



THE K-12 PUBLIC SCHOOL EMPLOYEE HEALTH BENEFITS REPORT

EXECUTIVE SUMMARY

Washington State
Health Care Authority



EXECUTIVE SUMMARY

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OVERVIEW

In June 2011, Governor Gregoire signed into law Chapter 50, 2011 Laws 1st Special Session PV. Section 213 of this law includes a directive for the Washington State Health Care Authority to ***“develop a plan to implement a consolidated health benefits system for K-12 employees for the 2013-14 school year.”***

For K-12 employees and Washington’s taxpayers, a consolidated purchasing system should be a system where dollars can be constantly measured and effectiveness and efficiency improved. Ultimately, school employees deserve a well-regarded and equitable health benefits system, while taxpayers deserve a well-run and transparent purchasing system. The design contained in this report is structured accordingly.

Approximately \$1B in public funds makes up the annual employer contribution from 295 local school districts and nine educational service districts for employee insurance benefits. Each district combines the State funds received with local levy monies, federal funds and other revenue sources to provide insurance benefits either directly or through contracts with benefit plan carriers, including the Health Care Authority (HCA). The 304 districts form a statewide K-12 array of separate employee health benefits programs - from Blaine to Vancouver and Cape Flattery to Asotin - serving more than 200,000 K-12 public school employees and their dependents.

This array is diverse with districts varying in size from less than 10 employees to more than 4,000 employees and employing a broad workforce of full-time and part-time management staff, administrative staff, certificated staff, classified staff, health services staff, and other employee types. The Washington State Health Care Authority has taken great care to prepare this report and its contents in a manner that acknowledges this diversity, and the associated complexities involved, and challenges posed in designing an employees’ health benefits purchasing system to consolidate the existing array.

This report is not intended to make a case for consolidated vs. non-consolidated or status quo vs. new. This report is intended to fulfill the Health Care Authority obligations to the State Legislature. The Health Care Authority recognized – and strived to achieve – a high level of objectivity in developing a viable approach to consolidated employees’ health benefits purchasing for the K-12 system.

BACKGROUND AND TASK

Since the late 1960s, Washington State has appropriated funds that provide health benefits for public school employees. In the early 1990's, State activities related to health care reform placed a focus on K-12 public school employees' health benefits resulting in an unsuccessful attempt to consolidate the individual district health benefits programs into a single statewide purchasing system in combination with state public employees' health benefits. Since that unsuccessful attempt, discussions have continued, studies have been conducted, and proposed consolidation legislation has been considered, but not adopted.

During the 2011 Legislative session, the State Auditor's Office presented a performance review of the K-12 public school employees' health benefits array that included an accompanying study conducted by the HayGroup®. The information presented by the State Auditor's Office generated a high level of interest among State policy makers, K-12 public school officials and employee representatives. The directive contained in Chapter 50, 2011 Laws 1st Special Session PV directed the Washington State Health Care Authority to develop a proposal for a consolidated health benefits purchasing system for K-12 employees. The goal of the directive is to improve administrative efficiency, transparency, and equity in the delivery of K-12 public school employees' health benefits, and to dedicate any prospective cost savings back to Washington's public schools. The proposal is to include the design of a consolidated purchasing system and an implementation strategy for ensuring a successful transition.

This report has three volumes that accomplish the legislative request. The three integrated volumes draw upon each other and comprise the full report.

1. Volume One - Design Proposal.
2. Volume Two - Implementation Plan.
3. Volume Three - Financial Modeling.

VOLUME ONE – DESIGN PROPOSAL

Volume one presents detailed information relating to the Health Care Authority design proposal for a consolidated K-12 public school employees' health benefits purchasing system. Two scenarios specified by the Legislature were evaluated for consideration as the structure for the Health Care Authority's proposed consolidated purchasing system. Three case studies and results of focused interviews with selected Washington school districts are also presented in Volume one.

The two scenarios considered are:

1. Mandatory district purchasing through the Public Employees' Benefits Board (PEBB) Program.
2. Separate statewide risk pool for K-12 public school employees' health benefits.

