December 17, 2007

Feasibility of Offering Health Care Coverage to School Employees as Outlined in AB 256

CalPERS and CalSTRS

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

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Contents

1. Executive Summary 4
- Background 4
- Populations Included in the Study 5
- Project Objectives and Scope 5
- Key Data Findings and Observations 7
- Conclusions 9

2. Data Included In the Study 14
- Sources of Data 14
- Data Limitations 15
- Data Collected by School Services of California, Inc. (SSC) 16
- CalSTRS Benefits Survey Data 17
- CSEA Member Survey: Health Care Reform 17
- Census Studies Performed by CalPERS and CalSTRS 18
- Mercer 2006 National Survey of Employer-Sponsored Health Plans 19
- Customized Survey of Current Large Purchasing Organizations 20

3. Health Care Coverage for Active Employees 21
- Total Numbers of Active Employees 21
- Who Provides Health Care Coverage to Active Employees 23
- School District Cost Based on Size of District 24
- Comparing Districts to Other Large California Employers 25
- Who is Covered – and Who Is Not Covered 30
- Access and Affordability for Active Employees 34
- Estimated Total Cost of Active Coverage 35

4. Current Health Care Coverage Landscape for Retirees 36
- Total Numbers of Public School System Retirees 37
- District Coverage and Retirees 38
- District Retiree Medical Coverage Compared to Survey Data 39
- The Current District Approach to Providing Retiree Medical Coverage 39
- Access and Affordability for Retiree Coverage 40
- Estimated Total Cost of Retiree Coverage 40

5. Current Health Care Coverage Landscape for School Districts 41
- How School Districts Contract for Health Care Coverage 41
- Identifying Efficiencies and Inefficiencies within the Current System 42
- Size-Based Immediate or Near-Term Savings Opportunities 42
- Additional and Longer Term Savings Opportunities 48

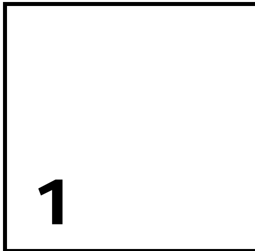
6. Creating a Health Care Pool 54
- Benefits of Creating a Pool 54
- Potential Drawbacks 56
- An Examination of a Mandatory Pool Compared to a Voluntary Pool 57

7. Plan Design Options for a Statewide Health Care Pool 59
- Illustrative Array of Plan Design Offerings 60
- PPO Plan Design Options 61
- HMO Plan Design Options 64

8. Feasibility of Using PEMHCA 65
- Advantages to Using PEMHCA 65
- Disadvantages to Using PEMHCA 66
- Estimate of Increased Costs if Using the State Plan (PEMHCA) as It Currently Exists 67
- Summary 70

9. Key Special Issues 71
- Regional Rating Compared to Statewide Rating 71
- Conditions for Joining or Exiting Existing Pools 72

10. Appendix 75



Executive Summary

Background

Assembly Bill 256 requires the Board of Administration of the Public Employees' Retirement System to conduct a study to examine the feasibility and cost-effectiveness of:

- Creating a single statewide health care pool that would cover all public school employees, either on a mandatory or a voluntary basis; or

- Including all school employees in the Public Employees' Medical and Hospital Care Act (PEMHCA) and covering them within the programs offered by CalPERS.

On January 4, 2007, representatives from the California Public Employees' Retirement System (CalPERS), the California State Teachers' Retirement System (CalSTRS), the California School Employees Association (CSEA), and the California Teachers Association (CTA) met with the team from Mercer to discuss the study and the data needed to conduct it. The purpose of this report is to document Mercer's analysis, findings and conclusions related to the study, as well as the data sources used.

Mercer would like to thank CalPERS, CalSTRS, CSEA, CTA and the contributing constituent groups for their cooperation and assistance in preparing this report.

Populations Included in the Study

The populations to be included in the study include:

- Active employees of the public school system[1].
- Retired employees of the public school system.
- The dependents of those active employees and retirees.

The following were considered outside the scope of this study:

- Public school employees not actively-at-work because of they are on leave, they are not able to find work, or for other reasons.
- Employees and retirees of private schools (about 9% of California students attend private schools[2]).

Project Objectives and Scope

AB 256 outlined specific objectives in evaluating the feasibility and cost-effectiveness of creating a single statewide coverage pool for all public school employees. These objectives included improving access to health care coverage for the school district employees who do not currently have coverage because they are not eligible (those who do not work enough hours to qualify) or the coverage is unaffordable (the lowest wage earners).

This study was intended to develop a realistic representation of the financial structure of healthcare coverage for school district employees and retirees in California, so that the current situation would be better understood and high-level recommendations could be made. Stated areas of interest included the following:

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[1] AB 256 contemplated inclusion of community colleges as a part of the potential health care pool. Many of our primary data sources did not include community college information, but we believe our broad recommendations would not change if the community colleges were included. If they are included, then the dollar amounts of the estimated savings shown would increase.

[2] Web site: California Department of Education, General Information for Fiscal Year 2006-07.

- A review and analysis of the costs, potential savings, benefits and drawbacks of creating a health care pool for all public school employees in California, including retirees.
- A discussion of the health care pool rating approach, both on a statewide basis and including regional rating structures.
- A high level cost impact analysis of the single health care pool approach compared to the current market process which includes many different pools and plans.
- A high level examination of appropriate plan design options for a statewide health care pool.
- An examination of the feasibility and cost savings of including all school employees under a health care pool.
- A review and analysis of the costs, potential savings, benefits and drawbacks of expanding coverage of school employees within the current programs offered by CalPERS.

It was beyond the scope of this project to take an in-depth look at the census, plan, and cost data of each and every district individually. Rather, we used readily available information supplemented by a few focused surveys and by our knowledge of the California healthcare industry.

Key Data Findings and Observations

Data sources on certificated employees were extensive enough for us to develop a reasonably good picture of how health care coverage is provided to them, and what the actual cost is to the districts[3] and to certificated employees themselves. Data on classified employees was not as extensive within the data sources used. Therefore, we identified possible similarities and differences between certificated and classified employees, and developed assumptions based upon them.

Observations Related to the Potential Market or Structural Inefficiencies in the Current System

Key observations related to potential market or structural inefficiencies in the current system include:

- Most school districts (almost 80%) already provide coverage under various arrangements that include some elements of pooling (JPA, Trust, or CalPERS). They currently gain some level of administrative efficiency, effective program management, and negotiation leverage, but results are not consistent.

- Compared to other large California employers[4], school districts pay more for medical coverage on a per employee basis and charge their employees less for that coverage. The higher cost is likely tied to a combination of factors, including:

  - School districts cover more dependents than most California employers.

  - School districts generally provide richer benefits than other large California employers, including benefits offered through CalPERS.

- Based on a regression analysis of the cost of coverage for school districts, employee group size does not appear to be a significant factor in current plan cost. This may be, in part, because smaller districts are more likely to be participating in one of the existing pooling arrangements. Smaller districts, on average, also charge their employees more for the cost of coverage.

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[3] We use "district" in this report broadly. Coverage within a district can vary based on a number of factors, including whether employees are certificated or classified. Some organizations which provide coverage to the districts use the term "unit" instead to demonstrate that there may be multiple units within a district.

[4] Based on the Mercer Survey of Employer-Sponsored Health Plans, large employers have 500 or more employees.

- Health plan enrollment is predominantly in Kaiser, Blue Cross and Blue Shield, but districts make arrangements for coverage with the same carriers through many different plans and approaches. The approach to the market is highly fragmented.

Observations Related to Access and Affordability

Key observations related to reviewing medical coverage access and affordability include:

- Certificated employees who work full-time generally have good access to affordable medical coverage. While classified employees are, on average, paid less than certificated, a large percentage does have access to the same benefit levels as the certificated – at the same or similar contribution levels.

- Medical coverage for part-time employees is generally accessible for those who work at least half-time – though it is often much less affordable when analyzed on the basis of individual income.

- Compared to other large California employers, school districts do a good job of providing comprehensive medical coverage to early retirees to bridge the transition to coverage under Medicare, as long as the retiree has sufficient service to qualify. Once retirees reach Medicare age, they are much less likely to have district-provided coverage. However, while some district retirees are not eligible for Medicare coverage, many do get it from other sources (e.g., spouse's coverage or coverage from other employment).

Conclusions

Properly structured, there is a viable opportunity for districts to benefit from being placed in a statewide health care coverage pool. We believe that such a pool should be mandatory because:

- A single purchasing pool would be large enough to drive market change and to demand better quality and better service, and create more partnership.
- A mandatory pool would have considerable mass and leverage, and would be able to implement many best practices in a consistent manner.
- A voluntary pool would be an addition to an existing state which already includes many pooled options. Districts would be free to shop coverage against it and would only join the pool if it were best for them financially. Unless the pool could protect itself against some of this selection, it could find itself in a selection spiral – and ultimately fail. These selection issues would not be a factor for a mandatory pool.
- Savings estimates represented in this report assume a mandatory pool. While there could be some economies of scale sufficient to make a well-run voluntary pool competitive in the market place, the savings shown would be considerably reduced.

While there are several drawbacks to creating a pool, they are not insurmountable and we believe that the added benefits of a mandatory pool make the effort needed to address or overcome them well worth it. If a purchasing pool is developed, those drawbacks should be taken into consideration as the basic structure is put in place. A well-conceived, timed and executed transition strategy could alleviate many of the issues associated with implementing a pool, including those specific to a mandatory pool.

Size-Based Immediate or Near-Term Savings Opportunities

There are opportunities to obtain immediate or near-term savings by creating a health care pool for all public school employees in California, including retirees. Total potential savings depend upon how efficiently and effectively the pool operates compared to the current system, but some savings opportunities are scale based and thus can be realized by consolidating into a single pool. These include:

- Reduced Direct Expense. Insurance contracts include a number of direct expenses that are generally related to the size of the group. These include retention, premium tax, commission or broker fees, and stop loss coverage. These expenses could be reduced or eliminated in a self-funded, mandatory pool.

- Reduced and Streamlined Administration. Currently, each district must make its own arrangements for administration internally or on an outsourced basis. A single pool would allow for reduced and streamlined administration through economies of scale, by eliminating redundant and overlapping systems and administrative practices.

- Improved Prescription Drug Costs. Large purchasers can demand the biggest reductions in wholesale price, increased rebates, and the best plan management. A single pool would have significant leverage in this area; in the current system, only districts covered by CalPERS enjoy this degree of size-based purchasing leverage.

- Improved Network Discounts. Not all districts currently benefit from the best available discounts for medical coverage. Some do not contract with networks that offer the deepest discounts.

A summary of the range of estimated immediate or near-term cost savings that are solely based on pool size is shown in Table 1. The savings estimates are based on estimated total premium for 2007/2008 for the active and retiree population.

Table 1 – Range of Estimated Immediate or Near-term Size-Based Cost Savings for Implementing a Mandatory Pool

	Upper Bound		**Lower Bound**	
Savings Opportunity	**Dollars in Millions**	**Percentage of Premium**	**Dollars in Millions**	**Percentage of Premium**
Reduced Direct Expense	$165	2.45%	$ 98	1.45%
Reduced and Streamlined Administration	$ 34	0.50%	$ 34	0.50%
Improved Prescription Drug Costs	$101	1.50%	$ 51	0.75%
Improved Network Discounts	$101	1.50%	$ 34	0.50%
Total	$401	5.95%	$217	3.20%

Additional and Longer Term Savings Opportunities

In our review of the current situation, we discovered additional opportunities for savings. Since these opportunities are not just scale-based, actions in these areas may be more difficult to take but the savings potential is real. For some of these opportunities, results may only emerge over time, but these longer-term strategies – if rigorously implemented and supported – could allow the districts to improve the overall health of the population and to impact cost trend. Therefore, any implementation of a mandatory purchasing pool should include further analysis and discussion of these potential areas of savings. They include:

- Implement best practices for health, wellness and disease management. These programs are intended to improve health and thus lower costs. If implemented successfully and effectively communicated to the membership, we would expect to see ongoing, long-term savings in the form of reduced trend. We estimate a potential trend reduction of 1% per year.

- Consider the impact of selection against the current plans in developing rate and tier structure. If the dependent ratio in the pool more closely approximated norms in the market place, annual savings of approximately 1% to 3% of premium – or from $67 to $203 million – could be achieved by reducing the impact of dependent coverage selection against the plans.

- Implement best practices for plan administration. In developing systems to support the districts, utilize and maintain uniform best practices for plan administration, including tracking terminations and additions, effective eligibility management, and monitoring Medicare enrollment. Effective eligibility management alone has been shown to save 2% to 3% of premium, or $134 to $203 million.

- Review plan design alternatives. If plan designs in the pool more closely approximated PEMHCA plans, rather than those currently favored by the districts, savings of about 3% of premium, or $203 million, could be realized.

The size-based immediate or near-term savings opportunities are significant on their own, but the additional and longer-term savings opportunities deserve thoughtful consideration. They represent the greater opportunity to successfully implement a viable, long-term strategy for providing comprehensive, affordable health care coverage to the districts. If they are not implemented and supported, the long-term value of a mandatory pool could be diminished.

Issues Associated with Using PEMHCA

There are several issues associated with using PEMHCA to provide the vehicle for the health care pool for the districts.

Barriers to Using PEMHCA

There are barriers to using the PEMHCA plans. These include:

- The districts favor a composite approach to premium payment and contributions. CalPERS offers a three-tier rate structure for both actives and retirees. While this does not preclude districts from using the composite approach for employee contributions, it does – by implication – discourage it. And premium payment must be made on the three-tier basis.

- There are currently many plan design alternatives available to school district employees, but most employees are covered by plans that are relatively rich compared to the CalPERS benefit plans.

- CalPERS does not currently offer all of the services that some of the other large purchasing pools offer. Districts that offer coverage through CalPERS must make additional arrangements for COBRA administration, eligibility and termination monitoring, and communications preparation.

