Legislative Budget and Finance Committee

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

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The Feasibility of Placing Public School Employees Under the Commonwealth's Jurisdiction for the Purpose of Providing Health Benefits

Conducted Pursuant to
House Resolution 159 of 2003

February 2004

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To the Members of the General Assembly:

House Resolution 159 of 2003 directs the Legislative Budget and Finance Committee to conduct a study of the feasibility and cost-effectiveness of placing public school employees under the Commonwealth's jurisdiction for the purposes of providing health benefits.

Due to the specialized nature of this study, the Committee issued a Request for Proposal for assistance with this study in May 2003. In July 2003, the Committee contracted with the Hay Group to conduct the study. The Hay Group is one of the world's largest human resources consulting firms. They are also the actuarial consultants to the Pennsylvania State Employees' Retirement System.

The Hay Group's report is contained herein. As with all LB&FC reports, the release of this report should not be construed as an indication that the Committee or its individual Committee members necessarily concur with its findings and recommendations.

Sincerely,

Philip R. Durgin
Executive Director

Hay Group. Inc.
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January 20, 2004

Mr. Philip R. Durgin
Executive Director
Pennsylvania Legislative Budget and Finance Committee
Room 400 — Finance Building
Harrisburg, PA 17105-8737

Dear Mr. Durgin:

On behalf of the Hay Group we are pleased to present the Report on the Study to Determine the Feasibility and Cost Effectiveness of placing Public School Employees under the Commonwealth's Jurisdiction for the Purposes of Providing Health Benefits.

We wish to thank those who generously gave of their time to meet with us and provide us with their counsel as well as the information that we used in this study, including the administrators at hundreds of school districts and Intermediate Units who completed the health benefits surveys.

If you or your committee members have any questions concerning our report, we would be happy to meet with you.

Yours truly,

Edwin Hustead, FSA, EA

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Executive Summary

Pursuant to House Resolution No. 159, the Hay Group was commissioned by the Pennsylvania Legislative Budget and Finance Committee (LB&FC) to study the feasibility and cost effectiveness of merging public school employees and Commonwealth employees under one health benefits program.

We conclude that a Commonwealth-wide health plan for public school employees could, in the aggregate, have saved approximately $585 million in 2003 in health care costs out of an estimated total expenditure of $2.4 billion. The composition of these savings is shown in Table ES-1.

Table ES-1
Total Estimated Savings

	$Millions
1. Savings for actives	$524.0
2. Savings for retirees	$38.0
3. Savings from stop loss	$15.3
4. Savings from prescription drug rebates	$ 8.1
5. Total estimated savings	$585.4
6. Current health and stop loss premium	$2,447
7. Percent savings	23.9%

Local Education Agencies (LEAs) paid $9,558 for health insurance per employee in 2003. We estimate that the premium would have been only $7,375 or a savings of $2,183 per employee if the LEAs had all participated in a Commonwealth-wide health plan.

It would take some time to establish a statewide plan, and LEAs should only be required to join after their current collective bargaining agreements expire. Absent extraordinary legislative action, we believe that July 2005 would be the earliest practicable effective date for a statewide health plan for LEA employees.

Depending on the design of the plan, we project first year savings of $83 million to $129 million in fiscal year 2005-06 with savings rising to $682 million to $835 million by fiscal year 2009-10 when all of the current bargaining agreements would have expired. These eventual savings are much higher than the $585 million that would have been saved in 2003 because of anticipated health care inflation.

Although our study considers various alternatives, we recommend that the Commonwealth establish, by statute, the outline for a Commonwealth health plan for LEA employees. We further recommend that the statute specify that the plan be governed by a board with equal representation from labor and management. After assessing the various options, we believe the most efficient administrative arrangement would be to share administrative services with the Pennsylvania Employee Benefits Trust Fund (PEBTF), which provides health benefits to Commonwealth employees, retired employees, and their dependents. Other possible

administrative structures would be through an expansion of the Pennsylvania School Employees Retirement System (PSERS) or another Commonwealth agency.

A critical issue is whether a statewide plan should be mandatory or voluntary. A mandatory plan would achieve a higher level of savings more rapidly than a voluntary plan. However, we found substantial resistance to a mandatory plan. If that resistance were to delay implementation, then the voluntary plan might achieve more savings in the early years.

While aggregate savings could be achieved through a statewide plan, some LEAs would see an increase in cost or reduction in benefits. A statewide plan could offer a range of choices of health plans and levels of participation and contribution by the participants to diminish the chance of additional costs. The widest practical range of choice would reduce the additional cost to individual LEAs to $13 million, or around two percent of the savings. We recommend that the two percent of the savings be used to make sure that no LEA pays more for health insurance than they would under a separate plan.

We compared the benefits that would be available through a statewide plan, to the benefits currently provided by the LEAs. For the widest choice plan, we found that employees would lose, on average, less than one percent of the value of the current benefits.

An alternative we considered would be a mandatory plan with no choice of level of benefit, participation or cost sharing similar to the Commonwealth employee's plan. This design would remove the health plan as a local collective bargaining issue because, as with the retirement plan, the LEA would not have any choice of design or contribution. However, the requirement for a single plan would either diminish the total savings or increase the number of LEAs that would have to pay more than they do now.

To arrive at our recommendations, we gathered and analyzed detailed health plan information from 146 LEAs. The respondents to our survey are listed in Appendix A. We found with relatively few exceptions, the LEA health plans have broadly equivalent benefit levels. Where there were observable differences, the current array of plan designs could map into one of two benefit levels (e.g. a Basic plan and an Enhanced plan) with little or no impact on cost. These findings are presented in Section I.

In Section II we describe the different ways retired school employees currently obtain health insurance coverage. LEAs are required to extend coverage to retirees who meet certain eligibility conditions until age 65. Most LEAs only provide coverage to age 65, with the full cost paid by the retiree. Alternatively, retirees can participate in the Health Options Plan (HOP) administered by PSERS. Most retired employees are eligible for a $100 monthly premium subsidy paid through PSERS. We considered the advisability of including retirees in a state-wide health plan, and conclude that the extent and cost-sharing of such coverage should be optional. Proposed changes in government accounting rules for retiree medical benefits and in Medicare will likely influence the decision.

We held extensive discussions with the PEBTF and analyzed their current health plans. These plans are described in Section III of this report. PEBTF representatives expressed interest in pursuing an arrangement to provide health care to LEA employees, with appropriate lead-time. We compared the value of the benefits for Commonwealth employees to those for employees of

the LEAs and found that the Commonwealth benefits had a value that was more than 25 percent greater than the average LEA benefit. The higher value for the Commonwealth benefit derives from the much more liberal conditions for post-retirement benefits.

In Section IV we report on our findings from surveying the health plan arrangements in ten other states. These states include those bordering Pennsylvania as well as others of particular interest. The most common arrangement is a voluntary statewide plan. Two of the statewide plans are mandatory. We found the statewide plans are either administered through an independent agency or directly by the administration. Details on the health insurance plans for education employees in other states are included in Appendix B.

We discussed the possibility of a statewide plan with thirteen organizations that would be affected by creation of such a plan. Section V reports on the results of our discussions with these interested parties. We found some organizations that were in favor of the concept of a statewide plan and some that were opposed to any statewide plan. However, the most common response was that the organization would wait for the results of the Hay Group study to determine if they would support a statewide plan.

In Section VI we report on our findings from comparing the cost and benefits of the LEA plans to the cost and benefits of alternative statewide plans. The supporting documentation for our analysis is presented in Appendix C. The analysis shows that if all LEAs had participated in a statewide plan with a choice between a Basic or Enhanced benefit the total cost would have been reduced by $585 million in 2003. If the LEAs had participated in a statewide plan with only the Enhanced benefit available, the savings would have been $509 million.

In Section VII we consider the possible construction and cost of a statewide health plan. We identified four major variables in the design of a statewide health plan:

- whether or not the plan should be voluntary or mandatory,
- how the plan should be administered,
- the range of options that should be allowed in a statewide plan, and
- the degree to which retirees can and should be included in a statewide plan.

It is unlikely that a statewide plan could be implemented before July 1, 2005, and we recommend that, even for a mandatory plan, LEAs not be required to join until their current collective bargaining agreements end. Section VIII shows the projected savings that would develop as the statewide plan would gradually include LEAs when their collective bargaining agreements expire.

Our conclusion, presented in Section IX, is that the Commonwealth should enact legislation establishing a Pennsylvania School Employees Trust (PSET), to be governed by an independent board of trustees. We concluded that the LEAs should be required to join the statewide plan upon completion of current collective bargaining agreements and that the statewide plan should permit a wide range of choice in design, participation, and cost-sharing. We found that implementation would be quicker if the plan were administered by PEBTF than through PSERS.

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I. Health Insurance Provided by Employers of Education Employees

The number of public school employees covered by a consolidated plan and the number of employers affected would vary depending on the definition of a school employee. The most encompassing definition of a public school employee would include employees of:

- School districts
- Vocational and special education facilities
- Charter schools
- Intermediate units
- Public pre-schools

In this report, these employees are collectively referred to as "Education Employees" or "LEA Employees" and their employers are collectively referred to herein as "Local Education Agencies" or "LEAs."

This section presents our findings in two ways. First we show the design of the LEA plans and compare those to the design of all plans in our national survey. Second, we compare the value of the plans using the Hay Benefit Value Comparison (BVC) method.

We designed two surveys to obtain information on the current plans of the LEAs. The first was administered through the Pennsylvania Association of School Business Officials (PASBO) to collect plan design, enrollment, and pricing information on the plans offered by LEAs to their eligible employees. A second survey was sent to the Intermediate Units since some of these run a health consortium for LEAs in their unit.

The surveys were distributed during the week of August 8, 2003, with a submission date of August 22. A telephone hotline was provided for respondents with questions. Most of the questions received on the hotline dealt with specific survey questions, the applicability of the survey to vocational schools, and requests for extension for submitting responses. The first survey responses were received the next day and by the August 22 submission deadline over 100 surveys had been submitted. In response to several requests, the data collection period was extended through the end of August. We obtained a broad geographic representation of the LEAs, receiving responses from LEAs in 26 of the 29 Intermediate Units. For the separate survey of Intermediate Units, we received 19 responses out of the 29 Intermediate Units. Of the 19 Intermediate Units that submitted surveys, three responded that they were not a part of a consortium and that benefits were handled by the LEAs within their unit.

Appendix A is a list of the surveys that we received. Some of these were not processed because they were received too long after the August 31 cutoff date. In total, we processed 146 surveys, covering 65,000 employees.

To ensure that the survey data collected was representative of school districts of all sizes, we compared employee data from the Pennsylvania Department of Education's database to the survey responses. Specifically, we aggregated the number of teachers and support staff for each LEA using the 2001-2002 school year data. [1]

[1] D04 – District Staff from http://www.paprofiles.org/ pa0001/datafiles/datafiles.htm

Table 1.1 shows the results of the analysis of the number of employees in each LEA by size of employer as well as the number of surveys by size of employer. Of the 146 surveys that were processed, 138 included the number of employees. The surveys processed included almost one-quarter of the largest LEAs (those with more than 1,000 employees) including Philadelphia as well as over one-third of the most common LEA size (those with between 100 and 250 employees).

Table 1.1
Analysis of Surveys Received by Size of LEA

Number of Employees In the LEA	No. of LEAs	Surveys Processed	Percentage of LEAs
Not reported		8	
0-99	151	17	11%
100-249	188	67	36%
250-499	182	33	18%
500-999	93	13	14%
1,000 or more	33	8	24%
Total	**647**	**146**	**23%**

Through discussions with the Pennsylvania State Employee's Retirement System (PSERS), we understand that employees eligible for benefits through the LEAs are almost the same as the employees covered by the retirement system. An exception is that the retirement system covers some employees of colleges and universities that would not be covered by a consolidated school employee's health plan. We believe it is reasonable to base our overall cost estimates on the number and characteristics of the 240,000 employees participating in PSERS on June 30, 2002.

The data on retirees from the surveys was inconsistent. Some LEAs reported all former employees with extension of coverage even if those employees were only on a limited COBRA extension. As noted in Section II, retirees who meet certain age and service conditions can receive a $100 per month subsidy from PSERS for qualified health plans. PSERS reported that 20,000 retirees in LEA plans were receiving the subsidy in 2002. A comparison of the LEA surveys to the PSERS subsidy data showed that in many cases about 50 percent of retirees in LEA plans were not receiving the subsidy because they did not meet the age and service conditions. Based on this, we estimate that the LEAs now cover about 30,000 retirees in total and assumed these would be covered in a statewide plan.

Table 1.2 compares the total number of employees and retirees in the 146 processed surveys to the estimated universe of participants in LEA plans in Pennsylvania in 2003. The processed surveys include over a fourth of the LEA employees and 40 percent of the LEA retirees participating LEA plans.

Table 1.2 Total Employees and Annuitants		
	Actives	**Retirees**
In the processed surveys	65,000	12,000
Not in the surveys	175,000	18,000
Total	**240,000**	**30,000**
Percent in processed surveys	**27%**	**40%**

Data from the surveys was entered into a database and checked for reasonableness and internal consistency. A subset of this database containing complete information on current plan design, premium rates, and enrollment data was then used to perform the analyses presented in this report.

The first of the analyses in this section covered prevalence of primary plan design; eligibility conditions for coverage; employee contributions; deductible and copay cost-sharing; and specific features of the prescription drug, dental, and vision benefits. The tables compare the prevalence of the features from the LEAs with our national database that includes data from more than 1,000 employers. For each LEA, the data shows the features of the plan with the highest enrollment in that LEA (the primary plan).

Plan Prevalence Information

The types of plans and plan provisions of the LEA health plans are markedly different from the plans sponsored by both governmental plans and private-sector employers that participate in the Hay Group's report. The following table compares the data from the LEA surveys with the results from the 2003 Hay Benefits Report's summary of over 1,000 employers and from the subset of governmental plans included in the Hay Benefits Report. Table 1.3 shows the prevalence of the primary plan.

Table 1.3 Primary Plan			
Plan Type	**LEAs**	**Governmental Plans**	**All Employers in HBR**
Fee-for-Service	36%	10%	3%
Point-of-Service	33%	10%	15%
PPO	29%	42%	57%
HMO	2%	38%	25%

Table 1.4 shows the distribution of the LEA employees reported in the surveys and Pennsylvania Employee Benefit Trust Fund (PEBTF) members by plan type. The percentages in table 1.4 are for all employees, not just those in the primary plan as shown in table 1.3. Enrollment in PEBTF was taken in 2003 prior to the recent plan changes which are discussed in Section III.

Table 1.4 Enrollment by Plan Type		
Plan Type	**LEA Employees**	**PEBTF Members**
Fee-for-Service	24%	43%
Point-of-Service	11%	10%
PPO	50%	19%
HMO	15%	28%

Table 1.5 shows the typical plan designs for fee-for-service (FFS), point-of-service (POS), and preferred provider organization (PPO) plans among the LEAs studied for health care provided by participating physicians and hospitals. Benefits received from non-participating physicians and hospitals require a larger copayment by the employee. Generally about 70 percent of treatment is from participating physicians and hospitals.

Table 1.5 Summary of Key Design Features In-Network Benefits for Typical Plan Designs			
Type of Care	**FFS**	**PPO**	**POS**
Plan Deductible	$100	$0	$0
Maximum Out-of- Pocket Limit	$1,500	$0	$0
Coinsurance rates (percentage of cost of service paid by the plan)			
Inpatient hospital	100%	100%	100%
Outpatient hospital	100%	100%	100%
Physician Visits	80%	100% after $10 copay	100% after $5 copay
Specialist Visits	80%	100% after $10 copay	100% after $5 copay
Surgical	100%	100%	100%
Mental Health and Substance Abuse Treatment	50%	100% after $15 copay	100%
Preventive Services	Covers	Covers	Covers

Eligibility

Eligibility for health care coverage varies by LEA and employee classification. Some LEAs set eligibility based on a minimum number of days worked in a year, while others set eligibility based on a minimum number of hours worked per day. A summary of these requirements is shown in Tables 1.6 and 1.7. Typically, LEA employees are required to work 6 to 7 hours a day and/or 180 to 260 days per year for coverage by the LEA health plan.

Table 1.6 Health Care Eligibility by Hours Worked					
Employee Classification	**Reporting Surveys**	**Lower Quartile**	**Median**	**Upper Quartile**	**Average Hours Per Day**
Professional Staff	117	4	7	7.5	5.9
Instructional Aides	114	5	6	7	5.7
Administration	116	5	7.5	8	6.6
Support	132	5	6	7.5	6.0

Table 1.7 Health Care Eligibility by Days Worked					
Employee Classification	**Reporting Surveys**	**Lower Quartile**	**Median**	**Upper Quartile**	**Average Days Per Year**
Professional Staff	117	183	185	187	172
Instructional Aides	89	180	183	187	178
Administration	113	240	260	260	236
Support	106	180	244.5	260	219

Employee Contributions

Approximately four out of five schools pay the full cost of the health insurance for employee coverage, and three out of four pay the full cost for family coverage. Tables 1.8 and 1.9 compare the employee contribution provisions of the LEAs with governmental employers and all employers in the Hay Benefits Report.

Table 1.8 Cost-sharing of Premiums for Employee Medical Coverage			
Funding	**LEAs**	**Governmental Employees in HBR**	**All Employers in HBR**
100% employer-paid	79%	49%	19%
Involves cost sharing	21%	51%	81%

Table 1.9 Cost-sharing of Premiums for Family Medical Coverage			
Funding	**LEAs**	**Governmental Employees in HBR**	**All Employers in HBR**
100% employer-paid	76%	18%	9%
Involves cost sharing	24%	82%	91%

For those LEAs that require employees to pay premiums towards the cost of coverage, the average employee contribution was ten percent of the premium for employee coverage. As there was considerable variation in the number of employees in each LEA, we also determined the weighted-average employee contribution based on enrollment. The average for all LEAs, including those fully paid by the employer, was 5.1 percent of the premium.

Medical Plan Deductibles, Copays, and Out-of-Pocket Limits

Forty percent of the LEAs' primary plans have an annual deductible, in line with the prevalence for employers in the Hay Benefits Report.

Table 1.10
Medical Plan Deductible (Primary Plan)

Medical Plan	LEAs	All Employers in HBR
Has a deductible	40%	41%
No deductible	60%	59%

For those LEA plans that require participants to pay a deductible, the most common deductible is $100, whereas most deductibles among nationwide employers are between $200 and $300.

Table 1.11 shows the variation in individual deductibles and Table 1.12 shows the variation in Family deductibles between the LEAs' primary plan and the primary plan for employers in the Hay Benefits Report.

Table 1.11
Dollar Amount of Individual Deductible (Primary Plan)

Individual Deductible	LEAs	All Employers in HBR
Under $100	-	1%
$100	52%	8%
$125-$150	12%	9%
$151-$199	-	-
$200	5%	20%
$201-$299	26%	28%
$300	2%	12%
Greater than $300	3%	22%

Two-thirds of the LEAs with deductibles have family deductibles of $300 or less, whereas nationwide only 13 percent of employers with deductibles have family deductibles of $300 or less.

Table 1.12 Dollar Amount of Family Deductible (Primary Plan)		
Family Deductible	**LEAs**	**All Employers in HBR**
Under $200	-	1%
$200	9%	4%
$201-$299	-	-
$300	57%	8%
$301-$399	-	1%
$400	2%	13%
$401-$499	-	4%
$500	14%	16%
$501-$599	-	1%
$600	4%	14%
$601-$749	-	4%
$750	13%	10%
Greater than $750	2%	24%

Table 1.13 shows the percent of recognized charges paid by the plan after the deductible has been satisfied. Two out of three LEA plans pay 100 percent of the recognized charges — a somewhat higher prevalence than found nationwide.

Table 1.13 Percent of Recognized Charges Paid by the Medical Plan		
Plan Coinsurance	**LEAs**	**All Employers in HBR**
100% coinsurance	68%	55%
90% coinsurance	1%	27%
80% coinsurance	31%	16%

For the 32 percent of LEAs that require coinsurance, the maximum dollar amount of individual out-of-pocket limits were as shown in Table 1.14. Plans that do not require deductibles and coinsurance do not typically have out-of-pocket limits since there is only a small likelihood that the individuals in those plans would have significant out-of-pocket expenses.

Table 1.14 Dollar Amount of Individual Out-of-Pocket Limit		
Out-of-Pocket Limit	**LEAs**	**All Employers in HBR**
Less than $500	10%	2%
$500	3%	6%
$501-$999	3%	10%
$1,000	-	29%
$1,001-$1,500	3%	21%
$1,501-$2,000	79%	20%
$2,001 or greater	-	12%

Table 1.15 shows that only 20 percent of LEAs require a deductible for hospital stays compared to over half of all employers in the HBR.

Table 1.15
Hospitalization Coverage

Hospital Deductible	LEAs	All Employers in HBR
No Deductible	80%	46%
Daily Co-Pay	2%	22%
Medical Plan Deductible	18%	32%

Tables 1.8 through 1.15 show that the LEAs' prevalent medical plan design is significantly more generous than the typical plan offered by the employers in the Hay Benefits Report.

Prescription Drug Benefits

All of the LEAs provide prescription drug coverage, either in a stand-alone plan or as part of the medical plan. Table 1.16 shows that a higher percentage of LEAs provide the coverage under the medical plan than employers nationwide.

Table 1.16
Prescription Drug Coverage

Prescription Drugs	LEAs	All Employers in HBR
Separate Plan	83%	96%
Same Plan	17%	4%

Twenty-two percent of the LEAs require mandatory generic drugs, about double the prevalence found in the Hay Benefits Report. Just over half of the LEAs have a mail order plan, but fewer than 10 percent of these LEAs make mail order mandatory for maintenance drugs. The most common coverage required fixed dollar copays. Table 1.17 shows the generic (or lowest copay) levels and compares the prevalence of different copay amounts with the plans in the Hay Benefits Report (HBR), and Table 1.18 shows the copay amounts for brand drugs.

Table 1.17
Copayments for Generic (or Lowest Copay) Prescription Drug Programs

Generic (or Lowest Copay)	LEAs	All Employers in HBR
Less than $5	4%	2%
$5	77%	26%
$6	2%	1%
$7	3%	7%
$7.01-$9.99	5%	5%
$10	9%	49%
Greater than $10	-	10%

Table 1.18 Copayments for Brand Prescription Drug Programs		
Brand Copay	**LEAs**	**All Employers in HBR**
Less than $10	10%	2%
$10	61%	8%
$10.01-$14.99	3%	1%
$15	13%	9%
$15.01-$19.99	7%	1%
$20	2%	10%
Greater than $20	5%	69%

Dental Benefits

To encourage good dental hygiene and effective use of the dental plan benefits, the typical dental plan pays 100 percent of the cost for preventive treatment, requires some cost sharing for basic restorative care (typically 80 percent) and less for major restorative care (typically 50 percent).

Tables 1.19 through 1.25 describe the dental benefit coverage for LEAs and compare plan designs with the HBR database.

Table 1.19 Dental Plan Coverage		
Dental Coverage	**LEAs**	**All Employers in HBR**
Separate Plan	99%	100%
No Plan	1%	0%

Table 1.20 Cost-sharing of Premium for Employee Dental Coverage		
Dental Plan Funding for Employees	**LEAs**	**All Employers in HBR**
Employer Paid	91%	29%
Cost Sharing	9%	59%
Employee Paid	-	12%

Table 1.21 Cost-sharing of Premium for Family Dental Coverage		
Dental Plan Funding for Dependents	**LEAs**	**All Employers in HBR**
Employer Paid	85%	29%
Cost Sharing	14%	59%
Employee Paid	1%	13%

Over 90 percent of LEAs pay the full cost of dental plan premiums for employees and 85 percent pay the full premium for family coverage. This compares with under 30 percent of the over 1,000 employers in the Hay Benefits Report database for both employee and family dental coverage.

Table 1.22 Dental Coverage Preventive Care Coinsurance		
Percent of Recognized Charges	**LEAs**	**All Employers in HBR**
Covered at 100%	99%	90%
Covered at 81-99%	-	3%
Covered at 80%	1%	6%
Covered at 51-79%	-	1%

Table 1.23 Dental Coverage Basic Restorative Coinsurance		
Percent of Recognized Charges	**LEAs**	**All Employers in HBR**
Covered at 100%	80%	8%
Covered at 81-99%	-	8%
Covered at 80%	17%	70%
Covered at 51-79%	-	7%
Covered at 50%	3%	7%

Table 1.24 Dental Coverage Major Restorative Coinsurance		
Percent of Recognized Charges	**LEAs**	**All Employers in HBR**
Covered at 81-99%	-	1%
Covered at 80%	26%	7%
Covered at 51-79%	6%	16%
Covered at 50%	68%	73%
Less than 50%	-	3%

Table 1.25 shows that the typical LEA plan limits orthodontia coverage to $1,000 per person for all years. Most plans in the HBR have limits greater than $1,000.

Table 1.25 Dental Coverage Orthodontia Lifetime Maximum Benefit		
Lifetime Maximum	**LEAs**	**All Employers in HBR**
Under $750	-	1%
$750	10%	2%
$751-$999	-	1%
$1,000	60%	43%
$1,001-$1,500	27%	38%
$1,501-$2,000	3%	12%
Greater than $2,000	-	3%

Most LEA plans provide significantly better dental benefits than typical plans. The typical LEA dental plan does not require employee contributions and pays the full cost of both preventive and basic restorative services. However, the typical orthodontic benefit plan provided by the LEAs is less valuable than the national average.

Vision Benefits

Over 80 percent of the LEAs reported that a vision care plan was available as a separate plan. This compares to 70 percent of all HBR employers. Over 90 percent of LEAs reporting premium information stated that the plan paid the full cost.

Table 1.26 Vision Care Coverage		
Vision Care	**LEAs**	**All Employers in HBR**
Separate Plan	82%	70%
No Plan	18%	30%

Funding of Health Benefits Plans

The funding of health benefits plans has evolved as LEAs in some Intermediate Units have combined into health purchasing consortia. Two consortia (Allegheny and Lincoln) have grown to cover a significant number of employees.

In 1983, several regional trusts formed the Pennsylvania Trust (PA Trust) with the goal of increasing purchasing power for services and programs provided by the growing number of self-funded employee benefit trusts. The PA Trust is an alliance of 10 trusts and arranges catastrophic stop-loss insurance, a preferred provider dental discount program, a prescription drug program through a Pharmacy Benefits Manager (PBM), negotiated provider network access and retention fee contract with Capital Blue Cross as well as other member services. The PA Trust covers 87 LEAs and over 28,000 employees. The 10 members of the PA Trust are:

- Northwestern Region Employee Benefit Trust
- Midwestern Pennsylvania School Employees' Benefit Trust
- Central Pennsylvania School Employees' Benefit Trust
- Schuylkill County School Employees' Health and Welfare Trust
- Lincoln Benefit Trust
- NEPA School Districts Health Trust
- Central Susquehanna Region School Employees' Health and Welfare Trust
- Employee Benefit Trust of Eastern Pennsylvania
- Berkshire Employees' School Trust
- Ephrata Area School Employee Benefit Trust

In addition to the IUs, the Pennsylvania Public School Health Care Trust, which was established in October 1999, is available to LEAs. The Trust was created by five organizations: the Pennsylvania Association of School Administrators (PASA); the Pennsylvania Association of School Business Officials (PASBO); the Pennsylvania Federation of Teachers (PaFT); the Pennsylvania School Board Association (PSBA); and the Pennsylvania State Education Association (PSEA) and is available to participants. Thirteen LEAs participate in the Trust.

Around two-fifths of LEAs purchase insurance on a fully insured basis. The other three-fifths are self funded or have some element of insurance. The great majority of the insurance is with one of the four Blue Cross organizations:

- Independence Blue Cross servicing the greater Philadelphia area
- Highmark Blue Cross servicing western Pennsylvania
- Capital Blue Cross servicing the capital region and the greater Allentown/ Bethlehem/ Easton area
- Blue Cross of Northeastern Pennsylvania

Appendix D includes a discussion of the evolution of the Blue Cross and Blue Shield organizations in the United States and in Pennsylvania. The recent changes in the Blue Cross and Blue Shield structure in Pennsylvania have affected the access to and type of funding for the LEAs.

The Blue Cross organizations operate the Keystone Health Plan HMOs throughout Pennsylvania and there are 18 other HMOs as listed in Appendix D. Employees of the LEAs are usually eligible to participate in all HMOs in their area.

To avoid budget overruns, many LEAs purchase stop-loss insurance to limit their exposure to catastrophic claims as well as a concentration of claims in any one year.

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.

As over three-quarters of all LEAs pay the full cost of the medical plan, and the average employee contribution for those LEAs that require employee contributions is less than 10 percent of the cost, the comparisons included in the report are on a "total value" basis where the existence of employee contributions is ignored. This provides a pure look at comparative design.

Chart 1.1
Medical Benefits
BVC Value Relative to Average Plan Value

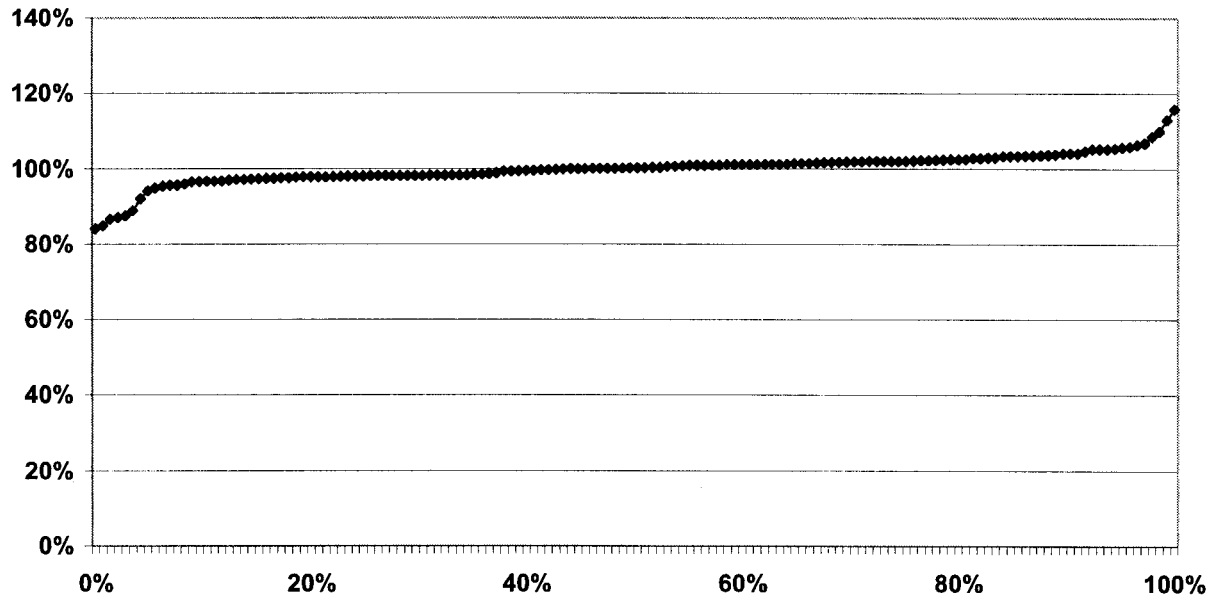


Chart 1.1 shows the relative value of the medical benefits for 146 LEAs. The chart shows there is relatively little variation in plan value for the primary plan among the LEAs. Only a handful of LEAs have plans with BVC values more than 10 percent higher than the average or 10 percent lower than the average. This is consistent with the fact that 60 percent of the plans have no deductible, and of those that do, two-thirds have a deductible of $200 or less.

Chart 1.2
Prescription Drug Benefits
BVC Value Relative to Average Plan Value

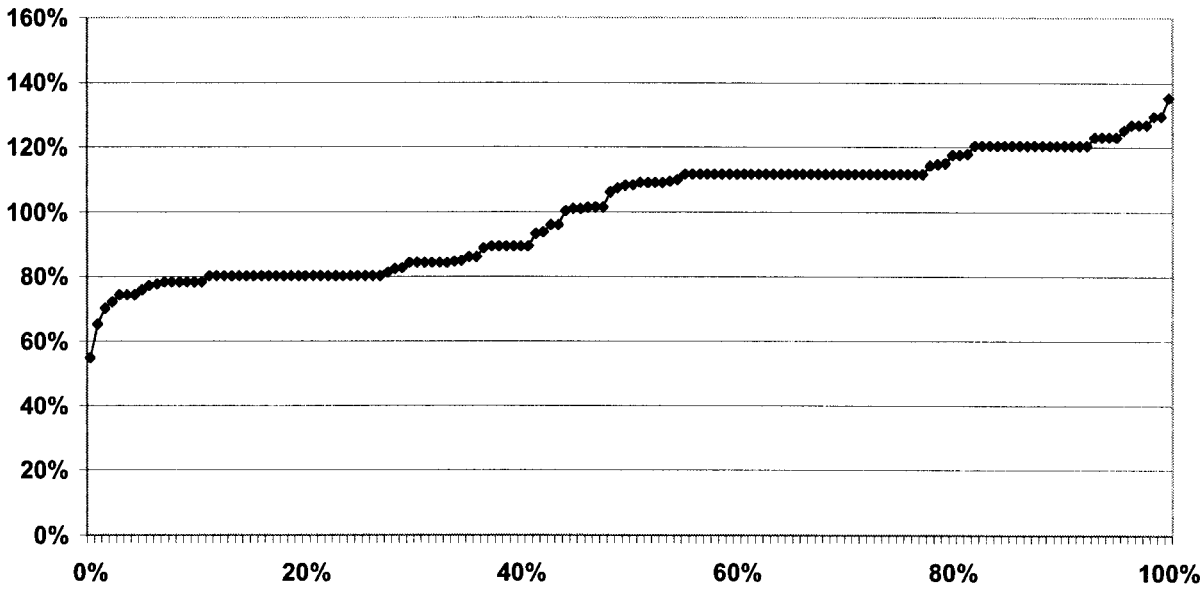


Chart 1.2 shows the relative value of the prescription drug benefits for 146 LEAs.

The chart shows there are many LEAs with common plan designs, however there is some variation in the cost sharing among LEAs. This information indicates it would be necessary to have a minimum of two plan designs to closely match the current cost-sharing arrangements for the bulk of the LEAs. The small number of LEAs with plan values below 80 percent of the average is consistent with the data reported in Table 1.18 that just 5 percent of the LEAs require copays for brand drugs of $20 or more. Similarly, the small number of LEAs with plan values above 120 percent of the average reflects the few LEAs with copays of under $5.

