UMP | 163,134 | 64.03% | 46,539 | 59.81% | 1,267 | 78.74% | 519 | 69.29% | 211,459 | 63.13% |
| Total: | 254,787 | 100.00% | 77,805 | 100.00% | 1,609 | 100.00% | 749 | 100.00% | 334,950 | 100.00% |

Washington State Health Care Authority
PEBB Enrollment Report for June 2010 Coverage
Report 2: Total Subscriber Summary

| Medical Plan | ACTIVE | | | RETIREE | | | OTHER | | Total Subscribers |
|---|---|---|---|---|---|---|---|---|---|
| | K-12 | PEBB | Political Subs | K-12 | PEBB | Political Subs | COBRA | LWOP/RIF | |
| Aetna Public Employees Plan | 265 | 6,360 | 2,251 | 920 | 435 | 57 | 126 | 47 | 10,461 |
| Group Health Classic | 315 | 17,337 | 2,233 | 4,754 | 6,234 | 228 | 106 | 68 | 31,275 |
| Group Health Value | 315 | 19,861 | 1,365 | 836 | 1,090 | 56 | 105 | 59 | 23,687 |
| Kaiser Permanente Classic | 9 | 1,797 | 90 | 947 | 521 | 11 | 15 | 7 | 3,397 |
| Kaiser Permanente Value | 1 | 255 | 3 | 76 | 25 | 0 | 5 | 2 | 367 |
| No Plan Selected | 0 | 175 | 0 | 0 | 0 | 0 | 0 | 0 | 175 |
| Premera Blue Cross Medicare Supplement E | 0 | 0 | 0 | 1,209 | 598 | 15 | 1 | 0 | 1,823 |
| Premera Blue Cross Medicare Supplement F | 0 | 0 | 0 | 5 | 1 | 0 | 0 | 0 | 6 |
| Premera Blue Cross Medicare Supplement J With Prescription | 0 | 0 | 0 | 937 | 199 | 12 | 0 | 0 | 1,148 |
| Premera Blue Cross Medicare Supplement J Without Prescription | 0 | 0 | 0 | 2,111 | 539 | 35 | 2 | 0 | 2,687 |
| Secure Horizons Classic | 0 | 0 | 0 | 947 | 881 | 15 | 0 | 0 | 1,843 |
| Secure Horizons Value | 0 | 0 | 0 | 68 | 52 | 0 | 0 | 0 | 120 |
| Uniform Medical Plan | 1,293 | 63,981 | 5,612 | 14,568 | 15,606 | 687 | 778 | 287 | 102,812 |
| Total: | 2,198 | 109,766 | 11,554 | 27,378 | 26,181 | 1,116 | 1,138 | 470 | 179,801 |

| | ACTIVE | | RETIREE | | COBRA | | LWOP/RIF | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Subscribers | HMO% | Subscribers | HMO% | Subscribers | HMO% | Subscribers | HMO% | Subscribers | HMO% |
| HMO | 43,581 | 35.28% | 22,402 | 40.97% | 234 | 20.56% | 136 | 28.94% | 66,353 | 36.90% |
| UMP | 79,937 | 64.72% | 32,273 | 59.03% | 904 | 79.44% | 334 | 71.06% | 113,448 | 63.10% |
| Total: | 123,518 | 100.00% | 54,675 | 100.00% | 1,138 | 100.00% | 470 | 100.00% | 179,801 | 100.00% |

Washington State Health Care Authority
PEBB Enrollment Report for June 2010 Coverage
Report 3: Actives

| Medical Plan | K-12* | | PEBB** | | Political Subdivisions | | TOTAL ACTIVE | |
|---|---|---|---|---|---|---|---|---|
| | Subscriber | Member | Subscriber | Member | Subscriber | Member | Subscribers | Members |
| Aetna Public Employees Plan | 265 | 514 | 6,360 | 13,018 | 2,251 | 4,759 | 8,876 | 18,291 |
| Group Health Classic | 315 | 706 | 17,337 | 34,526 | 2,233 | 3,919 | 19,885 | 39,151 |
| Group Health Value | 315 | 797 | 19,861 | 43,945 | 1,365 | 2,910 | 21,541 | 47,652 |
| Kaiser Permanente Classic | 9 | 26 | 1,797 | 4,070 | 90 | 217 | 1,896 | 4,313 |
| Kaiser Permanente Value | 1 | 3 | 255 | 525 | 3 | 9 | 259 | 537 |
| No Plan Selected | 0 | 0 | 175 | 181 | 0 | 0 | 175 | 181 |
| Premera Blue Cross Medicare Supplement E | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Premera Blue Cross Medicare Supplement F | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Premera Blue Cross Medicare Supplement J With Prescription | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Premera Blue Cross Medicare Supplement J Without Prescription | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Secure Horizons Classic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Secure Horizons Value | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Uniform Medical Plan | 1,293 | 3,138 | 63,981 | 130,593 | 5,612 | 10,931 | 70,886 | 144,662 |
| Total: | 2,198 | 5,184 | 109,766 | 226,858 | 11,554 | 22,745 | 123,518 | 254,787 |
| Average Family Size: | | 2.36 | | 2.07 | | 1.97 | | 2.06 |

*Educational Service Districts are contained within the K-12 group.
**PEBB contains both State Employees and Higher Education employees.

| Dental Plan | K-12 | | PEBB* | | Political Subdivisions | | TOTAL ACTIVE | |
|---|---|---|---|---|---|---|---|---|
| | Subscriber | Member | Subscriber | Member | Subscriber | Member | Subscribers | Members |
| Deltacare | 166 | 364 | 8,462 | 17,704 | 313 | 690 | 8,941 | 18,758 |
| No Plan Selected | 0 | 0 | 172 | 180 | 1 | 1 | 173 | 181 |
| Uniform Dental Plan | 2,058 | 5,058 | 91,724 | 187,950 | 5,615 | 12,066 | 99,397 | 205,074 |
| Willamette Dental | 120 | 271 | 15,492 | 33,739 | 525 | 1,164 | 16,137 | 35,174 |
| Total: | 2,344 | 5,693 | 115,850 | 239,573 | 6,454 | 13,921 | 124,648 | 259,187 |

Washington State Health Care Authority
PEBB Enrollment Report for June 2010 Coverage
Report 4: Retirees