- Employers are required to contribute towards the cost of employee and retiree premiums in order to be covered. Districts that do not currently offer or pay for retiree coverage would need to do so, resulting in significant increased current costs. The school districts would also incur an increase to their GASB obligations. A further discussion of this issue follows.

Retiree Medical Cost and GASB Implications

A major issue in using PEMHCA as the vehicle for a mandatory pool for school districts is the PEMHCA requirement for retiree coverage for those who are under age 65 and for those who are Medicare eligible; only about 15% of the districts currently offer coverage to retirees this way.

For the remaining districts, this requirement would introduce a significant additional cost for new retiree benefits:

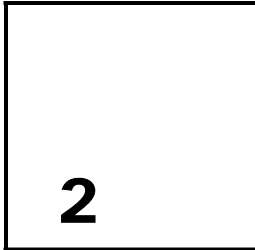
- About one third of districts provide coverage to active employees only.
- Almost all of the remaining districts currently provide benefits to active employees and to non-Medicare eligible retirees who qualify for benefits. They do not provide coverage to Medicare-eligible retirees.

In addition, there would be a new or increased GASB obligation to account for the increased cost of the expanded coverage requirement.

However, GASB accounting rules allow PEMHCA to base the valuation on the blended active and non-Medicare rates, while other similarly-situated plans must base the valuation on the actual cost. For the majority of districts – those that provide benefits to active employees and non-Medicare eligible retirees – moving to the PEMHCA model would reduce GASB costs for non-Medicare benefits. This change would mitigate the added GASB obligation for the added benefits somewhat, but does not mitigate the actual additional costs.

Conclusions Related to Using PEMHCA

The disadvantages outlined above make it impossible for us to recommend using PEMHCA as the vehicle for a mandatory pool for the districts. If, however, modifications to current PEMHCA rules were made such that these disadvantages could be resolved – especially as relates to the significant additional cost associated with providing benefits to retirees – then PEMHCA could be a realistic option. It may, for example, be possible to set up a district-only pool using PEMHCA's existing systems, management and expertise.



Data Included In the Study

This section is intended to provide background on the data used in the study, including the limitations to the study data.

Sources of Data

The data used to conduct this study was taken from the following major sources:

- Data collected by School Services of California, Inc. (SSC). SSC compiles data for school districts for purposes of conducting annual reporting and preparing competitive analyses.
- A health care cost survey conducted by CalSTRS, and delivered to Mercer in February of 2007.
- A 2007 survey conducted by CSEA on Health Care Reform.
- Census studies provided by CalPERS (April, 2007) and CalSTRS (February, 2007).
- The Mercer National Survey of Employer-Sponsored Health Plans, 2006 Survey Report.
- A survey of several large purchasing organizations used by the districts (large JPAs, Trusts, Districts and CalPERS).

Data Limitations

None of the above data sources presented a complete and consolidated picture of the delivery of healthcare to school district employees and retirees. Key elements were missing from each source. As a result, we had to aggregate information from multiple sources to develop a broad picture of the current situation. Where data was unavailable, we made assumptions. These assumptions are outlined in the report.

When survey information was involved, Mercer relied upon the data as provided by the various responding organizations. Mercer did not perform an audit of the data nor did we validate the quality of the data. All data capture processes involve some level of human error and inconsistency. However, we applied a number of reasonability tests and followed up, where possible, for data clarification.

As it turned out, some surveys were not specifically focused on the needs of the project as they were commissioned either in advance of the project or without respect to it. Other surveys, while focused, suffered because data submission was incomplete. To mitigate this issue, we supplemented results derived from surveys and readily available information with our knowledge of the California healthcare industry and with specific school district knowledge.

While it would have been preferable to have each school district and each provider provide full and complete information, we believe that the conclusions derived from our processes are valid, although the range of cost results are broader than would otherwise have been the case. We believe that the cost results reflect a realistic representation of the financial situation of healthcare for school district employees and retirees in California.

An overview of each of the major data sources, and a discussion of limitations, follows.

Data Collected by School Services of California, Inc. (SSC)

SSC compiles annual reports for school districts, including one on compensation and benefits for certificated employees. Their data is compiled from information provided by the California Department of Education, with follow-up from SSC, on about 80% of the school districts (842 of the 1,054[5] school districts) in the State of California.

Mercer made arrangements with SSC to receive:

- An electronic file, by school district, containing: current enrollment by plan, total plan cost by plan, and district contributions toward the cost for active certificated employees.
- An electronic file, by school district, containing: current enrollment by plan, total plan cost by plan, and district contributions toward the cost for retired certificated employees. This data is provided separately for retirees over age 66, and for retirees age 65 and under.
- Access to their data tool *Bargaining Hunter™* – which includes copies of bargaining agreements. We used this tool to obtain and compare some plan design and contribution information for both classified and certificated employees in specific school districts.

The SSC data received reflected costs and coverage for the 2005–06 year. Given the comprehensive nature of the SSC data, we used it extensively in developing exhibits for this report. While comprehensive, the SSC data does not include information on classified employees, other than in the bargaining agreements. Based on our discussions with SSC and the information gleaned from the CalSTRS survey cited in this report, a large percentage of benefits for classified employees duplicate those offered to certificated employees. Given that, we used the SSC data along with other data sources to make reasonable estimates of the health plan cost and coverage for classified employees.

The SSC data does not include costs by tier (i.e., single, two-party, family) for about 55% of the active plans since they report their costs on a composite basis. This, unfortunately, reduces the information available on dependents.

[5] State of California Department of Education web site indicates there are 1,052 school districts for 2006-07; SSC data relates to the 2005-06 year, when there were 1,054 districts.

CalSTRS Benefits Survey Data

This is the second time that CalSTRS has conducted a benefits survey. The survey tool itself was developed and sent out before this study was commissioned, and it was not designed specifically to meet the study's data needs. Therefore, it did not provide answers to all of our questions.

While the survey did not provide all of the needed information, it proved to be a valuable tool. We used it to test results and assumptions made from the SSC data, and it provided useful information on current and planned plan design features, as well as information on how coverage is currently provided.

CSEA Member Survey: Health Care Reform

CSEA conducted telephone interviews with 800 CSEA members during the period January 30 to February 6, 2007, using *Fairbank, Maslin, Maullin & Associates*. The main purpose of the survey was to obtain member's opinions on issues related to pending health care reform. However, several questions were asked related to health care coverage patterns among the members, including access to and affordability of health insurance. The margin of sampling error in the survey was +/- 3.5%.

We used results obtained in this survey to roughly project the numbers of the uninsured population and as an indicator of some of the underlying reasons why they do not have coverage.

Census Studies Performed by CalPERS and CalSTRS

Table 2 presents a summary of the components of the census files provided by both CalPERS and CalSTRS. These census files were intended to provide a snapshot of the AB 256 eligible population as of the dates the studies were conducted.

Table 2 – Components Included in the Census Studies Performed by CalPERS and CalSTRS

AB 256 Eligible Population	CalPERS Census (April, 2007)	CalSTRS Census (February, 2007)
Certificated Active	Zip, age, gender, carrier, coverage tier, district	Zip, age, gender, assignment code (district available)
Certificated Retiree	Zip, age, gender, carrier, coverage tier, district	Summary data on age, sex, zip
Dependent of Certificated	Data included	Data not available
Classified Active	Zip, age, gender, carrier, coverage tier, district	Data not available
Classified Retiree	Zip, age, gender, carrier, coverage tier, district	Data not available
Dependent of Classified	Data included	Data not available

The gaps include:

- CalPERS census, while more complete for purposes of this study, represents only a small portion of the eligible population. Based on the data collected in the CalSTRS survey, we expect that it represents no more than 7% of the eligible population.
- CalPERS does not maintain certificated/classified or full time/part time status information, so the data cannot be used to perform any separate analyses of those populations.
- CalSTRS data does not include information on classified employees, dependents, or health care coverage.
- Neither census includes contribution information (how much the district charges the employee or retiree for his or her coverage).

Given the gaps, the census studies were of limited use individually. We did, however, use them as a consistency check for some of the results obtained for this study.

Mercer 2006 National Survey of Employer-Sponsored Health Plans

The Mercer National Survey of Employer-Sponsored Health Plans was established in 1986, and is conducted annually. The survey uses a national probability sample of U.S. employers with 10 or more employees (including local and state governments) stratified by employer size and region to ensure a representative mix of employers. Each year around 3,000 employers participate. Because the database is so large, it is a powerful benchmarking resource. Mercer has developed a number of standard benchmarking reports that employers can use to compare their programs to meaningful industry, size, or geographic norms.

One of those break-outs provides results for large California employers. Given regional differences in medical costs, we used the California employer survey data extensively in this study to benchmark medical costs. In the survey, large employers are defined as those with 500 or more employees. There were 126 California employers who participated in the 2006 survey.

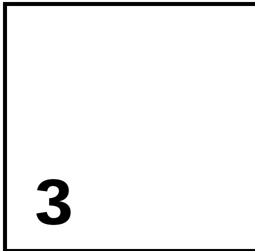
Additional break-outs provide results for large and small government plans. For plan design benchmarking, we used these break-outs in addition to the large California employer break-out. The 2006 survey includes 242 large government and 165 small government participants. Government participants included city, county and state government employers.

Customized Survey of Current Large Purchasing Organizations

The CalSTRS survey results indicate that close to 80% of the coverage currently provided by school districts is provided under an arrangement that already includes some elements of pooling (JPA, Trust, or CalPERS). We developed a customized survey to collect information from several large purchasing organizations. We asked for information on:

- Service area and products offered to school districts
- Plan design alternatives available
- Rate structure
- Cost and care management practices
- Services provided and the resultant expense loads
- Conditions for joining and exiting the pool

The survey tool was sent to these organizations through the California Education Coalition for Health Care Reform (CECHCR), which offered to help CalPERS and CalSTRS obtain survey responses. While responses were somewhat uneven, the respondents completed the survey with the understanding that results would not be individually identified. Therefore, we are not naming the organizations who participated in the survey in this report, and only summary information is included. Jointly, however, they cover about half of the district population.



Health Care Coverage for Active Employees

In assessing the current situation for health care coverage for active employees, we examined:

- Total numbers of active employees
- How coverage is provided to them
- School district costs based on size
- How school district plans and employees compare to other large California employers
- Who is covered – and who is not

This examination allowed us to develop an assessment of access to coverage currently for active employees, as well as relative affordability. Using this information, we developed a projected total cost of coverage. We then projected those costs to the uninsured population in order to develop a projection which assumes all currently uninsured employees also have coverage.

Total Numbers of Active Employees

Information contained in the California Department of Education (CDE) web site provides a high-level understanding of the approximate total numbers of employees who are actively-at-work in the public school system. They are grouped into two major categories: certificated, who need state-approved credentials, and classified, who do not. The total number of actives for both certificated and classified is in Table 3, shown on the next page.

There was limited direct information on classified employees available for use in this study. However, the CalSTRS Health Care Survey of Employers for 2006 included a question about whether the district or county office provided a different level of benefits for certificated employees than for classified employees. Of the responding organizations, 77% said that they had the *same* level of benefits. Staff at SSC provided anecdotal information to confirm this based on their knowledge of district bargaining agreements; they indicated that a majority of classified employees have benefits and contributions that are the same as the certificated employees. Additionally, another group of classified employees have the same benefits, but different contribution levels.

Given the similarity in benefits between certificated and classified, we used the certificated employee data as a proxy for the classified employee data. We used classified data in developing assumptions where data was available, and we also used it to confirm similarities or to highlight differences between the populations.

Table 3 – Active Employees in the Public School System

Type of Staff – 1,052 School Districts	Number of Staff	Percentage of Total
Certificated Employees		
Administrators	27,826	4.3%
Pupil Services	26,634	4.1%
Teachers	308,790	47.4%
Total Active Certificated	363,250	55.8%
Classified Employees		
Paraprofessionals (instructional or library aides)	101,372	15.6%
Office/Clerical	60,386	9.3%
Other (business managers, custodians, bus drivers, cafeteria workers, etc.)	125,780	19.3%
Total Active Classified	287,538	44.2%
Combined Active Total	650,788	100.0%

Source: California Department of Education, Educational Demographics Office for 2006-07.

Who Provides Health Care Coverage to Active Employees

While the CalSTRS survey data tells us how coverage is provided, the SSC data provides further information on who provides it. While there are reporting issues[6], Table 4 results show that smaller districts are more likely to purchase coverage from CalPERS.

Table 4 – Current FTEs Health Care Plan Enrollment Distribution for Active Certificated Employees

Size of District	# of Districts	Blue Cross	Blue Shield	Health Net	Kaiser	PacifiCare	CalPERS	Other	Grand Total
2000+	13	26,526	4,403	5,787	28,521	10,817		6,813	82,867
1500-1999	14	4,268	4,681		7,360	2,419		4,912	23,640
1000-1499	37	15,202	5,195	1,197	13,875	2,109	177	6,672	44,427
900-999	6	2,972	279	125	1,226		420	741	5,763
800-899	17	4,111	2,181	1,082	4,408	547	125	1,980	14,433
700-799	13	1,597	2,274	498	2,551	665	416	1,667	9,668
600-699	18	2,700	1,312	270	2,573	343		4,416	11,614
500-599	20	2,966	1,725		2,754	1,200	805	1,609	11,059
400-499	40	4,281	3,034	897	5,895	1,605	304	2,072	18,089
300-399	52	3,158	2,519	1,270	4,949	2,662	1,080	2,450	18,088
200-299	76	5,645	2,473	716	4,682	1,742	918	2,499	18,675
100-199	138	5,764	2,029	981	3,510	814	847	6,179	20,123
0-99	398	4,444	936	301	2,192	759	315	5,111	14,058
Grand Total	842	83,633	33,041	13,123	84,497	25,682	5,406	47,121	292,505
Percentage of Total	79.9%[7]	28.6%	11.3%	4.5%	28.9%	8.8%	1.8%	16.1%	100.0%

[6] Districts self-report in the SSC database. Some report the health care plan as CalPERS while the carrier is Blue Cross, Blue Shield, Kaiser or WHA. Some report the health care plan as Blue Cross, Blue Shield, Kaiser or WHA, even though they purchase their coverage through CalPERS (or JPA/Trust).

