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K–12 Health Benefits Report Short Overview

On December 16, 2011, the Health Care Authority (HCA) released the report on K–12 health benefits that was called for in a proviso within the June 2011 Supplemental Budget signed by Governor Gregoire. That proviso called on the HCA to develop a plan to implement a consolidated health benefits system for K–12 employees for the 2013–14 school year.

The report's implementation plan focuses on these major areas:

- **Equity.** Equitable access to quality and affordable plans that reduce insurance costs for K–12 employees that have a family (dependents) and calls for single payers to pay some of the cost of increasing this improved equity.
- **Transparency.** Making it more evident what dollars are used for health benefits and where, what and how they are used. As an example, no findings were available to the HCA from insurance companies, Premera and Group Health, that refused to share experience data.
- **Cost.** Cost-effectiveness, shared cost responsibility and movement toward value-based purchasing are expected to reduce costs.
- **System Wide.** Consolidation that integrates consistent policies and administration throughout the K–12 system.

The report's design proposal calls for:

- **Mandatory Participation.** Districts must purchase health benefits through the consolidated Public School Employees' Benefits Board. There is the possibility of a "school district opt-out provision" that could be included in the anticipated legislation. If provided, the report asks that any school district that opts out be required to meet specific guidelines and be monitored by the HCA.
- **Separate Insurance Pool.** A statewide risk pool separate from the PEBB is formed for K–12 public school employees' health benefits.

The report financial modeling for the project was done by the HCA's actuarial consultant, Milliman, and calls for:

- **Revenue Neutral.** The financial modeling for the K–12 health benefit project was designed to be revenue neutral
- **Rates.** The projected rates for the employee-only tier are set at 15 percent with the district (state and local funds) rate at 85 percent. The family payer rate was set at 35 percent with the district (state and local) rate set at 65 percent. The rate for the family through this action would be reduced from 43 percent to 35 percent.

- **Benchmark Plan.** The benchmark plan chosen within this design is the WEA Premera 2 plan which is slightly richer then the PEBB Uniform Medical plan.
- **Plan Cost Choice.** Under the fixed premium contribution percentage methodology, when an employee chooses a plan other than the benchmark plan, the employee incurs the full cost associated with selecting a more expensive plan and gets the entire savings for making a less expensive choice, subject to minimum contribution requirements.
- **Eligibility.** Eligible employees are those that meet the purchasing system criteria of 0.5 FTE or greater as defined by the school district. The system will allow grandfathering of those under 0.50 FTE for five years.
- **Hold Harmless.** Within some district there may be a significant shift of more employees choosing to cover dependents and thus causing increased district costs. The legislation may need to look at state level re-insurance or some type of hold harmless provision for that situation.
- **Plan Variation.** The financial model calls for four different plan cost tiers and a total of thirteen plans involved in the offerings.

Collective bargaining and health benefit governance:

- **Governing Board Decisions.** Moves decisions currently bargained at the local level to the consolidated purchasing system governing board. This board, appointed by the Governor, will be responsible for the sponsors and carriers, point-of-service co-pays, plan design and set employer, employee-only and dependent contribution rates.
- **Local Bargaining Change.** Because of the new statewide K–12 consolidated health benefit pool local pooling will not be necessary and local K–12 health benefit bargaining is removed.
- **Make-up of Governing Board.** The governing board will be composed of representatives of the State, school district officials, organizations representing employees, and persons with benefits administration and health care expertise. The board will retain ongoing interaction with a larger advisory group.
- **District Continued Responsibilities.** Local school districts will continue maintaining enrollment (enrollment will move to web-based enrollment), eligibility, customer care, and use of the current payroll systems. Districts will continue to pay the retiree remittance since retirees, at least at the beginning, will continue to be serviced within the PEBB. Districts will also continue to be responsible for the life insurance and long term disability offerings at least during the initial year.

Other changes:

- **Opt Out.** Depending on the developed legislation districts may be able to opt out of the new system, however there would be a strong HCA monitoring of their district local health benefits offerings.
- **RCW Changes.** There would be a need for seventeen RCWs to be eliminated or modified.

This document was developed from the lengthy final HCA reports on the K–12 Health Benefits Project, *http://www.hca.wa.gov/k12report/report.html*. Some statements are taken directly from the reports, while other statements are an attempt to give an interpretation that is abbreviated. This document was developed by John Kvamme, WASA and AWSP Consultant.