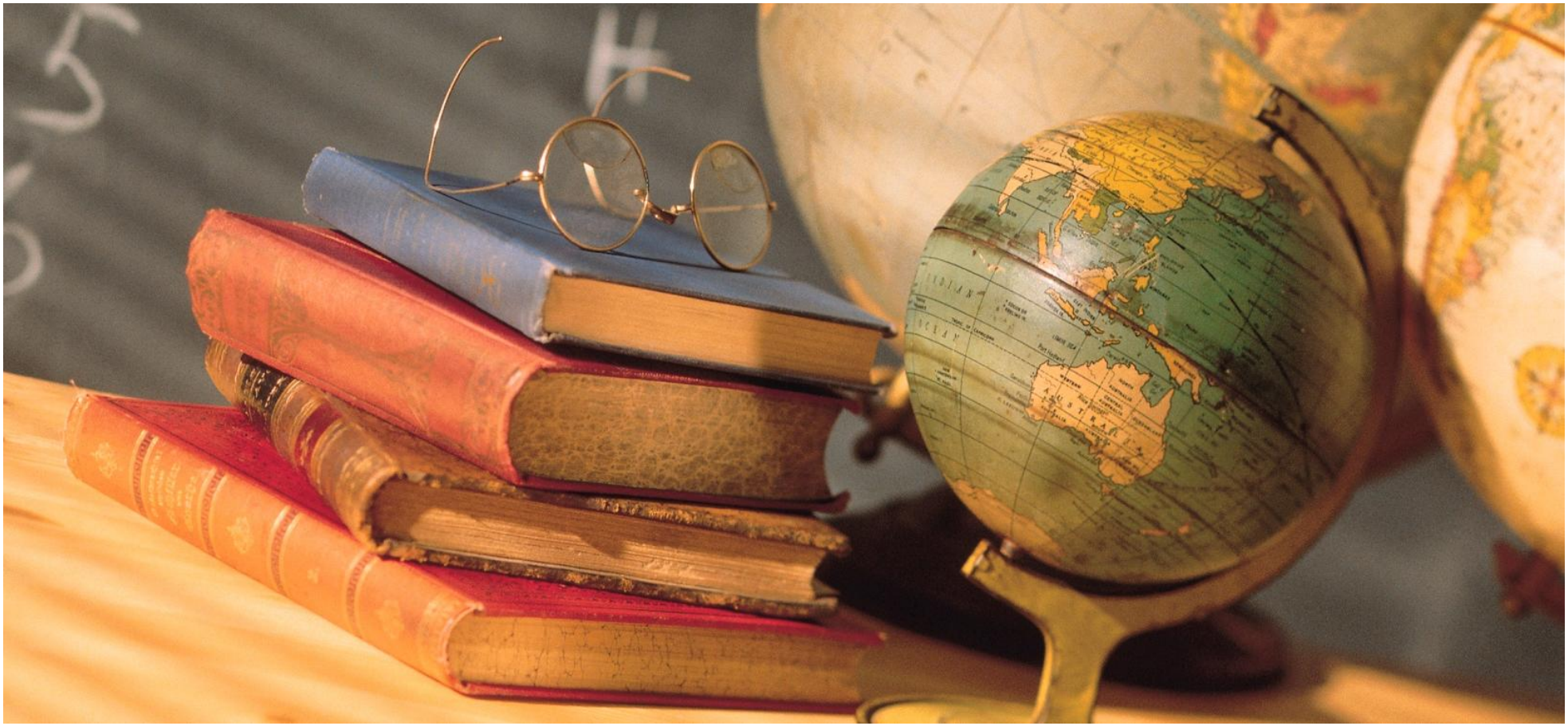
December 6, 2013

State of Alaska

State Managed Group Health Insurance Program for Alaska Public School Employees

HayGroup®



Senator Kevin Meyer
Co-Chairman
Senate Finance Committee
Legislative Office Building
129 6th Street, Room 222
Juneau, Alaska 99801-1182

Dear Senator Meyer:

On behalf of the Hay Group, we are pleased to present the results of our review of the current system for providing health benefits to public school employees in the State of Alaska.

We find that there are substantial opportunities for streamlining the funding of these benefits. We also discuss four policy design alternatives for establishing a state-wide health benefit system for school employees. These alternatives are based on the approach of centralizing resources and standardizing the health benefits offered to school employees. The options provide alternatives designed to minimize disruption of existing health plan designs while offering various options for establishing a state-managed health plan that adopts cost-saving strategies, market-competitive designs and provide parity as well as school district flexibility.

The successful and timely completion of our report depended on the generous assistance provided by your office, as well as the timely and complete responses provided by local school districts and the many organizations that provided input into our study. We wish to thank all those who gave generously of their time to meet with us and provided their counsel as well as the information we used in the study, including the administrators of the 100 percent of the school districts that completed our health benefits survey, which is the backbone of this study.

Sincerely,

John Hennessy
Senior Principal

Contents

I. Executive Summary

Overview

The Alaska Senate Finance Committee (SFC) engaged Hay Group to perform a review of the current system for providing health benefits to public school employees in the State of Alaska (the State). The scope of the assignment included reviewing the benefits provided through the current system, the cost of the current system, and the opportunities available for containing or reducing future health care costs. In performing our review we surveyed local school districts around the State, interviewed representatives of key groups and organizations currently involved in the provision of health benefits to school employees, compared the benefits provided by other employers, and evaluated several alternatives for controlling future costs.

The cost of health care, and as a result, the cost of providing health benefits, continues to outpace overall economic growth and other elements of compensation. Large employers have often succeeded in offsetting much of the rising cost of health care through coordinating multiple approaches to control costs. Smaller employers, including a great number of individual school districts are often unable to achieve these savings. Unfortunately, this often leads to an increased health care budget or reduced benefits for employees.

Note: Technical terms, abbreviations, and acronyms used throughout the report are defined in the Glossary in the Appendix.

Current Costs

As shown in the table below, school district health care costs[1] are approximately $264 million, which represents an estimated 16% of the funding received by the school districts. This amount is net of employee contributions of approximately $31 million. The total annual health care spend is $295 million. All costs and estimated cost savings are, unless specifically indicated otherwise, based on the latest information provided to us.

[1] School district health care costs represent total cost of health care including administrative charges and stop loss fees less any applicable employee contributions. Note Mt. Edgecumbe was not a part of this study.

Budget and Employer Health Care Costs by District Size				
District Size	# of Districts	State, Local and Federal Funding**	Total Employer Health Care Costs	Employer Health Care as a Percentage of Funding
0 - 24 Employees	10	$11,535,000	$2,141,383	18.6%
25 - 49 Employees	12	$40,402,000	$8,606,534	21.3%
50 - 99 Employees	14	$103,556,000	$17,142,699	16.6%
100 - 499 Employees	11	$246,718,000	$46,896,359	19.0%
500 - 999 Employees	2	$117,605,000	$22,678,154	19.3%
1,000 - 6,000 Employees	4	$1,172,556,000	$166,290,051	14.2%
	53	**$1,692,372,000**	**$263,755,181**	**15.6%**

*Projected FY14 Basic Need = ADM * Adjustments * Base Student Allocation ($5,680). Calculated by district.

**FY14 Money to School Districts estimated by using average amount per ADM

Savings Potential

On average, the 53 public school districts allocate less than one full-time employee to the administration and management of health care plans. All districts agree this benefit makes up a significant and growing portion of their overall budget. This report takes a proactive look at addressing this issue through examining potential areas of savings through a State managed group health insurance program.

The areas of potential savings attributable to moving to a consolidated pool are:

Provider Networks	■ Claims administrators and health insurers (vendors) access or manage a network of health care providers. These vendors negotiate discounts from a provider's typical charges which provide savings when compared to a consumer who uses the provider's services without accessing the vendor's arrangement.

Provider Networks *(continued)*	▪ All vendor provider networks are not created equal and the savings potential can be realized through accessing the best available provider networks. ▪ School districts currently utilize a variety of provider networks with various provider reimbursement arrangements dependent on geography and network provider. ▪ Some current pharmacy benefits are provided through the medical claims administrator under which the plan sponsor has little to say about the terms and conditions that were negotiated. By negotiating contract terms and conditions directly with a Pharmacy Benefit Manager, plan sponsors are able to remove fees that bear no relationship to the performance of their plan or the cost of providing a pharmacy benefit. ***Savings Opportunity: Moving all school district health plans to a provider network that provides better discounts without sacrificing quality of care, and through increases in automated claims adjudication, they may actually reduce cost and in some cases improve quality of care.***
Overhead (non-claims expenses)	School districts pay for a number of health care related items that do not directly go towards paying health care claims, preventing illness, or improving health outcomes. Savings will occur by reducing the following elements of overhead: ▪ **Broker Revenue:** generally a percentage of premiums paid to the insurance broker who places the business of health care administration and insurance. ***Savings Opportunity: Although brokers can provide insurance advice, broker fees are paid only on the placement of insurance; broker interests and school district interests are not inherently aligned. Establishing procurement guidelines which limit broker revenue will reduce the amount of overhead.*** ▪ **Premium Taxes:** state taxes paid on premiums for plans which are fully insured. This tax is 2.7% for the state of Alaska.[2] ▪ **Stop Loss Fees:** for school districts which are large enough to self insure, stop loss insurance can be purchased to protect against catastrophic claims. As group size increases, the need for stop loss insurance diminishes.

[2] Eliminating fully insured arrangements will correspondingly reduce tax revenue. In this report we do not take into account the resulting loss of this tax revenue to the State.

Overhead (non-claims expenses) *(continued)*	▪ **Insurance profit, risk, and pooling charges:** when a group purchases fully insured group health insurance through an insurance company, company profit is built into the premiums. In addition, insurance companies build in margins to cover possible deviation in expected claims. ***Savings Opportunity: Although full insurance makes sense for smaller districts with limited ability to absorb risk, expanding the group health insurance pool can eliminate the need for unnecessary overhead.***
Plan Design	▪ Changing the deductible, out-of-pocket maximum, coinsurance, and copay provisions of health care plans has a direct affect on the amount of claims the health plan pays. ***Savings Opportunity: Current health care plans reimburse a high percent of allowed costs. Standardizing health care plans produces opportunity for savings.***
Cost Sharing	▪ Cost sharing is the proportion of total premium costs paid by school districts or employees. ▪ Changes to cost sharing arrangements are generally done by altering the tier structure (for example the ratio of the employee + spouse premium to the employee only premium) and level of employee/dependent subsidies. ***Savings Opportunity: Alaska school districts subsidize the premium cost for employees and dependents by the same or similar percentage of total cost. Market practice suggests employers typically subsidize employee coverage more than they subsidize dependent coverage.***

In addition, a State managed health plan for school district employees can provide increased purchasing power for all elements of employer-provided health benefits. Centrally managed procurement, administration, and strategic management will provide for greater opportunity to offer school district employees health benefits more effectively and more economically.

The strategies presented in this report take these savings opportunities into consideration. All options are based on the consolidation at the State level of procurement, administration, and management. The level of employee impact depends upon the extent of plan design consolidation, and the establishment of cost sharing guidelines that reduce school district costs.

The following are four options for reducing school districts' health care costs.

- **Option 1: Optimize Program Performance** – uses centrally managed procurement, enterprise health care program management and optimized vendor/provider contracting
  - Estimated financial impact: savings ranging from $17.1 million (M) – $28.8M, which represent savings of 5.8% - 9.8% of current health care costs
- **Option 2: Leverage AlaskaCare Plans** – consolidates all health care coverage under existing AlaskaCare plans
  - Estimated financial impact: ranging from an increase in cost of $8.7M to a savings of $34.9M, which represents an increase of 2.9% to a decrease of 11.8% of current health care costs
- **Option 3: Centrally Managed School District Program with Standard Health Plan Options and Cost Sharing** – provides an independent set of three health plan options that are customized to best suit the needs of school districts, using a State-managed health program that is independent of AlaskaCare. Under this option, there would be uniform premium cost sharing
  - Estimated financial impact: savings ranging from $22.6M – $33.7M, which represents savings of 7.7% - 11.4% of current health care costs
- **Option 4: Centrally Managed School District Program with Standard Health Plan Options Only** – provides an independent set of three health plan options that are customized to best suit the needs of school districts, using a State-managed health program that is independent of AlaskaCare. Under this option; however, each school district would have discretion in setting premium cost sharing levels for its district
  - Estimated financial impact: savings ranging from $9.4M – $64.9M, which represents savings of 3.2% - 22.0% of current health care costs

Hay Group recommends Option 3 to optimize plan performance, achieve significant savings and provide a better managed health program to school district employees. However, if it is desirable for school districts to retain some discretion in setting employee cost sharing level, Option 4 is a suitable alternative.

II. Current Alaska School District Health Plans

A. Data Collection Process

In Hay Group's experience, the success of this type of study relies heavily on obtaining accurate, robust, and relevant data from a variety of sources. Data came from the following sources for this study:

- Survey of health plan data from Alaska school districts
- Input from stakeholders regarding current school district health benefit programs as well as the Alaska health care marketplace
- Legislative documentation regarding the current structure, requirements, and funding of school district health care programs

B. Survey Development and Use

With the State's permission, Hay Group leveraged its national survey group which focuses solely on obtaining data from organizations, as well as our industry experience and proven data collection procedures to maximize participation. With the support of the SFC, we achieved 100% survey participation by school districts.

Based on initial project planning, Hay Group developed a draft survey tool (Excel based) designed to capture data to address the project objectives. Requested data included health plan designs, premiums, cost sharing, enrollment, and other administrative information. The draft survey was submitted to the project manager, Senator Kevin Meyer, for review and comments. The survey tool was finalized and distributed to all school districts.

Where possible, health plan data was pre-populated in the survey for school districts, simplifying the data collection process. Communications were customized based on Hay Group's ability to pre-populate the survey tool.

The Alaska project manager, with information provided by the Department of Education and Early Development, provided a complete list of school district contact information. The SFC distributed an introductory letter to all school districts explaining the health plan analysis and requested full survey participation. Following the distribution of the SFC letter, Hay Group released the

survey via email to all participants during the week of August 19, 2013. Districts were given three weeks – until September 9, 2013 – to respond to the survey. In coordination with the SFC, reminder emails were sent and follow-up calls placed to districts to ensure participation and to respond to any questions.

Included in the appendices is a copy of the survey instrument and a summary of enrollment and benefits information collected from the responding school districts.

C. Other Stakeholder Input

A successful study must also consider the views of all of the stakeholders in the current system. These include the management of schools, employees, their unions, insurers, and the State. Through a series of phone interviews with many of these stakeholders, Hay Group collected valuable information on the operations of the current health plans and gained a better understanding of Alaska's health care market. The stakeholders interviewed include:

- NEA-Alaska Health Plan Trust
- Department of Administration
- Alaska Association of School Boards
- Alaska Association of School Administrators
- Various health insurance companies: Aetna, Premera Blue Cross Blue Shield, and Cigna

Interview summaries are included in the Appendix.

D. Analysis of Current Plans, Structures, and Costs

From surveying the 53 school districts we found material differences in the plan designs offered, the way health insurance is procured, and the funding arrangements of the plans. Together these elements and factors can be shaped to produce savings.

The three key drivers of a plan's costs are: (1) the extent to which the plan pays for the cost of care (i.e., how much hospitals, doctors, and other care providers are paid), (2) the utilization of those benefits by plan members (i.e., the frequency and intensity of illness, disease, injury, and visits to care providers), and (3) the non-benefit costs that are required to administer the plan (e.g., costs of claims processing).

While plan design does influence utilization, once the plan of benefits is determined, the primary driver of the total plan cost is effective administration and management of the plan. Hence, one of the most controllable elements of health care costs is the administrative cost.

Unless otherwise noted, health care costs include the combined cost for medical, prescription drug, dental, and vision care. Approximately 75% of school district plans include dental and vision benefits as part of the medical and prescription drug plan. In order to more accurately reflect current cost and estimate future savings, the costs for all coverages have been combined into one overall health care cost.

Also, while the total annual cost to provide health care to school district employees and their dependants is $295 million, the employees participating in these school district plans contribute $31 million to the $295 million by means of payroll deductions. The term "PEPY" (per employee per year) as referenced in this report represents the total health care cost per employee per year, and includes the portion of premiums paid by employees.

The number and wide variation of plans offered can be reduced to just a few plan designs while still offering meaningful choice among low, medium, and high-valued plan designs. The entire range of plan designs can be consolidated into three plans which are reasonably close in value to the current plans offered. Premium cost sharing with employees can still be determined at the district level, if desired. Minimizing the number of options offered will also create efficiencies in administration and communication. This can also make it easier to determine parity among school districts in terms of their health benefits.

School district plans could be managed more efficiently by transferring the procurement and administration to the State's current resources, thereby reducing the administrative burden on individual school districts. The modest amount of time currently available for a school district staff member to focus on a benefit that constitutes a significant portion of the annual budget may be better employed elsewhere. Health plan responsibilities may be shifted to a centralized staff such as the State's since the State already has resources that are focused on health plan management. Costs could be reduced by applying a uniform set of administrative procedures; in addition, by using best practices for plan administration, further efficiencies will be achieved.

From our survey, we found that Alaska school districts have a number of methods for acquiring health care coverage for their employees. These different approaches vary in how the health plan is funded. The cost of providing a given set of benefits to a

specific group of employees will vary depending on the way the benefits are funded and administered. The approach taken to funding a health plan directly affects the level of non-benefit claim expenses (i.e., the administrative "load" in excess of direct benefit payments). For instance, if a health benefit plan is fully insured the premium will include a risk charge by the insurer that would not be paid if the plan were self-funded. If a mid-sized school district with 300 employees were self-insured it would likely purchase stop-loss insurance. Stop-loss insurance would not be necessary for a self-funded district with 10,000 employees because the risk is sufficiently spread among a large enough population that significant variations in benefit costs can be adequately measured and taken into account for purposes of premium rate setting. Thus savings can be achieved by leveraging the group's size to self-fund and eliminate the need for stop loss insurance and administrative loads imposed on fully insured health insurance.

With this background in mind, the following sections provide a detailed analysis of the current school district health plans, including the plans' eligibility and enrollment, plan design, plan funding, and cost sharing features.

E. Enrollment in School District Plans

The table below summarizes reported employee enrollment (school district employees who elect health care benefits) by district size. These employee enrollment counts are used in the weighted average health care cost calculations in this report.

Enrollment by District Size		
District Size	# of Districts	Total Covered Employees
0 - 24 Employees	10	130
25 - 49 Employees	12	451
50 - 99 Employees	14	1,016
100 - 499 Employees	11	2,705
500 - 999 Employees	2	1,237
1,000 - 6,000 Employees	4	10,229
	53	**15,768**

Based on an approximate total population of 19,000 school district employees, the enrollment information suggests 17% of school district employees decline school district coverage, i.e., those opting out of health care coverage. Those opting out, however, may

have access to coverage through a family member, the Indian Health Service, the military, or some other means, thereby eliminating the need to purchase coverage through their school district.

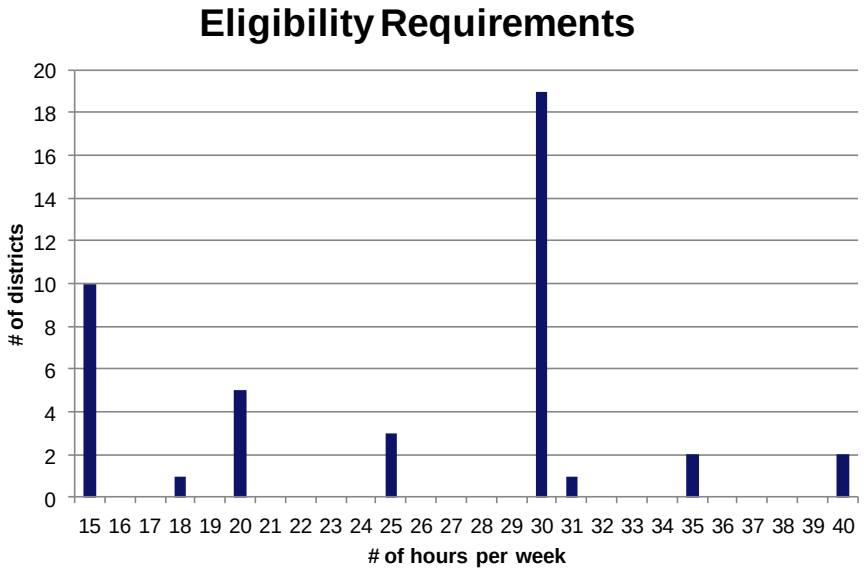
The four largest school districts by employee size (Anchorage, Fairbanks North Star Borough, Mat-Su, and Kenai Peninsula Borough) represent approximately 65% of all school district employees with school district-provided health care.[3]

F. Eligibility Requirements for School District Plans

The median eligibility requirement for health plan coverage among the 53 school districts is for employees to work a minimum of 30 hours per pay period; however, eligibility requirements range from 15 hours to 40 hours. There is little variation in the minimum hours required for eligibility based on employee categories (e.g., instructional staff, clerical, food service, custodial, etc.).

The chart on the following page indicates that school districts use different minimum weekly hours worked requirements as the basis of eligibility for health plan coverage, with the predominant requirement being 30 hours per week. It would not be disruptive for a State health plan to develop a single, consistent minimum hours per week standard for all employees, which would be easy to administer and fair to all employees.

[3] Unless otherwise indicated, reference to "employees" is to employees covered by a school district's health plan.