[7] The California Department of Education website indicates that during the 2005-06 year there were 1,054 school districts in California. The 842 school districts represented in the SSC data therefore make up almost 80% of the total.

School District Cost Based on Size of District

A basic premise of this study is that a larger membership pool can create the leverage needed to obtain more competitive health care costs. A first step was to determine if there is currently an appreciable difference in cost based on the size of the district. Using the SSC data for all size school districts, we conducted a regression analysis in order to determine the linear relationship – or "best fit" – using total cost, employee cost, and employer cost for districts with 2,000, 500, and 100 full-time employees (FTEs), by major health plan. We compared the average total weighted cost, by carrier, split between the employer cost and the employee cost.

The cost differences in Table 5 do not take into account:

- Demographic differences such as family composition or average age.
- Geographic costs variances that exist in the State (e.g., North versus South, Urban versus Rural).
- Cost features such as plan design differences and differences in health care delivery (for example, HMO versus PPO or JPA versus CalPERS).

Table 5 – Regression Analysis of Medical Cost by Carrier and by Size of District

	For District with 2,000 FTEs			For District with 500 FTEs			For District with 100 FTEs		
	Total	**Employee**	**Employer**	**Total**	**Employee**	**Employer**	**Total**	**Employee**	**Employer**
Carrier 1 (Mixed)	$ 9,298	$ 1,333	$ 7,966	$ 9,394	$ 1,397	$ 7,997	$ 9,420	$ 1,414	$ 8,005
Carrier 2 (Mixed)	$ 7,896	$ 941	$ 6,955	$ 8,066	$ 1,541	$ 6,525	$ 8,112	$ 1,701	$ 6,410
Carrier 3 (HMO)	$ 8,004	$ 675	$ 7,329	$ 8,201	$ 1,659	$ 6,542	$ 8,253	$ 1,921	$ 6,332
Carrier 4 (HMO)	$ 7,217	$ 1,067	$ 6,150	$ 7,260	$ 1,163	$ 6,096	$ 7,271	$ 1,189	$ 6,082
Carrier 5 (HMO)	$ 8,078	$ 1,775	$ 6,303	$ 8,167	$ 1,878	$ 6,289	$ 8,191	$ 1,906	$ 6,285
CalPERS (Mixed)	$ 7,811	$ 2,435	$ 5,376	$ 7,867	$ 2,213	$ 5,654	$ 7,881	$ 2,153	$ 5,728
Other	$ 8,711	$ 672	$ 8,039	$ 9,195	$ 1,317	$ 7,877	$ 9,324	$ 1,489	$ 7,834

For a district with 100 FTEs, the total cost for the highest cost carrier is 1.3% higher than for a district with 2000 FTEs. The employee contributions for the 100 FTE district are 6.1% higher. For a district with 100 FTEs, the total cost for the lowest cost carrier is 0.7% higher than for a district with 2000 FTEs. The employee contributions for the 100 FTE district are 11.4% higher.

On the surface, the implication is that the size of the employee group is not a significant factor in plan cost, but smaller groups charge their employees more and thus are less likely to be selected against for dependent coverage. However smaller groups may be more likely to enroll in a CalPERS plan, and those costs, on average, are slightly lower than those for most other carriers. Smaller plans may also be somewhat more likely to join a purchasing pool than to contract directly; thus they may already be obtaining some of the advantages of increased size.

Comparing Districts to Other Large California Employers

We compared the districts to other large California employers in several areas in order to benchmark their results to others. Through this benchmarking process, we hoped to develop a better understanding of where potential areas of opportunity – or existing efficiencies – might exist. We used the Mercer Survey[8] results for this purpose.

Comparing District Costs to Other Large California Employers

We compared health care costs for school districts based on the SSC data to those of large California employers in order to determine if there was a discernable difference; the results are shown on Table 6. We focused on the California survey, instead of using data for other government employers, given regional differences in medical costs. However, in order to fairly compare those costs, we needed to eliminate known differences, including:

- The SSC cost data were for the 2005/2006 plan year, while the survey costs were for 2006. We accounted for the difference by adding a half-year of trend to the SSC data, using a 10% assumed annual trend factor.
- Based on the data we had on plan design, the school district plans appeared slightly richer than those offered by other large California employers. In order to estimate the cost impact of those differences, we used MedPrice, our proprietary medical plan pricing tool to model the effect of the relative design differences.
- The family content and the average age of school district plans were slightly different than those of employers within the survey; we therefore adjusted for those factors.

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[8] Mercer Health & Benefits National Survey of Employer-Sponsored Health Plans for 2006, results for large (+500) California Employers.

Table 6 – Normalization of School District Costs Compared to Survey Results

		Average Medical			HMO Only[9]		
		Total Cost	Employee Cost[10]	Employer Cost	Total Cost	Employee Cost	Employer Cost
1)	Average School District Cost (05/06)	$8,081	$803	$7,278	$7,175	$691	$6,484
	Adjusted for the impact of ½ year of trend to 2006 (+5%)	$8,485	$843	$7,642	$7,534	$726	$6,808
2)	Plan Design Adjustment (School District 1.2% richer on average and 1% richer for HMO benefits)	$8,383	$833	$7,550	$7,458	$718	$6,740
3)	Family Composition Adjustment (School District 1.86 / Mercer Survey 1.81)	$8,158	$811	$7,347	$7,258	$699	$6,559
4)	Adult Age Adjustment (School District 45 / Mercer Survey 41 – 2.1% / year)	$7,508	$746	$6,762	$6,680	$643	$6,037
5)	Mercer Survey Benchmark (California Employers – 2006 Costs)	$6,941	$1,811	$5,131	$6,286	$1,572	$4,715
6)	Percentage Difference between Benchmark and School Districts	-8%	+143%	-24%	-6%	+144%	-22%
	Consistency Check—From CalSTRS Survey (compare to line 1)	–-	–-	–-	$6,912	$564	$6,348

Based on this comparison of normalized results, which eliminates several extraneous factors, it appears that:

- Districts pay 8% more on average (6% for HMOs) than similarly-situated California employers, after adjusting for known differences. This may be an indicator of a high level of utilization, and suggests an opportunity for implementation of best practices with respect to health, wellness and disease management.

- California employers charge their employees significantly more in contributions for coverage than do school districts. Other California employers have increased contributions (or reduced benefits) to save money, making the district plans increasingly attractive in comparison. This appears to have caused the district plans to be selected against, particularly for dependent coverage. This result may be attributable in part to past practice of diverting compensation increases to maintain benefits rather than increase wages.

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[9] Identified in the SSC data as covered by HealthNet, Kaiser, or PacifiCare; these cost data may include a small number of POS options

[10] We also compared the average district contribution to those for public sector employers based on Mercer survey results. Employee contributions, as a percentage of total cost, were approximately: 10% for school districts, 21% for large public sector employers and 28% for small public sector employers.

Comparing District Salaries to Other Large California Employers

We compared the average salary from the Mercer survey to some statewide salary averages for school districts, based on SSC data. This is an area where the classified employees differed significantly from the certificated employees. As a result, the comparison to other employers is provided for both.

Table 7 – District and Teacher Average Salary[11] Ranges

	Teacher FTE Statewide for 2005/06	Unified Teacher Statewide Scheduled for 2005/06
Lowest	$34,777	$37,872
Scheduled Average	$49,787	$58,930
Highest	$68,296	$79,989

The computed average teacher salary for 2005-06, based on SSC data, is $59,815 statewide. This compares to the Mercer Survey average salary for 2006 of $56,632. From the comparison to survey, it appears that full-time teachers are not disproportionately burdened by health care contributions when compared to contributions charged by other large California employers.

While the focus of the SSC data is certificated employees, they do collect some information on classified employees. Annual salary information is not available in the same format as it is for certificated employees, but SSC was able to provide average salary expense per average daily attendance (ADA) for both. That comparison is shown in Table 8.

Table 8 – Salaries for Certificated and Classified Employees per Average Daily Attendance (ADA)

	Certificated Salaries per ADA	Classified Salaries per ADA	Classified as a Percentage of Certificated per ADA
All Districts	$3,987.92	$1,207.67	30.3%

[11] District and Teacher Average Salary information taken from reports developed using SSC's *BargainingHunte*r™ Tool. As used in this context, "teacher" salaries do not include all certificated employees, but can include some non-teaching certificated employees such as librarians, nurses, counselors and psychologists if they are within the same salary schedule. CalSTRS reported that, as of June 30, 2006, the average earnable salary for all active classified employees was $57,698.

They then provided an estimated calculated annual salary amount of just over $25,000. They developed this estimate based on the following assumptions:

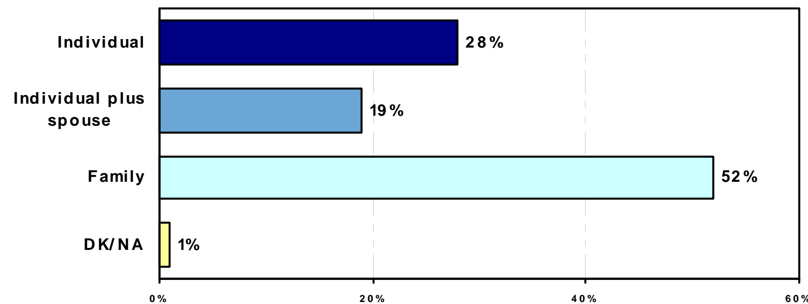
- Calculated average salary amount of $36,371 based on reported salary expenditures and staff numbers
- Part-time salaries are about 40% of full-time salaries
- Most classified employees are 10-month employees

While classified employees are paid substantially less than certificated, a large percentage does have access to the same benefit levels as the certificated employee population – and at the same contribution levels.

Comparing District Coverage for Dependents to Other Large California Employers

As discussed previously, comprehensive census information on the dependents of school district employees (or retirees) is not available. In the CSEA survey, classified members with coverage were asked if they had individual health coverage, individual plus spouse coverage, or family coverage. Table 9 illustrates the results.

Table 9 – Enrollment by Tier for Classified Employees



In the Mercer survey, 54% of employees elect to cover their dependents. While the results in Table 9 include coverage provided by other employers as well as school districts, the data suggest that school districts may cover more dependents (individual plus spouse or family) than do other California employers.

In order to determine if this is the case for dependents of certificated employees, we reviewed SSC data. Of the school districts included in the SSC data, 155,974 of the 292,505 enrollees – or 53.3% – were reported on a composite basis. Since a composite rate structure does not differentiate between single and family coverage, this provides no insight into the currently-covered dependents. However, for these districts we would infer – based upon the absence of employee contributions for coverage – that we would find a higher percentage of employees who cover their dependents under the district plans. Employees who do not make added contributions for dependent coverage are likely to cover their dependents under the plan without contributions, even if the dependent is eligible for coverage through another employer's plan.

The remaining 46.7% of enrollees, who are clearly required to contribute for dependent coverage, can be broken out based on enrollment on a three-tier basis. Table 10 provides information on that break out. Where dependent contributions are required, the percentage of employees who cover their dependents is similar to other large California employers.

Table 10 – Enrollment by Tier for Active Certificated Employees (FTEs) Excluding Those Reporting on a Composite Basis

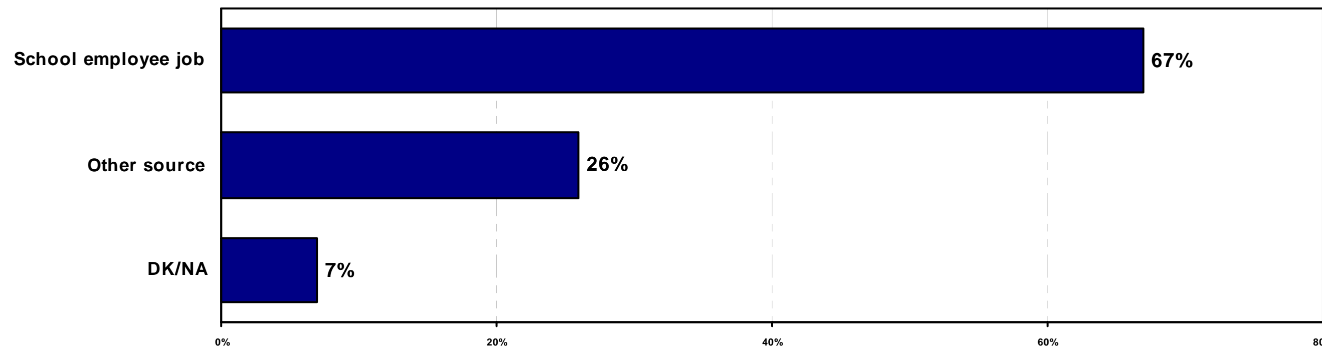
	Reported by Tier	Percentage
Employee Only	63,100	46.2%
Two Party	29,183	21.4%
Family	44,281	32.4%
Total	136,564	100%

Who is Covered – and Who Is Not Covered

In order to understand if a single statewide health care pool for all public school employees would be feasible and cost-effective, it is important to understand who the uninsured are, how many of them there are, and why they lack coverage.

Although we do not have specific information on this, the CSEA survey of classified employees asked specific questions about whether or not the respondents were uninsured, who the uninsured were, and why they did not have coverage. Broadly, the CSEA results indicate that most employees have some form of health coverage; the results are included in Table 11.

