# Legislative Budget and Finance Committee

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

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# Feasibility and Cost Effectiveness of Merging Pennsylvania Public School District Health Care Plans

Conducted Pursuant to
SR 2013-250

December 2015

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December 2015

To the Members of the General Assembly:

Senate Resolution 2013-250 directs the Legislative Budget and Finance Committee to conduct a study of the feasibility and cost-effectiveness of merging public school district health care plans.

Due to the specialized nature of this study, the Committee issued a Request for Proposal for assistance with this study. In May 2015, the Committee contracted with the PRM Consulting Group to conduct the study. The PRM team was led by Mr. Adam Reese, an Enrolled Actuary and a Fellow of the Society of Actuaries.

The PRM Consulting 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

PRD:tlb

prm CONSULTING GROUP

# Feasibility and Cost Effectiveness Study:

# Merging Commonwealth of Pennsylvania Public School District Health Care Plans

**PREPARED FOR: LEGISLATIVE BUDGET AND FINANCE COMMITTEE**

**NOVEMBER 30, 2015**

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# INTRODUCTION

The Commonwealth of Pennsylvania has 500 school districts, each with separate contracts and one or more collective bargaining agreements, governing working conditions, pay and benefit provisions for the employees working for each school district.

School business managers and school board members have noted that the costs of benefits, and in particular, healthcare costs were among the fastest growing expenditures in the districts' budgets, a concern that was seen as acute in rapidly growing and urban districts. The costs for coverage are directly impacted by the size and demographic composition of the insured group with larger groups generally able to negotiate better premium rates. As health benefit coverages are negotiated locally, the State has little control over the growth of the expenditures and therefore the General Assembly of Pennsylvania passed Senate Resolution 250 ("SR250"):

> "Directing the Legislative Budget and Finance Committee to conduct a study relating to the feasibility and cost-effectiveness of merging public school district health care plans."

Given the technical nature of such a study, the Legislative Budget and Finance Committee ("LBFC") issued an RFP for proposals to conduct the study. PRM Consulting Group's ("PRM") proposal was accepted by LBFC and this report is submitted and contains the results of PRM's analyses.

SR250 directed that the study include medical, dental, vision, and prescription drug benefits and that the report study address the following eleven areas:

a. A detailed analysis of the specific health benefits, policies and contracts currently provided by or operated by at least 50 percent of the school entities throughout this Commonwealth, the premium costs related thereto and the pattern of growth in these costs.
b. Cost of current benefits for the next five years.
c. Cost of current school employee contribution or average per employee.
d. Impact on the Public School Employees' Retirement System and State Employees' Retirement System.
e. Comparison of coverage with average taxpayer in the relevant region.
f. Regionalization versus one health care plan.

g. Cost savings realized with consortia compared to prior consortia.

h. Administrative, staffing, and technology costs associated with forming mergers.

i. Comparison of school employees versus Commonwealth employees.

j. Cost of least used benefits by school employees.

k. Cost impact of the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119).

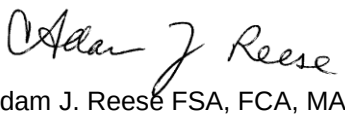
## Organization of the Report

The Report includes an Executive Summary followed by a description of the methodology used to collect data and information that was compiled and used in the analysis, and separate sections addressing each of the eleven study areas set out in SR250.

The successful completion of the study was made possible by the time that all stakeholders generously gave in meeting with us, sharing their knowledge of the current healthcare arrangements, answering the detailed survey questions sent to each school district, and providing the historical claims information. The report includes an Acknowledgements section which lists each of the school districts that submitted data. We recognize that business managers were busy closing out the FY2014-15 fiscal year, getting their schools ready for FY2015-16 and therefore the timing of the study was in conflict with high priority activities. For these reasons the original closing date for the survey data was extended, which allowed additional schools to submit their data. As a result, the data collected covers over 50 percent of the school districts and is fully representative of the wide range of current healthcare programs and funding arrangements.

We welcome the opportunity to discuss the findings of the study.

Submitted by



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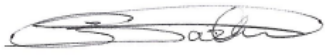


Joanne Bartholomew – Senior Consultant

# EXECUTIVE SUMMARY

In contrast to the findings of LBFC's 2004 study,[1] which found significant savings opportunities if all local education agencies participated in a Commonwealth-wide plan, this study finds that there are modest savings opportunities of approximately 5 to 6 percent of costs in the near-term from merging public school district health care plans. That difference in findings reflects to a large extent changes since the 2004 study, and especially the increasing development of scale through school districts' participation in consortia arrangements, which now cover over 85 percent of all participants. In addition to these savings, larger cost-avoidance opportunities exist in the longer-term by forming multiemployer healthcare plans or by reforming the existing consortia to address the Excise Tax established by the Patient Protection and Affordable Care Act ("PPACA" or "ACA").

## Comparison of Coverage with the Average Tax Payer

The ACA established standardized health plans (the so called "metal" plans of Platinum, Gold, Silver and Bronze). These coverage levels provide a useful benchmark for comparing plan designs (i.e. the plan's actuarial value) rather than costs, as costs are influenced by a range of factors including demographics and geography. We compared the actuarial value of the school districts' health plans to the plans provided by other Commonwealth employers or purchased by individual Commonwealth tax payers.[2] The chart below shows that whereas 31 percent of Commonwealth tax payers (excluding school district and state employees) were enrolled in health plans at or above the Platinum level, 85 percent of School District employees were enrolled in health plans at or above the Platinum level.

| Health Plan Coverage Level | Actuarial Value | PA Tax Payer | Schools |
|---|---|---|---|
| Platinum plus | Above 92% | 8% | 71% |
| Platinum | 88% to 92% | 23% | 14% |
| Gold plus | 82.1% to 87.9% | 17% | 14% |
| Gold | 78% to 82% | 19% | 1% |
| Silver plus | 72.1% to 77.9% | 11% | 1% |
| Silver | 68% to 72% | 16% | 0% |
| Bronze & bronze plus | 60% to 67.9% | 6% | 0% |

[1] http://lbfc.legis.state.pa.us/Resources/Documents/Reports/115.pdf The Feasibility of Placing Public School Employees Under the Commonwealth's Jurisdiction for the Purpose of Providing Health Care Benefits.

[2] The "PA Tax Payer" information is based on over 2.8 million covered lives including over 400,000 individual policies purchased on the Exchange and excludes data on School Districts.

An analysis by region was also conducted and showed that there was a small difference in plan values by region, with slightly higher values in Western Pennsylvania and slightly lower values in Southeastern Pennsylvania.

## Consortia Provide Most of the Coverage for School Districts Health Benefits

Over 85 percent of school districts currently obtain healthcare coverage for their employees from one of 37 health trusts or consortia. These consortia are generally local or regional in nature covering school districts in one or more adjacent counties. The largest consortium, Allegheny County Schools Health Insurance Consortium ("ACSHIC"), includes 48 school districts with 52 entities in total. This consortium alone covers over 48,000 lives, about one-quarter the size of the Pennsylvania Employee Benefit Trust Fund ("PEBTF") which manages healthcare benefits for Commonwealth employees.

Information gathered from the consortia indicates that these separate healthcare pools, ranging in size from a few thousand covered lives to several with over 10,000 covered lives, are implementing cost-containment strategies that have resulted in low annual healthcare cost increases.

Some of the strategies the consortia have implemented, such as high performance narrow networks, achieve cost efficiencies by aligning the benefit plans with lower-cost hospitals and physician groups.

Other strategies have included adding a qualified high deductible health plan with a Health Savings Account, providing financial incentives, and equally important tools for their membership to become better informed and more savvy purchasers of healthcare.

## Near-term Savings Opportunities

We identified three near-term savings opportunities that could be implemented with no change in benefits or cost-sharing between School Districts and employees.

First, if the prescription drug benefit was "carved-out" of each of the School District health plans and a state-wide pharmacy program was competitively bid, we estimate that this would yield savings of between $100 and $160 per covered life before taking into account plan design differences. For ease of administration and communication, a limited set of pharmacy plan designs should be considered.

The following chart shows the range in current plan designs, with modest differences between the low copay plans and the high copay plans. Also shown are the copays currently required in the Commonwealth employees plan (labelled PEBTF) and the average copays from the 2015 Kaiser Family Foundation ("KFF") study of employer healthcare benefits.

| | Schools Pharmacy Copays | | | PEBTF | KFF |
|---|---|---|---|---|---|
| | LOW[3] | MEDIAN | HIGH[4] | | |
| Retail Generic Copay | $5 | $8 | $10 | $10 | $11 |
| Retail Brand Formulary Copay | $10 | $20 | $35 | $18[5] | $31 |
| Retail Brand Non-Formulary Copay | $15 | $35 | $60 | $36[3] | $54 |
| Retail Specialty | $15 | $35 | $70 | $36[6] | $93 |

First, based on our estimate of 190,000 public school employees and 450,000 covered lives, a state-wide pharmacy program would be expected to save up to $72 million per year starting in 2017.

Second, if the schools that are currently not in consortia were to join a pool, we estimate that the costs for these school districts would be about 4-5 percent lower, resulting in additional annual savings of about $20 million.

Third, establishing a state-wide reinsurance pool would likely yield savings of $18 per covered life for those groups now purchasing stop-loss insurance. As not all consortia purchase stop-loss insurance, the expected annual savings from such an arrangement are an additional $5 million per year.

Combined, these near-term changes are expected to save approximately $100 million per year.

In addition to these near-term savings, if a state-wide health program were established with school districts participating upon the expiration of their current Collective Bargaining Agreement (CBA), then additional savings of about $31 million could be generated. Due to the layered dates at which the CBAs expire, it would take at least 3 years before half of the school districts were able to participate and more than 5 years before all school districts could join. By 2020 assuming all school districts join a state wide program total annual savings (including the pharmacy and stop-loss savings) would reach $200 million per year. By 2020, assuming all school districts joined a statewide plan, total annual savings (medical and prescription drugs) would reach $209 million.

## Longer-term Cost Avoidance Opportunities

The excise tax under PPACA is effective in 2018 for "high-cost" health plans and will be levied on plans' costs above certain thresholds. The unadjusted thresholds in 2018 are $10,200 for self-only coverage and $27,500 for "other than self-only" coverage. This tax will apply to governmental employers, including

*[3] 10 percent of SDs using copay designs have copays at or below the values shown*
*[4] 10 percent of SDs using copay designs have copays at or above the values shown*
*[5] Plus the cost difference, if any, between the brand and the generic*
*[6] Members must use the Prescription Benefit Manager's specialty care pharmacy, CVS pharmacy or Rite Aid pharmacy. If any other pharmacy is used to purchase specialty medications, the member pays the full cost.*

school districts. As the thresholds increase by statute with consumer price inflation, and healthcare cost increases have been and are expected to exceed CPI, it is inevitable that even today's "low cost" plans will eventually have costs above the thresholds and the excess will be subject to the 40 percent excise tax.

In plans other than multiemployer plans, the cost thresholds above which the tax is assessed are separate for self only and family participants. For multiemployer plans, however, the cost threshold is set at the family cost level ($27,500 in 2018) regardless of the mix of self only participants and those who cover dependents.

Although we did not find any school districts that are currently at this level, this represents a major future opportunity for the Commonwealth, if the plans for school districts are organized so that they meet the statutory definition of a multiemployer plan and qualify for this more favorable treatment.

We have illustrated the financial impact of utilizing the multiemployer thresholds for the first 10 years of its operation, assuming that a hypothetical school's costs would be slightly above the threshold in 2018. The projection shows that the excise tax can be avoided completely for up to 7 years and that the annual cost avoidance per employee for the multiemployer plan would be about $1,500 per school employee, or 5.2 percent of the projected annual premium cost over the period illustrated.

## Comparison of School Employees to Commonwealth Employees

The average benefit level for school employees is comparable to the benefits provided by PEBTF to Commonwealth employees. Whereas all Commonwealth employees have access to a single "benefit package" that includes medical, prescription drug, dental, vision, and hearing coverages, school employees may be offered some but not all of these coverages. In particular, the prevalence of dental (93 percent) and vision (72 percent) coverages varies, and a hearing benefit may not be included in the medical plan. For school district employees who are offered all benefits, the level of benefit coverages are similar – but the amount that employees are required to pay as contributions has distinct differences, as shown in the table below.

| | PEBTF--Enrolled in Get Healthy program | PEBTF--Not Enrolled in Get Healthy program | Schools Average[7] |
|---|---|---|---|
| Employee Contribution Rate as a Percent of Base Pay | 2% | 5% | N/A |
| Average annual employee contribution for single coverage | $1,109[8] | $2,772 | $693 |
| Average annual employee contribution for other than single coverage | $1,109 | $2,772 | $1,453 |

[7] *Average annual contribution, including employees who have no required contributions.*
[8] *Illustration based on the average pay of $55,450*

The standard employee contribution for Commonwealth employees is 5 percent of pay. The amount is the same whether the employee enrolls in single coverage or covers eligible dependents. Commonwealth employees can reduce the contribution rate to 2 percent by participating in the PEBTF "Get Healthy" program. Commonwealth employees pay about $400 more per year than school employees for single coverage but about $400 per year less than school employees pay for other than single coverage.

## Other Differences

Two other key differences exist between Commonwealth and school employees. First, most school districts provide a payment to school employees who waive coverage. These amounts vary from $1,000 to $7,000 and the average amount for waiving single coverage is $1,930. Commonwealth employees who waive coverage do not have to pay the employee contributions but are not otherwise compensated. Second, Commonwealth employees are eligible for lifetime retiree healthcare coverage if upon retirement they meet the superannuation age and 20-year service requirements. All school employees can purchase COBRA coverage from retirement until Medicare age and some school districts subsidize this coverage. After retirement, school employees who meet the age and service requirements are eligible for reimbursement of $100 per month out-of-pocket cost premium reimbursement. Some school districts also provide subsidized coverage to Medicare-eligible retirees.

## Summary of Potential Savings

The table below illustrates the potential savings that can be achieved.

| Projected Total Cost and Potential Savings<br>Amounts in $millions | | | | | | |
|---|---|---|---|---|---|---|
| Fiscal Year | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 |
| Current Arrangements | $2,693 | $2,797 | $2,937 | $3,093 | $3,260 | $3,439 |
| Carved Out Prescription Drug | | | $74 | $78 | $82 | $87 |
| Total Savings under State-wide Arrangement | | | $107 | $147 | $191 | $216 |

# STUDY METHODOLOGY

To prepare the study we gathered data and information from a number of different sources, including:

- Interviewing stakeholders
- Designing and administering a survey for individual school districts
- Designing and administering a survey of healthcare consortia
- Obtaining data on healthcare benefit coverage for a typical Pennsylvania tax payer from health insurance carriers

## Stakeholder Interviews

We scheduled and held stakeholder interviews (either in-person or by conference call) with

- Pennsylvania Association of School Business Officials (PASBO)
- Pennsylvania Employee Benefits Trust Fund (PEBTF)
- Pennsylvania State Education Association (PSEA)
- Pennsylvania School Employees' Retirement System ( PSERS)
- State Employees' Retirement System (SERS)
- Philadelphia Federation of Teachers Health and Welfare Fund
- Department of Education
- State Board of Education
- Pennsylvania Association of Intermediate Units (PAIU)
- Governor's Office of Administration
- Pennsylvania Association of Health Underwriters

## School District Surveys

As there is no central database on spending for school health benefits, a detailed survey was developed and sent by email to a list of over 500 addresses provided by the staff at PASBO. The survey tool we used enabled recipients to start the survey and either complete the information and submit in one sitting, or save the partially completed survey and resume at a later date. The survey was managed by our survey partners, Economic Systems, Inc. ("Econsys").

Prior to being released, a draft of the survey questions was sent to members of the PASBO health care team who participated in a "beta test" to ensure the survey worked as planned. The beta testers provided useful feedback that was incorporated in the final survey.