MANDATORY DISTRICT PURCHASING THROUGH THE PUBLIC EMPLOYEES' BENEFITS BOARD PROGRAM

After analyzing the impacts of this approach, in the end the Health Care Authority concluded that a strategy to develop a consolidated purchasing system utilizing the existing Public Employees' Benefits Board program, even with reasonable modifications, poses serious financial risks to the Public Employees' Benefits Board program while achieving only limited improvement to the K-12 public school employees' health benefits array in the areas of importance for the Governor and Legislature. Attempting to blend two employees' benefits system business models causes negative impacts for both benefits systems while achieving a diminished level of potential gain in quality and affordability for the employees.

SEPARATE STATEWIDE RISK POOL FOR K-12 PUBLIC SCHOOL EMPLOYEES' HEALTH BENEFITS

This is the essence of the Health Care Authority proposed consolidated system and covers a broad array of issues, considerations, and options. Five key design elements of a health benefits purchasing system are addressed:

1. The consolidated system's **governance structure**.
2. The **population served** by the consolidated system.
3. The **scope and structure of the health benefits portfolio**.
4. The **revenue sources and cost sharing responsibilities**.
5. **Options and discussions in response to the Legislature's request for specific information** relating to required district participation, potential administrative savings, and other topics.

A synopsis of the Health Care Authority proposed design is included in this Executive Summary.

CASE STUDIES

Approximately half the states in the nation do not provide public school employees access to a state-sponsored employee health benefits program. The majority of those states that do, have provisions for voluntary participation in the state employees' benefits program similar to the current Washington arrangement. Only a small number sponsor a separate statewide program for public school employees.

Volume one includes a look at three of the states that have previously tackled the challenges presented by a separate consolidated statewide K-12 employee health benefits program: Oregon, Texas, and New Jersey. One state has a mandatory program, one offers a combination of mandatory and voluntary (depending on district size), and one state provides a completely voluntary program.

1. **The Oregon Educators Benefit Board (OEBB)** case study may be most useful as the neighboring state created a consolidated system in 2007, and has documented a great amount of the work. Currently providing coverage to 150,000 employees and their dependents, the OEBB has significant regulatory, budgeting and administrative responsibility. It is mandatory for school districts to participate in the OEBB – with some exceptions that must be approved by the OEBB.
2. **The Texas Retirement System Active Care (TRS-ActiveCare)** was established in 2001 and

provides coverage for almost 75% of the state's 650,000 K-12 employees in 90% of 1,257 school districts. Participation is mandatory for some school districts and optional for others.

3. **The New Jersey School Employees' Health Benefits Program (SEHBP)** was created in 2007 and is administered by the State Division of Pension and Benefits. It is an entirely voluntary benefits program, where the local school employer must adopt a resolution to participate. Approximately 50% of the state's 660 school districts are currently participating.

VOLUME TWO – IMPLEMENTATION PLAN

Six factors of a consolidated system have guided the Health Care Authority's work on this report:

1. Equitable access to quality and affordable health plans for K-12 employees.
2. Cost-effectiveness for the State, the school districts and their employees.
3. Shared responsibility of costs through State, school district and employee participation.
4. System wide integration that provides consistent policies and administration throughout.
5. Transparency of the financing: what dollars are used, where, and for whom.
6. Value-based purchasing of insurance products to be offered to K-12 employees in a manner consistent with State health care purchasing policy.

FINDINGS

- A. In order for the Health Care Authority to accomplish all six factors, a well designed and resourced strategy is essential to establish the infrastructure for performing the broad range of purchasing system operations that will be critical to an effective and efficient statewide benefits purchasing system.
- B. Because the proposed design is different from the current Public Employees' Benefit Board program within the Health Care Authority, and also different from the current independent programs that each K-12 district administers, a significant amount of work must be done to implement as early as the 2013-14 school year.