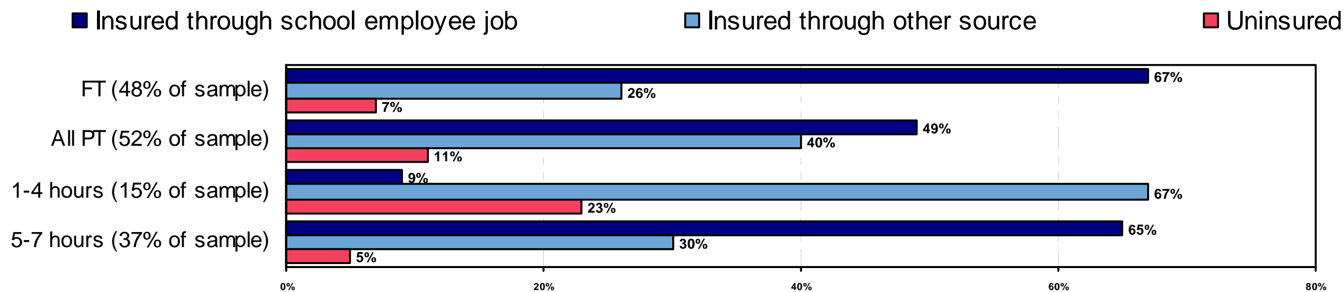
Table 11 – Percentage of Classified Employees with Some Form of Health Insurance



Impact of Part-Time Employment

The CSEA survey also provided break out information on the uninsured population based on whether or not they work full-time or part-time. As can be seen in Table 12, part-time workers are much more likely to be uninsured than full-time workers, particularly those working 1-4 hours per day.

Table 12 – Break-Out of the Uninsured Population Comparing Full-time to Part-time Employment



Since part-time employees are often not eligible for health insurance through their own employment, we reviewed the bargaining agreements for the largest school districts, in order to determine if coverage for part-time employees was available for certificated and classified employees. Our review of bargaining agreements provided the following impression of trends, which reinforce the CSEA survey results:

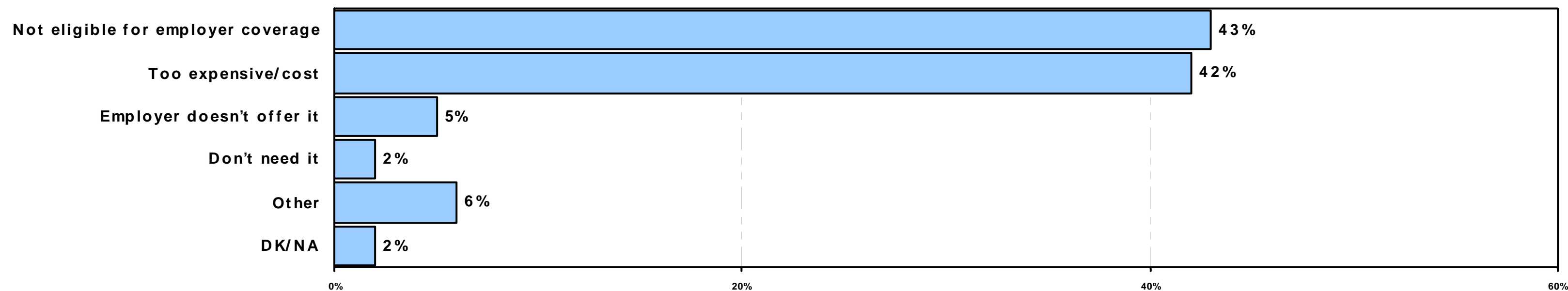
- In most cases an employee will have access to healthcare coverage if he or she works at least half-time, though he or she may pay much more for coverage than a full-time employee.
- If an employee works more than half-time but less than full-time, he or she will almost always have access to healthcare coverage and will receive a pro-rata share of the district's contribution amount. This may cause the employee to have to make a sizeable contribution for coverage.
- If an employee works three-fourths time, but less than full-time, he or she will usually be deemed to be a full-time employee.

A summary of the language related to coverage for part-time employees contained in the bargaining agreements for the largest school districts is contained in the Appendix.

Reasons for Lack of Coverage

A follow-up question within the CSEA survey, asked only of the uninsured population, sought to clarify the reason(s) why members did not have health insurance. The response to an open-ended question which asked “What’s the main reason you do not currently have health insurance?” is shown in Table 13.

Table 13 – Main Reasons Uninsured Classified Members Do Not Have Health Care Coverage



Relative Size of the Uninsured Population

SSC provided a break out of part-time to full-time classified employees; the total closely matched the total number of employees from the CDE web site. Using the percentages of the uninsured population contained in the CSEA survey applied to that break out, we can develop a rough estimate of the uninsured classified population:

Table 14 – Estimated Number of Uninsured Classified Employees

Classified Employees	Number of Employees Based on SSC Data	Percent of Total	Estimated Number of Uninsured	Percentage of Uninsured
Full-time Employees	126,046	44.1%	8,823 (7% of full-time)	33.5%
Part-time Employees	159,455	55.9%	17,540 (11% of part-time)	66.5%
Total Employees	285,501	100.0%	26,363	100.0%

SSC also provided a break-out of certificated employees on a part-time versus a full-time basis; they indicated there were 332,293 full-time employees and 23,196 part-time employees. We were able to verify the relative magnitude of that break-out using the census files provided by CalSTRS. While some teachers had multiple assignment codes in the census – because they work at more than one school – we sorted them into categories. If they had at least one code that indicated they were under contract full-time, we assumed that they were employed full-time. For the remaining employees, we sorted based on part-time and "other" codes (usually, these indicated substitutes).

We then applied the assumed percentages of uninsured employees, based on the classified data, to that break out. However, given that full-time classified employees make higher salaries, it is likely that fewer full-time employees decline coverage due to cost issues. Therefore, the estimated number of uninsured full-time certificated employees shown in Table 15 is likely *overstated.*

Table 15 – Estimated Number of Uninsured Certificated Employees

Certificated Employees	Number of Employees Based on SSC Data	Percentage of Total	Estimated Number of Uninsured	Percentage of Uninsured
Full Time	332,293	93.5%	23,260 (7% of full-time)	90.1%
Part-Time	23,196	6.5%	2,552 (11% of part-time)	9.9%
Total	355,489	100.0%	25,812	100.0%

Because we believe the estimate derived in Table 15 is overstated, we believe an estimate of the total number of uninsured active employees for both the certificated and the classified populations at 52,175 is conservative. For the classified population, the uninsured are made up of part-time employees who may not be eligible for coverage and those who find it to be too expensive. For the certificated population, it appears that many work more than one job – but a large percentage has at least one job in which they are classified as full-time, and thus are likely to be eligible for coverage.

Access and Affordability for Active Employees

Most district employees currently have good access to comprehensive and affordable coverage. Those with access and affordability issues are primarily part-time employees who may not be eligible for coverage and those who find it to be too expensive.

Access can be made available to these employees:

- On an employee-pay-all basis. This approach is already in use by retirees under some of the current pool arrangements. While coverage is costly, it is available. One of the problems with this approach is that employees who can qualify for coverage elsewhere will select it; this will leave only the worst risks remaining in the pool.

- On a district-subsidized basis. One concept might be to develop a pro-rata approach; for example, if a person works ¾ time, he or she gets a ¾ subsidy relative to the full-time employee. This, of course, would increase district costs.

Without a subsidy, coverage that is as comprehensive as is currently offered to full-time employees is unaffordable. Some employers are resolving this issue by offering part-time employees a plan of benefits that is less rich than the plan offered to full-time employees. While the coverage is not as comprehensive, it does typically provide comprehensive preventive benefits and offer protection against financial disaster in the event of serious illness or injury.

Estimated Total Cost of Active Coverage

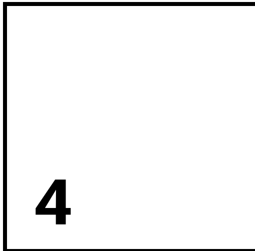
The districts paid an average of $8,081 per employee per year to provide coverage during *2005/06*, less an employee-paid cost of $803, for a net employer cost of $7,278. We estimated the cost of coverage for *2007/08* for the currently insured population, and the additional cost were coverage to be extended to those who do not currently have coverage. The results are as shown in the following Table 16.

Table 16 – Estimated Total Cost of Active Coverage for 2007/08 (in billions)

	Employer Cost	Employee Cost	Total Cost
For Currently Insured Population	$5.85	$0.58	$5.27
Estimated Additional Cost to Insure Uninsured Population	$0.51	$0.05	$0.46
Total Estimated Cost	$6.36	$0.63	$5.73

Assumptions:

- 650,788 total active employees; 52,175 are not insured
- Cost share for newly-insured population is the same as the cost share for the currently-insured population
- 2005/06 costs are adjusted to 2007/08 using 10% trend each year
- No adjustment for additional selection or plan design changes



Current Health Care Coverage Landscape for Retirees

In assessing the current situation for health care coverage for district retirees, we examined:

- Total numbers of retirees
- How coverage is provided to them
- How school district plans compare to other employers
- How retiree health care coverage is provided overall
- The estimated pay-as-you go cost of retiree coverage (i.e., cost of benefits less any retiree contributions), not including the additional funding or accrual costs required by the imminent GASB standards

This examination allowed us to develop an assessment of access to coverage currently for retirees, as well as relative affordability. Using this information, we developed a projected total cost of coverage.

Total Numbers of Public School System Retirees

Most certificated employees are eligible for service retirement, survivor, and disability benefits under the California State Teachers' Retirement System (CalSTRS). CalSTRS provided census data to us on this population. As of the February, 2007 census, CalSTRS had 183,568 service retirements, distributed as shown on Table 17.

Table 17 – Number of Certificated Service Retirees

Total Benefit Recipients	Male	Female	Total	Percentage of Total
Medicare Eligible	56,930	95,503	152,433	83.0%
Under 65 (Not Yet Eligible for Medicare)	9,950	21,185	31,135	17.0%
Total Number of Retirees	***66,880***	***116,688***	***183,568***	***100.0%***

Source: CalSTRS census as of February 2007

We do not have a similar break-down of the number of potentially-benefit-eligible classified retirees. However, if the ratio of classified retirees is similar to the ratio for active classified employees, then we would assume the following for classified retirees:

Table 18 – Estimated Number of Classified Service Retirees and Total Retirees

Total Benefit Recipients	Certificated Retirees from Census	Percentage of Active	Estimated Classified Retirees	Percentage of Active	Total Retirees
Active Employees from Table 3	363,250		287,538		650,788
Medicare Eligible	152,433	41.9%	120,478	41.9%	272,911
Under 65 (Not Yet Eligible for Medicare)	31,135	8.6%	24,728	8.6%	55,863
Total Number of Retirees	***183,568***		***145,206***		***328,774***

The estimated number of classified retirees may be quite high, however, since the percentage of part-time workers is so much higher for the classified employees than it is for certificated employees, and part-time workers are less likely to achieve eligibility for benefits (see discussion above). This is especially true of retirement benefits, which usually have even tougher eligibility rules[12] than is the case for benefits for active employees.

[12] Assumes only service retirement benefit recipients are to be included in the study.

District Coverage and Retirees

The SSC data contains information on how districts provide medical coverage to certificated retirees. A break out of the results can be found at Table 19.

Table 19 – District Approach to Providing Certificated Retiree Health Care Coverage

Coverage Provided	Number of Districts	Percentage of Total Districts	Number of Active Employees	Percentage of Total Active Employees	Number of Covered Retirees under 65	Number of Covered Retirees Age 65+
Active Only	289	34.3%	38,803	13.3%	0	0
Active and Retiree under 65	414	49.2%	134,794	46.1%	13,904	0
Active and Retiree 65+	11	1.3%	2,736	0.9%	0	854
Active, Retiree<65, Retiree 65+	128	15.2%	116,172	39.7%	8,767	43,610
Total	842	100%	292,505	100.0%	22,671	44,464

While the SSC data does not provide information on all school districts, at least 22,671 retirees of the under-65 population of 31,135 from the CalSTRS census have district-provided coverage. This is 72.8% of that population. A smaller percentage of the age 65 and older population has district coverage (29.2%). These retirees, however, are – by and large – eligible for Medicare coverage either through their own employment or through a spouse's coverage.

If the ratio of covered to non-covered retirees is similar for the classified population, then we would expect about 18,000 of the 24,728 under age 65 classified retirees have district-provided retiree medical coverage. This is, however, an estimate based on an estimate, but if we use it, the estimated total number of under-age-65 retirees currently without coverage is 15,195. If only 29% of the age 65 and older population has coverage, then 71% of the estimated 272,911 age 65 and older retirees – or about 193,667 of them – do not currently have coverage other than Medicare. The estimated total number of current retirees without coverage is 208,862.

The number of active employees who can qualify for retiree medical coverage is quite high. Almost 86% work in a district which allows them to qualify for retiree medical coverage that would act as a bridge to Medicare.

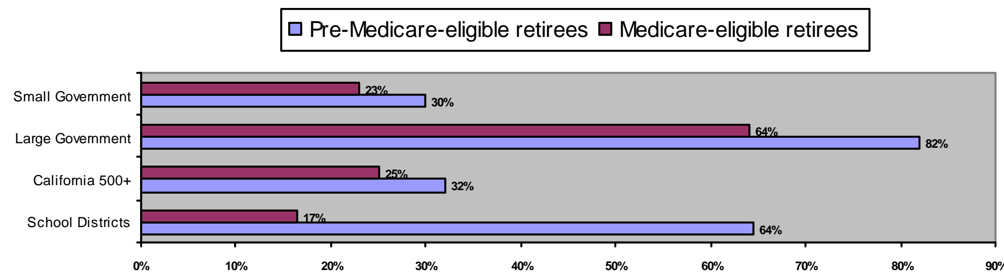
A discussion of the cost implications of providing coverage, and of the impact of GASB, is included in a latter section of this report.