| Medical Plan | K-12 RETIREES SUBSCRIBERS Non Medicare | K-12 RETIREES SUBSCRIBERS Medicare | K-12 RETIREES SUBSCRIBERS Total Subscribers | K-12 RETIREES MEMBERS Non Medicare | K-12 RETIREES MEMBERS Medicare | K-12 RETIREES MEMBERS Total Members | PEBB RETIREES SUBSCRIBERS Non Medicare | PEBB RETIREES SUBSCRIBERS Medicare | PEBB RETIREES SUBSCRIBERS Total Subscribers | PEBB RETIREES MEMBERS Non Medicare | PEBB RETIREES MEMBERS Medicare | PEBB RETIREES MEMBERS Total Members | POLITICAL SUB RETIREES SUBSCRIBERS Non Medicare | POLITICAL SUB RETIREES SUBSCRIBERS Medicare | POLITICAL SUB RETIREES SUBSCRIBERS Total Subscribers | POLITICAL SUB RETIREES MEMBERS Non Medicare | POLITICAL SUB RETIREES MEMBERS Medicare | POLITICAL SUB RETIREES MEMBERS Total Members | Total Subscribers | Total Members |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aetna Public Employees Plan | 382 | 538 | 920 | 568 | 736 | 1,304 | 152 | 283 | 435 | 249 | 367 | 616 | 18 | 39 | 57 | 34 | 52 | 86 | 1,412 | 2,006 |
| Group Health Classic | 505 | 4,249 | 4,754 | 763 | 6,019 | 6,782 | 623 | 5,611 | 6,234 | 1,007 | 7,669 | 8,676 | 48 | 180 | 228 | 85 | 252 | 337 | 11,216 | 15,795 |
| Group Health Value | 538 | 298 | 836 | 827 | 482 | 1,309 | 646 | 444 | 1,090 | 991 | 654 | 1,645 | 25 | 31 | 56 | 52 | 40 | 92 | 1,982 | 3,046 |
| Kaiser Permanente Classic | 164 | 783 | 947 | 272 | 1,139 | 1,411 | 80 | 441 | 521 | 127 | 610 | 737 | 1 | 10 | 11 | 3 | 14 | 17 | 1,479 | 2,165 |
| Kaiser Permanente Value | 28 | 48 | 76 | 49 | 74 | 123 | 5 | 20 | 25 | 16 | 29 | 45 | 0 | 0 | 0 | 0 | 0 | 0 | 101 | 168 |
| No Plan Selected | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Premera Blue Cross Medicare Supplement E | 0 | 1,209 | 1,209 | 0 | 1,675 | 1,675 | 0 | 598 | 598 | 0 | 848 | 848 | 0 | 15 | 15 | 0 | 21 | 21 | 1,822 | 2,544 |
| Premera Blue Cross Medicare Supplement F | 0 | 5 | 5 | 0 | 6 | 6 | 0 | 1 | 1 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 8 |
| Premera Blue Cross Medicare Supplement J With Prescription | 0 | 937 | 937 | 0 | 1,134 | 1,134 | 0 | 199 | 199 | 0 | 236 | 236 | 0 | 12 | 12 | 0 | 16 | 16 | 1,148 | 1,386 |
| Premera Blue Cross Medicare Supplement J Without Prescription | 0 | 2,111 | 2,111 | 0 | 2,748 | 2,748 | 0 | 539 | 539 | 0 | 721 | 721 | 0 | 35 | 35 | 0 | 46 | 46 | 2,685 | 3,515 |
| Secure Horizons Classic | 0 | 947 | 947 | 0 | 1,317 | 1,317 | 0 | 881 | 881 | 0 | 1,137 | 1,137 | 0 | 15 | 15 | 0 | 19 | 19 | 1,843 | 2,473 |
| Secure Horizons Value | 0 | 68 | 68 | 0 | 95 | 95 | 0 | 52 | 52 | 0 | 71 | 71 | 0 | 0 | 0 | 0 | 0 | 0 | 120 | 166 |
| Uniform Medical Plan | 3,652 | 10,916 | 14,568 | 5,401 | 15,889 | 21,290 | 2,505 | 13,101 | 15,606 | 4,143 | 18,081 | 22,224 | 171 | 516 | 687 | 298 | 721 | 1,019 | 30,861 | 44,533 |
| Total: | 5,269 | 22,109 | 27,378 | 7,880 | 31,314 | 39,194 | 4,011 | 22,170 | 26,181 | 6,533 | 30,425 | 36,958 | 263 | 853 | 1,116 | 472 | 1,181 | 1,653 | 54,675 | 77,805 |

| Dental Plan | RETIREES K-12 Subscriber | RETIREES K-12 Member | RETIREES PEBB Subscriber | RETIREES PEBB Member | RETIREES POLITICAL SUBS Subscriber | RETIREES POLITICAL SUBS Member | RETIREES DENTAL ONLY Subscriber | RETIREES DENTAL ONLY Member | OTHER COBRA Subscriber | OTHER COBRA Member | OTHER SELF-PAY Subscriber | OTHER SELF-PAY Member | TOTAL Subscriber | TOTAL Member |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deltacare | 583 | 870 | 374 | 519 | 29 | 42 | 0 | 0 | 68 | 108 | 38 | 66 | 1,092 | 1,605 |
| No Plan Selected | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 |
| Uniform Dental Plan | 17,952 | 25,751 | 20,213 | 28,769 | 691 | 1,037 | 0 | 0 | 879 | 1,229 | 331 | 543 | 40,066 | 57,329 |
| Willamette Dental | 418 | 591 | 768 | 1,072 | 55 | 87 | 0 | 0 | 84 | 128 | 41 | 68 | 1,366 | 1,946 |
| Total: | 18,954 | 27,214 | 21,355 | 30,360 | 775 | 1,166 | 0 | 0 | 1,031 | 1,465 | 410 | 677 | 42,525 | 60,882 |

# Appendix E

# Relevant Washington Laws and Regulations

*"It is the paramount duty of the state to make ample provision for the education of all children residing within its borders, without distinction or preference on account of race, color, caste or sex."* **—Washington Constitution, article IX, section I**

- RCW 28A.400.200 – "The goal of this act is to provide access for school employees to basic coverage, including coverage for dependents, while minimizing employees' out-of-pocket premium expense." This section sets salary and benefit minimums for certificated instructional staff. The minimums may be exceeded "only by separate contract for additional time, for additional responsibilities, for incentives, or for implementing specific measurable innovative activities, including professional development, specified by the school district to: (a) Close one or more achievement gaps, (b) focus on development of science, technology, engineering, and mathematics (STEM) learning opportunities, or (c) provide arts education."
- RCW 28A.400.270(3) – Allows "basic benefits" (medical dental, vision, group term life and group long-term disability insurance coverage) to be determined through local bargaining.
- RCW 28A.400.275(2) – Requires school districts to annually submit reports about health plans provided to employees and demographic information about employees and dependents in a format and schedule provided by the Health Care Authority.
- RCW 28A.400.275(3) – Requires insurers to make data requested by HCA available to school districts.
- RCW 28A.400.280 – Details the use of the pooling mechanism at the local district level.
- RCW 41.05.050(4)(a) – HCA is authorized to collect from districts and ESDs an amount equal to that charged to state employees for groups of district employees enrolled in HCA plans. The amount may be collected based on district fiscal year rather than calendar year.
- RCW 41.050(5) – HCA recommends the amount of the employer contribution for state employees to the governor and the director of financial management for inclusion in the proposed budgets submitted to the legislature.
- RCW 41.05.065(4) – Allows health benefits eligibility to be set by bargaining unit including establishment of eligibility criteria.
- RCW 48.62.071 – Provides laws for self-insured health and welfare benefits programs.
- WAC 182-08-190 – State agencies and employer groups that participate in the PEBB program under contract with the HCA must pay premium contributions to the HCA for insurance coverage for all eligible employees and their dependents.

- WAC 182-12-111(2)(a) – If PEBB is selected by a bargaining unit all members in the bargaining unit must join PEBB.

Significant Court Decisions

*Seattle School District No. 1 v. State*, 585 P.2d 71, 1978 -- The Washington Supreme Court interpreted article IX, section 1 of the State Constitution to mean that the State Legislature must define a "basic program of education," distinguished from all other educational programs or services, and sufficiently and amply fund it from a regular and dependable source not dependent on local tax levies. Local tax levies may be used to fund enrichment programs and programs outside the legislative definition of "basic program of education".

The above case was originally decided in Thurston County in 1977 by Judge Doran; that decision is commonly referred to Doran Decision I.

*Seattle School District No. 1, et al., vs. State of Washington, et al.* (1983) – The Seattle School District was joined by 25 other districts in returning to court on issues of school funding, and was again successful in an oral decision by Judge Doran on April 29, 1983, commonly known as Doran Decision II. Here, Judge Doran ruled that "The legislature's constitutional duty to fully fund basic education includes not only the program contained within the 1977 Basic Education Act, but also the following supplemental programs which the legislature has statutorily mandated or statutorily committed itself to funding: (a) special education programs for handicapped children; (b) transitional bilingual education program; (c) the remediation assistance program; and (d) a transportation program for 'some' children such as the handicapped and children for whom transportation may be necessary due to their distance from school or hazardous walking conditions."

*Washington State Special Education Coalition vs. State of Washington, et al.* (1991) – In this decision, commonly known as Doran Decision III, Judge Doran upheld the formula approach to funding special education and the formula itself. The court deferred to the Legislature to consider and devise an appropriate remedy.

*McCleary vs. State of Washington* (2010) – King County Judge John Erlick found that the State had failed its constitutional duty to fund education and ordered the State Legislature to establish the cost of providing a basic education for all students and pay for it. However, this court also deferred to the Legislature to consider and devise an appropriate remedy.

# Appendix F

# Group Health Insurance Principles

The essential concept of insurance is protection against risk. Typically, the individual or entity desiring protection pays a (smaller) premium to protect against a (larger) potential financial risk. The entity accepting the premium (the "insurer") agrees to pay should the loss occur to the insured. The insurer sets the premium with the expectation of collecting premiums from those at financial risk which in aggregate are more than sufficient to cover the actual losses of the insured group.

