



# **HEALTH CARE FEASIBILITY STUDY REPORT**

*Revised December 1999*

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# California State Teachers' Retirement System

## Health Benefits Feasibility Study

### Final Report

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**EXECUTIVE SUMMARY**

After years of unsuccessful efforts, the Governor signed legislation last year that requires the Teachers' Retirement Board to conduct a feasibility study on the need and demand for healthcare, including vision and dental insurance, for active, disabled, and retired CalSTRS members, their beneficiaries, children and dependent parents. Currently, there is no statewide healthcare program for California State Teachers' Retirement System (CalSTRS) members. Healthcare coverage varies greatly and is provided by school district employers on a district-by-district basis, as negotiated in agreements with employee bargaining representatives. Only a few districts offer vested health insurance benefits to retired CalSTRS members. Some districts make these benefits available, but some only subsidize the premium until the retiree reaches the age of 65. The healthcare issue for members is further compounded because some retired CalSTRS members are not eligible for Medicare coverage. Healthcare costs can threaten a member's economic security; therefore, affordable healthcare coverage should be an integral part of a secure retirement for all CalSTRS members.

This is the revised report to the Teachers' Retirement Board (Board) on the results of the feasibility study and various alternatives available to the Board. The information was compiled through a collaborative effort that included CalSTRS staff, an outside consultant and members of the Health Benefits Task Force (Task Force). Additional input was also obtained from the Health Executive Advisory Review Committee (a group of healthcare professionals).

With the cooperation of school districts, community college districts, county offices of education, Joint Power Authorities, Trusts (collectively referred to as plan sponsors), and the active and retired membership of CalSTRS, sufficient information from surveys regarding healthcare coverage and needs was obtained to help CalSTRS fulfill its "study" responsibility. The overall response from CalSTRS' solicitation for information from the plan sponsors and CalSTRS' active and retired population was substantial. Specifically, 38.1 percent of the surveyed actives and 60.1 percent of the surveyed retirees responded to the health benefits survey. Of the plan sponsors surveyed, 29.2 percent of the school/community college districts and county offices of education responded, as well as 9.7 percent of the JPAs and Trusts.

We wish to express our appreciation to the plan sponsors and CalSTRS' active and retired membership who participated in this study. A very special thank you goes out to the members of the Task Force for their commitment to this project and the many hours spent in numerous meetings discussing the healthcare needs of their constituents. We hope that the results will be useful in providing a much improved and different health care benefits program than what currently exists for many of CalSTRS educators and retired members.

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## **BACKGROUND**

The California State Teachers' Retirement System (CalSTRS) was required by Chapter 968, Statutes of 1998 (SB 1528) to determine the feasibility of providing health insurance benefits, including vision and dental care benefits, for active, disabled, and retired members, beneficiaries, children, and dependent parents. Chapter 968 required the study to assess the lack of access to health insurance benefits for retired teachers and evaluate:

- the need and demand for health insurance benefits;
- the integration of health insurance benefits and Medicare coverage; and
- the manner in which health insurance benefits would be administered and provided.

To assist with the feasibility study, CalSTRS contracted with William M. Mercer, Inc. (Mercer). Mercer, along with CalSTRS staff, developed health benefit surveys to obtain pertinent information for the study. These surveys were sent to 10,000 selected active, retired and disabled CalSTRS members; 1,117 plan sponsors; and 31 Joint Power Authorities and Trusts (which are groups of employers and/or employee organizations that combine to administer health benefit programs). Mercer, in conjunction with CalSTRS staff, was also responsible for the statistical analysis of the information obtained from the surveys.

Additional research for the study by CalSTRS staff included the completion of telephone interviews of various states that responded to an original screening questionnaire concerning their state's health care benefits program for school district employees. A screening questionnaire was mailed to all 50 states. Forty-two states responded. Based on the information provided, 10 states were asked to participate in an in-depth telephone interview because their state's profile regarding teachers' benefits was most similar to CalSTRS'. The states selected were Arizona, Colorado, Louisiana, New Jersey, Ohio, Oklahoma, Tennessee, Virginia, Washington, and Wisconsin.

CalSTRS also established a Health Benefits Task Force, consisting of representatives from various school districts, community college districts, constituency groups, Trusts, the State Controller's Office and the State Treasurer's Office. The purpose of the Task Force was to provide CalSTRS and Mercer insight into the needs of the retirees, employees, and employers, identify options currently available to CalSTRS members, and to provide information that would assist in the development of recommendations for consideration by the Board. Additionally, the Task Force provided information to Mercer in the development of the survey instruments and other critical data gathering needs. The Task Force initially met with CalSTRS staff and Mercer on March 22, 1999, with regularly scheduled meetings thereafter.

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## **DISCUSSION**

Mercer has completed Phase One of their services in which they conducted a comprehensive survey and analysis resulting in an in-depth study for the Board. Their full report with discussion, analysis, data and conclusions is included as Attachment I.

The surveys provided invaluable information – some of which was unexpected. For instance, the survey indicated that more than 90% of the retiree respondents currently have medical coverage other than Medicare. However, most retirees pay all or a significant portion of the monthly premium for the coverage. In addition, almost 80% of the retiree respondents over the age of 65 have Medicare Part A coverage at no cost to themselves, through their own Medicare eligibility or that of their spouse (another 5% purchase Medicare Part A coverage for \$309 a month).