District Retiree Medical Coverage Compared to Survey Data

While not all districts provide retiree health care coverage, they provide it much more frequently for early retirees than most other California employers. They are in the middle compared to large and small government employers, which makes sense – since they are a combination of those groups.

They provide coverage to Medicare-eligible retirees a little less frequently than any of those groups. A comparison using Mercer survey results follows in Table 20.

Table 20 – Prevalence of Employer-Provided Retiree Medical Coverage



The Current District Approach to Providing Retiree Medical Coverage

While not everyone receives retiree medical coverage, the approach used by many districts of providing coverage to retirees to bridge any gap between retirement and eligibility for Medicare is valuable to the retirees who receive it. The cost of retiree medical coverage is not offset by benefits received from Medicare, and thus it is more costly to provide. Under this approach, Medicare itself is viewed as a "retiree medical plan".

And, while not everyone receives retiree medical or qualifies for it due to service requirements, some of the plans that provide pooled coverage options to school districts also provide options to retirees to continue their medical benefits on a self-pay basis. This allows those retirees who do not have an employer-paid alternative to purchase coverage that is effectively a group coverage alternative. While coverage is expensive on a retiree-pay-all basis, it does provide an option to the retiree that is not available in the market place to other under-65 retirees.

Access and Affordability for Retiree Coverage

Based on the SSC data, we estimate that only 34.3% of districts, covering 13.3% of employees, do not provide any retiree health care coverage. The number of active employees who can qualify for retiree medical coverage is quite high. Almost 86% work in a district which allows them to qualify for retiree medical coverage that would act as a bridge to Medicare, as long as they work a sufficient number of years to qualify for it.

As stated above, some pools currently allow retirees to stay in the pool on a retiree-pay-all basis if they retire without coverage (the district may pay part or the entire premium, depending upon the retiree's eligibility). This allows retirees to have access to coverage until they become entitled to Medicare. Once entitled to Medicare, the pool offers Medicare supplement alternatives.

This arrangement allows retirees to have access to coverage, although it can be quite expensive without the district subsidy. We would expect that there is some selection against these plans as well as retirees with other, less expensive, options would choose that coverage.

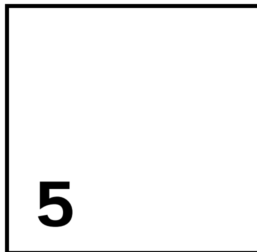
Estimated Total Cost of Retiree Coverage

We estimated the cost of coverage for 2007/08 for the currently insured population based on the SSC data, applied to the estimated covered retiree population at $912 million.

Assumptions:

- 328,774 retirees
- There are 208,862 Medicare and non-Medicare eligible retirees who do not have coverage currently
- 2005/06 costs are adjusted to 2007/08 using 10% trend each year
- No adjustment for additional selection or plan design changes

The objectives of AB 256 included improving access to health care coverage for the school district employees who do not currently have it because they are not eligible or the coverage is unaffordable, but an expansion of retiree medical coverage was not mentioned. Therefore, we did not attempt to calculate a specific cost for an expansion in this section, as we did for active employees. There is an additional cost issue, however, that is addressed further in the section of the report dealing with the feasibility of using PEMHCA as the vehicle for providing a health care pool.



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Current Health Care Coverage Landscape for School Districts

In order to compare the current situation to the proposed alternatives, our first steps were to document and understand – at a high, overall level – the existing health care coverage alternatives and the costs to both the school districts and to the members.

How School Districts Contract for Health Care Coverage

School districts contract with a variety of sources to secure health care coverage. Surveys conducted by CalSTRS in 2003 and 2006 indicate that districts provide health care coverage for their members as follows:

Table 21 – Current Health Care Providers

Survey Year	Direct Contract with Health Plan	JPA or Trust	CalPERS	Both Direct Contract and JPA	Other
2003 Survey	15%	66%	8%	8%	3%
2006 Survey	16%	68%	7%	5%	4%

From the CalSTRS survey results, it appears that close to 80% of the coverage currently provided by school district employers is provided under an arrangement that already includes some elements of pooling (JPA, Trust, or CalPERS). Presumably, that large percentage of employees is already experiencing some level of administrative efficiency and negotiation leverage. However, a premise of this study is that a single health care pool – which includes many different pools and plans – could result in increased negotiation leverage and improved administrative efficiency. This depends upon how efficient the current plans are, and whether or not negotiation leverage would truly reduce actual health care claims costs. A high-level discussion is contained later in this report.

Identifying Efficiencies and Inefficiencies within the Current System

Since such a large percentage of the population is currently covered through an arrangement that already includes some level of pooling, we developed a customized survey to collect information about how these large purchasing organizations provide coverage. We used the results of that survey, plus our general knowledge of the industry, to compare their costs, plans, procedures and services provided to each other and to "best practices" within the industry.

These results helped us develop a more refined picture of the current coverage provided to district employees and retirees, and where it might be efficient – or inefficient. This allowed us to identify savings opportunities and make savings projections. Some savings opportunities are primarily based on size. Others are not just scale-based, and these actions may be more difficult to take and to implement. However, they represent real opportunities to improve the overall health of the population, lower costs and impact trend.

A summary of our findings follows.

Size-Based Immediate or Near-Term Savings Opportunities

Reduced Direct Expense

There are a number of direct expenses within the current system that are often related to the size of the group. These are direct costs that are built into insurance contracts such as:

- Retention –- is the amount kept by an insurance company for expenses and profit. For smaller groups not included in a pooled arrangement, this amount is typically a percentage of the premium as determined by the carrier. Larger groups can negotiate this amount. In addition, retention amounts include a risk charge which depends upon the size of the group: the larger the group, the smaller the risk charge.

- Premium tax – insurance premiums collected within the State are taxed. The amount may vary based on the insurance arrangement, but a district can expect to pay about 2.3% in premium tax on a fully-insured contract. A self-funded indemnity contract does not pay premium tax, as there is no "insurance."

- Commission or broker fees – commission is often payable under fully-insured arrangements, and small groups typically pay more as a percentage of premiums than large groups. Actual commission payment varies based on the carrier and the broker

involved. Carriers typically reduce the commission percentage as the group's annual premium increases. For example, commissions may be 10% on the first $30,000 in premium, and then drop to lower and lower percentages as premium increases to specified levels.

- Stop loss coverage – Many school districts mitigate their risk of cost volatility by purchasing stop loss coverage. However, the larger pools leverage the amount of risk that they can handle, which in turn reduces the need for stop loss insurance.

Smaller districts that are insured and are not included in some type of pooling arrangement will pay more for the above expenses than groups in a large pool will pay. Moving from the fully-insured arrangements that exist today to self-funding can reduce these direct expenses. A range of estimated savings is shown in Table 22.

Table 22 – Development of Estimated Cost Savings Related to Direct Expense in Insured Contracts

	Risk Charges	Premium Tax	Commission	Stop Loss
Estimated average cost levels	4.0%	2.3%	1.5%	2.0%
Upper range of population impacted	30.0%	20.0%	25.0%	20.0%
Lower range of population impacted	20.0%	10.0%	15.0%	10.0%
Estimated % range of savings	0.80% to 1.20%	0.23% to 0.46%	0.225% to 0.375%	0.20% to 0.40%
Estimated upper bound of $ savings	$81 million	$31 million	$26 million	$27 million
Estimated lower bound of $ savings	$54 million	$16 million	$15 million	$13 million

The upper bound of the estimated range of savings is 2.45%, or $165 million. The lower bound of the estimated savings is 1.45%, or $98 million.

These savings are based on the following assumptions:

- The pool is mandatory.

- HMO alternatives will remain fully insured and the relative enrollment in them would approximate current levels, and thus premium paid to them is excluded from these estimates.

- Self-funding would apply to all non-HMO plan alternatives. All self-funded options would be included in a single pool, which could be regionally rated but would not include stop loss coverage.

- Stop loss premium is estimated at 6%, with a 2/3 loss ratio. This leaves about 2% that remains with the insurance carrier and is not recovered.

- Dollar range is based on 598,613 active employees with an average cost of $9,778 (2007/2008 dollars) plus 119,912 insured retirees with an average cost of $7,605, for a total estimated premium cost of $6.765 billion.

Reduced and Streamlined Administration

Every district must also administer its plans, and under the current system each district has a variety of arrangements: they may outsource some tasks or administer everything in-house. The cost of administrative expense is generally related to the efficiencies of the administration and the administrative systems. A badly-run large system can be as costly as efficiently-run smaller systems.

Under the current system, the large purchasing pools provide many administrative services to their clients in order to realize some economies of scale that would not otherwise exist. These generally include:

- Enrollment and billing systems
- Eligibility and termination monitoring and maintenance
- Customer service function
- Compliance with state and federal laws and regulations
- COBRA administration
- Open enrollment systems and assistance
- Employee communications

CalPERS provides some, but not all, of these services as well. Districts that offer coverage through CalPERS must arrange for COBRA administration, eligibility and termination monitoring, and communications preparation.

A single, state-wide system would eliminate the current duplicative systems, and allow for reduced and streamlined administration through economies of scale. In addition, the current multiple administration systems would not need to be supported (though the effort to develop a single system would be large). The savings associated with reducing and streamlining administration are difficult to estimate since good data on current direct and indirect costs is unknown. However, an examination of expense for the largest,

most efficient purchasing pools compared to those that were less efficient indicates that savings of about 0.5% could be possible. This translates to an annual savings of $34 million. This does not factor in the costs of system development.

Centralized administration could also have some additional effects whose savings potential is difficult to estimate:

- If the single pool offers a range of services similar to those offered by the large purchasing pools, it would allow districts which currently must conduct open enrollment, prepare communications, handle administration and COBRA continuation, etc., to access those services. This could eliminate some of the administrative tasks that must be performed at the districts, or consolidate them to a centralized location(s). Districts may be able to do their work with a smaller staff, generating some savings.

- Since the offerings will be defined, the district's efforts in bargaining should be simplified. This may reduce preparation time and effort for the bargaining process for both the districts and the collective bargaining units, as the sheer number of decisions would be reduced.

Improved Prescription Drug Costs

Prescription drug costs have been increasing sharply. According to the Mercer survey[13], increases peaked in 2000 at 18% among large employers. Employers responded by implementing tiered co-payments and encouraged greater use of generics and preferred brand-name drugs – and increased the employee share of the cost. In 2006, large employers reported that the increase in prescription drug spend was 9.9%, suggesting that these efforts have had the desired effect. Underlying drug trend, which is based on the actual cost of pharmaceuticals and the rate of utilization, was around 12% during this period.

Large employers in California also took actions that were similar to those of employers nationally. By 2006:

- 69% had implemented three-tier co-payments for retail coverage (generic, formulary, non-formulary); another 5% had implemented 4 or more tier levels.

- 61% had implemented three-tier co-payments for mail coverage; another 5% had 4 or more tier levels.

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[13] These results are for large employers nationally.

While some of the large purchasing organizations use or offer three-tiered co-payment approaches in order to control drug trend, the most common prescription drug plan designs in use by the districts are one or two-tier plans. These typically have a fixed co-payment – $5 and $10 are commonly used. CalPERS uses a three-tier co-payment approach for all plans except Kaiser (where drugs are filled automatically at the Kaiser pharmacy with generics or brand formulary drugs).

Some other trends in prescription drug coverage include:

- Widening the gap between the co-pay levels for generics and brand drugs, suggesting that employers are increasingly committed to encouraging the use of generics.
- Widening the gap between the co-pay levels for formulary bands and other non-formulary brand drugs, in order to take maximum advantage of pricing discounts and maximize the capture of manufacturer rebate revenues.
- Increasing use of coinsurance rather than co-payments, because coinsurance offers greater price transparency and allows employers to share cost consistently with employees even when drug prices fluctuate.
- Joining purchasing pools, because a group of employers gain significant negotiating power by acting as a single buyer. In the prescription drug market place, large purchasers can demand the biggest reductions in wholesale price, increased rebates, and the best plan management.

In the current system, the districts covered by CalPERS enjoy a high degree of size-based purchasing leverage. A school pool could realize that level of size-based leverage. This represents a significant opportunity. We estimate that a prescription drug program designed to take full advantage of available rebates, reductions in wholesale price, and increased use of generics and mail order, would generate savings in the range of 0.75% to 1.5%, or $51 to $101million.

In addition, while they are not *currently* a large portion of the population, a pool could bring value to Medicare eligible retirees in the area of prescription drug coverage if it examined issues such as becoming a Prescription Drug Plan (PDP).

Improved Network Discounts

As mentioned previously, a large percentage of the population is currently covered by Anthem Blue Cross, Blue Shield of California and Kaiser. Another significant portion of the population is covered by other managed care plans (HMO or POS). The Anthem and Blue Shield networks are large and comprehensive, and provide members with access to good discounts. Kaiser, a staff model plan, is quite limited.

Some of the population lives and works in rural areas of the state, where effective managed care networks are not available.

The plans offered by the major large purchasing organizations tend to mirror those found within the population as a whole (this is not unexpected, since such a large part of the population currently purchases coverage through these organizations), though some of the large purchasing organizations have embraced high performance networks as a cost and care management strategy. Under a high performance network arrangement, network providers are divided into groups on the basis of quality, cost-efficiency, or other factors. There are generally three types of tiered networks:

- Multiple co-pay tiered networks, in which the consumer selects a physician with the understanding that out-of-pocket costs will be greater for less-efficient providers.
- Pay-for-performance networks, in which a small portion of provider payment is based on quality and efficiency measures, but the payment process is not visible to the consumer.
- Narrow networks, which include only the providers that score highest in quality and efficiency.

CalPERS added the Blue Shield NetValue HMO and PERS Select PPO high performance network plans for 2008. In prior years they also eliminated certain hospitals which did not meet the appropriate quality and efficiency standards from the HMO option, but maintained those hospitals in the PPO in order to provide choice to participants. In addition, they continue to study the problem of rural access and cost.