PROPOSED PLAN

- A. The implementation plan presented in Volume two leverages existing systems and capabilities, in combination with newly developed features. The State will need to develop, or partner with others to implement, three key systems to operate the new K-12 program. The new systems are:
 1. A web-based benefits enrollment tool(s).
 2. Additional interfaces of data between: (a) districts and carriers, (b) districts and the Health Care Authority, and (c) carriers and the Health Care Authority.
 3. Additional data warehouse functionality within the Health Care Authority.
- B. The Health Care Authority recognizes a consolidated purchasing system will significantly revise current roles and the new system will have impacts on districts, partners and the Health Care

Authority. Outreach, education and strong communication will be essential during the transformation from the current system. The Health Care Authority will do some of this new work and some will occur in a collaborative manner with similar work already being conducted by the carriers and school districts.

- C. Key features and budget required for startup implementation are outlined in this volume. Two potential sources of funding start up implementation are proposed for the Legislature to consider.

VOLUME THREE – FINANCIAL MODELING

The Health Care Authority engaged the services of its actuarial consultant, Milliman, for the financial modeling underlying the purchasing system proposal. Detailed modeling results are presented in Volume three. In addition to collecting and processing data underlying the current Washington K-12 health care benefits, Milliman also performed financial modeling of a consolidated purchasing system for those benefits. The modeling provides a picture of what a consolidated system would look like during the 2010-2011 school year; it does not project what the financials would look like in 2013-2014, or beyond.

Entities providing data from the 2010-2011 school year to support the modeling included the following:

1. The Washington School Information Processing Cooperative (WSIPC)
2. The Washington Office of the Superintendent of Public Instruction (OSPI)
3. Over 175 school districts
4. Regence BlueShield of Washington
5. Kaiser Permanente

When it comes to financial modeling, data is important. The collection of data for this report included a public disclosure request, and strong support from many stakeholders. The request also coincided with the 2011-2012 school year start, and included a tight timeline to meet the Report's deadlines. In some instances, the request was problematic to a local school district's information systems. While the Health Care Authority was unable to collect data for all K-12 employees, the Health Care Authority believes the sample collected is representative of the whole K-12 benefits array. Data will continue to be gathered as additional districts and carriers provide that information.

The difficulties experienced by the Health Care Authority in gathering a uniform set of data elements from all school districts and major carriers underscores the need for major improvements in transparency of K-12 school employees' health benefits data. The data elements the Health Care Authority endeavored to collect are essential for the effective purchasing and administration of employee health benefits, whether by individual school districts, independent benefits trusts, or a consolidated statewide purchasing system.

PURCHASING SYSTEM DESIGN PROPOSAL SYNOPSIS

This section provides a condensed overview of the major design goals, assumptions, and policies that are the foundation of the Health Care Authority proposed consolidated public school employees' benefits purchasing system. The final design decisions summarized in this section are extracted from more extensive presentations of options considered and analysis results that are contained in the report volumes.

HIGH POINTS OF DESIGN

- A. The proposed purchasing system design drives two fundamental changes into the K-12 employees' health benefits array:
 - 1. In the current system, the employer's funding allocation is independent of the employee's benefit selection. The new system will require districts to bear the added risk of varying employer contributions, based on employees' tier selections.
 - 2. In the current system, employees seeking employee-only coverage are often isolated from the financial impacts of their benefit plan choices. In the new system, when an employee chooses a plan other than the benchmark plan, the employee incurs the full cost associated with selecting a more expensive plan (richer benefit package) and gets the entire savings for making a less expensive choice (subject to minimum contribution requirements).
- B. Activities happening now in individual districts in the K-12 employees' health benefits array to achieve equal access to benefits by all district employees are replicated in ways that enable all K-12 employees to receive equal access.
- C. K-12 public school employees' health benefits consolidation is currently occurring around a few insurance benefit carriers. The proposed Health Care Authority design consolidates K-12 public school employees' health benefits around the purchaser.
- D. Employee health benefits are removed from the scope of collective bargaining laws and employee's health benefit decisions currently bargained among 300+ districts move to the consolidated purchasing system governing board. The following decisions move to the governing board:
 - 1. Benefit purchasing system eligibility standards.
 - 2. Benefit plan design, including point of service employee cost-sharing arrangements.
 - 3. Benefit plan sponsors and carriers.
 - 4. Employer contribution to premiums.
 - 5. Employee contribution to premiums for self coverage.
 - 6. Employee contribution to premiums for dependent coverage.