There are still 20% without Medicare eligibility, which represents an estimated 22,000 retirees over the age of 65. This is still a staggering number. Of the 20% without Medicare eligibility, 10 % also have no healthcare coverage. The main reason survey respondents gave for not having medical coverage was cost related and most retirees without coverage are those at the lower income levels.

Staff had anticipated a lower rate of health care coverage by the retirees. In further analysis, however, the data indicates that only 35% of the retirees over the age of 65 receive health care coverage from a former education employer. Of these retirees, almost 50% pay between \$2 and \$250+ a month for the coverage.

Following is some statistical information that demonstrates the survey findings when extrapolated to the retired membership:

- As of 6/30/98, CalSTRS had 145,000 retirees  
100,228 – or 76% - are over 65
  - The single largest group of these retirees, 45% - or 49,500 – have individual coverage. Over 88% - or 43,500 – pay \$2 to more than \$250 per month, in fact, 17% - or 8,415 – pay more than \$250 per month.
  - Of these retirees, 36% - or 40,000 – receive medical coverage from their former education employers; however, 50% pay between \$2 and more than \$250 a month for the coverage. Therefore, only 20,000 retirees over the age of 65 receive fully subsidized healthcare from their former education employers.
  - The remaining 19% receive medical coverage from a former employer that is not an educational employer (3%) or a spouse's employer (16%) – 21,000 retirees – of which 50% pay between \$2 and more than \$250 a month for the coverage.

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- 22,000 – or 20% - of retirees are not eligible for Medicare coverage.
  - Of these retirees, 90% have medical coverage leaving, however, 10% - or 2,222 – with no medical or Medicare coverage. Of the 20,000 with medical coverage as well, 70% - 14,000 – pay between \$2 and more than \$250 a month. These retirees are typically the lower paid.

35,000 – or 24% - are under the age of 65

- Of these retirees, 60% - or 21,000 – receive fully subsidized coverage from their former employer.

As evidenced on the information provided by the survey and input from the Task Force, a substantial number of retirees have access to healthcare but costs are a significant issue. However, the Task Force participants feel it is critical to point out that while some retirees are currently receiving health care coverage from their former employer at a reduced rate, they do not believe many employers will be able to maintain the current level of subsidy in the future due to the rising cost of health care. A number of employers confirmed this information.

Some Task Force participants also pointed out that the number of retirees with subsidized health care is likely artificially high because of prior incentives used to encourage early retirements, such as, extended or lifetime health care coverage. According to many employers, these types of incentives, however, are not expected to continue in the future, again, because of the rising cost of health care.

The primary needs identified from the active and retiree surveys are to:

- ensure that retiree health care coverage is stable and available for CalSTRS members and their dependents;
- provide coverage for all California public school educators at lower cost, while preserving or improving access and quality of care.

In the final analysis, the survey respondents and Task Force participants believe that CalSTRS should proceed to design and offer health care coverage, including dental and vision options. In order to proceed, however, it is critical to continue working with the Task Force and to partner with them in its implementation. CalSTRS staff feels strongly that all Task Force participants are committed to the successful completion of this project and will maintain a strong and active involvement in future phases.

## **ALTERNATIVE APPROACHES**

Mercer has developed the following high level alternative approaches to providing health care coverage should the Teachers' Retirement Board choose to proceed. While these alternatives are not all-inclusive they represent Mercer's suggestions of the most viable options having the highest likelihood of success given our membership and the survey results. The alternatives are

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not mutually exclusive and the Board may adopt a combination of the alternatives. The Board, of course, may direct staff to proceed in a different manner:

1. Establish a CalSTRS medical benefits program by contracting with existing vendors of health care coverage;
2. Establish a CalSTRS medical benefits program by contracting directly with the providers (physicians, hospitals, laboratories, etc);
3. Establish a voluntary medical benefit program for retirees/part-time employees;
4. Establish a pharmacy/prescription drug benefit program;
5. Establish dental/vision programs for school districts by contracting with existing vendors of dental/vision coverage;
6. Establish dental/vision programs for individual voluntary enrollment only;
7. Provide funding for retirees not eligible for Medicare Part A; and
8. Allow individual CalSTRS members to participate in a tax advantaged savings program for retiree health care.

## **RECOMMENDATIONS**

Staff recommends the Board proceed to develop a healthcare benefits program. Although the majority of retirees currently have medical coverage, it is not affordable to most retirees and all indications are that health care costs will increase significantly in the near future. It is anticipated that CalSTRS' buying power as a large purchaser would reduce costs. Staff recommends the Board adopt the following alternatives and actions:

- Alternative 2; Direct Contracting initiated on a pilot basis, as specified below
- Alternative 3; Voluntary medical benefit program for retirees/part-time employees, modified as specified below
- Alternative 4; Pharmacy/prescription drug program
- Alternative 5; Dental/vision program
- Alternative 7; Medicare Part A funding, as specified below
  
- Additional Alternative; CalPERS, as modified (could be a supplement to or in place of Alternative 2 above)
  
- Direct staff to obtain the expertise to develop criteria and recommendations for Alternative 2.

(Please refer to Attachment I for a detailed discussion of each alternative.)

Alternative 2 – provides a great opportunity to CalSTRS by proposing to obtain health care services through direct contracts with providers. Rapidly consolidating health plans have resulted in fewer options on the market for employers making direct contracting an advantageous method at this time. Also, many providers have expressed dissatisfaction with their interaction with existing health plans. This opens up opportunities for contracting directly with providers in

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search of good rates and better service. Employers would be allowed to participate on a voluntary basis.