Chart 1.3
Dental Benefits
BVC Value Relative to Average Plan Value

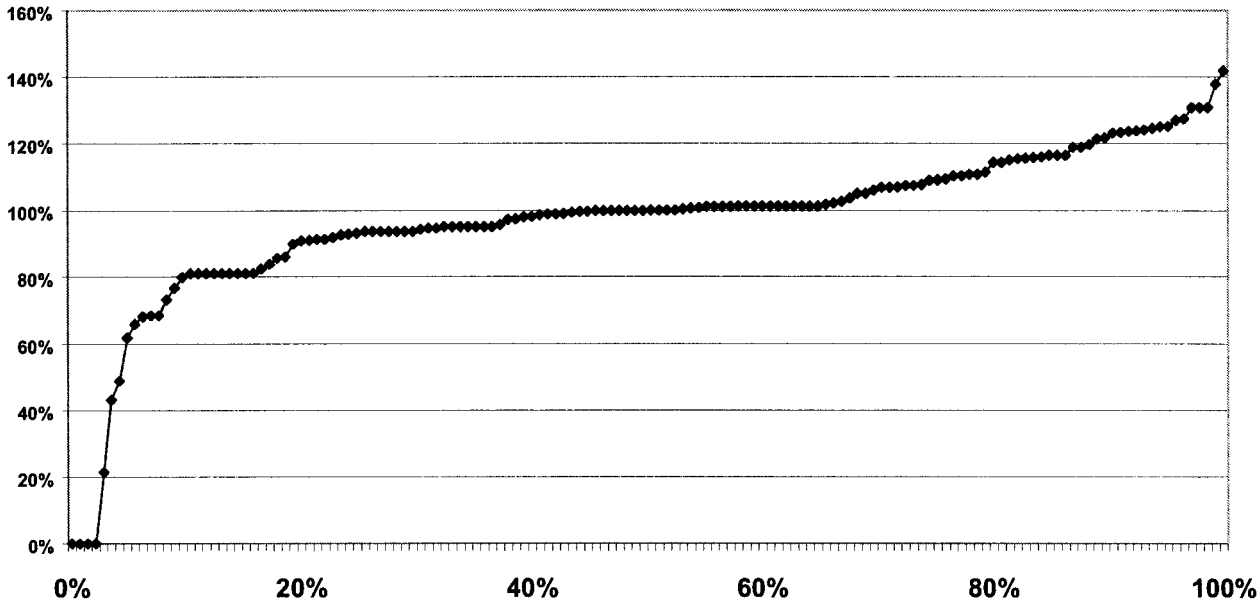


Chart 1.3 shows the relative value of the dental benefits. Over 95 percent of LEAs provide dental benefits, and there is significantly more variation in this benefit than in the medical or pharmacy benefits. The analysis shows that 80 percent of the LEAs have plans whose benefit values are between 80 percent and 120 percent of the value of the average plan.

Given the wider variation in plan design evidenced in the dental benefits, implementing a statewide dental plan for all LEAs would require three levels of benefit, or a common benefit level at a higher cost than current, or maintaining the current costs by adopting a higher level of cost-sharing. About one-quarter of the plans have a BVC value more than 10 percent above the average. This is consistent with the plan design descriptions (Tables 1.24 and 1.25) that showed that 26 percent of the LEAs had plans that paid 80 percent of the recognized charges for major restorative care, and thirty percent of the LEAs had lifetime maximum orthodontic benefit of more than $1,000.

Chart 1.4
Vision Benefits
BVC Value Relative to Average Plan Value

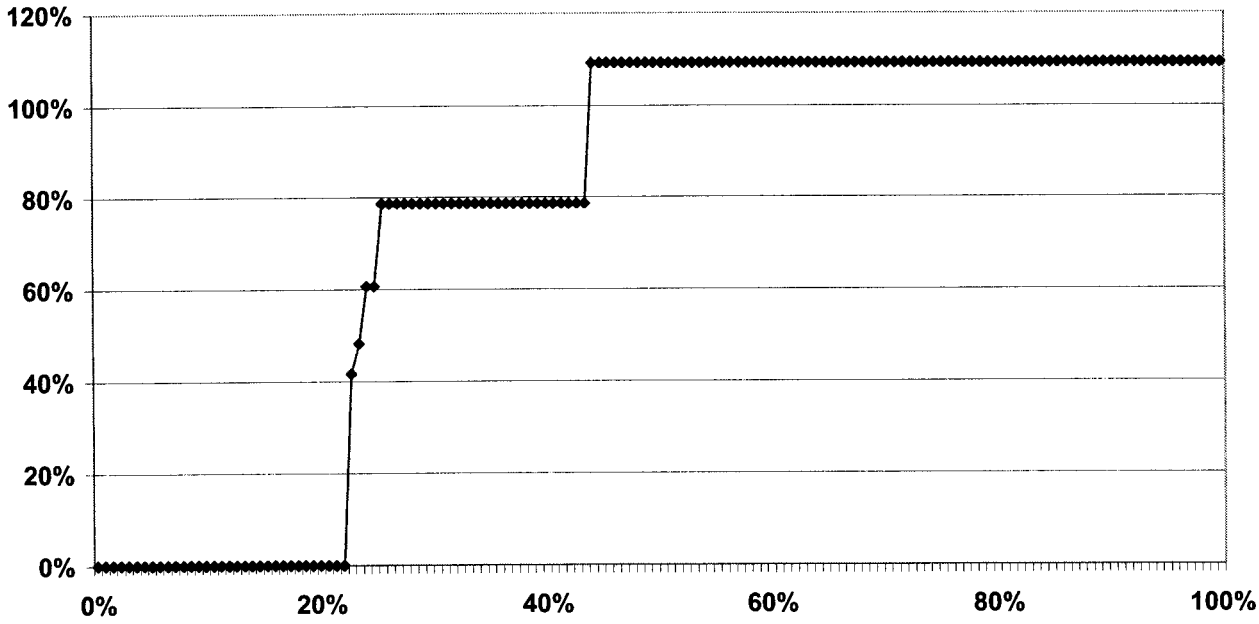


Chart 1.4 shows the BVC values for the vision benefits. About 20 percent of the LEAs do not provide a vision benefit. Most of the LEAs provide a high level of benefit covering annual checkups and full reimbursement of lenses and frames. The plans with a lower value pay a relatively small dollar amount for lenses and frames rather than the full amount.

Chart 1.5
Total Health Plan
BVC Value Relative to Average Plan Value

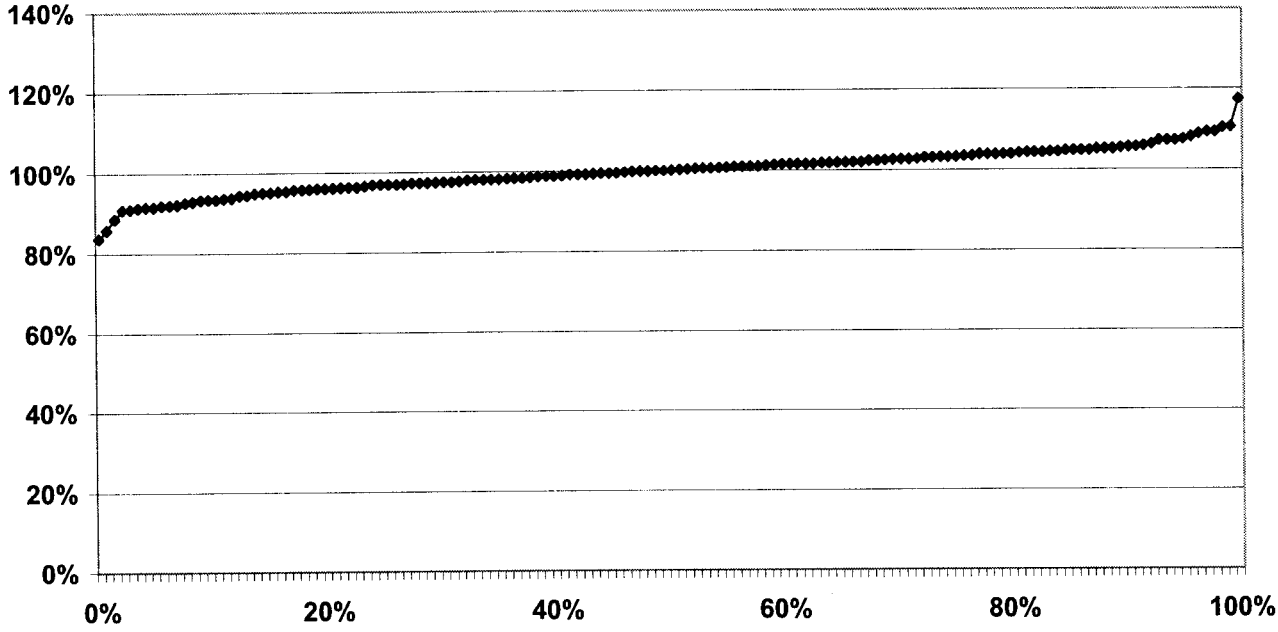


Chart 1.5 looks at the total health plan by combining the benefit values from the medical, prescription drug, dental, and vision plans. As the bulk of the cost for health plans comes from the medical benefits, the variation in total health plan value is similar to the variation of the medical plans.

Chart 1.5 shows that all but a handful of LEAs have health plans whose benefits are within 10 percent of the statewide average.

II. Benefits for Retired School Employees

LEAs must provide health benefits coverage to some retirees, and some LEAs go further and extend the coverage to all retirees. Commonwealth law (Acts 1988-110 and 1989-43) specifies the conditions under which LEAs must extend coverage to retired employees. The law does not define which plans have to be made available to the retiree. Further, the employer can charge the full active employee cost plus two percent to the retiree. Retirees can also join the Health Options Program (HOP) offered through PSERS.

Many retirees in HOP or the local LEA plans are eligible for a $100 a month subsidy through PSERS. Eligible retirees must show that they have an out-of-pocket premium expense of at least $100 from an approved health plan to receive the full subsidy.

Table 2.1 shows the conditions that the retiree must meet in order for the LEA to be required to continue coverage. Table 2.2 shows the conditions under which the $100 subsidy is available. The $100 subsidy is available to many retirees who do not meet the minimum requirement for coverage by the LEA. If the LEA does not provide wider coverage, the retired employees who do not meet the minimum LEA requirements can join HOP and receive the $100 subsidy.

Table 2.1
Commonwealth Requirements for Continuation of Coverage to LEA Retirees

- Age 62 at retirement with 30 or more years of service, or
- Receiving a disability annuity from PSERS,

AND

- Not over age 65

Table 2.2
Premium Assistance Program Eligibility

Retirees enrolled in either their former LEA's health plans or the PSERS sponsored HOP qualify for the assistance if they meet the following eligibility requirements:

- 24.5 years of credited service, or
- 15 years of credited service if termination of employment and retirement occurred after age 62, or
- Receiving a disability annuity from PSERS,

AND

- Have an out-of-pocket premium expense from an approved health insurance plan.

We found that some of the LEAs provided the minimum amount of coverage required by the Commonwealth. Retirees in those plans pay the full COBRA premium. A few of the LEAs extend retiree coverage after age 65, and some charge less than the full COBRA premium to retirees. Some of the LEAs charge $100 a month so that the retiree receives the HOP subsidy.

HOP offers a high and standard option as well as participation in HMOs. Table 2.3 summarizes the high option and standard options.

Table 2.3 Health Options Program Traditional Plan High and Standard Option 2003 Summary of Key Design Features		
Type of Care	**High Option**	**Standard Option**
Inpatient hospital	100% for 365 days	100% after $250 for 365 days
Outpatient physician	Not covered	Not covered
Surgical	100% of UCR**	100% of UCR***
Major Medical Expenses	80% after $250 deductible 100% after you pay $750.00 per person	50% after $500 deductible 100% after you pay $1,750.00 per person
Prescription Drug Plan (NPA/BeneCard):		
Annual Limit Maximum	50% after $250 deductible	Not Covered
After Annual Limit Maximum Paid	$3,000	
Inpatient psychiatric	100% for 30 days	100% after $250 for 30 days
Outpatient psychiatric	Not Covered	Not Covered
Inpatient Substance Abuse	100% for 30 days	100% after $250 for 30 days
Outpatient Substance Abuse	100% for 30 visits per year	100% for 30 visits per year
Preventive Services	Not Covered	Not Covered
Dental	Not Covered	Not Covered
Vision	$30 for exam $30 for single vision lenses $41 for bifocal lenses $50 for trifocal lenses	Not Covered
**Usual, Customary, Reasonable		
***Coverage after Standard Base Deductible of $500 has been satisfied		

Table 2.4 compares the features of the basic option available for retired Commonwealth employees through PEBTF to the high and standard options of HOP.

Table 2.4 Comparison of Health Options Program and PEBTF for Non-Medicare Eligible Retiree Members 2003 Summary of Key Design Features			
	PEBTF	**Health Options Program**	
Type of Care	**Basic Option**	**High Option**	**Standard Option**
Inpatient hospital	100%	100%	100% after $250
Outpatient physician	Not Covered	Not Covered	Not Covered
Surgical	100%	100%	100%
Major Medical Expenses	100%	80% after $250 deductible 100% after you pay $750 per person	50% after $500 deductible 100% after you pay $1,750 per person
Prescription Drug Plan (NPA/BeneCard):			
Annual Limit Maximum	Not Covered	50% after $250 deductible	Not Covered

Table 2.4 (Continued) Comparison of Health Options Program and PEBTF for Non-Medicare Eligible Retiree Members 2003 Summary of Key Design Features			
After Annual Limit Maximum Paid	Not Applicable	$3,000	Not Applicable
Inpatient psychiatric	Provided by UBH	100% for 30 days	100% after $250 for 30 days
Outpatient psychiatric	Provided by UBH	Not Covered	Not Covered
Inpatient Substance Abuse	Provided by UBH	100% for 30 days	100% after $250 for 30 days
Outpatient Substance Abuse	Provided by UBH	100% for 30 visits per year	100% for 30 visits per year
Preventive Services	Not Covered	Not Covered	Not Covered
Dental	Not Covered	Not Covered	Not Covered
Vision	Not Covered	$30 for exam $30 for single vision lenses $41 for bifocal lenses $50 for trifocal lenses	Not Covered

Table 2.5 summarizes the eligibility for and receipt of the $100 subsidy in 2002. Two-thirds of the retirees were eligible for the subsidy but only 70 percent of those eligible received the subsidy. Over half of those receiving the subsidy participated in HOP, and the rest participated in an LEA plan.

A survey performed by HOP, found that there were three approximately equal reasons that the subsidy was not used. One reason was that the retiree was able to find less expensive coverage through other insurance, such as the retiree insurance offered by AARP. Others either received coverage through a spouse's plan or did not have any coverage other than Medicare.

Another reason for the failure to participate is that cost-of-living allowances (COLAs) provided to annuitants in PSERS have been well below the premium increases for both LEA plan participants and HOP. The average COLA has covered half the increase in general inflation which, in recent years, has been around three percent a year, so the COLAs have averaged 1.5 percent a year. By contrast, health insurance premiums have increased at a rate significantly higher. As shown in Section VI, the average PEBTF premium increased by over 9 percent a year between 1999 and 2003.

Table 2.5 Eligibility for and Receipt of $100 Per Month PSERS Subsidy in 2002		
Group	**Total**	**Percentage of Total**
Eligible for premium assistance but not receiving	32,000	24.1%
Premium assistance		
PSERS' HOP enrolled	36,000	27.1%
Local School Plan	20,000	15.0%
Total receiving premium assistance	56,000	42.1%
Total eligible for premium assistance	88,000	66.2%
Not eligible for premium assistance	45,000	33.8%
Total	**133,000**	

Table 2.6 shows the distribution of retirees covered by HOP as of June 30, 2002. The large majority of retirees are over 65. Eligible retirees under age 65 can join their LEA plans, but 66 percent of LEAs do not extend coverage over age 65, so HOP is the only option available through prior LEA employment.

Table 2.6
HOP – Traditional - All Options
June 30, 2002

	Age Categories					
Member Category	**Under 20**	**20 - 34**	**35 - 49**	**50 - 64**	**65+**	**Total**
Male Contract Holder	1	1	19	221	9,237	9,479
Female Contract Holder	1	0	21	631	20,619	21,272
Male Spouse	0	0	0	37	2,872	2,909
Female Spouse	0	0	3	53	3,412	3,468
Male Dependent	3	6	10	6	2	27
Female Dependent	6	4	12	5	0	27
Total	**11**	**11**	**65**	**953**	**36,142**	**37,182**

Table 2.7 shows the history of enrollment in HOP options from 2000 through 2003.

Table 2.7
Enrollment History

Option	**2000**	**2001**	**2002**	**2003**
High	27,474	26,419	29,465	28,977
Standard	4,033	4,836	1,847	2,568
HMO	11,728	11,770	11,592	12,089
POS	748	750	592	454
PPO	0	87	281	709
Total	**43,983**	**43,862**	**43,777**	**44,797**

The Future of Health Insurance for Retirees

The recent changes to Medicare will result in changes to retiree health insurance design and cost. Plans will also have to conform to new rules set by the Governmental Accounting Standards Board (GASB). It is too early to predict the impact of these changes since the LEAs will need time to carefully respond to the two changes. We believe that there would be a similar cost impact on LEAs for either the current system of local plans or a statewide system.

In December 2003, President Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The Act will add a voluntary prescription drug benefit to the Medicare program.

Beginning in 2006, Medicare beneficiaries will have the option of obtaining prescription drug coverage through stand-alone private drug plans or through private preferred provider organizations or health maintenance organizations. Beneficiaries will pay monthly premiums of about $35. After an annual deductible of $250, beneficiaries pay 25 percent of up to $2,000 of prescription drug costs, with Medicare paying 75 percent. Once annual drug costs reach $2,250, beneficiaries pay 100 percent of their drug costs until their out-of-pocket expenses reach $3,600.

This out-of-pocket limit is reached when total drug expenses reach $5,100 ($250 + 25% x $2,000 + 100% x $2,850 = $3,600). Above that level the catastrophic coverage feature of Medicare pays 95 percent of the drug costs with beneficiaries paying just 5 percent.

To encourage employers to continue providing retiree health coverage, qualifying retiree plans would receive subsidies for 28 percent of the drug costs from $250 to $5,000 for each of their retirees who are enrolled in Medicare.

Other provisions in the bill include a $25 billion increase in Medicare payments to doctors and hospitals in rural areas. It also eliminates reductions in payments to physicians that were scheduled for 2004 and 2005 and instead increases payments by 1.5 percent each year. Hospitals that submit certain quality data to the Center for Medicare and Medicaid Services can prevent future reductions in payments. In addition, the bill increases Medicaid payments to hospitals that serve a large number of disadvantaged patients.

For physician practices with a mix of Medicare and non-Medicare patients, the increases in payments will alleviate some of the pressure for them to raise rates for non-Medicare patients to maintain practice revenues. As such, these "other provisions" can be expected to result in lower rate increases than otherwise would have been the case.

On February 14, 2003, the Governmental Accounting Standards Board (GASB) issued its long awaited exposure draft on *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions* (OPEBs).

The standard covers both post-retirement and post-employment benefits. The types of benefits covered include medical, dental, vision, hearing, life insurance, long term disability, and long term care.

The effective date for the new standard depends on the size of the employer. For entities with revenues in FY 2003 over $100 million, the effective date will be the fiscal year beginning after June 15, 2006. Entities with smaller revenues have later effective dates.

The purpose of this standard is to treat post-employment benefits in a manner similar to pensions. Governmental employers should recognize that OPEBs constitute compensation for employee service and they should recognize the cost of benefits during the periods when employee service is rendered. By accounting for OPEBs, GASB believes the accounting statement will improve the relevance and usefulness of financial reporting, provide information about the size of the liabilities and the extent to which they are funded, and ensure systematic accrual-basis measurement over employee service.

The most common and most expensive of the OPEBs are retiree medical benefits, which provide a valuable component in employees' retirement benefits program. Most governmental employers fund their retiree medical plans on a pay-as-you-go basis. When effective, the GASB standard will require employers to measure the unfunded postemployment benefit obligation and determine an "Annual Required Contribution" (ARC) amount that would be sufficient to fund the liability over the next 10 to 30 years. Employers who choose not to advance fund the benefits will have to record the unfunded liability on their annual statements. Those governmental entities that provide subsidized retiree medical benefits and who choose not to

fund the ARC are likely to find that their credit rating is reduced by the credit rating agencies. Thus, Local Educational Agencies which provide subsidized retiree medical coverage will face higher costs — either through funding the ARC or through higher interest payments on future debt (and possibly trigger higher interest payments on existing debts).

Commonwealth law (Acts 1988-110 and 1989-43), combined with GASB's new accrual accounting rules, will probably result in a larger share of LEA funds being used for retiree health care in the future. This will most likely come about as LEAs establish retiree health care trusts and pre-fund their retiree health obligations in a manner similar to pensions. The financial burden LEAs face from supporting a growing retiree population could put pressure on LEAs to seek legislative relief from these laws.

III. Health Benefits for Commonwealth of Pennsylvania Employees

The Commonwealth has entered into an agreement with Council 13 of the American Federation of State, County and Municipal Employees, AFL-CIO (AFSCME) to create the Pennsylvania Employees Benefit Trust Fund (PEBTF) to provide health insurance for its employees and their dependents and, through a separate fund, to retired employees. The fund was established in 1988, primarily to control the rapid and continuing increase in health care costs. The PEBTF administers the health care benefits for all eligible employees, retirees, and their dependents under a jointly administered, multi-union health and welfare fund. Almost all of the fund's contributions are received from the Commonwealth of Pennsylvania and its agencies. A Board of Trustees comprised of both Commonwealth and Union representatives governs the PEBTF.

PEBTF administers the health care benefits for approximately 85,000 active employees and 52,000 retirees and their dependents, covering a total of approximately 300,000 lives. Commonwealth employees who are not represented by AFSCME or other participating unions are covered through other health insurance arrangements. For example, legislative and judicial employees are not covered by PEBTF.

The PEBTF offers four options to eligible active employees and retirees. These are the Comprehensive option, a point-of-service (POS) option, a preferred provider (PPO) option and an HMO option. Employees can also choose supplemental benefits such as vision, dental, and prescription drugs. As a result of collective bargaining in 2003, the eligibility and cost sharing of the plans was changed in a series of steps beginning August 1, 2003. Employees hired on or after August 1, 2003, will contribute one percent of their bi-weekly base gross salary towards health care whether they choose medical only, supplemental only, or both.

Eligibility – Active Employees

Employees hired in full-time positions are immediately eligible to join the health plan. Part-time employees who are scheduled to work at least half of the full-time hours are eligible for benefits under the same terms and conditions as full-time employees.

Employees hired after August 1, 2003, are not allowed to elect the Basic Option, and they are not immediately eligible for the supplemental benefits. During the first six months of employment, newly hired employees are only able to enroll in the least costly plan that is available in the county that they live in and they must pay one percent of their biweekly gross salary for coverage. A new employee can join a more expensive plan and cover dependents if the employee pays the difference in cost for that plan.

After completing six months of employment, new employees (hired on or after August 1, 2003) are then allowed to obtain dependent coverage under the least expensive plan and contribute one percent of their bi-weekly gross salary towards their premium share. Supplemental coverages are available to new employees after completing six months of service at no additional charge.

For retirees, PEBTF administers the benefits and is reimbursed by the Commonwealth for the actual cost of benefits and plan administration monthly. For active employees, PEBTF receives per contract contributions from the Commonwealth and is, in theory, at risk for all costs. However, in the event of a shortfall, the PEBTF would reopen negotiations to bring the contributions in line with the benefits.

The changes in 2003 include a requirement that spouses of employees hired after August 1, 2003, be required to obtain health insurance coverage through the spouse's employer if that coverage is available. Spouses of employees hired before August 1, 2003, are only required to participate in the employer plan if there is no premium charge to the spouse. This will lower the dependent cost to PEBTF covered employees.

Currently none of the premium is paid by employees hired before August 2003. These employees will contribute 0.5 percent of their salary for health insurance in July 2005, and the contribution will increase to 1 percent of salary in January 2007.

Eligibility – Retirees

Employees enrolled in, or eligible to enroll in, the PEBTF's active employee health program are eligible to participate in the retired employee health program (REHP).

Retirees who meet the following conditions will have the full cost of their health care premium paid for by the Commonwealth until July 1, 2005:

- age 60 at retirement with at least 15 years of credited service
- any age at retirement with at least 25 years of credited service
- approved disability with at least 5 years of credited service

The Commonwealth only pays $5 a month toward the cost of coverage for annuitants not qualifying for the fully paid coverage criteria.

An employee retiring on or after July 1, 2005, must contribute one percent of their base salary at retirement for health benefits.

Medicare-eligible retirees can join a variety of plans that supplement Medicare. Younger retirees who retire after July 1, 2004, will be able to participate in the same options as employees. Younger retirees who retire before July 1, 2004, will be able to continue in plans that were available to retirees before that date.

PEBTF Benefits

The benefits provided under the three non-HMO options were modified effective October 1, 2003. Table 3.1 shows the benefits currently in effect. The primary change in the plans was to increase the deductibles. The Basic Option deductible had been $100, the POS out-of-network deductible had been $200 and the PPO out-of-network deductible had been $250.

Table 3.1 PEBTF 2003/2004 Summary of Key Design Features					
Type of Care	**Basic Option**	**POS Option**		**PPO Option**	
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Plan Deductible (per person)	$500	$0	$400	$0	$400
Maximum Out-of- Pocket Limit (per person)	$3,000	Not Applicable	$1,500	Not Applicable	$1,500
Coinsurance rates (percentage of cost of service paid by the plan)					
Inpatient hospital	80%	100%	70%	100%	70%
Outpatient hospital	80%	100%	70%	100%	70%
Physician Visits	80%	100% after $15 copay	70%	100% after $15 copay	70%
Specialist Visits	80%	100% after $25 copay	70%	100% after $25 copay	70%
Surgical	80%	100%	70%	100%	70%
Mental Health and Substance Abuse Treatment	This is a carve-out plan with all mental health services provided by United Behavioral Health (UBH).				
Preventive Services	Not Applicable	100% after $15 copay	70%	100% after $15 copay	70%

Table 3.2 compares the Basic PEBTF plan for new employees to the typical LEA plans. The LEA FFS plan is much more generous than the current PEBTF Basic plan. The LEA plan has a $100 deductible and pays all hospital expenses. The PEBTF Basic plan pays 80% of all expenses after a $500 deductible. Tables 3.3 and 3.4 show that the PEBTF in-network PPO and POS plans are similar in design to the typical LEA plans.

Table 3.2 Summary of Key Design Features In-Network Benefits for Fee-for-Service Plan Designs		
Type of Care	**2003/2004 PEBTF**	**Typical LEA FFS Plan**
Plan Deductible	$500	$100
Maximum Out-of- Pocket Limit	$3,000	$1,500
Coinsurance rates (percentage of cost of service paid by the plan)		
Inpatient hospital	80%	100%
Outpatient hospital	80%	100%
Physician Visits	80%	80%
Specialist Visits	80%	80%
Surgical	80%	100%
Mental Health and Substance Abuse Treatment	Provided by UBH	50%
Preventive Services	Not Applicable	Provides

Table 3.3 Summary of Key Design Features In-Network Benefits for Preferred Provider Organization Plan Designs		
Type of Care	**2003/2004 PEBTF PPO**	**Typical LEA PPO Plan**
Plan Deductible	$0	$0
Maximum Out-of Pocket Limit	Not Applicable	$0
Coinsurance rates (percentage of cost of service paid by the plan)		
Inpatient hospital	100%	100%
Outpatient hospital	100%	100%
Physician Visits	100% after $15 copay	100% after $10 copay
Specialist Visits	100% after $25 copay	100% after $10 copay
Surgical	100%	100%
Mental Health and Substance Abuse Treatment	Provided by UBH	100% after $15 copay
Preventive Services	100% after $15 copay	Provides

Table 3.4 Summary of Key Design Features In-Network Benefits for Point-of-Service Plan Designs		
Type of Care	**2003/2004 PEBTF POS**	**Typical POS LEA Plan**
Plan Deductible	$0	$0
Maximum Out-of- Pocket Limit	Not Applicable	$0
Coinsurance rates (percentage of cost of service paid by the plan)		
Inpatient hospital	100%	100%
Outpatient hospital	100%	100%
Physician Visits	100% after $15 copay	100% after $5 copay
Specialist Visits	100% after $25 copay	100% after $5 copay
Surgical	100%	100%
Mental Health and Substance Abuse Treatment	Provided by UBH	100%
Preventive Services	100% after $15 copay	Provides

PEBTF Plan Administration

The PEBTF administers eligibility and benefits for approximately 300,000 covered lives. This pooling of a large number of lives in a compact number of plans has enabled the plan administrators to develop special programs, in-house information technology expertise, and governance arrangements to minimize expenditures. These programs include:

- subrogation recoveries
- identification and administration of Medicare Secondary payer savings
- carved-out and specialty managed benefits for prescription drugs and mental health/substance abuse

- collections and credit activities, including identification and collection from overpayments, ineligible students, unauthorized utilization, retro-terminations, and audits
- durable medical equipment contract savings

The above activities produced savings of over $2,500,000 in FY 2003.

PEBTF recently launched a disease management program targeted at members with chronic conditions. The initial program, covering three chronic conditions (cardiac, COPD, and diabetes), enrolled over 9,000 members with a projected savings of over $20 million over the next three years.

Characteristics of PEBTF Enrollment

Table 3.5 shows the distribution of employees and dependents by type of plan in 2003. The largest enrollment is in the basic Blue Cross plan, closely followed by the enrollment in the HMOs. Around 18 percent are in the PPO plans and 11 percent in the POS plan. The distribution of enrollment will shift significantly in the future since the Basic plan has been redesigned as the Comprehensive plan with a higher deductible and new employees cannot join that plan. The percents in table 3.5 are of the total 204,996 enrollees. After the latest open season, only 5,000 employees remained in the Comprehensive plan.

Table 3.5
PEBTF Active Employee and Dependent Enrollment as of June 2003

Plan Name	Totals		
Blue Cross	**Male**	**Female**	**Total**
Capital Blue Cross Basic	15,634	16,125	31,759
Highmark Basic	15,526	15,415	30,941
Northeast Basic	8,141	7,927	16,068
Subtotal	**39,301**	**39,467**	**78,768**
Percentage of Total	**19.17%**	**19.25%**	**38.42%**
HMO			
Keystone Central HMO	7,125	7,761	14,886
Geisinger Health Plan HMO	5,258	5,122	10,380
Keystone West HMO	4,960	5,136	10,096
Health America Central HMO	4,232	4,404	8,636
First Priority Health HMO	2,835	2,799	5,634
Aetna US Healthcare HMO	2,175	2,279	4,454
UPMC HMO	1,325	1,362	2,687
Keystone East HMO	904	1,049	1,953
Healthguard of Lancaster HMO	865	925	1,790
Health America Pittsburgh HMO	644	653	1,297
Keystone Lehigh HMO	356	394	750

Table 3.5 (continued) PEBTF Active Employee and Dependent Enrollment as of June 2003			
Subtotal	**30,679**	**31,884**	**62,563**
Percentage of Total	**14.97%**	**15.55%**	**30.52%**
PPO			
Capital Blue Cross PPO	8,624	9,200	17,824
Personal Choice PPO	9,261	10,178	19,439
Subtotal	**17,885**	**19,378**	**37,263**
Percentage of Total	**8.72%**	**9.45%**	**18.18%**
POS			
Highmark POS	11,820	12,036	23,856
Percentage of Total	**5.77%**	**5.87%**	**11.64%**
Others			
No Medical- Supplemental Benefits Only	1,266	1,262	2,528
Chose No Benefits	4	4	8
Personal Choice Medicare	1	1	2
Capital Blue Cross Medicare Supplement	4	2	6
Northeast Blue Cross Medicare Supplement	-	2	2
Subtotal	**1,275**	**1,271**	**2,546**
Percentage of Total	**0.62%**	**0.62%**	**1.24%**
Total	**100,960**	**104,036**	**204,996**

Tables 3.6 through 3.8 show the plan selection PEBTF annuitants. The percents shown are of the 84,472 total enrollees.

Table 3.6 PEBTF Annuitant and Dependent Enrollment Medicare Eligible as of June 2003			
	Total Enrollment		
Plan Name	**Male**	**Female**	**Total**
Capital Blue Cross Medicare A&B	8,144	11,134	19,278
Western Blue Cross Medicare A&B	7,246	9,028	16,274
Personal Choice PPO Medicare A&B	2,751	3,800	6,551
Northeast Blue Cross Medicare A&B	2,912	3,447	6,359
Personal Choice Part B Supplement	1	-	1
Subtotal	**21,054**	**27,409**	**48,463**
Percentage of Total	**24.92%**	**32.45%**	**57.37%**
Medicare Supplement			
Capital Blue Cross Medicare Supplement	1,795	2,615	4,410
Medicare Supplement	70	25	95

Table 3.6 (continued) PEBTF Annuitant and Dependent Enrollment Medicare Eligible as of June 2003			
Other Plans	7	8	15
Subtotal	**1,872**	**2,648**	**4,520**
Percentage of Total	**2.22%**	**3.13%**	**5.35%**
MHMO			
Security Blue MHMO	238	406	644
GHP MHMO	236	315	551
Advantra MHMO: Allegheny County	25	35	60
Advantra MHMO: Centre County	26	26	52
Advantra MHMO: Fayette, Green, Lawrence, and Westmoreland counties	13	12	25
UPMC MHMO	9	11	20
Advantra MHMO: Armstrong, Beaver, and Butler Counties.	5	9	14
Advantra MHMO Washington County	1	2	3
Subtotal	**553**	**816**	**1,369**
Percentage of Total	**0.65%**	**0.97%**	**1.62%**
Medicare Total	**23,479**	**30,873**	**54,352**

Table 3.7 PEBTF Annuitant and Dependent Enrollment Non-Medicare Eligible as of June 2003			
	Total Enrollment		
Plan Name	**Male**	**Female**	**Total**
Highmark Blue Cross	3,368	4,625	7,993
Capital Blue Cross	3,068	4,567	7,635
Northeast Blue Cross	1,370	1,725	3,095
Subtotal	**8,466**	**11,869**	**20,335**
Percentage of Total	**10.02%**	**14.05%**	**24.07%**
HMO			
Keystone HP West HMO	593	653	1,246
Geisinger Health Plan HMO	529	536	1,065
Keystone HP Central HMO	451	501	952
Health America Central HMO	231	270	501
Aetna US Healthcare HMO	153	195	348
UPMC HMO	147	159	306
First Priority Health HMO	140	119	259
Healthamerica Pittsburgh HMO	96	92	188
Healthguard of Lancaster HMO	65	65	130

Table 3.7 (continued) PEBTF Annuitant and Dependent Enrollment Non-Medicare Eligible as of June 2003			
Keystone HP East HMO	53	71	124
Keystone HP Lehigh HMO	22	22	44
Subtotal	**2,480**	**2,683**	**5,163**
Percentage of Total	**2.94%**	**3.18%**	**6.11%**
PPO			
Personal Choice PPO	1,438	2,098	3,536
Capital Blue Cross PPO	493	593	1,086
Subtotal	**1,931**	**2,691**	**4,622**
Percentage of Total	**2.29%**	**3.19%**	**5.47%**
Non-Medicare Total	**12,877**	**17,243**	**30,120**

Table 3.8 PEBTF Annuitant and Dependent Enrollment Summary			
	Male	**Female**	**Total**
Medicare eligible	**23,479**	**30,873**	**54,352**
Non-Medicare eligible	**12,877**	**17,243**	**30,120**
Total	**36,356**	**48,116**	**84,472**

Comparison of Value of Commonwealth and LEA Plans

Sections I through III have set forth the design of the health plans available to LEA and Commonwealth employees. We applied our BVC analysis to the two sets of plans to determine the relative value of the plans. The results are shown in table 3.9. The values shown are the composite for self-only and family coverage.