- E. The consolidated program design is oriented to the aggregated school district level; each district and its employees will be impacted differently with respect to consolidating to a purchasing system that establishes a high level of consistency and uniformity on a statewide basis.

FUNDAMENTAL DESIGN FEATURES TO ACHIEVE IMPROVEMENT

- A. A participatory benefits purchasing governance structure with full system wide decision authority for health benefit purchasing policy, benefit plan design, and premium cost-share responsibilities.
- B. A benchmark plan as the foundation for a range of benefit plan choices within the portfolio intended to offer choices comparable in value to the current system.
- C. Fixed employer premium contributions percentages set for the benchmark plan.
- D. Defined acceptable employer contribution percentage ranges for employee-only and dependent tiers as alternatives to the modeled fixed percentages.
- E. Sufficient risk pool size to support stable, sustained purchasing system operations.
- F. Competitive purchasing environment to support cost-effective benefits purchasing.
- G. Structured information exchange systems and other electronic capabilities designed to support streamlining of administrative processes.
- H. Data reporting to the purchaser in a standardized format.
- I. Structured system wide information dissemination systems to rapidly disseminate and receive feedback on pending policy decisions, portfolio design changes, etc., and to distribute clinical best practices, decision support tools, and other information to create informed consumers and providers.

RISKS TO ADDRESS

- A. Benefit plan premiums constitute the vast majority of purchasing system cost under a fully-insured risk management design. Although it is believed a single consolidated procurement for 200,000 covered lives will result in lower premiums, actual premium levels for the benefit plan portfolio will not be known until a competitive procurement of the initial plan portfolio is completed.

In order to conduct a credible competitive procurement, current risk pool information will have to be collected from health plan carriers. The Legislature must address requirements for health plan carrier release of the necessary information to the Health Care Authority.

- B. Under this model, districts will acquire the new risk of varying employer contributions, depending on whether an employee selects employee-only coverage, or coverage including dependents. In the current system, the employer's funding allocation is independent of the employee's benefit selection. The new system will require districts to bear the added risk of varying employer contributions, based on employees' tier selections. While an expected amount of tier migration is

built into the modeling, migration in excess of expectations will result in additional district costs. For the first year of a new consolidated purchasing system, some form of risk mitigation should be afforded to the participating districts through a State level re-insurance arrangement or other hold-harmless provision.

CORE PURCHASING SYSTEM DESIGN GOALS AND FEATURES

The following goals and design features form the core structure of the Health Care Authority proposed purchasing system design. A detailed discussion of each design feature is presented later in this report and the financial modeling underlying the design is presented in Volume three.

- A. **Goal:** Design a single statewide public school employees' health benefits purchasing system to serve Washington's K-12 public school system.
 - 1. Purchasing System Structure
 - a. Risk Pool and Insurance Risk
 - i. A single community-rated statewide risk pool for the public school employees' benefits system separate from the community-rated statewide risk pool for the public employees' benefits system.
 - ii. Initially all benefit plans in the public school employees' benefits system will be fully-insured with the flexibility to allow transition of any or all of the benefit plans to self-insured status at a later date.
 - b. Eligible Entities
 - i. Employer Groups: All K-12 public school districts and educational service districts. Provisions for a voluntary non-participation exception with terms are presented for Legislative consideration.
 - ii. Employee Groups:
 - 1. Active certificated employees
 - 2. Active classified employees
 - 3. Active administrative employees
 - 4. Active management employees
 - 5. Active special services employees (health professionals)
 - 6. COBRA eligible post-employees as further defined
 - 7. Other groups allowed by authorizing statute
 - c. Eligible Individuals
 - i. An employee in a covered employee group that the district determines meets the purchasing system criteria of 0.5 FTE or greater as defined by the district.

- ii. An employee in a covered employee group that the district determines qualifies under a system grandfathering arrangement.
- iii. Dependents as defined by the authorizing statute.