A second type of eligibility requirement is a specific eligibility waiting period (i.e., the length of time an employee must wait before qualifying for health plan benefits). In the case of the school districts, the health plans' waiting periods are generally less than 90 days, which complies with the Affordable Care Act (ACA) requirement that allows for a waiting period of up to 90 days with no penalty. The fairly narrow range of waiting periods suggests that a uniform waiting period for a State health plan would not be, in most cases, detrimental to employees or onerous to school districts.

G. Current School District Health Care Plan Designs

Medical Plans

The following table shows the various types of medical plans offered by Alaska school districts. School districts provide medical benefits through a variety of plan types; Preferred Provider Organization (PPO) and Point of Service (POS) plans are the most prevalent plan design representing 79% of all plans. Only 13% of plans are high deductible health plans (HDHP). Use of a HDHP presents an opportunity for cost savings through claims cost control and heightened awareness for health care consumerism.

Thirteen school districts offer more than one plan design to their employees; three of these 13 school districts offer coverage with the NEA-Alaska Health Plan. In the chart below, there are 72 plans because many school districts offer more than one type of plan.

Types of Medical Plans	
Plan Type	**# of School District Plans**
PPO/POS	57
PPO/POS with HRA	3
HDHP	6
HDHP with HRA/HSA	3
FFS	3
	72

The following table shows the distribution of school district plan designs. Using Hay Group's actuarial plan design model, we determined the relative richness of each school district's plan designs. An overview of Hay Group's plan design factor methodology is outlined in the Appendix. Using this actuarial analysis allows us to rank each of the plan designs to determine which plans are in the 25th percentile (P25) (least valuable), 50th percentile (P50), and 75th percentile (P75) (most valuable), based on their plan designs. The 25th percentile represents the plan design that is less rich than 75 percent of the plan designs, and a plan in the 75th percentile is among the richest designs.[4] For ranking purposes, the plan designs are weighted by enrollment.

[4] The more "rich" a plan, the more the plan pays in benefits, and the less the employee has to pay out of his or her pocket.

Plan Design Summary			
In-Network Plan Design	**P25**	**P50**	**P75**
Individual Deductible	$1,000	$525	$200
Family Deductible	$3,000	$1,575	$600
Individual Out-of-Pocket Max	$4,000	$4,000	$1,900
Family Out-of-Pocket Max	$12,000	$12,000	$5,700
Primary Care Visit	20%	20%	20%
Specialist Visit	20%	20%	20%
Inpatient Visit	20%	20%	20%
Retail Generic Rx Copay	$10	$10	$10
Retail Preferred Brand Rx Copay	$20	$20	$20
Reimburses % of Allowed Charges	78%	86%	90%

The table above outlines the differences in plan designs offered by school districts. However, it is important to note that the difference in plan value between the P25 plan and the P75 plan is only 12%, which is not significant from an actuarial perspective. Costs do vary among school districts, which suggests the following: disruption created by moving to fewer plan designs would not be significant and cost savings is not solely achieved through plan design consolidation. A comprehensive strategy that addresses not only plan design, but also provider networks, funding arrangement, and administrative costs may also generate cost savings.

Dental Plans

The table below summarizes the different dental plans offered to school district employees. There are only slight differences in the deductibles and benefit maximums, and the coinsurance levels remain consistent within plans. These plans are typical of those in the general market with little variation in plan design components. The majority of school districts require medical and dental as one election; approximately 25% of school districts allow a separate election for medical and dental plans.

While dental plan designs have not changed much over the last 20 years, the costs for dental services have increased. Premiums have remained relatively constant, but members are simply paying more out of pocket for services obtained. Not all members require non-preventive medical care, but most members require non-preventive dental care. Dental issues are increasingly seen as leading indicators of medical conditions, so a dental program that promotes oral health and maintain a plan design that encourages employees to utilize appropriate dental services contributes to a better medical program and better medical care.

	Dental						Orthodontia		
	Individual Deductible	Family Deductible	Plan Maximum Non-orthodontia	Preventative	Basic Restorative	Major Restorative	% of Plans that offer Orthodontia	Plan Maximum Orthodontia	Orthodontia Coinsurance
P25	$50	$150	$2,000	100%	80%	50%	31%	$1,500	50%
P50	$25	$75	$2,500	100%	80%	50%		$1,750	50%
P75	$0	$0	$3,000	100%	80%	50%		$2,000	50%

Vision Plans

There is little differentiation in vision plan designs among school districts. The copayments and allowances outlined below are in line with prevalent market practice.

	Vision			
	Exam Copay	Materials Copay	Frame Allowance	Contacts Allowance
P25	$25	$25	$100	$130
P50	$25	$25	$175	$130
P75	$25	$25	$195	$150

Including vision coverage with medical coverage is largely a public sector trait. Typically, in the private sector, vision coverage is a voluntary benefit that the employer procures, but is 100% employee-paid.

H. Current School District Health Care Plan Costs

The table below shows total health care costs by district size as collected through Hay Group's survey process. Total health care costs per employee per year (PEPY) include total premiums paid by the plan sponsor and employee as well as any applicable administrative and stop loss fees.

Appendix VII provides more extensive data, by school district, including number of employees enrolled in health care coverage, PEPY, and plan funding.

Since the school districts' plans vary in design, in order to compare health care costs across plans, we established a baseline plan design and then compared the relative value of other plans to the baseline. Using Hay Group's actuarial plan design model, we determined the value of the average school district plan design and then used this as the common basis on which to compare health care costs. These adjusted costs are shown in the "Normalized Health Care Costs PEPY" column below. Once normalized to a common plan design, costs can then be compared. A normalized cost which is lower than actual cost (in the "Health Care Costs PEPY" column) indicates a richer plan design relative to the median plan design. For example, the school districts in the 100-499 and 500-999 employee size have richer plan designs.

Health Care Costs by District Size

District Size	# of Districts	Health Care Costs PEPY*	Normalized Health Care Costs PEPY**
0 - 24 Employees	10	$17,904	$18,870
25 - 49 Employees	12	$19,450	$19,751
50 - 99 Employees	14	$17,898	$18,029
100 - 499 Employees	11	$18,188	$17,580
500 - 999 Employees	2	$18,919	$18,056
1,000 - 6,000 Employees	4	$18,277	$18,504
	53	**$18,318**	**$18,318**

*Health Care Costs do not include administrative and stop loss fees

**Plan costs adjusted based on common design. Adjustments for plan design, not enrollment, geography or utilization

Typically, the larger the group, the lower the cost is per employee per year. Large employers have more tactics available to them to control costs while smaller employers, such as the smaller school districts, are often limited in cost containment means. The survey results support this assumption to some degree, although the four districts with the largest employee groups have a normalized health care cost that is larger than the average.

The following table shows school district health care costs based on the type of funding arrangement. As we would expect, smaller districts are more likely to be fully insured, while larger districts tend to be partially or self insured. With the exception of a few outliers, PEPY health care costs for partially or self insured programs are lower than for insured programs. The cost of a plans' funding method is analyzed in the next section. Because Anchorage and Juneau school districts participate both in the NEA-Alaska Health Plan and provide other coverage, the number of school districts totals to 55. Based on our survey, Anchorage and Juneau are the only school districts where more than one health plan is in place as the result of multiemployer union health plans being offered.

Health Care Costs by District Size and Insured Status									
	Fully Insured			NEA-Alaska Health Plan			Partially Insured/Self Insured		
District Size	# of Districts	Health Care Costs PEPY*	Normalized Health Care Costs PEPY**	# of Districts	Health Care Costs PEPY*	Normalized Health Care Costs PEPY**	# of Districts	Health Care Costs PEPY*	Normalized Health Care Costs PEPY**
0 - 24 Employees	7	$16,711	$17,619	3	$19,583	$20,630	0	-	-
25 - 49 Employees	6	$18,929	$19,409	4	$21,300	$21,480	2	$17,454	$17,459
50 - 99 Employees	1	$15,948	$17,151	6	$19,214	$20,633	7	$17,273	$16,388
100 - 499 Employees	2	$11,244	$12,040	0	-	-	9	$19,299	$18,466
500 - 999 Employees	1	$16,800	$18,951	1	$20,204	$19,867	1	$19,007	$16,734
1,000 - 6,000 Employees	0	-	-	2	$17,895	$18,734	3	$18,614	$18,301
	17	**$15,126**	**$16,217**	**16**	**$18,228**	**$19,018**	**22**	**$18,725**	**$18,106**

*Health Care Costs include claims costs, administrative and stop loss fees

**Plan costs adjusted based on common design. Adjustments for plan design, not enrollment, geography or utilization

Fully Insured 100 - 499 Group: Nome and Sitka have very few dependents which drives down PEPY cost.

Although our analysis did not include a detailed review of district claims experience, there is benefit in understanding how claims cost drivers affect employer costs. There are a number of claims factors which affect health care plan costs PEPY which are listed below in order of magnitude to the school district population:

- Richness of plan design (how much does the member pay out-of-pocket)
- Cost per service (how much the doctor's visit costs)
- Utilization (i.e. how often members go to the doctor)
- Contract size (how many dependents do employees cover)

National market average health care plan costs PEPY are roughly $13,000 for 2013[5] compared to $18,318 for the State. Plan designs in Alaska school district tend to be more generous than the national market which is a driver of higher health care costs for districts[6]. Due to the unique provider community in Alaska, cost per service is likely a key driver in the difference in health care costs compared to the national market. Aggregate claims in Alaska suggest costs per health care service are higher than national market costs while utilization is lower than national market data[7]. The contract size estimate of school district plans is generally consistent with the number of members covered under employer plans in the national market. The combination of these factors contributes to the higher costs in the school district population when compared to the national average.

Provider Networks

School districts currently utilize a variety of provider networks, many of which have less competitive network discounts. Health care procurement is currently handled by individual districts except in cases where districts participate in the NEA-Alaska Health Plan or other multiemployer health care trusts. Some vendors have an advantage in contracting and negotiating deep discounts with medical providers.

To help us determine the feasibility and cost-savings potential of consolidation, we examined school district coverage by geographic area (i.e., zip code) and claims administrator. We found that some school district plans are accessing multiple provider networks, thereby minimizing their purchasing power. Network discounts may not produce a material impact in rural areas with noncompetitive provider access, but greater purchasing power will create greater savings in concentrated urban areas with the biggest opportunities for discounts. Solely by optimizing the use of provider networks for all school districts, Hay Group estimates that savings between $9.8 million and $20.8 million can be achieved.

As indicated in the table below, the NEA-Alaska Health Plan − represented by Employee Benefits Management Services (EBMS) − has the largest share of school district employees, with approximately 36% of the total. The second largest block of employees is covered by Aetna (30%), followed by a variety of other moderately sized plans administered by Third Party Administrators (TPAs) (26%). Hence, the school districts appear to be coalescing around a few arrangements, but without the financial advantages of doing so.

[5] Based on Hay Group's 2013 Hay Benefits Report
[6] Based on Hay Group's 2013 Hay Benefits Report
[7] Based on national benchmark claims data which utilizes over 20 million lives. For more information, see Appendix IX.

EBMS is the current third party administrator for the NEA-Alaska Health Plan; in addition, one school district outside of the NEA-Alaska Health Plan utilizes EBMS as its claims administrator.

Health Care Enrollment by Zip Code and Claims Administrator/Health Insurer														
	Aetna / Meritian		Cigna		EBMS		Premera BCBS		Other*		No data provided		Total	
3-Digit Zip Code	Districts	Employees	Districts	Employees	Districts	Employees	Districts	Employees	Districts	Employees	Districts	Employees	Districts	Employees
995	5	2,639	0	0	4	3,236	2	96	2	741	2	155	15	6,867
996	4	893	2	101	4	2,002	2	69	1	1,242	0	0	13	4,307
997	5	800	0	0	3	197	1	44	2	2,154	1	6	12	3,201
998	1	240	0	0	5	500	3	287	0	0	1	2	10	1,029
999	1	220	0	0	1	47	3	97	0	0	0	0	5	364
	16	**4,792**	**2**	**101**	**17**	**5,982**	**11**	**593**	**5**	**4,137**	**4**	**163**	**55**	**15,768**

*Other represents Rehn & Associates, Moda, WPAS and Integrity Administrators

**Based on Hay Group's survey and knowledge of the provider network market

Estimated Provider Network Savings: $9,800,000 - $20,800,000**

Pharmacy Benefit Managers (PBMs)

In looking for savings opportunities we examined how school districts health plans provide prescription drug benefits. As noted earlier, separate pharmacy benefit managers (PBMs) increase the opportunities for lower drug benefit costs. As indicated in the following chart, approximately 60% of the school districts use integrated PBMs, suggesting significant prescription drug savings opportunities, on the order of $1 million to $1.7 million in annual savings.

Carved Out Prescription Drugs by District Size			
District Size	Separate PBM	Integrated PBM	Total
0 - 24 Employees	2	8	10
25 - 49 Employees	3	9	12
50 - 99 Employees	6	8	14
100 - 499 Employees	4	7	11
500 - 999 Employees	3	0	3
1,000 - 6,000 Employees	3	2	5
	21	**34**	**55**

Estimated PBM Savings*: $1,000,000 - $1,700,000

*Based on Hay Group's survey and knowledge of the PBM arrangements

By effectively leveraging the centralized procurement of a single PBM for all school districts, savings will be realized through a competitive bidding process, improved pricing and more favorable contract terms.

I. Funding Methods

Employers, including school districts, have two basic choices when it comes to funding their health plans. They can purchase health insurance or they can self-insure. As discussed in this section, school districts in Alaska have a third option of purchasing health coverage through a separate trust, which has features of both a fully insured plan and a self-insured plan.[8] Each of these approaches has its advantages and disadvantages.

In brief, a fully insured health plan is one in which the school district pays a fixed premium per employee, and the insurance company bears all of the risk (and reward) of health care claims experience, regardless of whether those costs of benefits and administration exceed (or are less than) the total paid by the school district and its employees. Built into the premiums are reserves (in case claims exceed what is expected) and premium taxes which the insurance company must pay to the State. Two

[8] Even though the NEA-Alaska Health Plan is self-insured, for purposes of this report we treat it as fully insured because school districts are fully indemnified against excess claims.

key features of fully-insured plans tend to make them more expensive. Typically, state premium taxes on fully-insured health plans are approximately 2-4%. Additionally, as a general matter, insurance companies will price premiums conservatively to minimize the risk that they will pay out more than they collect in premiums.

Self-insured health plans bear the risk of costs being above those expected. Contributions are based on a best guess of plan costs (claims and administrative costs), but if plan's costs exceed total contributions, the plan sponsor (most commonly the employer) must absorb the difference. To mitigate this risk, self-insured employers often purchase stop-loss insurance, which will reimburse the plan sponsor if and when claims exceed certain "attachment points." For example, stop-loss insurance premiums for individual claims in excess of $500,000 are much less expensive than stop-loss coverage for individual claims in excess of $100,000. As a general matter, large employers (e.g., groups greater than 1,000) are more likely to self-insure than small groups, since risks become more manageable as group size increases.

The NEA-Alaska Health Plan is technically a self-insured plan, but, with respect to the 16 participating school districts, the NEA-Alaska Plan functions like a fully insured plan. This is because once the NEA-Alaska Plan sets the contribution rate for each of its plans, it indemnifies the participating school districts against costs that exceed the contribution rate. Further discussion about the NEA-Alaska Health Plan is contained in Section J.

In addition to the NEA-Alaska Health Plan, there are a few other multiemployer union health plans that provide health benefits to specific groups of school district employees. Local 71 of the Laborers International Union of North America (LIUNA) (Local 71), which, in relevant part, covers building support personnel in the Anchorage School District.[9] A relatively small number of school district employees participate in these multiemployer health plans. For this reason, we do not believe these other health trusts are a significant barrier to creating a State-wide health plan.

In the four options presented in this report, we assume the NEA-Alaska Health Plan and the other multiemployer union health plans cease to provide school district employee coverage because that coverage is provided through the State-managed plan. However, nothing would inherently prevent the State, in its enabling legislation, from "grandfathering" or otherwise permitting school districts to stay with their current plans. However, as has been noted throughout this report, each aspect of maintaining the

[9] Other groups of employees represented by Local 71 that are covered by the Local 71 health trust are: State of Alaska, Haines Borough, and Municipality of Anchorage. Three years of rates for the Local 71 plan are: for the 2011-12 plan year $1,150; for the 2012-13 plan year $1,235; and for the 2013-14 plan year $1,315. On average a 7% year-over-year increase.

status quo erodes the potential savings that could be accomplished with a larger covered population. We estimate there are about 6,500 school district employees in the NEA-Alaska Health Plan and other multiemployer union health plans. (See chart on page 18.)

The State's school districts are fairly evenly divided among insured plans, self-insured plans, and the NEA-Alaska Health Plan, as shown in the chart below.

Insurance Arrangement by District Size

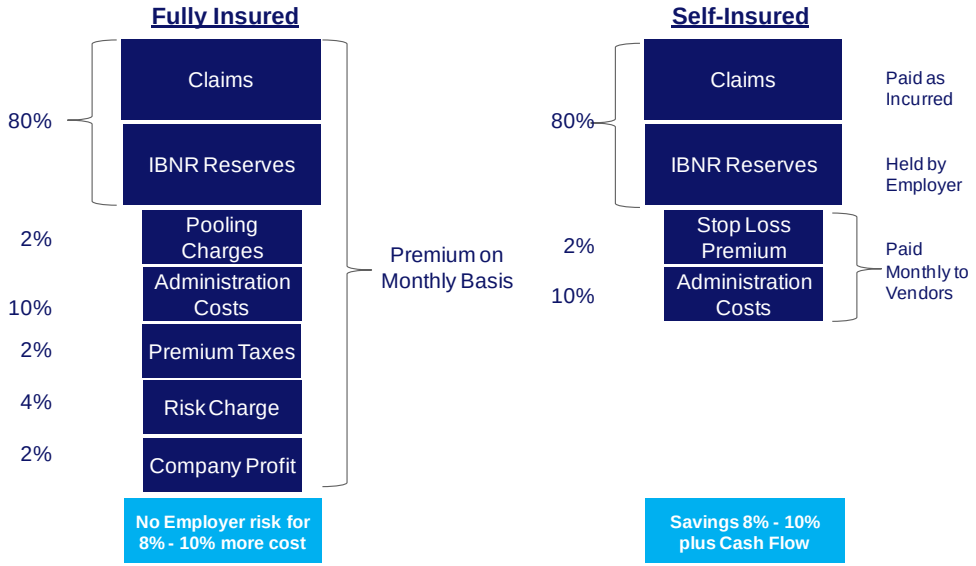
District Size	Fully Insured	Partially Insured			NEA-Health Plan	Self Insured*	Total
		Individual Stop Loss Only	Aggregate Stop Loss Only	Individual and Aggregate Stop Loss			
0 - 24 Employees	7	0	0	0	3	0	10
25 - 49 Employees	6	1	0	1	4	0	12
50 - 99 Employees	1	0	0	4	6	3	14
100 - 499 Employees	2	1	0	8	0	0	11
500 - 999 Employees	1	0	0	1	1	0	3
1,000 - 6,000 Employees	0	0	0	3	2	0	5
	17	**2**	**0**	**17**	**16**	**3**	**55**

*It is likely the three districts who reported 'self-insured' have some level of stop loss

Note: Fully insured also includes other fixed fee arrangement such as multiemployer union plans where school districts make fixed contributions to union trusts. Based on the insurance arrangements, outlined below are the overhead costs associated with each funding type. Self insured arrangements do not have this overhead.

The number of employees covered under a health plan has an indirect correlation with per capita health care costs. Small groups tend to find more advantages to being fully insured which assures the group of a fixed, predictable cost for the year. However, being fully insured automatically includes insurance costs of taxes, insurance company profits, risk charges and pooling charges.

As group size increases, larger groups tend to find more advantages in taking on risk in exchange for lower expected costs. Premium taxes are no longer applicable, nor are insurance profits. Risk charges are not paid but could be absorbed if claims exceed expected budget. Stop loss insurance can be purchased to insure against catastrophic claims. The illustration below outlines the two basic funding structures:



There are 17 school districts that have fully-insured health care plans. Under these arrangements, the school district may have some or all of its employees covered by a commercial health insurance carrier, such as Premera Blue Cross Blue Shield, Aetna, or Cigna. As indicated above, in these insured arrangements a school district (typically with employees paying a portion of the total premiums) pays a fixed premium for the type of coverage purchased and has no liability if actual benefit costs exceed the total premiums paid.

However, in addition to the actual cost of benefits, insurance carriers build into their premiums the following overhead costs:

- Risk charges (typically 4% of premiums)
- Reserves to cover the possibility of benefit costs exceeding their projections (typically 2% percent of premiums),

- Profit (typically 2% percent of premiums)
- Premium taxes (2.7% of premiums in Alaska)
- Stop loss premiums (partially insured only)
- Broker compensation revenue

Regardless of whether the school district participates in a fully-insured arrangement or a multiemployer union-sponsored health plan, there is no free lunch when it comes to paying for health benefits. If a plan's costs exceed its premiums in a given year, the costs of coverage in following years will increase to absorb some of those losses, unless there are sufficient offsetting gains from prior years.

Small groups (e.g., groups of less than 500 employees) generally buy health insurance or participate in a multiemployer plan that protects them against these types of losses, rather than self-insure, because the costs and risks of unexpected large claims cannot be absorbed.