The values shown are for the current Commonwealth health plans after the benefits changes in 2003. Currently Commonwealth employees hired before 2003 do not pay for their health benefits but, by 2007, all Commonwealth employees will be paying one percent of salary for the benefits. The table shows the value of the benefits before and after the contribution requirement.

The first line is the aggregate value across all plans. The LEA benefits have a higher total value than the Commonwealth benefits primarily because of the 2003 reduction in the value of the Basic/Comprehensive plan for Commonwealth employees.

The LEA employees contribute 5.1 percent of the premium on average, so the net employer-provided value is reduced. The reduction is about the same as it will be for Commonwealth employees after the one percent of salary contribution is required.

There is a very substantial difference in the retirement benefits. Commonwealth retirees can continue health insurance coverage throughout retirement. Current retirees do not pay any of the cost, but eventually they will have to pay an equivalent of one percent of salary after

retirement. Even after this payment, the post-retirement benefits have a substantial value to Commonwealth employees.

LEA retirees, on the other hand, seldom have full continuation of coverage, and many with a continuation of coverage are charged the full cost for the post-retirement benefits. We set the retiree value equal to the $100 per month PSERS contribution for the proportion of employees who receive that contribution.

The net result is that the employer-provided value for the entire health insurance package, for employees and retirees, for Commonwealth employees is substantially more valuable than for LEA employees. Even after the requirement for contributions, the Commonwealth benefit will be more than 25 percent more valuable than the average LEA benefit.

Table 3.9
Comparison of Value of Commonwealth and LEA Health Insurance

	Commonwealth Employees		Average LEA
	Current Basis	With 1 percent of pay contribution	
Total value for employees	$8,643	$8,643	$9,009
Employee contribution	0	$450	$459
Net employer-provided value	$8,643	$8,193	$8,550
Retiree value	$3,457	$3,277	$505
Total employer-provided value	$12,100	$11,470	$9,055
Commonwealth/LEA	1.34	1.27	N/A

IV. Other States

We surveyed the health plans of school employees in ten states for this report. These are the states close to Pennsylvania as well as others that are of particular interest. Two of the states provide health insurance for school employees only through a state health plan, and five states permit school districts to voluntarily participate in the state health plan for state employees. The remaining three states surveyed do not permit school districts to participate in the state health plan. Table 4.1 summarizes the coverage for the ten states surveyed. Appendix B provides details on the ten states.

Table 4.1
Summary for School Health Plan Design for School Employees

State	Mandatory Participation in State Health Plan	Voluntary Participation in State Health Plan	No State Health Plan for School Employees
California		X	
Delaware	X		
Louisiana		X	
Maryland			X
New Jersey		X	
New York		X	
North Carolina	X		
Ohio			X
South Carolina		X	
Virginia			X

For the states that provide a state plan only or voluntary participation in the state plan, Table 4.2 provides the plan name and the year school employees joined the plan. Delaware and North Carolina could not provide an exact date, but they did confirm that school employees have participated since before 1990.

We did not find any instance of a recent change similar to that being considered for Pennsylvania. We found that Oregon has recently changed their health care system by combining two separate funds that covered State employees. However, school employees in Oregon were not included in that change so we did not include Oregon in this study.

Table 4.2 State Plan Health Care Coverage		
State	**Plan Name**	**Effective Year for School Employee Eligibility**
California	CalPERS	1967
Delaware	State of Delaware Group Health Insurance Program	Before 1990
Louisiana	State Office of Group Benefits Health Insurance Program	1980
New Jersey	New Jersey State Health Benefits Program	1964
New York	New York State Health Insurance Program	1958
North Carolina	North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan	Before 1990
South Carolina	South Carolina Employee Insurance Program	1971

The table below provides a listing of the state health plan options available to eligible employees.

Table 4.3 State Health Care Plan Options			
State	**FFS**	**PPO/POS**	**HMO**
California		2	2
Delaware	2	1	2
Louisiana		1	2
New Jersey	1	1	5
New York		2	6
North Carolina	1		
South Carolina		2	2

Administration

A major question facing Pennsylvania would be how to administer a statewide system. Administration of the state health plans varies from state to state for the seven states that have a state-wide plan. Two of the states administer the plan through a combined health and retirement plan structure. Two have established a separate unit to administer the health plan and three administer the plan through the state office of administration and/or budget.

California

In California, the Board of Administration manages the CalPERS program for both retirement and health insurance. The Board consists of a total of 13 members. Six of the members are elected, three are appointed, and four hold state offices. The Board's responsibilities include setting employer contribution rates, determining asset allocations, and providing actuarial valuations with regard to their health and retirement programs as well as various other program benefits available. Changes cannot be made to the benefits without the approval of the State Legislature.

Delaware

The Group Health Plan was established by state statute, which also established a state employee benefits committee, which governs the Group Health Plan. 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 State Personnel Office's Division of Benefits administers the Group Health Plan.

Louisiana

The Louisiana Legislature created the Board of Trustees of the State Employees Group Benefits Program in 1979 to administer the state insurance program. An executive director is appointed and the agency functions under the auspices of the Louisiana Civil Service. The Board currently has 16 members.

New Jersey

The State Health Benefits Program (SHBP) is operated by the State Health Benefits Commission which is the executive body of the plan established by statute. Daily administrative activities of the SHBP are handled by the Division of Pension and Benefits. Plan members are provided the opportunity to appeal to the Health Benefits Commission for resolution of any complaints with their plan, after they have completed the formal grievance process with their plan administrator.

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. The New York State Department of Civil Service Employee Benefits Division administers the program, and the NYSHIP is the largest public employer health insurance program in the nation outside of the Federal government. The program covers over 1.1 million state and local government employees, retirees, and their families.

North Carolina

Through the provisions and limitations of the North Carolina General Statutes, the state provides health care benefits to teachers, employees, retirees, and their eligible dependents. Health benefits for employees are based upon legislation enacted by the North Carolina General Assembly. In addition, the Executive Administrator and Board of Trustees approve comprehensive medical policies.

South Carolina

South Carolina's Employee Insurance Program (EIP) is governed by the South Carolina Budget and Control Board which is the central administrative agency for South Carolina. The Board is responsible for operating the state retirement system as well as the health plan available to state and school employees. The Board's functions include assisting state and local agencies and employees in their operations. The Governor chairs the five-member board, which selects the Budget and Control Board's Executive Director, who serves as the agency's chief administrative officer.

Relevance of Other States Practice to Proposed Pennsylvania Plan

The varying practice of administration shows that states have been successful either administering the health benefits plan through a separate entity (as would be the case with PEBTF) or through the executive branch of the state. So either of these approaches is feasible, and Pennsylvania can find models to use for either design.

Participation in most plans is voluntary, although two of the statewide plans are mandatory. This shows that voluntary plans are financially and administratively feasible and either approach could be used. The preponderance of voluntary plans suggests that political reality may have resulted in that approach more commonly than not.

Most plans offer available HMOs and one or two of the other types of design. This suggests that states have found that the number of options should be limited.

V. Discussions With Interested Parties

House Resolution Number 159 specified that we discuss the concept of a Commonwealth-wide plan with interested parties and named eight specific organizations that should be contacted. We discussed the concept with thirteen organizations including the eight that had been identified. The organizations are as follows with those identified in the resolution indicated by an asterisk:

The Pennsylvania Department of Education*
The Pennsylvania School Boards Association*
The Pennsylvania State Education Association*
The Pennsylvania Federation of Teachers*
The Governor's Office of Administration*
Pennsylvania Association of School Business Officials*
Pennsylvania Public School Employees Retirement System*
Pennsylvania State Employees Retirement System*

Pennsylvania Association of Health Underwriters
Capital Blue Cross
Blue Cross of Northeastern Pennsylvania
Highmark Blue Cross/Blue Shield
Independence Blue Cross

As part of our interview, we asked each of the organization's to provide a statement of the organization position on the concept of a Commonwealth-wide plan. The statements follow.

The Pennsylvania Department of Education

The Department of Education would be supportive of a consolidation of the school district health plans into a statewide system if there are demonstrable savings without a reduction in benefits. Even with overall savings, the Department is concerned that some school districts would have to pay more in a statewide system. The Department would prefer a menu of choices if that would avoid increasing health insurance costs for individual school districts.

The Pennsylvania School Boards Association (PSBA)

The PSBA recognizes that health care costs are an increasing concern and welcomes any opportunity to lower health care costs. They are very much interested in reviewing the Hay Group study but are not able to provide specific comments on House Resolution 159 until the study is complete. The PSBA would hope that if a statewide plan were to include supplementary coverage (e.g. dental and vision insurance) that LEAs would be permitted to choose alternatives to the supplementary coverages if other sources provided better coverage at lower rates.

The Pennsylvania State Education Association

PSEA is highly concerned about the exploding fiscal and human burden that health insurance for school employees is placing on our education system. We believe a well-designed statewide health plan has the potential to lower administrative expenses, stabilize year-to-year costs, ease the local budget development process for school districts, and protect school employees and retirees from unnecessary cuts in their benefits. It can also reduce the time school administrators and local union leaders dedicate to health insurance matters, enabling them to redirect their focus to education matters.

We look forward to working with the Legislature on this issue.

The Pennsylvania Federation of Teachers (PFT)

The Pennsylvania Federation of Teachers (PFT) and the Philadelphia School District sponsor a jointly trusteed health benefit fund (the Fund). The Fund is opposed to the Philadelphia LEA health benefits being provided by a state administered plan because:

The Philadelphia LEA has difficulty in attracting and retaining teachers and others and therefore to limit this problem needs:

- To maintain a high level of benefits
- To maintain benefits that are oriented to local needs and reflect local conditions
- To respond to approximately 2,000 calls a month
- To have flexibility in benefits offered, including making changes during the year
- To continue to provide local services which are more effective

The Fund would be more cost effective than a state pool because:

- Fund Rx, dental, vision trends have been kept lower than typical
- Fund internal administrative cost is less than 2%
- Fund is able to provide additional services to teachers and the LEA at minimal cost

Other state funds are having financial problems:

- The Pennsylvania Employee Benefit Trust Fund (PEBTF) is probably bankrupt and has cut benefits dramatically.
- There have been previous investigations to add Philadelphia LEA to the State Fund – they proved not to be feasible (cut in benefits and increased costs).
- In New York State The Empire Fund excludes the United Federation of Teachers Health and Welfare Fund (New York City) – the state fund is having financial difficulties.
- After three or four thousand employees, the economy of scale is irrelevant. Pittsburgh and Philadelphia would probably find an increase in costs.
- Small districts could best be served if they were offered the opportunity to share in a larger risk pool. The set up of a central fund that offers benefits in a competitive setting after constructing a risk sharing pool for small groups could help such groups.

The best way to save costs is to have the State Insurance Department require better data from for-profit and non-profit insurance companies and to regulate increases more carefully.

- Lack of control over the growth of health care expenditures has more to do with lack of proper state oversight by the Insurance Department, and the State Legislature, not the source of a tax.
- Unless there is oversight on premiums, reserves, expenditures, alternative sources of medications, costs will increase regardless of the tax source.
- Claims drive charges, not size. Information on how much is collected by a company and how much is spent is difficult to extract. What oversight does the company provide on the actual plans? What are the actual audits of hospitals minus their real estate holdings?

The Governor's Office of Administration

The Office of Administration expressed the view that, based on its experience with the PEBTF, a state-wide plan for school employees should be organized with adequate planning and lead time to provide the best and most cost effective service to the employees and their families. With proper planning and development, a health and welfare trust fund for school employees could result in the same or similar savings, economies of scale, and efficiencies as the PEBTF currently enjoys. Any suggestion that school employees ought to be added to PEBTF, rather than participating in their own separate trust fund, must take into account the impact of such a change on the PEBTF and the Commonwealth employees it serves, including the potential for deterioration in service and/or adverse financial consequences. One potential concern that should be carefully reviewed is the impact on computer and administrative systems. Finally, the Office of Administration expressed the view that, given the wide coverage of providers possible through a PPO plan, it is probably not necessary to include FFS option in a state-wide plan. In addition, the PEBTF's experience is that the FFS option is the most expensive form of health care coverage.

Pennsylvania Association of School Business Officials (PASBO)

While PASBO has not taken a position on the creation of a statewide health plan, we will actively review the data from the study. With the continued rising costs of employee benefits, particularly health coverage, any proposal that can demonstrate cost savings to local education agencies and their taxpayers is deserving of consideration. Implementing a statewide system will pose several significant barriers. From a geographic perspective, the Commonwealth is more like a five region composite than a homogeneous state. This geographic diversity and the resulting variation in local education agencies, health care costs, and culture will make any unification efforts a challenge.

Pennsylvania Public School Employees' Retirement System (PSERS)

If a statewide plan is created, the main impact on PSERS would be that the HOP plan would probably be transferred to the new organization. Since PSERS has in place a process for collecting retirement contributions from all of the school districts that would be covered in a statewide plan, it could assist the health plan administer of the new organization in setting up a parallel system to collect health plan premiums from the school districts. PSERS will be happy to comment on the Hay Group report once that report is finalized.

Pennsylvania State Employees Retirement System (SERS)

Most employees covered by the Commonwealth health plan provided through the PEBTF are also covered by SERS. Adding school system employees and retirees to PEBTF would not have any impact on SERS because these employees would not be added to SERS.

Pennsylvania Association of Health Underwriters (PAHU)

The Pennsylvania Association of Health Underwriters (PAHU) believes that health care plans should remain under the control of local LEAs. The local LEAs and the underwriters who serve those plans best understand the health care needs and costs at the local level. The underwriters act as school employee advocates who assist LEAs in navigating the insurance system. Many insurance providers also work with the LEAs to meet their specific needs in all lines of insurance. This means that the LEA also has an advocate in assessing the overall insurance requirements of the LEA as well as being able to focus on health. That important function would be diminished in a state-controlled plan. A statewide system would be another unfunded mandate that would have to be supported by the LEA budget. LEAs would lose their ability to adapt benefit programs to their particular need and budget. In addition, political pressure to the state level would have the effect of raising school employee benefits to a higher standard, thus imposing a higher cost on those LEAs that can least afford it.

Capital BlueCross

Capital BlueCross has over 50 contracts with individual school districts, as well as, Intermediate Unit coalitions. Capital BlueCross has very effective, frequent meetings with these groups on a regular basis (typically monthly or quarterly). These meetings often include leadership from the teacher's union. Capital BlueCross' contracts vary by school district and include both fully insured and self-funded arrangements. The insured arrangements are typically retrospectively rated (arrangements which have been in place, in some cases, for 20 to 30 years). Capital BlueCross believes that these arrangements allow the schools, over time, to pay precisely what they owe for a defined set of benefits. Some years there are deficits and other years there are surpluses, but the funding mechanism, nonetheless, allows the schools to budget their health care expenses.

We understand that the consolidation program would be administrative services only. Capital BlueCross believes it is important to allow the continuation of the existing funding arrangements on a district-by-district basis as an important tool in allowing the school districts to control costs.

In addition, Capital BlueCross has a number of serious questions concerning the feasibility of a statewide arrangement (the existence of multiple unions, benefit plans, differences in eligibility requirements, and the question of subsidization of one district by another).

One of the points made was that one central point of contact under a consolidation program would result in administrative savings. However, we believe that each district would want to continue to be provided reporting and information relative to their own utilization. We expect the districts would continue to need support at open enrollments, and continue to receive individualized services of the type they have received in the past. To do this, we would need to

continue to maintain existing relationships with each school district. Given that Capital BlueCross' administrative costs are already low, we have some question as to the scope of any savings to be realized.

Our question as to feasibility of a statewide program remains, whether the program is voluntary or mandatory.

It is Capital BlueCross' experience that school districts have, and will continue to explore, alternative benefit designs to control costs. School districts are acutely aware of health care costs, and the impact on their budgets, and are working closely with Capital BlueCross on a number of different initiatives, including implementation of a three-tier prescription drug benefit and additional cost-sharing features such as copays and deductibles.

Blue Cross of Northeastern Pennsylvania

BCNEPA provides services to about 70 school districts in 13 counties in Northeastern Pennsylvania. Most of these 70 school districts belong to one of several consortia that provide healthcare benefits through a trust, with only a handful of school districts contracting directly with BCNEPA. Currently, the range of services BCNEPA provides varies for each of the trusts.

For several reasons, including the bargaining process and the rural nature of this part of Pennsylvania, traditional indemnity fee-for-service plans are the most common plan designs, with just a handful of HMOs, and a small but growing number of PPOs.

If the administration of the health benefits for school district employees were consolidated into a statewide plan, BCNEPA would anticipate that this could facilitate certain plan efficiencies. Balancing these administrative savings, BCNEPA would expect there to be increased reporting requirements. One advantage BCNEPA sees if the administration of school district employees' health benefits were handled by the PEBTF is that BCNEPA already has a very strong working relationship with PEBTF.

Highmark Blue Cross/Blue Shield

Highmark Blue Shield is a major health care insurer for school district employees. In Western Pennsylvania, Highmark has enrollees from 210 of the 223 school districts, covering over 95 percent of the members. The majority of these school districts use consortia or trusts to arrange health care coverage for employees. In Central Pennsylvania and Lehigh Valley there are 69 school districts and consortia, of which 27 are enrolled in Highmark.

Highmark estimates that about 90 cents out of every premium dollar covers medical costs with only 10 cents covering administration services. If the school districts were consolidated in a single health plan, similar to the PEBTF structure, Highmark recognizes there would be some efficiencies and reduction in the number of client managers, but no impact on their member services. Highmark estimates that consolidation would have very little impact on their administration costs.

Reflecting the variation in the concentration of specialists in different cities, and variation of hospital costs between metropolitan and rural hospitals, Highmark uses a regional pricing

structure. Regional pricing not only helps Highmark match their costs to their covered populations, but also addresses concerns raised by their school district clients about being pooled with a group in a different region that has higher costs.

One option that Highmark sees that could lead to improved cost efficiencies would be if schools adopted a standard plan design that incorporated common measures of cost-sharing, such as deductibles and coinsurance.

Independence Blue Cross

Independence Blue Cross is the principal insurer of health care for the school employees of the City of Philadelphia and the surrounding four counties of Bucks, Delaware, Chester, and Montgomery.

The Heinz Trust attempted to build a multi-county healthcare cooperative several years ago. The trust was not able to attract any participation in Southeastern Pennsylvania since strong affiliation programs already existed at the county level.

The healthcare market in and around Philadelphia is well established, with high HMO and PPO managed care enrollment. Negotiations with the school districts/IUs typically deal with small tweaking to the existing benefit structure.

The cost for City of Philadelphia school employees is substantially higher than for the surrounding counties, creating a real barrier for consolidation within a uniform pool.

Can expect significant resistance from the teachers if they are pooled with the PEBTF as the teachers see their healthcare needs as different from those of commonwealth employees.

Independence Blue Cross would be concerned if there were a state-wide plan for several reasons: the disparity of benefits between the central and western part of the state, where the benefits offered have very little cost-sharing and are predominantly traditional indemnity designs; the disparity of costs between different regions; rural and suburban counties would wind up subsidizing the urban centers; counties whose costs declined would not raise any objections, however, counties whose costs increase would likely be fiercely opposed to any changes, as they would cause the counties to have to raise local taxes.

The current model in the four suburban counties of Southeastern Pennsylvania is very efficient. Pooling with a statewide program would probably represent a step backwards.

This type of model exists today in New Jersey. It worked well initially but in recent years, as good risk school districts have pulled out of the New Jersey State Health Benefits Program, it has placed a strain on the state to properly reserve for catastrophic risks.

Summary of Responses

Several of the organizations supported a statewide plan and several opposed a statewide plan. However, the most common response was that the organization would wait for the results of the Hay Group study to determine if the structure and cost of the proposed options justified a move to a statewide plan.

Most of the organizations that support or might support a statewide system said that the main reason they would do so would be if substantial cost savings could be achieved.

Another reason indicated by some for supporting a statewide plan would be to remove the health insurance from collective bargaining. Some referred to PSERS as an example of removing a major issue by standardizing retirement benefits and contributions.

The main reason cited for opposing a statewide plan is that there is variation needed at the local level and that would not be possible in a statewide plan. Some respondents referred to earlier studies that had suggested that a statewide plan would not result in savings. We reviewed several of these reports and found that they concerned a merger of one plan with PEBTF and had a much narrower scope than the current study.

Opponents noted that the system is naturally evolving to large consortia that are more effective in negotiating insurance design and cost than the local LEAs and that they did not believe that a mandatory statewide plan would achieve greater savings more rapidly than the evolving situation with the local LEAs and consortia. While we found some movement toward consortia, we did not find that the movement was extensive enough to achieve savings approaching those that could be achieved through establishing a statewide plan.

Many of the responders noted that LEAs need health insurance costs that are both predictable and stable. They recognized that health insurance costs have increased and will continue to do so, but they preferred a steady increase to wide swings in premiums. Several responders believed that predictability and stability is best achieved through local LEAs, but others believe that a statewide plan would be better at achieving this goal.

Both supporters and opponents were concerned about the fact that even a system that saves money overall will increase the costs, or reduce the benefits, for some school systems. Our analysis in Section VI quantifies those differences and how they might affect LEA employees and LEAs across the Commonwealth.

Few of the responders had a strong opinion as to whether a statewide system should be through PEBTF, PSERS, or another Commonwealth agency. Some cautioned that PSERS should remain a retirement system and not take on the added responsibility of a statewide health care system for employees as well as retirees. There was some concern about the financial soundness of PEBTF, but we found that the PEBTF was well run and financed.

VI. Comparison of Cost of Plans

In this section we report on our findings from comparing the cost of the LEA plans under the current structure with the cost they could expect from covering all employees in a statewide plan. The analysis shows the savings that would have been realized if the statewide plan had been in effect for all LEAs in the year ending June 30, 2003. As we show in Section VIII, it is unlikely that a statewide plan could be implemented before July 1, 2005, and we recommend that, even for a mandatory plan, LEAs not be required to join until their current collective bargaining agreements end. Section VIII shows the projected savings that would accrue as the statewide plan gradually includes LEAs as their collective bargaining agreements expire.

To estimate the potential savings from covering all LEA employees in a single health care program, we compared the cost paid for the current LEA plans with the cost paid for participants in the Pennsylvania Employee Benefits Trust Fund (PEBTF). In this analysis we took account of the following factors that influence the cost of the benefits:

1. **Demographic differences that could affect the cost.** Almost all LEA employees who are covered in health plans are participants in the PSERS. Similarly, almost all employees participating in the PEBTF health plans are participants in SERS. We therefore collected current active participant data from SERS and PSERS to analyze the demographic composition of the two populations and adjust the health care costs for the differences in age and gender.

2. **Covered population differences that could affect the cost.** The PEBTF covers retirees in a separate plan from active employees whereas the LEA plans include both employees and retirees in the same plan. Non-Medicare retirees are older on average than active employees and typically have higher health care expenses so including them in the same rating pool as actives affects the average cost for LEAs.

3. **Plan design differences that could affect the cost.** We developed a plan design that permits LEAs to select between a Basic and Enhanced plan for the FFS, PPO, and POS designs. We assumed that the LEA would purchase the Enhanced plan if that cost less than the current LEA plan. Otherwise we assumed the LEA would purchase the Basic plan.

4. **Administration and financing arrangements that influence the cost but which do not affect the benefits.** Here we identified the savings that could be achieved through negotiating lower rates with health care carriers by enrolling a very large number of participants in a single contract. We also identified and measured the impact of changing stop-loss insurance as well as negotiated formulary rebates under a single statewide prescription drug benefit plan.

5. **Other factors.** The merger of over 600 LEA plans into one plan will have a number of other impacts on the savings that could be achieved. These include the savings from merging the health plan administration into one unit and the cost or savings of differences in utilization patterns. We believe that these other factors would only have a minor impact on the projected cost savings.

Demographic Differences

Table 6.1 compares the two active populations. The primary difference between the two populations is the gender mix with 72 percent female in PSERS and 42 percent female in SERS. The PSERS population is 0.6 years younger than the SERS population with an average of 1.0 year's less service. The differences in the ages and percent female will have a significant impact on the relative health care cost of the two plans.

Table 6.1
Comparison of SERS and PSERS

	Males			Females			Total		
Age Group	SERS	PSERS	PSERS-SERS	SERS	PSERS	PSERS-SERS	SERS	PSERS	PSERS-SERS
< 20	0.0%	0.0%	0.0%	0.1%	0.0%	-0.1%	0.1%	0.0%	0.0%
20-24	1.3%	2.0%	0.7%	2.3%	2.0%	-0.3%	1.7%	2.0%	0.3%
25-29	4.5%	8.1%	3.6%	5.0%	7.8%	2.8%	4.7%	7.9%	3.2%
30-34	9.9%	10.7%	0.8%	8.1%	9.3%	1.2%	9.1%	9.7%	0.6%
35-39	12.3%	9.8%	-2.5%	10.0%	9.5%	-0.5%	11.3%	9.6%	-1.7%
40-44	13.9%	10.8%	-3.1%	14.4%	13.2%	-1.2%	14.1%	12.5%	-1.6%
45-49	16.2%	14.5%	-1.7%	19.5%	18.2%	-1.3%	17.6%	17.2%	-0.4%
50-54	18.8%	21.2%	2.4%	20.1%	20.8%	0.7%	19.4%	20.9%	1.5%
55-59	15.0%	14.4%	-0.6%	13.4%	12.2%	-1.1%	14.3%	12.9%	-1.4%
60-64	5.8%	5.4%	-0.4%	5.3%	5.0%	-0.3%	5.6%	5.1%	-0.5%
65+	2.2%	3.0%	0.8%	1.8%	2.0%	0.2%	2.1%	2.3%	0.2%
Total	**100.0%**	**100.0%**		**100.0%**	**100.0%**		**100.0%**	**100.0%**	
Average Age	**46.2**	**45.7**	**-0.5**	**46.0**	**45.4**	**-0.6**	**46.1**	**45.5**	**-0.6**
Average Service	**13.6**	**14.3**	**0.7**	**13.5**	**11.8**	**-1.7**	**13.5**	**12.5**	**-1.0**

Table 6.2 summarizes the key demographics for these two groups.

Table 6.2
Summary of Demographic Characteristics

	LEAs (PSERS)		PEBTF (SERS)	
	Males	**Females**	**Males**	**Females**
Average age of employees	45.7	45.4	46.2	46.0
Average service of employees	14.3	11.8	13.6	13.5
Percent of total enrollment	28%	72%	58%	42%

Health care costs increase with age, therefore an adjustment was made to take account of PEBTF participants' higher average age (0.5 years for males and 0.6 years for females). Health care costs for males are generally lower than for females for ages below age 60, and higher for ages above 60. Due to the relatively low employee contribution for family coverage under both the

LEA plans and the PEBTF, most married employees will choose to cover their spouses under these plans. Allowance was therefore made for the spouses of employees, based on national age-based marriage rates to develop the age and demographic composition of the covered adult populations of the two groups. A second adjustment was then made to account for the larger proportion of LEA employees who are female.

The PSERS average demographic cost was slightly lower than the SERS average demographic cost. In other words, all other things being equal, the PSERS population would have a health care cost slightly lower than the SERS population.

Covered Population Differences

The PEBTF operates a separate plan for retirees, whereas LEAs provide coverage for early retirees in the same health plan as their active employees. Currently, there is considerable variation in subsidy levels for retirees among LEAs. For retirees under the age of 65, some LEAs require a monthly premium of $100, with the LEA paying the balance of the cost. More commonly, we found that retirees are paying the COBRA premium, so on paper this looks like there is no cost to the LEA. However, as health care costs increase with age, these pre-65 retirees are substantially older than the average age of the employees, and in aggregate the COBRA premiums they pay do not cover the full cost of the services they use. Thus, even for retirees who are paying the COBRA premium, there is an indirect subsidy incurred, which is included in the current LEA costs. We have estimated the statewide cost of covering early retirees in the same plan as active employees at $67 million. The development of this cost is shown in Appendix C.

Plan Design Differences

Using the detailed plan design information received from each of the LEAs, we determined a Benefit Value Comparison (BVC) value for each LEA's primary plan. Separate BVC values were developed for the medical, prescription drug, dental, and vision plans. For those medical plans that cover prescription drugs under the medical plan, a separate value was determined for the pharmacy benefit and subtracted from the total medical plan value to determine a separate medical-only plan value. In parallel, we developed BVC values for the Basic and Enhanced options under the proposed statewide plan for the FFS, PPO, and POS plans. In developing the estimated savings, we assumed that LEA employees would remain enrolled in the same plan type (FFS, PPO, POS, or HMO) in which they are currently enrolled.

For employees enrolled in FFS, PPO, and POS plans, we assumed the cost of the coverage would be the same as for the PEBTF members, adjusted for the differences in plan design between the PEBTF plans and the Basic and Enhanced plans of each of the three types. For employees enrolled in HMOs we assumed the premium rate would not change since we assumed that the HMO would not make any price distinction between employees in a statewide system and employees who join through an LEA.

For the cost comparison, we restricted our analysis to those LEAs for which we had premium and enrollment information as well as the detailed descriptions of the primary plans needed to determine the BVCs. This database comprised 116 LEAs covering over 50,000 employees and

over 110,000 participants. The following tables show the results of the cost comparison for this dataset on a per employee basis.

Table 6.3 shows the breakdown of the savings among medical, prescription drugs, dental, and vision plans.

Table 6.3 shows that over 90 percent of the overall savings related to the medical and prescription drug benefits. Three percent of the savings relate to the vision benefits, which from the above analysis shows the largest percentage reduction in costs. We believe this level of savings on the vision benefit could only be fully achieved by implementing a network-based benefit similar to the PEBTF benefit.

Table 6.3
Benefit Plan Comparison
Costs shown on a Per Employee Per Year Basis

		Medical	Drugs	Dental	Vision	Total
1.	Average premium paid by schools in 2003	$6,731	$1,999	$692	$136	$9,558
2.	Average premium that would be paid by schools in statewide plan. Premium for active employees.	$5,035	$1,518	$520	$92	$7,164
3.	Premium increase for retiree subsidy	$162	$49	–	–	$211
4.	Total paid by schools in statewide plan (2) plus (3)	$5,197	$1,567	$520	$92	$7,375
5.	Savings attributable to statewide plan (1) minus (4)	$1,534	$432	$172	$45	$2,183
6.	Total Savings as a percent of actual premiums	22.8%	21.6%	24.9%	33.2%	22.8%

Table 6.4 shows the estimated statewide annual savings from covering all LEA employees in a single health program. For this estimate we have assumed that only those LEAs that currently provide dental or vision coverage will continue to do so.

The total savings on line 3 can differ from line 1 times line 2 because of rounding.

Table 6.4 Estimated Savings for All LEAs					
	Medical	**Drugs**	**Dental**	**Vision**	**Total**
1. Number of school employees	240,000	240,000	240,000	240,000	240,000
2. Expected savings per employee	$1,534	$432	$172	$45	$2,183
3. Total annual savings (1 times 2) ($millions)	$368.2	$103.9	$41.3	$10.9	$524.0

There will be additional savings for retired school employees covered by LEA plans. Currently, about 30,000 retired LEA employees are enrolled in the LEA health plans. We determined the estimated savings for the retirees, assuming that the number and characteristics of the covered retirees and dependents would not change. Since the proposed statewide plan would permit LEAs to continue their current post-retirement coverage, it is reasonable to assume there would be little change in the number and characteristics of those covered. Health care costs increase with age through age 65. To account for these variations in cost by age, we developed adjustment factors to reflect the retiree cost relative to the active employee cost. The development of these factors is shown in Appendix C.

About two-thirds of LEA retirees with health coverage are under age 65. The total expected savings for those retirees is shown in table 6.5. The cost of health insurance for retirees over age 65 is driven by Medicare negotiations. Since the Medicare rates are the same for all retirees, we assumed that there would not be any savings for retirees over age 65 in a statewide plan.

Table 6.5 Estimated Savings for All LEAs for Retirees Under Age 65					
	Medical	**Drugs**	**Dental**	**Vision**	**Total**
1. Number of retired school employees enrolled in plans with identified savings	20,000	20,000	20,000	20,000	20,000
2. Retiree cost relative to active employee cost	1.5	1.5	1	1	
3. Number of covered lives per retiree/number of covered lives per employee	0.6	0.6	0.6	0.6	
4. Expected savings per employee	$1,534	$432	$172	$45	$2,183
5. Total annual savings ($millions) (1 times 2 times 3 times 4)	$ 27.6	$7.8	$2.1	$0.5	$38.0

Administration and Financing Arrangements

In addition to the savings identified above, we identified two other sources of savings that would result from combining the plans. These are the elimination of stop loss insurance and increase in rebates on prescription drugs.

From the surveys we noted that some LEAs that are self-funded are purchasing stop loss coverage to protect the LEAs budget from overruns. Both individual and aggregate stop loss policies are useful risk management tools for LEAs concerned about either a catastrophic

medical claim, or an accumulation of several large (but not catastrophic) claims. If the health benefits were provided through a statewide health program, there would be no need to purchase stop loss coverage because the pool of participants would be large enough to avoid any significant variation resulting from a few large claims. Based on the number of employees covered in LEAs that reported they maintained stop loss coverage relative to the total school population, we estimated the savings from not purchasing stop loss coverage to be $15.3 million. The development of this estimate is shown in Appendix C.

The premiums shown above for prescription drug coverage for PEBTF members did not take into account the rebates PEBTF had negotiated with their Pharmacy Benefit Manager. Some of the consortia operated by Intermediate Units have negotiated rebates, similar to, but somewhat lower than, those negotiated by PEBTF. We estimated that applying the PEBTF level of negotiated prescription drug rebates to all LEAs would yield rebates totaling $8.1 million more than currently provided.[2]

Table 6.6 summarizes the estimated annual savings from all sources if the statewide plan had been in effect in the year ending June 30, 2003. Section VIII will show the impact of the savings if the statewide plan is effective July 1, 2005, and LEAs join as current collective bargaining agreements expire.