## Healthcare Consortia

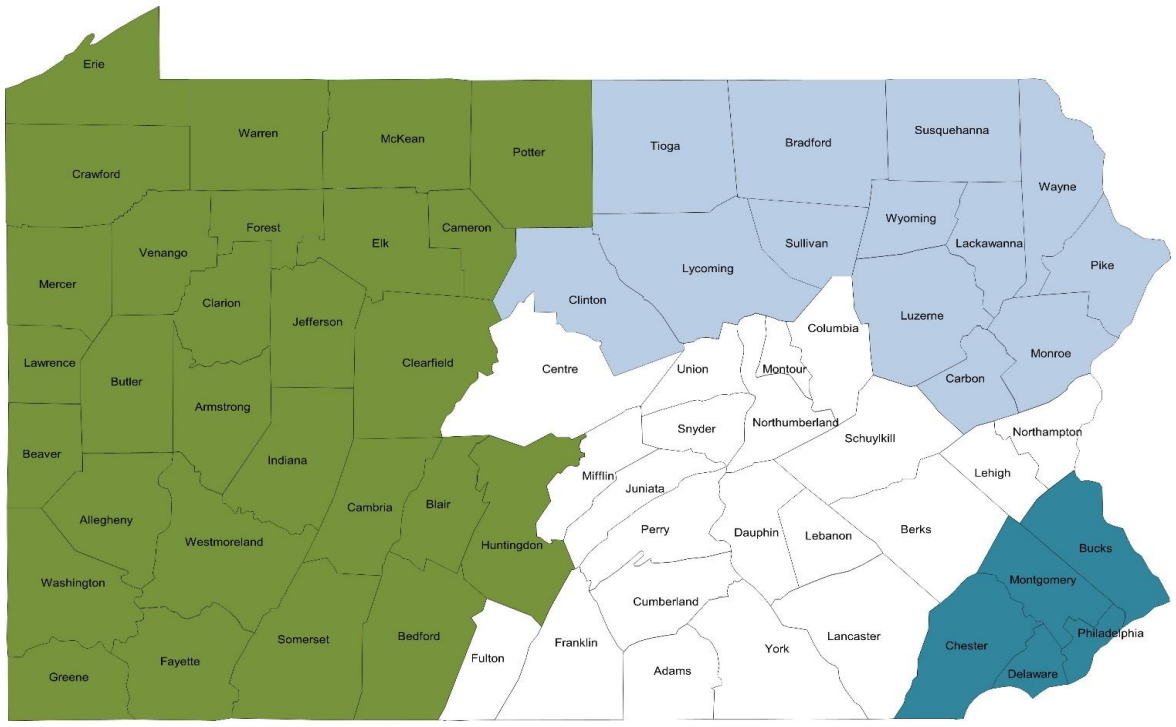
Consortia were contacted and asked to provide historical enrollment and claims information for the past 5 years, together with stop-loss premiums and recoveries data, as well as administrative charges. In addition, the consortia were asked to provide information on the governance of the trust, such as the number and make-up of the trustees and how often the trustees meet.

The consortia were also asked to provide concrete examples of actions taken to manage costs and their views on regionalization or a state-wide health plan.

Data was provided on 27 of the 37 consortia.

## Health Insurance Data on Pennsylvania Tax Payers

Health insurance data on Commonwealth of Pennsylvania tax payer ("PA tax payer") health benefit coverage was submitted by Aetna, Capital Blue Cross, Aetna, Geisinger, Highmark, and Independence. Data was obtained from multiple carriers in each of the four identified regions as shown in the county map below, which we have referred to as Western, Central, Northeastern, and Southeastern.



## Enrollment and Census Data

PEBTF provided aggregate enrollment data by age group, gender and member status (employee, spouse and or dependent). SERS provided aggregate census data on Commonwealth employees by age and gender. PSERS provided aggregate census data on PSERS active members by age and gender as well as HOP enrollment by age and gender.

# DETAILED ANALYSIS OF HEALTH BENEFIT POLICIES AND CONTRACTS, PREMIUM COSTS AND PATTERN OF GROWTH OF COSTS

## Wide Range of Health Plan Benefit Coverages

Health benefit coverages and cost-sharing provisions are usually set out in collective bargaining agreements (CBA). There is a wide range of health plan designs as well as cost-sharing provisions. Based on an analysis of 269 School Districts ("SDs") we found that the majority of SDs provide health plans that have an actuarial value above 90 percent (i.e., "Platinum plus" based on the "metal tiers" concept promulgated by the Center for Consumer Information and Insurance Oversight ("CCIIO") [9]. The actuarial value represents the proportion of an average participant's health care costs that would be reimbursed by the plan. The range in actuarial values was from 72 to 98 percent.

## Employee Contribution Rates

A review of the submitted data from the SDs shows that 88 percent of employees enrolled in medical plans contribute towards the cost of premiums. The average contribution for employee only medical coverage is $57 per month, and the average contribution for other-than-self coverage is $118 per month. About 25 percent of employees elect employee only medical coverage, so the average contribution per school employee is $1,229 per year. Dental benefits were provided at no cost to 50 percent of employees and 57 percent of employees electing vision coverage paid no premiums for benefits. The average employee contributions for dental and vision coverage are $29 and $5 per year respectively.

In each of the charts below the averages shown include all SDs where the data was found to be usable. That is, the averages include zeros where no employee contributions are required.

| MEDICAL | Total | EE only | EE + Spouse | EE + Child | EE + Children | EE + Family |
|---|---|---|---|---|---|---|
| Enrollment | **100%** | 25% | 18% | 4% | 5% | 48% |
| Average contribution per employee $ | **$1,229** | $679 | $1,269 | $1,096 | $951 | $1,535 |
| Average contribution as a % of cost | **7.90%** | 9.20% | 7.60% | 7.50% | 6.20% | 7.90% |

[9] *CCIIO is the government entity charged with implementing many of the provisions affecting health insurance plans under the Patient Protection and Affordable Care Act*

| DENTAL | Total | EE only | EE + Spouse | EE + Child | EE + Children | EE + Family |
|---|---|---|---|---|---|---|
| Enrollment | **100%** | 26% | 16% | 2% | 3% | 53% |
| Average contribution per employee $ | **$29** | $12 | $19 | $25 | $22 | $41 |
| Average contribution as a % of cost | **5.00%** | 4.10% | 3.40% | 4.30% | 4.10% | 5.70% |

| VISION | Total | EE only | EE + Spouse | EE + Child | EE + Children | EE + Family |
|---|---|---|---|---|---|---|
| Enrollment | **100%** | 26% | 12% | 1% | 1% | 59% |
| Average contribution per employee $ | **$5** | $2 | $3 | $5 | $4 | $6 |
| Average contribution as a % of cost | **5.10%** | 3.80% | 4.20% | 6.40% | 4.80% | 5.40% |

## Payments for Waiving Coverage

Many SDs provide incentives for employees to opt-out or waive coverage. The opt-out payments are designed to reduce the costs for the school district, particularly where the CBAs provide school district funding for most of the costs for both the employee and any eligible dependents, including spouses. The most common amounts are $1,000 to $2,000 per year, with some SDs providing much larger incentives. Several SDs provide payments over $3,000 per year, including one SD with a $4,000 payment for waiving single coverage and a $7,000 payment for waiving family coverage. Some SDs set a waiver credit of 25 or 33 percent of the premium equivalent cost. The average opt-out credit for those SDs with fixed dollar amounts was $1,779 for waiving single coverage and $2,580 for waiving family coverage.

| Opt-Out Credits | Medical |
|---|---|
| Average for single coverage | $1,779 |
| Average for family coverage | $2,580 |

Approximately 12 percent waived coverage and received an incentive. On average the opt-out payments were $2,165 per employee.

## Spousal Coverage

Policies varied greatly with respect to eligibility for spouses. A few SDs limit eligibility for spouses to those not working for another State agency or the Federal government (e.g., if a spouse was a Commonwealth employee they would not be allowed to enroll in the SD plan). Some SDs required a surcharge of $500 to $600 per year if the spouse has access to health insurance through their own employer but enroll in the SD plan.

Some SDs applied the “50 percent rule”, whereby employed spouses were eligible to enroll in the SD plan if the cost of coverage in their own employer plan was more than 50 percent of the premium.

## Type of Benefit Plan

The most prevalent medical, dental and vision plan options were network based Preferred Provider Organizations (PPOs) and Point of Service (POS) plans, with Indemnity plans having the next highest prevalence. The following table summarizes the coverage frequency.

| Coverage Type | Medical | Dental | Vision |
|---|---|---|---|
| EPO | 2% | 1% | 0% |
| HMO | 5% | 3% | 1% |
| PPO/POS | 78% | 78% | 67% |
| Indemnity | 7% | 18% | 32% |
| HDHP with HRA | 7% | N/A | N/A |
| HDHP with HSA | 1% | N/A | N/A |

## High Deductible Health Plans

For school districts that offer high deductible health plans, there was a wide range of contributions for both Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs). The following table shows the summary based on the current data set.

| Annual Contribution | HRA | HSA |
|---|---|---|
| Single – Minimum | $100 | $300 |
| Single – Maximum | $2,000 | $2,000 |
| Family – Minimum | $200 | $600 |
| Family – Maximum | $4,000 | $4,000 |

## Prescription Drug Plans

Most school districts provide prescription drug benefits within the same plan as the medical coverage.

| Prescription Drug Plans | |
|---|---|
| Prescription Drug Benefits are included in Medical Plan | 86% |
| Prescription Drug Benefits are separate from Medical Plan | 14% |

## Grandfather Plan Status

The Affordable Care Act allowed plans which did not meet certain ACA requirements to remain "grandfathered" so long as no plan changes were made. If a change is made above certain minimal thresholds (e.g., increasing the office visit copay from $15 to $20) then the plan would need to make other changes to comply with ACA. The survey data showed that almost 40 percent of the plans continue to have grandfathered status.

| Grandfather Plan Status | |
|---|---|
| Grandfathered | 38% |
| Not Grandfathered | 62% |

## Funding Arrangement

About 85 percent of School Districts self-insure their medical coverage, either directly or through a consortium, and over half self-insure their dental and vision benefits.

| Coverage Type | Medical | Dental | Vision |
|---|---|---|---|
| Fully Insured | 15% | 43% | 40% |
| Self-Insured | 85% | 57% | 60% |

## Retiree Subsidies

Relatively few SDs provide the same level of subsidy to retirees as are provided to active employees. Almost half the SDs provide no direct subsidy for retiree medical and 69 percent provide no subsidy for dental. As the costs for pre-65 retirees are higher than the average cost for all school employees, there is an implicit subsidy even if the SD is not providing a direct premium subsidy.

| | Medical | Dental |
|---|---|---|
| Subsidized differently from actives | 47% | 19% |
| Subsidized same as actives | 8% | 12% |
| No subsidy | 45% | 69% |

## Consortium Participation

Most school districts obtain healthcare benefits through a consortium. However, 14 percent are obtaining benefits on their own either self-insured or fully-insured.

| Consortium Participation | |
|---|---|
| School districts participating in a consortium | 86% |
| School districts not participating in a consortium | 14% |

## Recent Healthcare Cost Increases

Based on the summary of healthcare costs over the last five years, we observed that the pattern of healthcare cost increases incurred by the SDs has been slightly below the national average. We measured the healthcare cost increases by comparing the per capita costs after aggregating the costs using data obtained from the consortia where data was provided for each of the last five years. These costs reflect benefit changes (e.g., if the cost increase before plan changes was 5 percent, but benefits were reduced in value by 2 percent, the trend rate in per capita costs shows a 3 percent increase).

| Healthcare Cost Rate Increases | | | | | |
|---|---|---|---|---|---|
| | **2012/2011** | **2013/2012** | **2014/2013** | **2015/2014** | **Average** |
| Consortium average trend [10] | 6.1% | 1.7% | 4.9% | 0.5% | 3.3% |
| Federal Employees Health Benefit Program | 3.8% | 3.4% | 3.7% | 3.2% | 3.5% |
| Kaiser Family Foundation | 4.3% | 4.0% | 2.9% | 4.0% | 3.8% |

## Summary of Medical Plan Provisions

To illustrate the range of health plan provisions provided by the SDs, we have prepared the following charts. The charts show the 25th and 75th percentiles – indicating that half of the plan designs have provisions that fall between these values as well as the 10th and 90th percentiles to indicate the range of

[10] Enrollment weighted same consortia all five years

difference provisions found. We also show the median (50th percentile) value. The following chart shows the plan provisions across all plans, including plans with no deductibles.

| Percentiles | 10% | 25% | Median | 75% | 90% |
|---|---|---|---|---|---|
| **Summary across all plans, including plans with no deductibles** | | | | | |
| **Individual** | | | | | |
| In-Network Deductible | $- | $- | $100 | $350 | $1,300 |
| Out of Network Deductible | $200 | $250 | $400 | $700 | $1,500 |
| In Network Out-of-Pocket maximum | $515 | $1,888 | $6,350 | $6,350 | unlimited |
| In Network Coinsurance | 100% | 100% | 100% | 100% | 100% |
| Out of Network Coinsurance | 70% | 80% | 80% | 80% | 100% |
| **Family** | | | | | |
| In-Network Deductible | $- | $- | $300 | $700 | $2,600 |
| Out of Network Deductible | $400 | $500 | $800 | $1,500 | $3,000 |
| In-Network Out-of-Pocket maximum | $1,230 | $3,075 | $12,700 | $12,700 | unlimited |

Not all plans have deductibles; therefore, the following chart shows the range of plan provisions across only those plans that use deductibles.

| Percentiles | 10% | 25% | Median | 75% | 90% |
|---|---|---|---|---|---|
| **Summary across only plans with deductibles** | | | | | |
| **Individual** | | | | | |
| In-Network Deductible | $100 | $231 | $350 | $713 | $1,300 |
| Out of Network Deductible | $200 | $250 | $450 | $700 | $1,500 |
| In Network Out-of-Pocket maximum | $515 | $1,888 | $6,350 | $6,350 | unlimited |
| **Family** | | | | | |
| In-Network Deductible | $300 | $500 | $700 | $1,500 | $2,600 |
| Out of Network Deductible | $500 | $500 | $950 | $1,500 | $3,000 |
| In Network Out-of-Pocket maximum | $1,230 | $3,075 | $12,700 | $12,700 | unlimited |

The most commonly used services are physician office visits and diagnostic services. The following chart shows the copays required for these types of services. The top part of the chart shows the values across all plans, including plans that do not use copays. The bottom part of the chart shows the values across only those plans that use copays.

| Percentiles | 10% | 25% | Median | 75% | 90% |
|---|---|---|---|---|---|
| **Summary across all plans, including plans with no copays** | | | | | |
| **Office Visits** | | | | | |
| Primary Care Physician | $- | $- | $10 | $20 | $20 |
| Specialist | $- | $10 | $20 | $25 | $30 |
| Emergency Room | $- | $- | $35 | $75 | $100 |
| Routine Lab | $- | $- | $- | $- | $10 |
| Radiology | $- | $- | $- | $- | $10 |
| **Summary across only those plans with copays** | | | | | |
| **Office Visits** | | | | | |
| Primary Care Physician | $10 | $10 | $15 | $20 | $25 |
| Specialist | $10 | $15 | $20 | $25 | $30 |
| Emergency Room | $25 | $35 | $50 | $100 | $100 |
| Routine Lab | $10 | $10 | $15 | $20 | $21 |
| Radiology | $10 | $10 | $15 | $20 | $26 |
| **Hospital and Outpatient Copays** | | | | | |
| Hospital In Network Per Admission | $22 | $38 | $100 | $250 | $365 |
| Hospital In Network Per Day Copay | $75 | $75 | $75 | $88 | $150 |
| Outpatient In Network Copay | $13 | $20 | $30 | $75 | $100 |

## Summary of Prescription Drug Plan Provisions

About 20 percent of the school district plans have separate deductibles for the prescription drug benefit. For plans that use copays, the most common structure used three tiers, with the lowest copays for generic drugs and the highest copays for brand non-formulary drugs. Some SD plans use a fourth tier for specialty drugs with a higher copay.

| Percentiles | 10% | 25% | Median | 75% | 90% |
|---|---|---|---|---|---|
| **Summary across only those plans using deductibles** | | | | | |
| Separate Rx Deductible | $25 | $50 | $100 | $100 | $125 |
| Separate Rx Out of Pocket maximum | $170 | $275 | $1,650 | $5,475 | $6,600 |
| **Summary across only those plans using copays** | | | | | |
| Retail Generic Copay | $5 | $5 | $8 | $10 | $10 |
| Retail Brand Formulary Copay | $10 | $15 | $20 | $30 | $35 |
| Retail Brand Non-Formulary Copay | $15 | $25 | $35 | $50 | $60 |
| Retail Specialty Copay | $15 | $25 | $35 | $50 | $70 |

| Percentiles | 10% | 25% | Median | 75% | 90% |
|---|---|---|---|---|---|
| Mail Order Generic Copay | $7 | $10 | $12 | $20 | $20 |
| Mail Order Brand Formulary Copay | $20 | $25 | $40 | $50 | $70 |
| Mail Order Brand Non-Formulary Copay | $20 | $35 | $60 | $90 | $110 |
| **Summary across only those plans using coinsurance** | | | | | |
| Retail Generic Coinsurance | 18% | 20% | 20% | 20% | 20% |
| Retail Brand Formulary Coinsurance | 20% | 20% | 20% | 20% | 25% |
| Retail Brand Non-Formulary Coinsurance | 20% | 20% | 20% | 20% | 40% |
| Mail Order Generic Coinsurance | 18% | 20% | 20% | 20% | 20% |
| Mail Order Brand Formulary Coinsurance | 20% | 20% | 20% | 20% | 22% |
| Mail Order Brand Non-Formulary Coinsurance | 20% | 20% | 20% | 20% | 40% |

# COST OF CURRENT BENEFITS FOR THE NEXT FIVE YEARS

To develop a baseline for the current cost of healthcare benefits for school employees we compared the enrollment data obtained from the consortia and individual school districts with the best available data on the total number of public school employees. The projection of the cost of the current benefits for the next five years is based on the following information.

| | |
|---|---|
| A. Number of School Employees[11] | 190,000 |
| B. Covered lives per Employee | 2.5 |
| C. Opt-out rate (Percentage of employees waiving coverage) | 12% |
| D. Number enrolled in SD health plans [A x B x (100%-C)] | 418,000 |
| E. Cost per covered life in 2015 | $6,443 |
| F. Aggregate cost in 2015 [D x E] | $2,693,000,000 |

Using data from the January 2012 population projection report prepared by Catherine Tucker at the Population Research Institute at Pennsylvania State University, the number of children between the ages of 5 and 17 is projected to decline by 73,486, or 4.5 percent between 2015 and 2020. This reduction in school enrollment may lead to a small reduction in the number of school employees; however in many school districts the decline in enrollment will primarily affect class size and not the number of classrooms, teachers, and other support staff. If class size remains unchanged, the decline in the number of school age children will likely result in a 0.8 percent annual decline in the number of school employees.

| Total Projected Population of Pennsylvania School Age Children, 2010 - 2020 | | | | | |
|---|---|---|---|---|---|
| | Age | | | | |
| Year | 0 - 4 | 5 - 9 | 10 - 14 | 15 - 19 | Ages 5 - 17 |
| 2010 | 700,290 | 727,063 | 765,299 | 875,878 | 1,930,301 |
| 2015 | 668,999 | 703,229 | 730,390 | 768,560 | 1,817,899 |
| 2020 | 676,141 | 671,377 | 706,207 | 733,658 | 1,744,413 |
| 2020 less 2015 | 7,142 | -31,852 | -24,183 | -34,902 | -73,486 |

Healthcare costs have increased above the rate of consumer price inflation and are expected to continue to do so. In developing the projected cost, the current costs are increased using assumed health care cost trend rates obtained from the Society of Actuaries Long Term Healthcare Cost Trends Resource

[11] Source: OpenPAgov.org

Model v2014_b. The 2015 rate of 4.7 percent is expected to increase gradually over the next four years before stabilizing at 5.5 percent.