The following tables illustrate the current overhead costs for fully and partially insured districts:

Overhead by District Size					
	Fully Insured			Partially Insured	
District Size	Premium Tax*	Pooling Charge, Risk Charge, and Company Profit**	Total Overhead	Stop Loss Premiums	Grand Total Overhead
0 - 24 Employees	$34,291	$101,604	$135,895	$0	$135,895
25 - 49 Employees	$116,014	$343,745	$459,759	$12,083	$471,843
50 - 99 Employees	$32,726	$96,966	$129,692	$173,335	$303,028
100 - 499 Employees	$113,238	$335,521	$448,759	$323,878	$772,638
500 - 999 Employees	$0	$0	$0	$22,981	$22,981
1,000 - 6,000 Employees	$0	$0	$0	$528,001	$528,001
	$296,270	**$877,837**	**$1,174,106**	**$1,060,279**	**$2,234,386**

*Alaska insurance premium tax is 2.7%

**Charges estimated based on industry average of 2% pooling charge, 4% risk charge and 2% profit

Broker Revenue by District Size			
District Size	# of Districts	Broker Revenue as a % of Premiums	Total Broker Revenue
0 - 24 Employees	1	0.4%	$9,835
25 - 49 Employees	4	1.3%	$114,020
50 - 99 Employees	9	2.0%	$368,665
100 - 499 Employees	8	4.6%	$2,308,491
500 - 999 Employees	2	1.9%	$448,201
1,000 - 6,000 Employees	3	0.4%	$738,805
	27	**1.4%**	**$3,988,018**

The variety of funding arrangements among the school districts allows for an opportunity for cost savings. If all school districts were to become part of a self-funded state plan, the costs for stop-loss, broker compensation revenue, and premium taxes would be eliminated.

As indicated in the table below, of the 53 school districts, there are 22 that have partial or self funded health plan arrangements, not counting arrangements with the NEA-Alaska Health Plan and other multiemployer union-sponsored health plans. While partially insured programs pay stop loss premiums, as outlined above, they also pay administrative fees, as do self insured arrangements. The table below lists the range of administrative fees currently paid by school districts that are partially or self insured.

Self Funded Administrative Service Fees				
Per employee per month	# of Districts	P25	P50	P75
Current	22	$29.32	$39.15	$59.29

J. The NEA-Alaska Health Plan

The NEA-Alaska Health Plan, established in 1996, covers approximately 5,800 school district employees and approximately an additional 11,000 dependents, for a total of 17,000 covered lives, which represents approximately 36 percent of the total lives covered by all State school district plans.

Relationship between the NEA-Alaska and the NEA-Alaska Health Plan

The NEA-Alaska sponsors and created the NEA-Alaska Health Plan, which is a tax-exempt trust under federal law. In order for a school district to participate in the NEA-Alaska Health Plan, at least one group of the school district's employees must be represented by the NEA-Alaska local affiliate and their bargaining agreement must provide for health plan coverage through the NEA-Alaska Health Plan. Therefore the NEA-Alaska Health Plan is not available to all school districts and is not available to employers that do not have a collective bargaining agreement with the NEA-Alaska, such as boroughs that purchase joint coverage with some school districts.[10]

Legal Status of the NEA-Alaska Health Plan

The NEA-Alaska Plan is a voluntary employee benefits association (VEBA) tax-exempt, nonprofit trust under section 501(c) (9) of the Internal Revenue Code (Code). The Code prohibits a VEBA trust from using trust assets for any purpose other than for paying benefits and administrative costs of paying benefits. Thus, under federal law, the NEA-Alaska Plan is prohibited from giving any of its assets to the National Education Association (NEA) or for using any of its assets for lobbying.

Finances of the NEA-Alaska Health Plan

The NEA-Alaska Trust provides medical, prescription drug, dental and vision benefits to employees in 16 out of 53 school districts (30%). It received approximately $115 million in contributions from contributing employers and employees, and spent approximately $107 million in benefits (93%) for the fiscal year ending June 30, 2012. This excess is available to pay claims or reduce future premium increases, for example.

The NEA-Alaska Health Plan is a self-funded multiemployer arrangement, but, like a fully-insured plan, participating employers pay a fixed capitated rate for the fiscal year, and employers are not liable for any claims costs in excess of the amount paid nor do

[10] The VEBA Trust document permits the NEA-Alaska Health Plan to cover up to 10% of its membership without a collective bargaining relationship, provided all members are public school employees. This permits the plan to cover, for example, non-unionized administrators in a school district that has a collective bargaining agreement with the local NEA affiliate.

employers receive a credit or refund if claims costs are less than the amount paid. Any difference between contributions and costs are absorbed by the NEA-Alaska Health Plan. The NEA-Alaska Health Plan maintains a Rate Stabilization Reserve that may be used to reduce contribution rate increases when those increases exceed 12 percent. The Rate Stabilization Reserve is funded on a discretionary basis by the board of trustees of the NEA-Alaska Health Plan after the annual audit of the trust's financial statements has been completed.

The NEA-Alaska Health Plan also has the flexibility to draw from its VEBA trust general fund to reduce what its board of trustees may consider an excessive rate increase. For example, in the FY12-13 year, the trustees used trust reserves to buy-down what would have been a 10.2% increase to 6%. Therefore the NEA-Alaska Health Plan has more than one source of funding to smooth out significant increases in claims experience. Whether the NEA-Alaska Health Plan can continue to buy down rates depends on many actuarial factors.

The rate history of the plan for the past three years has been as follows:

FY2010-11	A rate increase of 19% was reduced to 12%
FY2011-12	No rate increase
FY2012-13	A rate increase of 10.2% was reduced to 6%

A summary of key financial information about the NEA-Alaska Health Plan (as of June 30, 2012) is provided below.

NEA-Alaska Health Plan Key Financial Statistics (as of June 30, 2012)		
	Millions of Dollars	Percentage of Revenue/Explanation
Revenue	**$115.5**	
Benefit Payments	$107	93%
Claims Administration	$3	<3%
Other Administration	$1	<1%
Stop-Loss Insurance	$.5	<.5%
Surplus	$1.7	1.5%

NEA-Alaska Health Plan Key Financial Statistics (as of June 30, 2012)		
	Millions of Dollars	Percentage of Revenue/Explanation
Reserves	$41	
Rate Stabilization Account	$8	7% of premiums – used to reduce premiums
Crisis Benefit Fund	$10	Provide benefits to participants during labor disputes
Termination Liability Reserve	$2	18 months of claims run out

The NEA-Alaska Health Plan provides medical, prescription drug, dental and vision coverage. It offers seven medical plans, two dental plans, and a total of 29 plan combinations. The plans have different copays, coinsurances, deductibles, and out-of-pocket limits, which determine the total cost of each plan's coverage.

The NEA-Alaska Health Plan pools all claims and administrative costs and applies the same rate increase percentage across all plans. Thus, for purposes of setting rates, some plans may expend less than the contributions received for those plans, while others may expend more than is collected. This means that all participating employers and employees share the total cost of coverage, regardless of which plan they are in.

Excluding the plan subsidies, claims increased on average over the three-year period by approximately 9 percent – somewhat higher than national averages for the period, but not unreasonable. The plan cannot indefinitely subsidize rates by drawing down on its reserves or surpluses, and if this pattern continues, much higher rate increases will be passed on to participating employers and their employees. This, in turn, could spur some school districts to withdraw from the plan, as the NEA-Alaska Health Plan permits employers to withdraw annually.

Overall Observations about the NEA-Alaska Health Plan

The NEA-Alaska Health Plan provides coverage for approximately one-third of the State's school district employees and their eligible family members. The school districts that use the NEA-Alaska Health Plan appear to be a fairly stable group. The NEA-Alaska Health Plan has low marketing expenses because of its relationship to the NEA-Alaska. However, because of the required collective bargaining relationship, in 17 years of history, the NEA-Alaska Health Plan is unlikely to significantly increase its

penetration in the school district health plan market, absent a significant market disruption. Its provider network contracted through a TPA will have a difficult time competing with larger, more robust networks that large carriers, such as Aetna, Premera, and others may provide, which are essential to recognize significant discounts. The EBMS provider network will have difficulty providing the patient volume necessary to get the largest provider discounts in urban areas where provider competition is more feasible. Additionally, without a large provider network, the plan will be at a disadvantage when seeking reductions in administrative costs. It seems unlikely that the NEA-Alaska Health Plan could accommodate all school district employees.

Despite its current structure and arrangements with school districts, it is evident that the NEA-Alaska Health Plan fills a valuable role in the structure of health plan coverage for school districts and their employees. Based on our discussions with the CFO of the NEA-Alaska Health Plan, there is a strong focus on member services, quality of vendor services, and a pride in understanding the needs of school district employees. Although it is beyond the scope of this report, it would not be antithetical to any of the options presented in this report if there were a role for the NEA-Alaska staff and/or support in a State-wide health plan, which does not compromise its VEBA's tax-exempt status. Whether this could be a long-term relationship would depend on the cost of that relationship and the advantages it brings.

K. Other Collectively Bargained Arrangements

According to our school district survey results, the vast majority of school district health plans are the result of collective bargaining between a union and a school district. We did not examine the collective bargaining agreements, but would expect that the collective bargaining agreements, to various degrees, lock in the health plan arrangements for the term of the agreement. As discussed in section J of this report, collective bargaining agreements with NEA-Alaska are the basis for approximately one-third of all school district employees' health care coverage. Local 71, Laborers International Union of North America (LIUNA), represent approximately 350 custodians from the Anchorage School District, who is covered by the Local 71 Public Employees Trust Fund, a multiemployer health plan. In addition to the Local 71 Health Plan and Trust, school districts participate in a handful of other union-sponsored multiemployer health plans, covering a relatively small percentage of school district employees. To our knowledge the NEA-Alaska Health Plan does not surcharge school districts for leaving its Health Plan. We do not know whether the other multiemployer plans have surcharges for departing employers, though those arrangements are rare. Insured health plans would not have termination surcharges.

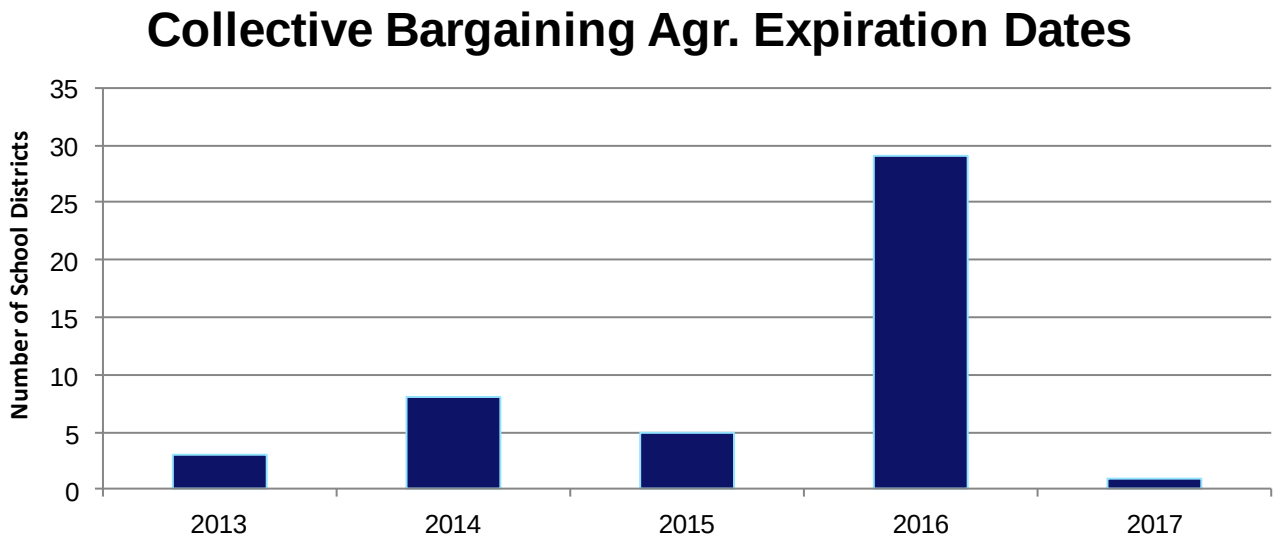
As indicated in the following chart, virtually all collective bargaining agreements expire by 2016 (presumably by June 30, 2016), with a handful expiring before that and one after that. The expiration dates of these agreements would be a major consideration

regarding the latest date a school district would be required to enter a State-run health plan, unless State law mandated a sooner or later change.

The fact that most collective bargaining agreements expire several years from now gives the State and school districts a reasonable amount of time to prepare for this transition. Implementation obstacles are discussed later in this report.

For example, legislation could mandate that a school district must enter the State health plan no later than the later of the expiration date of the last collective bargaining agreement or insurance policy in effect on the date the legislation's enactment.

Alternatively, legislation could provide an exemption for collectively bargained health plan coverage, or it could provide special accommodations for collectively bargained arrangements, but any accommodation would reduce potential savings, both in terms of delaying cost reductions and in terms of reducing the purchasing power that the State health plan would have because of a diminished group size.



L. Alaska Municipal Plan

Alaska provides access to health insurance for State municipalities, school districts, and other State political subdivisions through its Political Subdivisions Group Health and Life program (the Political Subdivision Health Plan). The Political Subdivision Health Plan is under the control of the State's Department of Administration, which arranges through a commercial health insurance carrier (currently Aetna) to make available health insurance to the participating employers.[11] The health benefit program is fully insured, and Aetna sets the rates for each of the four plan options available to participating employers. The Department of Administration is not involved in setting the rates. All of the plan options include medical, prescription drug, dental, vision, and auditory benefits.

We understand that governmental employers may annually opt in or out of the Political Subdivision Health Plan as they choose. The voluntary nature of the plan makes the underlying group highly volatile, making it difficult for an insurance company to reliably forecast health care costs. Typically, in this type of situation, an insurance company will require larger reserves (and thus higher premiums) to cover the risk of greater than predicted health care costs. In turn, these higher premiums tend to deter governmental employers from participating in the Political Subdivision Health Plan.

We understand that, generally, the Political Subdivision Health Plan is viewed as the health plan of last resort. That is, governmental employers generally do not obtain health insurance through the Political Subdivision Health Plan unless the premium rates they have been offered by other providers are more expensive for the benefit features they seek. This also suggests the premiums being charged under the Political Subdivision Health Plan include hefty reserves needed to cover claims if and when an employer withdraws from this plan. Indeed, in the course of our stakeholder interviews we heard about a situation in which a school district was faced with an extremely large rate increase from the Political Subdivision Health Plan, and joined the NEA-Alaska Health Plan, at a substantial rate reduction – though we were not told whether the before and after plans provided comparable benefits. Regardless of the reasons, the Political Subdivision Health Plan is not viewed as a good alternative for most school districts.

[11] The Political Subdivision Health Plan is exempt from paying the 2.7% insurance premium tax.

If the Political Subdivision Health Plan is not a good option for school districts, it may not be a good option for the 33 municipalities in this plan (4 of which are school districts). We have not examined why the Political Subdivision Health Plan is expensive, but as a matter of first principles for health plans, an unstable population is an expensive population.[12] If the State were to establish a self-funded health plan for school districts, we would expect that it also would be a good value for the municipalities that currently participate in the Political Subdivision Health Plan. For this reason, the State, in its enabling legislation, may want to consider creating an option for municipalities and other State instrumentalities to join the State-managed health plan for school districts.[13] Permitting municipalities to participate in a State health plan for school districts would also eliminate the problem that some boroughs have where the borough and the school district purchase health plan coverage jointly.

M. Cost Sharing

Cost sharing refers to the allocation of annual premiums (in the case of fully-insured plans) or annual contributions (in the case of self-insured plans) between the school district and employees. Typically cost sharing is expressed in terms of a percentage of the total health plan cost that the employee is required to pay. The percentage of total health plan costs paid by an employer is sometimes referred to as the "employer subsidy." Typically, in the private sector, employers provide a greater subsidy for employee coverage and a smaller subsidy for spouse and dependent coverage. Another aspect of cost sharing is how the health plan's total cost is allocated among single employees, employees with families, and other combinations of family units.

Alaska school districts structure health plan enrollment in three different ways:

- 40% offer one coverage tier or one composite rate regardless of number of dependents covered;
- 9% offer an "employee only" tier and a "employee plus dependent(s)" tier; and
- 51% offer a more traditional four tier method: employee only, employee plus spouse/domestic partner, employee plus child(ren) and employee plus family.

[12] There may be many other reasons that the Political Subdivision Health Plan may not be working, and we welcome an opportunity to examine that in greater detail.

[13] It is beyond the scope of this report to determine whether the health claims experience of school district employees is significantly different from those of municipal employees.

School district employees pay for roughly 11% of total health care costs for employees and dependents in aggregate. Twenty-one districts pay for the entire cost of health care; however, these districts are smaller and only represent 14% of all 53 school districts' spending. Of those 32 districts with cost sharing, the average employee share is 13%.

The table below shows the cost sharing breakdown:

Cost Sharing by District Size						
District Size	# of Districts	Districts with Cost Sharing	Health Care Costs PEPY	ER Cost Share	EE Cost Share	EE Cost Share %
0 - 24 Employees	10	6	$17,904	$16,472	$1,432	8.0%
25 - 49 Employees	12	5	$19,614	$19,083	$531	2.7%
50 - 99 Employees	14	7	$18,395	$16,873	$1,522	8.3%
100 - 499 Employees	11	9	$18,720	$17,337	$1,383	7.4%
500 - 999 Employees	2	1	$19,038	$18,333	$705	3.7%
1,000 - 6,000 Employees	4	4	$18,666	$16,257	$2,409	12.9%
	53	**32**	**$18,708**	**$16,727**	**$1,980**	**10.6%**

For purposes of comparison, we show below how State employee cost sharing varies by plan design. The chart shows that the State covers the full cost of Economy Plan coverage, and requires employees to pay for the difference when selecting the Standard or Premium Plan.

State Employee Cost Sharing				
AlaskaCare Plan	Health Care Costs PEPY*	ER Cost Share	EE Cost Share	EE Cost Share %
Premium Plan	$24,984	$16,668	$8,316	33.3%
Standard Plan	$18,432	$16,668	$1,764	9.6%
Economy Plan	$16,668	$16,668	$0	0.0%

*Health Care Costs include total medical plan premiums, Preventative dental plan, and no vision coverage

N. Summary

The analysis of the current structure of school district health benefit programs shows there are variations across plan design, funding, and cost sharing arrangements.

School districts have competitive plan designs combined with highly competitive premium cost sharing arrangements. School district cost sharing is at or above market median for the public sector, which contributes to higher health care costs for the districts.

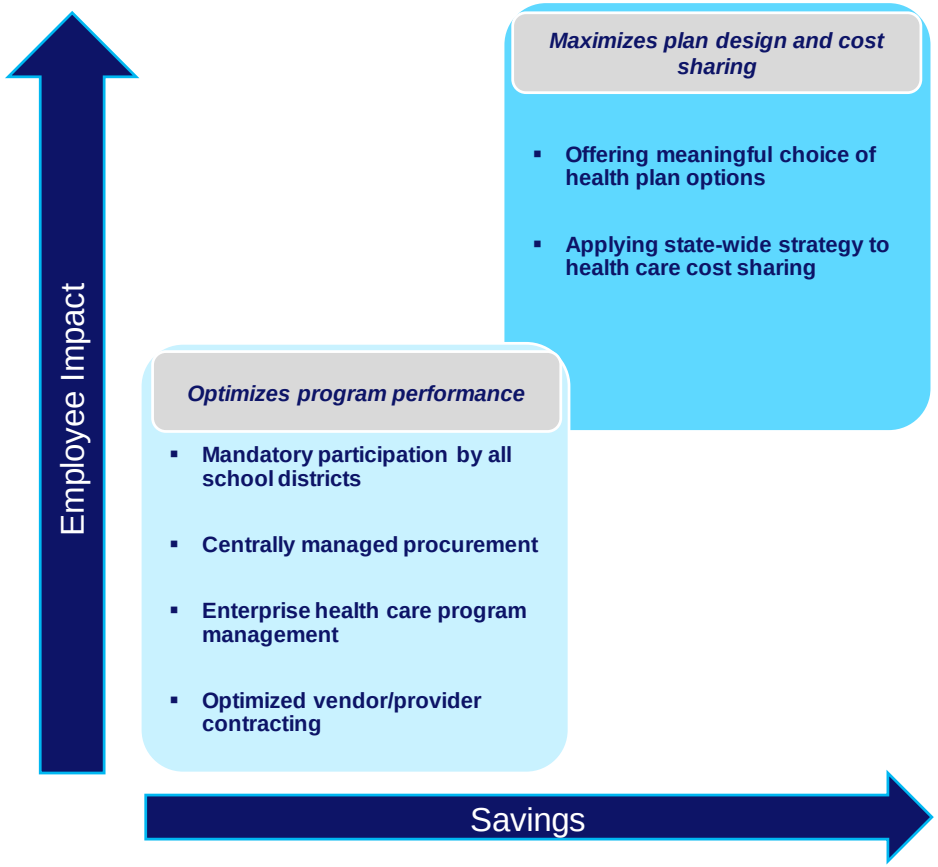
School districts are distributed fairly evenly among fully, partially and self insured funding arrangements and maintain relationships with a variety of health plan vendors. No health plan covers a majority of school district employees. The largest percentage of school district employees are covered by the NEA – Alaska Health Plan (38%) followed by Aetna/Meritain (30%). Thus two-thirds of the covered school district employees are covered by these two providers. The next largest group of employees is covered by TPAs, such as Rehn & Associates, which specializes in Taft-Hartley multiemployer plans; Moda Health, a provider with one office in Anchorage and one million covered lives combined in Oregon, Washington, and Alaska; and Integrity Administrators. As a general matter these TPAs must "rent" provider networks, which is a more costly approach than contracting directly with a large insurance carrier that can negotiate the best provider discounts. The fifteen school districts that are fully insured clearly present opportunities to reduce costs by moving them to a large self-insured arrangement, which does not have costs for insurance company reserves, commissions, profit, marketing and other insurance company overhead. The small self-insured plans, including those groups that participate in relatively small union-sponsored multiemployer plans, are not obtaining economies of scale and cannot provide large-scale innovative health programs.