Table 6.6
Total Estimated Savings That Would Have Been Achieved in Year Ending June 30, 2003

	$Millions
1. Savings for actives	$524
2. Savings for retirees	$38.0
3. Savings from stop loss	$15.3
4. Savings from prescription drug rebates	$ 8.1
5. Total estimated savings	$585.4
6. Current health and stop loss premiums	$2,447
7. Percent savings	23.9%

[2] See Appendix C for calculation of savings

Winners and Losers

Most LEAs would pay less in premium in a statewide plan, and most employees and retirees would receive better benefits. However, some LEAs would pay more because they had achieved lower costs than the statewide plan. Some employees and retirees would receive less because they had been in plans of greater value than the statewide option that would be purchased by the LEA.

We determined that 22 percent of the LEAs would pay more in a statewide plan, but the total additional cost would only be $13 million a year, or 2 percent of the total savings. The Commonwealth may choose to subsidize this cost to achieve the greater savings with no increase in cost for any single LEA.

The total loss in benefit value for employees and retirees would be around one percent of the total current value of the plans. This amount could be adjusted for during the collective bargaining process.

Mandated Plan Without Choice of Option

A mandated plan without a choice of option would have to be a compromise between the options available in a mandated plan with choice structure. One approach would be to use the Enhanced benefit level for each plan from the mandate with choice plans. This would reduce the savings but also reduce the number of employees adversely affected and lessen the impact on losses for individual employees. Another approach would be to use the Basic option. This would increase the LEA savings but also increase the number and amount of losses to individual employees.

We analyzed the cost if the Enhanced option were the only one available. We determined that there would have been aggregate savings of $509 million in 2003. Almost half of the LEAs would pay more in premium, and the average additional cost would be $33 million, or over 6 percent of the savings.

The total loss in benefit value for employees and retirees would still be around one percent of the total current value of the plans. There would be a smaller loss on the medical plan, but an increase in the loss because LEAs would have to join the statewide vision and dental plans. These plans typically are of a lower value than many of the LEA plans.

Effect on Increases in Health Care Costs in Future

The majority of cost control measures introduced in health insurance plans have a one-time effect but little if any effect on the increase in cost after the first year. We expect most of the savings we found in this study to be of the same type. In other words, if the statewide plan reduces costs by 20 percent then we would expect the costs to remain 20 percent below the sum of the individual plans, but we do not believe the savings would increase much beyond the 20 percent without additional action.

However, a statewide plan does permit quicker and more effective introduction of new cost control measures. For example, a statewide plan could implement a disease management program and roll it out to all education employees using a coordinated communication campaign.

It is probable that savings could be achieved through a disease management plan, so these savings would be achieved more rapidly through a single plan than through gradual introduction by the over 600 LEAs.

Table 6.7 shows the premium increases reported by various sources. The first is for the 16,000 employees and retirees covered by the Allegheny IU. The second is for LEAs reporting increases for the last two years. The third is for PEBTF. For comparison purposes, we also show the medical premium increases reported by companies in the Hay Benefits Report (using the weighted average of the same plan and some companies) and the premium increases for the Federal Employees Health Benefit Program (FEHBP), which covers over 8 million government employees and their dependents.

The PEBTF increases in the last two years are substantially below Allegheny and the LEAs. For 1999 through 2002, the PEBTF trends are close to those of the other groups. The fact that these increases were fairly close confirms our opinion that changes in the cost due to factors such as consolidation or introduction of new programs have a one-time impact but little effect on the overall trend.

Table 6.7
Historical Trend Rates

	Allegheny County IU	**LEAs**	**PEBTF**	**HBR**	**FEHBP**
Number of covered lives	16,000	5,000	205,000	3,000,000	8,000,000
1999	6.6 %		7.0 %	5.6 %	9.4 %
2000	8.2 %		9.3 %	4.8 %	8.9 %
2001	8.0 %		10.6 %	10.0 %	10.8 %
2002	12.3 %	14.4 %	10.5 %	14.5 %	12.9 %
2003	NA	13.9 %	8.8 %	15.5 %	10.6 %

VII. Possible Construction and Cost of a Commonwealth-wide Health Plan

We have identified four major variables in the design of a statewide health plan. The first is whether or not the plan should be voluntary. The second is how the plan should be administered. The third is the range of options that should be allowed in a statewide plan. The fourth is the degree to which retirees can and should be included in a statewide plan. This section considers each of these variables and concludes with our recommended approach.

Mandatory or Voluntary

The statewide plan could be mandatory or voluntary. A mandatory plan would require all LEAs to contract for at least the medical plan through the statewide plan, with supplements to the medical plan permitted at the local level. A voluntary plan would permit, but not require, LEAs to participate in the statewide plan.

For participation to be mandatory, the plan should provide health benefits that are comparable to those currently available to Local Education Agencies, and the structure of the Fund governing the plan should ensure adequate representation by all interested parties. Without adequate representation, Education Employees and Local Education Agencies will strongly resist and resent mandatory participation in a plan in which they have no voice.

We examined two approaches to a mandatory plan. The "mandatory with choice" plan would provide two options for each type of health care plan (FFS, PPO, and POS) as well as any qualified HMO. The choice plan would also permit LEAs to either elect the dental and vision plans offered by the statewide plan, elect an alternative, or elect not to provide the plan.

The "mandatory without choice" plan would only have one option of each and LEAs would be required to join all four statewide plans (medical, prescription drug, dental, and vision). All employees would pay the average 5 percent of premium. This would be an increase for most employees and reduction for those who now pay a premium.

Alternatively, if participation in the plan is voluntary, a statewide plan would only be viable if it could provide comparable benefit designs for lower prices than are available in the commercial marketplace. A voluntary plan would almost certainly result in adverse selection. This means that if participation in a statewide plan were voluntary and premium rates were developed for the entire group of participants, Local Education Agencies with poor experience (*i.e.*, unusually high benefit claims experience) would want to participate in the plan, and Local Education Agencies with exceptionally good experience (*i.e.*, unusually low benefit claims experience) would not because they could find lower premium rates in the market place. That would result in a larger premium for LEAs in the statewide plan.

A primary concern with a voluntary system would be that the average cost of the system would be greater than for a mandatory plan because of adverse selection by lower cost plans. Under a voluntary system, the higher and middle cost plans would join and many of the lower cost plans would choose not to join. If those who opt-out did so purely for economic reasons, then the total cost of health care for all LEAs, in and out of the statewide system, would be about the same as for the mandatory approach. However, the savings from a voluntary plan would lag behind those from the mandatory plan because LEAs would not join the statewide system as quickly. And the

ultimate savings would probably be lower because some LEAs would opt-out for other than economic reasons.

Another concern is that a voluntary system would not remove the health insurance from collective bargaining. However, a mandatory system could still permit variations, such as the employee and retiree contribution and plan options, that would be subject to collective bargaining.

One approach to increase the stability of a voluntary statewide plan and minimize the effect of adverse selection would be to require LEAs to commit to a minimum period of participation (*e.g.*, five years) or incur some type of withdrawal charge. However, the potential of a minimum period of participation or withdrawal charge might be counterproductive--further deterring voluntary participation in such a plan. Voluntary participation would still require Local Education Agencies to periodically test the marketplace to determine whether the statewide plan continued to provide the best available premium rates. As a consequence, there would be more pressure on the plan, and the Commonwealth to ensure that the plan offered sufficiently low premium rates to sustain the participation of Local Education Agencies. While this free-market competition may be healthy in the economy as a whole, it is inherently unstable when applied to designing a financially viable plan.

Despite the benefits of a mandatory arrangement, such arrangements are not currently particularly common. Among the states we surveyed, only Delaware and North Carolina have a mandatory plan. In those states that permit LEAs to participate in a statewide health plan, the LEAs are permitted to participate in the health plan provided to state employees. Many, but by no means all, of the LEAs participate voluntarily in the state employee plan. In New Jersey, 311 of the 590 school districts participate in the New Jersey State Health Benefits Program (SHBP). All participating school districts are rated together for purposes of establishing premium rates. (Retirees are rated as a single group for premium purposes.) Of the remaining 279 New Jersey school districts, some participate in purchasing coalitions and some make their own arrangements for health benefits. Presumably LEAs that have not opted into their respective state plans have found either that they can pay less for a plan that is similar to the state-employee plan, or that the state-employee plan does not offer the plan design(s) those LEAs and employees want.

Administration of Health Plan

We identified three possible constructions for administration of a statewide health plan. These would be the PEBTF, PSERS, or another Commonwealth agency.

As part of our study, we closely examined the PEBTF, the voluntarily created joint labor-management trust fund which provides health care benefits to all Commonwealth employees. The PEBTF's governing Board of Trustees consists of seven labor union and seven Commonwealth Trustees. The PEBTF is a self-funded health plan that provides several health care program options to Commonwealth employees. The Commonwealth's rates of contribution to the PEBTF are established through collective bargaining between the Commonwealth and its respective unions, Council 13 of AFSCME in particular. By virtually all accounts the, PEBTF is an excellent example of joint labor-management cooperation providing quality health care plans at affordable prices.

Based on discussions with PEBTF representatives, it appears possible that PEBTF would be willing to consider the feasibility of having Local Education Agencies participate, in some way, in the PEBTF. We have considered two alternative arrangements between the PEBTF and the proposed Pennsylvania School Employees Trust. One arrangement would be to ask the PEBTF to permit Local Education Agencies to participate in the PEBTF as currently structured. A variation on this arrangement would be to expand the current PEBTF Board of Trustees to include education representatives.

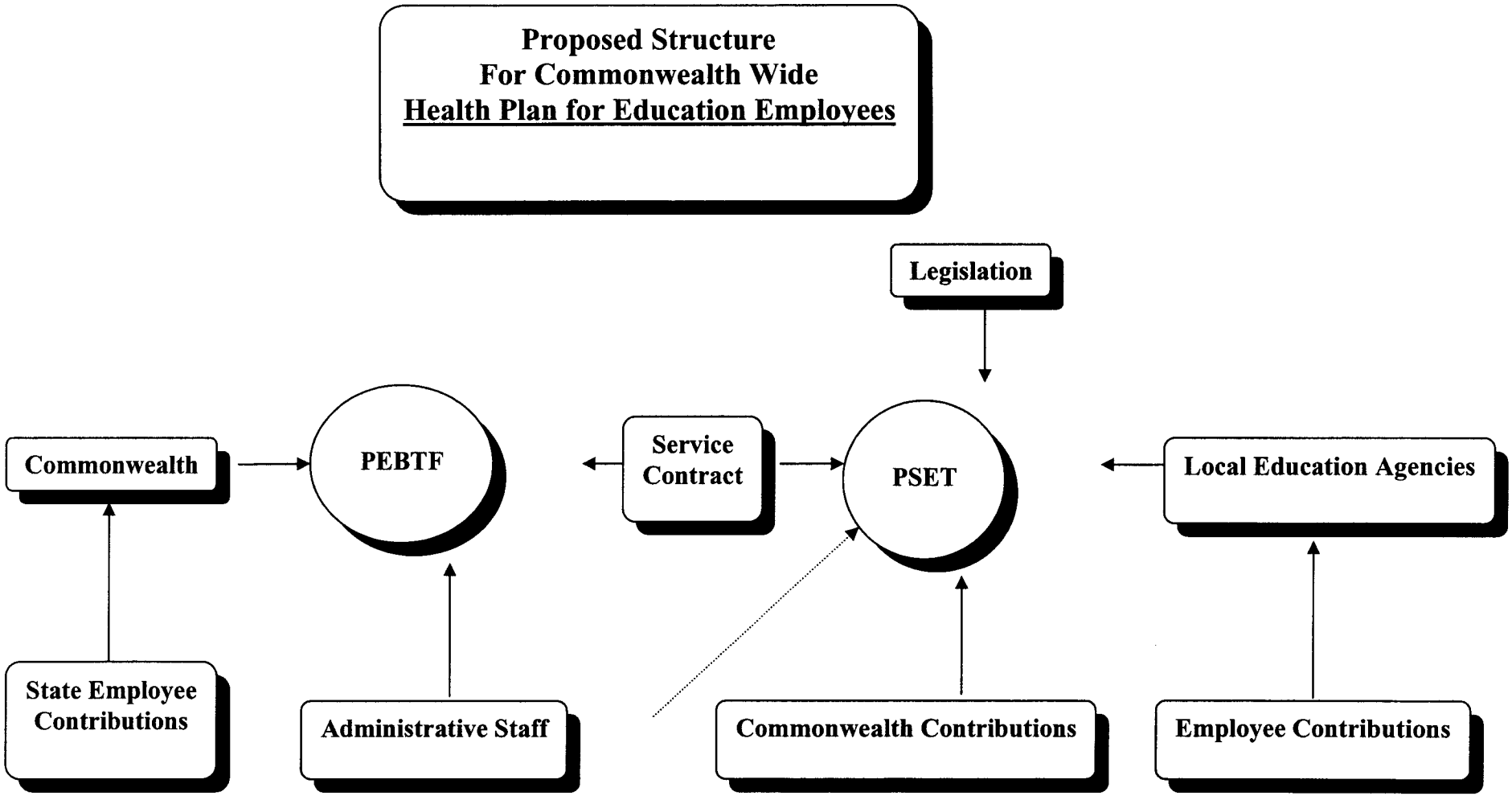
We have two types of concerns with adding the Local Education Agencies into the PEBTF: one legal, the other practical. As a legal matter, legislation permitting or requiring LEAs to participate in the PEBTF creates some presumption that the PEBTF will continue to exist in a form acceptable to the Commonwealth. Since the PEBTF is a trust that could be dissolved without legislative approval, the Commonwealth would be placing considerable reliance on a completely voluntary organization. It is altogether common for a state to require the purchase of insurance (*e.g.*, car insurance or professional insurance); but it would be highly unusual, if not prohibited under Commonwealth law, to specify in legislation a particular private carrier.

We did not find anything in current law that would prevent LEAs from obtaining coverage for their employees through the PEBTF. However, as a practical matter, we rather doubt that seeking to include Local Education Agencies in the PEBTF would appeal to the PEBTF Board of Trustees for the following reasons:

- PEBTF representatives have indicated to us an unwillingness to assume any risk for the Local Education Agencies that could jeopardize the PEBTF's mission to provide health care benefits to state employees. Even if PEBTF created a separate rating pool for LEAs, the PEBTF would be liable for all benefits if premiums were not sufficient to cover benefit liabilities and administrative expenses.
- The interests of over 600 Local Education Agencies, each with fiscal autonomy, are not necessarily identical to the interests of state employees, their unions, and their employer, namely the Commonwealth;
- The plan design and contribution requirements for the approximately 240,000 Education Employees and 600 Local Education Agencies around the Commonwealth may be different than those of the state employees and the Commonwealth as employer.

For these and other reasons, we recommend that the legislature create a separate Pennsylvania School Employees Trust (PSET). If possible, the PSET would enter into a service agreement with the PEBTF for the Pennsylvania School Employees Trust to share most PEBTF administrative services and to use PEBTF's established arrangements with BlueCross, Blue Shield and other organizations for access to their health care provider network. The Pennsylvania School Employees Trust would be a separate fiscal and legal entity that would provide Local Education Agencies similar (but not necessarily identical) health plan options for their Education Employees. A proposed structure for this concept is shown in Chart 7.1.

Chart 7.1


Proposed Structure
For Commonwealth Wide
Health Plan for Education Employees
Legislation
Commonwealth
PEBTF
Service Contract
PSET
Local Education Agencies
State Employee Contributions
Administrative Staff
Commonwealth Contributions
Employee Contributions

Although PSET would be a separate fund, it would still have the advantages of using the proven negotiation and administrative practices of the PEBTF. Our experience is that health plans of over 100,000 people can achieve the maximum savings attributable to size. As a result, we do not believe there would be any significant difference in total cost in the long run if the PEBTF and PSET were totally separate or acted as a combined operation. A combined approach would achieve savings more rapidly because the PSET would be able to join an already existing statewide system.

An important question is the assignment of risk. We recommend that risk be minimized by establishing a reserve equal to one month of premiums. This should be sufficient to cover unexpectedly high claims in most years. The contract with PEBTF would specify that any variation in cost above the one-month reserve would be borne by the LEAs. The measurement and payment of additional risk premiums would be on the performance of the PSET plan as a whole and not on individual LEAs. This will result in an increase in cost in a few years but this variation would be much lower than experienced in the current system, where a poor performance by an individual LEA must be absorbed by that LEA.

We recommend that the Commonwealth enact legislation establishing the Pennsylvania School Employees Trust, to be governed by an independent board of trustees. The legislation would specify that the board must consist of various representatives, including at a minimum, union representatives, representatives of the Governor, one or more representatives of the Local Education Agencies and a retiree representative (if the Plan will provide retiree benefits).[3] The guiding principle regarding the number of representatives for each constituency should be guided by the time-tested rule requiring equal representation from both labor and management, as is the case with the PEBTF. While not binding on the Commonwealth, the origin of this principle of equal labor and management representation on benefit funds is the Taft-Hartley Act of 1947, which amended federal labor law.[4] The Commonwealth's statute would serve as the basis for the development of a more detailed trust agreement, which would govern the rights and responsibilities of the trustees.

The Pennsylvania School Employees Trust would, in turn, enter into a contractual agreement with the PEBTF for most, if not all, administrative services, including use of the provider networks negotiated with BlueCross, BlueShield and similar organizations. The typical approach would be to track the cost of services used by each entity and charge the services to the separate fund. This would enable the newly created PSET to take immediate advantage of a fully operational, highly effective administrative operation. Of equal importance, the agreement with PEBTF would give the combined funds (the PEBTF and the Pennsylvania School Employees Trust) even greater leverage when negotiating prices with network providers and other vendors.

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[3] The composition of the board of trustees would be defined in the legislation at a level of specificity similar to that used to create the State Employees' Retirement Board. *See* Section 71 Pa.C.S. § 5901 et.seq.

[4] The Taft-Hartley Act is also known as the Labor-Management Relations Act of 1947, 29 U.S.C. §§ 141-197. Multiemployer plans are often known as "Taft-Hartley plans." *See also* ERISA § 3(37) for definition of "multiemployer plan." Under the Taft-Hartley Act, a collectively bargained benefit plan must be governed by an equal number of management and labor representatives. The Taft-Hartley Act also requires the use of arbitration in the event of a deadlock between or among the trustees. This bilateral structure has worked very well for unionized employers and employees, with remarkably few deadlocks and thus little reliance on, or need for, arbitration.

If the PEBTF declines to enter into a relationship along the lines here recommended or the relationship with PEBTF appears to be unworkable for other reasons, we recommend the Commonwealth consider establishing a stand-alone statewide health plan for Local Education Agencies and their employees. Although the start-up costs would be greater than entering into a relationship with PEBTF, a stand-alone Commonwealth health plan for LEAs could eventually save the Commonwealth almost as much as could be achieved through a relationship with PEBTF. A proposed structure for this concept is shown in Chart 7.2.

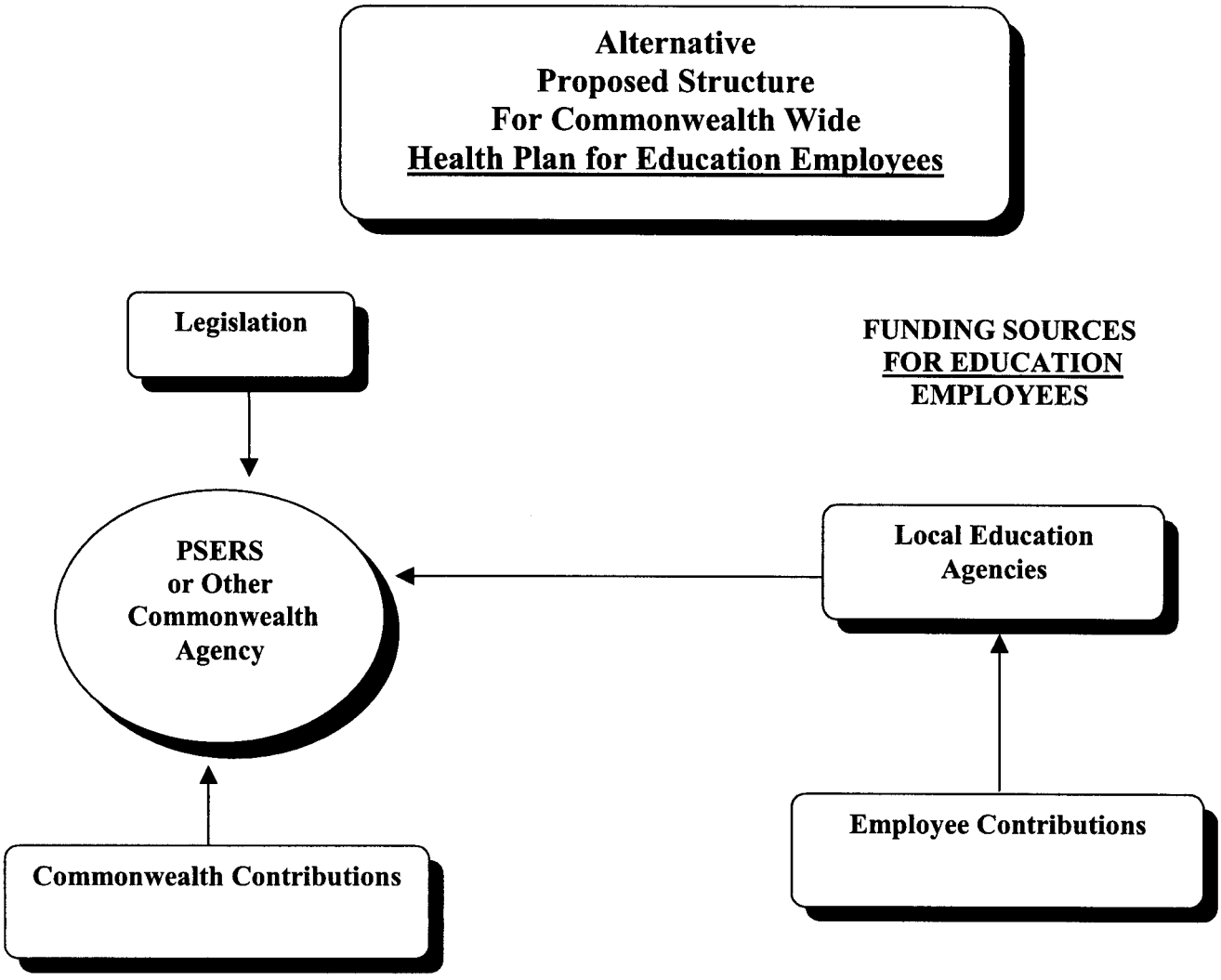
One approach would be to expand the role of PSERS to include the provision of health benefits plans for school employees. PSERS has the advantage of already having in place a retirement contribution and enrollment system that includes the great majority of employees and retirees that would be covered by a consolidated plan. And, the HOP could be expanded to cover all retirees. On the other hand, PSERS officials have noted the difficulty of operating even a limited health plan within a retirement plan. PSERS may be unable or unwilling to assume the additional burden of taking on a health plan that would cover almost all of the PSERS employees and many of the PSERS retirees.

A third option would be to establish a new administrative unit similar to that created by New Jersey. The legislature would enact a statute creating an independent commission (other states call these groups a commission, or committee). The statute specifies the composition of the commission. For example, in New Jersey, the commission consists of three governor appointees from the state's departments of personnel, banking and insurance, and treasury, plus a representative of the AFL-CIO and a representative of the New Jersey Education Association. The scope of the commission's duties are set forth in statute. For example, in New Jersey, the commission sets rates and determines plan design, among other duties. The decisions of the commission are implemented and the state health plan would be administered through a division of state government.

All of the states we studied that provide a statewide health plan to their school districts, already had in place a state-administered health plan for state employees. The addition of school district employees merely expanded the responsibilities of the state health plan. In some states, the pension and health plan administration is performed by a single state office, as is the case with New Jersey's Division of Pensions and Benefits. That combined benefit delivery system offers some opportunities for efficiencies in areas such as employee eligibility, call center, and centralized administrative services.

Of the states we studied we did not find one dominant structure or delivery system, nor was there agreement among those we contacted about which arrangement works best.

Chart 7.2


Alternative
Proposed Structure
For Commonwealth Wide
Health Plan for Education Employees
Legislation
FUNDING SOURCES
FOR EDUCATION
EMPLOYEES
PSERS
or Other
Commonwealth
Agency
Local Education
Agencies
Commonwealth Contributions
Employee Contributions

The principal drawback to a stand-alone plan is the additional time that it would take to start such a plan and to ensure its economic success. We would estimate that it would take an additional 12 to 24 months to establish a fully operational stand-alone plan, compared to the time it would take to have a fully operational plan in cooperation with the PEBTF. Staff needs to be hired, equipment purchased, and office space obtained. Therefore, in deciding the appropriateness of an arrangement with the PEBTF, the Commonwealth should consider not only the costs of starting a stand-alone plan but also the lost savings during the additional time it would take to establish a stand-alone plan.

Use of PSERS for administration would result in less lead-in time than establishing a new administration unit. However, we do not believe that the faster implementation would significantly alter our suggested implementation date of July 2005 because the budget, legislative, and school calendar cycles effectively control when a new benefit program can be introduced.

Health Plan Options Provided by Commonwealth-Wide Health Plan

The third major consideration is the range of options that would be available to local LEAs. The primary choices are the extent to which a local LEA could select a range of health plan design and establish cost-sharing between the LEA and its employees and retirees. Other issues include the extent to which the LEA could vary the definition of a participant, for example, minimum qualification conditions and type of employee.

The range of choice, particularly for plan design, is a tension between efficiency of design and tailoring of the plan. At one extreme, there would only be one plan of each type, other than HMOs, consistent with the current PEBTF structure. At the other extreme, there would be a wide range of choices of plan design.

We recommend that the Pennsylvania School Employees Trust make available to all Local Education Agencies six plan options in addition to the HMOs. Our analysis of the health plan designs provided by Local Education Agencies in our sample indicates that most health plans fall into either of two groups, a middle-cost or high-cost group, with only a small percentage of plans studied falling to a low-cost or very high-cost range. Accordingly, we recommend that the PSET would offer to all Local Education Agencies, and establish premium rates for, the following plan options:

- Basic and Enhanced Fee for Service Plans
- Basic and Enhanced Option PPO
- Basic and Enhanced Option POS
- HMOs

The tables below show the summary of key design features for the Enhanced and Basic plan options that would be available in a statewide plan.

Table 7.1 Summary of Key Design Features Benefits for Typical Enhanced Option Plan Designs					
Type of Care	**FFS Enhanced**	**PPO Enhanced In-Network**	**PPO Enhanced Out-of-Network**	**POS Enhanced In-Network**	**POS Enhanced Out-of-Network**
Plan Deductible	$100	$0	$0	$0	$0
Maximum Out-of Pocket Limit	$1,500	None	None	None	None
Inpatient hospital	100%	100%	100%	100%	80%
Outpatient hospital	100%	100%	80%	100%	80%
Physician Visits	80%	$10 copay	80%	$5 copay	80%
Specialist Visits	80%	$10 copay	80%	$5 copay	80%
Surgical	100%	100%	80%	100%	80%
Mental Health and Substance Abuse Treatment	80%	$15 copay 60 visits max	80%	100%	70%
Outpatient Imaging/X-ray & Lab	100%	100%	80%	100%	80%
Preventive Services	Provides	Provides	Provides	Provides	Provides

Table 7.2 Summary of Key Design Features Benefits for Typical Basic Plan Designs					
Type of Care	**FFS Basic**	**PPO Basic In-Network**	**PPO Basic Out-of-Network**	**POS Basic In-Network**	**POS Basic Out-of-Network**
Plan Deductible	$250	$250	$250	$0	$200
Maximum Out-of Pocket Limit	$2,000	None	None	None	None
Inpatient hospital	80% after deductible	100% after deductible	80%	80%	80%
Outpatient hospital	80% after deductible	100% after deductible	80%	100%	80%
Physician Visits	80%	$15 copay	80%	$10 copay	80%
Specialist Visits	80%	$15 copay	80%	$10 copay	80%
Surgical	100%	100% after deductible	80% after deductible	100%	80%
Mental Health and Substance Abuse Treatment	50%	$15 copay 30 visits max	50%	100% 30 visits max	50%
Outpatient Imaging/X-ray & Lab	80%	100%	80%	100%	80%
Preventive Services	Subject to deductible	Subject to deductible	Subject to deductible	Provides	Provides

The decision of whether to issue statewide premium rates or to geographically subdivide those rates could be made either by statute or by the Trustees of the Pennsylvania School Employees Trust. We recommend a middle ground by which the statute expresses a preference for uniform premium rates, and gives the final discretion to the Fund's Trustees, thereby ensuring that premium rates are economically feasible while expressing a preference for uniformity.

Subject to geographic availability at HMOs, each Local Education Agency would determine which plans and which options would be made available to its education employees. Each Local Education Agency would be required to pay the premium rate established for each plan, less any amount contributed by the Commonwealth directly to the Pennsylvania School Employees Trust. The allocation of the premiums between the Local Education Agency and its employees and the definition of who could participate would be the subject of collective bargaining at the local level.

Our analysis shows that substantial overall savings can be achieved through consolidation into a statewide plan. While there are average savings, there are some LEAs that would have to pay more for a statewide plan and some employees who would receive lower benefits.

Under the mandatory plan, LEAs with low premiums would have to pay more if they participate in a statewide system. One approach to ameliorating at least the short-term impact on the budgets of these LEAs would be a Commonwealth contribution to pay the difference between the cost of the statewide system and the cost the LEA would have incurred by continuing their local contract. To offset that cost increase, we recommend that either the cost of these plans be subsidized, so that no LEA would have to pay more than under their current plan for comparable coverage, or the Commonwealth investigate using regional pricing. The aggregate cost of the subsidy would be around $13 million, which is only a small part of the net savings we project would be realized under the statewide system.

A voluntary plan would not have to offer as wide a range of options or require a subsidy since lower-cost LEAs could remain outside the statewide system. However, the fewer the number of options, the less likely LEAs would be to participate. Under a voluntary system, an LEA with higher benefits than available in the statewide plan could choose not to participate. If they did participate, then the effect of the reduction in benefits would be recognized as part of the collective bargaining agreement.

Participation of Retirees

Currently LEAs are required to extend health insurance coverage to some retirees but LEAs can, and most do, limit the coverage to retirees who are under age 65 and require payment of the full premium by the retiree.

We recommend that LEAs be permitted to include retirees in the statewide plan. As now, the LEA could select the retirees to be covered and the cost-sharing arrangement. If schools continued their current level of coverage, there would be savings to both the districts and the retirees. We also recommend that the HOP plan and the PSERS $100 subsidy be continued

unless and until the statewide plan for LEAs is expanded to provide mandatory coverage for all retirees. Our projections assume continuation of the $100 subsidy and the HOP plan.

Changes in the coverage of retirees is complicated by current court decisions such as *Erie*[5]. If the system is voluntary or mandatory with choice, then any legal complications on continuation of coverage could be resolved by each LEA. If the system is mandatory without choice, then the requirements for retiree coverage would have to be carefully examined for conformance with the court decisions. For instance, a law that limits retiree coverage to specific former employees might have to include a provision to make sure that current retirees not suffer a reduction in benefit.

Cost Impact on the Commonwealth and LEAs and Their Employees

The immediate effect of the savings that would be achieved through a statewide plan would be a reduction in the cost of the health plans for most LEAs. For the mandatory and voluntary plans, the savings would presumably be shared with employees through collective bargaining. If the share of cost is the same as in the current plans, 5 percent of the savings would accrue to the employees, and 95 percent of the savings would accrue to the LEAs.

The share of the savings between the Commonwealth and the LEAs would depend on how these savings are reflected in the determination of Commonwealth grants to the LEA. Commonwealth grants for basic education are not earmarked for specific expenses such as health insurance. However, even without specific designation of the savings, the reduction in costs for health insurance would reduce the grants needed.

The Commonwealth could assure that savings are shared by reducing the grant to the LEA by an amount equal to (1) the LEA health insurance costs times (2) the Commonwealth grant as a percent of the expenditures for that LEA. The Commonwealth would contribute an amount to PSET equal to (1) the anticipated health insurance cost for the LEA for Pennsylvania School Employees Trust times (2) the Commonwealth grant as a percent of the expenditures for that LEA. The Commonwealth and the LEA would then both share in the savings achieved through participation in the statewide plan.

Assume, for example, that the Commonwealth pays a grant equal to 40 percent of the basic education expenses for an LEA and the LEA would be expected to pay $10,000,000 in health insurance in fiscal year 2005/2006 for school employees, the savings would be shared as shown in table 7.3.

[5] Erie County Retirees Association vs. County of Erie, 140 F. Supp. 2d 466 (W.D. Pa. 2001)

Table 7.3 **Example of LEA and Commonwealth Share of Savings**	
1. Projected health insurance costs for LEA without statewide fund	$10,000,000
2. Commonwealth support of LEA basic education	40%
3. Implicit support of health insurance costs [40% of $10,000,000]	$4,000,000
4. Implicit cost to LEA for health insurance without statewide fund [(1) – (3)]	$6,000,000
5. Projected health insurance costs for LEA in statewide fund	$8,000,000
Commonwealth Share of Savings	
6. Reduction in direct payment to LEA	$4,000,000
7. Commonwealth payment to statewide fund for LEA [40% of $8,000,000]	$3,200,000
8. Reduction in Commonwealth expenses [(6) – (7)]	$800,000
Impact on LEA	
9. Implicit cost to LEA for health insurance without statewide fund (4)	$6,000,000
10. LEA payment to statewide plan [(5) – (7)]	$4,800,000
11. Reduction in LEA expenses [(9) – 10)]	$1,200,000

VIII. Implementation

If the Commonwealth were to mandate that all Local Education Agencies be required to participate in a single statewide health plan, we recommend that the Local Education Agencies be permitted to phase into the PSET not later than upon the expiration of their collective bargaining agreements. If the PSET rates were attractive enough, some labor and management groups might reopen contract negotiations to permit early transition into the Commonwealth's Plan.

The Commonwealth could preempt the collective bargaining process and enact a law that would require all Local Education Agencies to participate in a statewide 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 as collective bargaining agreements expire. A gradual transition will permit a more orderly start-up of the statewide plan. However, the statewide savings that could be realized would not be fully achieved until 2008. Table 8.1 shows the year of expiration of collective bargaining agreements in our survey.

Table 8.1
Year of Expiration of Collective Bargaining Agreements

Number of Collective Bargaining Agreements	Year of Expiration
44	2004
61	2005
38	2006
21	2007
6	2008

In some cases, it may not be possible to terminate the existing health plan contract without significant penalties. For example, there may be a deficit that the plan and 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 room to shut-down existing arrangements past the end of the collective bargaining agreement in unusual circumstances.