Staff recommends the Board implement direct contracting on a pilot basis, with criteria developed in concert with the consultant and Task Force. This Alternative is a reasonable approach to testing the viability of direct contracting. A pilot provides the least exposure to the Board in the event direct contracting does not provide the intended results.

Staff also recommends that CalSTRS contract for consulting legal services to assist staff in the development of appropriate contract documents. As staff becomes more familiar with the requirements of this subject area, staff could assume responsibilities for this function internally.

Improved quality of care is an intended outcome of this methodology. In addition, although administrative costs would be higher because the contracting process would be more labor intensive, direct contracting should result in lower program costs that would more than offset the increased administrative costs.

Implementing a voluntary health care program through direct contracting on a pilot basis, however, does not immediately address the needs of the target population – uncovered retirees. Therefore, staff recommends the Board adopt the following alternatives for a comprehensive approach to a CalSTRS program.

i. Kaiser

Forty percent of the district respondents offer Kaiser as an option to their employees. Staff believes that a CalSTRS health care program would not be viable without the ability for employers and employees to choose Kaiser. Therefore, staff believes that CalSTRS should offer Kaiser either through CalPERS, as modified for public schools, or through a separate CalSTRS program.

In addition to direct contacting in identified geographic regions and Kaiser, this alternative is proposed to include an out-of-area plan for those individuals living outside of the provider area; and an out-of-network option (e.g., Preferred Provider Organization/Point of Service).

ii. Alternative 7

This alternative provides funding for those retirees without Medicare eligibility. Staff, however, believes that this subsidy should be provided only to those retirees whose total income is below a specified threshold. Criteria for a means test should be developed and implemented to insure subsidies are not provided to those retirees with the resources to pay for health care coverage.

This alternative, however, addresses only those retirees who are 65 and older. Therefore, staff recommends the Board adopt a modified version of Alternative 3 to provide



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healthcare coverage to those retirees under the age of 65 who have not yet become eligible for Medicare or do not have Medicare eligibility. The same criteria for a subsidy should be applied to this group as well.

Staff believes it is essential for the Board to implement this alternative at a minimum in order to meet the fundamental health care needs of CalSTRS retirees. Alternative 7 can be implemented on a statewide basis at the outset.

iii. Additional Alternative – CalPERS

There are approximately 1100 school districts of which 98 have contracted with the California Public Employees' Retirement System (CalPERS) for their health care coverage. In order to participate in the CalPERS PEMHCA program, school districts must comply with the laws and rules governing their program. Most notably, the CalPERS requirement that any employer participating in the PEMHCA program is mandated to provide health benefit coverage for their retirees through PEMHCA in the same manner as active employees. Most school districts have not been willing to comply with a number of the provisions; therefore, they have not contracted with CalPERS for the PEMHCA.

A few years ago CalSTRS client organizations introduced legislation to amend those provisions in the CalPERS PEMHCA program that school districts opposed. The legislation was not successful largely due to opposition from CalPERS and their client organizations. In addition to the statutory requirements, many school districts prefer plan design options not provided by the CalPERS program.

CalPERS staff has extended an invitation to CalSTRS staff to present CalSTRS' initial findings to the CalPERS Health Benefits Committee at their December meeting. If the CalPERS Board were to change their historical position on the previous legislative amendments to PEMHCA, a joint venture might be possible.

- iv. In addition to providing a statewide healthcare program, staff is recommending CalSTRS establish statewide dental/vision programs, Alternative 5, and a prescription drug program, Alternative 4, as separate options to employers. Employers would be given reasonable choices among options consistent with the ability to control adverse selection.

### **HEALTH BENEFITS TASK FORCE INPUT**

The alternatives prepared by Mercer were presented in draft form to the Health Benefits Task Force. Their comments are incorporated in the following discussion and were considered by staff in the development of the recommendations.

The following section of this report presents the detailed discussions and key findings of each issue by the individual organizations. As presented by the Task Force, these factors are their

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recommendations for the foundation on which a statewide health benefits program, if developed, be based in order to meet the varying needs of the CalSTRS membership.

A. Approach

*How should CalSTRS secure the services of health care providers? What services/programs in addition to healthcare should CalSTRS provide?*

| <b>Vendors<br/>Alternative 1</b> | <b>Direct Contract<br/>Alternative 2</b> | <b>Prescription<br/>Alternative 4</b> | <b>Dental/Vision<br/>Alternative 5</b> | <b>CalPERS</b> | <b>No<br/>Position</b> |
|----------------------------------|--|---------------------------------------|--|----------------|------------------------|
|                                  | CTA                                      | CVT                                   | FACCC                                  | FACCC          | CRTA                   |
|                                  | VEBA                                     | FACCC                                 |  |                | CCA                    |
|                                  | LACCD                                    | CSBA                                  |  |                |                        |
|                                  | ACSA                                     | ACSA                                  |  |                |                        |
|                                  | FACCC                                    |                                       |  |                |                        |
|                                  | CSBA                                     |                                       |  |                |                        |
|                                  | ART                                      |                                       |  |                |                        |
|                                  | UTLA                                     |                                       |  |                |                        |
|                                  | CFT                                      |                                       |  |                |                        |
|                                  | LAUSD                                    |                                       |  |                |                        |
|                                  | ACCCA                                    |                                       |  |                |                        |
|                                  | CVT                                      |                                       |  |                |                        |

The overwhelming choice was for CalSTRS to obtain the services through direct contracting with hospitals, physician groups, labs, etc. The Task Force recognizes the increased administrative effort that would be required, however, the potential for increased quality of service and patient care outweighed the increased administration. There was significant discussion about the necessary research and controls that would be required to reduce the risk of provider insolvency and bankruptcy. These safeguards should be identified and implemented during the provider acquisition phase.