We have incorporated these findings into the development of feasible options for consideration. All options are designed around the assumption of consolidating procurement, administration, and management. These best practices provide the foundation on which savings are based, with additional plan management strategies to gain further potential savings.

III. Options for Health Plan Consolidation

A. New Structure and Design Options

All options presented in this report for the State's health plan consolidation for school district employees will require centrally managed procurement, administration, and management from the State. The graph below shows a general overview of potential savings based on employee impact. Specific options from this chart are detailed further in this section.



It is important to recognize the lower left portion of the graph represents savings which are achieved purely through minimizing overhead, optimizing health care program management, and leveraging resources to obtain a better deal in contracting with vendors; all stakeholders benefit from this situation in providing the current level of benefits at a reduced cost.

The upper right portion of the graph represents, in some form, cost shifting from school districts to employees and their dependents through a reduction in the number of plan options, less rich plan designs and increased premium cost sharing.

Option 1 represents a scenario entirely in the lower left of the savings quadrant. Option 2 represents a scenario which moves partially to the upper right by leveraging the State's AlaskaCare plans. Option 3 represents a scenario entirely in the upper right by offering meaningful choice in plan design and a state-wide cost sharing strategy. Option 4 represents a moderated Option 3 scenario whereby there is a meaningful choice of plan design but school districts retain the discretion for setting cost sharing. This section outlines these options in detail; please refer to the Appendix for a one-page comparison summary of the options.

We considered the feasibility of putting all existing school district health plans under the State's management, but have not included that structure as one of our recommended options for several reasons:

- Attempting to manage so many different plan designs from a central office would be a daunting and an inefficient undertaking that would have a good chance of generating numerous errors and problems.
- Having the State maintain so many different plans would not yield appreciable savings because the economies and savings proposed in this report could not be readily accomplished.
- Using a large number of plan designs would not be efficient in terms of the administrative costs of processing claims and responding to customer inquiries.
- Many plan designs are aligned with particular administrative processes, making it difficult for some designs to be administered by a different administrator with a different network of medical providers.

For these and other reasons, a State takeover of plans in their current state is not, in our view, a viable solution.

Please note: an offset to the savings presented in these options should be considered for the cost of additional staff and consulting resources necessary to implement these options. In addition, we have not considered the impact to administrative service fees, as these fees are largely dependent on the network, employee population size, and plan complexity. Depending on the level of risk desired, a high level of individual stop loss insurance ($800,000 or above) can be considered to protect against catastrophic claims.

B. Option 1: Optimize Program Performance

This option consolidates all school districts into a combined pool with centrally managed procurement, enterprise health plan management, and optimized vendor/provider contracting by a state-managed entity (or Department). The table below outlines the sources of savings:

Source	Potential Savings
Provider Networks	
Medical provider network	$9,800,000 - $20,800,000
Pharmacy carve out	$1,000,000 - $1,700,000
Overhead	
Fully Insured Overhead	$1,200,000
Stop Loss Fees	$1,100,000
Broker Revenue	$4,000,000
Plan Design	Cost neutral
Cost Sharing	$0
Total Savings	**$17,100,000 - $28,800,000**
% of total costs	**5.8% - 9.8%**

Provider Network

The Department will leverage buying power to procure advantageous provider discounts. In addition, the Department should leverage size to obtain an improved PBM carve out plan.

Overhead

Fully-insured overhead, stop loss fees, and broker revenues will be eliminated by self-insuring the state managed pool. However, it may be prudent to purchase a high level of individual stop loss to insure against catastrophic claims at least until the State plan has sufficient experience to appropriately set rates.

Plan Design

Under option 1, we propose a gradual reduction and narrowing of the health plan design options available to school districts. Perhaps initially as many as seven different plan design options might be offered to minimize the disruption from the status quo. Gradually, over time, the number of plan design options could be reduced – further increasing efficiencies and lowering costs.

Rate Setting/Cost Sharing

In option 1, the Department handles rate setting for all plan designs offered by school districts based on pooled experience. As part of the rate setting process, total premium rates are determined and charged to school districts who can then independently determine how much to charge their employees and dependents for coverage. We have assumed school districts maintain current cost sharing levels under this option.

The following table outlines the positive and negative outcomes associated with Option 1:

Positive Outcomes	Negative Outcomes
Cost savings with same level of benefits	Reduce district decision-making
Improve vendor contract terms	Reduce district staff administration
Increase in compliance	Increase State administration
Reduce annual volatility in costs	
Consistent benefits offering to all districts	
Reduce duplicative resources[14]	
Efficient health management	
Simplified collective bargaining	
Districts allowed to set contributions	

[14] Resources refers to district staff tasked with managing current health care programs. A centrally managed program will reduce or eliminate work currently performed at the district level.

C. Option 2: Utilize the Department of Administration's AlaskaCare

This option consolidates all school districts into a combined pool with centrally managed procurement, enterprise health plan program management, and optimizes vendor/provider contracting by leveraging the AlaskaCare program managed by the Department of Administration (DOA). It also adopts the plan options currently available through AlaskaCare. The following table outlines the sources of cost and savings:

Source	Potential Savings
Provider Networks	
Medical provider network	$9,800,000 - $20,800,000
Pharmacy carve out	$1,000,000 - $1,700,000
Overhead	
Fully Insured Overhead	$1,200,000
Stop Loss Fees	$1,100,000
Broker Revenue	$4,000,000
Plan Design	($25,800,000) - $6,100,000
Cost Sharing	$0
Total Savings	**($8,700,000) - $34,900,000**
% of total spend	**(2.9%) - 11.8%**

Under option 2 we show that, depending on which AlaskaCare plan design options are available and selected by school districts, the impact could range from costing an additional $8.8 million to saving $6 million. This is because the AlaskaCare-Economy Plan is close in value to the value of the average school district health plan, while the AlaskaCare Standard and Premium Plans are considerably more valuable than the average school district plan. To illustrate this point, if all school districts could and did elect the AlaskaCare - Premium Plan, it would increase overall cost by almost $26 million.

This raises the question of why this option 2 should be considered, given the potential for increased costs due to richer plan designs currently offered through AlaskaCare. AlaskaCare represents an established entity that has the capability to administer

large programs and can use its size to leverage savings in other areas, such as provider networks and overhead. The State can mitigate the risk of increased plan design costs by only offering the Economy and/or Standard plans to employees.

Provider Network

The DOA will leverage buying power to obtain advantageous provider discounts. In addition, the DOA should leverage size to obtain an improved PBM carve out plan.

Overhead

Fully-insured overhead, stop loss fees, and broker revenues will be eliminated by self-insuring the state managed pool. However, it may be prudent to purchase a high level of individual stop loss to insure against catastrophic claims.

Plan Design

The following table provides an overview of the three AlaskaCare plan designs, ranging from the most valuable (i.e. the plan that the State pays the largest share of health care costs) in the Premium Plan, to the least valuable Economy Plan.

For consistency in analysis and modeling, these AlaskaCare plans represent the July 1, 2012 to June 30, 2013 plan designs which is in-line with the plan year of the survey. The DOA is currently in a six month plan year (July 1, 2013 – December 31, 2013) in order to change from a fiscal plan year to a calendar plan year.

Plan Design Summary			
In-Network Plan Design	**AlaskaCare Premium Plan**	**AlaskaCare Standard Plan**	**AlaskaCare Economy Plan**
Individual Deductible	$250	$250	$500
Family Deductible	$500	$500	$1,000
Individual Out-of-Pocket Max	$300	$1,000	$2,000
Family Out-of-Pocket Max	$600	$2,000	$4,000
Primary Care Visit	Coinsurance		
Specialist Visit			
Inpatient Visit	10%	20%	30%
Retail Generic Rx Copay	20% coinsurance $13 minimum, $61 maximum		
Retail Preferred Brand Rx Copay			

The following table compares the value of each AlaskaCare plans to the lowest quartile (P25), median (P50) and highest quartile (P75) of school district plan values. A positive percentage indicates a richer AlaskaCare plan. The table shows that, on average, the AlaskaCare Premium plan is 13.6% richer than the median (P50) school design plan design. This means the Premium plan is expected to reimburse claimants 13.6% more than the P50 plan design of school districts; hence the Premium plan is a richer plan. The table also indicates that the AlaskaCare - Economy plan is approximately 5% more valuable than the school district plans in the lowest quartile (P25), 2% more valuable than the median school district plan, and 2% less valuable than the average school district plan. In other words, the AlaskaCare- Economy plan is very similar in value to the typical school district plan.

State AlaskaCare Plan Relative Values			
Relative Values *(From School District Plan to AlaskaCare)*	**AlaskaCare Premium Plan**	**AlaskaCare Standard Plan**	**AlaskaCare Economy Plan**
P25	17.3%	13.1%	5.4%
P50	13.6%	9.5%	2.0%
P75	6.1%	2.3%	-4.7%
Average	9.0%	5.1%	-2.1%

From a pure plan design perspective, moving to the State's AlaskaCare plans can add cost or create savings based on which plans school district employees elect. If an employee elects coverage under a richer plan than they currently have, the health care cost for this employee should increase, as more claims costs will be covered by this richer plan. Savings can be achieved if employees overall elect less rich plans. This variability in plan selection creates an uncertainty in the financial impact of this change. Strategy around which plans and at what cost-sharing to offer would mitigate this uncertainty.

Based on our analysis, an estimated $6.0 million can be saved by offering only the Economy Plan to all school district employees and eliminating all other options. This savings represents the reduction in claims paid by the Economy plan.

Rate Setting/Cost Sharing

In this option, the DOA handles rate setting and administration. School districts would be rated separately from current State employees. As part of the rate setting process, total premium rates would be determined and charged to school districts which can then independently determine how much to charge their employees and dependents for coverage. For the purposes of estimating impacts, we have assumed school districts maintain current cost sharing levels under this option.

The table below outlines the positive and negative outcomes associated with Option 2:

Positive Outcomes	Negative Outcomes
Cost savings but different benefits	Reduce district decision-making
Improve vendor contract terms	Reduce district staff administration
Increase in compliance	Disruption in plan design
Reduce annual volatility in costs	Collective bargaining restricted
Consistent benefits offering to all districts	
Reduce duplicative resources	
Efficient health management	
Districts allowed to set contributions	
Leverage State resources already in place	

D. Option 3: Centrally Managed School District Program with Standard Health Plan Options and Cost Sharing

This option builds upon Option 2 by further enhancing the procurement, administration and management of the pooled school district health insurance by either building onto the current administrative structure the DOA has in place or establishing a new entity to manage procurement and the administration of the State's school district plans. The primary difference under Option 3 is that employees would be offered a different menu of health plan options than the current AlaskaCare lineup that are more closely aligned with current school district offerings. In addition, Option 3 creates a uniform premium cost sharing strategy for school districts to follow. The table below outlines estimated potential savings:

Source	Potential Savings
Provider Networks	
Medical provider network	$9,800,000 - $20,800,000
Pharmacy carve out	$1,000,000 - $1,700,000
Overhead	
Fully Insured Overhead	$1,200,000
Stop Loss Fees	$1,100,000
Broker Revenue	$4,000,000
Plan Design	($7,700,000) - $36,100,000
Cost Sharing	$13,300,000 - ($31,200,000)
Total Savings	**$22,700,000 - $33,700,000**
% of total spend	**7.7% - 11.4%**

Provider Network

The DOA or new entity will leverage buying power to procure advantageous provider discounts. In addition, the DOA should leverage size to obtain an improved PBM carve out plan.

Overhead

Fully-insured overhead, stop loss fees, and broker revenues will be eliminated by self-insuring the state managed pool. However, it may be prudent to purchase a high level of individual stop loss to insure against catastrophic claims.

Plan Design

Offer three plan options to employees: High deductible plan, Basic plan (median) and Enhanced plan (P75). If employees migrate to the Enhanced plan or richer plans than they currently have, health care costs should increase, by an estimated $7.7 million, as more claims costs will be covered by the richer plan. Maximum savings of an estimated $31.6 million can be achieved if employees overall elect less rich plans; however, it is more probable that employees will select a comparable plan, resulting in plan design savings in the middle of the range. This variability in plan selection creates an uncertainty in the financial impact of this change. Strategy around how many and which plans to offer would mitigate this uncertainty.

Plan Design Summary			
In-Network Plan Design	**HDHP**	**Basic**	**Enhanced**
Individual Deductible	$1,500	$525	$200
Family Deductible	$3,000	$1,575	$600
Individual Out-of-Pocket Max	$3,500	$4,000	$1,900
Family Out-of-Pocket Max	$7,000	$12,000	$5,700
Primary Care Visit	20%	20%	20%
Specialist Visit	20%	20%	20%
Inpatient Visit	20%	20%	20%
Retail Generic Rx Copay	$0	$10	$10
Retail Preferred Brand Rx Copay	$0	$20	$20
Reimburses % of Allowed Charges	76%	86%	90%

Cost Sharing

Set the Enhanced (or P75) plan employee contributions at 15%, the Basic (or median plan) contributions at 5%, and require no employee cost sharing for the High Deductible Health Plan. There is a cost savings of $13.3 million associated with more

enrollment in the Enhanced plan, as the proposed 15% cost sharing is higher than current cost sharing. This runs counter to the plan design impact of increased Enhanced plan enrollment, but is reasonable based on current enrollment and cost sharing levels. If more employees elect the Basic or High Deductible Health Plans, the savings associated with cost sharing will decrease, as the cost sharing levels will remain similar to current levels. At the extreme, if all employees elect the no cost plan, costs would increase by an estimated $31.2 million.

The table below outlines the positive and negative outcomes associated with Option 3:

Positive Outcomes	Negative Outcomes
Cost savings but different benefits	Eliminate district decision-making
Improve vendor contract terms	Reduce district staff administration
Increase in compliance	Disruption in plan design
Reduce annual volatility in costs	Collective bargaining restricted
Consistent benefits offering to all districts	
Reduce duplicative resources	
Efficient health management	
All districts have same contributions	

E. Option 4: Centrally Managed School District Program with Standard Health Plan Options Only

Option 4 is a variation of option 3 that provides continued discretion to school districts to set their own premium cost sharing levels based on their individual requirements. The table below outlines the potential savings under this option 4:

Source	Potential Savings
Provider Networks	
Medical provider network	$9,800,000 - $20,800,000
Pharmacy carve out	$1,000,000 - $1,700,000
Overhead	
Fully Insured Overhead	$1,200,000
Stop Loss Fees	$1,100,000
Broker Revenue	$4,000,000
Plan Design	($7,700,000) - $36,100,000
Cost Sharing	$0
Total Savings	**$9,400,000 - $64,900,000**
% of total spend	**3.2% - 22.0%**

Provider Network

The DOA or new entity will leverage buying power to procure advantageous provider discounts. In addition, the DOA should leverage size to obtain an improved PBM carve out plan.

Overhead

Fully-insured overhead, stop loss fees, and broker revenues will be eliminated by self-insuring the state managed pool. However, it may be prudent to purchase a high level of individual stop loss to insure against catastrophic claims.

Plan Design

Offer three plan options to employees: High deductible plan, Basic plan (median) and Enhanced plan (P75). If employees migrate to the Enhanced plan or richer plans than they currently have, health care costs should increase, as more claims costs will be covered by the richer plan. Maximum savings can be achieved if employees overall elect less rich plans; however, it is more probable that employees will select a comparable plan, resulting in plan design savings in the middle of the range. This variability in plan selection creates an uncertainty in the financial impact of this change. Strategy around how many and which plans to offer would mitigate this uncertainty.

Plan Design Summary			
In-Network Plan Design	**HDHP**	**Basic**	**Enhanced**
Individual Deductible	$1,500	$525	$200
Family Deductible	$3,000	$1,575	$600
Individual Out-of-Pocket Max	$3,500	$4,000	$1,900
Family Out-of-Pocket Max	$7,000	$12,000	$5,700
Primary Care Visit	20%	20%	20%
Specialist Visit	20%	20%	20%
Inpatient Visit	20%	20%	20%
Retail Generic Rx Copay	$0	$10	$10
Retail Preferred Brand Rx Copay	$0	$20	$20
Reimburses % of Allowed Charges	74%	86%	90%

Cost Sharing

Districts will have the discretion to set employee contributions that best meets their financial and employee retention needs. For impact estimation purposes, we have assumed districts will continue current cost sharing practices, resulting in no additional cost and no savings. In addition, under this option, cost sharing is not used in conjunction with plan design to optimize the allocation of costs. As a result, the range of savings is much greater under this option than in option 3.

The table below outlines the positive and negative outcomes associated with Option 4:

Positive Outcomes	Negative Outcomes
Cost savings but different benefits	Reduce most district decision-making
Improve vendor contract terms	Reduce district staff administration
Increase in compliance	Disruption in plan design
Reduce annual volatility in costs	Collective bargaining restricted
Consistent benefits offering to all districts	
Reduce duplicative resources	
Efficient health management	
Districts retain cost sharing discretion	

F. Other Advantages of Creating a Centrally Managed Program

Creating one large group has several other advantages. First, it ensures benefit comparability across all districts. Second, it facilitates ease of communication to members regarding benefit changes such as changes in the generic status of drugs. Third, it makes it possible to take full advantage of the size of the group and have the purchasing power to negotiate with carriers and obtain favorable contract provisions and service arrangements. Fourth, it creates credibility in experience used for forecasting and understanding trends in health care claims.

Also effective plan administration is essential to providing benefits effectively and is critical for customer satisfaction. The advantage of being one large group is partnering with best in class vendors with the best resources to administer and manage all aspects of the plan.

G. Additional Opportunities to Reduce Costs and Improve Health Outcomes

There may be additional areas of savings not included in the estimates for these options. A very small number of school districts currently utilize a health and welfare consultant to procure or manage health benefit programs. One of the benefits of a state-managed health insurance pool is the opportunity to implement and execute a health and welfare benefits strategy over the entire group in order to maximize benefits for school districts employees.

The following tables show a wide array of possible strategies the State can pursue to maintain affordable health care and encourage healthy living. The various plan design management and administration strategies are viewed in three categories:

- Estimated financial impact
  - $ represents a small financial impact (less than 1% of total claims)
  - $$ represents a medium financial impact (1% to 5% of total claims)
  - $$$ represents a large financial impact (above 5% of total claims)
- Administration (Admin)
  - **Red** represents a plan design with a higher potential for administration challenges
  - **Yellow** has a medium level of administrative challenges
  - **Green** represents a plan design which is routine to administer
- Prevalence
  - Determines if the plan design is typically offered among other organizations

Design Change	Financial Impact	Admin	Prevalence
Medical Plans			
Introduce a high deductible health plan with health savings account (HSA) or health reimbursement account (HRA)	$$		Prevalent
Separate coinsurance or co-pays based on specified facilities or networks	$-$$		Not prevalent but trending
Promote the use of accountable care organizations (ACO)	$-$$		Not prevalent but trending
Promoting high performance networks	$-$$		Not prevalent
Prescription Drug Plans			
Adding a fourth tier for specialty drugs	$-$$		Prevalent
Custom drug formulary	$		Not prevalent
Value based copays (diabetes, blood pressure, osteoporosis, cholesterol)	$-$$		Not prevalent but trending
Coinsurance design (with minimums or maximums)	$$		Prevalent
Mandatory generics	$$		Somewhat prevalent
Step therapy	$$		Somewhat prevalent
Wellness Programs			
Tobacco cessation programs	$$		Prevalent
Weight management programs	$$		Prevalent

Exercise programs	$		Prevalent
Screenings (biometric, BMI, cholesterol, glucose, etc.)	$$		Prevalent and trending
Health Risk Assessments	$$		Prevalent
Establish a Primary Care Physician for all employees	$		Prevalent
Health fair	$		Prevalent
24/7 nurse line	$		Prevalent
Nutrition education	$		Not prevalent
Health coaching	$		Not prevalent but trending
On-site physical exam	$		Not prevalent
Patient Advocacy	$-$$		Not prevalent but trending
Administration			
Direct contracting with providers	$$		Not prevalent
Claim audits (medical, Rx, disability)	$		Prevalent but not frequently done
Dependent verification audits	$-$$		Somewhat prevalent
Eligibility management	$-$$		Somewhat prevalent
Reference pricing	$		Not prevalent
Facility audits (provider billing practices)	$		Not prevalent
Telemedicine	$		Not prevalent

Medical tourism	$		Somewhat prevalent
Create State stop-loss trust	$-$$		Not prevalent
Cost Sharing			
Establish and implement a cost sharing philosophy	$$		Prevalent and trending upward
Banding: requiring higher contributions or deductibles to be met for higher income levels	$		Not prevalent
Fix future contributions to ACA safe harbor requirements	$$$		Not prevalent
Apply wellness credits to employee premiums	$		Not prevalent, but trending
Surcharges			
Tobacco surcharge	$-$$		Not prevalent, but trending
Spousal surcharge	$-$$		Not prevalent, but trending
Wellness surcharge	$		Not prevalent
Obesity surcharge	$		Not prevalent

H. Analysis of Other Considerations Associated with the Options

There are numerous advantages and disadvantages to establishing a State-run health plan for school districts and their employees. On balance, we think the advantages significantly outweigh the disadvantages and obstacles to creating such a plan. Overall, a State-run health plan, with mandatory participation and minimal exemptions to school district participation, is expected to result in short and long-term savings, improved health care, reduced administrative burdens on school district leadership and staff, greater cost stability, more money for school districts to spend on their core mission of educating children, and helping to attract and retain the best staff.

i. Cost Reductions

As our analysis indicates, there are savings to be had if the State were to create a State-wide health plan requiring all school districts to participate. Considerably smaller savings would be expected if school district participation were optional.