2. Covered Benefits

- a. Initially the following benefits will be offered through the purchasing system:
 - i. Medical and Pharmacy
 - ii. Dental
 - iii. Vision
- b. Life & LTD benefits will not be purchased by the consolidated benefits program for the initial benefit year.

Note: Further analysis is required to determine the scope of financial impacts that would result from the transfer of K-12 Pre-Medicare Retirees from the public employees' risk pool to a separate risk pool for a consolidated K-12 public school employees' benefits purchasing system. This analysis is underway. If the decision is to transition Pre-Medicare retirees to the K12 consolidated benefits purchasing system, implementation will occur the second benefit year.

B. **Goal:** Effective use of existing and newly developed business systems is suited to the K-12 public school system environment to achieve cost-effective program management and operations.

1. Existing Systems

- a. Payroll and finance in districts
 - i. Use of current payroll systems requiring no conversions.
 - ii. Current payroll systems are standardized for 97% of districts (one system has (93%, the next has 4%).
- b. Insurance payment from districts
 - i. Design incorporates current process where districts pay carriers.
- c. Infrastructure of the Health Care Authority to support the purchasing system.
 - i. Health Care Authority's purpose is to provide this service.
 - ii. Health Care Authority uniquely has capabilities to support the new purchasing system.
- d. Minimized change
 - i. Use of current systems minimizes change for districts.
 - ii. Reduces resourced requirements for program implementation.

2. To Be Developed
 - a. Data warehouse and interfaces
 - i. Extending current data warehouse functionality.
 - ii. Developing decision support to serve the program.
 - b. Financial modeling for benefit budgeting and procurement.
 - c. Web based enrollment
 - i. Reduces administrative work in districts.
 - ii. Provides an improved experience for employees.
 - iii. Reduces data entry errors and re-work.
3. Implementation and Budget
 - a. Implementation
 - i. Required development time of 20 to 24 months before go-live.
 - ii. Significant change management effort.
 - b. Estimating cost of:
 - i. \$1.7M FY12
 - ii. \$10.3M FY13
 - iii. \$9.5M FY14
 - iv. \$7.1M ongoing.
 - c. Three major work streams
 - i. Governance, communication, and change management.
 - ii. Technology development.
 - iii. Procurement and Operation.
 - d. Major assumptions
 - i. Initial implementation effort does not include retirees who will remain in the PEBB program.
 - ii. Design is adopted as recommended.
 - iii. Approval and funding received by April 1, 2012; changes to this date impact a January 1, 2014 go-live.
- C. **Goal:** Provide equitable access to quality and affordable health services for all eligible employees and their eligible dependents.
 1. Benefit Plan Portfolio Design
 - a. A statewide benchmark medical/Rx PPO plan comparable in value to the 2011 WEA-Premera Plan 2.

- b. Approximately 10 additional PPO plans and 3 HMO plans will complete the medical plan portfolio.
 - i. Plans will be designed with higher and lower relative values in comparison to the benchmark plan to provide an overall relative value range at least as broad as the current K-12 employees' medical benefit plans portfolio.
 - ii. Initial plans are expected to incorporate multiple carriers through a competitive procurement to ensure value and sufficient provider access in all areas.
 - iii. The medical plan portfolio will include a consumer-directed health plan with an associated health savings account or health reimbursement account.
 - c. A dental portfolio will be provided that replicates the approach to offering medical plan choices, but with fewer plan options.
2. Cost Sharing Responsibilities
- a. Premium Cost Sharing: The employer will contribute a fixed percentage of the premiums for employees and a separate fixed percentage for dependents.
 - i. The employer premium contribution for employee-only tier of the benchmark PPO plan will be set at 85% of the total premium.
 - ii. The employer premium contribution for the dependent tiers of the benchmark plan will be set at 65 % of the marginal dependent premium in addition to the 85% contribution for the employee.
 - iii. Under the fixed premium contribution percentage methodology, when an employee chooses a plan other than the benchmark plan, the employee incurs the full cost associated with selecting a more expensive plan (richer benefit package) and gets the entire savings for making a less expensive choice, subject to minimum contribution requirements.
 - iv. Prorating:
 - 1. Health plan premium rate schedules will be established in accordance with a uniform methodology for proration of employer contribution based on FTE status from 1.0 FTE through 0.5 FTE. The established rate schedules will be in effect for the full benefit year.
 - 2. The proration methodology will account for the expected full employer contribution to non-medical benefits.
 - 3. Individuals in an employment status less than 0.5 FTE under the initial 5-year grandfathering arrangement will participate at the 0.5 FTE level.
 - b. Point of Service Cost Sharing: Employee point of service cost sharing levels will be set through the initial portfolio design and health plan procurement process.