Even after reflecting the decline in the population of school employees, the expected cost is projected to increase by over $100 million per year, rising from $2.7 billion in FY2014-15 to $3.4 billion in FY2020-21.

| Projected Total Cost of Healthcare for All School Employees<br>Amounts in $millions | | | | | | |
|---|---|---|---|---|---|---|
| **Fiscal Year** | **2014-15** | **2015-16** | **2016-17** | **2017-18** | **2018-19** | **2019-20** |
| **A. No change in number of school employees** | $2,693 | $2,820 | $2,961 | $3,118 | $3,286 | $3,467 |
| **B. Baseline, includes population change** | | $2,797 | $2,937 | $3,093 | $3,260 | $3,439 |
| **Assumptions** | | | | | | |
| **1. Healthcare cost trend** | 4.7% | 5.0% | 5.3% | 5.4% | 5.5% | 5.5% |
| **2. Population change** | -0.8% | -0.8% | -0.8% | -0.8% | -0.8% | -0.8% |

In addition to these premium costs, school districts are projected to incur waiver payments of $50 million in 2015, or about 2 percent of the aggregate healthcare costs. Most school districts defined the size of the waiver payment ("opt-out") credit as a fixed dollar amount that did not vary by year through the duration of the CBA. Some SDs set the opt-out credit as a percentage of the premium cost. Given the projected decline in the number of school employees in the next five years and the mix of policies on opt-out credits, we expect the amount of waiver payments to remain fairly steady at $50 million per year.

# AVERAGE COST PER EMPLOYEE

The following tables show the range in employer contribution amounts paid for medical, prescription drug, dental and vision coverage by employee election. For school employees enrolled in school district health plans, the charts show the smallest and largest amounts, as well as the values at the 10th, 25th, 50th, 75th and 90th percentiles.

| Medical & Prescription- Employer Contributions by Coverage Tier | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Coverage Tier** | **Min** | **10%** | **25%** | **50%** | **75%** | **90%** | **Max** |
| Employee only | $3,042 | $5,438 | $5,974 | $6,305 | $6,861 | $7,666 | $17,256 |
| Employee & spouse | $8,847 | $12,744 | $14,254 | $15,940 | $17,142 | $17,991 | $21,809 |
| Employee & child | $7,336 | $10,864 | $12,894 | $13,974 | $15,385 | $16,308 | $19,507 |
| Employee & children | $8,919 | $12,897 | $13,970 | $14,910 | $16,316 | $18,108 | $20,796 |
| Employee & family | $11,047 | $15,444 | $17,052 | $17,849 | $18,628 | $20,495 | $24,054 |

| Dental - Employer Contributions by Coverage Tier | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Coverage Tier** | **Min** | **10%** | **25%** | **50%** | **75%** | **90%** | **Max** |
| Employee only | $40 | $190 | $273 | $319 | $400 | $273 | $1,140 |
| Employee & family | $40 | $592 | $717 | $823 | $971 | $717 | $1,668 |

| Vision - Employer Contributions by Coverage Tier | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Coverage Tier** | **Min** | **10%** | **25%** | **50%** | **75%** | **90%** | **Max** |
| Employee only | $0 | $24 | $40 | $53 | $69 | $40 | $157 |
| Employee & family | $0 | $44 | $85 | $122 | $152 | $85 | $384 |

The average annual employer cost per employee, taking into account the actual enrollment by coverage tier, is $14,396 for medical and prescription drug coverage, $548 for dental and $85 for vision, or a total of $15,028 for all coverages.

The average annual employer cost per employee for employees who waive medical and prescription drug coverage is $2,165.

# IMPACT ON THE PUBLIC SCHOOL EMPLOYEES' RETIREMENT SYSTEM AND STATE EMPLOYEES' RETIREMENT SYSTEM

The Senate Resolution stated that the study evaluate the impact on the Public School Employees' Retirement System and State Employees' Retirement System.

The Public School Employees' Retirement System ("PSERS") administers the Health Options Plan ("HOP") as well as the reimbursement of incurred premium expense benefit of $100 per month. The HOP program itself would not change if there were either a statewide program or regional healthcare programs for retired school employees. Currently, to administer the premium expense reimbursement program where a retired teacher is enrolled in a health plan sponsored by the school district, PSERS communicates with each school district to verify that retirees are enrolled in a SD health plan and incurring a premium expense of at least $100 per month. As there is no single statewide health plan, changes in enrollment (i.e., additions and deletions) are managed and administered at each school district. If there were a statewide health plan for school employees and retired school employees were enrolled in the plan, then the statewide health plan administrator could provide enrollment / disenrollment information on a monthly or weekly basis to ensure the PSERS had the most up-to-date and accurate information. In addition to being more accurate, PSERS would only need to collect the enrollment changes from one source rather than from all 500+ school districts.

From the stakeholder interviews with staff from the State Employees' Retirement System ("SERS"), we did not identify any issues that would impact the system whether or not the consolidation of health benefits for school district employees were to be provided solely on a regional basis or through a state-wide plan.

# COMPARISON OF COVERAGE WITH AVERAGE TAXPAYER IN THE RELEVANT REGION

We obtained a summary of enrollment in group and individual policies administered by major Pennsylvania health insurance companies.[12] Data was collected for 2.8 million covered lives, of which over eighty percent was for group policies. The data obtained was the actuarial value of the health plans categorized in one of seven levels from the lowest level of Bronze/Bronze Plus, to the highest level of Platinum Plus. The table below shows the actuarial value associated with each coverage level.

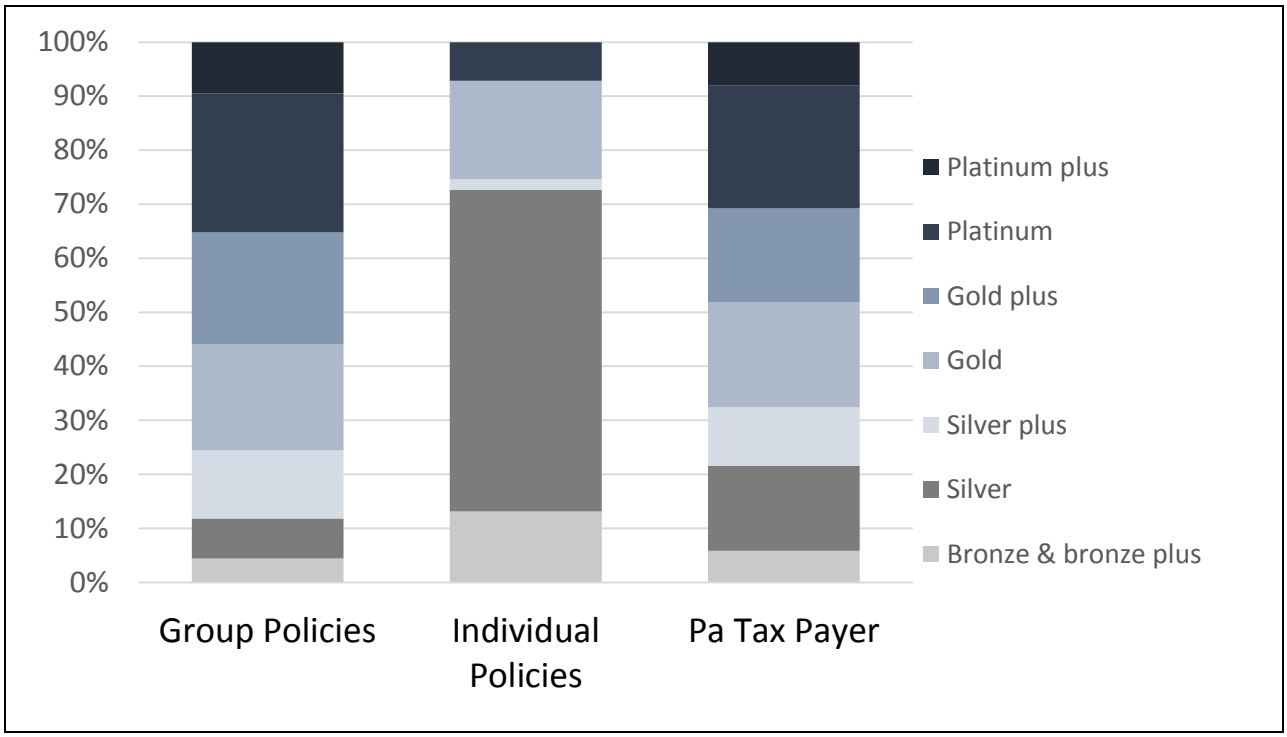
| Health Plan Coverage Level | Actuarial Value |
|---|---|
| Platinum Plus | Above 92% |
| Platinum | 88% to 92% |
| Gold Plus | 82.1% to 87.9% |
| Gold | 78% to 82% |
| Silver Plus | 72.1% to 77.9% |
| Silver | 68% to 72% |
| Bronze & Bronze Plus | 60% to 67.9% |

The median value of the individual policies was at the Silver level, while the median value of the group policies was at the Gold Plus level. The combined data for Pennsylvania tax payers shows that the median value was at the Gold level, as shown in the table below.

| Health Plan Coverage Level | Group Policies | Individual Policies | PA Tax Payer |
|---|---|---|---|
| Platinum Plus | 9% | 0% | 8% |
| Platinum | 26% | 7% | 23% |
| Gold Plus | 21% | 0% | 17% |
| Gold | 20% | 18% | 19% |
| Silver Plus | 13% | 2% | 11% |
| Silver | 7% | 60% | 16% |
| Bronze & Bronze Plus | 4% | 13% | 6% |

[12] Based on data provided by Highmark, Capital Blue Cross, Independence Blue Cross, Aetna, and Geisinger

This information is also shown graphically in the following chart.




Data was collected by geographic region. While each region showed a similar pattern of a mix of policies purchased or provided, there was a noticeable difference (between 2 and 4 percent lower Actuarial Value) between the plan richness in southeastern Pennsylvania and the other three regions. The lower actuarial value of the plans provided in southeast may be a consequence of higher healthcare costs in that region.

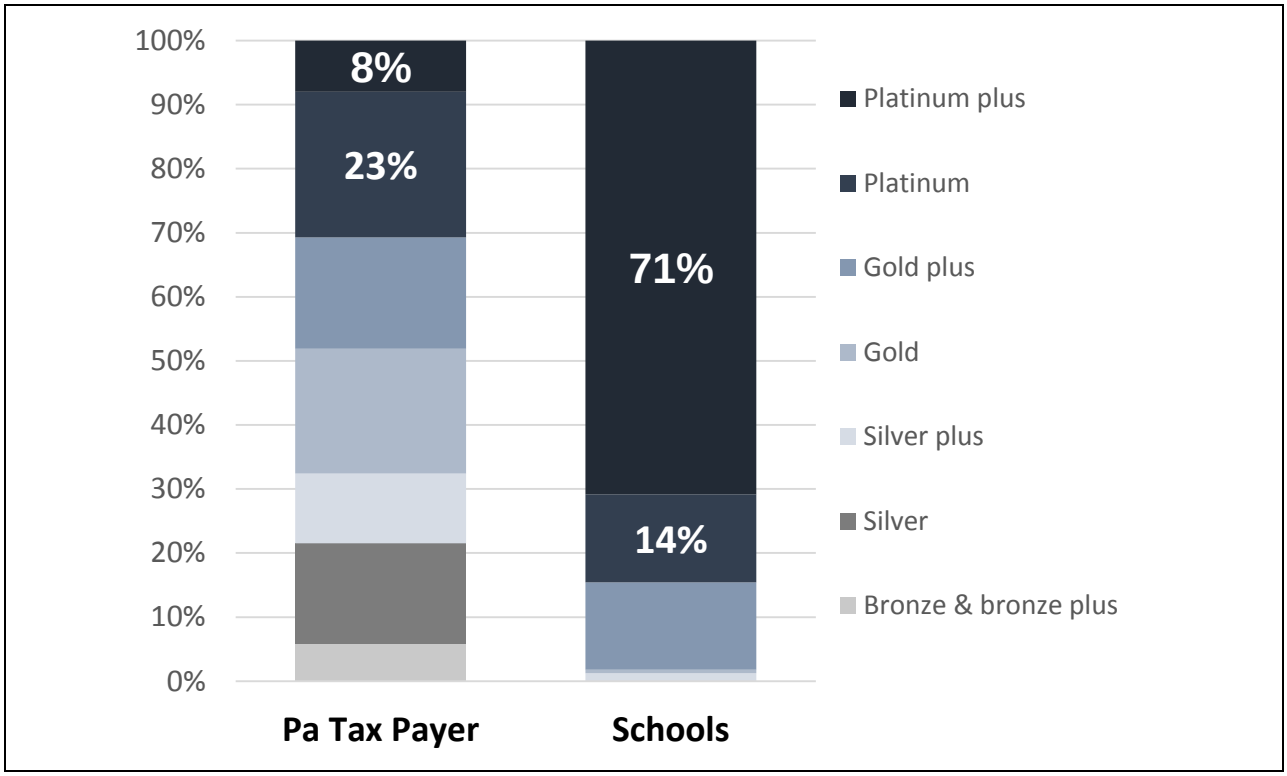
| Actuarial Value of PA Taxpayer Health Benefits | | | | | |
|---|---|---|---|---|---|
| | **Western** | **Northeastern** | **Central** | **Southeastern** | **Total** |
| **Group** | 85.4% | 85.2% | 83.4% | 80.7% | 82.9% |
| **Individual** | 73.7% | 75.9% | 73.7% | 71.1% | 72.7% |
| **Combined** | 83.1% | 81.3% | 81.3% | 79.4% | 81.3% |

The following chart compares the school district health plan actuarial values to the data collected from the major carriers that represents the benefit levels of Commonwealth of Pennsylvania tax-payers.

The table shows that over 70 percent of school employees have health plans with an actuarial value that places them in the “Platinum Plus” category, compared with 8 percent of PA tax payers. The median PA tax payer plan has a Gold level whereas the median School District plan as a Platinum Plus level.

| | PA Tax Payer | Schools |
|---|---|---|
| **Platinum plus** | 8% | 71% |
| **Platinum** | 23% | 14% |
| **Gold plus** | 17% | 14% |
| **Gold** | 19% | 1% |
| **Silver plus** | 11% | 1% |
| **Silver** | 16% | 0% |
| **Bronze & bronze plus** | 6% | 0% |

This information, comparing the typical PA tax payer’s health plan to School employees’ health plans is also shown graphically in the following chart.



# REGIONALIZATION VERSUS ONE HEALTH CARE PLAN

As part of the study, we examined the advantages and disadvantages of regional health care plans versus one state-wide health plan. As noted in the January 2004 study, several states (including DE and NC) utilize a single state-wide health plan for school employees. Some states have a state-wide plan that is voluntary (including CA, LA, NJ, NY, SC), and others, like the Commonwealth of Pennsylvania, do not have any state-wide plans (including MD, VA, and OH).

With over 85 percent of school districts already participating in one of the 37 health care consortia, we observe that from a practical perspective the current structure is already partly regionalized. The consortia and survey participants were asked their views on the pros and cons of one health care plan versus regionalization and the respondents' views were mixed.

**Reasons noted for a state-wide plan included:**

- Establishing a state-wide plan will enable this element of total compensation to be removed from the bargaining process;
- Increased purchasing power will lower costs through competition and economies of scale;
- Ability to develop a carved-out prescription drug benefit plan;
- Can leverage centers of excellence and management of high-cost cases; and
- Ability to collect data directly from carriers for real-time and actionable analytics

**Reasons noted for regionalized health care plans included:**

- Concern that pooling rural districts with large urban districts can result in higher health plan costs;
- Regional Consortia are in the best position to take advantage of local, low cost options. Statewide plans may make narrow network products impossible when those products can lower costs;
- Smaller groups have the flexibility to implement tailored wellness programs across the membership;
- Unless there is consumer buy-in (in this case, the district and its employees), it is a challenge to truly achieve cost savings. The districts and employees know the doctors and hospitals in their area and can affect the cost of care if they know and understand what drives their cost;
- Just like any industry, the school district must provide a competitive salary and benefits package to attract teachers. Removing the health plan to a state plan will not offer the competitive advantage over what an individual can get in industry;
- Healthcare is very local so a statewide trust would likely involve some subsidizing across county boundaries depending on the risk/funding setup;

- Some of the goals of regionalization could be to limit networks, choose cost-effective providers, and changing benefits to incent the use of cost-effective providers; and
- Bigger is not always better.