Group health insurance in the United States typically involves a group of employees and their dependents, for whom the employer arranges coverage against the financial risks associated with health care. Insurers in this field typically specialize in health insurance and are heavily regulated by the governments of the states in which they offer coverage. Employers typically pay a significant portion of the cost of coverage for employees, and a lesser portion of the cost of coverage for dependents. Employers typically set eligibility conditions for these benefits. For private sector employers, these employee benefits are regulated by federal law, most notably by the Employee Retirement Income Security Act of 1974 (ERISA). Government employers are largely exempt from regulation under this law, although the design of their employee benefit plans is often similar to private sector benefits. Recent federal healthcare reform applies to all US employers.

In addition to participating in the cost of the premium, employees and their dependents must typically pay for a portion of the cost of their claims, through annual deductibles (typically, an amount of claims the employee must pay in a calendar year before the plan has liability for claims) and co-pays (a flat fee or percentage of total cost the employee must pay for certain services, like doctor office visits). The employee's annual cost is typically limited by an "out-of-pocket maximum"; once the employee has paid this amount in a calendar year, the insurer is fully liable for all further claims. In past years, the insurer would often limit its total liability by annual or lifetime maximum benefits applicable to covered individuals. However, recent federal healthcare reform has eliminated these restrictions.

The plan design also specifies the manner in which medical care is delivered. Current delivery systems are as follows:

- Fee-for-Service (FFS): The employee or dependent has free choice of their medical provider.
- Preferred Provider Organization (PPO): There is a specified network of medical providers; the employee or dependent must pay higher co-pays and out-of-pocket maximums for out-of-network providers.
- Health Maintenance Organization (HMO): The employee or dependent must use the providers in the HMO. The HMO may either use a network of providers and facilities in the community (open panel model) or may maintain its own facilities, with medical providers as its employees (closed panel)

- Point-of-Service (POS): The employee or dependent may choose between a network of gatekeeper managed care providers or FFS-style coverage with higher co-pays.

In recent years, as the cost of medical coverage has increased, employers have typically looked to manage rising costs by reducing benefits (i.e., the employees and dependents face higher deductibles, co-pays and out-of-pocket maximums) or raising employee contributions. In particular, as more families have both spouses working, employers have used various techniques to encourage employees to have their spouse insure the family's dependents. The most common approach is to reduce or eliminate the employer subsidy for dependents. Conversely, employers who maintain significant benefits for dependents are selected against, meaning that they end up insuring a disproportionate number of dependents and pay a larger number of dependent subsidies than if the dependents were equally distributed among all employers.

In the preceding paragraph, the term "subsidy" was used to reflect employer payment toward employee coverage (specifically, employee dependent coverage). The term "subsidy" has a broader usage in insurance arrangements, and relates to income (premium) from one group covering the expected claims of another group. For example, in employer group health insurance, subsidies occur when two groups are covered under one plan, where one group is paying more in premiums than it is receiving in claims, and the other group is receiving more claims payments than it is expending in premiums. The overall plan is in financial balance, but the first group is subsidizing the second. Since claims are not totally predictable, subsidies happen all the time in operating insurance programs; however, there are also structural subsidies in group health plans. Here, "structural" means that the way premiums are set creates inherent subsidies that would be expected to recur year after year. The most obvious example in employer group health plans is that premiums are set without regard to individual age; the 20 year old employee pays the same amount as the 60 year old employee. Since the average 60 year old has much higher expected claims than the 20 year old, the 20 year old subsidizes the 60 year old. In general, younger employees subsidize older employees in group health plans, in the sense that the (non-age-rated) premium paid on the younger employees' behalf is larger than the expected claims for that group.

As another example, suppose the K-12 retirees and the state retirees are together in one retiree pool (which they currently are at PEBB), and one group has a higher average age than the other (either group could be older, but some difference in average age would be expected). Again, there is a structural subsidy (a bit more complex with retirees because of Medicare, but the principle is the same). The same problem occurs for two active groups in the same pool, where one has different current age, different demographics, and/or different retirement patterns than the other (and we'd expect all of these differences between school and state employees as a group). So, for example, placing school employees in PEBB raises potential structural subsidy issues between their group and the state employee group. The only way to guarantee one group does not subsidize the other is to place each in a separate pool.

This also appears to be the reason for the large number of pools for employer funds at each school district – each bargaining unit is concerned it could potentially subsidize the others, and would rather show their members isolated bargaining on the member's behalf with the employer dollars paid for their group.

# Appendix G

## Survey of 23 State Programs for the Provision of Health Care Benefits to Public School Employees

## Alaska

Alaska has 54 school districts. Of these, 15 provide healthcare benefits to (some or all) employees through the NEA Alaska Health Trust. However, some districts maintain single employer coverages; for example, Anchorage maintains a program through Aetna in addition to the coverage of its teachers through the NEA trust.

## Arizona

The Arizona School Boards Association Insurance Trust (ASBAIT) was established in 1981 by the Arizona School Board Association. Its formation was in response to Arizona school administrators desire to obtain comprehensive health benefits at reasonable costs. ASBAIT has provided employee health care benefit programs to participating Arizona school districts and community colleges.

ASBAIT offers member districts the option to participate in medical, dental, vision, prescription drug, flexible spending account, and life insurance programs. There are 9 medical plan choices. Over 28,000 employees from 176 schools and community colleges were enrolled for the 2010-2011 school year (for reference, Arizona has 589 school districts). Operational authority of ASBAIT is by a board of trustees. The Board of Directors of the Arizona Association of School Boards appoints the trustees. The trustees consist of at least one school district governing board member, at least one superintendent of a school district, and at least one school district business manager.

Some school districts have chosen to develop their own trusts. For example, the Yavapai Unified Employee Benefits Trust provides benefits to the Prescott Unified School District and the Humboldt Unified School District. The program includes medical, dental, prescription drug and short term disability benefits.

## California

California permits active school district employees to participate in the CalPERS statewide health plan.

Eligible retired teachers may participate in the California State Teachers' Retirement System (CalSTRS) health care program that pays Medicare Part A premiums.

The CalPERS Health Benefits Program was established for state employees in 1962 by the Public Employees' Medical & Hospital Care Act. Participation was extended to other public employers, including school districts, in 1967. CalPERS purchases health benefits for the State of California and more than 1,100 local and government agency and school employers. The program provides benefits to more than 1.3 million public employees, retirees, and their families. CalPERS is the second largest purchaser of health care in the nation. State employees are covered by the program by law and local public agencies and school employers can contract to have CalPERS provide benefits to their employees whether or not they contract for the CalPERS retirement program.

The following CalPERS health care plans are available to active school employees in participating districts.

- Three health maintenance organization (HMO) plans – Blue Shield of California ("Blue Shield") NetValue, Blue Shield Access+, and Kaiser Permanente
- Three self-funded preferred provider organization (PPO) plans – PERS Select, PERS Choice, and PERSCare

More than two-thirds of members are enrolled in HMO plans. All plans offer separate Medicare supplemental plans for those members eligible for Medicare. Health plans offered, covered benefits, monthly rates and co-payments are determined by the CalPERS board, which reviews health plan contracts annually.

In California, the Board of Administration manages the CalPERS program for both retirement and health insurance. The Board consists of 13 members. Six of the members are elected, three are appointed (two by the Governor) and four hold state offices (i.e. Treasurer, Comptroller, Director of State Personnel, and a designee of the State Personnel Board).

## Colorado

The Colorado Association of School Boards is a sponsor of the BEST Health Plan**.** The Boards of Education Self-funded Trust (BEST) is a partially self-funded trust established in 2004 that offers state-wide medical plans to Colorado school districts.

BEST is a tax-exempt, not-for-profit corporation which sponsors the BEST Health Plan. The BEST Health Plan is a private label health plan designed for Colorado school districts, with a focus on education, wellness and prevention.

In addition to medical coverage, BEST offers life, AD&D, dental, vision and disability programs.