It would be difficult to gain the cost savings of a self-insured plan if the State plan were voluntary because, as is the case with the Municipal Employee Health Plan, it is difficult to determine from year to year how many employees and family members will be covered by the State plan. Without this stability, the allocation of administrative costs (including stop-loss insurance to protect against the risk of large claims) and the reliable projection of claims costs are seriously undermined, which increases costs.

ii. Provide Sophisticated Vendor Selection and Monitoring Across the Entire State

We understand many small school districts are at a disadvantage to obtaining the best possible contracts with vendors because of their lack of bargaining power. A State-wide health plan would presumably ensure the State plan has the sophistication and resources to select the best providers at the best prices. Additionally, by putting this responsibility on the State, it substantially reduces the time, effort, and resources that all school districts – regardless of size – must employ to periodically evaluate vendors, negotiate new contracts with them, and monitor vendor performance. Having each school district do this separately is inefficient and does not optimize the results for small and rural school districts that need the most help.

iii. Reduce Administrative Burdens on School Districts

In our interviews with stakeholders and our review of testimony at the SFC hearings, we understand that school district leaders believe school districts spend too much time and resources analyzing health care proposals and dealing with health plan issues, including monitoring health plan vendor performance, negotiating pricing, and related matters such as negotiations with unions over the vendors. Our survey results suggest that on average less than one full staff person is allocated to this work in each school district.

A State-wide health plan would eliminate the need for much of the work school districts now expend dealing with health insurance or self-funded health plans, provided the State plan is well administered and managed. However, we anticipate districts will remain involved in decision-making through an advisory board or committee.

iv. Simplify Collective Bargaining

The creation of a State health plan for school district employees would optimize results if the existing law were modified to require school districts to purchase their health care coverage from the State plan. Other aspects of health care coverage could remain the subject of collective bargaining, where applicable. For example, the overall goals of cost reduction, improving health care and reducing school district administrative burdens could still be met even where a school district maintains discretion over:

- which of the State plan options the school district would purchase (provided there is more than one option);
- the portion of the total cost of health care coverage premiums (contributions) will be paid by the school district and how much will be paid by employees (cost sharing); and
- which coverage tiers will be offered; e.g., single coverage, family coverage, etc.

Continuing to allow school districts to adjust these elements of health care cost would still give unions and school districts some discretion over the allocation of health plan costs. But it may also be a source of contention between school boards and unions. To further reduce the possibility of disputes over health care coverage, the State could establish a single plan of coverage and could establish a fixed cost-sharing percentage (e.g., school districts pay 80% of the premiums). This would mandate the same health benefits and the same cost for all school district employees across the State. If this were done, school districts would need to focus on other ways to attract and retain qualified employees to their school districts.

Perhaps the organization with the greatest stake in the status quo will be the NEA-Alaska, which sponsors the NEA-Alaska Health Plan, covering over 5,800 school district employees, plus their families. Unless the NEA-Alaska Health Plan were willing and able to change its governance structure and its governing trust document, we do not see how the NEA-Alaska Health Plan could have a meaningful role in providing health benefits to school district employees over the long term if the State requires all school districts to participate in a State health plan.[15]

In order for the NEA-Alaska Health Plan to continue providing coverage to school district employees, the State would need to consider: (1) grandfathering all existing arrangements with plan providers, including but not limited to the NEA-Alaska Health Plan; (2) permitting school districts to opt out of the State plan if they meet certain requirements (e.g., demonstrate they can obtain comparable or better benefits at an equal or lower price); or (3) having a collective bargaining agreement that requires the school district to use a particular health plan or vendor. As indicated in this report, all such exemptions will decrease savings expected from the State health plan.

There are a few other school district arrangements that require the school district to participate in a multiemployer union health plan or the Alaska Public Employees Insurance Group. There are relatively few of these arrangements and the number of people covered by these other union health plans is relatively small.

v. Create a Dependable Pool of Employees and Eligible Dependents, Creating Stable Rates

As indicated in this report, requiring mandatory participation in a State health plan will help ensure reasonably stable rates and the long-term viability of such a plan[16]. Because of the potential enrollment volatility in a voluntary plan, they usually are insured arrangements, which, as discussed throughout this report, typically mean higher administrative costs. Some school districts indicated in our survey that the people covered by their health plans are relatively young and healthy. If it

[15] The NEA-Alaska Health Plan is funded through a VEBA trust under section 501(c)(9) of the Internal Revenue Code. As such the organization must satisfy certain requirements, which, in similar arrangements, includes a bargaining relationship with 90% or more of its members. For the NEA-Alaska Health Plan, as a funded entity, to play a different role in the provision of health care to school districts and other governmental groups without a collective bargaining relationship through NEA-Alaska (or its affiliates) would likely create a significant legal challenge to the NEA-Alaska Health Plan.

[16] When we refer to "stable" rates we mean rates that do not vary drastically based on large swings in enrollment. We also cannot anticipate the possibilities of significant changes in the structure or delivery systems of health care that could dramatically alter the cost or efficacy of coverage under a State-wide plan.

is true that some school district employee groups are healthier (with lower claims costs), it is altogether possible that by combining the school district health plans into a single rate group for purposes of setting contribution (or premium) rates, the school districts with young and healthy groups could experience higher premium rates than they would if rated separately by themselves.[17] Although this is very plausible in the short-term, over the long-term, all school districts will benefit from a stable pool of experience, which would contain people covering the spectrum of age and health. Even though school districts might currently experience lower health care costs based on population and demographics, all populations change over time and in general, the bigger the population, the less volatility the population experiences.

vi. Effect on the State Public Employees Retirement System (PERS) and Teacher Retirement System (TRS)

The State's Retirement Systems provide retiree health care coverage. As an initial matter we would not advise that a State health plan for active employees and their families take on the additional responsibilities for providing retiree health coverage. If and when the new State health plan is fully functioning and has demonstrated its advantages over school district-purchased health coverage for active employees, then it might be worth considering whether it would be more efficient to move the responsibilities for retiree health coverage from the Retirement Systems to the new State health plan. We would recommend waiting at least five years to see whether the new State health plan is viable for retiree health care coverage

It is conceivable that if a State-wide health plan were to improve the quality of healthcare across the State, retirees might live longer, raising retirement costs. It is unlikely, however, that a direct correlation between the creation of a State health plan and health and mortality improvements could be established.

Beyond this observation we have not analyzed the retiree health coverage provided through the Retirement Systems, other than to note that the health benefits provided through the Retirement Systems are protected by the State's Constitution against net reductions.

[17] As noted elsewhere in this report, the NEA-Alaska Health Plan, and undoubtedly some if not all of the other multiemployer union health plans, combine experience across several employers when setting contribution rates. So while a young and healthy group may help to keep rates low, that group is being combined with other groups with other characteristics, thus resulting in a blended rate that reflects the experience of everyone in the rating pool.

vii. Example Impact on a Sample School District

The following example illustrates how consolidation would affect an individual school district. Assume the following facts:

- 400 employees electing health care
- The school district offers a relatively rich plan design to its employees
  - The plan is expected to reimburse 14% more of the health care claims than the median plan design of all school districts
- Employees currently pay $736 per year for this plan, or 3% of the total health insurance cost
- The school district pays $22,064 per employee, which is 97% of the total health insurance cost
- This school district is partially insured and pays stop loss insurance premiums of $80,000 to insure against catastrophic claims
- The district pays $125,000 to the brokerage firm in exchange for assistance in procurement of health plans

	Total Health Insurance Cost		Employer Cost		Employee Cost				
Total Employees Electing Health Care	Total Spend	PEPY	Total Spend	PEPY	Total Spend	PEPY	Avg. Employee Cost Share	Plan Design Value Relative to P50	Insured Arrangement
400	$9,119,838	$22,800	$8,825,449	$22,064	$294,389	$736	3%	1.14	Partially Insured

Option 1:

Based on optimized health plan performance in the State-managed health plan, the State, and not the school district, would handle the administration and procurement of the health plan program. The State would offer a plan very similar to the district's current plan so there is no change in plan design. The school district would not pay a broker to help procure health insurance, nor would the district pay fees for stop loss insurance. Based on the State's buying power and centrally-

managed procurement, improved contracting can be achieved through increased medical provider networks and PBM carve out arrangements both of which reduce total health insurance cost by lowering claim amounts.

Result: The school district offers the same plan to its employees at a reduced cost to the district: between $800,000 (9%) and $1,440,000 (16%)[18]. The district decides how to set contributions for its employees; the new employee cost for the same health plan will be determined by the district.

Option 2:

Similar to option 1, the State, and not the school district, would handle the administration and procurement of the health plan program. However, the school district would be forced to choose different plan design(s) to offer to its employees. The district would have the choice of offering any combination of the DOA's AlaskaCare plans. Because the district's current plan is similar in value to the AlaskaCare Premier plan, the district chooses to offer all three plans (Premier, Standard, and Economy) to employees. With the new plan design options, for each employee who elects the Standard or Economy plan, the district saves money in the form of claims avoidance since these plans typically reimburse less claims costs than the Premier plan. All plans are offered based on the improved contracting and reduced overhead based on the State-managed pool.

Result: The school district offers its employees only the Economy plan at a reduced cost to the district: between $1,670,000 (18%) and $2,250,000 (25%)[19]. The district decides how to set contributions for its employees; the new employee cost for the same health plan will be determined by the district.

Option 3:

Similar to option 2, the school district will no longer be able to offer their current plan. Three new plan designs will be offered to the district's employees: an Enhanced, a Basic, and a HDHP. The district's current plan is relatively rich and more generous than the Enhanced plan. As a result, each plan design would typically reimburse less in claims costs which

[18] Savings estimates assume the district utilizes EBMS in the 995 zip code area, an integrated PBM, $80,000 in stop loss fees, and $120,000 in broker revenue. No savings is calculated from changing cost sharing as the district can decide to keep employee contributions unchanged. Although this savings estimate is calculated at the district level, this assumes no adjustment was made to account for an increase or decrease in medical/prescription utilization.

[19] In addition to the savings assumptions from Option 1, the Option 2 savings estimates assume a 10% decrease in medical/prescription claims based on the Economy plan design.

saves the district money. In addition, employee contributions are fixed at 15% for the Enhanced plan, 5% for the Basic plan, and 0% for the HDHP. Because district employees currently pay for 3% under their current plan, employees would pay higher contributions in the Enhanced or Basic plans, but nothing in the HDHP.

Result: The school district offers three plans of less rich plan design but also more favorable contracting which reduces district costs: between $2,150,000 (24%) and $2,700,000 (30%)[20]. Employee contribution rates are fixed by the State which results in employees paying more in the Enhanced and Basic plans but less in the HDHP.

Option 4:

Similar to option 3, the plan design options are an Enhanced, a Basic, and a HDHP. The district's current plan is relatively rich and more generous than the Enhanced plan. However, in this option, the district has discretion in setting contribution amounts for employees.

Result: The school district offers three plans of less rich plan design but also more favorable contracting which reduces district costs: between $2,020,000 (22%) and $2,570,000 (28%)[21]. The district decides how to set contributions for its employees; the new employee cost for each health plan will be determined by the district.

[20] In addition to the savings assumptions from Option 1, the Option 3 savings estimates assume 25% of employees will enroll in the Enhanced plan, 25% will enroll in the Basic plan, and 50% of employees will enroll in the HDHP plan. The Enhanced plan assumes a 6% decrease in medical/prescription claims, the Basic plan assumes a 12% decrease in claims, and the HDHP assumes a 20% decrease in claims based on the comparison to the current plan design.

[21] In addition to the savings assumptions from Option 3, the Option 4 assumes no savings is calculated from changing cost sharing as the district can decide to keep employee contributions unchanged.

IV. Implementation

A. Barriers to Implementation

There are numerous barriers to implementation, assuming the Legislature and Governor come to terms on a new State health plan for school district employees. As noted in this report there are various stakeholders who would be expected to oppose a State-run health plan. But assuming these obstacles are overcome and a State-wide health plan for school district employees was enacted into law, several barriers to implementation exist.

Assuming the State's DOA oversees the State health plan for school districts and their employees, the DOA would face a number of challenges. It would need additional staff support and consulting expertise to handle the increased load. Although we have not attempted here to quantify the additional resources that would be needed, we would anticipate that at least four full-time equivalent positions would be needed to manage a new State-wide health plan that has the potential of covering more than 45,000 lives.

When we talked to the DOA, we learned that AlaskaCare is transitioning to Aetna as the principal TPA. This, in and of itself, is a large and ambitious undertaking. Additionally the DOA has a number of other priorities in terms of making AlaskaCare effective and efficient. We cannot comment on how successful the DOA will be with this undertaking and its other initiatives. We are concerned that if the State were to mandate that the DOA manages a large State-wide health plan for school district employees before the DOA is ready to take on that obligation the new plan might not get off to a good start.

It is critical that staff responsible for a new health plan of this magnitude be given adequate time to properly plan and prepare for the transition. Generally we would suggest 12 to 18 months lead time from legislative enactment to the expected opening of the plan.

We would anticipate that a new State-wide health plan would be self-sustaining, and not require State funding. However, depending on the details of the funding and structure of a new State-wide health plan it may be prudent for the State to provide additional financial seed money that will help ensure the new health plan remain financially stable through the first few years of its operations, with the expectation that the health plan could gradually, over time, repay the State.

Given the still early implementation stages of the ACA's Exchanges, we cannot anticipate what impact these Exchanges will have on the healthcare marketplace in Alaska and how health insurance companies will respond over the next 5-10 years. While we do not anticipate the Exchange in Alaska will have an adverse effect on a new State-run health plan for school district employees, we cannot predict how the ACA will impact employer-sponsored health plans.

B. Governance Structure of New Health Plan

A new State-run health plan for school districts and their employees and families should be under the control of the DOA. Whether that would be run under the same unit as AlaskaCare or a separate unit should be evaluated.

If the new State health plan is not made a part of AlaskaCare and the existing management by the DOA, there are a number of options for managing a State-run health plan for school district employees. Some states have put these plans under the direct control of an executive unit under the governor's control. This could be under the same unit that controls the state employee health plan, or it could be a separate executive department, such as administration, finance, health, or labor, as just a few examples. Each state has its own considerations. Putting the State health plan for school employees under the direct control of the governor's office could be expected to stir objections that traditional stakeholders in the school districts' healthcare decisions are being left out of the process. Getting stakeholder buy-in is an important consideration.

If a separate structure for a State-managed health plan for school districts and their employees were established, we recommend the State health plan for school employees be governed by a board (Board) consisting of members representing various stakeholders appointed by the Governor and confirmed by the Legislature. Commonly boards of this type have representatives of State administration, school district administrators, employees, unions, and noted experts in related fields. The Board should have the power to determine and implement the details of the plan administration set forth in statutes and to adopt regulations pursuant to those statutes for the effective management and operation of the plan. The Board should have the flexibility to select service providers and enter into contracts, set contribution rates, plan designs, eligibility rules, and perform most functions of a plan sponsor, subject to the State's controls and oversight.

C. Phased-in School District Participation

If participation in a State-wide health plan is mandatory, school district participation in the State plan should be phased in over time to ensure an orderly transition. Once a State plan is open for business, school districts should be allowed to participate, after a reasonable communications and enrollment period. However, school districts that do not participate voluntarily would be required to participate within a time period specified by law following the expiration of the collective bargaining agreement in effect as of the enactment date of the plan legislation, disregarding any automatic or mutually agreed-upon extensions. For those employees not covered by a collective bargaining agreement, they would be required to participate in the statewide plan upon its initial coverage date.

State law could override collective bargaining agreements with respect to the date that school districts could be required to participate in the statewide plan; however, in our view, that would be disruptive to existing coverages and arrangements, and there is an advantage to growing the statewide plan gradually as collective bargaining agreements expire.

As indicated throughout this report, the more flexibility the State allows and the more a new State-wide health plan accommodates school district autonomy, the less the potential savings are to be realized. If, for example, the State were to give school districts an additional five years before they were required to join the State health plan, that would smooth the transition, but reduce the expected savings.

D. Statewide Plan Eligibility

Legislation could consider addressing the situations where school districts and local municipalities (commonly borough governments) jointly purchase healthcare coverage for their employees. In our interviews with stakeholders, people expressed concern that under a State-wide plan for only school districts and their employees, the local municipalities would probably pay more for health insurance because they would lose size and purchasing power.[22]

Absent some constraints we are not aware of, there should be no inherent reason to prohibit local municipalities from participating in a State-wide health plan for school districts and their employees. Indeed, if the goal of the legislation is to be as helpful to as many people as possible, it might make sense to permit those municipalities that already have joint purchasing arrangements with school districts to opt in to a statewide health plan, provided the municipality participates on the same basis as all other school

[22] Presumably these arrangements have been market tested and the joint coverage has consistently proven more economical. We have not, however, attempted to validate this presumption.

districts. Although beyond the scope of our engagement, the State could consider expanding eligibility to other state governmental units such as junior or community colleges, as did Oregon in their statewide health plan for school employees. Regardless of which governmental units were permitted to participate in the State-wide plan, it would be important that the opportunities for adverse selection (i.e., employers selecting against the plan) be avoided. For example, being able to opt in and out of the State-wide plan from year to year could be highly detrimental to a health plan.

Whether school district employees should be permitted to opt out of coverage, however, is a different question altogether. Employees who opt out of school district health plan coverage are saving the school district (and the State) money because the school district is not paying its share of the cost of coverage, which is significantly more than the employee's contribution. Any State health plan created should permit employees to opt out of coverage.[23] A school district would not incur a charge for an employee that opts out of health plan coverage.[24] Indeed, some school districts around the country have provided financial incentives for employees to decline school district coverage – in the hope that the employee (and family members) will obtain health care coverage from a spouse's plan or through another source.[25]

For purposes of our analysis in this report we have assumed that the same number of employees will continue to be covered through their school districts, that the same number of employees will continue to opt out of any State health plan, and the same number of dependents will be covered. If, however, school districts or the State were to pay a larger share of health plan costs or if school district health plans designs were made more valuable to employees, that might cause more school districts employees to

[23] Some would argue that employees should be required to take health plan coverage unless they can demonstrate they have alternate coverage. We recommend that is a policy decision that each school district could make.

[24] We understand the Anchorage School District had a provision in its collective bargaining agreement with the Anchorage Education Association requiring the School District to effectively pay for all eligible bargaining unit employees' health coverage, regardless of whether the employee opted out. We understand that provision will terminate after June 2015. These funds were used to reduce the cost of employee coverage, thus accruing to the benefit of the employees, but having no impact on the NEA-Alaska Health Plan or its funding. We further understand these types of provisions may have existed with other school districts but have been eliminated over time.

[25] The problem with these incentives is that it is difficult to determine how many people would have opted out of coverage anyhow, which makes it difficult to determine whether financial incentives really produce savings. A related issue is whether employers should reward employees for doing something they would have otherwise done.

take the State health plan, which, in turn, would increase costs and decrease potential savings. Conversely, if cost sharing or plan designs were made less favorable to employees, that could increase the number of employees who opt out, which, in turn, would further decrease costs and increase potential savings.

E. Legal Considerations

We have been asked to consider what, if any, legal challenges could arise out of the consolidation under a State-managed health care plan for public school employees. Specifically, the analysis is to focus on whether the State could face potential litigation (either from a school district or a school district employee, or his or her representative organization) due to a perceived loss of benefits as a result of such consolidation.

To address this concern we have looked at a number of legal sources, and we provide here our analysis, with the caveat that we are not providing a legal opinion with respect to this matter.

We begin with the Alaska State Constitution, Article XII, section 7, which provides:

Retirement Systems. Membership in employee retirement systems of the State or its political subdivisions shall constitute a contractual relationship. Accrued benefits of these systems shall not be diminished or impaired.

Under this section of the State Constitution retirement benefits are "regarded as an element of the bargained-for considerations given exchange for an employee's assumptions and performance of the duties of his employment."[26] In this context retirement benefits have been understood to include retiree health benefits. But the prohibition against diminishment or impairment does not mean that reasonable modifications of retiree health benefits cannot be made, but "to be sustained as reasonable, changes that result in disadvantages to employees should be accompanied by comparable new advantages."[27] The Alaska State Supreme Court, in *Duncan*, concludes that the term "accrued benefits" … "includes all retirement benefits[28] that make up the retirement benefit

[26] *Hammond v. Hoffbeck,* 627 P. 2d 922, 926 (Alaska 1994) (death benefits payable to the beneficiaries of retirees were protected by section 7 of Article 12 of the State Constitution).

[27] *Duncan v. Retired Public Employees of Alaska, et al., 71 P.3d 882 (Alaska 2003),* Op Slip. 5.

[28] Retiree health benefits are provided under Title 39, which is part of the State's retirement system's provisions.

package that becomes part of the contract of employment when the public employee is hired, including health insurance benefits."[29] However, this quotation must not be misconstrued.

Duncan does not address protections for governmental active employees' health benefits. The reference in the preceding sentence to "including health insurance benefits" refers only to the provision of retiree health benefits provided by the State's retirement system. It says nothing with respect to the protection or provision of health benefits for active employees. Indeed, nothing in the *Duncan* ruling suggests that Article XII, section 7 of the State Constitution applies to protect health benefits provided either by State school districts or provided by the State itself to active employees and their eligible family members – provided the active employee health benefits are not provided by the State's retirement system.