**Concerns raised with respect to implementing a state-wide plan or regional plans limited to just school district employees included:**

- Consortia currently include several groups other than School Districts, including IUs and Community Colleges. Consideration would need to be given to how these groups would access affordable healthcare options if regional plans were limited to just school districts.

## State-Wide Healthcare Program

If a state-wide healthcare program were established to facilitate a smooth transition in costs and employee plan design cost-sharing, the healthcare program should include a range of health plan designs as is the case currently for most school districts. School Districts could select which plans to make available to their employees (e.g., all options or a specific set of plans), with associated premium cost-sharing arrangements determined through collective bargaining at the school district level. This structure would facilitate the economies of scale and cost-efficiencies from combining the purchasing power of all school employees and dependents enrolled in a single program with the local budgeting and decision making on employee premiums and employee contribution policies.

A state-wide program would likely require harmonization of eligibility and coverage policies, including policies on spousal coverage, and when coverage starts and ends.

# COST SAVINGS REALIZED WITH CONSORTIA COMPARED TO PRIOR CONSORTIA

## Use of Consortia to Provide Health Insurance

A key finding from the study is that in stark contrast to the prior study completed 11 years ago, we found that over 85 percent of school districts obtain their coverage through one of 37 consortia that provide health insurance to over 400 school districts. The consortia range in size from 4 school districts to 48 school districts. The smallest consortium has 1,450 covered lives and the largest has over 48,000 covered lives.

The aggregate data from the consortia provided a solid base of claims information for our analysis. The consortia provided up to five years of historical claims and enrollment data which allowed us to examine both the current cost and the pattern of annual health care cost changes over the last four years. Examining the trend for the experience of those consortia that provided data for all years, the 4-year average healthcare trend was 3.3 percent.

| Cost increase from | Trend Rate |
|---|---|
| 2011 to 2012 | 6.1% |
| 2012 to 2013 | 1.7% |
| 2013 to 2014 | 4.9% |
| 2014 to 2015 | 0.5% |
| 4-year average | 3.3% |

## Consortia savings

A key finding from the study is that most school districts are obtaining health benefit coverage through one of 37 consortia. These consortia are dynamic, with some adding new school districts and others dissolving. The consortia provided details on the actions that they have taken to manage healthcare costs and dampen health cost increases. There was a wide range of actions.

- One consortium began narrowing the provider network leading to claims savings of over $13 million last year alone on a budget of $250 million. They anticipate additional savings this fiscal year by providing a narrower, tiered, high value network within their region.

- A consortium has realized costs savings through negotiation of administrative fee reductions through a loyalty agreement with the Medical and Rx Carrier. In 2014, the Consortium implemented a Consumer Driven Health Plan that targets reductions in annual trends. The consortium has also

evaluated the contracts for provider, pharmacy, stop loss reinsurance and broker/consulting services and has found the current arrangements to be very competitive.

- Aggressive efforts on consortium-wide reinsurance programs inclusive of specific and aggregate caps have consistently reduced expected market costs by 5 to 7 percent annually ($84,000 to $189,490 annual range). A rate lock guarantee for a second year renewal with a consortium option to accept or decline provided additional cost avoidance during Affordable Care Act transition and elimination of maximum insurance level coverage.

- Administration (Third Party Administrator) costs are being heavily negotiated. For 2013-14, administration cost to claims ratio was 2.19 percent and the number falls below 2 percent if fixed costs (mostly reinsurance) are added to claims. Using the secure base and the expertise provided by the consortia, more than half of the districts have added / offered optional high deductible plans, Qualified High Deductible Plans with Health Savings Accounts (HSA), or Health Reimbursement Accounts (HRAs) provide other variations in plan design changes to leverage downward medical cost trends. Plan design changes are well supported via the consortia brokers, TPAs, and actuary and consulting professionals engaged to assist school districts in managing plan design directions.

- Pharmacy Benefit Management is through the carrier's formulary, although one of the consortium members has moved to carve out prescription drugs.

- One consortium reported: "High performance tiered product will save a lot of money in addition to just a narrower network implemented this year. Negotiations with health care provider saved $15 million over 3 years regardless of claims. In discussion with local hospitals to see if additional partnerships can provide savings in the future. Will be looking at a prescription carve out program when this contract expires. This is available through a partnership with the Pittsburgh Business Group on Health which bids out this program in our region."

- Another reported: "Stop loss premiums cost $1,443,618 over the past five years, wellness programs paid by the consortium (not the individual members) totaled approximately $188,600, the TPA fees paid by the consortium (not the individual members) totaled approximately $446,500. The effectiveness of wellness initiatives and prescription plans such as Rx 'n Go[13] cannot be objectively measured from a fiscal prospective. However, medical statistics have shown that these programs reduce the long-term health care costs of individuals."

[13] *Rx 'n Go is a prescription medication savings program that delivers up to a 90-day supply of generic maintenance medications right to your doorstep. Rx 'n Go has more than 1,100 generic drugs available across four flat-fee pricing tiers. That's nearly three times the number of drugs as retail generic programs whose lists usually contain no more than 400 drugs.*

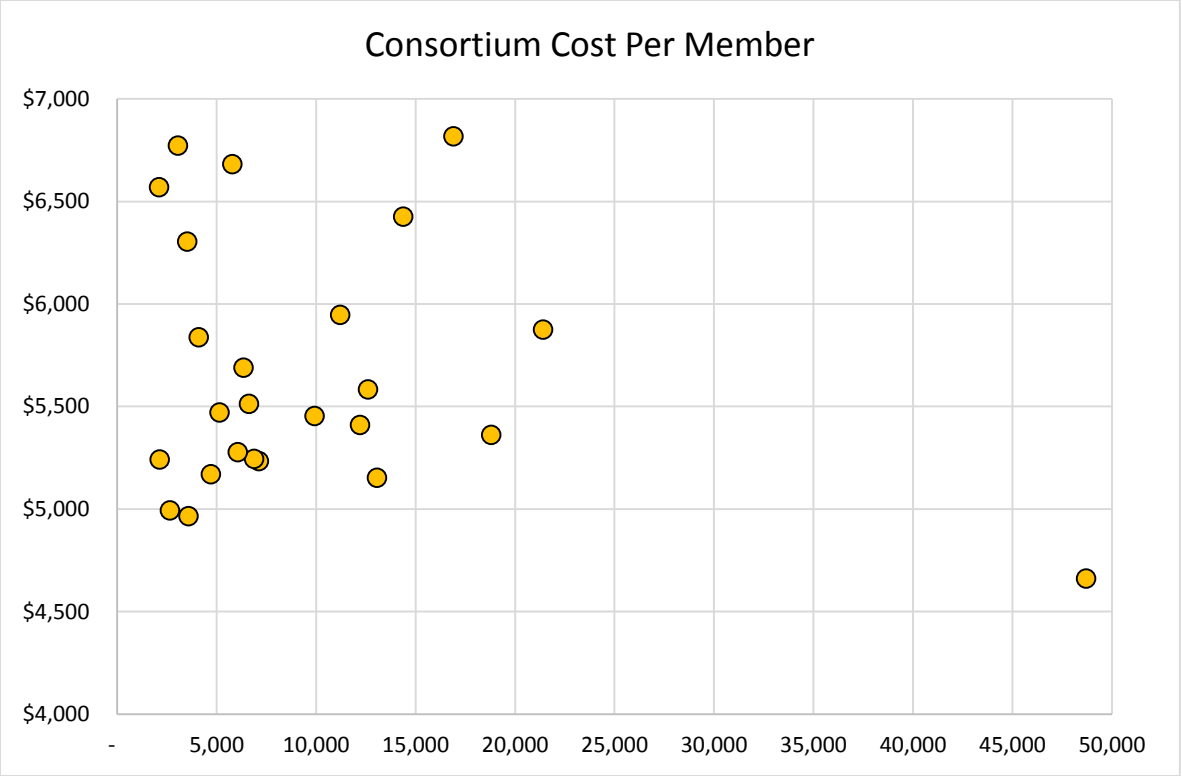
- The Trust manages a stop-loss pool up to $300,000. School district has flexibility to choose deductible and the associated stop-loss pool rate. The Trust is also a member of the PA Trust for the purchase of stop loss reinsurance. A maxi-pool was established to manage claims up to $500,000. The members have the benefit of the savings of stop loss reinsurance. Trust negotiates on behalf of all members for medical, dental and vision. Contract renewals were negotiated for medical with a rate hold for three years in addition to a competitive drug rebate contract. Trust is assisting districts to strategically structure their benefit plan designs to achieve the most savings. Qualified high deductible plans are being put in place to replace the old PPO plan designs.

- Trust became self-funded in 2012-13. In 2013-14, Trust changed from a two-tier prescription plan at copays of $10/$24 with a $100 deductible to a three tier plan with copays of $5/$35/$70 with a $100 deductible. Also in 2013-14 Trust changed office visit copays from $15 per visit (all care settings) to $15 for general practitioners, $30 for specialists, and $40 for urgent care. The ER copay went from $40 to $100 in 2013-14 also.

In summary, whereas a decade ago the consortia were operating primarily as pooled purchasing cooperatives, today's consortia are examining cost drivers and developing and implementing novel programs to manage the costs of the coverages, no doubt contributing to the relatively low trend increases in cost over recent years.

## Healthcare Costs by Size of Consortium

We compared the healthcare costs across all of the Consortia. The following chart shows the 2015 annual healthcare cost per member for each of the Consortia. Costs are influenced by a number of factors including benefit plan richness, economies of scale, demographics and geography, and provider contracting.




The chart shows the annual cost per member relative to the size of the Consortium. The chart also shows a range of per member costs from $4,600 to $6,800. Note that the largest consortium, the Allegheny County Schools Health Insurance Consortium, which has 48,000 members, had the lowest cost at $4,661 per member.

Note that this analysis does not include Philadelphia School District which covers over 10,000 members as it is not structured as a Consortium. The annual cost per member for employees in the Philadelphia School District is $8,815.

# ADMINISTRATIVE, STAFFING, AND TECHNOLOGY COSTS ASSOCIATED WITH FORMING MERGERS

Based on the information reported in response to our survey, it is evident that the vast majority of school districts have in effect outsourced most functions associated with the administration of health care plans for the districts' participants. Such administration functions in the context of health care plans typically include all the following:

| Summary of Activities by Functional Categories | | | |
|---|---|---|---|
| Marketing | Provider & Medical Management | Account & Member Administration | Trust Governance Services |
| ▪ Market research<br>▪ Plan design<br>▪ Marketing campaigns<br>▪ Advertising & public relations<br>▪ Broker relations & commissions<br>▪ Rating & underwriting | ▪ Provider network/ contracting<br>▪ Provider and program quality admin and reporting<br>▪ Medical management<br>▪ Pharmacy management | ▪ Enrollment & billing<br>▪ Claims and encounter administration<br>▪ Information technology<br>▪ Customer service<br>▪ Member communications<br>▪ Fraud controls | ▪ Finance and accounting<br>▪ Actuarial<br>▪ Risk management<br>▪ Legal, compliance and filing<br>▪ Corporate executive & governance<br>▪ Investment services |

*Source: Developed by Solucia Consulting, consistent with the Sherlock Company's functional mapping, printed by American Academy of Actuaries, Critical Issues in Health Reform: Administrative Expenses, September, 2009*

Note that this review by the American Academy of Actuaries covered all areas in which health care vendors provide coverage, including individual and small group health coverage, which in some respects (especially under the marketing activities described above) would not be relevant to large group health care plans, and especially to those plans which cover multiple Pennsylvania school districts through the existing consortia.

Very few of the school districts responding to the survey, whether the district is in a stand-alone plan or is in one of the consortia, reported maintaining any dedicated, permanent staff committed solely to the administration of the health plan. That does not of course mean that the districts incur no cost since ultimately the district must be the source for reporting eligible participants and changes in eligibility, to the vendor or vendors performing the administration of the health care plan. The districts also perform other functions, such as administering payroll deductions for participant contributions and initiating continuing coverage under the provisions of the COBRA rules. Only the district will know, for any coverage period, who among its employees has elected to participate in the plan and when employees are no longer eligible or participating in the plan. Unless the obtaining of dependents' data has been outsourced to the

vendor to compile, based on the eligibility file that will be controlled by the district, the district is also commonly the source of dependents' coverage data.

There are some examples in the health care marketplace where a large health care or benefits system has in place an administrative entity with dedicated staff to perform certain functions on behalf of multiple employers or multiple units within a given employer, and we cite below three such examples to illuminate how administrative costs are developed in such systems. We should note, however, that in these systems the reported costs for administration do not represent the entire administrative costs, including staffing and technology costs, since inevitably many of those costs are borne by the health care vendor with the central responsibility for adjudicating and settling claims and many of the other functions identified in the last three columns of the table immediately above.

## Pennsylvania Employees Benefit Trust Fund (PEBTF)

The Pennsylvania Employees Benefit Trust Fund was established in1988. PEBTF is charged with the following administrative functions:

- Enrolling and maintaining enrollment information on the following classes of participants:
  - Active members
  - Non-Medicare eligible retiree members
  - Medicare eligible retiree members
- Administering Get Healthy, the Commonwealth's program to provide wellness screening for employees and covered spouses /domestic partners
- Providing through MyActiveHealth support information to encourage wellness through
  - FAQ's
  - A Webinar program
  - Registration information
  - Information on syncing a mobile device or application
- Through Quit for Life, encouraging members to quit smoking
- Providing extensive communications to members through such sources as:
  - Publications
  - News Bulletins
  - FAQ's
  - Various other programs to encourage a healthier and better informed member population
- Through the Trust managing the collection of participant and employer contributions, including the investment of trust fund reserves and distributing required premiums to participating vendors.

PEBTF's administrative cost is less than 2 percent of the total cost of providing health care benefits to employees, retirees and family members who participate in the PEBTF program.

## A Large Multiemployer Fund Administrator

A large multiemployer fund administrator in a vital U.S. industry administers health and welfare benefits for funds with more than 35,000 beneficiaries. This fund administrator maintains eligibility and all records for both retirement funds and for four health and welfare funds, and provides extensive communications and other support services for beneficiaries. Since they break out costs separately for each of the funds they administer, they were able to provide us with costs associated with just their administration of the health and welfare funds. The administrator also administers Medicare benefits for retirees within the funds' retiree population, and they are reimbursed for those Medicare administration costs by Medicare.

They are not a third party administrator serving other multiemployer plans—their services are dedicated just to administering the plans for collectively bargained employees and retirees within the industry they serve.

In 2014 there were 88 full-time staff allocated to the health and welfare funds. Total operating costs allocated to the four funds were $20.6 million, net of Medicare reimbursements of $21.5 million. Total income for all four funds was $334 million for the same period. Thus administrative costs represented just under 6.2 percent of income for the period.

The IT budget for 2014 represented a very small fraction of total operating expenses. At just under $250,000 for the year, IT services (computer services and computer/equipment and supplies) accounted for just 1.2 percent of the funds' operating expenses for the year.

The most important observation to note is the much higher expenses incurred by these funds, compared with the costs reported by PEBTF. That cost differential illustrates at least anecdotally the importance of scale in driving the costs of administration for health and welfare plans.

## Federal Employees Health Benefits (FEHB) Program

The Federal Employee Health Benefits (FEHB) Program was established by Congress in 1960. As of 2015, the FEHB program covered some 8.2 million employees, retirees and their dependents, reflecting the fact that FEHB is the largest employer-sponsored health care plan in the United States. Total premiums for the plans provided through FEHB exceed $40 billion.

Office of Personnel Management (OPM) oversees the program through a staff of just over 100 persons, including actuaries and staff who negotiate with the carriers participating through the program. It issues

annual “call letters” which stipulate for each carrier programs and rules/requirements for plans for the coming year which OPM is entitled to develop through regulatory power provided OPM under the governing statute.

They also monitor and adjust reserve levels, including contingency reserves, which from time to time are drawn down to maintain reserves at the appropriate level and to modulate the volatility of rate changes. OPM also coordinates with agencies participating in FEHB the collection of participant and employer contributions and the remittance of those contributions to the participating health care plans. Finally, they are responsible for oversight of the Temporary Continuation of Coverage (TCC) program, which mirrors COBRA continuation of coverage mandated by statute for employer-sponsored health care plans outside the federal government.

Some 230 different plans participate in the FEHB system, including fee for service (PPO) plans and health maintenance organization (HMO) plans. Some plan offerings also include personal care accounts associated with a high deductible health care plan, similar to health savings account plans (HSAPs) and health reimbursement account plans (HRAs) in the private sector and in some state and local government plans. In practice, since many of the plans are locality based in any given geographical area, a participant will have the choice of a dozen or more plans.

The direct administrative costs for OPM’s share of administration functions is limited by law to no more than 1 percent of premiums, and the reported costs are significantly less than that statutory limitation reflecting the limited staff dedicated to FEHB administration. However, it must be noted that as with the other programs described, that number does not capture the full cost of administration since it does not include administrative costs incurred at the agency level by participating federal employers, nor does it include the administrative costs incurred by the health care vendors in performing their administrative functions under the plans they provide.