**Delaware**

The State of Delaware is required to provide employee health benefits through the State of Delaware Group Health Insurance Program (Delaware GHIP) to local school district employees, as well as employees of the State and local governments (collectively denoted below as government employees). Delaware GHIP provides medical and prescription drug coverage. Dental and vision benefits for government employees are available but the employee must pay the full cost. Also, some school districts offer employee-paid dental and vision plans. School employees may also subscribe to a separate district-sponsored prescription drug plan, which would be in addition to the Delaware GHIP plan, as part of the employee's medical coverage. Coverage in the Delaware GHIP medical/prescription drug plan is for active employees and retirees. Retirees and their dependents must enroll in Medicare Parts A and B when they become eligible or their coverage under the Delaware GHIP medical plan will terminate. Several levels of medical coverage are available, as described in the following section. The State pays the full cost for the Basic level of coverage after three months of service. The school district may pay a share of the premium in the interim.

Medical benefits are delivered through four plans. Aetna administers the Aetna HMO option and Blue Cross Blue Shield of Delaware administers the following three plans:

- First State Basic Plan (traditional indemnity)
- BlueCARE (HMO)
- Comprehensive PPO Plan

The prescription drug benefit is administered through Medco. All four plans include prescription drug coverage.

The Delaware GHIP was established by state statute, which also established a state employee benefits committee, which governs the Delaware GHIP. The committee, which meets quarterly, consists of certain senior-level state officials, including the director of state personnel, the state's

human resources officer, and the comptroller. The committee determines benefits and premiums. The State Personnel Office's Division of Benefits administers the Delaware GHIP.

## Georgia

The State of Georgia permits, but does not require, school districts to participate in the Georgia Public Employees Health Benefits programs, including the State Health Benefit Plan (GA-SHBP). GA-SHBP covers eligible state employees, and those school districts that elect to participate. If a school district does not elect to participate, the school district may be required to participate if at least 75% of the employees petition to participate.

To be eligible under the GA-SHBP, a school district employee must be employed at least 60% or work at least 15 hours per week on a regular, non-emergency basis. Cigna and UnitedHealthCare each offer SHBP members the following options:

- Health Reimbursement Arrangement
- High Deductible Health Plan
- Health Maintenance Organization
- Medicare Advantage PPO (for retirees and their spouses age 65 and older who are enrolled in Part B)

The Georgia Department of Community Health has within it the Division of Public Employee Health Benefits, which administers all the state-sponsored health and welfare plans available to state employees and other governmental employers. The GA-SHBP is the health plan operated by that Division. The Commissioner of the Georgia Department of Community Health is the chief administrative officer of the GA-SHBP and the other benefit programs under that Department's control. GA-SHBP is governed by the Board of Community Health, which is established pursuant to state statute. The Board establishes subscriber and employer rates.

## Idaho

The Idaho School District Council is a cooperative service agency which operates pursuant to Idaho Code Title 67, Chapter 23, Section 27-2328, and Title 33, Chapter 3, Sections 315-318. The membership includes public school districts, charter schools and other education-related organizations.

The purposes of the Council are to:

- Provide educational services more economically and/or efficiently through cooperation with two or more member districts;
- Develop and recommend cooperative programs, actions and policies;
- Study issues of mutual concern and interest; and
- Enter into contracts, as the member school district's representative, to employ specialized personnel and/or purchase materials or services, including insurance, on behalf of members.

The Idaho School District Council was formed to assist in the provision of affordable health care options to Idaho school employees through the Statewide School Health Plan (SWSHP). Since its inception over thirty-five years ago, the SWSHP has grown to provide coverage to over 100 public and charter schools with more than 35,000 members.

The Statewide Schools health insurance program is the largest program available through the Idaho School District Council. The Council contracts with Blue Cross of Idaho to make available a medical plan tailored to each district's or affiliate's individual needs from a variety of options. The options include deductibles, coinsurance, stop loss levels, prescription drug coverage, and vision plans.

In addition to the Statewide Schools Health Insurance Program, the Council also offers the following insurance programs:

- Dental Insurance
- Vision Insurance
- Retiree Health Insurance
- Life Insurance
- Employee Assistance Program
- Long Term Care Insurance

The Council is governed by a Board of Directors which includes six elected members, the president of the Idaho School Superintendents' Association, the executive director of the Council, and a representative of retired educators.

**Illinois**

Illinois school districts are permitted, on a voluntary basis, to participate in the Local Government Health Plan Option (LGHP). School districts are eligible to participate in the same health plan offered to employees of local governments, state agencies and instrumentalities.

Organizations interested in joining the LGHP submit demographic data and a premium rate structure is assigned to the unit. New rates are established at the beginning of each fiscal year. Units sign a two-year commitment agreement. The unit must agree to enroll 100 percent of its active, full-time employee population. However, up to 15 percent may elect to waive coverage. Units have the option of allowing enrollment of dependents, annuitants, part-time employees, elected officials and COBRA participants.

LGHP allows each individual member to select from the Local Health Care Plan or from a variety of managed care plans available in their geographic area. The health care plans include prescription drug benefits. In addition, dental and vision benefits are provided to all members regardless of the health plan selected.

The LGHP is controlled and managed by the Central Management Services for Illinois (Department of CMS). More specifically, LGHP operations are governed by the Bureau of Benefits, within the Department of CMS. The Department of CMS serves as a centralized coordinator and provider of services and resources to local governments, state agencies, and school districts.

**Kentucky**

The Kentucky Employees' Health Plan (KEHP) is a non-profit, self-funded plan operated by the Commonwealth of Kentucky. KEHP provides health insurance benefits to the employees and retirees of the Commonwealth of Kentucky, local school boards, some cities and county governments. KEHP covers 285,000 lives and partners with Humana, Inc as its Third Party Administrator (TPA) and Express Scripts, Inc as it Pharmacy Benefit Manager (PBM). Full-time employees of state agencies, Boards of Education, Health Departments and quasi-state agencies that contribute to one of the state-sponsored retirement systems are eligible to participate. In addition, retirees under the age of 65, who receive a monthly retirement payment from a state retirement system, including the Kentucky Teachers' Retirement System, are also eligible to participate.

Prior to 2006, KEHP participants paid monthly premiums to various for-profit, insurance companies. In 2005, a 52 percent premium increase caused KEHP to create the current self-funded, non-profit program. Since January 1, 2006, KEHP premiums have increased by approximately 7 percent per year.

**Louisiana**

Although school district participation in the Louisiana state-wide health plan is voluntary, a significant majority of Louisiana school districts participate in the state-wide health plan.

Since 1980 the State of Louisiana has made available, on a voluntary basis, a uniform benefit program (health and life insurance), provided through the State Office of Group Benefits (Louisiana OGB), to cover school district employees, in addition to employees in all other State agencies. The program has been self-insured since 1976, and is financed on a pay-as-you-go basis.

Active and retired employees of participating parishes/cities are eligible for coverage. To qualify for retiree health care coverage, the retiree must be enrolled in the Louisiana OGB health care plan at the time of retirement. Health care coverage includes medical, prescription drug, dental, and vision. The State shares in the cost of medical insurance for active and retired employees.

Medical benefits for active and retired employees are delivered through three state-wide plans: a PPO plan, an HMO plan, and an HSA-eligible plan. In addition, Medicare Advantage Plans are available to eligible retirees. The Medicare Advantage plans include a Regional HMO plan, two Regional HMO-POS plans, and (until December 31, 2010) two private fee-for-service plans.

**Maryland**

Maryland does not permit school employees to participate in any state-sponsored health plan, primarily because of the size and structure of Maryland's school districts. Maryland school districts are organized exclusively on a county basis, so that each county school district has its own health plans for its own employees. Even the smallest counties employ more than 1,000 employees while the largest employ close to 50,000. Consequently, Maryland school districts obtain economy of scale in the cost of school employees' health care coverage as a function of school systems' county structure.

**Minnesota**

Minnesota permits school districts to participate in the Public Employer Insurance Program (PEIP), a state-wide health plan for local governments, governmental agencies, and school districts. However, few of Minnesota's school districts participate in PEIP. In 2004, the Minnesota Legislature established a committee and commissioned a study to determine whether Minnesota should provide some type of state-wide health plan for school district employees. The committee endorsed a variety of state-wide solutions, with the majority supporting one mandatory state-wide, self-insured health plan for all school district employees.