If the statewide plan were to be voluntary, then there would not have to be any restrictions on participation dependent on collective bargaining agreements or current health plan contracts, since each LEA could choose to participate, or decline to participate, on a time schedule that best meets their current health insurance and collective bargaining arrangements.

Implementation Steps

The first step would be to develop legislation implementing the statewide 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

was mandatory, the legislation should include the conditions under which LEAs would have to join the plan (such as the conditions under which the LEAs could and would have to join the plan, the levels of benefit to be offered, and the administrative structure). We recommend that the legislation be silent on exact specifications of the plan such as deductibles, copayments, 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 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.

The development of the legislation should be an open process with discussion with many of the stakeholders identified in Section V to minimize opposition to the proposed legislation. This should include input from PEBTF and PSERS to best utilize their existing structures for premium collection and the purchase of health care for LEA employees and retirees.

After passage of the legislation, the organization responsible for implementation (PEBTF, PSERS, or a new organization) will study how best to implement the legislation on a timely basis. This consideration will include the following:

- How best to contract with LEAs to provide the health insurance to their employees and retirees.
- When and how to enroll eligible employees and retirees and permit changes after the first enrollment.
- The most effective approach for contracting with health-care providers and insurers to deliver the best insurance at the lowest possible cost.
- The organizational changes needed to implement the new statewide plan including staffing, space, and computer systems.
- How to determine and charge the premiums paid by the LEAs, employees, and retirees.
- The range of choices of health plan 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 LEAs that would be required to, or chose to, participate in the first year of the plan. These agreements would include the employees and retirees to be covered, the options selected by the LEA, and the financial arrangements between the organization and the LEA. The administrator would determine the date of entry of each LEA into the statewide plan based on provisions in the law such as consideration of collective bargaining and financial position with current health insurer.

The administrating organization would negotiate coverage with health care providers and insurers throughout the Commonwealth of Pennsylvania. 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 and retirees in each LEA 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 LEAs, (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:

- 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, LEAs, and providers.
- An executive director's office to manage the system.

Implementation Timetable

PEBTF has stated that they are prepared to make arrangements to quickly expand their operations to administer a new statewide school employee's plan. Since the statewide plan would require enabling legislation we believe that the earliest effective date would be July 1, 2005. The most rapid timetable for implementation using the PEBTF as administrator is set forth below.

Table 8.2
Implementation Schedule if Administered by PEBTF

Time Frame	Activity
March – May 2004	Enter into discussions with PEBTF regarding the feasibility of administrative services sharing agreement.
May 2004 – September 2004	Governor develops budget details and Administrative proposal, develops fiscal impact study and other supporting reports and materials, discusses proposal with stakeholders and adjusts proposals as necessary.

Table 8.2 (continued) Implementation Schedule if Administered by PEBTF	
October 2004	Enabling Legislation introduced.
November 2004	Enabling Legislation passed.
October – December 2004	PEBTF conducts study of plan design and premium structure and initiates contracts for administrative and other support services.
February 2005	Governor introduces FY 2005-06 budget and legislative initiative with costs and benefits enumerated.
January - March 2005	Contract negotiation with health care providers begins. Administrative structure developed for launch of program.
March – April 2005	LEAs and other interested parties notified of changes, effective July 1, 2005. Information materials and enrollment materials developed. Timetables for enrollment sessions developed. Termination notices given to current carriers as soon as necessary.
May - June 2005	Open Enrollment Period: LEAs and other Local Education Agencies distribute information and enrollment materials to their employees. Employee election forms returned by June 15, 2005.
July 1, 2005	New plan effective for first group of LEAs.

Implementation would take significantly longer if PSERS or a new agency were to be the administrator. A new agency would require extensive start-up time. PSERS would have to add a major new operation which would probably require almost as much time as a new agency. Table 8.3 shows the expected time line if PSERS or a new agency were to administer the statewide plan.

Table 8.3 Implementation Schedule if Administered by PSERS or Commonwealth	
Time Frame	**Activity**
May 2004 – September 2004	Governor develops budget details and Administrative proposal, develops fiscal impact study and other supporting reports and materials, discusses proposal with stakeholders and adjusts proposals as necessary.
October 2004	Enabling Legislation introduced.
November 2004	Enabling Legislation passed.
February 2005	Governor introduces FY 2005-06 budget and legislative initiative with costs and benefits identified.
July – December 2005	New agency organized or PSERS reorganized.
October 2005 – February 2006	Agency conducts study of plan design and premium structure and initiates contracts for administrative and other support services.
February - April 2006	Contract negotiation with health care providers begins. Administrative structure developed for launch of program.
March – April 2006	LEAs and other interested parties notified of changes, effective July 1, 2006. Information materials and enrollment materials developed. Timetables for enrollment sessions developed. Termination notices given to current carriers as soon as necessary.
May - June 2006	Open Enrollment Period: LEAs and other Local Education Agencies distribute information and enrollment materials to their employees. Employee election forms returned by June 15, 2006.
July 1, 2006	New plan effective for first group of LEAs.

Cost Impact of Implementation

The realization of the savings would depend on two factors. The first is how quickly the new plan could be implemented and the second is when individual LEAs join the plan.

We believe that the statewide plan could begin to operate as early as July 2005 if it is administered by PEBTF. We assume that even a mandatory plan would not require participation by LEAs until their current collective bargaining agreements expire. The following table

assumes all LEAs with collectively bargained agreements ending in 2004 or 2005 would join the statewide plan in 2005 and that the other LEAs would join the statewide plan in the year they expire. Full savings would not be achieved until 2009, after all current agreements would have expired. We have included an estimate of health insurance cost inflation so the ultimate savings are greater than the savings of $585 million that we estimated would have occurred in the year ending June 2003 in the prior section. Table 8.4 shows the projection of the savings for a mandatory plan. The chart shows the lower savings that would be achieved with either a voluntary plan or if the plan was mandatory without a choice of option.

Table 8.4
Savings From Initiation of Commonwealth-wide Plan on July 2005
(millions of dollars)

Fiscal Year	Mandatory With Choice	Mandatory Without Choice	Voluntary
2005-06	$129	$103	$ 83
2006-07	$412	$344	$265
2007-08	$643	$552	$443
2008-09	$767	$664	$588
2009-10	$835	$725	$682

If PSERS or another Commonwealth agency were to administer the plan, we believe that the statewide plan could not accept participants until a year later than could be done using the existing administrative operations of PEBTF. That results in the following series of savings for the mandatory and voluntary plans.

Table 8.5
Savings From Initiation of Commonwealth-wide Plan on July 2006
(millions of dollars)

Year	Mandatory With Choice	Mandatory Without Choice	Voluntary
2006-07	$264	$211	$177
2007-08	$600	$509	$419
2008-09	$767	$663	$588
2009-10	$835	$725	$682

IX. Conclusion

We found that substantial savings could be achieved through implementation of a statewide plan. If all LEAs had participated in a statewide plan with a choice of options in the year ending June 30, 2003, the amount that LEAs spent on health care coverage would have been $585 million less than actually spent in that year. Future projected savings would be $129 million in fiscal year 2005-06 with projected savings of $835 million in fiscal year 2009-10 when the plan would apply to all LEAs. Savings would depend on the percentage of LEAs enrolled in the statewide plan and would increase as health care inflation increases.

We examined two approaches to participation in a statewide plan. One would require all LEAs to join the statewide plan after their current collective bargaining agreements expire. The other would permit each LEA to join at any time but would not require participation. The savings in a voluntary plan would lag behind the savings in the mandatory plan because LEAs would not join as quickly as under a mandatory approach. The savings in the voluntary plan might eventually approach the savings in the mandatory plan unless LEAs opt out of the voluntary plan for reasons other than cost. Indeed, LEAs and unions with long-standing structures, such as jointly managed trusts, may be reluctant to give up such arrangements, regardless of cost.

The major advantages of a mandatory plan would be to achieve a higher level of savings than a voluntary plan, particularly in the next five years. A voluntary plan would have the advantage of permitting LEAs to continue to contract locally if there were design, service, or cost reasons for preferring a local plan. That would remove the concerns about a statewide system expressed by many of the organizations that we interviewed.

Another important question is how to administer the statewide plan. We recommend that the plan be administered by PEBTF since that organization has a proven ability to efficiently administer a statewide plan and PEBTF officials state that they are willing to consider expanding their administrative operations to serve LEA employees. We believe that PEBTF could implement the new statewide plan for LEA employees by July 1, 2005. We project that administration by either PSERS or another Pennsylvania administrative organization would delay implementation until at least July 1, 2006. There are concerns about the Commonwealth requiring that the administration be assigned to PEBTF which is a private organization. However, Section VII shows how the legislation could be structured to minimize any such problems.

We recommend that a mandatory plan at least offer all qualified HMOs and six other options. That would permit LEAs to select options that most closely fit the design and cost of their current plans. We find that about nine percent of LEA employees would have to increase their health plan contribution even with a range of choices if the statewide health plan were structured with uniform pricing. To offset that cost increase, we recommend that the cost of these plans be subsidized so that no LEA would have to pay more than under their current plan. The aggregate cost of the subsidy would be around $13 million, which is only a small part of the net savings we project would be realized under the statewide system. A voluntary plan would not have to offer as wide a range of options or require a subsidy since lower-cost LEAs could remain outside the

statewide system. However, the fewer the number of options, the less likely LEAs would be to participate.

We recommend that under either a mandatory or voluntary approach, each LEA be permitted to determine how to share the cost between the employees and the employer. We also recommend that the LEA be permitted to determine which retirees should be covered and the cost sharing arrangement between the retiree and the employer. Finally, we recommend that LEAs be permitted to select alternatives to the vision and dental coverage or to choose not to provide those supplements. This flexibility will permit the LEAs to recognize the savings of going to a statewide plan without increasing the cost-sharing or the coverage. On the other hand, this will continue to make health insurance a part of collective bargaining, wherever applicable.

Glossary

The glossary defines some of the technical terms used throughout the report for reference. These will include

Carve Out Plan - a plan covering certain benefits in a stand-alone plan (e.g. prescription drugs or mental health benefits) usually associated with a plan of benefits separate from the medical plan.

Claim – a demand for payment under the coverage provided by a plan or contract.

COBRA - from the set of laws (**C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct of 1985) setting out the right to continued health care coverage after termination of employment, where qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan. The period of coverage under federal law is 18 months (or up to 36 months contingent upon a post-termination event), and under Pennsylvania Law is up to ten years if the participant satisfies certain eligibility conditions.

Coinsurance - the portion of an eligible expense that is payable by the plan.

Community Rating - an approach for pooling experience whereby all those covered in the community pay the same rate for the same plan, regardless of their prior claims history, age, gender, or health status.

Copayment - the portion of an eligible expense that is payable by the participant.

Coverage – the terms and conditions of a plan or contract that provide for certain payments associated with contingent events.

Experience Rating - an approach for setting rates taking into account the prior claims history, age, gender, and health status of those covered by the plan.

Fee-for-Service (FFS) – a traditional indemnity plan that provides designated reimbursement to covered persons for designated health services. Covered persons are able to choose their providers without penalty. All providers of the same service are reimbursed at the same level; i.e., there are no "preferred" or "exclusive" providers. There may be a hospital precertification requirement as well as catastrophic case management. The plan can be fully or partially insured or self-insured.

Fully Insured - a contract where the insurer agrees to pay the full cost of the benefits in return for a fixed premium determined in advance.

Health Benefit Plan – a contract providing medical, prescription drug, dental, vision, or other health-related benefits, whether on a reimbursement, indemnity, or service benefit basis, regardless of the form or the risk-bearing organization, including benefit plans provided by self-insured or governmental sponsors.

Health Maintenance Organization (HMO) – managed care plan in which the individual must go through a "gatekeeper" primary care physician for all medical care. The gatekeeper refers the individual to a provider within the network if specialization is needed. There is no benefit provided out-of-network.

Insured - a participant covered by an insured health plan.

Out-of-pocket Expenses/Maximums - the maximum amount than an individual (or family) will have to pay regardless of the amount of claims incurred in a year.

Plan Provisions – the term includes administrative practices, plan interpretations, and arrangements with providers of health care.

Preferred Provider Organization (PPO) – medical plan that allows the employee to decide between a network of preferred providers (hospitals and/or physicians) with higher reimbursement levels and out-of-network providers for each time service is to be provided. If the network has a gatekeeper/primary physician requirements, it is not a PPO, but a POS.

Point-of-Service (POS) – also called open-ended HMOs. A medical plan that allows the employee to decide whether to use a medical care provider who is part of a network of gatekeepers or an indemnity plan, which gives the employee unrestricted access to medical care providers, but with higher employee copays each time the service is provided.

Self-Funded/Self-Insured - a funding method whereby the plan sponsor assumes all risk for the cost of the benefits.

Stand Alone Plan - see Carve Out Plan.

Stop-Loss Coverage – insurance protection providing reimbursement of all or a portion of claims in excess of a stated amount. Stop-loss coverage may be either individual or aggregate (sometimes referred to as *excess loss coverage*).

Trust Fund – an account to which income is credited and from which benefits, and often administrative expenses, are paid for a specified program.

Appendix A

List of Respondents

Intermediate Units
Allegheny Intermediate Unit #3
ARIN Intermediate Unit #28
Beaver Valley Intermediate Unit #27
Blast Intermediate Unit #17
Capital Area Intermediate Unit #15
Carbon Lehigh Intermediate Unit #21
Chester County Intermediate Unit #24
Colonial Intermediate Unit #20
Intermediate Unit #1
Lancaster Lebanon Intermediate Unit #13
Lincoln Intermediate Unit #12
Montgomery County Intermediate Unit #23
Northwest Tri-County Intermediate Unit #5
Riverview Intermediate Unit #6
Tuscarora Intermediate Unit #11
Westmoreland Intermediate Unit #7
School Districts
Alquippa School District
Altoona Area School District
Apollo Ridge School District
Armstrong School District
Avon Grove School District
Beaver Area School District
Bedford Area School District
Bellefonte Area School District
Bellwood-Antis School District
Benton Area School District
Berlin Brothers Valley School District
Berwick Area School District
Bethlehem Area School District
Big Beaver Falls Area School District
Blackhawk School District
Bloomsberg Area School District
Boyertown School District
Brentwood Borough School District
Brockway Area School District
Brookville Area School District
Brownsville Area School District
Burrell School District
Cambria Heights School District
Camp Hill School District
Canon-McMillian School District
Carlisle Area School District
Catasauqua Area School District
Center Area School District
Central Cambria School District
Central Columbia School District
Central Dauphin School District
Central Susquehanna #16
Central York School District
Clarion-Limestone Area School District
Claysburg-Kimmel School District
Clearfield Area School District
Cocalico School District
Columbia Borough School District
Conemaugh Township Area School District
Conewago Valley School District
Conneaut School District
Connellsville Area School District
Cornwall- Lebanon School District
Crawford Central School District
Danville Area School District
Delaware Valley School District
Dover Area School District
Dowingtown Area School District
DuBois Area School District
East Allegheny School District
East Pennsboro Area School District
Eastern Lebanon County School District
Eastern York School District
Elizabethtown Area School District
Elk Lake School District
Ellwood City Area School District
Ephrata Area School District
Everett Area School District
Exeter Township School District
Fairfield Area School District
Fairview School District
Fleetwood Area School District
Forest City Regional School District
Forest Hills School District
Freedom Area School District
Great Valley School District
Greenville Area School District
Greenwood School District
Grove City Area School District
Halifax Area School District
Hamburg Area School District
Hampton Township School District
Hanover Public School District
Harmony Area School District
Haverford School District
Homer Center School District
Indiana Area School District

Jeannette City School District
Jenkintown School District
Keystone Central School District
Lakeland School District
Lancaster School District
Laurel School District
Leechburg Area School District
Lewisburg Area School District
Ligonier Valley School District
Littlestown Area School District
Lower Merion School District
Lower Moreland School District
Manheim Central School District
Marion Center Area School District
Marple Newton School District
Mars Area School District
Mechanicsburg Area School District
MeyerSchool Districtale School District
Middleton Area School District
Midd-West School District
Midland Borough School District
Mifflin County School District
Millville Area School District
Milton Area School District
Minersville Area School District
Mohawk Area School District
Monaca School District
Moniteau School District
Mount Carmel Area School District
Mount Union Area School District
Muhlenberg School District
Nazareth Area School District
Neshaminy School District
New Hope-Solebury School District
Newport School District
North Allegheny School District
North Clarion County School District
North Penn School District
North Pocono School District
North Star School District
Northampton School District
Northeast Bradford School District
Northern York County School District
Northwest Area School District
Oil City Area School District
Oley Valley School District
Oxford Area School District
Palisades School District

Palmyra Area School District
Pen Argyl Area School District
Penn Hills School District
Pennridge School District
Penns Area School District
Penns Manor Area School District
Pennsbury School District
Penn-Tafford School District
Perkiomen Valley School District
Philadelphia School District
Phoenixville Area School District
Pleasant Valley School District
Plum Borough School District
Portage Area School District
Pottstown School District
Purchase Line School District
Radnor Township School District
Redbank Valley School District
Richland School District
Ridgway Area School District
Riverside Beaver County School District
Salisbury Township School District
Salisbury-Elk Lick School District
Schuylkill Haven Area School District
Selinsgrove Area School District
Seneca Valley School District
Shade Central City School District
Sharpesville Area School District
Shenango Area School District
Shikellamy School District
Slippery Rock School District
Solanco School District
South Butler County School District
South Fayette Township School District
South Middleton School District
South Park School District
South Western School District
Southern Columbia Area School District
Southern Fulton School District
Spring Cove School District
Spring Grove Area School District
Springfield School District
Spring-Ford School District
Stroudsburg Area School District
Sullivan County School District
Susquehana Township School District
The Reading School District
Tredyffrin/Easttown School District

Tulpehocken Area School District
Tussey Mountain School District
Tyrone Area School District
Union City Area School District
Upper Adams School District
Upper Darby School District
Valley Grove School District
Wallenpaupack Area School District
Warren County School District
Warrior Run School District
Warwick School District
Wayne Highlands School District
Waynesboro Area School District
Weatherly Area School District
Wellsboro Area School District
West Chester Area School District
West York Area School District
Western Beaver County School District
Westmont Hilltop School District
Williams Valley School District
Williamsport Area School District
Windber Area School District
Wyomissing Area School District
Yough School District
Charter and Vocational Schools
Beaver County Area Vocational and Technical School
Berks Career and Technology Center
Business Center for Arts and Technology
Center for Technical Studies
Clearfield County Technology Center
Collegium Charter School
Crawford County Area Vocational and Technical School
Cumberland Perry Area Vocational Tech School
Dauphin County Technical School
Easter Seals
Erie County Technical School
Franklin County Career and Technical Center
Greater Altoona Career and Technical Center
Green Woods Charter School
Indiana County Technology Center
Lawrence County Area Vocational and Technical School
Lehigh Career and Technical School
Lenape Area Vocational and Technical School

Mercer County Career Center
Monroe Career and Technical Institute
Northern Tier Career Center
School for Blind Children
Somerset County Technical Center
SusQ-Cyber Charter School
Upper Buck County Technical School
Venango Technology Center
Western Area Career and Technology Center

Appendix B

State Health Plans Summary

State Health Plans Summary

California

Health care benefits for active and retired school employees in California are provided through several sources:

- Through CalPERS for school districts that have contracted with the state to participate.
- Through those local school districts that participate in one of 12 Jointly Managed Trusts (JMTs) that cover most of California.
- Through those local school districts that participate in a Joint Powers Authority (JPA) health care purchasing coalition such as SISC (Self-Insured Schools of California).
- Eligible[6] retired teachers may participate in the California State Teachers Retirement System (CalSTRS) health care program that pays Medicare Part A premiums.

Health Care Plans

CalPERS

The CalPERS Health Benefits Program was established for state employees in 1962 by the Public Employees' Medical & Hospital Care Act (PEMHCA). Participation was extended to other public employers such as cities, counties, and school districts in 1967. The CalPERS comprehensive financial report for the fiscal year ending on June 30, 2002, shows that 109 school districts with a total of 70,100 active employees participate in the CalPERS medical program. CalPERS is the third largest purchaser of employee health benefits in the United States, ranking behind the Federal government and General Motors.

CalPERS provides health care benefits through Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), and Exclusive Provider Organizations (EPOs). Availability of the three types of plans depends on where the school employee lives and works. The following CalPERS health care plans are available to active school employees in participating districts.[7]

- PPOs: PERSCare, PERSChoice
- HMOs: Blue Shield Access + HMO, Kaiser Permanente, Western Health Advantage
- EPO: Blue Shield EPO.

The following CalPERS health care plans are available to supplement Medicare.

[6] Retired prior to January 1, 2001, and receiving a monthly CalSTRS allowance, not eligible for premium-free Medicare Part A, and enrolled in Medicare Parts A and B at age 65.

[7] Some CalPERS health care plans are available only to employees in certain groups such as highway patrolmen, firefighters, and correctional officers. These plans are not shown.

- PPO Supplement to Original Medicare Plans: PERSCare, PERSChoice
- HMO Supplement to Original Medicare Plans: Blue Shield Access + Choice, Western Health Advantage
- EPO Supplement to Original Medicare Plans: Blue Shield EPO
- HMO Medicare Managed Care Plan (Medicare + Choice): Kaiser Permanente Senior Advantage.

The tables below show the total monthly premium cost for each of the above health care plans for active employees and those covered by Medicare for 2004. Employer contributions would be deducted from these figures. Employer contributions vary from employer to employer, and can be subject to collective bargaining agreements. For state retirees, the amount of employer contribution is related to the length of service, ranging from zero percent of the premium for retirees with less than 10 years of service to 100 percent of the premium for retirees with 20 or more years of service.

Table B-1
2004 Total Monthly Premium (Employer and Employee Shares)
Active Employees – Basic Plans
CalPERS Health Care Plans

Plan	Subscriber Only	Subscriber & 1 Dependent	Subscriber & 2+ Dependents
Blue Shield HMO & EPO	$315.22	$630.44	$819.57
Kaiser Permanente	$305.42	$610.84	$794.09
PERSChoice	$349.41	$698.82	$908.47
PERSCare	$544.77	$1,089.54	$1,416.40
Western Health Advantage	$280.41	$560.82	$729.07

Source: California Public Employees' Retirement System, 2004 Health Plan Decision Guide, p. 6.

Table B-2
2004 Total Monthly Premium (Employer and Retiree Shares)
Medicare Enrollees – Supplemental Plans
CalPERS Health Care Plans

Plan	Subscriber Only	Subscriber & 1 Dependent	Subscriber & 2+ Dependents
Blue Shield HMO & EPO	$319.97	$639.94	$959.91
Kaiser Permanente	$273.86	$547.72	$821.58
PERSChoice	$305.67	$611.34	$917.01
PERSCare	$336.07	$672.14	$1,008.21
Western Health Advantage	$280.24	$560.48	$840.72

Source: California Public Employees' Retirement System, 2004 Health Plan Decision Guide, p. 6.

In July 2003, CalPERS adopted several major cost containment/management measures:

- Require each participating plan to have three care management programs and five disease management programs.
- Explore feasibility of establishing purchasing coalitions with other large health care purchasers in California and other states.
- Explore whether implementing a carve-out Rx drug plan would be cost effective.
- Establish multi-year contracts with HMOs.
- Seek legislative authority to use regional pricing and alternative benefit designs for local public agencies and schools.
- Consider addition of dental and vision benefits as an incentive for attracting and retaining local governments in the plan.

Table B-3 summarizes CalPERS health benefits program enrollment for active and retired employees and dependents as of July 1, 2003. Note this table includes all participants – school employees are not shown separately. Several plans are not open to school employees: California Association of Highway Patrolmen (CAHP), California Correctional Police Officers Association (CCPOA), and Peace Officers Research Association of California (PORAC).

- The 70,100 enrolled school employees represent approximately 18 percent of the total active employee enrollment and approximately 30 percent of public agency enrollment in CalPERS health care plans.

Table B-3
CalPERS Health Benefit Program Enrollment
Active and Retired
As of July 1, 2003

Health Plan	Total Subscribers	Total Covered Dependents	Total Covered Lives
Blue Shield HMO/EPO	189,201	270,975	460,176
CAHP	9,593	15,985	25,578
CCPOA	5,441	11,863	17,304
Kaiser Permanente	191,363	231,744	423,107
Kaiser (out of state)	1,214	690	1,904
PERSChoice	99,908	115,332	215,240
PERSCare	56,215	24,418	80,633
PORAC	4,498	7,150	11,648
Western Health Advantage	2,026	2,979	5,005
Totals	559,459	681,136	1,240,595
Source: www.calpers.ca.gov/health/program/enrollbyplan.htm			

Table B-4 shows the breakdown of enrollment by basic vs. Medicare, state employee vs. public agency (including schools), and active vs. retired.

Table B-4 CalPERS Health Benefit Program Enrollment As of July 1, 2003			
Category	**Total Subscribers**	**Total Covered Dependents**	**Total Covered Lives**
Active	390,003	579,036	969,039
Retired	169,456	102,100	271,556
Total	559,459	681,136	1,240,595
State	330,285	412,984	743,269
Public agency (includes schools)	229,174	268,152	497,326
Total	559,459	681,136	1,240,595
Basic	460,239	646,797	1,107,036
Medicare	99,220	34,339	133,559
Total	559,459	681,136	1,240,595
Source: www.calpers.ca.gov/health/program/enrollbyplan.htm			

Purchasing Coalitions - Jointly Managed Trusts

Two hundred sixty-five California school districts participate in one of 12 JMTs as shown in Table B-5. JMTs are Voluntary Employee Benefit Associations or VEBAs. In 1991, California JMTs formed a purchasing coalition called the California Public Employers/Employees Trust Fund Group which allows all trusts to purchase dental, vision, pharmaceutical, and other benefits at the coalition rate. All funds contributed to the JMT, as well as reserves and surpluses, must be used for the benefit of covered participants. A school district may withdraw from the JMT without payment of any fees or incurred but not reported claims.

Table B-5 California Jointly Managed Trusts Membership 2002				
Trust	**Nr. Districts**	**Covered Employees**	**Covered Dependents**	**Total Covered Lives**
Bay Area Schools Insurance Cooperative	8	4,100	7,500	11,600
Central Valley Schools Health & Welfare Trust	180	38,500	91,500	130,000
Chico Educators Health & Welfare Benefit Trust	1	780	1,300	2,080
Gold Coast Joint Benefits	3	4,400	8,800	13,200
High Desert & Inland Employee/Employer Trust	3	2,514	4,558	7,072

Table B-5 (continued) California Jointly Managed Trusts Membership 2002				
Imperial County Schools Voluntary Employee Benefits Assn.	12	1,640	3,700	5,340
Los Angeles County Schools Joint Benefits Trust	1	4,300	10,750	15,050
Metropolitan Employees Benefits Assn.	4	6,700	8,700	15,400
Monterey Bay Public Employees Trust	2	1,422	3,128	4,550
Southern California Schools Voluntary Employees Benefit Assn.	25	35,418	44,668	80,086
Sonoma County Health and Welfare Benefit Fund	1	700	1,100	1,800
South Counties Employers/Employees Trust	25	26,000	52,000	78,000
Totals	265	126,474	237,704	364,178
Source: California Schools Joint Employer/Employee Trusts 2002, California Teachers Association, p. 15.				

Table B-6 shows a summary of the health care benefits provided through each JMT.

Table B-6 California Jointly Managed Trusts Health Care Benefits 2002				
Trust	**Medical Plans**	**Presc. Drug**	**Dental Plans**	**Vision Plans**
Bay Area Schools Insurance Cooperative	HMO (2 plans) PPO (2 levels) EPO	Included in Medical	Delta Indemnity Delta Prepaid	VSP (2 levels)
Central Valley Schools Health & Welfare Trust	HMO PPO (2 plans)	Included in Medical	Delta Indemnity Delta DPO	VSP
Chico Educators Health & Welfare Benefit Trust	PPO	Included in Medical	Delta Indemnity	VSP
Gold Coast Joint Benefits	HMO (3 plans) PPO	Included in Medical	Delta Indemnity	VSP

Table B-6 (continued) California Jointly Managed Trusts Health Care Benefits 2002				
High Desert & Inland Employee/Employer Trust	HMO PPO	Included in Medical	Delta	MES
Imperial County Schools Voluntary Employee Benefits Assn.	PPO Supplemental (AFLAC)	Carve-out (ExpressScripts)	None	None
Los Angeles County Schools Joint Benefits Trust	HMO (2 plans) PPO	Included in Medical	United Concordia Delta PMI	VSP
Metropolitan Employees Benefits Assn.	HMO (2 plans) PPO POS Indemnity (out of area)	Included in Medical	None	VSP
Monterey Bay Public Employees Trust	HMO PPO (3 levels) EPO	Included in Medical	Delta Indemnity	VSP
Southern California Schools Voluntary Employees Benefit Assn.	HMO (2 plans) PPO POS Indemnity (out of area) Medicare Sup (2 plans)	Included in Medical + Merc-Medco mail order	Delta Indemnity CDN Dental PPO	VSP
Sonoma County Health and Welfare Benefit Fund	HMO (2 plans)	Included in Medical	Delta Indemnity	VSP
South Counties Employers/Employees Trust	HMO (2 plans) POS PPO (2 plans)	Included in Medical	Delta Indemnity Delta Select Delta PMI	VSP MESC
Source: California Schools Joint Employer/Employee Trusts 2002, California Teachers Association, pp. 3-14.				

Purchasing Coalitions – Joint Powers Authorities

JPAs are management-controlled purchasing pools. There are 100 school district JPAs in California representing 1,000 school districts. Accounting and management requirements differ between JPAs and JMTs. If a JPA generates a surplus, the excess is returned to the school district for its use, which may not be directly for the use of employees. In addition, a JPA may

not include the value of incurred but not reported (IBNR) claims in a rate quote. A school district that wants to withdraw from the JPA must pay an amount equal to its IBNR.

The Self-Insured Schools of California (SISC) is one of the largest school-focused JPAs in California, representing 278 educational agencies with 163,900 members. SISC provides the following health care benefits to its members.

- Medical: Blue Cross, Kaiser, Health Net, CaliforniaCare, PacificCare
- Behavioral Health: CIGNA, Blue Cross, PacifiCare
- Prescription Drug: Medco Health
- Dental: Delta Dental, Pacific Union Dental
- Vision: Vision Service Plan, Medical Eye Services.

Delaware

The state employee health benefit program (State of Delaware Group Health Insurance Program) covers local school district employees. This plan provides medical and prescription drug coverage. Dental and vision benefits for state 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 that would be in addition to the plan that is part of medical coverage.

Coverage in the state 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 state 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 3 months of service. The school district may pay a share of the premium in the interim.

For the 2003-2004 plan year, the employee premium contribution for the non-basic plans increased by 13.4%. After this increase, the state's share of the premium is 94% for single and family coverage.

Several cost control measures are being implemented for the 2003-2004 plan year. These are:
- Removal of some types of care
- Increased copayments
- Increased employee's premium share
- Require an active enrollment or the employee will be enrolled by default in basic coverage (only applies to state-payroll employees)
- Establish stronger spousal coordination of benefit (COB) procedures
- Require proof of eligibility when enrolling dependents for first time
- Begin step therapy prescription protocols

The State of Delaware Personnel Office manages the health insurance plan.

Health Care Plans

Medical benefits are delivered through five plans:
- Blue Cross Blue Shield of Delaware plans:
  - Basic (traditional indemnity)
  - First State (traditional indemnity)
  - Comprehensive PPO
  - BlueCare (HMO)
- Coventry Health Care (HMO)

The prescription drug benefit is provided through Express Scripts. The basic plan does not include prescription drug coverage.

Table B-7 shows the monthly premium for active employees and retirees. The total premium is divided into the employer and employee/retiree shares.

Table B-7
State of Delaware Group Health Insurance Program
Monthly Premium for Medical Coverage
As of July 1, 2003

Plan	State Share	Employee/Retiree Share	Total Premium
Basic			
Employee	$321.70	$0	$321.70
Employee & Child(ren)	485.26	0	485.26
Employee & Spouse	660.44	0	660.44
Family	825.52	0	825.52
First State			
Employee	$321.70	$4.06	$325.76
Employee & Child(ren)	485.26	9.94	495.20
Employee & Spouse	660.44	13.56	674.00
Family	825.52	16.94	842.46
Comprehensive PPO			
Employee	$321.70	$43.68	$365.38
Employee & Child(ren)	485.26	73.78	559.04
Employee & Spouse	660.44	92.48	752.92
Family	825.52	115.68	941.20
BlueCare			
Employee	$321.70	$14.04	$335.74
Employee & Child(ren)	485.26	24.56	509.82
Employee & Spouse	660.44	43.48	703.92
Family	825.52	52.74	878.26
Coventry			
Employee	$321.70	$19.06	$340.76

Table B-7 (continued) State of Delaware Group Health Insurance Program Monthly Premium for Medical Coverage As of July 1, 2003			
Employee & Child(ren)	485.26	34.42	519.68
Employee & Spouse	660.44	42.90	703.34
Family	825.52	51.02	876.54
Source: State of Delaware Open Enrollment 2003 Handbook, p. 4.			

Louisiana

In 1970 the State of Louisiana implemented a uniform benefit program (health and life insurance) to cover employees in all state agencies. The uniform program replaced approximately 300 different plans that had evolved among state agencies. The program became self-insured in 1976. The system is financed on a pay-as-you-go basis.

In 1979, the Louisiana legislature enacted provisions for local parish/city school boards to participate in the State Office of Group Benefits (OGB) health care plan that covers state employees. School board participation was authorized beginning in 1980. Nearly 69 percent (44 of 64) of the parish/city school boards now participate in the OGB plan. Non-participating school boards are responsible for providing health benefits for their employees. The OGB staff are unaware of any feasibility study that was done before the change in 1979.

Active and retired employees of participating parishes/cities are eligible for coverage. To retain medical coverage, the retiree must be enrolled in the OGB health care plan at the time of retirement.

Health care coverage includes medical, prescription drug, dental, and vision. The dental and vision benefits are provided in the form of discounted services from preferred provider networks. The dental and vision benefits are not insurance products.

The state shares in cost of medical insurance for active and retired employees. The percentage of the total premium that is paid for active employees ranges from about 75% for single coverage to 62% for family coverage, depending on the plan. The percentage of cost paid for retirees is based on years of participation in the plan. The percentage of the state's share of the premium for retirees ranges from 19% with 10 or fewer years of participation to 75% with 20 or more years of participation.

The program is administered by Office of Group Benefits within the Louisiana Department of Administration.

Health Care Plans

Medical benefits for active and retired employees are delivered through three statewide plans and two HMO plans that cover participants in nine regions of the state.

The statewide plans are:
- PPO (Administered by OGB)
- EPO (Administered by OGB)
- MCO (Provider network provided by FARA)

The regional HMOs are:
- Oschner Health Plan (Regions 1-8)
- Vantage Health Plan (Region 9)

The statewide plans are self funded and the HMOs are fully insured. The three statewide plans are part of a single risk pool and the premiums are actuarially established to meet the anticipated health care costs generated by participants in these plans. Oschner and Vantage establish the premiums for their plans and the state collects the premiums and transfers them to the HMOs.