While the report is dated, a 1992 report prepared by the GAO compared FEHB program administrative costs in their entirety with costs reported by CHAMPUS (now the TRICARE program for civilian employees of the military) and with large, self-insured programs surveyed by an independent consulting firm and cited in the GAO report. This GAO analysis included the direct costs of OPM administration, but also the costs incurred through the vendors responsible for paying health care claims and the other administrative functions required in a large employer-sponsored health care plan.

Interestingly the report found that all administrative costs for the large self-insured plans and the CHAMPUS plan were significantly less than costs within FEHB. Costs within FEHB were $8.56 for each $100 of claims costs. Costs for the CHAMPUS program were 54.4 percent of that amount or $4.66; costs

for the large self-insured programs surveyed were slightly less, at $4.52 or 52.8 percent of the FEHBP costs.

That cost difference, according to the GAO analysis, was attributed to a number of factors, but the key factors were identified as:

- The fact that the carriers within the FEHB program are essentially not subject to periodic competitive bidding, which remains the case today;
- The focus on auditing to insure that carriers' expenses did not exceed negotiated ceilings resulted in insufficient analysis and information to determine whether the carriers' reported expenses were in fact incurred by the carriers, which exacerbates the problem of the lack of periodic competition; and
- The multiplicity of plans and locality based smaller plans especially forfeit the economies of scale that create lower costs for larger plans compared with smaller health care plans, including the necessity to recover redundant costs of administration.

The important point illustrated by the GAO analysis is this point—that the economies of scale that result from larger versus smaller concentrations of participants in a health care plan will generally result in lower administrative costs, especially if accompanied by robust oversight and periodic competitive bidding to assure that administrative services are competitively priced on an ongoing basis.

## Administrative Costs and the Economies of Scale

Given that administrative costs represent a relatively small portion of the overall costs of a health care plan, the additive short term costs that might be incurred in further consolidation of school district plans in the Commonwealth of Pennsylvania are not so significant that they are likely to be a decisive factor in determining whether to move forward with considering further consolidation.

We use the term “further consolidation” in recognition of the fact that, in the eleven intervening years since this subject was last reviewed on behalf of the legislature, significant consolidation has occurred. A summary of savings realized through Consortia is described on pages 28-31.

While some short term costs are likely to be incurred in the event further consolidation follows the current legislative review—especially in the elimination of systems and processes currently in place and the replacement of those systems and processes in new and larger regional consortia or in a state-wide plan—those costs are not likely to be substantial. And in the longer term, they will be more than recovered by the economies of scale created when smaller plans and populations are melded into larger plans and populations.

The best evidence of these economies is the continued growth of the consortia. The adoption of this approach would not have occurred in the absence of continuing experience in achieving economies of scale by bundling plans and populations into a larger plan and population and through greater scale, making possible the investment of time and effort in developing and adopting cost savings initiatives that have characterized the most successful of the consortia in the eleven years since this subject was last reviewed by the legislature.

# COMPARISON OF SCHOOL EMPLOYEES VERSUS COMMONWEALTH EMPLOYEES

Commonwealth employees' health care benefits are provided through the Pennsylvania Employee Benefits Trust Fund (PEBTF). PEBTF is a jointly trusteed health trust with equal numbers of union and management trustees.

PEBTF arranges health insurance coverage through a single Preferred Provider Option (PPO) contract with Highmark in all counties as well as Health Maintenance Organization (HMO) choices in each county, using one or more local HMOs. Both the PPOs and HMOs have the same medical and prescription drug plan designs which require copayments for office visits and emergency room visits. The prescription drug plan requires copayments that vary by generic and brand, with higher copayments for non-preferred brands. Lower copayments are available for PEBTF members who utilize mail order.

The following table shows the PEBTF member cost-sharing for in-network and out-of-network services and compares the PEBTF plan provisions with the median schools health plan. The detailed plan provisions for both median schools plan and the PEBTF plans were evaluated using a health actuarial tool that determined the proportion of covered charges that would be paid by the plan, on average, across the full range of types of services by a typical group of insured lives. This value is referred to as the plan's "actuarial value."

| | In-Network | | Out-of-Network / Non-Network providers | |
|---|---|---|---|---|
| **Plan Feature/Benefit** | **School Median Plan** | **State PPO Plan** | **School Median Plan** | **State PPO Plan** |
| **Deductible** —Individual | $ 300 | None | $ 750 | $400 |
| —Family | $500 | None | $1,500 | $400 per person |
| **Member Coinsurance** | 20% | 0% | 20% | 30% |
| **Out-of-pocket limit** —Individual | $1,300 | $6,600 | $3,000 | $1,900 |
| —Family | $1,500 | $13,200 | $6,000 | $3,000 excluding deductible |
| **Hospital inpatient (**member pays) | 100% | 100% | 20% | 30% |
| **Outpatient care** (member pays) | 20% | $15 | 20% | 40% |
| **Emergency room** | $85 | $50 | | $50 |
| **Urgent care facility** | 20% | | | |
| **Office visit** —Primary care (member pays) | 20% | $15 | $25 | 30% |
| —Specialist (member pays) | 20% | $25 | $40 | 30% |

| | In-Network | | Out-of-Network / Non-Network providers | |
|---|---|---|---|---|
| **Plan Feature/Benefit** | **School Median Plan** | **State PPO Plan** | **School Median Plan** | **State PPO Plan** |
| **Prescription Drugs** | | | | |
| **Retail copays** | | | | |
| Generic drugs | $7 | $10 | Not Covered | |
| Formulary | $12 | $18* | | |
| Non-Formulary | $20 | $36 | | |
| **Mail Order Copays** | | | | |
| Generic drugs | $5 | $15 | Not Covered | |
| Formulary | $20 | $27* | | |
| Non-Formulary | $30 | $54 | | |

* Plus pay the difference between the cost of the generic and the brand drug.

Both the School median health plan and the Commonwealth employee benefit plan have an actuarial value above 92 percent, which makes the plans "Platinum Plus". The table below shows that on average, participants in the median school health plan have slightly larger out-of-pocket costs than participants in the PEBTF PPO.

| | Median School Plan | PEBTF PPO Plan |
|---|---|---|
| Average member cost sharing as a percent of total covered charges | 5% | 4% |
| Actuarial Value | 95% | 96% |

The PEBTF health plan covers medical, prescription drug, dental, vision and hearing benefits. The following tables summarize the dental, vision and hearing coverage under PEBTF.

## Dental Benefits

Most, but not all, schools provide dental coverage. For those schools that provided information on their dental plans, the following tables provides a summary of the school districts' dental benefit coinsurance levels for preventive, basic restorative, and major restorative services. Almost all (96 percent) of school districts cover preventive services at 100 percent. Most (83 percent) school districts cover basic restorative services at 100 percent. Only 21 percent of school districts cover major restorative services at 100 percent, with the most common level at 50 percent.

| | Coverage and Cost-sharing | Limitations |
|---|---|---|
| Deductible | $50 per family member | Does not apply to preventive, basic restorative, or orthodontic services |
| Routine examinations | 100% | Once every 6 months |
| Cleanings (prophylaxis) | 100% | Once every 6 months |
| Fluoride application | 100% | Under age 19, once every 6 months |
| Full mouth X-rays | 100% | Once every 36 months |
| Bitewing X-rays | 100% | Once every 6 months |
| Basic restorative | 90% | Once every 2 years on same tooth |
| Single crowns | 60% | Once every 5 years on same tooth |
| Fixed bridgework | 60% | Once every 5 years on same arch |
| Repairs to bridges | 60% | Once in 12 months |
| Dentures | 60% | Once every 5 years on same arch |
| General anesthesia | 90% | In conjunction with covered dental work |
| Maximum benefit | $1,000 | Per person per calendar year |
| Orthodontics | 70% | Up to $1,250 lifetime maximum |

About 15 percent of school district dental plans have deductibles, with the average deductible of $27.

| Percent Paid by Plan | Preventive Services | Basic Restorative Services | Major Restorative Services |
|---|---|---|---|
| 100% | 96% | 83% | 21% |
| 80% to 90% | 3% | 14% | 29% |
| 60% to 75% | 1% | 3% | 6% |
| 50% | 0% | 0% | 44% |
| Schools Average | 98% | 95% | 66% |

The following table compares the average school district dental plan to the PEBTF dental plan. The table shows the typical school district dental plan is very similar to the current PEBTF dental plan.

| Dental coverage | Average School Plan | PEBTF |
|---|---|---|
| Deductible | $27 average | $50 per family member |
| Preventive | 98% | 100% |
| Basic restorative | 95% | 90% |
| Major restorative | 66% | 60% |
| Maximum benefit | $1,215 average | $1,000 |

## Vision Benefits

The PEBTF vision plan uses a network of providers. For state employees who use a participating provider there is no out-of-pocket costs for the annual vision examination or glaucoma test. Those using a non-participating provider would likely incur costs if the charge is above the maximum plan allowance.

| | Participating Provider | Non-Participating Provider |
|---|---|---|
| Yearly vision examination | 100% covered | Allowance of up to $28 |
| Glaucoma test | 100% covered | Allowance of up to $3 |
| Lenses | Standard glass/plastic are covered in full | Single vision: $15<br>Bifocals: $24.50<br>Ex-Bifocals: $26.50<br>Trifocals: $31.00<br>Aphakic: $60.00 |
| Pink #1 or #2 Tint | | Single vision: $3.00<br>Multifocal:$4.00 |
| Photo Gray Extra (glass only) | | Single Vision: $14.00<br>Multifocal: $20.00 |
| Oversize Blank Lenses | | Single Vision: $6.00<br>Multifocal: $9.00 |
| Frames – up to $20 | Covered in full up to a maximum of $20 | $20.00 |
| Frames – above $20 | 80% covered | $20.00 |

Data from the schools survey shows that where the amount of benefit is subject to a dollar maximum, the vision benefits provided to school employees are somewhat more generous than the PEBTF plan.

| School District Vision Coverages | 25th Percentile | Median | 75th Percentile |
|---|---|---|---|
| Vision exam-amount plan pays (where not 100%) | $30 | $39 | $58.75 |
| Standard single lenses amount plan pays | 24 | 30 | 60 |
| Bifocal lenses-amount plan pays | 36 | 40 | 73 |
| Trifocal lenses-amount plan pays | 46 | 60 | 94 |
| Frames-amount plan pays | 24 | 55 | 62 |
| Medically necessary contact lenses-amount plan pays | 70 | 160 | 250 |
| Elective contact lenses-amount plan pays | 73.50 | 80 | 125 |

## Hearing Benefits

School District hearing plans were embedded in the medical plan. No additional information was made available.

| PEBTF Benefit | Limitation |
|---|---|
| Hearing aid | One per ear per 36-month period |
| Monaural aid | Allowance up to $900 |
| Binaural aids | Allowance up to $1,800 |
| CROS | Allowance up to $2,400 |

## Employee Contributions

Commonwealth employees pay 5 percent of base pay for coverage. Coverage can be employee only or employee & dependents including a spouse so long as the spouse's employer does not offer health insurance coverage. The contribution of 5 percent of base pay is the same whether the employee enrolls in employee only or employee & dependent coverage. Employees who participate in the PEBTF "Get Healthy" program are eligible for a reduced contribution rate of 2 percent of base pay. If a Commonwealth employee's spouse is also covered by PEBTF, then both the spouse and the employee must participate in the Get Healthy program to be eligible for the lower contribution rate. About three quarters of employees are eligible for the reduced rate of 2 percent. The employee contributions cover all covered benefits under the program.

The average base pay for Commonwealth employees is $55,450.

| PEBTF | | | |
|---|---|---|---|
| | Enrolled in Get Healthy program | Not Enrolled in Get Healthy program | Weighted Average |
| Get Healthy Enrollment | 78% | 22% | |
| Average annual employee contribution for single coverage | $1,109 | $2,772 | $1,475 |
| Average annual employee contribution for other than single coverage | $1,109 | $2,772 | $1,475 |

School districts often have separate dental or combined dental & vision programs, and employees can choose to enroll in the medical plan but decline the dental or vision coverage. The table below shows the average annual premium (including SDs where no contribution is required) for employee only coverage, and for all other coverage tiers combined. This all other coverage tiers data is therefore comparable to the PEBTF "other than single" coverage.

| School Districts | | | | |
|---|---|---|---|---|
| Coverage Type | Medical | Dental | Vision | Total |
| Average annual contribution (employee only coverage) | $679 | $12 | $2 | $693 |
| Average annual contribution (all other coverage tiers) | $1,412 | $35 | $6 | $1,453 |
| Overall average contribution per employee | $1,229 | $29 | $5 | $1,263 |

Comparing the above two tables shows that due in large part to the PEBTF contribution policy that has the same contributions regardless of the number of family members covered, school employees pay less than state employees if electing employee only coverage, but pay more if electing family coverage or coverage other than single. State employees who do not enroll in the Get Healthy program have a larger employee contribution than the average school employee regardless of coverage tier elected.

## Policies

In addition to differences in the health plan coverages and employee contributions, there are also differences in policies covering spousal eligibility, waiver of coverage, and eligibility for retiree healthcare coverage.

| | State Policy | School Policies |
|---|---|---|
| **Spousal eligibility** | Employees Hired Before August 1, 2003 To enroll for coverage in the PEBTF, if the Dependent spouse/domestic partner of an employee is eligible for medical or supplemental benefit coverage through his or her own employer and does not have to pay for coverage, he or she must take his or her employer's coverage as primary coverage. If the spouse/domestic partner has to pay for coverage or is offered an incentive not to take his or her employer's coverage, the spouse/domestic partner does not have to enroll in his or her employer's coverage and the PEBTF will remain as primary.<br><br>Employees Hired or Re-hired on or After August 1, 2003 Dependent spouse/domestic partner of an employee who is eligible for medical or supplemental benefit coverage through his or her own employer must take his or her employer's coverage as his or her primary coverage; regardless of any employee contribution the spouse/domestic partner must pay and regardless of whether the spouse/domestic partner had been offered an incentive to decline such coverage.<br><br>This rule does not apply for those spouses/domestic partners who are self-employed. | Policies vary by school district.<br><br>Some districts do not permit spouses to be covered if they are full-time employed in (a) another school district, (b) an employee of the Commonwealth, (c) an employee of the US Government, or (d) an employee of a college or university where healthcare is offered.<br><br>Some districts do not permit spouses to enroll if they have access to a health plan through their employer and the required premium is less than 50 percent of the cost. |
| **Waiver of coverage** | Employees can waive coverage. By waiving coverage they do not have to pay the required employee contribution. | About 12 percent of school employees elect to waive coverage, with amounts varying by school district. On average |

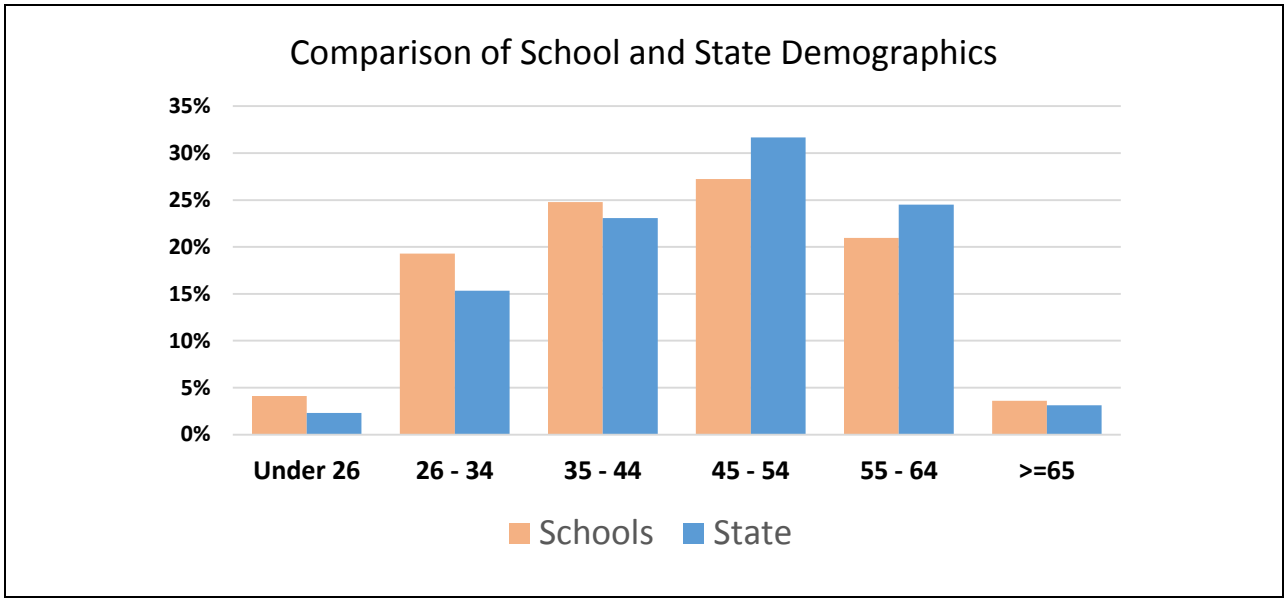
| | State Policy | School Policies |
|---|---|---|
| | | the amount paid for waiving single coverage is $1,779 and for waiving family coverage is $2,580. |
| **Retiree healthcare** | Retirees are covered under a separate health program | Retirees not eligible for Medicare are permitted to participate in the school district's health plan until they reach age 65.<br><br>Each school district can determine whether to charge the COBRA premium rate, subsidize the coverage at the same rate as employees, or subsidize the coverage at a different amount. |

## Comparison of Demographic Differences between School Employees and State Employees

We compared the age and gender profile of school employees to state employees by using data provided by PSERS (to represent the age and gender characteristics of school employees) and data provided by PEBTF, as well as data from the most recently published retiree healthcare valuation (to represent the age and gender profile of State employees).