In early 2010, the Minnesota House and Senate passed SF 915, a state-wide health insurance bill. The bill created a state-wide health insurance pool for school employees. However, Governor Pawlenty vetoed this bill. Governor Pawlenty cited concern that the bill did not address the drivers of rising health care costs and that mandatory participation impeded the local school districts' ability to address these health care cost drivers.

**Nevada**

The State of Nevada provides medical, dental, vision and life insurance benefits to state and local government employees through the Public Employees Benefits Program (PEBP). Participation is PEBP is voluntary, and most local governments (including school districts) choose not to participate for active employees (less than 10 of Nevada's 300 local governments participate). However, under state law, a retiring local government employee could elect to participate in PEBP as a retiree, with the local government required to pay a subsidy for this coverage based on years of service. While this option was closed for local government employees retiring after September 1, 2008, the majority of retirees before that date (including school district retirees) remain covered by PEBP.

There are 17 counties in Nevada, and there is one school district for each county. Thus, 15 of the 17 districts are rural, while two – Washoe County (Reno) and Clark County (Las Vegas) – contain major urban areas. Clark County School District is the largest government-employer in Nevada; with almost 40,000 employees, it is larger than the state government.

The Nevada League of Cities and Municipalities (NLC&M) created a group benefit plan in the late 1960's to provide members with comprehensive, pooled health insurance coverage. The League's health plan offers medical, dental, vision and life insurance for employees, dependents

and retirees. It is available to any city, county, school district, hospital, general improvement district, water district or other local government entity in Nevada.

However, many districts, notably including Clark County, have independent (that is, single employer) healthcare plans for their employees.

**New Jersey**

The New Jersey School Employees' Health Benefits Program (SEHBP) was established in 2007 by Chapter 103, P.L. 2007. It offers medical and prescription drug coverage to qualified school employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in SEHBP. The School Employees' Health Benefits Commission (SEHBC), established by statute, is the executive body responsible for the operation of the SEHBP. The Commission includes:

- the State Treasurer,
- the Commissioner of the Department of Banking and Insurance,
- an appointee of the Governor,
- an appointee from the New Jersey School Board Association,
- three appointees from New Jersey Education Association,
- an appointee from the New Jersey AFL-CIO, and
- a chairperson appointed by the Governor from nominations submitted by the other members of the commission.

The Director of the Division of Pension and Benefits is the Secretary to the SEHBC.

The New Jersey Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SEHBP.

Participants in the SEHBP can choose from two PPO plans offered by Horizon Blue Cross Blue Shield of New Jersey, an Aetna HMO, and a Cigna HMO. Prescription drug benefits are administered by Medco. Dental benefits are available to boards of education that have adopted a resolution to provide dental benefits under the Employee Dental Plans.

**New Mexico**

The New Mexico Public Schools Insurance Authority (NMPSIA) was created by the New Mexico legislature in 1986 to purchase insurance benefits for all New Mexico public school districts (except Albuquerque Public Schools). Other educational entities and charter schools participate in the NMPSIA program. The NMPSIA offers two medical plans, a High Option and a Low Option. Both options are PPO plans. Prescription drug coverage is also provided. In addition to the medical options, school districts may choose to participate in dental, vision, disability and voluntary life insurance programs. Plan designs and employee contribution rates are established by the Authority.

**New York**

In 1957, the New York State Health Insurance Program (NYSHIP) was established to provide health care benefits to state employees. A year later, in 1958, the program was opened to local governments, school districts, and municipalities. NYSHIP is one of the largest public employer health insurance programs in the nation, covering over 1.1 million state and local government employees, retirees, and their families.

NYSHIP provides health benefits through the Empire Plan, various Health Maintenance Organizations, the New York State Dental Plan, the New York State Vision Plan, and the Student Employee Health Plan. NYSHIP is administered by the Employee Benefits Division of the New York State Department of Civil Service (DCS), and other select DCS staff.

School employees in the State of New York, with the exception of New York City, receive health care benefits through their local school districts. These plans are generally bargained between the local school board and the employees' union. New York City public school employees obtain their benefits through the New York City Department of Education where basic coverage is of no cost to the employee. The New York City program is described below.

New York City school employees and retirees are covered under the New York City Health Benefits Program (NYC-HBP). Active employees must work at least 20 hours per week and have an appointment expected to last for more than six months to qualify for coverage. Retirees eligible for health benefits must have at least ten years of creditable service as a member of a retirement or pension system maintained by the City, have been employed by the City immediately prior to retirement and have worked regularly for at least 20 hours per week, and be

receiving a retirement annuity from a City pension plan. (Retirees who were employees of the City prior to 12/27/01 must have five years of credited service at retirement.)

The NYC-HBP offers a variety of plans. Three basic options are available to active employees and retirees and are fully paid by the City Department of Education. Additional basic options are available and require an employee contribution. Active school employees may elect optional prescription drug coverage under any of the basic options. Optional benefits require employee contributions.

Retired New York City school employees may enroll in a variety of plans, depending on their eligibility for Medicare. Medicare-eligible retirees who enroll in a Medicare HMO plan receive enhanced prescription drug coverage from the Medicare HMO if their union welfare fund does not provide prescription drug coverage, or does not provide coverage deemed to be equivalent, as determined by the NYC-HBP, to the HMO enhanced prescription drug coverage. The retirees contribute to the cost of this coverage through deductions from their pension payments. Eligibility for the optional drug coverage is determined automatically, and is not a discretionary election for the retiree.

**North Carolina**

North Carolina requires all school districts to participate in a state-wide health plan. Through the provisions and limitations of the North Carolina General Statutes, the state provides mandatory health care benefits to active and retired State employees as well as for school district employees, retirees, and their eligible dependents. The North Carolina State Health Plan (NC-SHP) insures more than 665,000 state employees, teachers, retirees, current and former lawmakers, state university and community college personnel, state hospital staff and their dependents. The plan offers two PPO options and is self-insured.

Permanent state employees, retired state employees and teachers, and their dependents are eligible to enroll in the plan. For state employees working at least 30 hours per week for nine or more months per calendar year, the state pays 100% of the cost of single coverage. Dependent coverage is fully paid by the employee. In addition, state employees working more than 20 hours but less than 30 hours per week are eligible to enroll; however, they must pay the full cost of coverage.

School district retirees may continue coverage under NC-SHP, up to and beyond Medicare eligibility. Retirees also receive State-paid coverage for themselves if they have been contributing members of the Teachers' and State Employees' Retirement Systems for at least five years and are receiving retirement benefits. Otherwise, retirees can pay the full cost of coverage. Retirees may purchase coverage for eligible spouses and dependents.

In 2010, the NC-SHP commissioned a study of Medicare Retiree plans to evaluate potential savings if the Plan moves Medicare primary members to a new plan. Medicare Advantage plans and a Medicare Supplement Plan (Plan F) were evaluated. The study indicated the Medicare Advantage option had the potential to provide savings of $20 to $25 million.

NC-SHP is run by a board of trustees and an executive administrator; however neither has the power to unilaterally change plan design or other aspects that have been established by State statute. The board of trustees consists of nine members: 3 appointed by the Governor, 3 appointed by the General Assembly upon the recommendation of the State Speaker of the House, and three by the General Assembly upon the recommendation of the Speaker Pro Tempore of the State Senate. No member of the Board of Trustees may serve for more than three consecutive two-year terms.

**Ohio**

Ohio does not permit active employees of school districts to participate in the state employee health plan. However, the State's two retirement systems provide retiree health benefits to their respective school district members. Health benefits for retired school district teachers and their surviving family members are provided through the State Teachers Retirement System of Ohio (STRS). Under the STRS, a retiree must have 15 years of service to qualify for retiree health benefits. STRS retirees may choose among an indemnity plan and several HMOs and PPOs. In addition, a Medicare Advantage plan is available to Medicare-eligible retirees.

Health benefits for retired non-teaching school district employees are provided through the School Employees Retirement System of Ohio. Retiree costs are determined on a sliding scale, requiring a retiree to pay 100 percent of premiums if she/he has less than 20 years of service, and grading down to 15% for retirees with 35 years of service. An additional 1% reduction in the retiree's share is applied for each year over 35. Retirees may choose among a variety of plans depending on geography and Medicare eligibility.