At the other end of the spectrum are districts that do not currently enjoy leverage based on size, or who do not contract with networks that offer the deepest discounts. These districts could realize savings. We estimate that a mandatory pool with all school district members could save an additional 0.5% to 1.5% of costs, or between $34 million to $101 million, through better discounts.

Additional and Longer Term Savings Opportunities

Implement Best Practices for Health, Wellness and Disease Management

This section of the report focuses on the range of programs which can have an impact on total costs and on health – from wellness to disease management. These programs are designed to improve workforce health, from:

- Wellness management – helping healthy workers stay healthy
- Health management – ensuring the identification of and appropriate care for acute conditions
- Disease management – ensuring the identification of and appropriate care for chronic conditions

Virtually all managed care plans currently provide members with access to tools to improve their health, and they include elements of health and disease management. In addition, many large employer groups have implemented one or more of these programs. They tend to be more prevalent in larger groups than in smaller groups because turnkey solutions have not been readily available for all of these programs.

The large purchasing organizations offering products to school districts are also beginning to place an emphasis on health, wellness and disease management and to include these programs as a standard part of their product offering – but they have not yet taken full advantage of all emerging best practices.

CalPERS has included high intensity case management, centers of expertise, and member incentives for healthy lifestyle a part of its strategic initiatives for health since 2005. Disease management has been an ongoing strategic health initiative since 2003.

Health, wellness, and disease management programs are intended to improve health and thus reduce costs. Savings are shown gradually over time. We believe that, if implemented successfully and fully supported by the mandatory pool and all of its sponsors – and if communicated effectively to the members – the pool could see ongoing, long-term savings in the form of reduced trend. Conservatively, we estimate a trend reduction of 1% per year. Due to the costs of implementation, we would expect no first year savings.

Consider the Impact of Selection

There are several ways that premiums for health care coverage can be paid. Typically, employers pay premium to insurance carriers or – if they are self-funded – calculate an accrual (or budget) rate. The rates are usually based on a structure that matches the approach used to calculate any employee contributions and/or COBRA rates. There is no inherent efficiency or inefficiency within the tier structure itself; the goal is to collect sufficient money to pay claims, cover plan expense, and fund reserves.

We found all of the following types of active employee rate tier structures within the data:

- Composite (one rate that pertains to all levels of coverage, whether single, employee + spouse, employee + child(ren) or family)
- Two tier (single, family)
- Three tier (single, employee + 1, employee + 2 or more)
- Four tier (single, employee + spouse, employee + child(ren), family)

Except for the composite tier structure, these are all commonly-used within the industry. We found commonly-used rate tier structures for the retiree population as well. A majority of school districts use a composite rate structure (SSC data indicated that 53.3% paid on a composite basis). This is simple for them to administer:

- They make premium payment based on the number of employees covered, and do not need to be concerned with the number of dependents covered[14].

- There is no employee contribution to collect through payroll deduction (usually also based on the number of dependents covered).

While this structure is easier to administer, it can have an impact on the number of dependents that the plan ultimately covers – and thus on total cost. This is particularly true over the past few years. During this period, many other employers increased contributions for dependent coverage or reduced benefits to save money, making the district plans increasingly attractive in comparison.

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[14] Note that this refers to premium payment only; dependent eligibility does need to be tracked in order to pay claims appropriately.

Some districts that use the composite approach also provide an incentive to the employee to waive coverage if it is not needed (for example, if the employee can obtain coverage through a spouse's plan). However, it can be difficult to structure the incentive properly so that they do not encourage employees who need coverage to drop it, and they discourage those who do not need the coverage from taking it. This is an ongoing issue, as other employers continually adapt their contribution strategies to counteract selection against them. An examination of the SSC data indicated that the waiver approach was used by a small number of districts, and that a small number of FTEs – less than 1% – waive coverage.

The major purchasing pools typically offer rate tier alternatives to the districts, so that they can pick the rate tier structure which most closely matches their needs. Some prohibit including incentives to waive coverage, because it can increase selection against the plan.

CalPERS offers a three-tier rate structure for actives and retirees as the only alternative. While this does not preclude districts from using the composite approach for employee contributions, it does – by implication – discourage it. And, premium payment must be made on the three-tier basis.

The identified differences between the costs paid by other California employers compared to the school districts represent a potential opportunity for the districts (see Table 6), though an in-depth analysis of the implications is beyond the scope of this study. Generally, however, it appears other California employers have increased contributions for their coverage and reduced benefits to save money, making the district plans increasingly attractive in comparison. This appears to have caused the district plans to be selected against, particularly for dependent coverage. Were districts to adopt practices that are more in line with market norms with respect to coverage tiers, the potential savings are estimated at between 1% and 3% per year – or between $67 and $203 million in estimated 2007/08 premium.

Implement Best Practices for Plan Administration

As discussed previously, a single, state-wide system would eliminate the current duplicative systems, and allow for reduced and streamlined administration through economies of scale. To make it more effective, the pool should apply uniform administrative procedures. If these are developed using best practices for plan administration which apply to the entire population, additional savings would be available. Some of these include:

- Daily updates of additions and terminations sent to the carriers. To avoid payment for services for ineligible members, membership should be monitored and people should be added and removed in a timely manner.

- Monitoring Medicare enrollment. While districts do not generally provide retiree medical coverage beyond Medicare eligibility, a best practice is to be certain that – if coverage is provided – the retiree actually enrolls for Medicare coverage.

- Effective eligibility management. A best practice is to add spouses and other dependents only with receipt of proper documentation, and student eligibility should be determined at least once each year, but this would be a huge task. Some large employers are currently conducting audits of dependents to make certain that ineligible members are not enrolled; at least one of the large purchasing organizations audits groups regularly. Mercer's audit experience in this area indicates savings of 2% to 3% through effective eligibility management. This represents an estimated savings of $134 to $203 million on the 2007/08 premium estimate.

Review Plan Design Alternatives

There are currently a large number of plan design alternatives available to school district employees. The large pools tend to offer a limited number of plan design alternatives in order to achieve some economies of scale, and districts tend to offer the same plans within those alternatives. Given the large percentage of school districts which participate in the current pooling arrangements, it is not surprising that the CalSTRS survey indicated a distribution around a limited range of plan designs.

The CalSTRS survey included limited plan design information, but – from it – we could determine the two most common plan design components for PPO and HMO plans. We reviewed the plans offered by the largest purchasing pools, and supplemented the CalSTRS survey information to develop a picture of the current plans.

We compared them to plans offered by CalPERS and to the median cost share for some of the same components for employers participating in the Mercer survey for the PPO plans.

Table 23 – District PPO Plans Compared to Mercer Survey and CalPERS

PPO Plan Design	School District Most Popular Plan	School District 2nd Most Popular Plan	Small Government	Large Government	Large California	PERS Choice
Median Deductible Ind. (in/out-of-network) Family (in/out-of-network)	 $0/$100 $0/$300	 $100 $300	 $500/$500 $1,000/$1,000	 $300/$500 $600/$1,000	 $300/$400 $750/$900	 $500 $1,000
Office Visit Co-Payments (in/out-of-network)	$0/80%	$10/70%	$20/30%	$20/30%	$20/30%	$20/60%
Inpatient Co-Payments (in/out-of-network)	$0/80%	90%/70%	20%/30%	20%/30%	10%/30%	80%/60%
Generic Rx Co-Payments	$5	$10	$10 (if offered through a card program)	$9 (if offered through a card plan)	$9 (if offered through a card plan)	$5

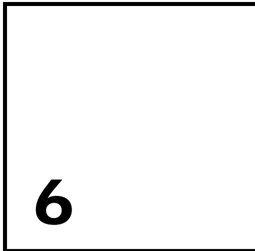
We developed the same comparison for the district HMO plans to those offered by other government and large California employers, and to the CalPERS design. The results are shown in Table 24.

Table 24 – District HMO Plans Compared to Mercer Survey and CalPERS

HMO Plan Design	School District Most Popular Plan	School District 2nd Most Popular Plan	Small Government	Large Government	Large California	CalPERS
Office Visit Co-Payments (in/out-of-network)	$10 (46%)	$0 (16%)	$10	$15	$15	$15
Inpatient Co-Payments (in/out-of-network)	$0 (72%)	$250 (17%)	$100 (38% of employers)	$250 (48% of employers)	$250 (42% of employers)	$100

Note: Percentages shown next to the school district plans reflect the prevalence based on the CalSTRS survey.

While it would be disruptive to the population, if plan designs in the pool more closely approximated PEMHCA plans, rather than those currently favored by the districts, savings of about 3% of premium, or $203 million, could be realized.



Creating a Health Care Pool

This section discusses the potential size of the pool, benefits and drawbacks of creating one, and includes a discussion of the issue of a mandatory versus a voluntary pool.

Benefits of Creating a Pool

Most insurance companies and other risk managers utilize the law of large numbers to mitigate and manage the risk inherent in health care coverage. The larger the risk pool, the more predictable the claims experience. As discussed in the previous chapter, as risk pools increase in size, the cost of risk management decreases since insured margins, stop loss premiums and other risk management expenses are mitigated. In addition, a larger risk pool can realize lower administrative costs, more sophisticated cost management techniques, and more professional program management. These advantages are largely scale based. For example, many large corporations have uniform plan design and plan administration – even across divisions and geographies – in order to minimize costs. Plan sponsors that have more decentralized structures generally have higher costs.

Collective purchasing itself is an excellent strategy, but many collective purchasing arrangements today are not just using their pooled purchasing power to gain a price advantage, they are also using it to change the market by demanding better quality, better service, and more partnership.

Potential Size of the Pool

Aggregating all California school district employees into a single risk pool would create a risk pool of approximately 720,000 employees and retirees. CalPERS currently covers almost 576,000 employees and retirees combined (including some school district employees and retirees). They also cover 660,000 dependents, insuring more the 1.2 million members. If we assume school district employees and retirees cover a similar number of dependents, we can develop an estimate of the total number of potential members in the districts. It we add the two and eliminate any double-counting, it represents the total potential population of the combined pool.

Table 25 – Potential Pooled Population

	CalPERS Alone	**School Districts Alone**	**Combined Total**
Employees and Retirees	514,000	720,000[15]	1,234,000
Dependents	601,000	830,000	1,431,000
Total Members	1,115,000	1,550,000	2,665,000

Source: CalPERS population was taken from their web site as of July 2007, rounded and reduced to eliminate double counting of school district lives.

Increased Negotiation Leverage

A single purchasing pool with more than 1.5 million school district members – or more than 2.6 million members overall were it joined with CalPERS – would have significant clout within the California market place. This is a possible area of financial gain for the districts not currently participating in a pool arrangement or not in a very large district since they do not currently enjoy negotiation leverage for cost. However, we expect the number of impacted members is quite small, since almost 80% of the coverage currently provided is through an arrangement that includes some level of pooling – and a portion of the remainder are large enough to enjoy some negotiation leverage on their own account. Therefore, we did not estimate savings separately for this category.

[15] While AB 256 referenced extending coverage to those not currently insured, the above assumes currently-insured employees and retirees only.

Potential Drawbacks

There are a variety of potential drawbacks to a single purchasing pool, however none of them is insurmountable. These drawbacks include the following:

- No matter how the pool is set up, there are likely to be winners and losers in the process. Some districts may find that they subsidize the cost of others; some may find that the pool is non-responsive to their specific needs or preferences.
- A pool would limit local control and input into major coverage decisions, such as the level and structure of coverage, contributions, extent of coverage, and health management techniques. The pool would need to be structured so that it provided an opportunity for on-going input from stakeholders, and sufficient flexibility in plan designs and coverage rules so that it met a broad range of district needs and preferences.
- If there are constraints in joining or leaving the pool, the districts could find these to be too costly or restrictive.
- It is not possible for a mandatory pool to offer all of the various choices that are currently available to the districts; a finite array of choices would be offered.
- A mandatory pool, with mandated benefits for school districts, would be difficult to achieve. While there is a potential for significant consolidation, it also implies that there would be a limited number of carriers providing benefits.
- If the pool is not efficient or well-run, it will be less effective than the current system which includes several large pools competing for district business.
- A budget shortfall currently impacts only the affected group. In a pool arrangement, some mechanism would need to be in place to limit the impact on the entire group of a budget shortfall within the pool.

If a purchasing pool is developed, these drawbacks should be taken into consideration as the basic structure is put in place.

An Examination of a Mandatory Pool Compared to a Voluntary Pool

School districts currently participate in pooling arrangements on a voluntary basis. They are currently free to join pools or remain autonomous. The current voluntary pools all contain some terms and conditions associated with joining; most require some minimum participation requirement so that they can limit selection.

Voluntary Pool Issues

If a voluntary pool were created, it would be an addition to the existing state. It would compete with all existing pools and all existing alternatives – and they would need to compete against it. If the pool were well run and responsive to membership, there could be economies of scale sufficient to make it a competitive force in the market place. However, districts would be free to compare alternatives to it, and would only join the pool if it were best for them financially. Unless the pool could protect itself against some of this selection, it would find itself in a selection spiral – and ultimately fail.

Some other states have dealt with this issue by adding limitations or incentives which help to assure that the plan is not selected against. A detailed discussion in this area is beyond the scope of this report, but we saw:

- States which prohibit a district from leaving the plan once they join.
- Requirements that a district to repay any claims deficit upon leaving the plan.
- Incentives structured to encourage the districts to participate, including only providing State funding if the district participated.
- Mandatory participation below a certain size (i.e., 500 employees).

Mandatory Pool Issues

If a mandatory pool were created, it would be a replacement to the existing state. This presents a significant disruption to the current system, and it will be difficult to satisfy the diverse goals and objectives of the many stakeholders. However, a mandatory pool would have considerable mass and leverage, and there are significant available savings opportunities through size-based immediate or near-term savings and – more importantly – through longer-term implementation of best practices in a consistent manner.