With respect to gender, 72 percent of school employees are female compared to 51 percent of state employees.

In addition to the gender difference, we found that there was also a difference in the age profile. The following chart compares the school and state employees in 10-year age groups. The chart shows that there is a higher proportion of school employees under age 45, with greater proportion of state employees aged 45-64 than school employees.




As a consequence of the state employing a greater proportion of older employees and as health care costs increase with age, all other things being equal, one would expect the state employees' health care costs to be higher. There are however, three other demographic factors that influence the relative costs of the covered populations. First, as noted above there is a much higher proportion of females than males in the school workforce. Second, spouses and dependents of the employees generally may be covered in the school district health plan. The eligibility policies are different between the State and school districts, and in particular, the state's "covered under own employer" working spouse rule which results in a smaller percent of covered dependents in the state compared to the schools. Based on enrollment data provided by PEBTF, 62 percent of male state employees and 45 percent of female state employees are covering dependent spouses in PEBTF, resulting in 54 spouses per 100 employees. Data collected on the enrollment in the main or prevalent plan from each of the School Districts shows that there are 66 spouses per 100 employees. The age-based cost comparison therefore took into account the number and age of the covered lives, not just the age and gender of the employees.

The third adjustment takes account of another difference between the schools and the state with respect to how each of the employers handles retiree healthcare. When state employees retire, if they satisfy the service and age requirements, they are eligible for coverage under the Retired Employees Health Plan ("REHP") – so their claims experience is separate from the PEBTF. In contrast, school employees under Medicare age are by Commonwealth law permitted to continue coverage in the school district plan until they are Medicare eligible. School districts provided the number of retirees who were covered in the school district health plan, which provides a prevalence rate for the age adjustment for covering older members. The REHP actuarial valuation report provides data on the number, age, and gender of the

non-Medicare retirees. That information was used to determine the impact on average healthcare costs from not covering non-Medicare retirees in the same healthcare pool.

| Comparison of PEBTF to Schools Data | | | |
|---|---|---|---|
| | Males | Females | Overall Weighted Average |
| A. PEBTF – average age | 46.7 | 46.9 | |
| B. PSERS – average age | 44.6 | 45.1 | |
| Age difference (A – B) | 2.1 | 1.8 | |
| C. PEBTF - Count of adults | 56,093 | 58,600 | 114,693 |
| D. Schools - Count of adults | 178,222 | 246,323 | 424,545 |
| Healthcare aging and cost factors | | | |
| E. PEBTF (all lives) | 1.190 | 1.495 | 1.346 |
| F. REHP Non-Medicare retirees | 2.010 | 2.027 | 2.017 |
| G. PEBTF & Non-Medicare retirees | | | 1.447 |
| H. Impact if PEBTF covered retirees | | | 7.5% |
| I. Proportion of retirees to actives in School Plans | | | 15.0% |
| J. Schools -actives | 1.164 | 1.491 | 1.352 |
| K. Schools -actives & retirees | | | 1.453 |
| L. State / School - actives | 1.02 | 1.00 | 1.00 |
| M. State / School - actives & retirees (all covered lives) [G/K] | | | 0.996 |
| N. State / School - actives & retirees (just employees) | | | 0.966 |

The above table shows that after adjusting for the difference in the demographics of the covered populations, the school population has a higher expected cost (risk score of 1.453) than Commonwealth employees (1.346) by about 7.9 percent. However, after adjusting the Commonwealth population to include pre-Medicare retirees (comparable to the Schools' population), the Commonwealth risk score of 1.447 is almost identical to the Schools risk score of 1.453. A similar analysis based on just employees electing single coverage shows a wider difference of 3.4 percent.

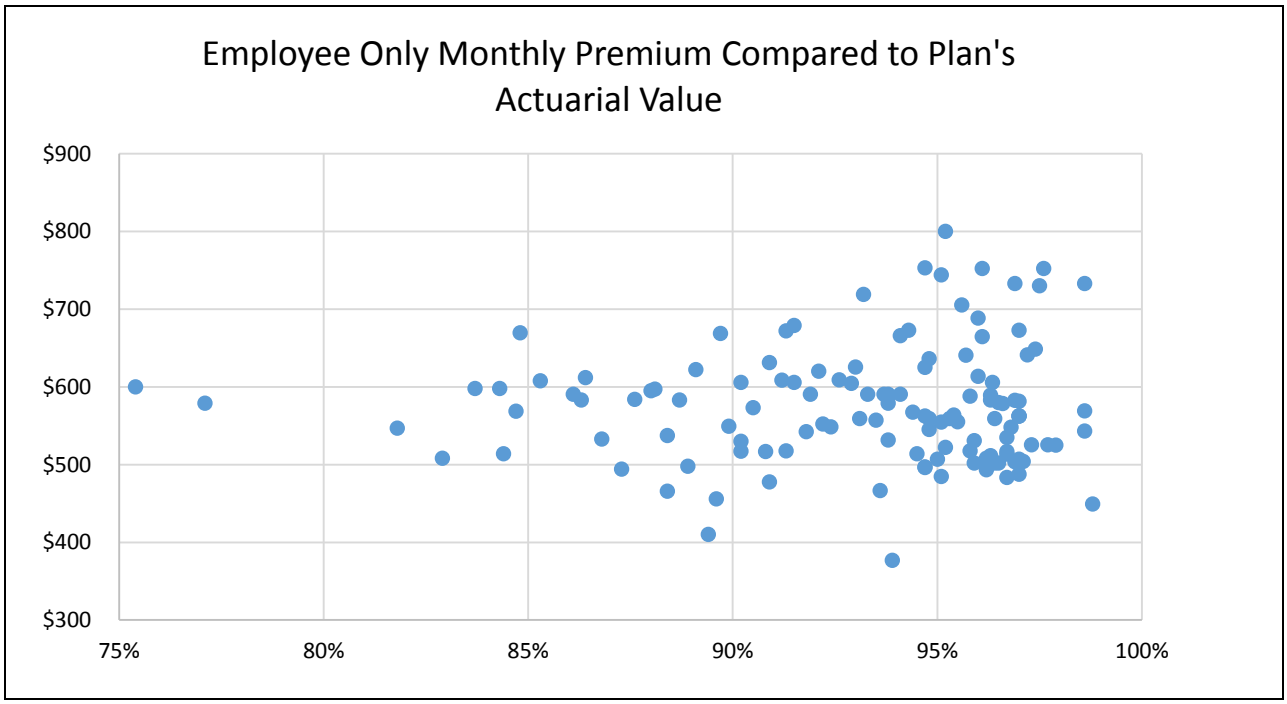
The following table shows that, after adjusting for plan design and demographic differences, the cost for single coverage under the state-wide PEBTF plan is about 5 percent lower than the current average cost among schools.

| | Schools Average Cost For Employee Only Coverage |
|---|---|
| A. CY2015 actual cost per employee per year | $7,889 |
| B. Plan design adjustment factor to match State plans | 0.8% |
| C. Adjusted for plan design difference (A x [1+B] ) | $7,955 |
| D. Age/gender adjustment factor | 0.966 |
| E. Adjusted for age/gender differences (C x D) | $7,688 |
| F. PEBTF CY2015 cost per employee per year | $7,303 |
| G. Estimated savings if School Districts were in a state-wide plan (E – F) | $385 |
| H. Estimated savings as a percent of current costs | 5% |

# COST EFFECTIVENESS OF MERGING PUBLIC SCHOOL DISTRICT HEALTH CARE PLANS

In this section of the report we examine the potential cost savings from merging public school district health care plans. As noted earlier in the report, the healthcare landscape for school districts has changed over the last dozen years has changed significantly, with over 80 percent of the school districts now obtaining coverage through one of three dozen consortia. The consortia pool the purchasing power of the school districts and are able to contract with health insurers for healthcare coverage at a lower cost than if each individual school were to seek coverage just for their employees.

We examined the potential cost savings if all public school district employees were to participate in a statewide health care program. The following chart shows the monthly premium for employee only coverage compared to the plan's actuarial value. The actuarial value is affected by the plan design, with higher values, for plans with smaller cost-sharing and lower out-of-pocket costs, and conversely lower actuarial values, for plans with larger deductibles and higher copays. The chart shows that most of the school district health plans have an actuarial value at or above 90 percent, with only two school districts whose primary health care plan has an actuarial value under 80 percent.




The amount of the monthly premium can be impacted not only by the plan design (i.e., actuarial value) but also by the demographics of the population covered by the plan, with lower costs expected for

younger employees and higher costs for older employees. The premium can also be affected by regional healthcare cost differences. Even within the same region, healthcare costs for similar population in terms of age and gender can vary due to differences in the underlying health status of the covered population.

In evaluating the cost effectiveness of merging SD health plans – either at a regional or statewide level, we have assumed that the entity administering the benefits will provide a range of healthcare plans with different cost-sharing levels (e.g., a Standard plan with an actuarial value around 85 percent, a Platinum plan with an actuarial value of around 90 percent, and a Platinum plus plan with cost-sharing similar to the plans currently provided by many school districts with an actuarial value of around 95 percent). By providing this array of choices, school districts would be able to select a plan that for practical purposes would be very similar in value to their current plan.

## Statewide Trust Providing Pharmacy Benefit Coverage

We examined the feasibility and potential cost savings of carving out prescription drug coverage and pooling the coverage in a statewide trust. For purposes of this section of the report, we have not accounted for the implementation costs for such a trust and have focused only on the potential cost savings from pooling the purchasing power of all school districts and securing best pricing on a competitively bid pharmacy contract. As noted on pages 17-18, there is little variation in the pharmacy plan designs in use currently. To estimate the potential savings, we compared the current cost for the current plan designs to the statewide cost under the PEBTF plan, taking into account plan design and population differences. The data obtained from the consortia broke out prescription drug claims separately from medical and included the number of covered lives. The PEBTF cost was therefore converted to a cost per covered life. The PEBTF cost was developed by adjusting the COBRA rates for the 2 percent administrative charge and then adjusting to a per covered life using the formula shown in row 10 below.

| | PEBTF |
|---|---|
| 1. PEBTF rate for single members (COBRA less 2%) | $1,226 |
| 2. PEBTF rate for multiple members (COBRA less 2%) | $3,154 |
| 3. Percent electing single coverage in PEBTF | 33% |
| 4. Number of Employees | 74,331 |
| 5. Number of Dependents | 65,378 |
| 6. Number of Spouses | 40,362 |
| 7. Number electing multiple coverage (4. x 67%) | 49,058 |
| 8. Covered lives in multiple tier ( 5.+ 6.+7.) | 154,798 |
| 9. Covered lives in single tier (4. x 33%) | 24,529 |
| 10. Average pharmacy cost per covered life per year (1. x 9. + 2. x 7.) / (8. + 9.) | $1,031 |

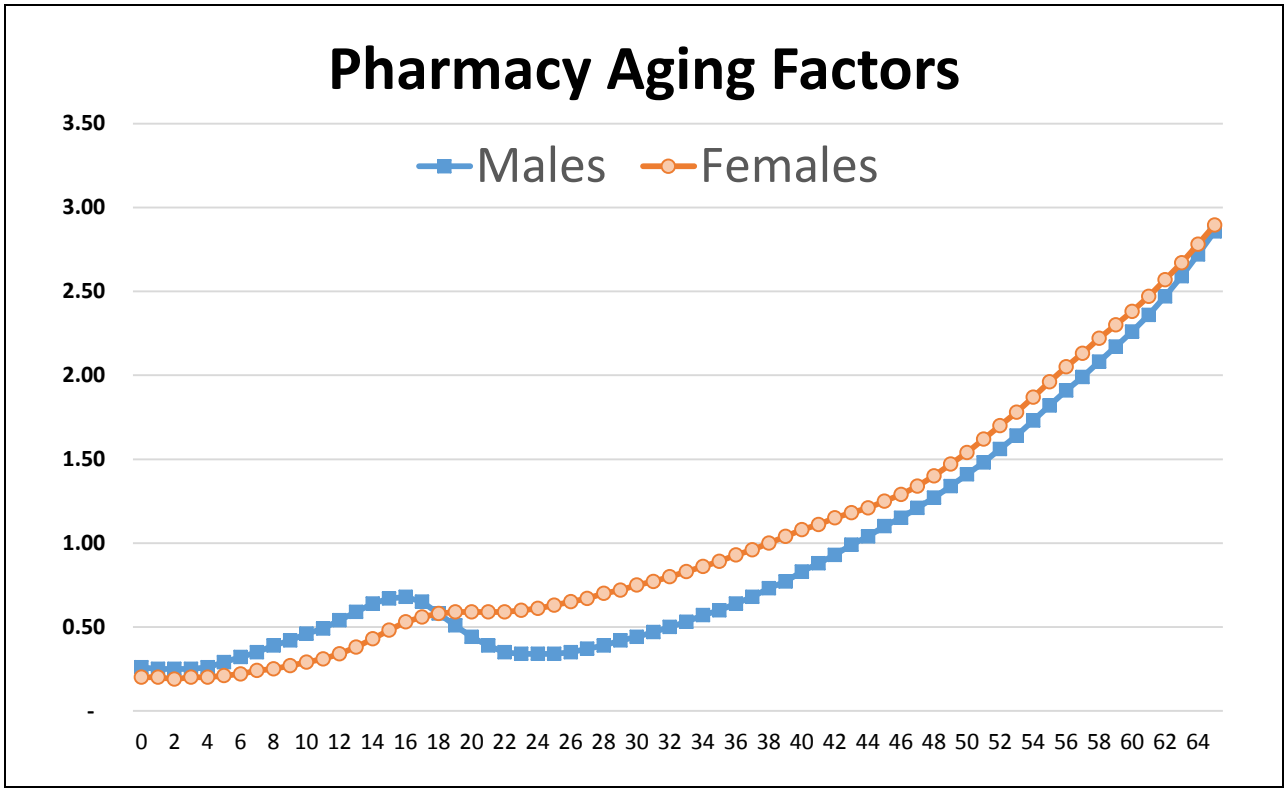
Data from the Consortia shows that the actual per covered life cost for prescription drug benefits was $1,188. This rate was developed from the aggregate pharmacy experience of 280,000 covered lives. We compared the median plan design used by the schools to the PEBTF plan design. The PEBTF plan design has slightly higher copays resulting in a plan value difference of 4.7 percent.

| | Schools | PEBTF |
|---|---|---|
| **Retail copays** | | |
| Generic drugs | $7 | $10 |
| Formulary | $12 | $18 |
| Non-Formulary | $20 | $36 |
| **Mail Order Copays** | | |
| Generic drugs | $5 | $15 |
| Formulary | $20 | $27 |
| Non-Formulary | $30 | $54 |
| Plan value | 100% | 95.3% |

There are differences in the population age and gender profiles between school employees and Commonwealth employees. Furthermore, retired school employees may continue coverage through the school district health plans until age 65, whereas retired Commonwealth employees obtain their coverage under the Retired Employees Health Plan.

The age and gender differences between the two populations were taken into account using the pharmacy age and gender factors from the Society of Actuaries' June 2013 report on Health Care Costs – From Birth to Death using data from Chart 9.[14]

[14] Society of Actuaries' June 2013 Report on Health Care Costs—From Birth to Death prepared by Dale H. Yamamoto.




After accounting for the non-Medicare retirees in the schools experience and that retirees are absent from the Commonwealth employee population, there was less than 1 percent difference in the age and gender profiles. After adjusting for the plan design and demographic differences, the cost per covered life for the schools is $1,129.

| | Schools |
|---|---|
| Actual cost per covered life per year | $1,188 |
| Plan design adjustment factor to match PEBTF | -4.7% |
| Adjusted for plan design difference | $1,132 |
| Schools age/gender Rx factor | 1.480 |
| State age/gender Rx factor | 1.476 |
| Cost per covered life, adjusted for age/gender differences | $1,129 |

With no changes in plan design, the analysis shows that a statewide health trust covering school employees prescription drugs would achieve a 9 percent lower cost if the contract matched the terms and conditions of the PEBTF contract. A school statewide health trust would cover a larger number of employees and covered lives than the PEBTF plan and through competitive bidding it is expected that the terms and conditions would yield an additional savings of 5 percent. A single pharmacy plan covering all

school employees would yield additional efficiencies through reduced administration and common application of best practices pharmacy benefit management protocols.

| Estimated Savings from Pooling Prescription Drug Purchasing | |
|---|---|
| School employees cost per covered life | $1,129 |
| Expected cost based on PEBTF contract rates | $1,031 |
| Expected savings from pooled plan | $98 |
| Expected savings percent of current cost | 9% |
| Additional savings from competitive bidding | 5% |
| Total pharmacy savings | 14% |
| Total pharmacy savings per covered life | $163 |

## Statewide Trust Providing Medical Coverage

As noted in the prior section, the estimated savings across all benefit coverages if school districts were in a state-wide plan is five percent (5 percent). This includes the pooled prescription drug savings of $98 per covered life identified above (before additional savings from competitive bidding), resulting in additional savings from a statewide trust providing medical coverage of $223 per covered life.

| | Cost Per Covered Life |
|---|---|
| A. CY2015 actual cost per covered life | $6,433[15] |
| B. Estimated savings from a state-wide trust | 5% |
| C. Estimated annual savings | $321 |
| D. Prescription drug savings | $98 |
| E. Medical/dental/vision plan savings | $223 |

## Stop-Loss Insurance

Consortia, covering about 70 percent of the group, purchase stop-loss coverage to ensure predictable and stable costs by year. In aggregate, we found that the net cost (i.e., premiums less recoveries) was about $18 per covered life per year. Under a state-wide plan, this expenditure can be avoided, saving about $12 per covered life per year.