**Oregon**

The Oregon Educators Benefit Board (OEBB) was created in 2007 with the signing of Senate Bill 426. The OEBB implementation was considered an emergency due to rising health care costs and other concerns about health care. As a result, the Board was formed immediately after the legislation was signed. The purpose of the OEBB is to provide health, dental, vision and other benefits for most of Oregon's school district employees. The OEBB is open to K-12 school districts, education service districts (ESDs), community colleges and some charter schools.

The Oregon Educators Benefit Board is made up of:

- Two members representing district boards
- Two members representing district management
- Two members representing non-management employees from the largest labor organization representing district employees – Oregon Education Association (OEA)
- One member representing non-management district employees from the second largest labor organization representing district employees – Oregon School Employees Association (OSEA)
- One member representing non-management district employees from a labor organization other than the largest or second largest labor organization representing district employees – AFT Faculty and Classified Federations at Portland Community College
- Two members with expertise in health policy or risk management

The OEBB provides more than 200 educational entities and their employees with a choice of nine medical, four pharmacy, eight dental and five vision plans. The program was implemented on October 1, 2008 and is administered by the OEBB. Districts were required to join the program in a phased approach based on the expiration of collective bargaining agreements. All employee groups were required to move to OEBB by October 1, 2010. The OEBB has adopted a policy that if the OEBB benefits are not comparable on a district-wide level to the district's current carrier's rates, then the district does not have to enter the OEBB. Comparability is assessed annually.

The OEBB expects to cover approximately 170,000 people once all school districts enter the pool in October 2010.

## South Carolina

All South Carolina school districts are required to participate in the South Carolina Employee Insurance Program (EIP). The EIP provides health (including prescription drugs), dental, life insurance, long-term disability, and long-term care benefits, a flexible benefits arrangement, and a vision discount program. The EIP covers more than 422,000 people throughout South Carolina. Approximately 600 employer groups participate in the program. State agencies, public colleges and universities and public school districts are universal required participants. Optional participants include counties, municipalities, and other government instrumentalities. Generally, employees who work at least 30 hours per week on a permanent, full-time basis are eligible to participate; however, participating employers have the option to reduce the general eligibility threshold to 20 hours per week. In addition, permanent part-time teachers who work at least 15 hours per week are eligible.

The EIP is part of the South Carolina Budget and Control Board, the central administrative agency for South Carolina state government. The Board is overseen by a five-member body chaired by the Governor. This body selects the Budget and Control Board's Executive Director, who serves as the agency's chief administrative officer.

The EIP offers the State Health Plan, which includes the Standard Plan and the Savings Plan, which are PPO options. In addition, two HMO options are available. Lastly, the EIP sponsors a retiree health program.

## Texas

Texas created a separate state-wide health system for school district employees independent of the state employee's health plan. Depending on the size of the school district, Texas school district employees are either required or permitted to participate in the state-wide health system for school employees. The state-wide school district health program is administered by the Teacher Retirement System of Texas (TRS) and is called TRS-ActiveCare. TRS also administers a separate health benefit program for retired school district employees called TRS-Care. This health benefit program went into effect September 1, 2002 and provides health coverage to employees of school districts, charter schools, regional education service centers, and other educational districts. Employees of the State of Texas, its governmental units, and higher education employees are eligible to participate in their own state-wide health plan.

As of September 1, 2003, Texas law required that active employees of all school districts with fewer than 500 participate in TRS-ActiveCare, unless the school district was already self-insured as of January 1, 2001. School districts with more than 500 but not more than 1,000 employees have the option of participating in TRS-ActiveCare, but once they elect to participate, they cannot leave the program. Effective September 1, 2005 active employees of school districts with more than 500 employees are permitted, but not required, to participate in TRS-ActiveCare. Participation in the program has grown to over 398,000 employees and dependents. Of the 1,257 districts/entities eligible to participate in TRS-ActiveCare, over 87 percent, or 1,101, now do so.

TRS-ActiveCare is a self-funded plan that is separate from the TRS Pension Trust Fund. The program is funded from several sources. First, school districts are required to contribute a minimum of $150 per month per covered TRS member (school districts may choose to contribute more). Second, the state contributes $75 per month per covered TRS member through school finance formulas. Third, the employee's contributes the amount remaining after the employer and state contributions for the plan he or she has selected. Additional funding sources are investment income and reimbursements related to the American Recovery and Reinvestment Act (ARRA for 2009 – 2012).

**Utah**

The Public Employees Health Program (PEHP) is a division of the Utah Retirement System. PEHP is a non-profit trust responsible for providing health benefits to Utah's public employees and their families. PEHP serves only the public sector — the state of Utah, its counties, cities, school districts, and other public agencies. PEHP's medical networks provide access to more than 12,000 providers and every major hospital in Utah. PEHP offers medical, dental, life and accident, long-term disability, flexible spending, health savings accounts, and COBRA administration. Approximately half of Utah's public entities participate in PEHP.

**Wyoming**

Wyoming School Support Services, Inc. is a wholly owned, non-profit subsidiary of the Wyoming School Boards Association. Wyoming School Support Services offers a variety of financial and insurance services to member districts. These include:

- Wyoming School Boards Association Insurance Trust
- Group Term Life/AD&D Insurance

- Property Casualty Insurance
- Voluntary Workers' Compensation
- Universal Whole Life Insurance Program
- Long Term Disability
- Health Insurance Consultant Services

The Wyoming School Boards Association Insurance Trust (WSBAIT) was created in 1996 in an effort to control the rising costs of health insurance premiums to Wyoming school districts. The WSBAIT is the largest school insurance trust in Wyoming. Through the use of network discounts and wellness benefits, WSBAIT provides a competitive health insurance program for members. In addition to health insurance for active employees, the WSBAIT offers an Early Retiree Program for employees who leave active employment but are not eligible for Medicare. Member districts have a variety of benefit plan options.

A separate trust is offered by the Wyoming Education Association. Founded in 1971, the Wyoming Educators' Benefit Trust (the Trust) provides members with employee benefit programs. Members include public educational entities, as well as cities, counties and other publicly funded employers. The Trust covers more than 5,200 employees and retirees. The trust is administered by a consultant who handles marketing, implementation of service and proposals. A third party administrator handles membership, adjudicates claims and provides customer service to Trust members. Lastly, there is a reinsurance company insuring catastrophic claims. The Trust is governed by a board of trustees. In addition to the medical benefits programs, the Trust provides optional dental, vision, life insurance and long term disability programs.

# Appendix H

# Actuarial Savings Assumptions

The anticipated system-wide cost savings were comprised of three main areas: eligibility management, self-funding and purchasing. Savings from eligibility management come primarily through more frequent and consistent eligibility updates. Financing savings are achieved by moving to a self-funded plan and reducing commission costs. Purchasing savings are achieved primarily through using the purchasing power of the plan, carving out specific benefit coverages and separately bidding and managing the contracts.

**Eligibility Management Savings**

We have assumed that a state-wide program would develop and maintain a single eligibility system. We would expect such a system to send weekly eligibility updates to carriers with a 72 hour grace period, after which no payments would be made to the carriers for benefits provided to individuals identified as ineligible in the last update.

**Self-Funding**

A large self-funded health plan will be relieved from paying for the costs of insurer risk charges, contributions to reserves, state premium taxes and high-risk pool assessments. In addition, a self-funded plan would avoid paying commissions to agents or brokers for placing the coverage.

***Insurer Gain***

When pricing fully insured health benefits, insurers include in their premiums a margin in excess of expected benefit costs and expenses. If actual benefit costs are equal to the level expected, this margin becomes a gain for the insurer. For commercial insurers, it provides the profit on capital provided by investors. For non-profit companies, which do not have the same access to capital markets, it provides a source for the capital and surplus necessary to maintain the financial soundness of the insurance operation and finance growth of the organization. A variety of terms are used to describe this margin, including profit, contribution to surplus, and contribution to reserves (i.e., referring to reserved capital, and not incurred but not reported claim reserves). We estimate the insurer risk charges and gain to represent approximately 0.25 percent of premiums for coverage purchased through the WEA, and 1. 5 percent of premiums for non-WEA plans, for an overall average of approximately 0.8 percent of premiums for the system as a whole.