A well-conceived, timed and executed transition strategy could alleviate many of the issues associated with implementing a pool, including those that are specific to a mandatory pool:

- Competition from existing pools would no longer exist; some other incentive for the pool to manage costs and be responsive to membership would be required.
- If the number of vendors were reduced significantly (for example, a "winner-take-all" approach), then provider contracting could be impacted. This could have positive or negative affects; for example, providers might believe that they are unable to negotiate fair contracts.
- If a mandatory pool is established, then it must mandate the aspects of health care management that led to the anticipated savings. Otherwise, those savings will be forfeited.
- It will be difficult to compel participation.
- If, for whatever reason, districts find that they must pay more to participate in the pool, and they can not afford the additional cost, the shortfall will need to be made up – possibly through increased employee contributions or decreased coverage levels.

Plan Design Options for a Statewide Health Care Pool

In this section we provide an illustrative array of plan design alternatives for a statewide health care pool. Limiting the number of plan design options limits administrative cost. However, it also limits choice for both the districts themselves and for the employee.

An examination of the alternatives offered by the purchasing pools shows that most limit choice in several ways:

- They limit the carriers/networks provided. Most offer no more than 3 choices (for example, Blue Cross, Kaiser and PacifiCare) and many offer only two.

- They limit the number of plan design choices; they may have several available (for example, 10 PPO plans, 10 HMO plans for active and a similar number for retirees), but they limit the number of choices that can be offered to a location (for example, only 2 PPOs and 2 HMOs)

- They generally carve-in prescription drug benefits when offering benefits through an HMO, but may have a carve-out prescription drug plan which provides a number of options. The district must select one or two.

We also asked the purchasing pools which plan designs were favored by the districts, and we used that information – along with the summary information from the CalSTRS survey – to develop a picture of the benefits offered to a majority of the population.

Illustrative Array of Plan Design Offerings

We would recommend that the pool offer no more than three PPO plan design alternatives and no more than three HMO plans. We developed an array of possible choices; they consist of a range of plan designs targeted at:

- Assuring that the majority of school districts can offer a plan comparable to that which is in place today;
- Allowing trade-offs between lower premiums or lower out-of-pocket costs to allow districts increased flexibility.

We are showing several PPO and HMO plan options that provide comprehensive coverage as alternatives since a very large percentage of the population is currently covered by similar plans. We do not believe the pool should only offer all of those options. Rather, a single comprehensive option should be offered as an alternative for those who currently have this coverage.

The costs in a mandatory pool will be impacted by the overall utilization patterns of the group. Therefore, consideration should be given to assuring that:

- The true cost differential of providing this level of benefit is reflected in the cost of the plan. Districts that provide this level of benefit must pay their fair share. Consideration should be given to requiring them to move towards less rich benefit levels over time. Otherwise, selection against the pool will continue to be a problem and will become worse over time.
- Districts do not use savings realized from implementing a mandatory pool to "buy down" to these richer benefit levels. If they are allowed to do so, this will drive up costs for all. This would increase overall utilization and further exacerbate the selection issue.

In addition, we believe it is important to allow a sufficiently broad range of benefit options so that most current coverage offerings can be accommodated. If they are not, districts which currently offer cost-effective alternatives will be forced to implement a less cost-effective program.

PPO Plan Design Options

The array of plans shown in Table 26 below provides options from comprehensive to cost-effective. Plans 1 and 2 are roughly based on the most common current plans used by the districts. These plans are quite rich compared to the plans currently offered by CalPERS; Plan 4 is roughly based on PERS Choice. This highlights a key issue with respect to using the current CalPERS plans as the only option; there would be significant disruption to the district populations – but their costs would be reduced. The estimated cost differential for the various plan designs is shown.

Other states with mandated pools have a narrower range of options. However, the districts currently enjoy a vast range of alternatives – even through the current pools. Currently, the range of benefits offered through the largest pools includes:

- PPO coverage without a deductible and with 100% coinsurance in-network.
- PPO coverage with deductibles as high as $2,000/$6,000, 80% coinsurance, and $4,000 out-of-pocket maximums, including Health Savings Account (HSA) compliant plans, so that employees may contribute to an HSA.

Very few districts currently offer the high deductible health plans, but some do. While we did not include an HSA compliant plan as an alternative, some consideration should be given to including it as an alternative since it does currently exist. However, this should be weighed against the increased administration.

Table 26 – Proposed PPO Plan Design Options

	PPO 1	PPO2	PPO 3	PPO 4	PPO 5
Deductible					
Individual	$0/$100	$100	$250/$500	$500	$1,000
Family	$0/$300	$300	$500$1,000	$1,000	$3,000
Office Visit	$0/80%	$10/70%	$10/70%	$20/60%	80%/60%
All Other Coinsurance	100%/80%	90%/70%	90%/70%	80%/60%	80%/60%
OOP Maximum*					
Individual	Not applicable	$500/$1,000	$1,000/$2,000	$3,000/none	$2,000/none
Family	Not applicable	$1,000/$2,000	$2,000/$4,000	$6,000/none	$4,000/none
Retail Rx co-payments					
Generic	$5	$10	$5	$5	5%
Formulary Brand	$10	$20	20%	$15	20% with min. and max.
Non-Formulary Brand	$25	$40	50%	$45	20% with min. and max.
Mail Rx co-payments					
Generic	$10	$20	$10	$10	5%
Formulary Brand	$20	$40	20%	$25	20% with min. and max.
Non-Formulary Brand	$50	$60	50%	$75	20% with min. and max.
Estimated cost differential	100.0%	93.4%	91.9%	82.9%	79.0%

* Excludes deductible

Note that member cost share with respect to deductibles and out-of-pocket limits will erode each year as medical costs increase; to maintain a cost share target, deductibles and out-of-pocket limits must be adjusted periodically. A plan design based on coinsurance helps insulate cost sharing against medical inflation and sensitizes members to the cost of services.

Medical and Health Management

The use of medical and health management best practices for school employees is uneven, particularly given the fragmented approach which results from the current health care coverage system. A significant opportunity exists to both manage costs and improve the long-term health of the population by developing targeted health improvement programs based on best practices related to: wellness, at risk, chronic conditions and case management. We would suggest that such programs be included in all plan options offered.

Pharmacy

A second major opportunity lies in creating a statewide plan for pharmacy benefits. A mandated single pool approach would drive critical mass into the program and provide the leverage required to negotiate the most competitive contractual terms. The administration of pharmacy benefit services is often transparent to members.

An alternative to including the prescription drugs as a “package” with the rest of the PPO is to offer a range of prescription drug alternatives – so that the districts could select the combination of medical plan design and drug coverage which best met their particular needs.

High Performance Networks

Another major opportunity lies in adopting plans which take advantage of high performance networks. These networks provide the best discount savings and can provide significant savings. Some of the PPO plan options should be structured to provide high performance network plan options, similar to CalPERS’ current approach.

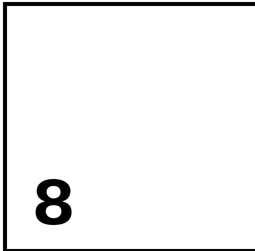
HMO Plan Design Options

A large percentage of school employees remain covered by HMO or other managed care options. The array of HMO plan design alternatives shown provides a range of benefits from comprehensive to more cost effective. Options 1 and 2 below are based on the most common current plans used by the districts. Option 3 is roughly based on the CalPERS HMO plan designs. Again, the difference between the benefit levels that the districts currently purchase and those offered by CalPERS can be seen. The estimated cost differential based on plan design is shown.

An alternative to offering several plan design options is to offer fewer plan design options through more than one HMO. This increases access to a range of network options.

Table 27 – Proposed HMO Plan Design Options

	HMO 1	HMO 2	HMO 3	HMO 4
Office Visit Co-Payment	$0	$10	$15	$25
Emergency Room Co-Payment	$25	$50	$75	$100
Hospital Co-Payment	$0	$0	$100 co-payment, then 100% coverage	$250 co-payment, then 100% coverage
Retail Rx				
Generic	$5	$5	$5	$10
Formulary Brand	$10	$15	$15	$20
Mail Rx				
Generic	$10	$10	$10	$20
Formulary Brand	$20	$30	$30	$40
Estimated Cost Differential	100.0%	97.1%	95.6%	91.9%



Feasibility of Using PEMHCA

School districts can already elect to be covered by CalPERS plans through the Public Employee's Medical and Hospital Care Act (PEMHCA). It could be said that the CalPERS plan is already a voluntary pool option.

Advantages to Using PEMHCA

There are several advantages to using the CalPERS plans:

- All basic systems are currently in place, so an entirely new system does not need to be developed.
- CalPERS is well-versed in managing and administering large, complex plans and alternatives.
- The time frame for implementing a pool could be significantly reduced.
- Given the predominant current school district plan designs as compared to those offered by CalPERS, a move to the CalPERS plans as they currently exist – while disruptive to the existing population – would result in significant savings based on the cost differential between the currently-used plans and those offered by CalPERS.

Disadvantages to Using PEMHCA

There are several disadvantages to using the CalPERS plans:

- There is a requirement to offer retiree medical coverage which will impact both current coverage costs and their GASB obligation. This is discussed in greater detail below.
- The impact to staff and systems of adding more than 1.5 million new members (if the pool were mandatory) would need to be determined.
- The systems, coverage, goals and objectives would not be specifically and solely related to and focused on the districts; however, the districts would potentially be a huge part of the population and – as such – would expect to have an impact on plan decisions, either immediately or in the future.
- The CalPERS plans do not currently offer districts the range of alternatives they currently enjoy, since CalPERS limits plans to a comparatively small number of PPO and HMO options. In addition, CalPERS plans compare with those offered by other large California employers, and so are less generous than those most commonly offered by the districts. Were CalPERS to expand its plan offerings to include richer benefits, it would increase the administrative burden. In addition, if it opened those alternatives to other state and local government employers covered by CalPERS, costs for the other employers could increase.
- CalPERS currently offers coverage on a three-tier basis only. The districts, which currently have options for different tier level structures, would need to adapt to this structure.
- The district members may end up subsidizing the other CalPERS employers or vice versa; given that the district costs are currently higher than the CalPERS costs overall, it may be that adding the district members to the CalPERS pool would drive up their overall costs. This is particularly true if richer benefit options were included.
- CalPERS does not currently offer all of the administrative services that the other voluntary pools provide. Were CalPERS to assume responsibility for a mandatory school pool, then they would either need to expand the scope of their services or the districts would need to find alternatives. The major services in question are COBRA administration, eligibility monitoring, and communications.

Estimate of Increased Costs if Using the State Plan (PEMHCA) as It Currently Exists

In addition to the above major issues associated with using the CalPERS plans as they currently exist, there are additional cost implications for the school districts:

- CalPERS currently requires employers to contribute towards the cost of employee and retiree premiums in order to be covered. This means that districts that do not currently pay for retiree coverage would need to do so, resulting in significant increased current costs.
- The school districts would incur an increase to their GASB obligations corresponding to any increased retiree coverage requirements.

Impact of Joining PEMHCA in Increased Retiree Medical Costs

A major issue in using PEMHCA as the vehicle for a mandatory pool for school districts is the PEMHCA requirement for retiree coverage for those who are under age 65 and for those who are Medicare eligible; only about 15% of the districts currently offer coverage to retirees this way.

For the remaining districts, this requirement would introduce a significant additional cost for new retiree benefits:

- About one third of districts provide coverage to active employees only.
- Almost all of the remaining districts currently provide benefits to active employees and to non-Medicare eligible retirees who qualify for benefits only.

We attempted to quantify the cost to provide retiree medical coverage. Preparing this estimate is complicated by the fact that many retirees who qualify for a pension may not receive retiree medical. In most cases, this is likely because they did not meet the age and service requirements for the coverage, or because they opt out because they have other coverage (through a spouse or another employer). Therefore, we attempted to separate retirees between those districts who do not currently offer retiree medical coverage and those who do. The results are shown in Table 28.

Table 28 – Estimated Cost to Extend Coverage to Retirees

	Under 65	Medicare Eligible	Total
Estimated Number of Retirees	55,863	272,911	328,774
Estimated Number Not Covered	15,195	193,667	208,862
Projected Premium	$116 million	$1.5 billion	$1.6 billion
Percent Districts without Coverage	14.2%	59.4%	
Inferred Retirees without Coverage			
▪ From Districts without Coverage	▪ 2,162	▪ 115,096	▪ 117,259
▪ From Districts with Coverage	▪ 13,033	▪ 78,571	▪ 91,603
Estimated Premium Cost to Cover Them			
▪ From Districts without Coverage	▪ $16.5 million	▪ $878.6 million	▪ $895.2 million
▪ From Districts with Coverage	▪ $99.5 million	▪ $599.8 million	▪ $699.3 million

Districts that do not provide retiree medical coverage currently would be required to provide it to under-65 retirees and to Medicare Eligible retirees. The cost would be something less than the $895.1 million, since – as noted above – not everyone would qualify for retiree medical benefits.

Districts that currently provide retiree medical are more likely to provide it to the under-65 retirees. Therefore, we assume that the 13,033 retirees who do not have retiree medical do not have it because they did not qualify or they opted out. Coverage would have to be extended to the Medicare eligible population, but the cost would be something less than the $599.8 million above.

Impact of Joining PEMHCA on Governmental Accounting Standards Board (GASB) Requirement

In addition to the increased cost of retiree medical, there would be a new or increased GASB obligation to account for the increased cost requirement.

GASB accounting rules allow PEMHCA to base the valuation on the blended active and non-Medicare rates, while other similarly-situated plans must base the valuation on the actual cost. For the majority of districts – those that provide benefits to active employees and non-Medicare eligible retirees – moving to the PEMHCA model would reduce GASB costs for non-Medicare benefits. This mitigates the added GASB obligation for the added benefits somewhat, but does not mitigate the actual additional costs.