[15] Based on Consortia data on 280,000 covered lives.

## School Districts Not in Consortia

We compared the annual average cost for the school districts health plans not in consortia and found that their costs were on average 5.4 percent higher than the consortium costs. A state-wide pool would therefore lower the costs for the 14 percent of schools not in a consortium by on average $363 per covered life of non-consortium participants or $50 on average across all SD participants.[16]

Therefore the aggregate expected savings from a State-wide health plan amounts to $383 per covered life (6 percent), including $98 (1.5 percent) of pooled prescription drug savings prior to competitive bidding, $12 in stop-loss insurance savings, and $50 in lowered costs for non-consortium participants.

The baseline cost for 2015 was developed from the survey data and information provided by the consortia. We extrapolated the data to the expected cost for all public school employees based on a total of 150,000 public school employees. Using a count of school employees for 2015, the expected total cost (including employee premiums) is estimated to be $2.6 billion (Row A below). This cost is projected to grow to $3.3 billion by 2020 based on the assumed healthcare cost trend rates shown in Assumptions line1.

| Projected Total Cost of Healthcare for All School Employees<br>Amounts in $millions | | | | | | |
|---|---|---|---|---|---|---|
| **Fiscal Year** | **2014-15** | **2015-16** | **2016-17** | **2017-18** | **2018-19** | **2019-20** |
| A. No change in number of school employees | $2,693 | $2,820 | $2,961 | $3,118 | $3,286 | $3,467 |
| B. Baseline, includes population change | | $2,797 | $2,937 | $3,093 | $3,260 | $3,439 |
| C. Baseline and statewide trust - Rx only | | | $2,863 | $3,014 | $3,177 | $3,352 |
| D. Baseline and statewide trust – Medical and other benefits | | | $2,904 | $3,024 | $3,151 | $3,310 |
| E. Rx only savings (B-C) | | | $74 | $78 | $82 | $87 |
| F. Medical and other benefit savings(B-D) | | | $32 | $68 | $108 | $129 |
| G. Total savings (E + F) | | | $107 | $147 | $191 | $216 |
| Assumptions | | | | | | |
| 1. Healthcare cost trend | 4.7% | 5.0% | 5.3% | 5.4% | 5.5% | 5.5% |
| 2. Population change | -0.8% | -0.8% | -0.8% | -0.8% | -0.8% | -0.8% |
| 3. Statewide trust - pharmacy savings (cumulative) | | | -2.5% | -2.5% | -2.5% | -2.5% |
| 4. Statewide trust - all other healthcare coverages (cumulative) | | | -1.1% | -2.2% | -3.3% | -3.8% |
| 5. Percent of SDs covered after expiration of the current CBA | | | 25% | 50% | 75% | 85% |

[16] Excludes Philadelphia, which has a unique healthcare plan arrangement.

If a state-wide carved-out prescription drug benefit program were implemented in FY2017-18, all, or almost all School Districts would be able to participate at the beginning of the 2016-2017 school year. Annual savings of $74 million would be achievable starting in FY2017-18. If a state-wide set of healthcare programs were implemented starting July 2016, we assume that only those school districts whose collective bargaining agreements terminate prior to July 2016 would participate in the first year, resulting in about 25 percent of the employees in FY2017-18, and an additional 25 percent in each of FY2018-19 and FY2019-20. The additional medical, dental, and vision savings would grow over time so that by FY2020-21 the total savings (medical and prescription drug) would reach $216 million.

# COST OF LEAST USED BENEFITS BY SCHOOL EMPLOYEES

Through the school district survey we obtained data on the prevalence and cost of medical, prescription drug, dental, vision, and hearing benefits.

All school districts provide medical and prescription drug coverage.

We found that 93 percent of school districts provide dental coverage, with an average school district cost per employee of $576.  This average is the blended average taking into account the actual enrollment by coverage tier.

With respect to vision coverage, we found that 72 percent of school districts provide vision coverage, with an average school district cost per employee of $89.  This average is the blended average taking into account the actual enrollment by coverage tier.

Hearing coverage, where provided, was usually included in the medical plan.  Three quarters of the school districts did not provide a hearing benefit, with one quarter indicating it was included in the medical plan. Only one school district indicated that they had a stand-alone combined vision/hearing appliance expense benefit, with an allowance of $550 per employee/family, with up to $300 that can be carried over from the prior year.

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# COST IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

## Cost impact of the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119)

The Affordable Care Act ("ACA") has resulted in additional costs for all school districts by virtue of the requirement for paying per person fees, including the Transitional Reinsurance Fee (which will expire after three years), and a fee for the Patient Centered Outcomes Research Institute (PCORI). These fees are now part of the base cost for healthcare, as is the cost associated with the requirement that preventive services must now be covered at 100 percent. Taken together, these fees and required plan changes generally amount to additive costs of about 1.5 to 2.5 percent of premiums.

A more pressing concern in the next few years (and for some districts, a more imminent concern) is the Excise Tax on so-called "Cadillac Plans" that is scheduled to take effect in 2018. This tax will result in additional costs for school districts whose health plan costs exceed the Excise Tax thresholds of $10,200 for single coverage and $27,500 for other than single coverage. These tax threshold amounts are scheduled to be indexed by consumer price inflation, with an additional 1 percent (i.e. CPI+1%) for 2019 and CPI-U thereafter.

The determination of the tax will depend in part on the regulations to be issued by Treasury and the IRS. The IRS Notices issued to date call for adjustments to the actual costs to reflect differences in the age and gender profile of the health plan participants compared to the working population. Furthermore, the regulations include upward adjustments for non-Medicare participants between age 55 and 64. These age and gender adjustments are likely to delay the effective date of the tax for many school districts and other employers until after 2018. We should note that Flexible Spending Account amounts will be added directly to health care plans nominal cost, as will amounts contributed toward HSAs and HRAs, which will make maintenance of these plans more problematic.

Finally, we should point out that there is in effect an exception to the normal thresholds that will apply to health care plans for levying the tax when such plans are provided as part of a multiemployer plan. Multiemployer plans will be taxed only if they exceed the family threshold cost of $27,500, which could represent a major savings opportunity for the school districts if the Commonwealth's plans can be restructured as a governmental multiemployer plan or plans.

We found that consortia were well aware of the impending Excise tax and were monitoring their costs and taking actions to defer the impact of the tax. Actions the consortia have taken in anticipation of the tax include adding lower cost health plan options, including qualified high deductible health plans.

## Additional Costs to Employer-Sponsored Health Care Plans Imposed by PPACA. The Excise Tax on High Cost Health Care Plans

The most problematic feature of the PPACA which will affect the cost of employer-sponsored health plans in future years is the imposition of the so-called "Cadillac Tax" on high cost health care plans. PPACA added § 49801 to the Internal Revenue Code. That Code section contains the provisions imposing this tax, and to date guidance on the tax has been published in IRS Notices 2015-16 and 2015-52.

Briefly, the key elements of this tax include the following:

- The tax will take effect under current law in 2018;
- The tax will be imposed on plans with an annual cost that exceeds the following thresholds in 2018:
  - Self only coverage $10,200
  - Family coverage $27,500;
- The tax is a non-deductible excise tax, equal to 40 percent of the excess cost above the statutory thresholds (even though school districts are tax exempt the fact that the tax is non-deductible may have the effect of increasing costs for tax exempt as well as taxable employers—we discuss this issue briefly below);
- The thresholds above which the tax is imposed are indexed to future inflation as follows:
  - 2019 CPI-U + 1%
  - 2020 and following CPI-U
- There are several adjustments which can have the effect of increasing the thresholds for certain employers, including:
  - The age and gender mix of the employer's population compared with the age and gender mix of the entire U.S. workforce (generally this adjustment is expected for most employers to increase the thresholds by between 5 and 10 percent);
  - An adjustment for coverage provided for retirees between ages 55 and 64 (non-Medicare);
  - An adjustment for high risk occupations

Normally a tax exempt employer would be unconcerned about the fact that the excise tax is not deductible. However, there is an additional tax risk for tax exempt employers which is discussed in the latest IRS guidance, Notice 2015-52. This guidance can be accessed at the following link: https://www.irs.gov/pub/irs-drop/n-15-52.pdf

As the Notice points out, the statute provides that for self-insured plans, it is the "coverage provider" that is responsible for payment of the tax. Coverage provider is further defined in the Act for self-insured plans as the "person that administers the benefits." The guidance goes on to point out that Treasury and the IRS are considering two alternatives with respect to determining who is therefore responsible for paying the tax for self-insured plans, as follows:

- The person who performs the day to day administrative functions such as paying claims, responding to inquiries and maintaining a technology platform for plan information; or
- The person who has ultimate authority over the administration of benefits (presumably under this latter alternative that would be in most cases the employer).

The guidance goes on to point out that if ultimately the coverage provider is determined to be a third party, and not the employer, it is expected that such third parties if they are taxable entities would pass on to the employer not just the cost of the excise tax, but also the additional income tax they would owe on the employer's reimbursement of the excise tax. So for example—if a third party taxable entity was providing services to a plan and was in a 33 percent corporate tax bracket, and the excise tax for a particular participant was $1,000 in a given year, to be made whole the third party payer would need to bill the employer for $1,500 to recover their cost for the excise tax and the additional income tax they would pay on both the $1,000 and the $500 gross up amount. Where the third party is also tax exempt (e.g., Blue Cross/Blue Shield Plans that remain tax exempt) this would not present an issue; but if a service provider is a taxable entity it will.

In August, 2015 the Kaiser Family Foundation published an Issue Brief on the impending effect of the tax, based on an analysis of the data from their 2015 Kaiser/HRET Survey of Employer Health Benefits. Based on the status quo (i.e., no reduction in current benefit levels) with respect to current and projected health benefit costs among their survey respondents, their data analysis projected that 16 percent of employers who sponsored health benefit plans would exceed the thresholds that trigger the tax in 2018 for at least one plan they offer, increasing to 36 percent by 2028. When the prevalence of Flexible Spending Account plans is taken into account, the percentage of employers with plans which will trigger the tax increases to 26 percent in 2018, and to 42 percent in 2028.

These data are shown in the Table from the Kaiser Issue Brief immediately below:

| Percent of Employers Offering Health Benefits with Plans that would exceed HCPT Threshold with 5% Annual Premium Growth | | | |
|---|---|---|---|
| Year | Self-Only Threshold | Health Plan Premium, Employer Contributions to HSA, HRA | Health Plan Premium, Employer Contributions to HSA, HRA & FSA |
| 2018 | $10,200 | 16% | 26% |
| 2023 | $11,800 | 22% | 30% |
| 2028 | $13,500 | 36% | 42% |

Source: Kaiser Family Foundation analysis

While the data we have developed in the survey indicates that most if not all school district plans responding have current costs below the excise tax thresholds, the spread between health care trend and the adjustment in the thresholds makes planning now prudent for many plans, especially given how rapidly the tax grows once the thresholds have been breached.

## Multiemployer vs. Single Employer Plans

In the context of this report, there is a particularly important distinction under PPACA between plans organized as multiemployer plans versus plans that are single employer plans or so-called multiple employer plans.

The definition of multiemployer plans is provided in IRC § 414(f) as follows:

(1) Definition

For purposes of this part, the term “multiemployer plan” means a plan

(A) to which more than one employer is required to contribute,

(B) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(C) which satisfies such other requirements as the Secretary of Labor may prescribe by regulation.

Some but not all multiemployer plans are Taft-Hartley plans. In a Taft-Hartley setting the plan is governed by a board of trustees with equal numbers of representatives of management and labor.

In plans other than multiemployer plans, the cost thresholds above which the tax is assessed are separate for self only and family participants. For multiemployer plans, however, the cost threshold is set by IRC § 4980I(b)(3)(B)(ii), at the family cost level ($27,500 in 2018) regardless of the mix of self only participants and those who cover dependents.

Although we found no school district health plans that currently exceed these thresholds, the multiemployer plan represents a major future opportunity for the Commonwealth, if the plans for school districts are organized so that they meet the statutory definition of a multiemployer plan and qualify for this more favorable treatment.

The magnitude of this opportunity is illustrated in the examples on the following two pages. Example 1 shows the cost over ten years for a hypothetical single employer school district plan covering 1,000 total participants, the cost of which in 2018 is 1 percent over the thresholds for both self only ($10,200) and family ($27,500) coverage.

In Example 2, we show the same cost for a multiemployer plan assuming the same 1000 total participants. Both examples assume that 30 percent of the participants cover self only, and 70 percent cover dependents. That would be approximately the ratio of self only to family participants we would expect in a plan which expressed costs on a per capita basis and did not differentiate in rates for self only versus family coverage.

Ignoring taxes, over the 10 year period 2018 – 2027 the total cost of both health care plans excluding the additional taxes would be $291.5 million, or $29,150 per participant per year.

PA School Districts Study 2015
Potential Effect if Plans Organized as a Multiemployer Plan

| | | Indexing of Threshold | |
|---|---|---|---|
| Assumed Trend for Medical: | 5.6% | 2019 | CPI-U + 1% |
| Assumed CPI: | 2.0% | Thereafter | CPI-U |

Example 1--Single Employer Plan Subject to Self Only and Family Thresholds

| Year | Self Only Cadillac Tax Threshold | Employer Plan Self Only Cost | Excess Subject to Excise Tax | Amount of Tax | Tax as % of Premiums | Family Cadillac Tax Threshold | Employer Plan Family Cost | Excess Subject to Excise Tax | Amount of Tax | Tax as % of Premiums |
|---|---|---|---|---|---|---|---|---|---|---|
| 2018 | $10,200 | $10,302 | $102 | $41 | 0.4% | $27,500 | $27,775 | $275 | $110 | 0.4% |
| 2019 | $10,506 | $10,879 | $373 | $149 | 1.4% | $28,325 | $29,330 | $1,005 | $402 | 1.4% |
| 2020 | $10,716 | $11,488 | $772 | $309 | 2.7% | $28,892 | $30,973 | $2,081 | $833 | 2.7% |
| 2021 | $10,930 | $12,131 | $1,201 | $480 | 4.0% | $29,469 | $32,707 | $3,238 | $1,295 | 4.0% |
| 2022 | $11,149 | $12,811 | $1,662 | $665 | 5.2% | $30,059 | $34,539 | $4,480 | $1,792 | 5.2% |
| 2023 | $11,372 | $13,528 | $2,156 | $862 | 6.4% | $30,660 | $36,473 | $5,813 | $2,325 | 6.4% |
| 2024 | $11,599 | $14,286 | $2,686 | $1,075 | 7.5% | $31,273 | $38,516 | $7,243 | $2,897 | 7.5% |
| 2025 | $11,831 | $15,086 | $3,254 | $1,302 | 8.6% | $31,899 | $40,673 | $8,774 | $3,510 | 8.6% |
| 2026 | $12,068 | $15,931 | $3,863 | $1,545 | 9.7% | $32,537 | $42,950 | $10,414 | $4,165 | 9.7% |
| 2027 | $12,309 | $16,823 | $4,513 | $1,805 | 10.7% | $33,187 | $45,355 | $12,168 | $4,867 | 10.7% |
| | Total Excise Taxes, 2018 - 2027 | | Self Only | $8,233 | | | | Family | $22,197 | |
| | Compound Annual Increase, 2018 - 2027 | | | 52.4% | | Compound Annual Increase, 2018 - 2027 | | | 52.4% | |
| | Total Assumed Participants | | | 300 | | | | | 700 | Grand Total |
| | Total Taxes, 2018 - 2027 | | | $2,469,895 | | | | | $15,537,736 | $18,007,630 |
| | Total Premiums, 2018 - 2027 | | | $39,979,374 | | | | | $251,504,235 | $291,483,609 |
| | | | | | | Excise Taxes as % of Premiums, 2018 - 2027 | | | | 6.18% |

PA School Districts Study 2015
Potential Effect if Plans Organized as a Multiemployer Plan

| | | Indexing of Threshold | |
|---|---|---|---|
| Assumed Trend for Medical: | 5.6% | 2019 | CPI-U + 1% |
| Assumed CPI: | 2.0% | Thereafter | CPI-U |

Example 2--Multiemployer Plan Subject Only to Family Threshold--Assumes 70% of Participants Have Dependents Coverage

| Year | Self Only Cadillac Tax Threshold | Employer Plan Self Only Cost | Excess Subject to Excise Tax | | Employer Plan, Family Cost | Family Cadillac Tax Threshold | Blended Cost, 30% Self Only, 70% Family | Excess Subject to Excise Tax | Amount of Tax | Tax as % of Premiums |
|---|---|---|---|---|---|---|---|---|---|---|
| 2018 | N/A | $10,302 | N/A | | $27,775 | $27,500 | $22,533 | $0 | $0 | 0.0% |
| 2019 | N/A | $10,879 | N/A | | $29,330 | $28,325 | $23,795 | $0 | $0 | 0.0% |
| 2020 | N/A | $11,488 | N/A | | $30,973 | $28,892 | $25,127 | $0 | $0 | 0.0% |
| 2021 | N/A | $12,131 | N/A | | $32,707 | $29,469 | $26,535 | $0 | $0 | 0.0% |
| 2022 | N/A | $12,811 | N/A | | $34,539 | $30,059 | $28,021 | $0 | $0 | 0.0% |
| 2023 | N/A | $13,528 | N/A | | $36,473 | $30,660 | $29,590 | $0 | $0 | 0.0% |
| 2024 | N/A | $14,286 | N/A | | $38,516 | $31,273 | $31,247 | $0 | $0 | 0.0% |
| 2025 | N/A | $15,086 | N/A | | $40,673 | $31,899 | $32,997 | $1,098 | $439 | 1.3% |
| 2026 | N/A | $15,931 | N/A | | $42,950 | $32,537 | $34,844 | $2,308 | $923 | 2.6% |
| 2027 | N/A | $16,823 | N/A | | $45,355 | $33,187 | $36,796 | $3,608 | $1,443 | 3.9% |
| | Total Excise Taxes, 2018 - 2027 | | Self Only | N/A | | | $291,484 | Blended Cost | $2,806 | |

| | | | |
|---|---|---|---|
| Total Assumed Participants | N/A | 1,000 | Grand Total |
| Total Taxes, 2018 - 2027 | N/A | $2,805,674 | $2,805,674 |
| Total Premiums, 2018 - 2027 | N/A | $291,483,609 | $291,483,609 |
| Excise Taxes as % of Premiums, 2018 - 2027 | | | 0.96% |

As the examples show, there is a significant advantage under PPACA for multiemployer plans, both in deferring the date at which the tax will be imposed and substantially mitigating the effect of the tax indefinitely over time.

