Washington State Health Care Authority

ESSB 5940: Status on HCA's Reporting on K-12 Employee Health Benefits

Senate Ways and Means Committee
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Presentation Objectives

- Provide background on HCA's reporting requirements of ESSB 5940 (equity target; consolidation analysis).
- Offer insights on data attained for analysis of K-12 employee health benefits.
- Give updates on HCA's ESSB 5940 models, analysis and reporting timeline.

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K-12 Stakeholder Engagement

- Joint Legislative Audit & Review Committee
- Governor's Office
- Senate & House Staff and Caucuses
- K-12 Labor Groups (WEA, PSE, AWSP)
- Office of the Insurance Commissioner
- Office of Financial Management
- Office of the Superintendent of Public Instruction
- Milliman (project contractor)

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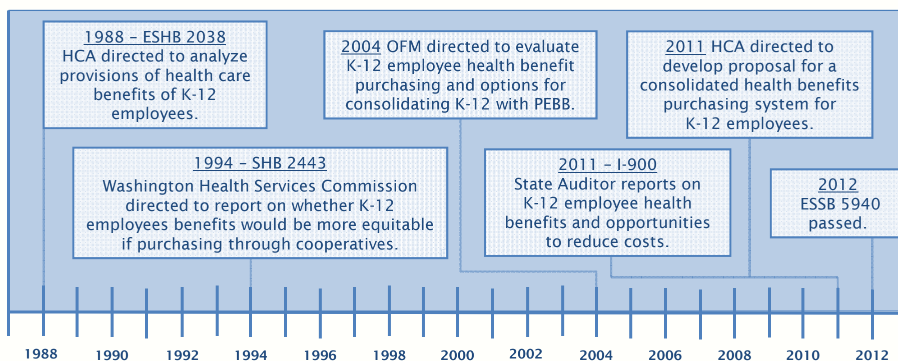
K-12 Employee Health Benefit Reporting History*



*Not comprehensive

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ESSB 5940 – HCA Requirements

- HCA's reporting requirements codified in RCW 41.05.655.
- Establish target for greater equity for K-12 plans between single and family coverage premiums.
- Report on advantages & disadvantages on consolidation of K-12 employee health benefits:
  - Consolidation within PEB or on its own;
  - Consolidation of classified or certificated employees.

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ESSB 5940 – Greater Equity

- Establish target for realizing greater equity between premium costs for employee only and full family coverage for same health benefit plan:
  - Consider whether a 3:1 employee's premium share ratio is an appropriate target, and
  - Consider alternatives based on data from OIC's school district health benefit reporting.

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ESSB 5940 – Consolidation

- Report on the advantages and disadvantages to the state, local school districts, and district employees of consolidation of:
  - K-12 employees into their own consolidated purchasing program;
  - K-12 employees with PEB; and
  - Certificated or classified employees separately or jointly with PEB.
- Report to include fiscal implications for state and school employees, impacts on existing purchasing programs, and proposed timeline for implementation.

Data Collection

- OIC/Treinen Public Reports
  - Summaries of data collected from school districts and carriers.
  - Year 1 (CY 2012 data) public report was released in November 2013.
  - Year 2 (CY 2013 data) public report was released in November 2014.
- OIC/Treinen Detailed School District Data
  - OIC has shared a detailed database of employee-level data collected from the school districts, for Year 1 and Year 2 data.
- HCA School District Supplemental Data Request
  - HCA requested supplemental data from all Washington school districts; majority of district data obtained through WISPC, 14 large school districts contacted directly.
  - This supplemental data request included additional information on medical, dental, and vision plans, and expanded demographic information on employees.
- Data Still to be Collected
  - Remainder of supplemental data request from large school district (295 of 296 school districts' data has been collected).

Preliminary Findings on Equity

Average Monthly Employee's Share of Premium Costs Full Time Employees Only										
	Certificated with Family Coverage	Certificated with Employee Only Coverage	Ratio	Classified with Family Coverage	Classified with Employee Only Coverage	Ratio	PEBB Year*	PEBB with Family Coverage	PEBB with Employee Coverage Only	Ratio
2010-2011 School Year	$583	$29	20 : 1	$485	$29	16.7 : 1	2014	$185	$64	2.9 : 1
2012-2013 School Year	$501	$38	13.2 : 1	$418	$35	11.9 : 1	2015	$200	$69	2.9 : 1
2013-2014 School Year	$564	$54	10.4 : 1	$484	$50	9.68 : 1	*For comparison purposes only.			