Further, although some Task Force participants did not expressly identify other programs to implement, the general consensus was to include a carve-out prescription drug program and the option to participate in a dental and/or vision program. While the Task Force felt that CalSTRS should offer these programs, they did not want employers to be required to utilize all the services. Employers should be able to choose which services are utilized from all the options offered subject to adverse selection controls.

Administration of the services and cost-containment methods were discussed briefly, however, that discussion was tabled for the next phase of the project.

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**B. Voluntary vs. Mandatory Participation**

*Should districts be allowed to voluntarily participate in a CalSTRS health benefits program or should districts be mandated to participate?*

| <b>Voluntary</b> | <b>Mandatory</b> | <b>No Position</b> |
|------------------|------------------|--------------------|
| CTA              |                  |                    |
| VEBA             |                  |                    |
| CVT              |                  |                    |
| LACCD            |                  |                    |
| ACSA             |                  |                    |
| FACCC            |                  |                    |
| CSBA             |                  |                    |
| ART              |                  |                    |
| UTLA             |                  |                    |
| CFT              |                  |                    |
| LAUSD            |                  |                    |
| CRTA             |                  |                    |
| ACCCA            |                  |                    |
| CCAЕ             |                  |                    |

As represented by the above table, all organizations agreed that participation in a CalSTRS healthcare program should be voluntary. The organizations also agreed that districts choosing to participate in the program should not be required to bring in their retirees. However, incentives for employers to provide health benefits coverage to their retirees should be provided. Also, the CalSTRS program should require employers who currently cover retirees for health benefits and subsidize all or some of the premiums, continue the same level of subsidy initially (one must be reminded that future bargaining agreements could modify the district subsidy for retirees).

Several other important questions surfaced regarding voluntary participation that require further research, as follows:

- should all employees be required to contribute if their employer chooses to participate in a system-sponsored plan in order to prevent adverse selection?
- what about employees who have coverage through a spouse or other employer?

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C. Pilot

*Should CalSTRS implement a health benefits program on a pilot basis?*

| Yes | No | Comments  |
|-----|----|---|
|     |    | Must include sm/med/lg employers, community college & rural |
|     |    | LACCD   |
|     |    | ACSA  |
|     |    | FACCC   |
|     |    | CSBA  |
|     |    | ART   |
|     |    | Including retirees  |
|     |    | UTLA  |
|     |    | CFT   |
|     |    | With dental and vision                                      |
|     |    | LAUSD   |
|     |    | CRTA  |
|     |    | ACCCA   |
|     |    | VEBA  |
|     |    | But not in San Diego  |
|     |    | CVT   |
|     |    | Proceed with caution  |
|     |    | CCAIE   |
|     |    | Must include adult education                                |

All participants felt strongly that a pilot was appropriate (although recommended proceeding with caution) and should include a cross-section of the population, such as small/medium/large employers, K-12/community college, adult education/part-timers, urban/rural, and active/retired members. CFT requested that dental/vision be included in the pilot.

Task Force members also determined that criteria for eligibility to participate in a pilot program should be established (during the next phase of the study), but must contain the following at a minimum:

- must have a good relationship between management and labor;
- must contain a specific contract provision; and
- financial commitment by employer.

The Task Force will assist CalSTRS in identifying employers most likely to be willing to participate in a pilot.

Further discussion disclosed that there should be at least two pilots. The determination of the appropriate locations for the pilots must consider the location of the active and retired members (inside and outside California), location of service providers and the willingness of all parties.

D. Membership Criteria

*What groups of CalSTRS members should be allowed to participate in the system-sponsored health benefits program?*

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| Active | Retired | Rural/<br>Urban | Dependents | Part-time<br>Adult Ed | Classified | School<br>Boards | Charter<br>Schools | All   |
|--------|---------|-----------------|------------|-----------------------|------------|------------------|--------------------|-------|
| CTA    | CTA     | CTA             | CTA        | CTA                   | CTA        | CTA              |                    |       |
|        |         |                 |            |                       |            |                  |                    | ACCCA |
|        |         |                 |            |                       |            |                  |                    | CCAE  |
| CVT    | CVT     | CVT             | CVT        | CVT                   | CVT        | CVT              |                    |       |
|        |         |                 |            |                       |            |                  |                    | CSBA  |
|        |         |                 |            |                       |            |                  |                    | VEBA  |
|        |         |                 |            |                       |            |                  |                    | LACCD |
|        |         |                 |            |                       |            |                  |                    | ACSA  |
|        |         |                 |            |                       |            |                  |                    | FACCC |
|        |         |                 |            |                       |            |                  |                    | CSBA  |
|        |         |                 |            |                       |            |                  |                    | ART   |
|        |         |                 |            |                       |            |                  |                    | UTLA  |
|        |         |                 |            |                       |            |                  |                    | CFT   |
|        |         |                 |            |                       |            |                  |                    | LAUSD |
|        |         |                 |            |                       |            |                  |                    | CRTA  |

The Task Force generally agreed that all employees should be able to participate in a health benefits program. However, there was some discussion surrounding the issue of requiring all employees to participate in order to avoid adverse selection. Several organizations participating in the Task Force also voiced concerns regarding the inclusion of part-time and adult education employees and charter schools. One organization thought that retirees should be included only if their employer currently pays for their health benefits.