***Sate Premium Tax***

A self-funded plan would pay no state premium tax. Our estimates are based on a tax rate equal to 2.0 percent of premiums.

### *High Risk Pool Assessments*

The State's self-funded Uniform Medical Plan and stop loss carriers pay an assessment that is one-tenth that paid by insurers for fully-insured coverage; we assume that a self-funded state-sponsored plan for school employees would also pay assessments at the reduced rate. Our specific assumption is based on a base assumption of $1.90 per member per month, times a 90 percent reduction. This is equivalent to approximately 0.45 percent of premiums. We chose $1.90 as a conservative assumption; our analysis suggests that the WEA plan paid $1.97 in 2008.

### *Commissions*

Premiums for insurance contracts placed through agents or brokers include agent commissions. A state-wide system would avoid this expense. Our assumptions is based on a review of the WEA commission level and considers the typical commission levels Hay Group actuaries have found in our other actuarial studies

## Purchasing Savings

### *Carving Out Pharmacy Benefits*

Pooling all prescription drug coverage, including that provided by HMOs, into one contract will enable the plan to bid this coverage competitively and obtain a single pharmacy benefit manager and the possibility of lower rates.

A = Pharmacy expenses as a percent of total health care costs = approximately 20%
B = Reduction in pharmacy costs from pooling and bidding the coverage = 7.5%
C = Savings in total health care costs from carving out pharmacy coverage = A x B = 1.5%

The 7.5% assumption in B is base don actual results from other large groups compared to non-pooled costs.

### *Carving Out Durable Medical Equipment*

Our experience shows that pooling all DME purchases into one contract produced savings in DME equivalent to 0.20 percent of total health care expenses.

## Likely Participation in a Voluntary Plan

We assumed that a state-sponsored plan would be:

1) Tailored to the needs of school employees, as discussed in the body of the report;
2) Actively promoted by the state; and

3) Would be the only other large self-funded insurance pool available to local districts.

Under those circumstances, we believe it is reasonable to assume that the market would effectively be divided between the two programs (with perhaps a few districts choosing to seek other coverage due to local bargaining or political reasons). Given that WEA covers a little more than half of Washington school employees who have health benefits, we believe it is reasonable to assume that a well run and effectively promoted state-sponsored plan would cover approximately 45 percent of school employees with health coverage when fully implemented.

## Summary of Savings Assumptions

(all savings assumptions expressed as a percentage of premiums)

| | Voluntary | Mandatory |
|---|---|---|
| **Eligibility Management** | | |
| Frequent updates | 0.25% | 0.25% |
| *Total* | 0.25% | 0.25% |
| **Self Funding** | | |
| Insurer Gain | 0.80% | 0.80% |
| State Premium tax | 2.00% | 2.00% |
| High Risk Pool Assessment | 0.45% | 0.45% |
| Commissions | 0.17% | 0.17% |
| *Sub-Total* | 3.42% | 3.42% |
| Percent Currently Not Self-Funded | 90% | 90% |
| *Final Total* | 3.30% | 3.30% |
| **Purchasing** | | |
| Pharmacy Carve-out | 1.50% | 1.50% |
| DME carve-out | 0.20% | 0.20% |
| *Total* | 1.70% | 1.70% |
| **Total** | 5.25% | 5.25% |
| | | |
| **Percentage of School Districts Participating** | 45% | 100% |
| **Aggregate Savings** | **2.36%** | **5.25%** |

# Appendix I

## Free-form Survey Responses

## "What aspect about the health benefits would you most like to see improved?"

| Survey Reponses to Part C, Question 15: "What aspect about the health benefits would you most like to see improved?" |
|---|
| 100% Coverage for all employees |
| Adequate funding by the State |
| Benefit options and lower deductibles |
| Better Benefits and lower premiums |
| Competitive pricing, without WEA control. Lower cost options for families, wellness incentives, uniform coverage. Pooling should also end as local dollars are what makes up the pool (benefits not fully funded by BEA allocation). Pooling language is old and assumes a fully funded pass through amount. Remove pooling language would be a start. Please do not make each district bargain with WEA to end coverage through union. Uniform legislative decision is needed if a change in funding is the outcome. |
| Control spiraling plan premiums or provide more affordable health care plans |
| Cost to classified employees |
| Full funding of medical benefits for all employees. Legislature would have to mandate that all school districts must join the HCA program that is a state program. |
| Lower costs for both employee and employer while keeping quality coverage |
| Lower Premiums |
| Premium costs for all medical plans/ Washington Dental Service- increase in benefit year maximum |
| Premiums |
| Premiums |
| Reduced premiums so more employees could cover their families |
| The amount of state funding provided |
| The benefits would be better and the cost (as a whole) would be less. |
| The cost and the coverage |
| The premium rates need to be lower |
| TORT reform & lower premiums |
| Value |

# Appendix J

# Benefit Value Comparison Methodology

**Health Care Benefit Value Comparison**

Hay Group has developed a technique of "common costs" that permits the assignment of dollar values using a common yardstick across all employers in the comparator group. Hay Group uses its proprietary Benefit Value Comparison (BVC) model to calculate quantitative values and the competitive position of an employer's benefit plan(s).

BVCs are computed using a common set of assumptions about demographic, geographic, and economic factors that isolate differences in benefit values as being solely attributable to differences in plan design. The resulting benefit values permit objective "apples-to-apples" comparisons of the benefit programs provided by various employers. Differences in benefit values for the employer plans being compared can be traced directly to design differences.

Benefit values are based on the average cost of providing the benefits to employees for a typical large U.S. employer. Valuations take into account the expected frequency and duration of use of a benefit.

The key to the Hay "common cost" approach is the use of a single, realistic method for all plans being valued. All plans in the study are, in effect, "purchased" for the same group of employees from the same source using the same financing technique. The "employees" are a typical mix of employees that might be found working for a large employer. The "providers" are a hypothetical group of insurance companies and/or trustees who are "selling" coverage using the same average group rates, actuarial assumptions, and experience ratings for all the plans in the study. The result is an actuarially derived "common cost" for each plan, expressed as a dollar value.

## Induction Effect in HCBVC

HCBVC 9.4 has six questions that determine a relative induction factor. Five of these are questions about the relative induction for specific types of health care: hospitalization and related expenses, prescription drugs, other expenses,) inpatient mental health and substance abuse, and outpatient mental health and substance abuse.

The five induction questions permit the user to enter a value between 0 and 200. The standard values are based on a set of assumptions developed by the Health Care Financing Administration (HCFA), which were later accepted by the Academy of Actuaries as one set of possible induction factors (MSA study - 1995). The standard input values are 30 percent for hospitalization, 100 percent for prescription drugs, 70 percent for other medical care, 30 percent for inpatient mental health and substance abuse treatment, and 100 percent for outpatient mental health and substance abuse treatment.

The sixth question is the extent to which the insured considers any individual health account balances to be savings. An individual health account may be a Health Reimbursement Account (HRA), Health Savings Account (HSA) or similar arrangement where health plan participants are credited with funds that may be used to cover allowable health care expenses during the current year, or accumulated to be used in future years. The individual health account question concerns the degree to which the account balance is viewed as insurance or savings. If the balance is viewed only as another form of insurance, then the out-of-pocket expenses will be fully offset by the allowable individual health account funds. If the balance is viewed as savings then the presence of an individual health account will not affect the insured individual's decision and the out-of-pocket expenses will not be changed. The result will be that the cost of the plan will decrease as the portion viewed as savings is increased. With the induction parameter set to 100, the presence of an individual health account has no impact on the cost of the plan.

The model may be used to evaluate the impact of a variety of different kinds of individual health accounts. In choosing an assumption for the extent to which account balances will be viewed as savings, it is important to understand the extent to which participants own their own account balances. In particular, are the accounts truly portable – can an employee take his or her accumulated funds when leaving the plan, or are they forfeited? If account balances are forfeited or are not truly portable, participants are less likely to view them as savings.