Governmental Accounting Standards Board (GASB) standards for reporting deferred compensation assets on governmental financial statements require that the future obligation be accrued. For those districts not currently providing retiree medical coverage, this would be an entirely new obligation. For those districts that currently do not fund beyond Medicare eligibility, the expected retiree medical costs double, as shown in the following illustrations:

Assumptions

Our assumptions are based on the most common district practice with respect to retiree medical coverage. We assumed:

- Retiree medical is provided to qualified non-Medicare eligible retirees and dependents applying the same level of contributions to the retiree as the active employee
- Coverage is not provided beyond Medicare eligibility
- The district will continue this practice when it joins PEMHCA
- Benefit costs are equal to PEMHCA costs; the district pays 100% of that cost
- As a result of joining PEMHCA, the district has to extend coverage to Medicare-eligible retirees
- As before, and consistent with the PEMHCA equal contribution approach, the district pays 100% of the cost
- CalPERS assumptions for a miscellaneous employee, age 45 with 10 years of service
- Interest discounts used to value benefits are:
  - 4.5% if the district does not pre-fund benefits
  - 7.75% if the district pre-funds benefits

Accrual amounts are for current service only; if past service were included, then a past service liability would be created and the annual accrual amounts would need to be increased for past service. Additionally, liabilities for retirees would be created, adding to the GASB obligation.

Illustrative Effects of GASB if the District DOES NOT Pre-Fund Benefits

If the district did not join PEMHCA, then we estimate the annual accrual at about $3,900. This includes the value of the “hidden subsidy”, which is the amount by which the average non-Medicare retiree cost exceeds the average cost of an active employee. By joining PEMHCA, the district does not need to value the hidden subsidy, so the annual accrual would be reduced to $2,000 if the district were only accruing to Medicare eligibility. However, since the district must now extend coverage beyond 65, the annual accrual must be increased to $6,600.

Therefore, the net impact is an increase to the annual accrual of about $2,700 per active employee.

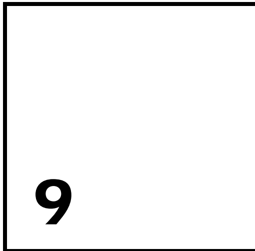
Illustrative Effects of GASB if the District Pre-Fund Benefits

If the district did not join PEMHCA, then we estimate the annual accrual at about $2,100. This includes the value of the “hidden subsidy”, which is the amount by which the average non-Medicare retiree cost exceeds the average cost of an active employee. By joining PEMHCA, the district does not need to value the hidden subsidy, so the annual accrual would be reduced to $1,200 if the district were only accruing to Medicare eligibility. However, since the district must now extend coverage beyond 65, the annual accrual must be increased to $2,900.

Therefore, the net impact is an increase to the annual accrual of about $800 per active employee.

Summary

The disadvantages outlined above make it impossible for us to recommend using PEMHCA as the vehicle for a mandatory pool for the districts under its existing rules. If, however, the current rules were modified such that these disadvantages could be resolved – especially as relates to the significant additional cost associated with providing benefits to retirees – then PEMHCA could be a realistic option. It may, for example, be possible to set up a district-only pool using PEMHCA’s existing systems, management and expertise.



Key Special Issues

We were asked to provide comment on some key special issues related to this study.

Regional Rating Compared to Statewide Rating

Health benefit cost varies within the State due to regional differences in the cost of living, average wage, employer benefit practices, provider competition, and the health care market itself. Virtually all districts currently pay for health care based on some sort of regional rating approach. Those who purchase coverage directly from an insurance carrier pay premium based on the carrier's underwriting of the group; this will always reflect the impact of the group's expected costs. Self-funded districts develop rates based on actual claims cost data, which inherently reflects local cost. The current large purchasing organizations also use regional rating approaches. CalPERS uses rates which reflect costs for:

- Los Angeles
- Other Southern California Counties
- Bay Area/Sacramento
- Other Northern California Counties

While regional rating is pervasive, it is not applied consistently under the current system since there are many approaches to it. How one carrier or one large purchasing organization identifies a region varies from plan to plan. However, since regional rating is the norm, a change to a fully-pooled structure in a mandatory pool without regional rating would be a significant change for all. In addition, variation by region can be significant, so eliminating it would result in significant gains for some at the expense of others.

Virtually all districts experience some level of regional rating currently, but the approach is fragmented. Moving to a single, one-cost-fits-all approach would represent a significant disruption to the existing state. If a common rating structure is provided, then some districts will win and some will lose. If a regional rating approach is developed, some districts will win and some will lose, but as long as the regions are structured so that there is equity based on location, the impact should be mitigated.

If a more uniform rate structure is desired, it is possible that the pool could be set up initially with regional rates, and it could move slowly to more uniform rating. This would ease the transition from the current structure.

Conditions for Joining or Exiting Existing Pools

We examined barriers to joining or exiting the existing pools in order to determine if there are elements within the current system which encourage or discourage cost effectiveness.

Existing pools do not impose extensive terms and conditions to exit the pool. They ask for reasonable advance notice and some limit the district's availability to re-enter the pool – for example, they may impose a waiting period. There are more barriers, terms and conditions associated with entering a pool. A discussion of the most commonly-used terms and conditions, and their impact on the plans, follows.

Minimum Participation Requirements and Their Impact

Most states require that insurance carriers set minimum participation requirements to protect against adverse selection, and this is a common industry practice. The large pools have adapted this common underwriting practice, but they generally require higher participation percentages than do insurance carriers. Insurance carriers usually require:

- 100% employee participation, if the coverage is non-contributory
- Some lesser percentage, if the coverage is contributory

The large purchasing pools may:

- <u>Require</u> 100% employee participation to join the plan. Since the districts must cover 100% of eligible employees, they have less flexibility in structuring employee contributions. Some offer a low-cost, high deductible plan as an alternative. The district can pay 100% of the cost of the low-cost plan as a base – or pay 100% of the employee-only cost of whatever plan(s) they elect to offer.

- Provide a discount relative to other groups based on high employee participation (for example, 90% to 100% of employees must select coverage to receive the discount) with absolute minimum participation requirements (for example, no less than 50%). This allows the districts somewhat more flexibility in structuring employee contributions, but it does provide an incentive to structure employee contributions in a manner that will ensure that the plan obtains the discount.

- Prohibit cash outs and waivers. This, like requiring 100% employee participation, limits contribution alternatives.

Self-funded plans are not subject to minimum participation requirements, so larger districts that self-fund have more flexibility in structuring their plans and their contributions.

CalPERS requires a minimum contribution for employee and retiree health premiums under one of two contribution methods: equal or unequal. The retiree requirements apply to retirees who are Medicare-eligible as well as to those who are not eligible for Medicare. No other large pools that we examined required retiree contributions in this manner.

As stated previously, small districts tended to require higher contributions than larger districts. The minimum participation requirements and other prohibitions may limit some small districts' ability to access them; if they can not afford to provide coverage at the minimum level required, then they can not join the pool.

Restrictions on Benefit Terms and Conditions

All purchasing pools provide set plan design alternatives. The districts can select from the menu of plan design options; more comprehensive coverage is more expensive than less comprehensive coverage. While CalPERS limits the number of plan alternatives to a select few, some of the purchasing pools offer many different options – though they may limit the number of options that can be offered at a location. This practice makes sense since offering too many options to employees:

- Increases the administrative cost
- Is confusing to employees
- Can encourage selection against particular plans
- Splits the risk among the plans

The pools limit alternatives in other ways as well; their goal is to offer an attractive menu of plans and services while keeping costs as low as possible. Some other terms and conditions that may be limited by the pools include:

- Coverage eligibility and effective dates
- Dependent eligibility options
- Open enrollment periods

Rating Adjustments Based on Risk

Absence of risk adjustment, even if some risk elements are omitted, can mean that some employers are overcharged while others are undercharged. All of the large purchasing organizations we examined currently include some element of protection against adverse selection or other risk. Carriers also use many of these approaches, though the terms and conditions may be less transparent to the purchaser.

Approaches within the current system included:

- Requiring minimum participation in the plan, or adding a risk charge if there is not minimum plan participation (for example, districts that pay 90% to 100% of the premium get a discount).

- Adding a risk charge to participate in the plan if it appears the district's experience will be less favorable than the pool's experience.

- Defining strict terms and conditions to use the pool, including outlining the terms and conditions which can be bargained. For example, at least one purchasing pool lists rules applicable to district collective bargaining on its website.

One of the major advantages of a mandatory pool is that it likely eliminates the selection issues and thereby eliminates the need for these types of rules and restrictions.

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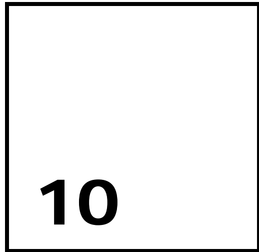

Appendix

Summary of Bargaining Agreement Language for the Largest School Districts – Coverage for Part-Time Employees (SSC website)

	Certificated			Classified		
District	Contract	Part-Time Eligibility	Part-Time Contributions	Contract	Part-Time Eligibility	Part-Time Contributions
Los Angeles Unified	2004-2006	Half-time or more, or 100+ days in prior year	Part-time may be eligible with pro-rata cost share	2004-2006	Full-time only	Full-time only
San Diego Unified	2003-2006	Half-time or more eligible	If less than half-time, can pay in full for medical	2003-2006	Half-time or more eligible	If less than half-time, can pay in full for medical
Long Beach Unified	2002	Half-time or more, including temporary contract	Contributions may be required	2003	At least 50% of a full time assignment (80 hours + quadriweekly) to be eligible	If not eligible, can purchase coverage directly; cost share for others
Santa Ana Unified	2004-2007	Part-time are eligible	If less than full-time, must pay proportion of benefit costs equal to proportion of the reduced hours	2001-2004	At least 4 hours per day or 20 per week to be eligible (some limits on election)	Contributions based on tier; same for all
San Bernadino City Unified	2003-2006	Part-time are eligible	Pro-rata employer contribution for those who work less than full-time	2003-2006	Part-time are eligible	Pro-rata employer contribution for those who work less than full-time
Elk Grove Unified	2004-2007	Half-time or more (regular or temporary), at least 20 hours per week to be eligible	Contributions may be required	2004-2007	At least 5.5 hours per day, if hired after 11/1/99 to be eligible	Not addressed
San Francisco Unified	2004-2007	Half-time or more eligible	District makes contribution based on tier	2005-2008	Comparable to certificated	Not addressed
Sacramento City Unified	2004-2007	Half-time or more (regular or temporary) eligible	No contributions for any eligible employee (full coverage)	2005-2006	Funding by employer for each eligible employee	District contributes an amount for each eligible employee
Capistrano Unified	2002-2004	At least 20 hours per week or 3 periods daily to be eligible	Pro-rata employer contribution for those who work less than full-time	2004-2007	At least 20 hours per week to be eligible	Pro-rata employer contribution for those who work less than full-time (55% for 4 hours; then staggered)
San Juan Unified	2005	Less than full-time eligible (grandfathering applies)	Pro-rata employer contribution for those who work less than full time	2004-2007	Employees hired after 4/14/89 who work less than 4 hours/day not entitled to member option money	Section 125 plan

	Certificated			Classified		
Garden Grove Unified	2006-2008	Full-time only	Full-time only	2003-2006	At least 20 hours weekly to be eligible	Same contributions required for all in tier
Oakland Unified	2002-2004	Eligible even if working less than 1/4th time	Pro-rata employer contribution for those who work less than full-time	2002-2004	Eligible even if working 1% of the time	Pro-rata contributions from 25% to 100% of premium (25% for 1-24% of full-time employment)
Corona-Norco Unified	2002-2006	At least 138 workdays/year for full-time	Pro-rata employer allowance for those who work less	2004-2007	At least 20 hours weekly to be eligible	Contributions (roughly) based on service with pro-rata opt-out incentive
Riverside Unified	2007-2009	Less than full-time eligible	Pro-rata employer contribution for those who work less than full-time (working 75% of time considered full time)	2005-2007	At least 20 hours weekly to be eligible	Pro-rata contributions from 50% to 100% of premium (50% for 20-22 hours)
Fontana Unified	2004-2007	Less than full-time eligible	Pro-rata employer contribution for those who work less than full-time	2001-2004	Table of assigned hours from 2.0 to 8.0 per day	Contributions based on a percentage of full-time (from 25% to 100%)
Sweetwater Union High	2005-2008	Hourly must be assigned at least 15 hours/week to be eligible	District pays up to cap for each eligible employee	2005-2008	Hourly must be assigned at least 15 hours/week to be eligible	District pays up to cap for each eligible employee
Stockton City Unified	2002-2005	Temporary the same as all others	Not addressed	2005-2006	At least 4 hours/day to be eligible	District pays an allowance for all eligible employees
Mt. Diablo Unified	2001-2004	Medical benefit dollar allocation for each member	Can sign-up for self-pay if on leave	2001-2004	Medical benefit dollar allocation for each member	Can sign-up for self-pay if on leave
Montebello Unified	2004-2007	Half-time or more (18 hours for adult education and 20 for vocational) to be eligible	District pays up to cap for each eligible employee	2007	A regular assignment of at least 4 hours to qualify for base funding	Amount the employer pays to cap is based on number of hours worked from 4 to 7 or more
Moreno Valley Unified	2004-2007	Part-time employees are eligible	District pays up to cap for each eligible employee; part-time get pro-rata share	2005-2008	Must work at least 4 hours to qualify for base funding	Amount the employer pays to cap is based on number of hours worked from 4 to 8

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Mercer (US) Inc.
777 South Figueroa Street, Suite 1900
Los Angeles, CA 90017
213 346 2200

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