The Task Force also discussed the desire to specifically include classified employees. CalSTRS staff did inform Task Force members that SB 159 does allow CalSTRS to include classified employees in the study population by defining "member" to include all employees of the employer. Representatives of classified employees will be invited to participate in future Task Force meetings.

Another issue of membership that was discussed is the need to develop a definition of *dependents*. CTA proposed the following:

Dependent Eligibility

An employee's legal spouse or eligible domestic partner and unmarried natural child, stepchild, legally adopted child, or a child for whom the employee has been appointed legal guardian by a court of law. A child in the process of adoption may be covered if CalSTRS receives legal evidence of the intent to adopt and the child is placed in the employee's physical custody for the purpose of adoption. Children would be eligible until age 25 if still unmarried. A child over age 25 who is unmarried and is incapable of self-support because of a mental or physical condition that existed prior to age 25 may be covered.

Dependent parents of employees, their spouse or domestic partner who are dependent upon the employee for financial support and qualifies as a dependent for federal income tax purposes would be eligible.

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Another persons' child under age 25 who has never married may be eligible for coverage if:

- The employee has been granted custody or joint custody by a court or the child is a grandchild, living in the employee's household in the absence of the birth, adopted or stepparent.

**This proposed definition requires further review and discussion by staff and the Task Force.**

E. Governance

*Who should control the governance of a system-sponsored healthcare program, should one be offered?*

- Currently, health care is a locally bargained item with significant input from both management and employee organizations. Health benefit costs are a significant budget item subject to negotiation, second only to salaries. The Task Force participants felt strongly that neither employers nor employee organizations would support a CalSTRS health benefits program unless they had some input into health care policy recommendations to be presented to the Board. Employee organizations participating on a Trust are very influential in the management of their healthcare programs and would likely be unwilling to participate in a CalSTRS program without an active role. For example, the employee organizations at Los Angeles Unified School District serve on a labor-only Health Benefits Committee that is responsible recommending for the district the design of the health benefits program. All Task Force members requested involvement in overseeing a CalSTRS health benefits program.

Suggestions regarding various examples of alternative governance structures were subsequently provided to staff for analysis. Discussions with the Task Force regarding this issue are ongoing.

F. Subsidy

*Should CalSTRS excess earnings subsidize all or some of a participating member's premium?*

| <b>Oppose</b> | <b>Retirees Only</b> | <b>Retirees &amp; Actives</b> | <b>No Position</b> |
|---------------|----------------------|-------------------------------|--------------------|
| CTA*          | VEBA                 | ACSA                          | LAUSD              |
| CFT           | FACCC                | CRTA                          |                    |
| CVT           | CSBA                 |                               |                    |
| LACCD         | ART                  |                               |                    |
| UTLA          |                      |                               |                    |
| ACCCA         |                      |                               |                    |
| CCAЕ          |                      |                               |                    |

Seven organizations oppose using CalSTRS excess earnings to subsidize all or some of the benefit premiums. However, seven organizations want to see retirees' premiums subsidized and

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two of these seven organizations would like CalSTRS to provide a subsidy for active members as well. The CTA and CFT's organizational policy prohibit subsidizing retiree benefits. To support a retiree subsidy would require a change in their organizational policy. Both organizations could, however, support subsidizing administrative financing of a system-sponsored health benefits program without changing their policy. It was also recommended that if CalSTRS' excess earnings are used, consideration should be given to a rate adjustment/composite rate for those employers who cover their retirees versus those employers who only cover active employees.

\* CTA expressed their willingness to discuss a change in policy regarding subsidizing retiree health care at their organization's next formal meeting.

**G. Medicare**

*Should retirees not eligible for Medicare be the first priority of receiving a subsidy from CalSTRS excess earnings? (Alternative 7)*

| <b>Funding for Non-Medicare Eligible</b> | <b>Solve Part A Problem</b> | <b>No Position</b> | <b>No</b> |
|--|-----------------------------|--------------------|-----------|
| CTA                                      | VEBA                        | CVT                | LACCD     |
| VEBA                                     | LACCD                       | FACCC              |           |
| ACSA                                     | ACSA                        | CCAE               |           |
| CSBA                                     | ART                         |                    |           |
| ART                                      | UTLA                        |                    |           |
| UTLA                                     | CFT                         |                    |           |
| CFT                                      | LAUSD                       |                    |           |
| LAUSD                                    | CRTA                        |                    |           |
| ACCCA                                    |                             |                    |           |
| CRTA                                     |                             |                    |           |

The Task Force generally agreed that retirees who are not eligible for Medicare coverage (and presumably not eligible for an employer-paid medical plan) should be the first priority for a subsidy from CalSTRS assets. The retiree could be purchasing either Medicare Part A or an individual medical policy. The cost is estimated to be less than \$100 million a year. However, the Task Force agreed that a means test should be applied to reduce the costs and to ensure that only the truly needy receive the subsidy (the criteria for eligibility would need to be established).