Participating agencies pay a share of the premium for both active and retired participants. Agencies pay 75 percent of the premium for an active employee for all coverages that cost the same as or less than the PPO. At present, only the EPO costs more than the PPO plan. For retired employees, the state share of the premium is determined by the number of years the retiree participated in the health plan, as seen in the following table.

Table B-8
Percentage of State Share of Premium for Retiree Medical Coverage

Years of Participation	Percentage of State Subsidy
10 years or fewer	19%
More than 10 years but fewer than 15	38%
15 years or more but fewer than 20	56%
20 years or more	75%
Source: Helpful Information for Plan Members, State of Louisiana Office of Group Benefits, 2003-2004, p. 5.	

The average age of participants and dependents by plan is shown in Table B-9. The table includes all health care benefit participants, including school and other state employees. As would be expected, the younger participants tend to enroll in the HMOs.

Table B-9 Average Age of Plan Participants (Years)				
	EPO	**HMO**	**PPO**	**Total**
Members	47.6	45.7	57.4	52.2
Dependents	26.8	24.5	37.0	30.8
Total	36.7	35.0	48.3	41.8
Source: *For Your Benefit – OGB 101: Introduction to Health Benefit Issues*, State of Louisiana, Office of Group Benefits, Summer 2003, p. 3.				

Table B-10 also shows the premiums for active employees that became effective July 1, 2003. The premium is divided into the state share, the employee share, and the total monthly premium.

Table B-10 State Health Benefits Plan Premiums for Active Employees As of July 1, 2003			
Plan/Enrollment Category	**State Share**	**Employee Share**	**Total Premium**
Statewide PPO			
Single	$291.06	$97.02	$388.08
With Spouse	461.54	267.50	729.04
With Children	337.74	143.70	481.44
Family	492.86	298.82	791.68
Statewide EPO (Blue Cross)			
Single	$291.06	$164.94	$456.00
With Spouse	461.54	395.06	856.60
With Children	337.74	227.98	565.72
Family	492.86	437.34	930.20
Statewide MCO (FARA)			
Single	$212.50	$70.82	$283.32
With Spouse	336.94	195.26	532.20
With Children	246.58	104.90	351.48
Family	359.80	218.12	577.92
Region 1 (New Orleans) – HMO (Oschner)			
Single	$241.56	$80.52	$322.08
With Spouse	376.44	215.40	591.84
With Children	278.50	117.46	395.96
Family	401.22	240.18	641.40
Region 2 (Houma/Thib.) – HMO (Oschner)			
Single	$241.56	$80.52	$322.08
With Spouse	376.44	215.40	591.84
With Children	278.50	117.46	395.96
Family	401.22	240.18	641.40
Region 3 (Hammond) – HMO (Oschner)			
Single	$280.60	$93.52	$374.12
With Spouse	429.40	242.32	671.72
With Children	323.82	136.74	480.56
Family	467.36	280.28	747.64
Region 4 (Lafayette) – HMO (Oschner)			
Single	$291.06	$109.58	$400.64
With Spouse	460.46	278.98	739.44
With Children	337.44	155.96	493.40
Family	491.58	310.10	801.68

Table B-10 (continued) State Health Benefits Plan Premiums for Active Employees As of July 1, 2003			
Region 5 (Lake Charles) – HMO (Oschner)			
Single	$245.28	$81.76	$327.04
With Spouse	382.34	218.82	601.16
With Children	282.80	119.28	402.08
Family	407.52	244.00	651.52
Region 6 (Baton Rouge) – HMO (Oschner)			
Single	$232.96	$77.64	$310.60
With Spouse	362.80	207.48	570.28
With Children	268.52	113.20	381.72
Family	386.66	231.34	618.00
Region 7 (Alexandria) – HMO (Oschner)			
Single	$247.38	$82.46	$329.84
With Spouse	385.68	220.76	606.44
With Children	285.26	120.34	405.60
Family	411.01	246.18	657.28
Region 8 (Shreveport) – HMO (Oschner)			
Single	$258.10	$86.02	$344.12
With Spouse	399.40	227.32	626.72
With Children	297.70	125.62	423.32
Family	429.24	257.16	686.40
Region 9 (Monroe) – HMO (Vantage)			
Single	$291.06	$100.26	$391.32
With Spouse	424.64	233.84	658.48
With Children	337.74	283.14	620.88
Family	492.86	319.90	812.76
Source: Louisiana State Office of Group Benefits, Official Schedule of Rates, Effective July 1, 2003.			

Retirees are covered by the same medical plans as active employees. Table B-11 shows total plan premium rates for retirees for each of the plans in Table B-10. The two premium rates shown reflect the different rates based on enrollment in Medicare. The first premium reflects the total premium rate for a retiree who receives Medicare. The second rate reflects the rate for the case where both the retiree and their spouse receive Medicare. In either case, the premium is shared between the state and the retiree, depending on the retiree's years of participation, as explained above.

Table B-11 State Health Benefits Plan Premiums for Retired Employees As of July 1, 2003 Total Premium (State Share + Retiree Share)		
Plan/Enrollment Category	**Retiree Only With Medicare**	**Retiree and Spouse Both With Medicare**
Statewide PPO		
Single	$243.62	N/A
With Spouse	931.20	$457.50
With Children	486.80	N/A
Family	1,174.44	584.30
Statewide EPO (Blue Cross)		
Single	$286.24	N/A
With Spouse	1,094.16	$537.56
With Children	571.98	N/A
Family	1,379.96	686.56
Statewide MCO (FARA)		
Single	$177.84	N/A
With Spouse	679.80	$457.50
With Children	355.36	N/A
Family	857.36	584.30
Region 1 (New Orleans) – HMO (Oschner)		
Single	$191.56	N/A
With Spouse	721.22	$323.98
With Children	750.64	N/A
Family	927.18	426.96
Region 2 (Houma/Thib.) – HMO (Oschner)		
Single	$191.56	N/A
With Spouse	721.22	$323.98
With Children	750.64	N/A
Family	927.18	426.96
Region 3 (Hammond) – HMO (Oschner)		
Single	$221.50	N/A
With Spouse	840.98	$376.38
With Children	875.38	N/A
Family	1081.86	496.82
Region 4 (Lafayette) – HMO (Oschner)		
Single	$236.72	N/A
With Spouse	901.90	$403.04
With Children	938.86	N/A
Family	1,160.58	532.36

Table B-11 (continued) State Health Benefits Plan Premiums for Retired Employees As of July 1, 2003 Total Premium (State Share + Retiree Share)		
Plan/Enrollment Category	**Retiree Only With Medicare**	**Retiree and Spouse Both With Medicare**
Region 5 (Lake Charles) – HMO (Oschner)		
Single	$194.40	N/A
With Spouse	732.62	$328.96
With Children	762.52	N/A
Family	941.92	433.62
Region 6 (Baton Rouge) – HMO (Oschner)		
Single	$184.96	N/A
With Spouse	694.84	$312.44
With Children	723.16	N/A
Family	893.12	$411.58
Region 7 (Alexandria) – HMO (Oschner)		
Single	$196.02	N/A
With Spouse	739.12	$331.82
With Children	769.28	N/A
Family	950.32	437.40
Region 8 (Shreveport) – HMO (Oschner)		
Single	$204.24	N/A
With Spouse	771.94	$346.18
With Children	803.48	N/A
Family	992.72	456.56
Region 9 (Monroe) – HMO (Vantage)		
Single	$291.04	N/A
With Spouse	1,078.08	$567.06
With Children	676.48	N/A
Family	952.48	952.48
Source: Louisiana State Office of Group Benefits, Official Schedule of Rates, Effective July 1, 2003.		

The following table shows the number of members and dependents who are enrolled in Office of Group Benefit health and life insurance programs. The table includes both school and non-school employees and retirees.

Table B-12 Number of Participants in State Health and Life Insurance Programs 2003					
	Male	**Female**	**Active**	**Retired**	**Total**
Members	45,109	81,470	86,385	40,194	126,579
Dependents	60,331	57,874	98,642	19,563	118,205
Total	105,440	139,344	185,027	59,757	244,784
Source: *For Your Benefit - OGB 101: Introduction to Health Benefit Issues*, State of Louisiana, Office of Group Benefits, Summer 2003, p. 1.					

Table B-13 provides aggregated information for active and retired school board employees.

Table B-13 Number of School Board Participants in State Health and Life Insurance Programs 2003	
	Active Employees and Retirees
Members	50,095
Dependents	52,038
Total	102,133
Source: Louisiana Office of Group Benefits.	

Table B-14 summarizes total premium and claims expenses for the 2001-2002 plan year.

Table B-14 Premium and Claims Costs Plan Year 2001-2002	
Expense	**Amount**
HMO Premium	$134,276,100
Health Claims	$410,419,819
Drug Claims	$100,407,426
Mental Health Claims	$6,358,673
Total	$651,462,018
Source: *For Your Benefit - OGB 101: Introduction to Health Benefit Issues*, State of Louisiana, Office of Group Benefits, Summer 2003, p. 2.	

Maryland

School employees in Maryland receive health care benefits through their local school districts. They receive retirement benefits through the State Retirement and Pension System (SPRS).

Health Care Plans

Following are summaries of health care benefit practices in several large Maryland school districts.

Montgomery County

Montgomery County Schools provide health care coverage for active and retired employees.

Five medical options:
- 3 HMOs (Kaiser, Optimum Choice, Care First BlueChoice);
- 2 POS plans (CareFirst BCBS Hi Option, CareFirst BCBS Standard POS)

Two dental plans (PPO, DMO)
Vision, Rx Drugs

Employee pays 5% of premium for HMO; 15-20% of premium for POS depending on years of service; 10% of premium for dental, vision, and Rx drugs regardless of service.

The table below shows the employee portion of the premium for the medical plan options based on years of service.

Table B-15
Montgomery County Schools Medical Plan Premiums for Active Employees
Calendar Year 2004
Employee Share

Plan/Enrollment Category	Coverage Level	Employee Percentage	Monthly Employee Portion
CareFirst High Option POS			
-MCEA with 12+ years of service	Individual	15%	$60.58
-MCEA with 7 to 12 years of service	Individual	20%	$80.75
-MCCSSE and MCAASP	Individual	20%	$80.75
-MCEA with 12+ years of service	Employee+1	15%	$121.14
-MCEA with 7 to 12 years of service	Employee+1	20%	$161.52
-MCCSSE and MCAASP	Employee+1	20%	$161.52
-MCEA with 12+ years of service	Family	15%	$164.82
-MCEA with 7 to 12 years of service	Family	20%	$219.74
-MCCSSE and MCAASP	Family	20%	$219.74

Table B-15 (continued) Montgomery County Schools Medical Plan Premiums for Active Employees Calendar Year 2004 Employee Share			
United Healthcare High Option POS			
-MCEA with 12+ years of service	Individual	15%	$56.63
-MCEA with 7 to 12 years of service	Individual	20%	$75.51
-MCCSSE and MCAASP	Individual	20%	$75.51
-MCEA with 12+ years of service	Employee+1	15%	$113.27
-MCEA with 7 to 12 years of service	Employee+1	20%	$151.02
-MCCSSE and MCAASP	Employee+1	20%	$151.02
-MCEA with 12+ years of service	Family	15%	$154.09
-MCEA with 7 to 12 years of service	Family	20%	$205.47
-MCCSSE and MCAASP	Family	20%	$205.47
CareFirst Standard Option POS			
	Individual	10%	$25.46
	Employee+1	10%	$50.91
	Family	10%	$69.29
United Healthcare Standard Option POS			
	Individual	10%	$23.81
	Employee+1	10%	$47.62
	Family	10%	$64.78
CareFirst BlueChoice HMO			
	Individual	5%	$10.25
	Employee+1	5%	$19.24
	Family	5%	$31.52
Kaiser HMO			
	Individual	5%	$12.87
	Employee+1	5%	$25.69
	Family	5%	$37.24
Optimum Choice HMO			
	Individual	5%	$11.48
	Employee+1	5%	$21.58
	Family	5%	$35.34
Source: Montgomery County Schools.			

Prince George's County

Prince George's County Schools provides coverage for active and retired employees.

Three medical options:
- HMO, PPO, Indemnity, all from CareFirst BCBS

County pays 75% of premium for employees with less than 8 yrs of service, 80% of premium for employees after 8 yrs of service.

Table B-16 below shows the premiums for active employees.

Table B-16
Prince George's County Public Schools Medical Plan Premiums for Active Employees
Effective 10-1-03

Plan/Enrollment Category	Coverage Level	Monthly Premium	Monthly Employee Portion
CareFirst BCBS Choice + Triple Option Medical			
-0 to 8 years of service	Employee	$241.66	$60.41
-0 to 8 years of service	Family	$617.73	$154.43
-8+ years of service	Employee	$241.66	$48.33
-8+ years of service	Family	$617.73	$123.55
Kaiser HMO			
-0 to 8 years of service	Employee	$363.18	$181.93
-0 to 8 years of service	Family	$980.59	$517.29
-8+ years of service	Employee	$363.18	$169.85
-8+ years of service	Family	$980.59	$486.41
Optimum Choice HMO			
-0 to 8 years of service	Employee	$284.87	$103.62
-0 to 8 years of service	Family	$821.64	$358.34
-8+ years of service	Employee	$284.87	$91.54
-8+ years of service	Family	$821.64	$327.46

Source: Prince George's County Public Schools.

Anne Arundel County

Anne Arundel County provides coverage for active teachers; no information available on retirees.

Two medical options:
- CareFirst BCBS traditional medical; HMO

Three dental options:
- CareFirst traditional dental
- CareFirst Dental PPO
- Dental HMO

Caremark Rx Drug card plan
CareFirst Vision Program.
School Board pays 90% of premium for dental PPO; 100% of premium for dental HMO; 90% of premium for vision; Rx drugs included in medical premium.

Below is a table with the healthcare premium rates for all active employees.

Table B-17
Anne Arundel County Public Schools Healthcare Costs for Active Employees
Effective 1-1-04

Plan/Enrollment Category	Total Monthly Premium*	Monthly Board's Share
CareFirst BlueCross BlueShield – Traditional Plan		
Individual	$624.19	$330.51
Parent and Child	$1,181.62	$615.14
Husband and Wife	$1,537.70	$800.93
Family	$1,826.71	$925.45
CareFirst BlueCross BlueShield – PPO		
Individual	$367.24	$330.51
Parent and Child	$683.49	$615.14
Husband and Wife	$889.93	$800.93
Family	$1,058.27	$952.45
BlueChoice – HMO		
Individual	$303.47	$330.51
Parent and Child	$431.14	$615.14
Husband and Wife	$742.19	$800.93
Family	$882.87	$952.45
Aetna HMO		
Individual	$287.41	$330.51
Parent and Child	$543.01	$615.14
Husband and Wife	$742.19	$800.93
Family	$848.87	$952.45

*Total Monthly Premium consists of medical and Caremark premium. Caremark handles prescriptions drug benefits.

Source: Anne Arundel County Public Schools

Howard County

Howard County provides coverage for active school employees; no info on retirees.

Six medical options:
- Traditional (closed plan) and alternate
- Four HMOs (Blue Choice, Cigna, Kaiser, Optimum Choice)

Two dental plans
Vision care plan
Health benefit is part of a cafeteria plan with credits for opting out of health coverage.

Healthcare premiums were not available for Howard County Schools.

Baltimore County

Baltimore County provides coverage for active employees and retirees.

Three medical options:
- CareFirst BCBS Triple Choice/MPOS
- Kaiser HMO
- Keystone Health Plan HMO

Three dental options:
- CareFirst BCBS Preferred Dental
- CareFirst BCBS Maryland Dental
- Cigna DMO

One vision plan (Vision Service Plan)

Active employees pay 10% of premium for medical; about 35%-48% for dental; and about 70% for vision.

Cost for retirees is based on years of service; retirees pay 100% if less than 10 yrs; 10% with 30 or more years of service.

The following table shows the monthly healthcare premiums for full-time employees.

Table B-18
Baltimore County Public Schools Healthcare Costs for Active Employees
Effective 9-1-03 Through 8-31-04

Plan/Enrollment Category	Total Monthly Premium	Monthly Employee Share
CareFirst BlueCross BlueShield Triple Choice/MPOS		
Individual	$361.29	$36.13
Parent and Child	$715.90	$71.58
Husband and Wife	$862.28	$86.23

Table B-18 Baltimore County Public Schools Healthcare Costs for Active Employees Effective 9-1-03 Through 8-31-04		
Plan/Enrollment Category	**Total Monthly Premium**	**Monthly Employee Share**
Family	$972.19	$97.22
Kaiser Permanente HMO		
Individual	$261.93	$26.18
Parent and Child	$497.68	$49.76
Husband and Wife	$615.55	$61.55
Family	$785.80	$78.56
Keystone Health Plan HMO		
Individual	$299.21	$29.92
Parent and Child	$583.45	$58.33
Husband and Wife	$658.25	$65.82
Family	$942.49	$94.23
Source: Baltimore County Public Schools		

New Jersey

Local school districts can apply to participate in the State Health Benefits Program (SHBP) that covers state employees and those local governmental organizations that apply for membership. SHBP was extended to local public employers in 1964. As of July 2002, 312 of 665 or 47 percent of New Jersey school districts participated in SHBP. The remaining districts contract directly for employee health benefits, most using CIGNA.

Employees and retirees of school districts that participate in SHBP receive medical and prescription drug benefits. SHBP dental and vision benefits are not available to school employees.

The state Division of Pensions and Benefits is responsible for administration of SHBP.

Eligible active employees must be full time as defined by the employer to be eligible for benefits. Eligible retirees who were covered by SHBP during active service are covered after retirement as long as they work up to their retirement date. Retired teachers who participated in the Teacher's Annuity and Pension fund (TAPF), or school board employees who participated in the Public Employees Retirement System (PERS) and served 25 years, or who retire on a disability retirement, are covered even if their employers did not participate in SHBP. This includes those who elect a deferred retirement with 25 or more years of service credit in the pension fund.

Health Care Plans

Medical benefits are delivered through the plans shown in Table B-19. The table also shows the enrollment for education employees and their dependents as of June 30, 2002.

Table B-19
State Health Benefits Plan Enrollment by Active Education Employees
As of June 30, 2002

Plan	Employees	Employee Dependents	Employees and Dependents
NJ Plus (POS)	30,926	47,939	78,865
Traditional (Indemnity)	35,998	48,113	84,111
Aetna (HMO)	10,552	16,982	27,534
CIGNA (HMO)	1,787	2,950	4,737
Oxford (HMO)	2,039	3,364	5,403
AmeriHealth (HMO)	1,089	1,808	2,897
Healthnet (HMO)	1,562	2,588	4,150
University (HMO) discontinued in 2003	61	102	163
Total	84,014	123,846	207,860
Source: New Jersey State Health Benefits Program Annual Report, 2002, p. 15.			

Table B-20 shows similar data for retirees.

Table B-20
State Health Benefits Plan Enrollment by Retired Education Employees
As of June 30, 2002

Plan	Retirees	Retiree Dependents	Retirees and Dependents
NJ Plus (POS)	6,255	4,788	11,043
Traditional (Indemnity)	46,199	27,524	73,723
Aetna (HMO)	2,403	1,732	4,135
CIGNA (HMO)	418	336	754
Oxford (HMO)	118	69	187
AmeriHealth (HMO)	251	225	476
Healthnet (HMO)	143	99	242
University (HMO) discontinued in 2003	20	10	30
Total	55,807	34,783	90,590
Source: New Jersey State Health Benefits Program Annual Report, 2002, p. 15.			

The state pays the full cost of retiree health benefits for 47,021 or 84.2 percent of all retired school employees covered by SHBP.[8]

Table B-21 shows combined data for active employees and retirees.

Table B-21
State Health Benefits Plan Enrollment by Active and Retired Education Employees
As of June 30, 2002

Plan	Active and Retired Employees	Active and Retired Employee Dependents	Total
NJ Plus (POS)	37,181	52,727	89,908
Traditional (Indemnity)	82,197	75,637	157,834
Aetna (HMO)	12,955	18,714	31,669
CIGNA (HMO)	2,205	3,286	5,491
Oxford (HMO)	2,157	3,433	5,590
AmeriHealth (HMO)	1,340	2,033	3,373
Healthnet (HMO)	1,705	2,687	4,392
University (HMO) discontinued in 2003	81	112	193
Source: New Jersey State Health Benefits Program Annual Report, 2002, p. 15.			

Table B-22 shows the total monthly employer cost per member for health care coverage for school districts that also provide the carve-out prescription drug benefit. The carve-out is administered by Horizon Blue Cross Blue Shield of New Jersey through Advance PCS. The table shows the cost of medical coverage for each plan and the separate cost of the prescription drug carve-out is shown at the bottom of the table. The total cost includes the cost for the individual employee and the additional cost for covering dependents. These premiums are in effect during calendar year 2003.

[8] Fiscal Year 2002 Annual Report, State Health Benefits Program of New Jersey, p.13.

Table B-22 State Health Benefits Plan Monthly Premiums (Includes Prescription Drug Carve-Out Plan) Active Employees Rates Effective 1/1/2003 – 12/31/2003			
Plan	**Active and Retired Employees**	**Active and Retired Employee Dependents**	**Total**
NJ Plus (POS)			
Single	$254.25	-----	$254.25
Member & Spouse	$255.69	$310.17	$565.86
Family	$256.22	$402.17	$658.39
Parent & Child	$254.88	$120.55	$375.43
Traditional (Indemnity)			
Single	$339.64	-----	$339.64
Member & Spouse	$341.08	$399.68	$740.76
Family	$341.61	$524.28	$865.89
Parent & Child	$	$	$
Aetna (HMO)			
Single	$273.69	-----	$273.69
Member & Spouse	$275.13	$329.47	$604.60
Family	$275.66	$427.56	$703.22
Parent & Child	$274.32	$130.60	$404.92
CIGNA (HMO)			
Single	$301.51	-----	$301.51
Member & Spouse	$302.95	$354.69	$657.64
Family	$303.48	$408.88	$784.36
Parent & Child	$302.14	$150.43	$452.57
Oxford (HMO)			
Single	$261.38	-----	$261.38
Member & Spouse	$262.82	$312.11	$574.93
Family	$263.35	$416.13	$679.48
Parent & Child	$262.01	$130.06	$392.07
AmeriHealth (HMO)			
Single	$291.55	-----	$291.55
Member & Spouse	$292.99	$355.62	$648.61
Family	$293.52	$461.86	$755.38
Parent & Child	$292.18	$138.18	$430.36
Healthnet (HMO)			
Single	$260.92	-----	$260.92
Member & Spouse	$262.36	$305.98	$568.34
Family	$262.89	$427.01	$689.90
Parent & Child	$261.55	$138.68	$400.23

Table B-22 (continued) State Health Benefits Plan Monthly Premiums (Includes Prescription Drug Carve-Out Plan) Active Employees Rates Effective 1/1/2003 – 12/31/2003			
Prescription Drug Program			
Single	$92.71	-----	$92.71
Member & Spouse	$92.71	$119.21	$211.92
Family	$92.71	$130.12	$222.83
Parent & Child	$92.71	$31.06	$123.77
Source: www.state.nj.us/treasury/pensions/			

Table B-23 shows the monthly cost per participant for school districts that do not provide the prescription drug carve out. These plans provide prescription drug benefits through the medical plan.

Table B-23 State Health Benefits Plan Monthly Premiums (Prescription Drugs Provided Through the Medical Plan) Active Employees Rates Effective 1/1/2003 – 12/31/2003			
Plan	**Active and Retired Employees**	**Active and Retired Employee Dependents**	**Total**
NJ Plus (POS)			
Single	$283.18	-----	$283.18
Member & Spouse	$284.62	$345.64	$630.26
Family	$285.15	$448.15	$733.30
Parent & Child	$283.81	$134.34	$418.15
Traditional (Indemnity)			
Single	$398.27	-----	$398.27
Member & Spouse	$399.71	$464.86	$864.57
Family	$400.24	$611.15	$1,011.74
Parent & Child	$398.90	$180.57	$579.47
Aetna (HMO)			
Single	$371.70	-----	$371.70
Member & Spouse	$373.14	$431.42	$804.56
Family	$373.67	$532.22	$905.89
Parent & Child	$372.33	$138.76	$511.09
CIGNA (HMO)			
Single	$401.69	-----	$401.69
Member & Spouse	$403.13	$458.90	$862.03
Family	$403.66	$587.87	$991.53

Table B-23 (continued) State Health Benefits Plan Monthly Premiums (Prescription Drugs Provided Through the Medical Plan) Active Employees Rates Effective 1/1/2003 – 12/31/2003			
Parent & Child	$402.32	$158.76	$561.08
Oxford (HMO)			
Single	$314.87	-----	$314.87
Member & Spouse	$316.31	$376.27	$692.58
Family	$316.84	$501.70	$818.54
Parent & Child	$315.50	$156.78	$472.28
AmeriHealth (HMO)			
Single	$382.71	-----	$382.71
Member & Spouse	$384.15	$467.29	$851.44
Family	$384.68	$606.89	$991.57
Parent & Child	$383.34	$181.57	$564.91
Healthnet (HMO)			
Single	$350.58	-----	$350.58
Member & Spouse	$352.02	$411.66	$763.68
Family	$352.55	$574.49	$927.04
Parent & Child	$351.21	$186.60	$537.81
Source: www.state.nj.us/treasury/pensions/			

Table B-24 shows the monthly premium for retired school employees.

Table B-24
State Health Benefits Plan Monthly Premiums
Retired Employees
Rates Effective 1/1/2003 – 12/31/2003

Plan	Single – No Medicare	Single – On Medicare	Single & Spouse – No Medicare	Single & Spouse – Both on Medicare
NJ Plus (POS)	$473.40	$297.02	$1,053.74	$594.06
Traditional (Indemnity)	$573.23	$303.90	$1,248.52	$607.84
Aetna (HMO)	$371.70	$300.68	$804.56	$601.41
CIGNA (HMO)	$401.69	$300.68	$862.03	$601.41
Oxford (HMO)	$314.87	$297.07	$692.58	$594.19
AmeriHealth (HMO)	$382.71	$308.74	$851.44	$617.53
Healthnet (HMO)	$350.58	$300.68	$763.68	$601.41
Source: www.state.nj.us/treasury/pensions/				

The SHBP bills school districts each month for the cost of health plan coverage. Separate bills are issued for coverage of active and retired employees. The districts may establish premium sharing arrangements and accounting programs to collect premiums and disburse payment to SHBP.

New York

School employees in 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 teacher's union (New York State United Teachers). Employees of public schools in New York City obtain their benefits through the New York City Department of Education where basic coverage is of no cost to the employee.

Approximately 140 of 750, or 19 percent, of school districts in New York State are Participating Agencies in the New York State Health Insurance Program (NYSHIP). Employees/retirees in these districts receive the same health care benefits as state employees/retirees. The State Health Insurance Program offers two levels of coverage: core benefits and core benefits plus enhancements. Local districts and the teachers' union determine the level of coverage and the premium sharing, subject to the statutory guidelines described below.

To be eligible for coverage in the State Health Insurance Program, active school employees must be expected to work for at least three months and work at least 20 hours per week or be paid at an annual salary rate of $2,000 or more. Retired school employees must have at least five years of service (not necessarily continuous) with the school district, be qualified for retirement as a member of a retirement system administered by the state (e.g., the New York State Teachers' Retirement System), and be enrolled in the State Health Insurance Program at the time of retirement.

The state sets the total premium. The NYSHIP plans are experience rated. All participants, including local school district employees, are included in the group for rating purposes. School districts that participate in the State Health Insurance Program are required by state law to pay at least 50 percent of the premium for individual coverage and at least 35 percent of the premium for dependent coverage. This premium-sharing arrangement applies to both active and retired employees.

New York City school employees and retirees are covered under the City Health Benefits Program (HBP). Active employees must work at least 20 hours per week to qualify for coverage. Retirees must have at least five 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 be receiving a retirement annuity from a city pension plan.

The city pays the cost for basic health insurance coverage. Employees and retirees pay for optional coverages and for benefit riders, as discussed below.

Health Care Plans

The NYSHIP benefit is insured and administered by several providers. Inpatient and outpatient hospital services are provided by Empire Blue Cross Blue Shield. Medical and surgical services are provided through United HealthCare. Prescription drugs are insured by CIGNA and administered by Express Scripts. Mental health and substance abuse benefits are insured by Group Health Insurance (GHI) and administered by ValueOptions.

Monthly premiums for core only and core plus coverages are shown in the following tables. As noted above, these premiums are the total cost for a participant and they are divided between the school district and the employee through the collective bargaining process in each district (adhering to the state law requirements for minimum employer contributions).

Table B-25
2003 Total Monthly Premium (Employer and Employee Shares)
Active and Retired Employees
Participating Agencies – New York State Health Insurance Program

Category	Monthly Premium	
	Core Only	Core Plus
Non-Medicare		
Individual	$351.21	$384.89
Family	$740.92	$811.41
Medicare		
Individual	$286.88	$297.50
Family – 1 Medicare	$676.00	$724.05
Family – 2 Medicare	$612.28	$636.67

Source: www.cs.state.ny.us/edb/edbonlinecenter/choices03/parates/

The New York City Health Benefits Program includes a variety of plans. The following three are basic coverage, are available to active and retired school employees and are fully paid by the City Department of Education.

- HIP Health Plan of New York (HMO)
- GHI-CBP Empire Blue Cross Blue Shield
- Medical Team (for District Council #37 only)

Active school employees may elect optional coverages and riders under the following plans. Generally the optional coverage is a basic plan and the riders are for additional prescription drug coverage that reduces the out-of-pocket drug costs under the basic plan. Optional coverages require employee contributions for the basic coverage and the rider(s).

- Aetna Healthcare
  - HMO
  - QPOS (POS)
- CIGNA Healthcare (HMO)
- Empire
- Exclusive Provider Organization
- HMO-New Jersey
- HMO-New York
- Group Health Insurance (GHI)
- GHI-CBP/Empire Blue Cross
- HMO
- HealthNet
- HIP
- Prime HMO
- Prime POS
- Vytra

Bi-weekly premiums for these plans are shown in the following table. The premium is shown for basic coverage and for the additional cost for a prescription drug and other riders where applicable.

Table B-26
Employee Monthly Premium
New York City Health Benefits Program
Effective July 2003

Enrollment	Individual	Family
Aetna HMO		
Basic	$60.69	$149.65
Prescription Drug Optional Rider	34.71	94.88
Total	95.40	244.53
Aetna QPOS		
Basic	$253.32	$612.12

Table B-26 (continued) Employee Monthly Premium New York City Health Benefits Program Effective July 2003		
Enrollment	**Individual**	**Family**
Prescription Drug Optional Rider	71.00	173.55
Total	324.33	785.67
Cigna Healthcare		
Basic	$42.60	$160.40
Prescription Drug Optional Rider	55.57	136.69
Total	98.17	297.09
Empire EPO		
Basic	$151.88	$390.45
Prescription Drug Optional Rider	49.11	120.35
Total	201.00	510.81
Empire HMO-NJ		
Basic	$4.52	$6.69
Prescription Drug Optional Rider	49.11	120.35
Total	53.65	127.05
Empire HMO-NY		
Basic	$13.62	$71.11
Prescription Drug Optional Rider	49.11	120.35
Total	62.75	191.46
GHI-CBP/Empire Blue Cross		
Basic	$0.00	$0.00
Prescription Drug Optional Rider	53.79	98.62
OP Mental Health/IP Chemical Dependency	1.47	3.35
Enhanced NYC Non-Par Provider Schedule	4.98	12.69
Total	60.25	114.68
GHI HMO		
Basic	$24.52	$85.04
Prescription Drug Optional Rider	45.21	115.26
Total	69.75	200.30
HealthNet		
Basic	$65.39	$201.17
Prescription Drug Optional Rider	88.22	228.10

Table B-26 (continued) Employee Monthly Premium New York City Health Benefits Program Effective July 2003		
Enrollment	**Individual**	**Family**
Total	153.61	429.28
HIP Prime HMO		
Basic	$0.00	$0.00
Prescription Drug Optional Rider	63.18	154.80
Appliances and Private Duty Nursing	2.34	5.76
Total	65.52	160.57
HIP Prime POS		
Basic	$0.00	$0.00
Prescription Drug Optional Rider	52.52	126.55
Total	52.52	126.55
Vytra		
Basic	$11.57	$73.58
Prescription Drug Optional Rider	36.75	96.65
Total	48.31	170.23
Source: www.nyc.gov/html/olr/html/healthb/pos_des.html.		

Retired school employees may enroll in a variety of plans, depending on their eligibility for Medicare. The various plans and the associated premiums are shown in the following table. The city reimburses eligible city retirees and their dependents for their Medicare Part B premiums, provided they are enrolled in Part B.

Medicare-eligible retirees who enroll in a Medicare HMO plan receive an 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 City Health Benefits Program, to the HMO enhanced prescription drug coverage. The retiree pays for this coverage through payroll deductions from retired pay. Eligibility for the optional drug coverage is determined automatically, and is not a discretionary election for the retiree.

The table excludes some plans available to NYC retirees that provide HMO coverage in PA and FL. Premiums vary by location in some instances. Not all locations are shown in the table. The complete premium table is available at the web site cited as the source of information at the end of the table.