We were unable to find an Alaska Constitution or statutory basis for a contention that the State would be prohibited from changing health benefits for active employees of a school district or any other component of the State. Absent governmental employees' health benefits being explicitly protected by State Constitution or other State law, we think an employee or an association of employees would be hard pressed to successfully argue that they have any protected right to current health benefits. Nonetheless, we consider a few arguments, as implausible as they may be:

- It might be argued that employees have a protected property interest in their health benefits, and that changing those benefits was a wrongful taking of property. Without any extensive legal research, we are not aware of any cases that acknowledge that an active governmental employee has a property right in his or her active employee health benefits, absent an express statement to that affect in a state constitution or statutes.
- It might be argued that school district employees have a contractual right to their health benefits, and that any State plan is interfering with their contractual rights. We are not providing a legal opinion in this regard, but it is our understanding that courts generally view rights of governmental employees as those rights created by state law. Therefore, rights created by state law – such as the scope of collective bargaining – could be altered by state law, except, perhaps, for certain vested benefits, which are expressly granted under state law.
- It might be argued that by creating a State health plan, the State is interfering with a long-standing relationship between employees, their representatives and their employers (the school boards) to determine the health benefits to be provided to

[29] *Duncan v. Retired Public Employees of Alaska, et al., 71 P.3d 882 (Alaska 2003), Op. Slip. 8.*

school district employees, and that the State has abdicated its right to interfere with such a long-settled matter that has been and must remain under the control of each school district. Again, as with the previous point, it is our understanding that states may control these aspects of the employment relationship between employees and state subdivisions and instrumentalities, including school districts. To our knowledge, there has not been a successful legal challenge in a state that requires or permits school districts from obtaining health care benefits from a state entity.

For these reasons, we are not aware of any particular basis for a successful challenge to an Alaska statute that would require school districts to use a State health plan to provide health benefits to their school district employees.

V. Recommendation

Based on the options outlined in section III of this report, Hay Group recommends the State pursue option 3. This option provides significant potential savings through the optimization of plan performance and consolidation of plan designs and cost sharing arrangements. This recommendation takes into consideration other factors that may influence the transition to a State-managed program for school districts.

Through a centrally managed school district program with standard health plan options and cost sharing, the State can provide a menu of health plan options that are customized to best suit the needs of school districts. In addition, a uniform premium cost sharing strategy would be implemented, ensuring internal equity and ease of administration and communication. The estimated financial impact of 7.7% to 11.4% of current health care costs is significant.

Alternatively, the State may want to consider option 4. The State would maintain a centrally managed school district program with standard health plan options, but it would give school districts decision making power over premium cost sharing. Leaving discretion to the school districts will help them design their programs to best attract and retain employees.

VI. Appendix: Sample Survey Instrument

State of Alaska

Public School District Health Benefit Survey

Thank you for your time and effort in completing these data submission materials. Hay Group has been engaged by the Senate Finance Committee to conduct a survey of public school district health benefits. All data is completely confidential and will not be released. In return for your participation, you will receive a free copy of survey results. If you need any assistance with data submission, please contact Smijai Peter, Aubrey Alleman or Aaron Hoffman whose information is listed below.

Completed by:

Name: _____
Phone: _____
Title: _____
County: _____
Address: _____
City, State, & Zip: _____
E-mail: _____

What is the name of your School District/Educational Service District:
(Please select from one of the the drop down lists)

A through G: _____
H through K: _____
M through S: _____
T through Z: _____

Complete data submission due by September 9, 2013

-- No individual school district data will be released --

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Please Send Completed Surveys to:

Smijai Peter
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Phone: (469) 232-3851
Email: Smijai.Peter@HayGroup.com

Aubrey Alleman
Hay Group, Inc
Phone: (469) 232-3852
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General Instructions

- This questionnaire asks for general information regarding the design, premiums, and administration of your health care benefit plans (Medical, Prescription, Dental, and Vision).
- Please complete this form based on the district's plans and premiums for the 2012/2013 school year. If this is not possible, indicate the plan year for which the form was completed here.
- If possible, please submit any Summary Plan Descriptions (SPDs) or Schedules of Benefit Coverage (SBC) to accompany your plan designs as an email attachment

Plan Year

Survey Section	Tab Name	Description
Enrollment and Premium Information	**Enrollment & Premiums**	Enrollment, premiums, and important information by health plan
Plan Design Information	**Medical - 1**	Important medical plan design information
	Medical - 2	*If more than one plan is offered*
	Medical - 3	*If more than two plans are offered*
	Dental & Vision	Dental and vision plan design information (if applicable)
Administration	**Administration**	Administrative fees, plan year, and stop loss arrangements
Eligibility	**Eligibility**	Requirements to become eligible for health care benefits
Definitions	**Definitions**	Terms and definitions used in this survey

Please complete each component tab in the spreadsheet to the best of your ability. Refer to specific definitions in the Definitions tab toward the end of the survey.

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Enrollment and Premium Information

1. Please provide enrollment and premium information for the health plans you offer your public school employees (e.g. including, instructional staff, instructional aides, administrative staff, support staff, others). Please list all plans even if you did not fill out the plan design information on previous tabs. You may provide the information in the table below or in a separate attachment.

Health plans (Medical, Dental, Vision)																			
Plan Information								Enrollment* (# of Employees)				Total Annual Premium*				Annual Employee Payroll Deduction			
Tab	*Insurer/TPA*	*Plan Name*	*Type of Plan*	*What group(s) are offered the plan?*	*Is this plan offered to collectively bargained group(s)?*	*Is this plan also offered to Retirees?*	*Are Prescription Drugs Carved out?*	*Employee*	*Employee + Sp. or D.P.*	*Employee + Children*	*Employee + Family*	*Employee*	*Employee + Sp. or D.P.*	*Employee + Children*	*Employee + Family*	*Employee*	*Employee + Sp. or D.P.*	*Employee + Children*	*Employee + Family*
Example	*Aetna*	*Choice POS II*	*POS*	*All employees*	*No*	*Yes*	No	*100*	*43*	*65*	*89*	*$5,556.00*	*$6,252.00*	*$5,268.00*	*$11,820.00*	*$1,111.20*	*$1,875.60*	*$1,317.00*	*$3,546.00*
Medical - 1																			
Medical - 2																			
Medical - 3																			
Dental			Dental				n/a												
Vision			Vision				n/a												
Additional plan if needed																			
Additional plan if needed																			
Additional plan if needed																			

If the group uses composite rather than tiered rates, please show enrollment and premium data in the "Family" column of each section. If the group uses three-tiered rates, please include EE+1 in the Employee+Spouse column, and EE+2 or more in the Employee + Children column.

Medical Plan 1

Integrated Medical & Drug Deductible?	☑
Inpatient Copay per Day (rather than per admission)?	☐
Skilled Nursing Facility Copay per Day (rather than per admission)?	☐
Use Separate Out-Of-Pocket Maximum **(OOP Max)** for Medical & Drug?	☐
Grandfathered Plan?	☐

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Employer Contribution Amount:	

Plan Benefit Design (Individual Coverage)	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
OOP Maximum ($) *(excludes deductible)*			
Separate OOP Maximum for Medical and Drug ($) (*excludes deductible)*			
Family deductible as multiple of the individual deductible?			

**** The "Combined" column should be populated if both medical and drug expenses apply to the same deductible and OOP Maximum***

Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different (%)	Copay, if separate ($)	Service Not Covered?
Medical	☐ All	☐ All			
Emergency Room Services	☐	☐			☐
All Inpatient Hospital Services (inc. MHSA)	☐	☐			☐
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	☐	☐			☐
Specialist Visit	☐	☐			☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐			☐
Rehabilitative Speech Therapy	☐	☐			☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐			☐
Preventive Care/Screening/Immunization			100%	$0.00	☐
Laboratory Outpatient and Professional Services	☐	☐			☐
X-rays and Diagnostic Imaging	☐	☐			☐
Skilled Nursing Facility	☐	☐			☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☐			☐
Outpatient Surgery Physician/Surgical Services	☐	☐			☐
Drugs	☐ All	☐ All			
Generics	☐	☐			☐
Preferred Brand Drugs	☐	☐			☐
Non-Preferred Brand Drugs	☐	☐			☐
Specialty High-Cost Drugs	☐	☐			☐

Medical Plan 2

Integrated Medical & Drug Deductible?	☑
Inpatient Copay per Day (rather than per admission)?	☐
Skilled Nursing Facility Copay per Day (rather than per admission)?	☐
Use Separate Out-Of-Pocket Maximum **(OOP Max)** for Medical & Drug?	☐
Grandfathered Plan?	☐

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Employer Contribution Amount:	

	Plan Benefit Design (Individual Coverage)		
	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
OOP Maximum ($) *(excludes deductible)*			
Separate OOP Maximum for Medical and Drug ($) (*excludes deductible)*			
Family deductible as multiple of the individual deductible?			

**** The "Combined" column should be populated if both medical and drug expenses apply to the same deductible and OOP Maximum***

Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different (%)	Copay, if separate ($)	Service Not Covered?
Medical	☐ All	☐ All			
Emergency Room Services	☐	☐			☐
All Inpatient Hospital Services (inc. MHSA)	☐	☐			☐
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	☐	☐			☐
Specialist Visit	☐	☐			☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐			☐
Rehabilitative Speech Therapy	☐	☐			☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐			☐
Preventive Care/Screening/Immunization			100%	$0.00	☐
Laboratory Outpatient and Professional Services	☐	☐			☐
X-rays and Diagnostic Imaging	☐	☐			☐
Skilled Nursing Facility	☐	☐			☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☐			☐
Outpatient Surgery Physician/Surgical Services	☐	☐			☐
Drugs	☐ All	☐ All			
Generics	☐	☐			☐
Preferred Brand Drugs	☐	☐			☐
Non-Preferred Brand Drugs	☐	☐			☐
Specialty High-Cost Drugs	☐	☐			☐

Medical Plan 3

Integrated Medical & Drug Deductible?	☑
Inpatient Copay per Day (rather than per admission)?	☐
Skilled Nursing Facility Copay per Day (rather than per admission)?	☐
Use Separate Out-Of-Pocket Maximum **(OOP Max)** for Medical & Drug?	☐
Grandfathered Plan?	☐

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Employer Contribution Amount:	

	Plan Benefit Design (Individual Coverage)		
	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
OOP Maximum ($) *(excludes deductible)*			
Separate OOP Maximum for Medical and Drug ($) (*excludes deductible)*			
Family deductible as multiple of the individual deductible?			

**** The "Combined" column should be populated if both medical and drug expenses apply to the same deductible and OOP Maximum***

Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different (%)	Copay, if separate ($)	Service Not Covered?
Medical	☐ All	☐ All			
Emergency Room Services	☐	☐			☐
All Inpatient Hospital Services (inc. MHSA)	☐	☐			☐
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	☐	☐			☐
Specialist Visit	☐	☐			☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐			☐
Rehabilitative Speech Therapy	☐	☐			☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐			☐
Preventive Care/Screening/Immunization			100%	$0.00	☐
Laboratory Outpatient and Professional Services	☐	☐			☐
X-rays and Diagnostic Imaging	☐	☐			☐
Skilled Nursing Facility	☐	☐			☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☐			☐
Outpatient Surgery Physician/Surgical Services	☐	☐			☐
Drugs	☐ All	☐ All			
Generics	☐	☐			☐
Preferred Brand Drugs	☐	☐			☐
Non-Preferred Brand Drugs	☐	☐			☐
Specialty High-Cost Drugs	☐	☐			☐

Dental Plan

	Dental Plan Design
Individual Deductible	
Family Deductible	
Plan Maximum Non-orthodontia	
Plan Maximum Orthodontia	

	In-Network	
Type of Benefit	Coinsurance	Copay
Class I: Diagnostic and Preventive (cleanings, X-rays, office visits)		
Class II: Basic Restorative Services (fillings, root canals, periodontics, oral surgery)		
Class III: Major Resortative Services (dentures, crowns, bridges)		
Orthodontic Services		

Vision Plan

	Vision Plan Design
Exam Copay	
Materials Copay *(for lenses, frames, etc.)*	
Individual Deductible	
Family Deductible	

	In-Network	
Type of Benefit	Coinsurance	Allowance
Base Lenses:		
Single Vision Allowance		
Bifocal Allowance		
Trifocal Allowance		
Lenticular Allowance		
Contact Lenses:		
Elective Allowance		
Therapeutic Allowance		
Frame Retail Allowance		
Frame Allowance		

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Administration

1. Are your health plan(s) self-insured (no stop loss insurance), partially insured, (some stop loss insurance), or fully insured?

2. If your health plan(s) are partially insured, please provide the following information.

Stop Loss	2012-2013 Plan Year
Individual Stop Loss	
Individual Stop Loss Level (e.g. $50,000)	
Monthly Premium for Individual Stop Loss	
On a per employee basis *or*	
On a per covered life basis	
Aggregate Stop Loss	
Aggregate Level (e.g., 125%)	
Monthly Premium for Aggregate Stop Loss	
On a per employee basis *or*	
On a per covered life basis	

3. What is the length of contract with your TPA/Insurer? Please include any (optional) extension years.

4. When does your current contract with your TPA/Insurer expire?

5. If your health plan(s) are self insured or partially insured, what administrative rate (per employee per year) do you pay?

6. What percentage of health care premiums are represented by broker fees/commissions? If the % is not known, enter a $ amount.

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

# of full-time employees

8. When is the beginning of your plan year?

9. If the health benefits are subject to collective bargaining, what is the expiration date of the current Collective Bargaining Agreement?

10. Does your district participate in a health plan trust (ex. NEA - Alaska Health Plan Trust)?

11. What aspects about your districts health benefits would you most like to see improved?

Eligibility

1. Who is eligible to enroll in the health care plans (Medical, Prescription, Dental, and Vision) regardless of who pays all or part of the premium?

	Enter Hour, Day or FTE Requirement as Applicable for An Employee to be Eligible for Coverage			
Employee Classification	**Yes or No?**	**Hours per Period**	**Contract Days per Year**	**FTE Designation**
Example	**Yes**	**30 hours per week, or**	**190 contract days per year, or**	**0.5 FTE**
Professional / Instructional Staff				
Instructional Aides				
Administrators (executive/administrator)				
Clerical Staff				
Transportation staff				
Food Service staff				
Custodial / Maintenance Staff				
Security				
Others: Please Specify				

Term	Definition
Integrated Medical and Drug Deductible	a type of deductible where both prescription drug and medical expenses contribute towards the deductible. If the deductible is not integrated, only medical claims accumulate to the medical deductible and prescription drug claims accumulate to the prescription drug deductible.
Grandfathered Health Plan	A grandfathered plan is a group health plan that was in place as of March 23, 2010. Plans remain grandfathered indefinitely unless companies: Significantly reduce benefits Increase costs to their employees, or Reduce how much the employer pays toward benefits As of November 17, 2010, employers have additional flexibility to keep grandfathered status if they: Change plan funding from self-insured to fully-insured Change insurance companies if they offer the same coverage
Inpatient & Outpatient Professional Services	Services Include But Not Limited To: Medical Care Visit (1 Per Day) Intensive Medical Care Concurrent Care Consultations Surgery Anesthesia Administration Newborn Exams
Fee-for-Service (FFS)	a traditional indemnity plan that provides designated reimbursement to covered persons for designated health services. The insured is able to choose the provider without penalty. All providers of the same service are reimbursed at the same level; i.e., there is no "preferred" or "exclusive" providers. There may be a hospital pre-certification requirement as well as catastrophic case management. The plan can be fully or partially insured or self-insured.
Health Maintenance Organization (HMO)	a managed care plan in which the individual must go through a "gatekeeper" primary physician for most medical care. The gatekeeper refers the individual to a provider within the network if specialization is needed. There is no benefit provided out-of-network.
Preferred Provider Organization (PPO)	a medical plan that allows the individual to decide between a network of preferred providers (hospitals and/or physicians) with higher reimbursement levels and out-of-network providers each time service is to be provided. If the network has gatekeeper/primary physician requirements, it is not a PPO, but a POS.
Point-of-Service (POS)	a medical plan that allows the individual to decide between a network of gatekeeper managed care providers or a PPO with a higher employee copayments each time service is provided.
Pharmacy Carve Out	Some health plans separate the prescription drug benefits from the medical benefits, to facilitate hiring a specialist firm to manage the benefits and obtain cost-effective pricing. This arrangement is usually called a “Carved Out” prescription drug program.

VII. Appendix: Alaska School District Health Survey Results

		Total Health Insurance Cost[1]		Employer Cost		Employee Cost					
District	Total Employees Electing Health Care	Total Spend	PEPY	Total Spend	PEPY	Total Spend	PEPY	Avg. Employee Cost Share	Total PEPY Cost Rank	Plan Design Value Relative to P50	Insured Arrangement
Alaska Gateway	54	$1,098,360	$20,340	$1,098,360	$20,340	$0	$0	0%	19	1.04	NEA-Alaska
Aleutian	6	$94,826	$15,804	$94,826	$15,804	$0	$0	0%	42	1.03	Fully Insured
Aleutians East Borough	48	$755,739	$15,745	$695,280	$14,485	$60,459	$1,260	8%	43	0.91	Fully Insured
Anchorage	5,571	$97,695,349	$17,536	$84,640,849	$15,193	$13,054,500	$2,343	13%	38	1.00	NEA-Alaska, Partially Insured, Local 71, Teamsters
Annette	32	$708,890	$22,153	$652,179	$20,381	$56,711	$1,772	8%	6	1.07	Fully Insured
Bering Strait	292	$5,628,581	$19,276	$4,974,101	$17,035	$654,480	$2,241	12%	24	1.20	Partially Insured
Bristol Bay Borough	24	$516,960	$21,540	$467,280	$19,470	$49,680	$2,070	10%	10	1.13	NEA-Alaska
Chatham	15	$307,260	$20,484	$243,630	$16,242	$63,630	$4,242	21%	16	0.93	NEA-Alaska
Chugach	39	$644,165	$16,517	$644,165	$16,517	$0	$0	0%	40	1.00	Partially Insured
Copper River	64	$1,314,816	$20,544	$1,238,016	$19,344	$76,800	$1,200	6%	14	0.98	NEA-Alaska
Cordova City	44	$903,936	$20,544	$831,600	$18,900	$72,336	$1,644	8%	14	0.98	NEA-Alaska
Craig City	47	$1,013,508	$21,564	$1,013,508	$21,564	$0	$0	0%	8	1.09	NEA-Alaska
Delta-Greely	92	$1,724,568	$18,745	$1,427,595	$15,517	$296,973	$3,228	17%	29	0.98	NEA-Alaska
Denali	53	$1,229,980	$23,207	$886,120	$16,719	$343,860	$6,488	28%	4	1.19	Self Insured
Dillingham	80	$1,458,005	$18,225	$1,291,073	$16,138	$166,932	$2,087	11%	33	1.05	Self Insured
Fairbanks North Star Borough	1,728	$36,116,708	$20,901	$32,059,758	$18,553	$4,056,950	$2,348	11%	13	1.11	Partially Insured
Galena City	150	$2,031,967	$13,546	$1,830,247	$12,202	$201,720	$1,345	10%	48	0.85	Partially Insured
Haines Borough	51	$907,596	$17,796	$907,596	$17,796	$0	$0	0%	37	0.90	NEA-Alaska
Hoonah City	38	$538,233	$14,164	$538,233	$14,164	$0	$0	0%	47	1.09	Fully Insured
Hydaburg City	12	$230,937	$19,245	$217,565	$18,130	$13,372	$1,114	6%	26	1.07	Fully Insured
Iditarad Area	38	$773,747	$20,362	$773,747	$20,362	$0	$0	0%	18	1.07	Alaska Public Employees Insurance Group
Juneau Borough	592	$11,143,740	$18,824	$10,272,000	$17,351	$871,740	$1,473	8%	28	1.07	NEA-Alaska & APEA
Kake City	15	$233,280	$15,552	$221,580	$14,772	$11,700	$780	5%	44	0.82	NEA-Alaska
Kashunamiut	96	$1,252,308	$13,045	$1,252,308	$13,045	$0	$0	0%	50	0.91	Self Insured
Kenai Peninsula Borough	1,242	$22,962,344	$18,488	$18,789,224	$15,128	$4,173,120	$3,360	18%	32	1.09	Partially Insured
Ketchikan Gateway Borough	220	$3,248,037	$14,764	$2,193,933	$9,972	$1,054,104	$4,791	32%	45	1.00	Partially Insured
Klawock	25	$631,350	$25,254	$601,717	$24,069	$29,633	$1,185	5%	2	1.13	Fully Insured
Kodiak Island Borough	262	$6,990,213	$26,680	$6,147,573	$23,464	$842,640	$3,216	12%	1	1.04	Partially Insured
Kuspuk	79	$1,522,247	$19,269	$1,522,247	$19,269	$0	$0	0%	25	1.15	Partially Insured
Lake and Peninsula Borough	94	$1,675,904	$17,829	$1,517,161	$16,140	$158,743	$1,689	9%	36	1.19	Partially Insured
Lower Kuskokwim	645	$12,406,154	$19,234	$12,406,154	$19,234	$0	$0	0%	27	1.18	Partially Insured