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The concern of the Task Force for retirees without Medicare eligibility is due in large part because of the changes to federal provisions enacted in the Balanced Budget Act 1997 (BBA). The changes now require participants in Medicare + Choice Health Maintenance Organization (HMO) plans to have Medicare coverage. If the retiree chooses to continue coverage under a Medicare Risk Plan (e.g., Kaiser Permanente Senior Advantage) they must purchase both parts A & B of Medicare for the current monthly fee of \$309 and \$45.40 respectively. However, some districts offer an alternative to a Medicare + Choice HMO plan that does not require Medicare coverage as a condition for eligibility. The Task Force agreed to work as a coalition to advocate on behalf of changes to federal provisions enacted in the BBA and other changes as necessary.

### **FUTURE ISSUES**

The Task Force also identified other critical issues surrounding the development of a CalSTRS health benefits program. These issues would require further discussion and resolution prior to the implementation of the program. It is planned that these issues will be discussed in detail during the next phase of the study. The issues are outlined as follows:

- Screening program for direct contracting
- Vesting requirements for retired health care coverage
- Part-time employees
- Tax free savings account
- Selection issues
- Mandatory retiree coverage
- Pre-fund retiree healthcare
- Funding strategy

### **NEXT STEP**

Should the Board adopt staff's recommendation to proceed with providing access to a CalSTRS health care program through, in part, direct contracts with service providers, staff recommends the Board direct staff to review CalSTRS demographics, develop criteria and recommend geographic areas for a proposed pilot program. External expertise will be required for this task.

Legislation establishing the specific plan design, administrative authority, etc., will be drafted upon the Board's adoption.



## SUMMARY OF RECOMMENDATIONS

Staff has compiled a summary list of all the recommendations contained throughout the document for ease of identification and discussion.

Staff recommends:

- the Board to proceed to develop a healthcare benefits program and specifically adopt:
  - Alternative 2; Direct Contracting initiated on a pilot basis, as specified below
  - Alternative 3; Voluntary medical benefit program for retirees/part-time employees, modified as specified below
  - Alternative 4; Pharmacy/prescription drug program
  - Alternative 5; Dental/vision program
  - Alternative 7; Medicare Part A funding, as specified below
  - Additional Alternative; CalPERS, as modified (could be a supplement to or in place of Alternative 2 above)
  - Direct staff to obtain the expertise to develop criteria and recommendations for Alternative 2.
- implement Alternative 2 on a pilot basis, with criteria developed in concert with the consultant and Task Force.
- at least two pilots as appropriate to include a cross-section of the population, such as small/medium/large employers, K-12/community college, adult education/part-timers, urban/rural, and active/retired members.
- Kaiser, and an out-of-network program and an out-of-area plan should be included with this alternative.
- contract for consulting legal services to assist staff in the development of appropriate contract documents.
- adopt a modified version of Alternative 3 to provide healthcare coverage to those retirees under the age of 65 who have not yet become eligible for Medicare or do not have Medicare eligibility. Criteria for a subsidy should be applied to this group as well.
- participation in a CalSTRS healthcare program should be voluntary. Districts choosing to participate in the program should not be required to bring in their retirees. However, incentives for employers to provide health benefits coverage to their retirees should be provided.

- require employers who currently cover retirees for health benefits and subsidize all or some of the premiums, continue the same level of subsidy initially.
- criteria for eligibility to participate in a pilot program should be established, but must contain the following at a minimum:
  - must have a good relationship between management and labor;
  - must contain a specific contract provision; and
  - financial commitment by employer.
- all employees of participating employers, including classifieds, should be able to participate in a health benefits program.
- continue discussions to determine an appropriate governance structure.
- establish regional healthcare service committees.
- a subsidy should be provided. However, if CalSTRS' excess earnings are used, consideration should be given to a rate adjustment/composite rate for those employers who cover their retirees versus those employers who only cover active employees.
- retirees who are not eligible for Medicare coverage (and presumably not eligible for an employer-paid medical plan) should be the first priority for a subsidy from CalSTRS assets.
- advocate on behalf of changes to federal provisions enacted in the BBA and other changes as necessary.

## **MEDICARE PART A (Hospital Insurance) ISSUE**

Currently, individuals who have earned 40 or more quarters under Social Security covered-employment, or paid Medicare taxes, are entitled to the Original Medicare Plan, Part A (hospital) at no cost, and Part B (physician visits) for a monthly premium. CalSTRS members who are hired to a position on or after April 1, 1986 are required to pay Medicare taxes and will receive benefits under that program beginning at age 65 if they have earned at least 40 quarters of participation. However, there are many CalSTRS members, who are retired and have reached age 65 who don't qualify for Medicare Part A coverage at no cost because they did not 1) work 40 quarters under Social Security covered-employment; 2) qualify under a spouses employment; or 3) pay Medicare taxes during the course of their working years. In order for these individuals to receive Medicare coverage Parts A & B, they must pay the monthly premiums on their own. The monthly premium payments for 1999 are \$309 and \$45.50, respectfully.

### **Balanced Budget Act of 1997**

There are actually two issues that came about as a result of the Balanced Budget Act of 1997 (BBA), Public Law 105-33, that impact California State Teachers' Retirement System (CalSTRS) members who are not entitled to Medicare Part A (*unless they purchase it on their own*), as follows:

#### ◆ Premium Free Medicare Part A:

Effective January 1998, the BBA provides relief from Medicare Part A premiums for CalSTRS retired members, or their beneficiaries, under the following conditions: 1) they are receiving a cash retirement benefit based on public sector work; 2) they have paid for Medicare Part A premiums on their own for seven years in a row; and 3) they have worked at least 10 years during their career. CalSTRS has processed over 600 claims from the Social Security Administration (SSA) on behalf of individuals who believed they were eligible for this relief, and will continue to coordinate these efforts for those retired members who reach age 65 and believe they may qualify.