- Data show that the gap between the percentage of premium paid by the employee has shrunk from the 2010-11 to 2013-14 school years.
- These values do not account for differences in the richness of benefits selected by employees, or demographic factors other than coverage tier and full-time status

Consolidation Models

- Consolidation examples from other states.
- Three separate models being prepared for analysis of K-12 employee health benefit consolidation.
- Model assumptions apply to all models.

K-12 Consolidation Examples

- Alabama – Public Education Employees' Health Insurance Plan (1983)
  - Single pool for K-14 employees and retirees.
  - Mandatory state-wide participation.
- Oregon Educators Benefit Board (2007)
  - Single pool for K-12 employees and retirees.
  - Carve-out for large, self-insured districts.
- New Jersey – School Employees' Health Benefits Program (2007)
  - Voluntary participation, ~50% of districts currently participate.

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Model Assumptions

- All benefit-eligible individuals receive a full funding allocation; no partial funding allocations.
- Employer contribution is 85% of full premium rate.
- Benefit eligibility will be aligned with that of PEB (50% FTE eligibility).

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Consolidation Model 1

- Consolidation of K-12 employees under PEB board governance.
- Creation of 2 separate risk pools:
  - K-12 employees + early retirees (pre-Medicare)
  - State employees + early retirees (pre-Medicare)
- Existing statutory authority for K-12 PEB Board members (RCW 41.05.055):
  - Representative of active K-12 employees, and
  - Retired representative of K-12 retirees.

Consolidation Model 2

- Creation of separate governance board, K-12 Employee Benefits Board ("KEBB").
- Creation of single consolidated K-12 employee risk pool.
- Options to leverage joint purchasing of new KEB and existing PEB.

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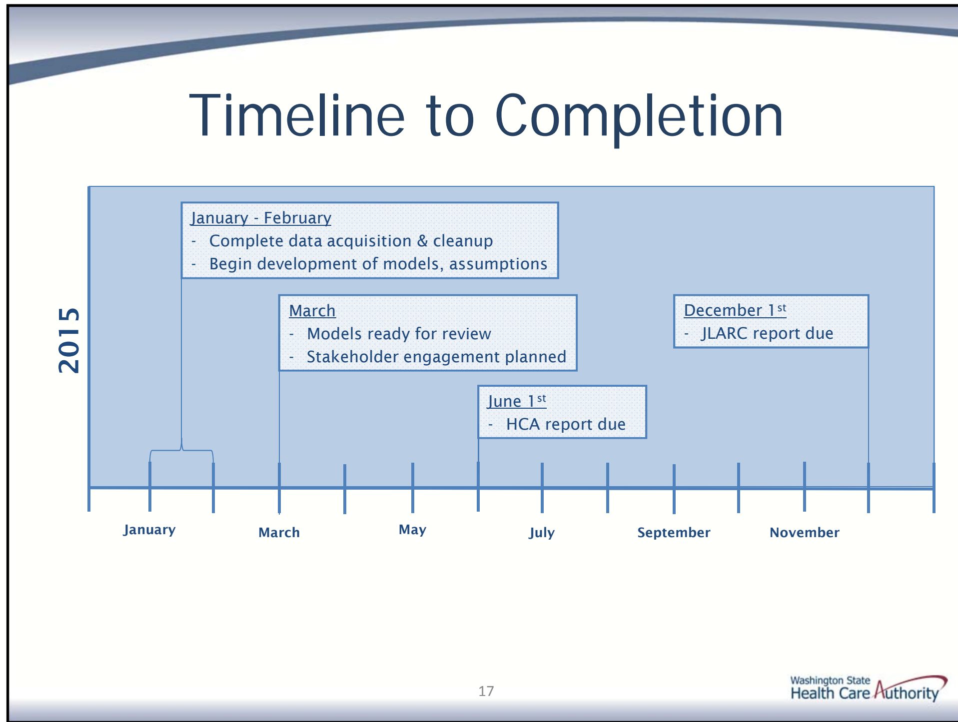
Consolidation Model 3

- Consolidation of K-12 employees under PEB board governance.
- K-12 employees consolidated with PEB employees in a single risk pool.
- K-12 employees combined with existing PEB "actives" pool.

Other Consolidation Considerations

- Consolidation of certificated or classified employees into separate pools.
- Possible carve-out for large, self-insured districts.
- Ensuring adequate network access and coverage statewide.
- Achieving targeted 3:1 ratio of premium, or identification of alternative method for greater equity within health benefit plan.


Timeline to Completion
2015
January - February
- Complete data acquisition & cleanup
- Begin development of models, assumptions
March
- Models ready for review
- Stakeholder engagement planned
June 1st
- HCA report due
December 1st
- JLARC report due
January
March
May
July
September
November
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Questions & Comments
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