		Total Health Insurance Cost[1]		Employer Cost		Employee Cost					
District	Total Employees Electing Health Care	Total Spend	PEPY	Total Spend	PEPY	Total Spend	PEPY	Avg. Employee Cost Share	Total PEPY Cost Rank	Plan Design Value Relative to P50	Insured Arrangement
Lower Yukon	391	$7,865,103	$20,115	$7,865,103	$20,115	$0	$0	0%	22	1.09	Partially Insured
Mat-Su	1,688	$34,157,268	$20,235	$30,800,220	$18,247	$3,357,048	$1,989	10%	21	0.98	NEA-Alaska
Nenana City	51	$1,037,340	$20,340	$1,037,340	$20,340	$0	$0	0%	19	0.99	NEA-Alaska
Nome	137	$1,274,969	$9,306	$1,083,740	$7,911	$191,229	$1,396	15%	53	0.88	Fully Insured
North Slope Borough	426	$8,459,419	$19,858	$8,459,419	$19,858	$0	$0	0%	23	1.12	Partially Insured
Northwest Arctic	364	$8,382,881	$23,030	$8,112,281	$22,286	$270,600	$743	3%	5	1.15	Partially Insured
Pelican City	2	$49,883	$24,941	$49,883	$24,941	$0	$0	0%	3	1.09	Fully Insured
Petersburg Borough	67	$1,199,568	$17,904	$955,752	$14,265	$243,816	$3,639	20%	35	0.93	NEA-Alaska
Pribilof	28	$609,840	$21,780	$609,840	$21,780	$0	$0	0%	7	1.09	NEA-Alaska
Sitka	236	$2,919,045	$12,369	$2,563,434	$10,862	$355,610	$1,507	12%	51	1.02	Fully Insured
Skagway	13	$243,007	$18,693	$243,007	$18,693	$0	$0	0%	30	0.91	Fully Insured
Southeast Island	28	$603,792	$21,564	$603,792	$21,564	$0	$0	0%	8	0.98	NEA-Alaska
Southwest Region	76	$1,212,079	$15,948	$953,048	$12,540	$259,031	$3,408	21%	41	0.96	Fully Insured
Saint Mary's	16	$196,700	$12,294	$170,517	$10,657	$26,182	$1,636	13%	52	1.01	Fully Insured
Tanana	6	$87,195	$14,533	$87,195	$14,533	$0	$0	0%	46	0.92	Fully Insured
Unalaska City	63	$1,329,610	$21,105	$1,329,610	$21,105	$0	$0	0%	11	1.16	Alaska Public Employees Insurance Group
Valdez City	116	$2,370,774	$20,438	$2,265,096	$19,527	$105,679	$911	4%	17	1.16	Partially Insured
Wrangell City	40	$840,870	$21,022	$820,739	$20,518	$20,131	$503	2%	12	1.01	Fully Insured
Yakutat City	21	$367,500	$17,500	$345,900	$16,471	$21,600	$1,029	6%	39	0.97	Fully Insured
Yukon Flats	44	$821,736	$18,676	$821,736	$18,676	$0	$0	0%	31	0.96	Fully Insured
Yukon-Koyukuk	96	$1,726,473	$17,984	$1,726,473	$17,984	$0	$0	0%	34	1.11	Partially Insured
Yupiit	111	$1,465,369	$13,202	$1,401,430	$12,625	$63,939	$576	4%	49	1.05	Partially Insured
Total	**15,768**	**$294,980,128**	**$18,708**	**$263,755,181**	**$16,727**	**$31,224,947**	**$1,980**	**10.6%**			

[1]Total Health Care Costs include premium rates, any applicable administrative and stop loss fees

The relative values for each school district represent the plan design factor of the district's most valuable plan over the weighted median value of the school districts (P50). For example, a school district value of 1.05 represents a school district's plan which is 5% more valuable than the median plan design of the school districts.

Plan design values range from 18 percentage points below median to 20 percentage points above median. The P25 value is 0.97, the P50 value is 1.0, and the P75 value is 1.07.

The majority of school districts (>26) fall within 9 percentage points of the median plan design (between a relative value of 0.91 and 1.09). Twenty school districts (38%) fall within 5 percentage points of the median plan design (between a relative value of 0.95 and 1.05).

This suggests that despite the range of plan design values, it would be reasonable to create just three plans that would be relatively close to the majority of the existing designs. These three plans, if offered by the State, would minimize the disruption of undertaking a large-scale change in plan design while still offering meaningful choice in plan design value.

VIII. Appendix: Discussions with Stakeholders

Interviewee: David Teal, Director of the Legislative Finance Division

Hay Group interviewed David Teal regarding the State's funding of health care for school district employees. Basically, Mr. Teal indicated that the Basic Student Allocation (BSA) does not, in any way, take into account a school district's cost of providing health care benefits to school district employees. He said that the BSA is a per student rate that the State uses to calculate the basic State-provided funding. The BSA is not adjusted for a school district's costs of goods or services, and there are no restrictions on how a school district expends those State grants.

Mr. Teal added that there are various adjustment factors applied to the BSA, but none account for a school district's costs for goods or services. He also explained that the State permits local jurisdictions to raise tax revenue for schools, but any required local effort is a direct offset against the BSA. The State does, however, permit up to 23% of voluntary local effort. Urban communities have required and local voluntary efforts. The community can put conditions on the payment of local voluntary efforts.

In theory, regional cost differences are accommodated by the geographical factor that is applied to the BSA. But overall, State funding is independent of each school district's expenses.

Last year school districts received, in the aggregate, $1.7 billion from all sources (Federal, State, and local jurisdictions) including Mt. Edgecumbe. Schools get a lot of Federal impact aid because so much of Alaska territory has Federal land, but most Federal impact aid is offset against State aid.

Mr. Teal indicated that while the BSA has not kept up with inflation, the overall grants of State aid to school districts continues to go up, even though the total number of students in school districts is less than it was 10 years ago. The average BSA used to be 1.4, and now that average has increased to 1.9. (Presumably these are factors applied to the BSA to determine a school district's allocation on a per pupil basis.)

In school districts where the State pays the entire cost of education, i.e., the Rural Education Attendance Areas (REAAs), the State provides a per-student BSA, which those school districts use as they deem appropriate. No special State allocation is provided due to health plan costs.

Mr. Teal expressed no opinion regarding using the status quo or moving to a State-wide health plan for school district employees. He assumed that if that were to occur it would not be necessary to change the BSA, though the State could change its approach to something more like that which it uses with those agencies that participate in the State Employee Health Plan (AlaskaCare). He did indicate that in the case of a State-wide plan, some school districts would be advantaged and some disadvantaged, and some school districts might find the cost of the State-wide plan is more expensive than their current coverage.

Interviewee: Mike Barnhill of the Alaska Department of Administration

Hay Group discussed with Mr. Barnhill the Alaska State Employees Health Plan.

AlaskaCare has 5 active plans:

1. AlaskaCare – for active State employees – approximately 6,800 employees are covered, with a total of 17,000 total lives as they use a 2.6 multiplier to extrapolate the number of total lives from the number of active employees. This plan covers non-union employees, exempt employees, governor appointees, partially exempt employees, attorneys in the Department of Law, and court employees. It also covers the following collectively bargained employee groups: supervisors, APEA, correctional employees ACOA, confidential employees, and marine engineers.

2. Retirees – similar to active plan. Covers all retirees from Public Employees Retirement System (PERS), Teachers Employee Retirement System (TERS), JRS (retired judges), EPORS – a closed group of 30-40 retirees.

Four "Opt-Out Plans: Collectively bargained – opted out and created their own trust

1. Alaska State Employee Association (ASEA) – general governmental unit, covers most State employees – 8,900 employees.

2. LTC – Laborers Trades and Crafts (Local 51) – smaller trust; includes other employers. It may have one school district - Anchorage

3. Public Safety Employees Association – they purchase insurance coverage from Aetna or Premera.

4. Masters, Mates and Pilots – health trust

Each of the separate trusts has its own actuary and TPA (except for the insured PSEA plan)

For all these plans, the State negotiates health benefit credits, which are built into each agency's budget. Usually the credit amount is about the same. In the past, there has been a $30- $40 negotiated "bonus" for general government employees, which goes on top

of pay in exchange for less leave time. Each agency sends plan contributions to the Division of Finance, which, in turn, sends the contributions to the right plan.

The benefit credit is tied to 100% of the cost of the Economy medical plan plus the Preventive dental plan in AlaskaCare The economy medical plan generally has a $500 deductible and $2000 MOOP, 100% preventive dental ($54). The total is $1,389, which is built into the budget. The premium is reflected on the employee's pay stub.

State Statute requires that the benefit credit covers family coverage. AS 39.30.090(a) would permit the Commissioner to allow single coverage by regulation, but no such regulation has ever been adopted. As a consequence, employees are indifferent to whether they need single or family coverage.

Standard and Premium plans are more expensive that the Economy plan, but the spread among the plans is close.

There's an implicit subsidy in the Premium plan because the Premium plan spends more than the State takes in for that plan.

There is also a Premium and Standard dental plan. The Premium dental plan covers $2,000 of orthodontia per year (this, in effect, is a pre-tax method of paying for orthodontia as the only people who enroll need braces). They will likely eliminate the Premium dental plan. They have contracted with Oregon Dental Service to be their dental claims administrator and network. ODS recently changed its name to MODA.

A description of the plan designs is available at doa.alaska.gov

Rate Setting – An actuary sets the rates.

They are currently in the process of changing from a FY plan year to a CY plan year.

The employee benefit credit is set for medical plans based on the Economy Medical plan, and for dental based on the Preventative dental plan. More valuable plans are available as a "buy-up" to employees, with no additional contributions from the State.

Current allocated amount is $1,335 for Economy Medical. Preventive Dental is $54, for a total of $1,389.

There is concern that the economy medical premium is inflated and collects much more than the economy medical costs. The Department is incrementally addressing this. Sudden changes would cause disruption to members.

They have recently increased the deductible of the Standard and Premium plans by $50.

In 2015, DOA intends to establish a high deductible health plan.

Plans have, until lately, been inexpensive for employees because of oil revenue, but that is now changing.

School funding can be found at AS 14.17.400 – 490, which includes all the basic formulas.

School districts come to the legislature to obtain an increase in the base allocation. This past year some larger school districts have been increasing their Benefit Credit.

Some large school districts want the State to take over the responsibilities of providing health benefits.

Rural school district employee may have relatively greater access to Indian Health Services facilities. This may explain lower Benefit Credits in some rural school districts.

Administration

The TPA for AlaskaCare has changed. It had been Health Smart out of Dallas, which was acquired by Wells Fargo in 2012. Before 2010 Premera was the TPA, and 4 years before that it was Aetna. The last time they did an RFP they didn't reprice claims, and the DOA ranked network discounts as only 3% of the possible score.

Mr. Barnhill has been told that independent TPAs cannot compete with insurance carriers when it comes to network discounts because insurance carriers will not rent their networks out at the same price they use for their direct customers. When Health Smart was the TPA, they had Beach Street network, but then they rented the Aetna network.

Some of the union plans belong to the Healthcare Cost Management Coalition. It has 110,000 covered lives, which may include members out of state. The HCMC just brought on the Aetna network.

Customer Service
The State has learned a lot about customer service. Basically the complexity of the plan, and its non-standard features, complicate administration, slow claims processing (because manual adjudication is required). The State wants to substantially increase the percentage of auto-adjudicated claims, which is now only 40%. That means that 18,000 claims are manually adjudicated monthly. DOA wants the auto-adjudication rate to be within best practice standards, but that may take some time.

Things to Fix
The network is being fixed. Aetna is getting closer in size to Premera.

There will be savings in the Retiree plan, because 40-50% of the covered retirees live in the lower 48. Aetna will be a big help.

There are system issues. The enrollment and eligibility system is home grown, and it was built on top of a database that was created in 1985. The State is transitioning off that system. The current system is not scalable, so they couldn't handle the school district employees with their current system. DOA has been advised to give the enrollment and eligibility duties to a HR benefits firm, which will handle open enrollment in the fall of 2014.

The retiree health plan has $3.8b in unfunded liabilities.

State-wide Plan for Schools
Officially the Department is neutral, but the Department will support exploring the concept of school district consolidation, primarily for the benefits that scale and leverage could bring. A higher priority is to re-absorb the State of Alaska employee health trusts back into the State pool – and get all State employees into AlaskaCare.

Currently, the State cannot control the costs of the small trusts.

Based on a demographic analysis only, the DOA actuary estimates that the school employees are approximately 0.2% more expensive because they are somewhat older and have a higher percentage of women in their workforce.

A separate pool for school districts makes sense to Mr. Barnhill (as Hay suggested in its Washington Report). Mr. Barnhill is concerned about high-cost claims. AlaskaCare has a number of ESRD patients, and one of those people has $2m in claims.

Mr. Barnhill mentioned that he understands that Texas has a statute that requires all public employees to be given access to the same healthcare plan options. From a policy perspective that may be worthy of consideration.

Plan Cost Controls
AlaskaCare has an enhanced wellness program, which entails shaping workplace behaviors, exercise, and diet. The plan covers 100% of preventive care. That change did not appreciably change utilization, but it increased cost by about $1m.

Under the new Aetna plan, there are standard pre-certification requirements. Aetna is placing a big emphasis on evidence-based medicine.

DOA is trying to control costs by standardizing the plan. The plan has been grandfathered under ACA, but they know that will have to change very soon. Chiropractic benefits are currently capped.

The Retiree plan, which is exempt from ACA benefit requirements, doesn't cover preventive care. The Department has been advised that some doctors circumvent this by diagnosing an ailment that makes the services covered.

Rx
Under the old arrangement the TPA subbed the PBM to Envision/Costco. They've done a good job. Under the new Aetna arrangement, Aetna partners with CVS/Caremark.

Interviewee: Bruce Johnson, Executive Director of Alaska Council of School Administrators (ACSA) and Alaska Association of School Administrators (AASA)

Current State of School District Health Plans
Although many superintendents' opinions may vary of the details, most want cost containment and efficiency in their health plans. He does not believe that school boards or superintendents select a health plan based on pressure at the bargaining table – it's solely economics.

Remote school districts use rich health plans, as a recruiting tool, to compete with the larger school districts. Often rural district plans have minimal or no copays.

School superintendents expect to see plan options in a state-wide system. Three plan levels would be reasonable.

There have been some concerns about what it would mean to have a state-wide health plan. For example, would that entail bargaining at the state level? Would that deprive school boards and superintendents of managerial discretion? What would be left for collective bargaining?

Mr. Johnson indicated that some school districts partner with cities or boroughs to get better economies. Would those municipalities be able to join a state-plan for school employees? If they couldn't it would probably hurt the municipalities.

Superintendents of large school districts believe that dealing with health plans – particularly the selection and evaluation process – is a pain, which they would prefer to avoid if possible. Superintendents would generally be happy to turn over the non-education functions to the state if the state could do it better or more cheaply. The legislature blames superintendents for not holding the line on health plan costs.

Without quantifying the time, effort, and cost of a school district sponsoring its own health plan, Mr. Johnson stressed that maintaining a health plan is a very time consuming task – particularly in years when a school district has put the plan out to market. He mentioned in Juneau and Kodiak the schools had poor plans, so they created a joint labor-management committee to study their options. This was a very time consuming exercise. The Business Office is constantly helping employees with all sorts

of health plan issues. Superintendents would prefer to devote staff efforts to teaching students. Additionally, the collective bargaining process is enervating and very stressful.

One way school districts control cost is by bargaining for multi-year contract, with a sharing of any cost increases above the base year. Mr. Johnson suggested that cost-sharing could be 50/50 in the out years of the contract.

Mr. Johnson indicated that a few years ago a school district had been in the municipal plan, but when it was hit with a large premium increase it shopped for a new plan, and went with the NEA-Alaska Plan. Leading up to the 2013-14 school year, the NEA-Alaska Plan initially announced a 13% increase, but it was eventually reduced by their reserves to a 6% increase for the current school year. Mr. Johnson indicated the NEA Plan cannot indefinitely subsidize the rates with reserves.

Regional Attendance Districts (REAA) are entirely funded by the State as there is no tax base. These REAAs are part of the 53 school districts. The REAAs are often on Indian, state or Federal land, which often constricts where teachers can live. Schools qualify for Federal Impact Aide, but the State keeps 90% of that money, transmitting only 10% to the affected schools.

Mr. Johnson mentioned that in Oregon, a voluntary participation arrangement for schools did not work well, making necessary to require schools' participation in the state plan.

Mr. Johnson said the Education Department would be able to provide us details on state funding.

Future of School District Health Plans

Mr. Johnson suggested that if the state were to establish, for example, three levels of health plans for schools – e.g., low, standard, and premium coverage – over time, he would think that schools and employees would gravitate to the standard coverage as schools would gradually shift the cost for the difference to employees.

Mr. Johnson stressed that Alaska's school districts are having an increasingly difficult time competing for good teachers and staff. He said that teacher pay has fallen behind that of the lower 48, and Alaska needs to free up money for teachers by reducing health plan costs. He indicated that he would expect that if money can be saved on health plan costs, those savings could be provided to employees in any number of ways, including, for example, healthcare spending accounts.

Mr. Johnson thought that rural school districts were more likely to use composite rates.

He also mentioned that some rural school districts may have low health plan participation rates, e.g., St. Mary's, because people are covered by the Indian Health Administration. St. Mary's pays employees a few hundred dollars a month to opt out of their school district coverage.

Mr. Johnson mentioned that he and others had recently met with Sen. Dunleavy, who stressed that the legislation for a state-wide plan would only work if it could reduce costs.

Interviewee: Joseph Reeves, Executive Director of Alaska Association of School Boards (AASB)

Mr. Reeves indicated that although the AASB has no official position on the subject of a State-wide health plan for school district employees, he knows superintendents and boards of education are expressing concern about increasing health plan costs. From the AASB's perspective, health plan coverage is important to attract and retain quality employees. He indicated that some school districts need rich plans to attract employees because they don't have the allure of some large school districts. He also mentioned that even though Juneau has no land access, it is a highly desirable place to work, in part because of its moderate climate. The school districts with little or no road access need strong health plans to attract employees.

Mr. Reeves indicated that there are three REAAs on the road system: Alaska Gateway, Delta Greenley, and Copper River. The State funds the entire school district budget for all REAAs.

Mr. Reeves acknowledged that health plans are employee-centric, and Alaska school districts' the health plans are very generous for employees. He knows some school districts use trusts. Regarding the NEA-Alaska Plan, his opinion is that some school boards are pushed into accepting the NEA Plan in exchange for some things at the bargaining table, but he acknowledged that from an employee perspective the NEA Plan is a good, but expensive, plan. He acknowledged that some school districts combine coverage with their local boroughs in order to get better rates. He wondered what would happen to the boroughs if the State created a plan only for school districts. He understands the following school districts combine coverage with their local governments: Fairbanks, Cordova, Ketchikan, and Unalaska.

Mr. Reeves indicated that Alaska competes with Oregon for school employees, and Oregon not long ago moved to a state-wide health plan for school employees, covering about 170,000 lives. Mr. Reeves hoped that any State-wide plan would require school districts to participate, and not have the plan be voluntary.

Mr. Reeves expects that some boards of education and superintendents will be concerned that a State-wide plan will take away local control and make it harder for some school districts to attract and retain the best employees.

Interviewee: Rhonda Kitter, CFO of NEA – Alaska Health Fund

Overview
NEA-Alaska Health Plan ("the health plan" or the "fund") has been a Code § 501(c) (9) VEBA trust since 2000. NEA-Alaska and the NEA-Alaska Health Plan are distinct legal entities. To qualify for health plan coverage, the school district must have a bargaining relationship with at least one group of a school district's employees and the school district cannot combine coverage with any other employer that doesn't have a bargaining relationship with NEA-Alaska.

Ms. Kitter said that under federal law the health plan may only use trust fund assets for paying benefits and related administrative expenses. She stated that no trust assets are used for any other purpose.

The health plan offers health & welfare benefits to public school districts and associations who are members of the NEA-Alaska. The health plan currently offers benefits to 18-19 different school districts and associations, covering approximately 17,000 lives, of which there are about 5,800 covered employees.

Plan Designs
There are a total of 7 different medical plan designs (options A through G) and an additional high deductible health plan w/ HSA. The medical plans all use the same network, and vary principally (if not exclusively) in their copays, coinsurance, deductibles, and out-of-pocket maximums.

2 dental plans are offered, both with and without orthodontia.

There are a total of 29 different combinations of plans: for example: medical plan A, with dental plan A, with orthodontia.

Premiums
Premiums are set with help from Gallagher Consulting Group, and are rated by plan, as explained below, in April for a July 1 plan year. Each year each participating school district is informed of all options and pricing (provided as an aggregate rate that doesn't distinguish between single or family coverage). School districts can change plan designs each year. All school districts with the same health plan pay the same rate. Although the fund does not technically issue insurance, the fund acts in the same manner by guaranteeing that school districts will not be required, in any given year, to pay more than the specified rate, even if aggregate

claims and expenses exceed aggregate premiums. No experience refunds are granted, and the fund reserves the right to apply any surplus to reduce subsequent years' rates. No school district is penalized for adverse claims experience.

When premiums are developed for the upcoming year, the entire pool is projected as a whole (i.e. all plans share one rate increase percentage). The health plan is indifferent to which plan schools pick. Ms. Kitter mentioned that three years ago Gallagher internally re-calibrated the plans.

School districts can decide, based on the health plan's total premiums, how they want to share cost with employees. They can also leave the trust at the end of any year. Premiums are given based on one composite rate, but they do offer the 4 tier approach (ee only, ee + spouse, ee + child(ren), ee + family). Only 2-3 districts offer a 4 ties approach.