Individuals who are age 65 or older who have earned 30 or more quarters (but less than 40 quarters) are entitled to a 45% reduction in their Medicare Part A premium. If the person pays the reduced premium for seven years and meets all other qualifying conditions, they may also become eligible for 100% premium free Medicare Part A coverage.

Congress purposely put in the BBA limited provisions to provide relief only for those individuals they perceived to be the "most needy". These are the retirees who pay their monthly Medicare Part A premiums on their own.

◆ Medicare+Choice Plans:

The BBA also established Medicare+Choice (M+C) plans. A M+C managed care plan is a Medicare approved network of doctors, hospitals and other health care providers that agree to give care in return for a set monthly payment from Medicare. One of the requirements for eligibility is that individuals must enroll in Medicare Parts A and B, and pay the Part B monthly premium. The availability and costs of different M+C plans vary depending on where an individual lives. M+C plans include several types of managed care plans such as Health Maintenance Organizations (HMO's like Kaiser). Beneficiaries in managed care plans may be restricted to which doctors and hospitals they can use. Managed care plans that participate in Medicare cover all the services covered by the Original Medicare Plan, and some cover additional services such as prescription medication. Some plans may charge a premium for additional covered services. These new Medicare regulations became effective January 1, 1999.

CalSTRS became aware of an issue that surfaced when retired CalSTRS members were notified by their districts of the new Medicare regulations imposed by the BBA. Some individuals who were enrolled in an eligible organization with a risk-sharing contract on December 31, 1998, such as Kaiser Permanente Senior Advantage (Kaiser) or CIGNA HealthCare for Seniors (CIGNA), were "grandfathered Medicare Part B only enrollees" and allowed to remain enrolled in these plans (these plans now hold contracts under the new M+C program as a result of BBA). This means they were not required to purchase Medicare Part A coverage on their own. This was a one-time opportunity for individuals who were enrolled in Medicare Part B and not entitled to Medicare Part A at no cost. (However, if they were to disenroll from the M+C organization, they are not eligible to elect a plan offered by another M+C organization, unless they also purchased Medicare Part A on their own.)

There are no known issues for those individuals who retired and reached age 65 and were "grandfathered Medicare Part B only enrollees" prior to January 1, 1999. There are concerns, however, with those individuals who are retired and will become age 65 in the future, are not eligible for premium free Medicare Part A and cannot be grandfathered into the new program now in effect.

This poses a problem for retirees whose employers offer subsidized health care benefits for life and are not eligible for Medicare benefits. Those retirees who participate in Medicare Risk Plans are now required to have both Parts A and B of Medicare upon reaching age 65 in order to continue with their coverage. Prior to the BBA changes, retirees were required to pay only the Medicare Part B monthly premium. This issue has caused significant concerns for those individuals who are or will be required to pay the Medicare Part A (hospital insurance) premiums on their own, if they wish to continue their M+C coverage (e.g., Kaiser or CIGNA). An alternative is to enroll in another district-sponsored non-M+C coverage, which does not require Medicare Part A. Retirees enrolled in either of these two plans must still purchase Medicare Part B, ***but are only required to enroll in Medicare Part A if it is available to them at no cost.*** This stipulation does not apply to M+C plans.

The problem these retirees face is now having to pay for Medicare in order to maintain the same health care provider they may have had for years when their employer had previously provided them coverage at no cost. The retiree may change to an alternative health care plan, but that could require them to change doctors which is often difficult, particularly for our older members.

It is unknown at this time the full impact BBA changes have had on other school districts and the retired community who do not qualify for Medicare. However, we know that when the BBA was proposed, Congress was not able to come up with offsetting reductions to relieve state and local government entities because it would be too costly to the federal government.

What we do know is that the BBA does not prohibit employers from paying premiums on behalf of their retired employees, in fact they are allowed, permitted and encouraged to do so. Employers would, however, be required to pay the Medicare part A premium for the life of the retiree. This means the employer will never qualify for premium free Medicare Part A on behalf of the employee unless Congress is willing to amend the BBA. At this time, there is no interest in Congress to provide eligibility for free Medicare Part A to retirees who have had their Medicare reimbursed or paid for by the employer.

CalSTRS plans to continue informing members of Congress of the negative impact the BBA has on California retirees and future retirees, and are working with them on possible solutions.

## HEALTH BENEFITS TASK FORCE MEMBERS

| <b>Organization</b>             | <b>Contact</b>   |
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| <b>ACSA</b>                     | Karen Stapf Walters, Association of California School Adm.   |
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| <b>CCAE</b>                     | Ernest Kettenring, California Council for Adult Education  |
| <b>CFT</b>                      | Dolores Sanchez, Legislative Advocate, CA Federation of Teachers<br>Carolyn Widener, California Federation of Teachers                                     |
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| <b>EGUSD</b>                    | James W. Knapp, Director of Finance & Risk Management<br>Elk Grove Unified School District   |
| <b>FACCC</b>                    | David Hawkins, Legislative Advocate, Faculty Assoc. of CA Comm. Col.<br>John Baley, Faculty Association of CA Community Colleges                           |
| <b>LACCD</b>                    | Jim Grivich, Los Angeles Trade-Technical College   |
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| <b>VEBA San Diego</b>           | Lois Shive, Voluntary Employee Benefits Assoc., San Diego<br>George McGregor, Voluntary Employee Benefits Assoc., San Diego<br>McGregor Van De Moere, Inc. |
| <b>UTLA</b>                     | Bill Callahan, Chairman LAUSD Health Benefits Comm.<br>United Teachers Los Angeles<br>Sam Kresner, Director, United Teachers Los Angeles                   |

# Health Benefits Feasibility Study

California State Teachers' Retirement System



**William M. Mercer, Incorporated**  
**December 8, 1999**





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# Section I. Executive Summary

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# Section I. Executive Summary

## 1. Goals

The primary goals of this study are to:

- Identify potential health care coverage needs of retired and active members of CalSTRS and of school districts as employers
- Develop and evaluate possible approaches that CalSTRS might use to help meet those needs.