Table B-27 Retiree Monthly Premium New York City Health Benefits Program Effective July 2003		
Enrollment	**Individual***	**Family**
Aetna HMO – Non-Medicare Eligible		
Basic	$132.21	$326.04
Prescription Drug Optional Rider	75.61	206.70
Total	207.82	532.74
Aetna HMO –Medicare Eligible – NY - 5 Boros		
Basic	$0.00	
Prescription Drug Optional Rider	329.57	
Total	329.57	
Aetna HMO –Medicare Eligible – NJ - Camden		
Basic	$49.42	
Prescription Drug Optional Rider	388.85	
Total	438.27	
Aetna QPOS- Non-Medicare Eligible		
Basic	$551.89	$1,335.54
Prescription Drug Optional Rider	154.70	378.08
Total	706.59	1,713.62
Blue Choice Senior Plan – Medicare Eligible – 5 Boros		
Basic	$0.00	
Prescription Drug Optional Rider	117.52	
Total	117.52	
CIGNA – Non-Medicare Eligible		
Basic	$92.77	$349.46
Prescription Drug Optional Rider	121.05	297.80
Total	231.82	647.27
ElderPlan – Medicare Eligible		
Basic	$0.00	
Prescription Drug Optional Rider	0.00	
Total	0.00	

Table B-27 (continued) Retiree Monthly Premium New York City Health Benefits Program Effective July 2003		
Enrollment	**Individual***	**Family**
Empire EPO – Non-Medicare Eligible		
Basic	$330.87	$850.65
Prescription Drug Optional Rider	106.99	262.18
Total	437.86	1,112.83
Empire HMO – New Jersey – Non-Medicare Eligible		
Basic	$9.88	$14.60
Prescription Drug Optional Rider	106.99	262.18
Total	116.87	276.78
Empire HMO – New York – Non-Medicare Eligible		
Basic	$29.68	$154.89
Prescription Drug Optional Rider	106.99	262.18
Total	136.67	417.07
Empire Medicare Related Coverage		
Basic	$142.02	
Prescription Drug Optional Rider	293.93	
Total	435.95	
GHI-CBP/Empire Blue Cross Blue Shield – Non-Medicare Eligible		
Basic	$0.00	$0.00
Prescription Drug Optional Rider	117.02	214.86
Mental Health & Chemical Dependency Svcs.	3.20	7.30
Enhanced Non-Par Schedule	10.87	27.65
Total	131.09	249.81
GHI-CBP/Empire Blue Cross Blue Shield – Medicare Eligible		
Basic	$0.00	
Prescription Drug Optional Rider	311.24	
365-Day Hospital	5.69	
Total	316.93	
GHI HMO – Non-Medicare Eligible	$53.43	$185.25
Basic	98.49	251.13

Table B-27 (continued) Retiree Monthly Premium New York City Health Benefits Program Effective July 2003		
Enrollment	**Individual***	**Family**
Prescription Drug Optional Rider	151.92	436.38
Total	303.84	872.76
GHI HMO – Medicare Eligible		
Basic	$53.19	
Prescription Drug Optional Rider	479.98	
Total	533.17	
HeatlhNet – Non-Medicare Eligible		
Basic	$142.45	$438.27
Prescription Drug Optional Rider	192.22	496.92
Total	334.67	935.19
Smart Choice – Medicare Eligible – 5 Boros		
Basic	$0.00	
Prescription Drug Optional Rider	305.84	
Total	305.84	
Med Prime – Medicare Eligible – New York Counties		
Basic	$4.31	
Prescription Drug Optional Rider	465.59	
Total	469.90	
HIP Prime HMO – Non-Medicare Eligible		
Basic	$0.00	$0.00
Prescription Drug Optional Rider	137.64	337.26
Appliances & Nursing	5.11	12.54
Total	142.75	349.80
HIP Medicare Cost Plan – Medicare Eligible		
Basic	$99.08	
Prescription Drug Optional Rider	297.13	
Total	396.21	
HIP VIP – Medicare Eligible		
Basic	$0.00	
Prescription Drug Optional Rider	202.58	
Total	202.58	

Table B-27 (continued) Retiree Monthly Premium New York City Health Benefits Program Effective July 2003		
Enrollment	**Individual***	**Family**
HIP Prime POS – Non-Medicare Eligible		
Basic	$215.97	$529.29
Prescription Drug Optional Rider	167.61	410.60
Total	383.58	939.90
Metroplus – Non-Medicare Eligible		
Basic	$0.00	$0.00
Prescription Drug Optional Rider	115.24	275.68
Total	115.24	275.68
Oxford – Medicare Eligible – 5 Boros		
Basic	$0.00	
Prescription Drug Optional Rider	252.43	
Total	252.43	
Vytra – Non-Medicare Eligible		
Basic	$25.22	$160.31
Prescription Drug Optional Rider	80.05	210.57
Total	73.81	370.88
* Per person for Medicare eligible enrollees including retirees and their Medicare-eligible dependents. Source: www.nyc.gov/html/olr/html/healthb/pos_des.html.		

The Comptroller's Annual Finance Report for the City of New York[9] provides a rough approximation of the number of school employees covered by the city's health care plan. The report for the Fiscal Year Ended June 30, 2002, shows that the NYC schools employed 94,162 teachers and 8,158 non-teacher employees for a total of 102,320 employees.

The Finance Report also shows the following data on the total number of city employees and retirees and the amounts spent on health care benefits.

[9] The City of New York Comprehensive Annual Financial Report of the Comptroller for the Fiscal Year Ended June 30, 2003.

Table B-28 Number of Employees, Retirees and Health Care Benefit Expenditures New York City – Fiscal Year Ending June 30, 2002			
	Active Employees	**Retired Employees**	**Total**
Number of Employees	347,237	187,145	534,382
Cost of Health Care	$1,628,206,000	$574,667,000	$2,202,879,000
The City of New York Comprehensive Annual Financial Report of the Comptroller for the Fiscal Year Ended June 30, 2003, p. 75.			

North Carolina

The state of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan provides health care benefits for active and retired teachers and state employees.

The state pays the full cost of health benefits for employee coverage. 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 and receive coverage.

Employees/retirees can also purchase coverage for eligible dependent spouses and children.

Health coverage in the Major Medical Plan includes medical and prescription drugs. Routine dental and vision services are not covered for teachers. However, state employees (not school employees) are eligible to purchase dental and vision coverage through the state's flexible benefits plan (NCFLEX).

Health Care Plans

The health plan is self-funded. BCBS of North Carolina is the present claims processing contractor. BCBSNC has an agreement ("CostWise") with participating doctors that limits the member out-of-pocket responsibility to the plan year deductible, the coinsurance amount, the $15 professional services copayment, and charges for services not covered by the plan. CostWise participating doctors file all claims, and do not bill the patient for charges that exceed the plan's usual, customary, and reasonable (UCR) allowance.

Members who see providers that do not participate in CostWise may be responsible for filing the claim and will be responsible for paying any charge that is above the plan's UCR allowance.

Active employees pay the following premiums for coverage. The state pays the full cost for employee coverage, and employees pay the full cost for dependent coverage.

Table B-29 State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan Monthly Premiums – Active Employees Effective October 1, 2003			
Enrollment Category	**State Contribution**	**Employee Contribution**	**Total Cost**
Employee Only	$285.92	$0	$285.92
Employee/Child(ren)	$285.92	$178.22	$464.14
Employee/Family	$285.92	$427.48	$713.40
Source: http://statehealthplan.state.nc.us/yourbenefits/2003RateSheet.htm.			

Retired employees eligible for Medicare pay the following premiums for coverage.

Table B-30 State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan Monthly Premiums – Retired Employees with Medicare Effective October 1, 2003			
Enrollment Category	**State Contribution**	**Retiree Contribution**	**Total Cost**
Employee only	$217.66	$0	$217.66
Employee/Child(ren)			
Employee Medicare Eligible	$217.66	$178.22	$395.88
Child(ren) Medicare Eligible	$285.92	$135.46	$421.38
Employee and Child(ren) Medicare Eligible	$217.66	$135.46	$353.12
Employee and Family			
Employee Medicare Eligible	$217.66	$427.48	$645.14
Dependent(s) Medicare Eligible	$285.92	$324.88	$610.80
Employee and Dependent(s) Medicare Eligible	$217.66	$324.88	$542.54
Source: http://statehealthplan.state.nc.us/yourbenefits/2003RateSheet.htm.			

The North Carolina Comprehensive Financial Report for the fiscal year ended on June 30, 2002, indicates that during the fiscal year the State Health Plan paid claims amounting to $1.182 billion. This total includes claims paid for active and retired participants who were schoolteachers, state employees' or other employees eligible to participate. The financial report also indicates that cost savings of between $240 million and $300 million were implemented as of July 1, 2001. Measures included higher dependent premiums, benefit reductions, and reduced payments to providers.

Ohio

Health benefits for active teachers and school employees are provided by the local school district.

Health benefits for retired teachers, and health benefits for survivors of deceased active teachers are provided through the State Teachers Retirement System of Ohio (STRS). The STRS Board recently adopted a provision increasing the service requirement to qualify for health care benefits from 5 to 15 years for those retiring after January 1, 2004. Current retirees with less than 15 years of service credit must now pay 100% of cost for coverage.

Established in 1937, health benefits for retired non-teaching public school employees are provided through the School Employees Retirement System of Ohio (SERS). The Ohio legislature has determined that health coverage for participants in the five state public employee retirement systems should be about the same. The cost is paid through participant premiums (based on years of service - 75% at 10 yrs; 50% at 15 yrs; 25% at 20 yrs; and 0% with 25 years) and a surcharge paid by the local school districts (percentage of covered payroll).

Health Care Plans

Table B-31 shows the retiree and dependent premium rates for the School Employees Retirement System (SERS) of Ohio for 2003.

Table B-31
School Employees Retirement System of Ohio
Retiree and Dependent Monthly Premiums
2003

Years of Service	Medical Mutual or Aetna PPO	AultCare PPO	Kaiser HMO	Aetna HMO	Paramount HMO*
Without Medicare A					
10-14.999	$305.00	$177.00	$223.00	$321.00	$440.00
15-19.999	$203.00	$118.00	$149.00	$214.00	$293.00
20-24.999	$102.00	$59.00	$74.00	$107.00	$147.00
With Medicare A					
10-14.999	$56.00	0	$60.00	$67.00	$69.00
15-19.999	$38.00	0	$40.00	$45.00	$46.00
20-24.999	$18.00	0	$20.00	$22.00	$23.00
Dependent Premiums					
Spouses Not Eligible for Medicare A	$157.00	$17.00	$208.00	$210.00	$411.00
Spouse with Medicare A	$51.00	0	$56.00	$63.00	$64.00
Dependent Child	$44.00	0	$38.00	$68.00	$148.00

Tables B-32 through B-34 show the monthly premium rates for the State Teachers Retirement System (STRS) of Ohio.

Table B-32
State Teachers Retirement System of Ohio
Monthly Health Care Premiums
Indemnity and Preferred Provider Organization (PPO)
2004

	Aetna Plus		Medical Mutual Plus		Aetna Catastrophic	
Years of Service	**STRS Ohio Cost**	**Employee Premium**	**STRS Ohio Cost**	**Employee Premium**	**STRS Ohio Cost**	**Employee Premium**
30+	$552	$146	$541	$135	$429	$114
29	$552	$160	$541	$149	$429	$124
28	$552	$173	$541	$162	$429	$135
27	$552	$187	$541	$176	$429	$145
26	$552	$200	$541	$189	$429	$156
25	$552	$214	$541	$203	$429	$166
24	$552	$227	$541	$216	$429	$177
23	$552	$241	$541	$230	$429	$187
22	$552	$254	$541	$243	$429	$198
21	$552	$268	$541	$257	$429	$208
20	$552	$281	$541	$270	$429	$219
19	$552	$295	$541	$284	$429	$229
18	$552	$309	$541	$298	$429	$240
17	$552	$322	$541	$311	$429	$250
16	$552	$336	$541	$325	$429	$261
15	$552	$349	$541	$338	$429	$271
Less than 15	$552	$552	$541	$541	$429	$429

Table B-33
State Teachers Retirement System of OHIO
Monthly Health Care Premiums
Preferred Provider Organization (PPO)
2004

	Medical Mutual Catatrophic		AultCare	
Years of Service	**STRS Ohio Cost**	**Employee Premium**	**STRS Ohio Cost**	**Employee Premium**
30+	$420	$105	$417	$40
29	$420	$115	$417	$40
28	$420	$126	$417	$40

Table B-33 (continued) State Teachers Retirement System of OHIO Monthly Health Care Premiums Preferred Provider Organization (PPO) 2004				
27	$420	$136	$417	$52
26	$420	$147	$417	$65
25	$420	$157	$417	$79
24	$420	$168	$417	$92
23	$420	$178	$417	$106
22	$420	$189	$417	$119
21	$420	$199	$417	$133
20	$420	$210	$417	$146
19	$420	$220	$417	$160
18	$420	$231	$417	$174
17	$420	$241	$417	$187
16	$420	$252	$417	$201
15	$420	$262	$417	$214
Less than 15	$420	$420	$417	$417

Table B-34 State Teachers Retirement System of OHIO Monthly Health Care Premiums Commercial Health Maintenance Organization (HMO) 2004				
	Kaiser Permanente		Paramount Health Care	
Years of Service	STRS Ohio Cost	Employee Premium	STRS Ohio Cost	Employee Premium
30+	$424	$40	$511	$105
29	$424	$40	$511	$119
28	$424	$45	$511	$132
27	$424	$59	$511	$146
26	$424	$72	$511	$159
25	$424	$86	$511	$173
24	$424	$99	$511	$186
23	$424	$113	$511	$200
22	$424	$126	$511	$213
21	$424	$140	$511	$227
20	$424	$153	$511	$240
19	$424	$167	$511	$254
18	$424	$181	$511	$268
17	$424	$194	$511	$281
16	$424	$208	$511	$295

Table B-34 (continued) State Teachers Retirement System of OHIO Monthly Health Care Premiums Commercial Health Maintenance Organization (HMO) 2004				
15	$424	$221	$511	$308
Less than 15	$424	$424	$511	$511

Oregon

The State of Oregon provides benefits to all its public employees through the Public Employees' Benefit Board (PEBB). The PEBB was established in 1997 and has the authority to purchase and oversee health and welfare benefits for more than 43,000 employees of the State of Oregon and their dependents.

Full-time employees are eligible for medical and dental insurance coverage as long as they are at work in regular paid status, scheduled for work during the month for which insurance coverage is requested, or using accrued leave on the effective date of coverage. Part-time employees are also eligible for coverage as long as they work at least eighty (80) hours per month.

Table B-35 2004 Medical Plan Monthly Premium Rates				
	Employee	**Employee & Spouse/ Partner**	**Employee & Child(ren)**	**Employee & Family**
Kaiser Permanente HMO (with Kaiser routine vision service)	$462.58	$689.23	$541.22	$721.62
Regence BCBSO PPO (with VSP routine vision service)	492.23	731.52	574.36	766.33
Part-time & Retiree Kaiser Permanente HMO	410.79	612.06	480.63	640.84
Part-time & Retiree Regence BCBSO PPO	401.24	598.72	469.74	626.94

Table B-36 2004 Dental Plan Monthly Premium Rates				
	Employee	**Employee & Spouse/ Partner**	**Employee & Child(ren)**	**Employee & Family**
Kaiser Permanente	$68.21	$101.63	$79.81	$106.40
ODS Preferred	53.66	79.94	62.78	83.71
ODS Traditional	58.15	86.64	68.04	90.71
Willamette Dental	48.10	71.67	56.28	75.03
ODS Part-time & Retiree Low Option	42.56	63.42	49.80	66.40

The following are rates for the medical plan available to all PEBB members who are enrolled through the retiree program.

Table B-37 Retiree 2004 Medical Plan Monthly Premium Rates				
	Self	**Self & Spouse/ Partner**	**Self & Child(ren)**	**Self & Family**
Kaiser Permanente HMO	$466.26	$694.71	$545.52	$727.36
Regence BCBSO PPO	496.15	737.34	578.93	772.41
Kaiser Part-time & Retiree HMO	414.06	616.93	484.45	645.94
egence BCBSO Part-time & Retiree PPO	404.43	603.48	473.48	631.92

South Carolina

Active and retired public school employees participate in the South Carolina Employee Insurance Program (EIP).

Medical benefits are provided through seven plans: two Preferred Provider Organization (PPO) plans (State Health Plan economy and standard plans); two traditional HMOs (Companion HMO, Cigna HMO); and three HMOs with POS options (Companion-Choices POS, Cigna POS, MUSC Options).

Dental benefits are provided through two plans, the State Dental Plan (basic coverage) and Dental Plus.

There is no separate vision insurance plan. However, the EIP has negotiated statewide limits on provider charges and established a discount plan available to employees.

The state shares in the cost of health insurance for active and retired as shown in tables below. Retired employees qualify for a state contribution towards health benefits if they meet certain age and service requirements. Retirees who do not meet these minimums may still qualify for continuation of health benefits after active service but they must pay the full premium.

The South Carolina Budget and Control Board administers the program.

Health Care Plans

Not all health care plans are available statewide. The state is divided into 12 health benefit service areas by county as shown in Table B-38. The table shows the availability of each state employee health insurance plan by service area.

Table B-38
Health Insurance Benefit Plans for South Carolina State and School Employees

Service Area/County	State Health Plans		Traditional HMO		HMO With POS Option		
	Economy	Standard	Companion	CIGNA	Companion	CIGNA	MUSC
1. Anderson, Greenville, Oconee, Pickens	X	X			X	X	
2. Cherokee, Spartanburg, Union	X	X		X	X		
3. Chester, Lancaster, York	X	X	X	X			
4. Abbeville, Greenwood, Laurens, McCormick, Saluda	X	X	X				
5. Fairfield, Kershaw, Lexington, Newberry, Richland	X	X	X			X	
6. Aiken, Barnwell, Edgefield	X	X	X				
7. Allendale, Bamberg, Calhoun, Orangeburg	X	X	X	X			
8. Clarendon, Lee, Sumpter	X	X	X	X			

Table B-38 (continued) Health Insurance Benefit Plans for South Carolina State and School Employees							
Service Area/County	**State Health Plans**		**Traditional HMO**		**HMO With POS Option**		
	Economy	Standard	Companion	CIGNA	Companion	CIGNA	MUSC
9. Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	X	X	X	X			
10. Georgetown, Horry	X	X	X	X			
11. Berkeley, Charleston, Colleton, Dorchester	X	X	X	X			X
12. Beaufort, Hampton, Jasper	X	X	X	X			
Source: South Carolina Insurance Program, Insurance Orientation and Education Handbook, 2003, p. 9.							

Table B-39 shows the employer and employee contribution to health care premiums for active school employees.

Table B-39 Total Monthly Premiums for South Carolina Employee Health Insurance Benefits Active Employees 2003			
Plan/Enrollment Category	**Employer Share**	**Employee Share**	**Total Premium**
State Health Plan – Economy			
Employee	$206.70	$47.44	$254.14
Employee/Spouse	404.12	132.04	536.16
Employee/Children	312.60	77.06	389.66
Full Family	466.72	168.12	634.84
State Health Plan – Standard			
Employee	$206.70	$50.46	$257.16
Employee/Spouse	404.12	151.60	555.72
Employee/Children	312.60	87.48	400.08
Full Family	466.72	196.60	663.32
Companion HMO			
Employee	$206.70	$45.54	$252.24
Employee/Spouse	404.12	149.28	553.40
Employee/Children	312.60	124.70	437.30
Full Family	466.72	288.46	755.18

Table B-39 (continued) Total Monthly Premiums for South Carolina Employee Health Insurance Benefits Active Employees 2003			
Plan/Enrollment Category	**Employer Share**	**Employee Share**	**Total Premium**
CIGNA HMO			
Employee	$206.70	$55.14	$261.84
Employee/Spouse	404.12	170.48	574.60
Employee/Children	312.60	141.42	454.02
Full Family	466.72	317.44	784.16
Companion Choices POS			
Employee	$206.70	$53.56	$260.26
Employee/Spouse	404.12	166.96	571.08
Employee/Children	312.60	138.66	451.26
Full Family	466.72	312.66	779.38
CIGNA POS			
Employee	$206.70	$70.74	$277.44
Employee/Spouse	404.12	204.92	609.04
Employee/Children	312.60	168.60	481.20
Full Family	466.72	364.50	831.22
MUSC Options POS			
Employee	$206.70	$49.90	$256.60
Employee/Spouse	404.12	146.64	550.76
Employee/Children	312.60	106.78	419.38
Full Family	466.72	234.90	701.62
Source. South Carolina Employee Insurance Program, Insurance Orientation and Education Handbook, 2003, p. 25.			

Table B-40 shows premium information for the two dental benefit plans for active employees.

Table B-40 Total Monthly Premiums for South Carolina Employee Dental Benefits Active Employees 2003			
Plan/Enrollment Category	**Employer Share**	**Employee Share**	**Total Premium**
Dental			
Employee	$11.71	$0.00	$11.71
Employee/Spouse	11.71	7.64	19.35
Employee/Children	11.71	13.72	25.43
Full Family	11.71	21.34	33.05

Table B-40 (continued) Total Monthly Premiums for South Carolina Employee Dental Benefits Active Employees 2003			
Plan/Enrollment Category	**Employer Share**	**Employee Share**	**Total Premium**
Dental Plus			
Employee	$11.71	$15.50	$27.21
Employee/Spouse	11.71	29.34	41.05
Employee/Children	11.71	32.02	43.73
Full Family	11.71	45.86	57.57
Source. South Carolina Employee Insurance Program, Insurance Orientation and Education Handbook, 2003, p. 25.			

Retirees who qualify for continuing health care coverage following active service may enroll in one of several options, depending on whether they are eligible for Medicare. The benefits are the same as were provided during active service.

The following table summarizes the available plans and the premiums for retiree coverage in the case where both the retiree and the retiree's spouse are Medicare eligible. Column (2) in the table is the amount the retiree must pay if he or she qualifies for a state contribution to retiree medical coverage. Column (3) is the amount the retiree must pay if he or she is required to pay all of the premium.

The state health care benefit is secondary payer for retirees who are Medicare eligible. The state plan pays benefits assuming the retiree is enrolled in Medicare Parts A and B.

Table B-41 Total Monthly Premiums for South Carolina Health Care Benefits Retiree and Spouse Eligible for Medicare 2003		
Plan/Enrollment Category **Col (1)**	**Employee Share (Qualifies for State-Funded Benefits)** **Col (2)**	**Employee Share (Does Not Qualify for State-Funded Benefits)** **Col (3)**
State Health Plan – Economy		
Retiree	Not Available	Not Available
Retiree/Spouse	Not Available	Not Available
Retiree/Children	Not Available	Not Available
Full Family	Not Available	Not Available
State Health Plan – Standard		
Retiree	$35.74	$242.44
Retiree/Spouse	124.44	528.56
Retiree/Children	72.76	385.36
Full Family	161.46	628.18

Table B-41 (continued) Total Monthly Premiums for South Carolina Health Care Benefits Retiree and Spouse Eligible for Medicare 2003		
Plan/Enrollment Category **Col (1)**	**Employee Share (Qualifies for State-Funded Benefits)** **Col (2)**	**Employee Share (Does Not Qualify for State-Funded Benefits)** **Col (3)**
Medicare Supplemental		
Retiree	$53.74	$260.44
Retiree/Spouse	160.44	564.56
Retiree/Children	90.76	403.36
Full Family	197.46	664.18
Companion – HMO		
Retiree	$45.54	$252.24
Retiree/Spouse	149.27	553.39
Retiree/Children	124.69	437.29
Full Family	288.46	755.18
CIGNA HMO		
Retiree	$55.14	$261.84
Retiree/Spouse	170.48	574.60
Retiree/Children	141.42	454.02
Full Family	317.44	784.16
Companion Choices POS		
Retiree	$53.56	$260.26
Retiree/Spouse	166.98	571.10
Retiree/Children	138.66	451.26
Full Family	312.66	779.38
CIGNA POS		
Retiree	$70.73	$277.43
Retiree/Spouse	204.91	609.03
Retiree/Children	168.59	481.19
Full Family	364.50	831.22
MUSC Options POS		
Retiree	Not Available	Not Available
Retiree/Spouse	Not Available	Not Available
Retiree/Children	Not Available	Not Available
Full Family	Not Available	Not Available
Source: South Carolina Employee Insurance Program, State Insurance Benefits Options for Retirees, 2003, pp. 51-52.		

Table B-42 presents similar information for retirees and spouses who are not Medicare eligible. Note that premiums for the HMOs and HMOs with POS options are the same for both Medicare and non-Medicare eligibles.

Table B-42
Total Monthly Premiums for South Carolina Health Care Benefits
Retiree and Spouse Not Eligible for Medicare
2003

Plan/Enrollment Category Col (1)	Employee Share (Qualifies for State-Funded Benefits) Col (2)	Employee Share (Does Not Qualify for State-Funded Benefits) Col (3)
State Health Plan – Economy		
Retiree	$47.44	$254.14
Retiree/Spouse	132.04	536.16
Retiree/Children	77.06	389.66
Full Family	168.12	634.84
State Health Plan – Standard		
Retiree	$50.46	$257.16
Retiree/Spouse	151.50	555.62
Retiree/Children	87.48	400.08
Full Family	196.60	663.32
Medicare Supplemental		
Retiree	Not Available	Not Available
Retiree/Spouse	Not Available	Not Available
Retiree/Children	Not Available	Not Available
Full Family	Not Available	Not Available
Companion – HMO		
Retiree	$45.54	$252.24
Retiree/Spouse	149.27	553.39
Retiree/Children	124.69	437.29
Full Family	288.46	755.18
CIGNA HMO		
Retiree	$55.14	$261.84
Retiree/Spouse	170.48	574.60
Retiree/Children	141.42	454.02
Full Family	317.44	784.16
Companion Choices POS		
Retiree	$53.56	$260.26

Table B-42 (continued) Total Monthly Premiums for South Carolina Health Care Benefits Retiree and Spouse Not Eligible for Medicare 2003		
Plan/Enrollment Category **Col (1)**	**Employee Share (Qualifies for State-Funded Benefits)** **Col (2)**	**Employee Share (Does Not Qualify for State-Funded Benefits)** **Col (3)**
Retiree/Spouse	166.98	571.10
Retiree/Children	138.66	451.26
Full Family	312.66	779.38
CIGNA POS		
Retiree	$70.73	$277.43
Retiree/Spouse	204.91	609.03
Retiree/Children	168.59	481.19
Full Family	364.50	831.22
MUSC Options POS		
Retiree	$49.90	$256.60
Retiree/Spouse	146.64	550.76
Retiree/Children	106.78	419.38
Full Family	234.90	701.62
Source: South Carolina Employee Insurance Program, State Insurance Benefits Options for Retirees, 2003, pp. 51-52.		

Virginia

The Commonwealth of Virginia provides The Local Choice (TLC) Health Benefits Program to local governments, local officers, teachers, commissions, public authorities, and other organizations created by or under an act of the General Assembly. The General Assembly was directed to create a program for local jurisdictions similar to the state employee program to assist local areas that were having difficulties procuring benefits for their employees. Approximately one fourth of eligible employees are currently enrolled in the program with more than 37,000 local employees and dependents covered.

Those school districts that choose not to participate in the program obtain their benefits by contracting directly for employee health benefits.

Full-time and salaried instructional, clerical, and administrative employees of local Virginia school divisions are eligible for membership in the Virginia Retirement System (VRS). The VRS administers a defined benefit plan, a group life insurance plan, a deferred compensation plan, and a cash match plan for Virginia's public sector employees. The VRS currently administers benefits for over 310,000 of Virginia's public employees.

Health Care Plans

TLC offers five self-insured statewide plans and eight fully insured regional plans for active employees. Five options are available to Medicare eligible retirees. The Department of Human Resources Management of the State of Virginia administers the program. The majority of these individuals are enrolled in the Key Advantage or Key Advantage with Expanded Benefits through Anthem Blue Cross and Blue Shield.

The Kaiser HMO plan is a regional plan and their rates are listed below in Table B-43.

Table B-43
Local Choice Monthly Premiums
Active Employees
Rates Effective 2003/2004

Coverage	Kaiser HMO
Employee Single	$291
Two Person	$538
Family	$786

The following self-funded statewide TLC health care plans are available to active school employees and non-Medicare retirees in participating districts and local jurisdictions.

Standard Package – Administered by Anthem Blue Cross and Blue Shield
- Key Advantage
- Key Advantage with Expanded Benefits
- Cost Alliance with Dental

Value Package – Administered by Anthem Blue Cross and Blue Shield
- KeyShare
- KeyShare with Expanded Benefits
- Value Alliance with Dental

The following TLC health care plans are available to supplement Medicare. Anthem Blue Cross and Blue Shield administer these plans.

- Advantage 65
- Dental/Vision Plan Offered with Advantage 65
- Medicare Complementary

Employee plus one and family rates are calculated based on the single employee rate. The employee plus one rate is the single coverage multiplied by 1.85 and the family rate is equal to the single rate multiplied by 2.70.

Although employer premium contributions differ among the various local groups, there is a required minimum employer contribution that must be made and is outlined in the following table.

Table B-44 Required Minimum Employer Contribution	
Full time single	80%
Additional cost of dependent	20%
Part-time single	40%
Additional cost for part time dependent coverage	10%

During the annual renewal process, an employer has the option of changing program benefit design. Groups with 25 or fewer eligible employees may select only one benefit plan.

The table below shows total enrollment in TLC for the past five years.

Table B-45 Total Employee Enrollment in The Local Choice	
Fiscal Year	**Total Enrollment**
1998	19,711
1999	22,366
2000	22,247
2001	21,695
2002	21,344

Appendix C

Actuarial Assumptions and Methodology

Actuarial Assumptions and Methodology

Composite Rates

Some of the school districts reported two tiers of premium rates (employee and family), while others reported three tiers of premium rates (employee, employee plus one, and family. For the analysis we developed composite rates for each school district using the following formulae.

Two tier plans

Composite Rate = Employee rate * 0.25 + Family rate * 0.75

Three tier plans

Composite Rate = Employee rate * 0.25 + Employee plus one rate * 0.30 + Family rate * 0.45

Actuarial Methodology for Determining Savings

For each of the LEAs included in the cost comparison we developed a composite premium rate using a blend of the employee, employee +1, and family premium rates for each of the different plans offered to LEA employees (i.e. FFS, POS, PPO, and HMO). Symbolically, let P^F be the premium for the FFS plan, P^S be the premium for the POS plan, and P^P be the premium for the PPO.

Each LEA selected one plan as their "primary plan" being the plan with the largest enrollment. For each LEA we collected detailed plan design information for the primary plan and using a suite of proprietary actuarial programs, determined the Benefit Value Comparison (BVC) value for that plan. Symbolically, let B^F be the BVC value for the primary plan if the primary plan is the FFS plan. The value of the other plans was estimated as the BVC value for the primary plan multiplied by the ratio of the other plan's composite premium rate divided by the composite premium rate for the primary plan.

Similarly, for the PEBTF plans, we developed composite premium rates, C^F for the premium for the FFS plan, C^S for the premium for the POS plan, and C^P for the premium for the PPO, and Benefit Value Comparison values for each of the plans. Let ${}_{PEBTF}B^F$ represent the BVC value for the FFS plan, ${}_{PEBTF}B^S$ for the POS plan, and ${}_{PEBTF}B^P$ for the PPO plan.

The premiums for the LEA plans were adjusted to reflect the fact that the LEA plans cover both employees and pre-65 retirees. A common adjustment factor was used for the FFS, POS, and PPO plan premiums. The adjusted premium AP^F, represents the premium that would be charged for FFS plan if it only covered active employees.

The premiums for the PEBTF plans were adjusted to reflect the differences in the demographic composition of the PEBTF members from the LEA members. Thus AC^F represents the composite premium for the PEBTF FFS plan, adjusted to reflect the premium that would be charged if the covered population had the age and gender composition of the LEA members.

The estimate of the savings that could be achieved through negotiating lower rates with health care carriers was the determined as the sum for each LEA of

$$\text{Enrollment in the FFS plan x } (AP^F - \frac{AC^F \times B^F}{PEBTF B^F})$$

$$\text{Plus enrollment in the POS plan x } (AP^S - \frac{AC^S \times B^S}{PEBTF B^S})$$

$$\text{Plus enrollment in the PPO plan x } (AP^P - \frac{AC^P \times B^P}{PEBTF B^P})$$

It was assumed that there would be no savings for members enrolled in HMOs.

Indirect Subsidy

When retirees under age 65 are enrolled in an active health plan, their average costs are usually significantly higher than the average cost for all other active plan participants. When these "early retirees" are required to pay the COBRA premium as a condition of eligibility for coverage, this premium understates the true cost of their coverage and they are in effect receiving an indirect subsidy.

We estimated the indirect subsidy using a set of aging factors that represent the relative cost of health care by age. These factors were developed from data obtained from the 1998 Medical Expenditure Panel Survey, a nationally representative survey of U.S. civilian non-institutionalized population. The MEPS is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS).

Table C-1
Aging Factors

Age Group	Aging Factor
Less than 20	0.504
20-24	0.595
25-29	0.629
30-34	0.735
35-39	0.752
40-44	0.827
45-49	0.980
50-54	1.110
55-59	1.383
60-64	1.506
65+	1.605
Actives	1.000
Retirees	1.506

Table C-1 shows that the indirect subsidy for retirees age 60-64 is $506 for every $1,000 of premium.

The surveys sent to school districts reported that there were 10,000 retirees covered under the plans and over 3,000 dependents of retirees. The surveys also included the number of participants on COBRA, and as under Pennsylvania law, COBRA can continue until the retirees attain age 65, we included a portion of these COBRA participants (where the number of COBRA participants was above 2 percent of the number of active employees).

Of these retirees, most are in LEAs who reported the coverage stopped at age 65 and some provided both pre-65 and post-65 coverage. From data on the number and ages of PSERS annuitants, we noted that 25 percent are under age 65. Therefore for LEAs that provided both pre- and post-65 coverage, we assumed that 25 percent of them were under age 65. This methodology produced a pre-65 retiree count of 7,200. Table C-2 shows the development of the estimated number of pre-65 retirees who are covered under the LEA health plans.

Table C-2
Estimated Number of Pre-65 Retirees Covered by LEAs in Health Plans

1. Number of pre-65 retirees reported in surveys, adjusted for COBRA participants	7,200
2. Number of active employees reported in these surveys	60,000
3. Number of pre-65 retirees per employee	0.12
4. Total number of school employees	240,000
5. Estimated number of pre-65 retirees	28,800
6. Dependents of retirees (30% x 5.)	8,640
7. Total number of retirees covered by LEAs (5. + 6.)	37,440

Finally, in Table C-3 we develop the estimate for the indirect subsidy being borne by the LEA health plans from covering early retirees.

Table C-3
Estimated Subsidy From Covering Pre-65 Retirees in the LEAs Health Plans

1. Estimated number of pre-65 retirees and dependents covered by LEAs in Health Plans	37,440
2. Average monthly non-HMO premium per employee	$297
3. Estimated monthly subsidy per retiree (50.6% x 2.)	$150
4. Estimated total annual subsidy (1. x 3. x 12)	$67,392,000

Table C-3 shows that the estimated cost of covering early retirees in the same plan as the active employees is about $67 million. That is, if retirees were covered under a separate plan, we would expect the aggregate claims cost for the LEAs to decline by $67 million more than the reduction in premiums.

Prescription Drug Rebates

Large employers who carve out their prescription drug coverage into a separate plan typically use a Pharmacy Benefit Manager (PBM) to administer these benefits. Contracts with the PBMs include all aspects of the benefit design, administration, and cost of filling prescriptions. These contracts often include formulary rebates for each prescription filled through mail order or retail pharmacies.

The PEBTF has such a contract that in the year ending June 30, 2003, produced rebates totaling $4,284,000 for their active employees, or an average of $50 per employee.

About one third of LEAs have managed pharmacy programs with formulary rebates similar to the PEBTF arrangement.

Table C-4 shows the development of the estimated savings from applying the PEBTF contract terms to all LEAs.