For the hypothetical single employer plan in Example 1, the tax is levied immediately for the 2018 plan year, since the example assumes that the plan is 1 percent above the cost threshold for both self only and family coverage as of that year. The tax in the first year for each self only participant is $41; by year ten (2027) the tax has increased to $1,805. Expressed as a percentage of premium, the tax grows from 0.4 percent of premiums in 2018 to 10.7 percent of premiums in 2027.

The same growth and order of magnitude for the tax increment applies for family coverage. The tax in 2018 is $110, or the same 0.4 percent of family premiums; by 2027 the tax has increased to $4,867 per family participant, or the same 10.7 percent of family premiums that applies to the self only premiums.

Over the entirety of the ten year period illustrated in Example 1, the total taxes add more than $18 million to this hypothetical employer's health care expense, against a total cost excluding the tax of $291.5 million. The taxes thus represent an additional 6.2 percent burden over and above this employer's total health care cost, or $1,800 per year per participant.

In projecting future costs in both examples, we have used the same assumptions used by the Congressional Budget Office in preparing revenue and cost estimates for PPACA, namely that health

care costs would increase over the period at a rate of 5.6 percent annually, and CPI would increase over the period at 2.0 percent annually.

Example 2 shows the much lesser tax burden created when this same calculation is done assuming the same 1,000 participants, with 700 participants covering dependents and 300 covering self only in a multiemployer plan setting. The blending of the self only and family costs produces a per capita cost in the first year of $22,533 per participant, well below the family threshold in the statute of $27,500 for 2018. Using the CBO assumptions, the multiemployer plan with the same underlying health care costs and distribution of self only and family participants will not incur additional tax cost until 2025, seven years into the period. And the total tax burden over the last three years of the ten year period will be just over $2.8 million, versus the $18 million in tax cost incurred by a single employer plan with the same health care costs and mix of self only and family participants.

And as we pointed out earlier, a very large difference in tax liability will pertain indefinitely over time. In addition, since the tax can be avoided only by reducing benefit levels, it is obvious that this lesser tax burden for multiemployer plans compared with single employer plans will require less dramatic reductions in benefits to further delay the onset of the tax, and reduce the amount of the tax liability, than would be required if the plan were a single employer plan.

While it is beyond the scope of this report to examine in depth the legal requirements and other considerations that will be involved in determining whether to organize the school district plans along those lines that would capture this benefit of multiemployer plan status, it is obvious that this particular approach to restructuring health care benefits for Pennsylvania school districts is among those steps that could yield substantial savings to the Commonwealth and to participants and taxpayers over time, assuming that the current statutory requirements imposing this tax remain in place.

## Other Fees for Employer-Sponsored Health Care Plans Imposed by PPACA - The Transition Reinsurance and Patient-Centered Outcomes Research Institute (PCORI) Fees

The Affordable Care Act's Transition Reinsurance and Patient-Centered Outcomes Research Institute (PCORI) fees are additional costs that school districts are be required to pay annually.

The Transitional Reinsurance program was established to stabilize premiums in the individual market. This program collects a fee to fund reinsurance payments, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury. It is an annual, fixed fee that is charged based on the average covered life (i.e. employees and dependents) enrolled in the plan and it is

applicable to calendar years 2014, 2015 and 2016. The transition period ends in 2016. The annual rates are illustrated in the chart below.

| Transition Reinsurance Fees | Per Covered Life |
|---|---|
| 2014 Benefit Year | $63 |
| 2015 Benefit Year | $44 |
| 2016 Benefit Year | $27 |

The PCORI fee helps to fund the Patient-Centered Outcomes Research Institute which is intended to assist patients, clinicians and policymakers in making informed health decisions by advancing the quality and relevance of evidence based medicine. This fee is also paid annually and moving forward it is assessed at $2 per average covered life (i.e. employees and dependents).

# ACKNOWLEDGMENTS

The following school districts responded to the request for survey data and provided information that was included in the study. We wish to recognize and thank the many individuals who invested their time in completing the detailed survey that provided the core data needed for the study.

Abington Heights SD
Albert Gallatin Area SD
Allegheny Valley SD
Annville-Cleona SD
Antietam SD
Armstrong SD
Athens Area SD
Austin Area SD
Avella Area SD
Bald Eagle Area SD
Baldwin-Whitehall SD
Bensalem Township SD
Benton Area SD
Bentworth SD
Bethel Park SD
Bethlehem-Center SD
Big Beaver Falls Area SD
Blackhawk SD
Blairsville-Saltsburg SD
Blue Mountain SD
Blue Ridge SD
Boyertown Area SD
Bradford Area SD
Brandywine Heights Area SD
Brentwood Borough SD
Burgettstown Area SD
Butler Area SD
California Area SD
Cambria Heights SD
Cameron County SD
Camp Hill SD
Canon-McMillan SD
Carbondale Area SD
Carlisle Area SD
Carmichaels Area SD
Centennial SD
Central Bucks SD
Central Cambria SD
Central Dauphin SD
Central Greene SD
Central York SD
Charleroi SD
Chartiers Valley SD
Chartiers-Houston SD
Cheltenham Township SD
Clarion-Limestone Area SD
Claysburg-Kimmel SD
Clearfield Area SD
Cocalico SD
Columbia Borough SD
Conemaugh Township Area SD
Conemaugh Valley SD
Conestoga Valley SD
Conneaut SD
Connellsville Area SD
Conrad Weiser Area SD
Cornwall-Lebanon SD
Corry Area SD
Coudersport Area SD
Cranberry Area SD
Crawford Central SD
Dallas SD
Dallastown Area SD
Danville Area SD
Delaware Valley SD
Derry Area SD
Donegal SD
Dover Area SD
Downingtown Area SD
Dubois Area SD
Dunmore SD
East Lycoming SD
East Penn SD
East Pennsboro Area SD
East Stroudsburg Area SD
Eastern Lancaster County SD
Eastern York SD
Elizabethtown Area SD
Ephrata Area SD
Erie City SD
Exeter Township SD
Fairfield Area SD
Fairview SD
Fleetwood Area SD
Forbes Road SD
Forest City Regional SD
Forest Hills SD
Fort Cherry SD
Fort LeBoeuf SD
Fox Chapel Area SD
Franklin Area SD
Franklin Regional SD
Frazier SD

Galeton Area SD
Gettysburg Area SD
Girard SD
Glendale SD
Governor Mifflin SD
Greater Johnstown SD
Greencastle-Antrim SD
Greensburg Salem SD
Greenville Area SD
Grove City Area SD
Hamburg Area SD
Hampton Township SD
Hanover Public SD
Harbor Creek SD
Harmony Area SD
Haverford Township SD
Hempfield Area SD
Hermitage SD
Homer-Center SD
Huntingdon Area SD
Indiana Area SD
Iroquois SD
Jefferson-Morgan SD
Jersey Shore Area SD
Johnsonburg Area SD
Juniata County SD
Kane Area SD
Keystone Central SD
Keystone SD
Kutztown Area SD
Lakeview SD
Lampeter-Strasburg SD
Laurel Highlands SD
Leechburg Area SD
Lehighton Area SD
Lewisburg Area SD
Ligonier Valley SD
Littlestown Area SD
Lower Moreland Township SD
Mahanoy Area SD
Manheim Township SD
Mars Area SD
McGuffey SD
Mechanicsburg Area SD
Mercer Area SD
Meyersdale Area SD
Mid Valley SD
Middletown Area SD
Millcreek Township SD
Milton Area SD
Monessen City SD
Montgomery Area SD
Montoursville Area SD
Montrose Area SD
Moon Area SD
Moshannon Valley SD
Mount Pleasant Area SD
Mountain View SD
Muhlenberg SD
Neshannock Township SD
New Brighton Area SD
New Hope-Solebury SD
New Kensington-Arnold SD
North Allegheny SD
North East SD
North Pocono SD
North Star SD
Northampton Area SD
Northeastern York SD
Northern Lebanon SD
Northern Lehigh SD
Northern Potter SD
Northern Tioga SD
Northern York County SD
Northwestern SD
Oil City Area SD
Old Forge SD
Oley Valley SD
Oswayo Valley SD
Otto-Eldred SD
Owen J Roberts SD
Palisades SD
Palmyra Area SD
Penn Cambria SD
Penn Manor SD
Penncrest SD
Penns Manor Area SD
Penns Valley Area SD
Penn-Trafford SD
Pequea Valley SD
Peters Township SD
Philadelphia City SD
Phoenixville Area SD
Pleasant Valley SD
Pocono Mountain SD
Port Allegany SD
Pottsgrove SD
Pottstown SD
Pottsville Area SD
Punxsutawney Area SD
Quaker Valley SD
Red Lion Area SD
Redbank Valley SD
Richland SD
Ridgway Area SD
Ringgold SD
Riverside SD
Rochester Area SD
Rose Tree Media SD
Saint Clair Area SD
Saint Marys Area SD
Salisbury Township SD
Salisbury-Elk Lick SD
Saucon Valley SD

Sayre Area SD
Schuylkill Valley SD
Scranton SD
Seneca Valley SD
Shade-Central City SD
Shamokin Area SD
Shanksville-Stonycreek SD
Sharpsville Area SD
Shenandoah Valley SD
Shenango Area SD
Shikellamy SD
Slippery Rock Area SD
Smethport Area SD
Solanco SD
Souderton Area SD
South Eastern SD
South Park SD
South Western SD
Southeast Delco SD
Southeastern Greene SD
Southern Columbia Area SD
Southern Fulton SD
Southern Huntingdon County SD
Southern York County SD
Southmoreland SD
Spring Grove Area SD
Susquehanna Community SD
Susquenita SD
Towanda Area SD
Trinity Area SD
Tri-Valley SD
Tulpehocken Area SD
Tunkhannock Area SD
Turkeyfoot Valley Area SD
Tuscarora SD
Twin Valley SD
Tyrone Area SD
Union SD
Uniontown Area SD
Unionville-Chadds Ford SD
Upper Darby SD
Upper Merion Area SD
Upper Perkiomen SD
Wallenpaupack Area SD
Warwick SD
Washington SD
Wattsburg Area SD
Wayne Highlands SD
West Branch Area SD
West Greene SD
West Jefferson Hills SD
West Mifflin Area SD
Western Wayne SD
Williams Valley SD
Williamsport Area SD
Wilmington Area SD
Wilson SD
Windber Area SD
Woodland Hills SD
Wyomissing Area SD
York City SD
York Suburban SD

The information in the study includes data obtained from the consortia listed below. We would also like to recognize and thank the individuals who invested the time needed to compile this data.

Allegheny County Schools Health Insurance Consortium
Armstrong Indiana Insurance Trust
Beaver County School Health Care Insurance Trust
Bedford Somerset Schools Cost Stabilization Consortium for Health Insurance
Berks County Schools Health Consortium
Blair County Schools Health Consortium
Central Intermediate Unit Insurance Trust
Central Susquehanna Trust
Chester County Public Schools Health Care Affiliation
Delaware Co. Health Care Affiliation
Employee Benefit Trust of Eastern PA
Greater Johnstown Area Cost Stabilization Consortium for Health Insurance
Intermediate Unit #19 Health Insurance Consortium Trust
Lancaster-Lebanon Public Schools Employees' Health Care Cooperative
Lehigh Schools Consortium
Lincoln Benefit Trust
Lycoming County Insurance Consortium
Midwestern Health Combine
Montgomery County Schools Health Care Affiliation
Multi-County Health Care Insurance Consortium
Northern Tier Insurance Consortium
Northwest School Health Consortium
Northwestern Region Employee Benefit Trust
Schuylkill County Trust
Seneca Highlands Immediate Unit Health Trust
Tuscarora Intermediate Unit Capital Insurance Trust
Western Pennsylvania School Health Care Consortium

We would also like to acknowledge the many stakeholders who generously gave of their time assisting us with this study. These stakeholder included:

- Pennsylvania Association of School Business Officials (PASBO)
- Pennsylvania Employee Benefits Trust Fund (PEBTF)
- Pennsylvania State Education Association( PSEA)
- Pennsylvania School Employees' Retirement System ( PSERS)
- State Employees' Retirement System (SERS)
- Philadelphia Federation of Teachers Health and Welfare Fund
- Department of Education
- State Board of Education
- Pennsylvania Association of Intermediate Units (PAIU)
- Governor's Office of Administration
- Pennsylvania Association of Health Underwriters

We would also like to acknowledge the participation of the major health insurers who, after ensuring that any information provided would be held confidentially in accordance with mutual confidentiality and nondisclosure agreements, identified Pennsylvania customers by region and provided enrollment information by plan value, fully meeting our request for such information. The health insurers who provided data for this study were:

- Aetna
- Capital Blue Cross
- Geisinger Health System
- Highmark Blue Cross Blue Shield
- Independence Blue Cross

THE GENERAL ASSEMBLY OF PENNSYLVANIA

# SENATE RESOLUTION

No. 250 Session of 2013

INTRODUCED BY ARGALL, TEPLITZ, BREWSTER, HUGHES, PILEGGI, YUDICHAK, WAUGH, SCARNATI, MENSCH, ERICKSON, STACK, TARTAGLIONE, SMUCKER AND BROWNE, NOVEMBER 12, 2013

AS AMENDED, MARCH 31, 2014

A RESOLUTION

Directing the Legislative Budget and Finance Committee to conduct a study relating to the feasibility and cost-effectiveness of merging public school district health care plans.

WHEREAS, There is increasing concern among the citizen taxpayers of this Commonwealth over the rising cost of education in our public schools; and

WHEREAS, School board members and business managers have noted that the costs of benefits, particularly those related to health care, 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 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; and

WHEREAS, It is critical to assure taxpayers that governmental agencies are providing services in an efficient and cost-effective manner based on a thorough examination of existing school entity insurance policies and contracts, including regional differences, so as to provide maximum utilization of taxpayer dollars; therefore be it

RESOLVED, That the Legislative Budget and Finance Committee be directed to conduct a study relating to the practicability and potential cost-effectiveness of merging public school employees under the same group health benefits package; 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) A detailed analysis of the specific health benefits, policies and contracts currently provided ~~by~~ or operated by at least 50% of the school entities throughout this Commonwealth, the premium costs related thereto and the pattern of growth in these costs.

(2) Cost of current benefits for the next five years.

(3) Cost of current school employee contribution or average per employee.

(4) Impact on the Public School Employees' Retirement System and State Employees' Retirement System.

(5) Comparison of coverage with average taxpayer in the relevant region.

(6) Regionalization versus one health care plan.

(7) Cost savings realized with consortiums compared to prior consortiums.

(8) Administrative, staffing and technology costs associated with forming mergers.

(9) Comparison of school employees versus Commonwealth employees.

(10) Cost of least used benefits by school employees.

(11) Cost impact of the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119); and be it further

RESOLVED, That in compiling this report the Legislative Budget and Finance Committee seek input from the Department of Education, the State Board of Education, the Pennsylvania Association of School Business Officials, the Pennsylvania School Boards Association, the Pennsylvania State Education Association, the Pennsylvania Federation of Teachers, 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 report its findings and recommendations to the Senate no later than November 30, 2014.