- D. **Goal:** Provide fiscal and purchasing system performance transparency.
1. Data Availability
 - a. Covered and non-covered populations by employee type and FTE status.
 - b. Distributions of covered employees by health plan choice and coverage tier.
 - c. Employer and employee contributions by population cohort.
 - d. Medical cost expenditures.
 - e. Administrative costs.
 2. Data Sources
 - a. Eligibility data provided by districts,
 - b. Premium contribution data provided by payroll administrators.
 - c. Claim data provided by carriers.
 - d. Administrative cost data provided by carriers and the Health Care Authority.
- E. **Goal:** School districts, employee group representatives, and at-large employees are active participants in purchasing system governance.
1. Governing Board: A Governor-appointed Public School Employees' Benefits Board will be established within the Health Care Authority to provide guidance and decision-making on aspects of purchasing system policy, design, and administration.
 2. Governing Board Duties:
 - a. The board will assume designated aspects of employer-employee benefits negotiation previously conducted at the individual district level related to covered benefits, types and numbers of benefits plans, benefit plan design, member and dependent eligibility requirements, and employer and employee premium contribution requirements.
 - b. The board will collaborate with the Health Care Authority in the selection and oversight of health benefits carriers, the incorporation of state health care policy through value-based purchasing, and assuring the financial integrity of the benefits purchasing system on an ongoing basis.
 - c. The board will utilize technical committees and consultation with subject matter experts to inform sound purchasing policy decisions and benefit designs aimed at:
 - i. Minimizing the financial burden which health care poses for the state, districts, and employees while at the same time allowing the purchasing system to provide the most comprehensive health care options possible.
 - ii. Incorporating evidence-based health care, prevention/wellness/chronic disease management, high performing provider systems, etc.
 - iii. Promoting participant engagement through education, outreach, and use of

incentives and disincentives to influence positive behavior among members, employers, health plans, and providers related to improvement and maintenance of individual health status and effective utilization of covered benefits.

- d. This committee is the conduit for K-12 public school system participation in development of recommendations that go directly to the Health Care Authority.
3. Governing Board Composition:
- a. The board will be composed of representatives of the State, school district officials, organizations representing employees, and persons with benefits administration and health care expertise.
 - b. The board will retain ongoing interaction with a larger advisory group representing a cross-section of districts, employee groups, benefit carriers, legislative and state entities involved with the K-12 public school system and health care policy, and other key stakeholders.

KUDOS

For this report, the Health Care Authority drew upon the internal resources of multiple state agencies, school districts, associations of school officials, associations and unions of school employees, legislative staff, and associations and individuals representing insurance consultants and brokers and health benefits carriers, as well as Health Care Authority contracted actuarial consultants, communications consultants, and benefits administration consultants.

Most notably, sincere gratitude goes out to the members of the **K-12 Project Advisory Team** representing education professionals, labor representatives, insurance carriers, school districts, insurance consultants and brokers, and other interested entities and individuals. The Advisory Team agreed to serve in a dual role to provide accurate descriptions of the current K-12 public school employee' benefits array and to share their perspectives and expertise to advance the quality and feasibility of a consolidated purchasing system design. The Health Care Authority accepted the participation of Advisory Team members with the understanding that participation did not constitute an endorsement of consolidation or an endorsement of the resultant proposal put forward by the Health Care Authority.