The health plan provides school districts with access to EBMS, which will establish and administer HRAs, FSAs, and HSAs.

In years when the fund has a surplus and rate increases would be unduly high, the health plan may use some of the trust surplus to "buy-down" the needed rate increase.

1 year ago – 10.2% increase bought-down to 6%
2 years ago – surplus, no increase
3 years ago – 19% increase bought-down to 12%

The health plan maintains an 18-month termination liability account. There are 2-3 other small reserve accounts.

Ms. Kitter said that in most school districts the cost-sharing is very generous. In Anchorage, the school district limits its costs, with the employees paying the difference.

Vendors
The health plan works with Gallagher Consulting Group out of Indiana for actuarial services (IBNR, pricing). They work with Wilson as an insurance based consulting firm, and also hire an investment firm.

Employee Benefit Management Services (EBMS) is the current TPA for medical. EBMS has a dedicated team that services the health plan.

Catamaran is the current PBM. (This is a relatively new PBM for the fund.)

BMI does claims audits.

Both claims payers have quality performance standards for accuracy and timeliness, with penalties where applicable.

The stop loss vendor is Elite (currently has only specific stop-loss at $700k)

The sense is that EBMS provides the benefit of being trainable, while Aetna and potentially BCBS is too corporate to meet the needs of the health plan. The health plan has trained EBMS on the local needs of Alaska school district employees (used example of giving customer service reps AK maps with maps of roads). The health plan views EBMS as a trusted partner and provides a dedicated health plan team with frequent status calls.

Total admin fee is 4-5% of total budget including investment income, or 6.25% excluding investment income

Strategy and Cost-containment
The health plan feels successful in mitigating health care cost trends. Currently employ patient-centered medical homes, and centers of excellence which are provided though Bridge Health to meet needs of employees and control costs.

Carving out Rx has shown significant performance improvement, as well as significant savings.

In addition, the health plan has conducted biometric screenings in Anchorage, and is looking to expand to Mat-Su.

Responsiveness
Ms. Kitter has only 3 additional people on staff, but she feels that when there's a problem EBMS is not handling properly, her staff gets involved to ensure the member receives care and benefits consistent with the plan documents. In one instance, EBMS made the wrong call and absorbed the cost of their mistake.

Challenges to the Health Plan
Ms. Kitter feels more school districts would join the health plan if they knew more about the health plan.
Lack of clarity – on a similar note, some school districts don't understand that the health plan is a VEBA trust separate from the NEA-Alaska and that all moneys must be used for purposes directly relating to H&W benefits, and cannot be used by the NEA-Alaska.

Despite this, they have managed to add a couple of school districts, and have not lost any.

Miscellaneous
There's only one city in Alaska with more than one hospital.

Very few school districts work with consultants or brokers.

Very few school district employees decline health plan coverage: 11% in Anchorage, 3-4% in Juneau.

Other School District Health Plans
NEA-Alaska Health Plan's main competition is:
Premera BCBS which is a TPA/insurer for smaller districts not in the health plan, and Aetna (Meritain) has presence in the state, including one of the state plans
Additionally, the Indian Health Service, which provides free health coverage, is widely used. Also, many people work for the military and get their healthcare coverage through Tricare.

Several Boroughs and school districts have trust/arrangement to jointly purchase health insurance, and because of the borough's inclusion in coverage, those school districts are not eligible to participate in the health plan.

The state offers two different health plans. In 2000 the State established a plan for all political subdivisions, including school districts. Smaller school districts can participate in a state-sponsored municipal plan, but very high premium increases have caused some to withdraw.

The State Employee plan currently offers 3 different plan options (there had been a 4th). Employees can buy up from basic coverage into either of the alternative plans. The State plan lacks dental and vision coverage, which the NEA-Alaska health plan feels are very important.

The health plan does not offer any retiree coverage. Retiree health coverage for school employees has been tied to the State Retirement Plan, but the State has been gradually eroding retiree health benefits for retirees.

Interviewee: Aetna, John Wagner – Market Head of Network and Tom Finn – Head of Regional Sales

Georgia uses state plans for school districts.
State of Alaska contains 86,000 members of Aetna's book of business.
In 2014, they pick up Health Care Cost Management Corporation (HCCMA) - 150,000 members across six states with a large portion of members in AK.

HCCMA contracts with several providers directly including Alaska Regional.

TPAs have historically provided limited discounts.
Providence hospital system is a big player in Alaska.
Alaska regional is another big hospital system Aetna contracts with for the SOA and HCCMCA.

These two hospitals compete against each other.

Travel benefits are a big point of concern.

How do you compare networks? Breadth and Value.
Alaska is unlike anything in the lower 48 states. Many providers won't work with insurance companies. For some providers willing to work with insurers, they work under unique financial arrangements – i.e. higher rates, or paying a percent of charges that could change at any time (no predictability in payment).

All competitors are trailing Premera who has the greatest market share based on enrollment. Aetna is in an advantageous unit cost position. Aetna has 85% of network capacity compared to Premera.

If looking at composition, Premera has much broader networks. Research is validated by third-parties. Aetna is unwilling to compromise contracting principles at egregious financial terms, which is the key reason for differences in network breadth relative to Premera and other competitors. Aetna's new clients will improve our ability to contract with physicians under financial terms favorable to employers.

Example: all cardiologists in Anchorage work for the same organization and contract as a whole entity, not as individuals. Outlying areas of Alaska clearly have gaps in coverage.

Overlying concern of the health care marketplace is not scarcity, its economics.

Aetna wrap around product – Network Advantage Plan, protects members from balance billing when accessing providers who are not contracted in Aetna's network, but are part of a rental network.

Can Aetna legitimately cover all Alaska school districts?
It depends on the geography of the schools. How creative can Aetna be? If we give the deeper discounts in the good market, and use wrap around products else-where we can use a multi-plan rental agreement with Aetna as primary to obtain good discounts.

Interviewee: Cigna, James Fitzpatrick and April Sinclair

Cigna is growing its Alaska network. They have good penetration in certain parts of the State, but not others. Cigna hired Ms. Sinclair to expand their provider network. She is actively working on adding hospitals in Juneau, Sitka, and elsewhere.

Their view is that given the limited number of hospitals and medical practitioners, it is very difficult to obtain deep discounts even for larger carriers with more covered lives. Providers expect, and generally get, payments close to their undiscounted rates.

Cigna said they have rigorous credentialing process for network providers, including provider credentialing which adheres to the NCQA standard.

As a general matter most of Cigna's members in Alaska are under ASO arrangements with employers headquartered not in Alaska. Their rough estimate is that they have about 20,000 covered lives in Alaska.

Cigna is focused on developing and maintaining direct networks. There are numerous administrative problems with trying to administer a plan with more than one network.

Cigna is proud of their evolving predictive modeling, through which Cigna can predict the severity of an illness and gaps in care, both of which can be remedied through communications with the member and/or the provider. Additionally, Cigna is engaged in developing direct interfaces with providers, in order to reduce gaps in care.

Interviewee: Premera, Jeff Davis, Jennifer Dahline, Lunn Rust Henderson

Premera has the largest provider network in the State. Behind Premera are Aetna and Moda. Because of the limited number of providers, there is very little competition among providers. Anchorage is the only area where there is competition for hospital services. Premera has contracts in place with all non-government hospitals.

In Anchorage, Providence Hospital has around 80% of the market. Other hospitals in the area are Alaska Regional and Matsu Regional, which is a preferred provider along with Providence.

Premera pointed out, for example, that in Fairbanks there is only one multi-specialty group. For example in Anchorage, Premera has 99 chiropractors, compared to 42 for Aetna.

Premera has the largest primary care network. It is difficult to get specialists in the network, because there are so few they don't need to accept network discounts. For this reason Premera has a Medical Travel program, which will enable people with certain health conditions to fly to the lower 48 for treatment.

Jennifer Dahline indicated that their network operations are based in Seattle. She has a staff of 5.

Premera is trying to pare down its network to get better pricing; they currently do not use a secondary network in the State of Alaska.

Premera covers 28,000 Federal employees in the State.

IX. Appendix: Health Plan Options Summary

Option 1: Optimize program performance

- Consolidate all school districts into one combined pool with centrally managed procurement, enterprise health care program management, and optimized vendor/provider contracting by a state-managed entity (or "Department").
- Includes gradual reduction and narrowing of the health plan design options available to school districts.
- This Department handles rate setting for all plan designs offered by school districts. School districts can then independently determine how much to charge their employees and dependents.

Option 2: Utilize the Department of Administration's AlaskaCare

- Consolidate as in option 1, but leverage the AlaskaCare program managed by the Department of Administration and adopt the plan options currently available through AlaskaCare. To mitigate risk of increased plan design costs, the State can limit the choice to just the Economy and/or Standard plans.

Option 3: Centrally managed school district program with standard health plan options and cost sharing

- Build upon option 2 but employees would be offered a different menu of health plan options than the current AlaskaCare lineup. This new menu would more closely align with the current school district offerings.
- Create a uniform premium cost sharing strategy for school districts to follow.

Option 4: Centrally managed school district program with standard health plan options only

- Variation of option 3 that provides continued discretion to school districts to set their own premium cost sharing levels based on their individual requirements.

	Potential Savings			
Source	**Option 1: Optimize Program Performance Only**	**Option 2: Utilize DoA's AlaskaCare**	**Option 3: New Entity with Standard Plan Options and Cost Sharing**	**Option 4: New Entity with Standard Plan Options (no standard cost sharing)**
Provider Networks				
Medical provider network	$9,800,000 - $20,800,000	$9,800,000 - $20,800,000	$9,800,000 - $20,800,000	$9,800,000 - $20,800,000
Pharmacy carve out	$1,000,000 - $1,700,000	$1,000,000 - $1,700,000	$1,000,000 - $1,700,000	$1,000,000 - $1,700,000
Overhead				
Fully Insured Overhead	$1,200,000	$1,200,000	$1,200,000	$1,200,000
Stop Loss Fees	$1,100,000	$1,100,000	$1,100,000	$1,100,000
Broker Revenue	$4,000,000	$4,000,000	$4,000,000	$4,000,000
Plan Design	Cost neutral	($25,800,000) - $6,100,000	($7,700,000) - $36,100,000	($7,700,000) - $36,100,000
Cost Sharing	$0	$0	$13,300,000 - ($31,200,000)	$0
Total Savings	**$17,100,000 - $28,800,000**	**($8,700,000) - $34,900,000**	**$22,700,000 - $33,700,000**	**$9,400,000 - $64,900,000**
% of total costs	**5.8% - 9.8%**	**(2.9%) - 11.8%**	**7.7% - 11.4%**	**3.2% - 22.0%**

	Positive Outcomes	Negative Outcomes
All Options	▪ Improve vendor contract terms ▪ Increase in compliance ▪ Reduce annual volatility in costs ▪ Consistent benefits offering to all districts ▪ Reduce duplicative resources ▪ Efficient health management	▪ Reduce district staff administration ▪ Reduce district decision-making
Option 1: Optimize Program Performance Only	▪ Cost savings with same level of benefits ▪ Simplify bargaining negotiations ▪ Districts allowed to set contributions	▪ Increase State administration
Option 2: Utilize DoA's AlaskaCare	▪ Cost savings but different benefits ▪ Districts allowed to set contributions ▪ Leverage State resources already in place	▪ Disruption in plan design ▪ Bargaining negotiations restricted
Option 3: New Entity with Standard Plan Options and Cost Sharing	▪ Cost savings but different benefits ▪ All districts have same contributions	▪ Disruption in plan design ▪ Bargaining negotiations restricted ▪ Eliminate district decision-making
Option 4: New Entity with Standard Plan Options (no standard cost sharing)	▪ Cost savings but different benefits ▪ Districts allowed to set contributions	▪ Disruption in plan design ▪ Bargaining negotiations restricted

X. Appendix: Plan Design Factor Methodology, Qualifications and Assumptions

Hay Group utilizes an actuarial health pricing model which is capable of isolating plan design differences when comparing health plans. This model relies on annually updated national benchmark claims data from over 20 million lives.

The value comparison methodology calculates the difference in health plan costs attributed solely to plan design by using a common set of assumptions about demographic, geographic, and economic factors. The resulting plan design factors permit objective "apples-to-apples" comparisons of the health plans provided by various employers. Differences in benefit values for the employer plans being compared can be traced directly to design differences.

Plan design factors are based on common assumptions between plans and can be adjusted for utilization, geography, demographics, and industry. By examining frequency, duration, and unit costs of all possible types of health care benefits, plan design costs and factors are developed based on the expected utilization and cost of the assumed population.

One key to this "common cost" approach is the use of a single, realistic method for all plans being valued. All plans in the study are, in effect, "purchased" for the same group of employees from the same source using the same financing technique. The "employees" are a typical mix of employees that might be found working for a large employer. The "providers" are a hypothetical group of insurance companies and/or trustees who are "selling" coverage using the same average group rates, actuarial assumptions, and experience ratings for all the plans in the study. The result is an actuarially derived "common cost" for each plan, expressed as a dollar value.

The projections utilized in this report are based upon data provided from public school districts and key stakeholders. Hay Group conducted checks for reasonability and provided follow-up where any data appeared inconsistent; however, we did not audit school district provided survey data.

Hay Group believes the savings estimates in this report are reasonable estimates for the purposes of making broad, strategic decisions. Health claims are random events and as such are subject to variance. Hence, savings estimates must be understood to have some unknown likelihood.

XI. Appendix: Glossary

ACA – the Patient Protection and Affordable Care Act (PPACA), or the Affordable Care Act (ACA) for short

Accountable Care Organization (ACO) – Created by the ACA as pilot programs under Medicare, an ACO is a group of physicians, hospitals, or other health care professionals, who agree to work together to coordinate care with the goal of limiting unnecessary spending, achieving better outcomes, and thus slowing the growth of health care costs. How it works: ACOs make providers jointly accountable for the health of their patients and are incentivized to improve clinical performance and reduce unnecessary care and treatments. In return, the medical practitioners receive a share of the savings as long as they meet a list of quality standards. ACOs are still paid based on the current fee for service structure but allows for a share of the savings as bonus payments. The ACO concept is fully functional and working well at Gessinger Health Plan in central Pennsylvania and the Cleveland Clinic, to name but a few examples.

Administrative Services Only (ASO) Contract – Contract with an insurance company or health plan to provide self-funded benefits to an employer or other plan sponsor. An ASO contract is not an insurance policy, because the health plan does not take any insurance risk, but only administers benefits funded by the health plan sponsor. In this case, the health plan administrator takes the role of a third-party administrator (TPA).

Base Student Allocation (BSA) – The Base Student Allocation is sometimes used as a measure of K-12 funding. The formula for K-12 funding is: Basic Need = BSA * Student Count (ADM) * Adjustment Factors

Carve-Out – Removing a specific benefit from the contract with the primary health plan and negotiating the coverage separately, usually with a specialty vendor or network. For instance, prescription drug coverage is often purchased separately on a self-funded basis from a specialized pharmacy benefit manager.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and similar provisions for governmental plans, providing extended health plan coverage for former employees and their eligible dependents.

Coinsurance – A common provision of healthcare plans in which the covered individual and the insurer or plan sponsor share in a specified ratio of health care expenses (*e.g.*, 80% paid by plan, 20% paid by participant). Typically the percentage of coinsurance refers to the percentage covered by the plan. In a PPO or POS plan, the ratio usually favors the covered individual when the costs are

incurred with providers who are part of the PPO or part of a specified network (*e.g.*, 100% coverage within the PPO or network and 70% coinsurance for providers outside the PPO or network).

Coordination of Benefits (COB) – A provision of a group health plan that eliminates duplicate payments from multiple carriers and prevents an employee from collecting more than 100 percent of the charges for the same medical expense. The provision also designates the sequence in which primary and secondary coverage will be paid when an individual is covered under two plans.

Co-payments – Payments which are required to be made by covered participants on a per service basis (*e.g.*, $20 co-pay per physician visit). Co-payments are commonly used to discourage inappropriate utilization and to help finance healthcare plans.

DOA – State of Alaska Department of Administration

Deductible – The amount paid by an employee for covered expenses in a group health plan before the plan pays benefits. A typical plan would follow a calendar year schedule and specify an individual deductible and a higher family deductible.

Experience Rating – A premium based on the anticipated claims experience of, or utilization of service, by a contract group according to its age, sex, and any other attributes expected to affect its health service utilization. Such a premium is subject to periodic adjustment, generally on an annual basis, in line with actual claims or utilization experience.

Fee-for-Service Plan (FFS) – A traditional plan which provides for each reimbursement for designated covered healthcare services on a fee-for-service basis, with no provider network or negotiated discounts.

Formulary – A list of preferred medications within a prescription drug plan that have been chosen by the pharmacy benefits manager (PBM). Typically, formularies are developed to steer plan participants and their physicians to cost effective or discounted drug alternatives, through lower co-pays or coinsurances.

FTE – Full time equivalents

Gatekeeper - Usually a primary care physician, who is responsible for directing the patient's care. To receive full benefits, participants must be referred to other medical specialists by their gatekeeper physician. This type of physician generally is found in HMOs and Point-of-Service (POS) networks.

Health Maintenance Organization (HMO) – A pre-paid medical group practice plan that provides a comprehensive predetermined medical care benefit. In order for an individual's healthcare costs to be paid, the individual must utilize services from the specified HMO network of providers. A participant's care is monitored and controlled by a selected primary care physician who is accountable for the total health services of the participant, arranges referrals and supervises other care, such as specialist services and hospitalization.

Health Reimbursement Account (HRA) – A tax free employer funded account that provides employees with medical care expense reimbursements. These accounts allow unused funds within the account to be carried forward to future years. HRAs are typically provided with high deductible medical plans.

Health Risk Assessment – A method of appraising the health status of a plan participant, generally via a health questionnaire and basic health measurements.

Health Savings Account (HSA) – A pre-tax account that is funded by employees and/or employers to cover employees' out-of-pocket expenses. These accounts require an employee to be enrolled in a qualified high deductible plan. Unused funds in the HSA may be carried forward to future years.

High Deductible Health Plan (HDHP) – For calendar year 2013, a "high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,250 for self-only coverage or $2,500 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,250 for self-only coverage or $12,500 for family coverage.

Indemnity Plan – A traditional plan which provides for each reimbursement for designated covered healthcare services on a fee-for-service basis, with no provider network or negotiated discounts.

LIUNA – Laborers International Union of North America

NEA-Alaska – The state affiliate of the National Education Association

Out-of-Pocket (OOP) Limit or Out-of-Pocket (OOP) Maximum – The maximum amount of out-of-pocket healthcare expenses that a participant is responsible for during a plan year. Every dollar spent on healthcare after this amount is generally reimbursed in full.

P50 – The 50^{th} percentile of the dataset.

Partially insured – benefit plan funding method in which the employer carries the risk for any claims but also has a stop-loss provision in place to insure against catastrophic claim(s).

Per Employee Per Year (PEPY) – A basis for measuring costs over an annual period per employee.

Per Member Per Year (PMPY) – A basis for measuring costs over an annual period per member (employees and their dependents).

Pharmacy Benefit Manager (PBM) – An organization that administers prescription drug benefits. PBMs can be stand alone organizations or part of the carrier that handles the medical benefits. Typically, PBMs negotiate deeper prescription drug discounts, use lists of preferred drugs called a "formulary," and coordinate and monitor patients' prescription drug utilization thus reducing dangerous drug interactions and in other ways enhancing patient care.

PPACA – Patient Protection and Affordable Care Act, or the Affordable Care Act (ACA) for short.

Precertification/Predetermination – An administrative procedure whereby a health care provider submits a treatment plan to a third party, such as a case manager, before treatment is started. The third party reviews the treatment plan, indicating the patient's eligibility, covered services, amounts payable, application of appropriate deductibles and co-payments and plan maximums.

Point-of-Service Plan (POS) – A type of managed care system that combines features of indemnity plans and HMOs and uses in-network and out-of-network features. A gatekeeper is used to direct an individual to medical care within the network. The covered participant also has the option to received care from any out-of-network provider. If care is received out-of-network, the participant will pay higher co-payments and/or deductibles.

Preferred Provider Organization (PPO) – A group of hospitals and physicians that contract on a fee-for-service basis with employers, insurance companies and other third party administrators, to provide comprehensive medical service. Providers exchange discounted services for increased volume. Participants' out-of-pocket costs are usually lower than under a traditional fee-for-service or indemnity plan. If the network-based health plan has gatekeeper/primary physician requirements, it is not a PPO plan, but a Point of Service (POS) plan.

SFC – Senate Finance Committee of the State of Alaska Senate

Self-administered Plan – Refers to a benefit plan in which the company assumes responsibility for full administration of the plan, including claims administration.

Self-funding or self-insured – A benefit plan funding method in which the employer carries the risk for any claims. The employer may contract with a third party administrator to pay claims in its behalf, or may develop its own department to administer the program.

SERS – State of Alaska School Employees' Retirement System

Stop-loss provision – A provision in a self-funded plan that is designed to limit an employer's risk of losses to a specific amount. If claim costs (for a month or year or per claim) exceed a predetermined level, an insurance carrier will cover the excess amount.

PERS – State of Alaska Public Employees Retirement System

TRS – State of Alaska Teachers Retirement System

Third Party Administrator (TPA) – In a health benefit plan, the person or organization with responsibility for plan administration, including claims payments.

Voluntary Employees' Beneficiary Association (VEBA) – A tax-exempt trust established to fund employee welfare benefits other than pensions. Also known as 501(c)(9) trust, after the section of the Internal Revenue Code authorizing their tax exemption.