The HCBVC expense grid represents anticipated charges for a fully insured plan with no cost controls in place. Almost all health plans require participant copayments for services. The copayments will clearly reduce the demand for services. This reduction in demand is what Hay calls "induction" (“elasticity” for economists). The induction methodology models the reduced demand for services because of copayments.

There are few studies on the magnitude of induction. The primary source is the RAND survey that was conducted in the 1970's. Many analyses of the survey have been performed. In addition, RAND has developed a regression model that calculates induction depending upon the copayment features. Hay used the RAND model results to develop an induction procedure for HCBVC 9.4. Hay was supplied with premiums developed by the RAND model with a variety of coinsurance percentages and maximum out-of-pocket features.

The RAND model results indicated that the first participant copayment dollars reduce demand considerably. Subsequent dollars have less of an effect. Accordingly, the HCBVC induction algorithm will reduce demand more for the first copayment dollars. The RAND study also indicated greater induction for outpatient services than for inpatient services. Accordingly, the degree of induction will depend upon the mix of services provided.

For each row in the grid, HCBVC 9.4 determines a reduction percentage to reduce all of the values in the row. The first step determines the beneficiary out-of-pocket expense ("copayment") based on the plan provisions and expense values in the row. Next, the benefit-specific induction factors entered by the user are used to calculate a weighted induction factor based on the mix of expenses in that row.

The copayment and weighted average induction factor for the row are then plugged into the following bounded equation to produce an estimated reduction in demand:

$$RD = A \times \text{Minimum} \left( (5{,}200 \times \text{Copayment})^{(1/2)} \right), 3 \times \text{Copayment} )$$

where

- Copayment equals the employee copayment based on the plan provisions and the grid
- A is the weighted induction factor
- RD is the reduction in demand

The new spending level, adjusted for the effect of cost-sharing on utilization, is expressed as a percentage factor of spending under a free plan: (Total - RD)/Total where "Total" is the sum of all the values in the row. The model restricts this percentage to the range from 0% to 100%, preventing the impact of induction from producing negative spending or spending that exceeds the "free plan" level. Each item in the row is multiplied by the resulting percentage to produce spending after the effect of cost sharing on the demand for health care. Finally, based on the reduced values and the plan provisions the employee copayment, plan payments are determined. The procedure is repeated for each row in the grid.

The induction algorithm can eliminate the demand of the total value for services if the row is small. In no case will the values be negative. The current grid has some demand for 90 percent of the population.

Because of the induction effect and typical plan provisions, there will be a demand for services for approximately 70 percent of the population.

Modifying the plan provisions for one benefit (e.g. prescription drugs) is modeled as having a behavioral impact on all benefits – either reducing utilization if the plan change increases out-of-pocket costs, or vice versa increasing utilization if the plan change lowers out-of-pocket costs. In other words, the model assumes that when considering whether or not to seek additional health care, individuals think about how much they've already spent on all forms of health care – not just what they've spent on the particular type of service they're considering. (When thinking about going to a physician one more time, they will think about how much they've already spent on prescriptions, drugs, and emergency room care – in addition to what they've already spent at the physician's office.)

The following numerical example illustrates this process.

| | |
|---|---|
| Total expenses for a free plan | $10,000 |
| Plan benefit value (before induction) | $8,500 |
| Out-of-pocket expenses | $1,500 |
| Weighted average induction factor | 0.70 |
| Reduction in demand | 0.70 x (5,200 x 1,500) ^ (1/2) = 1,955 |
| Reduction in demand for this record | Factor = (10,000 - 1,955) / 10,000 = 0.8045 |
| Reduced expenses for the benefit plan | $8,045 |
| Plan benefit value (after induction) | $6,838 |
| Out-of-pocket expenses | $1,207 |

The bounded equation used to estimate the reduction was selected based on several criteria. First, it had to be a monotonically increasing formula. Increasing a consumer's out-of-pocket costs by a dollar must never increase the demand for health care. Second, the slope of the equation should decrease as consumer out-of-pocket costs rise. The first dollar of cost sharing has a greater proportional impact on demand than the hundredth dollar, or the thousandth dollar. Third, the parameters were chosen so that, given a typical plan design, the equation produces the average reduction in demand over the entire expense grid as would be obtained by applying the weighted average induction factor with no adjustment for the level of out-of-pocket spending. This last "calibration" is important, because it preserves the meaning of the induction factors input by the user, rather than turning them into arbitrary index values. That is, if all of the induction factors were set to "50," then for a typical plan the resulting reduction in demand would on average equal half the beneficiary out-of-pocket expense.

## HCBVC 9.4 Medical Expense Grid

Each line in the grid for HCBVC 9.4 represents a single claim in the entire universe of claims. The grid breaks down the claim into 13 different medical expense categories:

1. Inpatient Hospital
2. Hospital Emergency Room
3. Other Outpatient Hospital
4. Inpatient Physician
5. Outpatient Physician
6. Outpatient Imaging and Lab
7. Hospice & Home Health Care
8. Pharmaceutical Cost
9. Inpatient Mental Health Treatment
10. Outpatient Mental Health Treatment
11. Inpatient Substance Abuse Treatment
12. Outpatient Substance Abuse Treatment
13. Dental Care

This expense grid represents medical spending under a "free plan" – a health benefit program with no beneficiary deductibles, coinsurance or co-payments. Because over 90 percent of employer-sponsored health benefit plans are based on provider networks with negotiated reimbursement levels, payments levels assume an average network discount to accurately reflect the value of deductibles and cost sharing in a typical network environment. Expense and utilization patterns are for a working-age adult; child expenses are developed by applying the child factors discussed in the Family/Adult/Child Factors section to adult costs.

Two other columns are also included the grid -- an identifier column (column 1) and a probability or "weights" column (column 2). Note that some medical expenses are not included in the grid. They include vision and preventive care services.

The grid begins as the total expense for a plan with no copayments (that is, the plan pays 100 percent of the total cost). HCBVC 9.4 allows for pricing more liberal plans, and represents the expenses in absence of any insured copayment. In other words, the baseline cost (or grid) is the total cost expected if the plan paid all expenses. Any induction effect resulting from copayments will reduce the expenses. The following steps outline how the grid calculates the plan cost for each expense band.

*Step 1.* The copayment structure is applied to the grid to determine the insured's payment. This is the amount paid by the insured before induction is considered in the cost.

*Step 2.* The values in the grid are reduced to account for the induction effect of copayments.

*Step 3:* The copayment structure is applied to the values in Step 2 to determine the insurer's payment.

*Step 4.* The cost from Step 3 (insurance cost) is multiplied by the probability of occurrence (column 2). The BVC for the core cost is equal to the sum of the products. If the probability of an expense row is equal to $p_i$ and the cost based on the plan provisions is $cost_i$, then:

$$BVC = S\ (p_i \times cost_i).$$

The HCBVC 9.4 expense grid is based on several sources, all trended to 2004: the MHBVC 2.2 expense grid; FEHBP standard option data from 2002; and the 1996 Society of Actuaries large claim study. The trended MHBVC 2.2 grid was taken as a base. Expenses were re-allocated to reflect the new categories used by HCBVC 9.4. To smooth the distribution of expenses by size, three copies were made of each row from the original table: one with the expenses unchanged, one with the expenses increased by 10 percent, and one with the expenses decreased by 10 percent. We also divided the weight for each row by three, so that the weights will still represent probabilities summing to 1.0. This procedure produced a more even distribution of medical expenses, with fewer discontinuities, without changing average expense levels. The FEHBP data and the SOA study did not include a detailed distribution of expenses by type. We blended the SOA results for catastrophic claims into the FEHBP data to develop a distribution of aggregate medical spending by amount representing recent experience adjusted to reflect information from the much larger SOA data base on catastrophic claims. We then compared the updated expense grid to the blended distribution of aggregate spending, adjusting the probabilities and amounts in the expense grid to produce an overall distribution for aggregate spending consistent with the FEHBP and SOA data. The base year costs were trended to 2010 for the study.

HCBVC 9.4 has over 1,300 lines with values allocated to fit the distributions from each of the sources of information, calibrated so that the results of the model are consistent with actual plan costs reported by employers.