Table C-4
Estimated Pharmacy Rebate Savings

	Education Employees	Current Rebate Per Employee	Optimum Rebate Per Employee	Savings Per Employee	Total Annual Savings
With Formularies	84,000	$46	$50	$4	$336,000
Without Formularies	156,000	$0	$50	$50	$7,800,000
Total	**240,000**				**$8,136,000**

Stop-Loss Premiums

From the data we collected we found that 93 LEAs covering 117,000 employees and dependents purchased stop loss insurance to limit their self-funded claims costs in 2003. While individual and aggregate stop-loss insurance is often useful when managing the costs for an individual health plan, this type of insurance would not be needed if employees were covered by a Commonwealth-wide plan. Accordingly, the stop-loss premiums, net of recoveries, would be another opportunity for savings.

Table C-5 2003 Individual Stop Loss				
Stop-Loss Level	**Number of LEAs**	**Monthly Premium Per Member**	**Number of Members**	**Total Annual Cost**
$50,000 - $75,000	16	$ 20.46	20,189	$ 4,956,552
$75,001 - $90,000	7	$ 25.22	8,236	$ 2,492,556
$90,001 - $125,000	8	$ 19.52	23,347	$ 5,467,686
$ 150,000	21	$ 13.66	27,455	$ 4,499,639
$ 200,000	24	$ 11.97	23,357	$ 3,354,766
$ 250,000	7	$ 11.54	6,586	$ 912,368
$ 300,000	11	$ 6.41	7,790	$ 599,462
Total	**94**		**116,960**	**$ 22,283,029**

Table C-6 2003 Aggregate Stop Loss Premiums				
Aggregate Stop Loss Level	**Number of School Districts**	**Average Monthly Premium Per Covered Life**	**Total Number of Covered Lives**	**Total Annual Premium**
120%	13	$1.18	18,937	$ 268,148
125%	22	$1.09	10,976	$ 143,566
	35		29,913	$ 411,714

Estimate of Savings

For the stop-loss premiums, we estimate about 40 percent of the premium accounts for underwriting, commissions, claims administration, and contribution to surplus, with 60 percent used to pay claims above the attachment level. The survey data covered 142,000 employees out of a system wide population of 240,000 employees. Table C-7 shows the development of the estimated savings attributable to individual stop-loss premiums.

Table C-7 Estimate of Savings From Cancellation of Stop-Loss Premiums	
1. Amount of premiums paid in 2003 • Individual • Aggregate • Total	 $22,283,029 $ 411,714 22,694,743
2. Portion not used for paying claims	40 percent
3. Ratio of total school population to school employees included in surveys	240,000 / 142,000 = 1.69
4. Estimated savings (1 x 2 x 3)	$15,342,925

Appendix D

Discussion of Pennsylvania Blue Cross and Blue Shield Organizations

Discussion of Pennsylvania Blue Cross and Blue Shield Organizations

National Background

For more than fifty years, Blue Cross organizations have been providing hospitalization coverage and Blue Shield organizations have been providing coverage for other medical services, e.g. physicians, tests, etc. in all 50 states.

These organizations are members of the Blue Cross Blue Shield Association, which was created in 1982 with the merger of the Blue Cross Association and the National Association of Blue Shield Plans.

Historically, some states had statewide Cross plans. Other states, particularly those with large populations, maintained different Cross plans in different regions of the state.

Prior to the 1982 Association merger, most states had separate Cross and Shield organizations, with the Shield plans typically being statewide. Since that merger, many state Blue organizations have merged their Cross and Shield organizations.

In addition, many states that maintained separate regional Cross plans merged them into one state plan. Further, in the last decade, there has been a movement for plans across states to merge, or be affiliated.

Major reasons for Blue organization consolidations include efficiency (economies of scale) and ability to better compete for employer-based business that spans regions and states.

Current National Situation

According to the Blue Cross Blue Shield Association, current Cross and Shield organizations are structured as follows:

- Forty-four states have one consolidated Cross and Shield organization for the entire state
- Seven of the above are consolidated under Anthem, and two under Wellmark (Maryland and Washington DC are consolidated under CareFirst)
- California, Idaho, and Washington state have separate statewide Cross and Shield organizations
- Missouri, New York, and Pennsylvania have two or more regional Cross plans

Current Pennsylvania Situation

Currently there are four regional Blue Cross organizations in Pennsylvania:

- Independence Blue Cross servicing the greater Philadelphia area
- Highmark Blue Cross servicing western PA
- Capital Blue Cross servicing the capital region and the greater Allentown/ Bethlehem/ Easton area
- Blue Cross of Northeastern PA

Historically, Pennsylvania had a separate Blue Shield organization called Pennsylvania Blue Shield (PABS). A few years ago, Highmark Blue Cross acquired PABS and was then able to provide Cross and Shield services on a consolidated basis in Western PA. In addition, PABS continued to offer Shield services in other regions in the state in partnership with the three other Cross organizations.

In 2000 and 2001, Highmark and Capital negotiated concerning their relationship. Highmark wanted to acquire Capital while Capital wished to remain independent and acquire the PABS business in their region. The two organizations were unable to reach agreement and in 2002 both organizations began to compete with each other and by each offering complete Cross/Shield coverage in the Capital region. PABS continues to partner with Independence and Northeastern Blue Cross in providing Shield coverage.

Forecast

As indicated above, Blue Cross and Blue Shield organizations have been consolidating to give them economies of scale efficiencies and greater ability to compete for business from organizations that are geographically dispersed. It is likely that this trend will continue.

Pennsylvania is one of only six states that does not have a consolidated statewide Blue Cross/Blue Shield organization. It appears likely that some consolidation within the Pennsylvania Blue organizations will occur in the next few years. The most likely change would be the acquisition of Capital and/or Northeastern by either Highmark or Independence.

Discussion of Pennsylvania HMOs

In Pennsylvania, a large portion of employer-provided medical insurance is provided by the four Blue Cross organizations:

- Independence Blue Cross
- Highmark Blue Cross
- Capital Blue Cross

- Blue Cross of Northeastern Pennsylvania

For HMO coverage, the above Blue Cross plans offer the "Keystone Health Plan", which has "East, Central, and West" plans.

Aetna is the largest commercial medical insurer in Pennsylvania. It also provides separate HMO plans in the east, central and western regions of the state.

In addition, there are currently eighteen other HMOs in Pennsylvania. The complete list of HMOs is shown below.

Advantage Health Plan Pittsburgh, PA
Aetna US Healthcare Wayne, PA
Aetna US Healthcare Pittsburgh, PA
Aetna US Healthcare Harrisburg, PA
Aetna US Healthcare, Inc. Blue Bell, PA
Alliance Health Network Erie, PA
AmeriHealth Philadelphia, PA http://www.amerihealth.com/
Best Healthcare of Western Pennsylvania Pittsburgh, PA
CIGNA Healthcare of Delaware Valley
First Priority Health Wilkes-Barre, PA http://www.bcnepa.com/
HealthAmerica - Eastern Region Harrisburg, PA
HealthAssurance HMO Pittsburgh, PA
Healthcare Management Alternatives, Inc. dba HMA Health Plan Philadelphia, PA
HealthCentral, Inc. Harrisburg, PA
HealthGuard Lancaster, PA
HIP Health Plan of Pennsylvania Trevose, PA
Intracorp Philadelphia, PA
Keystone Health Plan Central Camp Hill, PA
Keystone Health Plan East Philadelphia, PA
Keystone Health Plan West Pittsburgh, PA
Medigroup HMO of Pennsylvania Philadelphia, PA
NYLCare Plans of the Atlantic, Inc. Wayne, PA
Oxford Health Plans Oaktree Health Plan of Penn., Inc. Philadelphia, PA
Penn State Geisinger Health Plan Danville, PA www.psghs.edu/health_plan/index.htm
PhilCare Health Systems Philadelphia, PA
QualMed Plans for Health, Inc. QualMed Philadelphia Health Plan Philadelphia, PA
UPMC Health Plan Pittsburgh, PA

Appendix E

Pennsylvania Public School Health Care Benefits Survey for School Districts

Pennsylvania Public Schools

Health Care Benefits Survey

Completed by School Districts

Purpose: The Pennsylvania Legislative Budget and Finance Committee has authorized a study to determine the feasibility of placing public school employees under the Commonwealth's jurisdiction for the purposes of providing health benefits. Organizations who complete and return the survey will receive a summary of the survey results.

Completed by: **Name:** _____

Title: _____

Phone: _____

AUN Number (9 digits): _____

County: _____

Address: _____

_____

City, Zip: _____

_____

Fax: _____

E-mail: _____

complete data submission due ***August 22, 2003***

- All Material Is Kept Confidential -

HayGroup

General Instructions

- This questionnaire asks for general information about your health care benefit plans (medical, dental, vision and prescription) that is not normally found in Summary Plan Descriptions.
- Any additional information that is relevant to this survey can be written in the margins of the questionnaire (if submitting a hard copy) or provided on separate sheets of paper.
- **PLEASE INCLUDE COPIES OF ALL EMPLOYEE BENEFIT BOOKLETS, SUMMARY PLAN DESCRIPTIONS, PLAN DOCUMENTS, OR ANNOUNCEMENT BULLETINS DESCRIBING YOUR MEDICAL, PRESCRIPTION, DENTAL AND VISION BENEFIT PLANS OR POLICIES IN DETAIL. IF MATERIAL IS OUTDATED, PLEASE MAKE HANDWRITTEN CORRECTIONS OR PROVIDE SUPPLEMENTAL EXPLANATIONS.**
- If the health benefits are subject to collective bargaining, **PLEASE PROVIDE A COPY OF YOUR COLLECTIVE BARGAINING AGREEMENT.**
- Please provide a copy of your **BOARD POLICIES** regarding health care benefits.
- If you have any questions, please call Sevim Kuyumcu at (703) 841-3107.
- PLEASE RETURN COMPLETED SURVEY AND TWO (2) COPIES OF ALL REQUESTED BENEFIT PLAN BOOKLETS TO::

Sevim Kuyumcu
Hay Group, Inc.
4301 N. Fairfax Drive, Suite 500
Arlington, VA 22203
FAX: (703) 908-3005
Email: Sevim_Kuyumcu@haygroup.com

Terms

Fee-for-Service (FFS) a traditional indemnity plan that provides designated reimbursement to covered persons for designated health services. The insured is able to choose the provider without penalty. All providers of the same service are reimbursed at the same level; **i.e., there are no "preferred" or "exclusive" providers**. There may be a hospital precertification requirement as well as catastrophic case management. The plan can be fully or partially insured or self-insured. **For this survey please treat Fee-for-Service plans that have a "silent" PPO feature in which services rendered by "preferred" providers are reimbursed at the negotiated fee schedules as a PPO plan.**

Preferred Provider Organization (PPO) - medical plan that allows the employee to decide between a network of preferred providers (hospitals and/or physicians) with higher reimbursement levels and out-of-network providers each time service is to be provided. If the network has gatekeeper/primary physician requirements, it is not a PPO, but a POS. **This includes health plans that have a "silent" PPO in which services are reimbursed at higher levels for using "preferred" providers.**

Point-of-Service (POS) - also called open-ended HMOs. A medical plan that allows the employee to decide between a network of gatekeeper managed care providers or indemnity plan with higher employee copays each time the service is to be provided.

Health Maintenance Organization (HMO) - managed care plan in which the individual must go through a "gatekeeper" primary physician for all medical care. The gatekeeper refers the individual to a provider within the network if specialization is needed. There is no benefit provided out-of-network.

PART A

For Questions 1 through 3, please provide information regarding all of your health care plans that are offered to your employees.

General

1. **Please provide a list of all the health care plans benefits (medical, prescription, dental and vision plans) that your school district offers to your public school employees. Please indicate how the plan is financed by selecting one of the choices in the drop-down menu. You may provide the information below or in a separate attachment.**

   Type in the name of the health in the space provided. Under the "Types of Health Care Plans", a list of choices is provided in the drop-down menu (Fully Insured, Self-Insured, Other, NA). Place the mouse on the cell and an arrow will show. Click the arrow to select from the list.

Name of Health Plan (fill in name of plan)	Types of Health Care Plans						
	FFS	PPO	POS	HMO	Stand Alone Rx	Stand Alone Dental	Stand Alone Vision
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA	NA

2. **For your school district, please provide the number of covered lives as of March 1, 2003 for each health plan you have identified in Question 1. You may provide the information below or in a separate attachment. Type in the name of the health plan and the number of covered lives in the spaces provided.**

Name of Health Plan (fill in name of plan)	Number of Covered Lives (Enter Number in Space Provided)				
	Active Ees	Deps. Of Active Ees	Retirees	Deps. Of Retirees	COBRA

3. Who is eligible to enroll in the health care plans (medical, prescription, dental and/or vision) regardless of who pays all or part of the premium? Type in the information in the spaces provided.

MEDICAL PLANS	Enter the Hours or Days As Applicable for An Employee to Be Eligible	
Employee Classification	Hours Per Day	Days Per Year
Professional/Instructional Staff		
Instructional Aides		
Administrative Staff (executive/administrator)		
Support (clerical, transportation, food service, custodial)		
Other (please specify):		
Other (please specify):		

3.a. If you do not have a stand alone prescription drug plan, skip to 3.b

STAND ALONE PRESCRIPTION PLANS	Enter the Hours or Days As Applicable for An Employee to Be Eligible	
Employee Classification	Hours Per Day	Days Per Year
Professional/Instructional Staff		
Instructional Aides		
Administrative Staff (executive/administrator)		
Support (clerical, transportation, food service, custodial)		
Other (please specify):		
Other (please specify):		

3.b. If you do not have a stand alone dental plan, skip to 3.c.

STAND ALONE DENTAL PLANS	Enter the Hours or Days As Applicable for An Employee to Be Eligible	
Employee Classification	Hours Per Day	Days Per Year
Professional/Instructional Staff		
Instructional Aides		
Administrative Staff (executive/administrator)		
Support (clerical, transportation, food service, custodial)		
Other (please specify):		
Other (please specify):		

3.c. If you do not have a stand alone vision plan, skip to 4

STAND ALONE VISION PLANS	Enter the Hours or Days As Applicable for An Employee to Be Eligible	
Employee Classification	Hours Per Day	Days Per Year
Professional/Instructional Staff		
Instructional Aides		
Administrative Staff (executive/administrator)		
Support (clerical, transportation, food service, custodial)		
Other (please specify):		
Other (please specify):		

PART B

Please answer Questions 4 through 28 using the primary plan with the highest enrollment for your school district. (NOTE: The "primary" plan is the plan with the highest employee enrollment.)

Click on the box to select that option. Type in the data where applicable.

Health Care Plan

4. What is the name of the primary health plan?

_____

5. Who administers the primary plan?

	Medical	Prescription	Dental	Vision
Insurance Company	☐	☐	☐	☐
HMO	☐	☐	☐	☐
Coalition of Employers	☐	☐	☐	☐
Third Party Administrator	☐	☐	☐	☐
In-house/Self-Administered	☐	☐	☐	☐
Union/Taft-Hartley Plan	☐	☐	☐	☐

6. 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	$	$
Aggregate Stop Loss		
Aggregate Level	NA%	NA%
Monthly Premium for Aggregate Stop Loss	$	$

Prescription Coverage

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

7. Do you have a separate "carve out" retail prescription drug program?

☐ Yes
☐ No

8. Does your prescription plan utilize a formulary?

- ☐ Yes
- ☐ No

9. If yes, is it an open formulary or a closed formulary?

- ☐ Open
- ☐ Closed

10. Does your prescription drug program include a mail order plan?

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

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

- ☐ Yes
- ☐ No

Mental Health and Substance Abuse Care

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

- ☐ Yes, inpatient only
- ☐ Yes, outpatient only
- ☐ Yes, both
- ☐ Yes, other (please specify):
- ☐ Not a carved out benefit

Case Management

13. Does your school district sponsor a case management program for your health plan? If no, skip to Question 20.

- ☐ Yes
- ☐ No

14. Are you aware that case management is part of your health care plan? If no, skip to Question 20.

- ☐ Yes
- ☐ No

15. Does your organization's case management program include:

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

16. If your case management program includes management for specific conditions, please check which conditions: *(Check all that apply)*

- ☐ Asthma
- ☐ Diabetes
- ☐ Cardiac
- ☐ Hypertension
- ☐ COPD
- ☐ Behavioral Health
- ☐ Back and Neck
- ☐ Maternity
- ☐ Congestive Heart Failure
- ☐ Other (please specify):

17. Who administers your case management programs? (check all that apply)

- ☐ Insurance Company
- ☐ Third-Party Administrator
- ☐ Self-Administered
- ☐ Other

18. If your organization's program includes psychiatric care case management, what kind is it?

- ☐ Inpatient Only
- ☐ Inpatient and Outpatient
- ☐ Does not include psychiatric care case management

19. Is there an incentive to use the case management or utilization review program(s)? *(Check all that apply)*

- ☐ Yes, coinsurance paid at a higher percent for participating or reduced for not participating
- ☐ Yes, hospital deductible waived for participating or separate deductible imposed for not participating
- ☐ Does not include psychiatric care case management
- ☐ Yes, no psychiatric care coverage provided for not participating
- ☐ Yes, other (please specify):
- ☐ No incentive or penalty

Waiver of Health Coverage

20. Can employees receive cash incentives, bonuses, or other credits for opting out of your group health care plan?

- ☐ Yes, can receive cash or other credits
- ☐ No

21. Can employees receive cash incentives, bonuses, or other credits for opting out of your group dental plan?

- ☐ Yes, can receive cash or other credits
- ☐ No

22. If employees receive cash or other credits for waiving coverage, what is the amount?

- ☐ Full value of premium
- ☐ Percentage of premium %
- ☐ Flat dollar amount (per year)
  - $ for single medical coverage
  - $ for family medical coverage
  - $ for single dental coverage
  - $ for family dental coverage
- ☐ Other (please specify):

23. Does your organization allow employees to enroll their spouses on the school district's medical plan even if the spouse could have medical coverage through his/her own employer?

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

Medical Benefits for Retirees

24. Do you allow employees to continue medical plan coverage at retirement from active public school service?

- ☐ Yes, Non-Medicare Eligible Retirees Only
- ☐ Yes, Medicare Eligible Retirees Only
- ☐ Yes, Both Medicare and Non-Medicare Eligible Retirees
- ☐ Neither

25. What are the eligibility requirements to continue benefits into retirement?

- ☐ Age only, years
- ☐ Service only, years
- ☐ Age, years and service, years
- ☐ Sum of age and service, years
- ☐ Age years and/or service years
- ☐ Other (please specify):

26. What health care plans are retirees eligible for? *(Check all that apply)*

- ☐ None
- ☐ Medical
- ☐ Prescription Drugs (either through separate or part of medical plan)
- ☐ Dental
- ☐ Vision Care

27. Are dependents of retirees eligible for medical coverage?

- ☐ No
- ☐ Yes, but age and/or service requirements are more restrictive
- ☐ Yes, dependents are eligible only if not covered by another employer's plan
- ☐ Yes, dependents are eligible on the same basis as employee
- ☐ Yes, only spouse is eligible

28. If your plan allows retiree to continue coverage after Medicare eligible, how does it coordinate with Medicare?

- ☐ Active plan offset by Medicare expenses paid
- ☐ A supplement that fills in the gaps in Medicare's coverage
- ☐ Active plan except for a separate maximum on benefits
- ☐ Active plan offset by Medicare benefits available
- ☐ Other (please specify):

Administration/Management of Health Plans

29. Do you use the services of a broker for purposes of health care benefits?

☐ Yes
☐ No

30. Please describe the services your broker provides in regards to your health care plans?

_____

31. How many full-time equivalent employees are dedicated to the administrative and management tasks of the health care plans?

Specify number of full-time equivalent staff:

32. Please check the tasks that your staff is currently performing regarding the administration and management of your health care plans. Please specify other tasks not specifically listed.

Tasks	Medical (Prescription Part of Medical)	Stand Alone Prescription Plan	Stand Alone Dental Plan	Stand Alone Vision Plan
Plan Design	☐	☐	☐	☐
Develop Eligibility/Cost Sharing Policies	☐	☐	☐	☐
Benefit Cost Analysis/Strategy	☐	☐	☐	☐
Enrollment/ Election Changes/Record Changes	☐	☐	☐	☐
Develop Employee Communications	☐	☐	☐	☐
Prepare Documentation (Plan Doc/SPD)	☐	☐	☐	☐
Conduct Claims Denial & Appeal	☐	☐	☐	☐
Compliance Testing (e.g. HIPAA)	☐	☐	☐	☐
Contract Negotiations & Issues with TPA and Provider	☐	☐	☐	☐
Premium Collection Activities	☐	☐	☐	☐
Answer Employee Inquiries	☐	☐	☐	☐
Wellness programs	☐	☐	☐	☐

Tasks	Medical (Prescription Part of Medical)	Stand Alone Prescription Plan	Stand Alone Dental Plan	Stand Alone Vision Plan
Website management	☐	☐	☐	☐
Financial management	☐	☐	☐	☐
Interface with outside professionals (e.g. auditor, attorney, broker)	☐	☐	☐	☐
Interface with internal Board of Trustees (or other governing body)	☐	☐	☐	☐
Other (please specify):	☐	☐	☐	☐

PART C

Type in the dollar amount in the spaces provided.

Monthly Premium Rates as of March 1, 2003

Please provide the **monthly** premium rates for each health plan identified in Question 1. Composite coverage is one premium rate that is charged to all employees covered by the plan regardless of the number of dependents enrolled in the plan. If employee contributions vary depending on employee classification, please provide rates for each class of employees.

Name of Plan:
Class of Employees:

Active Employees

Coverage	Medical (Prescription Part of Medical)		Stand Alone (Carve-Out) Prescription		Stand Alone Dental		Stand Alone Vision	
	Total Monthly Premium	*Employee Contribution*	*Total Monthly Premium*	*Employee Contribution*	*Total Monthly Premium*	*Employee Contribution*	*Total Monthly Premium*	*Employee Contribution*
Employee Only	$	$	$	$	$	$	$	$
Employee + 1 Dependent	$	$	$	$	$	$	$	$
Family	$	$	$	$	$	$	$	$
Composite	$	$	$	$	$	$	$	$

Retirees (Under Age 65)

Coverage	Medical (Prescription Part of Medical)		Stand Alone (Carve-Out) Prescription		Stand Alone Dental		Stand Alone Vision	
	Total Monthly Premium	*Employee Contribution*	*Total Monthly Premium*	*Employee Contribution*	*Total Monthly Premium*	*Employee Contribution*	*Total Monthly Premium*	*Employee Contribution*
Employee Only	$	$	$	$	$	$	$	$
Employee + 1 Dependent	$	$	$	$	$	$	$	$
Family	$	$	$	$	$	$	$	$
Composite	$	$	$	$	$	$	$	$

Retirees (Age 65 and over)

Coverage	Medical (Prescription Part of Medical)		Stand Alone (Carve-Out) Prescription		Stand Alone Dental		Stand Alone Vision	
	Total Monthly Premium	*Employee Contribution*	*Total Monthly Premium*	*Employee Contribution*	*Total Monthly Premium*	*Employee Contribution*	*Total Monthly Premium*	*Employee Contribution*
Employee Only	$	$	$	$	$	$	$	$
Employee + 1 Dependent	$	$	$	$	$	$	$	$
Family	$	$	$	$	$	$	$	$
Composite	$	$	$	$	$	$	$	$

Appendix F

Pennsylvania Public School Health Care Benefits Survey for Intermediate Units

Pennsylvania Public Schools

Health Care Benefits Survey

Completed by Intermediate Units

Purpose: The Pennsylvania Legislative Budget and Finance Committee has authorized a study to determine the feasibility of placing public school employees under the Commonwealth's jurisdiction for the purposes of providing health benefits. Organizations who complete and return the survey will receive a summary of the survey results.

Completed by: **Name:** _____

Title: _____

Phone: _____

Intermediate Unit: _____

Name of Healthcare Consortium: _____

Address: _____

_____

City, Zip: _____

Fax: _____

E-mail: _____

complete data submission due ***August 22, 2003***

- All Material Is Kept Confidential -

HayGroup

General Instructions

- This questionnaire asks for information pertaining to the Intermediate Unit's (IU) roles and responsibilities regarding the administration and management of the Pennsylvania public school employees health care benefit plans (medical, prescription, dental and vision) for your Consortium. A survey has been sent to all school districts asking questions regarding the plan design, provisions and policies of their health care plans. The school districts in your consortium may contact you to assist them in completing their survey.

- Please enter the information in the space provided for the school districts in your consortium. For the purposes of this study, we are only interested in the school district employees (i.e. it is OK to exclude employees of area vocational tech schools and IU employees).

- Any additional information that is relevant to this survey can be written in the margins of the questionnaire (if submitting a hard copy) or provided on separate attachment.

- If you have any questions, please call Sevim Kuyumcu at (703) 841-3107.

- PLEASE RETURN COMPLETED SURVEY AND TWO (2) COPIES OF ALL REQUESTED BENEFIT PLAN BOOKLETS TO:

Sevim Kuyumcu
Hay Group, Inc.
4301 N. Fairfax Drive, Suite 500
Arlington, VA 22203
FAX: (703) 908-3005
Email: Sevim_Kuyumcu@haygroup.com

Terms

Fee-for-Service (FFS) a traditional indemnity plan that provides designated reimbursement to covered persons for designated health services. The insured is able to choose the provider without penalty. All providers of the same service are reimbursed at the same level; **i.e., there are no "preferred" or "exclusive" providers**. There may be a hospital precertification requirement as well as catastrophic case management. The plan can be fully or partially insured or self-insured.

Preferred Provider Organization (PPO) - medical plan that allows the employee to decide between a network of preferred providers (hospitals and/or physicians) with higher reimbursement levels and out-of-network providers each time service is to be provided. If the network has gatekeeper/primary physician requirements, it is not a PPO, but a POS.

Point-of-Service (POS) - also called open-ended HMOs. A medical plan that allows the employee to decide between a network of gatekeeper managed care providers or indemnity plan with higher employee copays each time the service is to be provided.

Health Maintenance Organization (HMO) - managed care plan in which the individual must go through a "gatekeeper" primary physician for all medical care. The gatekeeper refers the individual to a provider within the network if specialization is needed. There is no benefit provided out-of-network.

PART A

General

33. Please list all the school districts that are members of your Consortium for purposes of health care plans (medical, prescription, dental and vision). You may provide this information below or in a separate attachment.

Type in the Administrative Unit Number (AUN) in the space provided. Under the "Types of Health Care Plans", a list of choices is provided in the drop-down menu. Place the mouse on the cell and an arrow will show. Click on the arrow to select from the list. If you selected "Yes" under a plan types, please enter the number of plans in that category in the space provided. If you answered "NA" or "No", please leave blank in the space.

School District AUN (9 digits)	Types of Health Care Plans													
	FFS		PPO		POS		HMO		Stand Alone Rx		Stand Alone Dental		Stand Alone Vision	
	Y/N	#	Y/N	#	Y/N	#	Y/N	#	Y/N	#	Y/N	#	Y/N	#
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	
	NA		NA		NA		NA		NA		NA		NA	

PART B

Click on the box to select that option. Type in the data where applicable.

Case Management

34. Does your Consortium utilize case management programs for your health plans?

- ☐ Yes
- ☐ No

35. Does your Consortium's case management program include:

	Yes	No
Large Case Management	☐	☐
Psychiatric Case Management	☐	☐
Specific Disease Management	☐	☐

36. If your case management program includes management for specific diseases, please indicate which diseases:

- ☐ Asthma
- ☐ Diabetes
- ☐ Cardiac
- ☐ Hypertension
- ☐ COPD
- ☐ Behavioral Health
- ☐ Back and Neck
- ☐ Maternity
- ☐ Congestive Heart Failure
- ☐ Other (please specify):

37. Who administers your case management programs? (check all that apply)

- ☐ Insurance Company
- ☐ Third-Party Administrator
- ☐ Self-Administered
- ☐ Other

38. If your organization's program includes psychiatric care case management, what kind is it?

- ☐ Inpatient Only
- ☐ Inpatient and Outpatient
- ☐ Does not include psychiatric care case management

39. Is there an incentive to use the case management or utilization review program(s)? *(Check all that apply)*

- ☐ Yes, coinsurance paid at a higher percent for participating or reduced for not participating
- ☐ Yes, hospital deductible waived for participating or separate deductible imposed for not participating
- ☐ Does not include psychiatric care case management
- ☐ Yes, no psychiatric care coverage provided for not participating

☐ Yes, other (please specify):

☐ No incentive or penalty

Administration/Management of Health Plans

40. How many full-time equivalent employees are dedicated to providing administrative tasks for your Consortium?

Specify number of full-time equivalent staff:

41. Please check the tasks that your staff is currently performing regarding the administration and management of your health care plans. ***(Check all that apply)***

Please specify other tasks not specifically listed.

Tasks	Medical (Prescription Part of Medical)	Stand Alone Prescription Plan	Stand Alone Dental Plan	Stand Alone Vision Plan
Plan Design	☐	☐	☐	☐
Develop Eligibility/Cost Sharing Policies	☐	☐	☐	☐
Benefit Cost Analysis/Strategy	☐	☐	☐	☐
Enrollment/ Election Changes/Record Changes	☐	☐	☐	☐
Develop Employee Communications	☐	☐	☐	☐
Prepare Documentation (Plan Doc/SPD)	☐	☐	☐	☐
Conduct Claims Denial & Appeal	☐	☐	☐	☐
Compliance Testing (e.g. HIPAA)	☐	☐	☐	☐
Contract Negotiations & Issues with TPA and Provider	☐	☐	☐	☐
Premium Collection Activities	☐	☐	☐	☐
Answer Employee Inquiries	☐	☐	☐	☐
Wellness programs	☐	☐	☐	☐
Website management	☐	☐	☐	☐
Financial management	☐	☐	☐	☐
Interface with outside professionals (e.g. auditor, attorney, broker)	☐	☐	☐	☐

Tasks	Medical (Prescription Part of Medical)	Stand Alone Prescription Plan	Stand Alone Dental Plan	Stand Alone Vision Plan
Interface with internal Board of Trustees (or other governing body)	☐	☐	☐	☐
Other (please specify):	☐	☐	☐	☐
Other (please specify):	☐	☐	☐	☐

42. For your Consortium, please provide the number of covered lives as of March 1, 2003 for each health plan you administer. You may provide the information below or in a separate attachment. Type in the name of the health plan and the number of covered lives in the spaces provided.

Name of Health Plan (fill in name of plan)	Number of Covered Lives (Enter Number in Space Provided)				
	Active Ees	Deps. Of Active Ees	Retirees	Deps. Of Retirees	COBRA

Thank you for your input on this important project.

Please use the space below for any comments that could not be entered in the above survey grids.

Appendix G

House Resolution No. 159

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 159 Session of 2003

INTRODUCED BY DIVEN, PERZEL, COSTA, TIGUE, SOLOBAY, KELLER, BARRAR, BELFANTI, BUTKOVITZ, BUXTON, CAPPELLI, CAWLEY, CORRIGAN, CREIGHTON, CRUZ, CURRY, DALLY, DeLUCA, FAIRCHILD, FRANKEL, FREEMAN, GOODMAN, GRUCELA, HALUSKA, HARHAI, HENNESSEY, HERSHEY, HORSEY, HUTCHINSON, LAUGHLIN, LEACH, LESCOVITZ, LEWIS, MANN, McCALL, MELIO, NICKOL, PALLONE, PISTELLA, READSHAW, ROEBUCK, SAINATO, SCRIMENTI, STABACK, STERN, STURLA, SURRA, THOMAS, TURZAI, WALKO, WASHINGTON, WILT, YOUNGBLOOD, JAMES AND YUDICHAK, MARCH 26, 2003

REFERRED TO COMMITTEE ON RULES, MARCH 26, 2003

A RESOLUTION

Authorizing a study to determine the feasibility and cost-effectiveness of placing public school employees under the Commonwealth's jurisdiction for the purposes of providing health benefits.

WHEREAS, There is increasing concern among the citizen taxpayers of this Commonwealth over the rising cost of education in our public schools; and

WHEREAS, A recent report by the Department of Education through its "Your Schools, Your Money" initiative noted that salaries and benefits for school employees comprise almost 70% of all school district spending Statewide, and within this category spending on benefits accounts for more than $2 billion and 14% of all spending; and

WHEREAS, School board members and business managers have noted that the costs of benefits, particularly those related to

health, are among the fastest growing expenditures in a district's budget, and this problem is particularly acute in rapidly growing and urban districts; and

WHEREAS, The National Academy for State Health Policy reports that health care inflation is growing faster than overall inflation, noting that the growth in 1999 was 7.3% or three times that of overall inflation; and

WHEREAS, The size and composition of an insured group directly impacts the costs of coverage, with larger groups being afforded better rates; and

WHEREAS, The extent of health benefit coverage provided to school employees is currently negotiated locally, with the result that the State has no control over the growth in these expenditures, so if, in the future, reliance on the local property tax as the prime source of revenue for school district budgets is to be reduced and replaced by increased State revenues, it is incumbent on the General Assembly to find ways to control the growth in expenditures or be faced with routinely increasing State taxes; and

WHEREAS, It is critical to assure taxpayers that governmental agencies are providing services in an efficient and cost-effective manner so as to provide maximum utilization of taxpayer dollars; therefore be it

RESOLVED, That the Legislative Budget and Finance Committee examine the practicability and potential cost-effectiveness of placing public school employees under the same group health benefits package provided for employees of the Commonwealth of Pennsylvania; and be it further

RESOLVED, That for the purposes of this study, health benefits include medical, dental, vision and prescription drug

programs and that this study include:

(1) An analysis of the specific health benefits currently provided by school entities throughout this Commonwealth, the premium costs related thereto and the pattern of growth in these costs.

(2) A comparison of the cost of public school health benefits to those provided for Pennsylvania's State workers.

(3) The prospective benefits, particularly potential reductions in costs to both the Commonwealth and local school entities, that might accrue as a result of the addition of more than 240,000 active public school employees to the estimated 109,716 active State employees who currently make up the Commonwealth's pool of insured employees.

(4) Other considerations in a possible merger of these two groups for health benefit purposes, including the impact on collective bargaining and the possible effect on the Public School Employees' Retirement System and State Employees' Retirement System;

and be it further

RESOLVED, That in compiling this report the commission seek input from the Department of Education, the Pennsylvania Association of School Business Officials, the Pennsylvania School Boards Association, the Pennsylvania State Education Association, the Pennsylvania Federation of Teachers, the Governor's Office of Administration, group insurance providers and any other groups or individuals who may have information relevant to this study; and be it further

RESOLVED, That the Legislative Budget and Finance Committee review the manner in which other states may be providing health benefits for their public school employees in order to better

control the growth in related costs; and be it further

RESOLVED, That the Legislative Budget and Finance Committee report its findings and recommendations to the House of Representatives no later than December 31, 2003.