## 2. Member and District Needs

Needs were determined through four surveys: active teachers, retired CalSTRS members, school districts, and Trusts and JPAs providing benefits to teachers in California. The surveys were conducted according to standard and accepted statistical methodology and research design. Further, the results of the surveys were reviewed and interpreted by the Health Care Task Force.

The main needs that were identified from the active and retiree surveys are:

- Ensure that retiree health care coverage is stable and available for CalSTRS members and their dependents
- Provide coverage for all California teachers at lower cost, while preserving or improving access and quality of care

For active and retired CalSTRS members, the most important features in selection of medical plans (aside from cost) were the following:

- Trust in the organization sponsoring the plan
- Ease of referrals to specialists
- Coverage for prescription drugs.

For school districts, the most important single element in selection of medical plans was cost. Subject to a number of cautions discussed below, it appears from the district survey that a significant number of districts (about half) would be willing to change

source of coverage for their employees if annual cost savings were 7% or greater. With a 5% cost savings, the number of the districts willing to change coverage source drops to about one-fifth.

The survey data showed that the large majority ( about 90%) of retiree respondents now have health care coverage other than Medicare. Also, the large majority (about 85%) of retiree respondents over age 65 have Medicare Part A coverage. Most (about 80% of respondents over age 65) have Medicare Part A at no cost to themselves, through their own or their spouse's Medicare eligibility.

The Health Benefits Task Force members had serious questions about this part of the survey data because their experience is quite different than these data. There are several possible ways to reconcile these differences. For example, the survey looks at a point in time and the Health Benefits Task Force members are aware of the changing nature of retiree coverage, such as the plans of school districts and the districts' future finances. Also, Health Benefits Task Force members may hear many situations of no coverage because of their professional roles. Finally, of course, the survey data may not accurately reflect reality notwithstanding the use of accepted statistical methods.

In any event, we believe that in assessing member needs it is clear that providing secure and stable retiree health care coverage is very important. This conclusion is based on the strong concern among active members about their ability to have retiree coverage, the strong concern among Health Benefits Task Force members about providing such coverage, the changing health care market in California and the effect on limited school district finances, and the survey data from retirees.

As discussed in Appendices A and B, it should be noted that some issues occurred in the sampling process. However, based on our review of the data, we do not believe that these issues create any material differences in the results or recommendations contained in this report.

### 3. Overview of Approaches Evaluated

The following eight approaches to a CalSTRS health care program were evaluated in light of the needs identified in the survey and by the Health Benefits Task Force. Each of these approaches deals with the identified needs in different ways. Approaches 1 and 2 would establish and make available a statewide health benefits program for all active and retired CalSTRS members and retirees (and their dependents), to provide lower cost and high quality medical care, and stable retiree health care. Approach 3 would establish a health benefits program only for retirees, with the goal of establishing a stable program for this group. Approaches 4, 5, 6, 7, and 8 would establish more focused programs, based on needs and interests identified in the surveys. Note that these approaches are not intended to be in order of priority, but rather build upon one another to provide a basis for understanding the issues involved.



1. Medical benefits program using existing vendors of coverage
2. Medical benefits program using direct contracting with the provider community
3. Voluntary medical benefit program for retirees and/or part-time employees
4. Pharmacy/prescription drug benefit program
5. Dental/vision program for school districts using existing vendors of coverage
6. Dental/vision program for individual voluntary enrollment only
7. Medicare Part A funding
8. Individual member tax advantaged savings for retiree health care

CalPERS (PEMHCA) was not evaluated as an option because it is currently available to districts and therefore no action by CalSTRS is necessary for this coverage to occur.

In its discussions, the Health Benefits Task Force identified the following “three C’s” as important criteria for evaluating any CalSTRS health care program:

- Cost – Achieve cost containment or reduction for any health program established by CalSTRS
- Choice – Provide sufficient choice to members so the program fits well with what is currently provided and therefore is sufficiently attractive to members
- Control – Provide sufficient responsiveness to members and districts to resolve problems that arise in providing care for their members. In addition, provide a program that enables and encourages members to exercise increased control over their own care so they receive the highest quality care possible in a cost-effective manner.

The Health Benefits Task Force believes that if these three elements can be achieved, with an emphasis throughout on providing very high quality healthcare, the likelihood of a successful CalSTRS program will be substantially greater.

A description of each approach, and critical elements for evaluating each approach, is set out below.

### *Approach 1 – Statewide Medical Benefits Program Using Existing Vendors*

**Concept** – CalSTRS would act as group purchaser of health care for all school districts that opted to join the program. CalSTRS would: establish coverage options available, negotiate the rates, arrange for needed administration and establish a rapid response program for local carrier and provider problems. Coverage would be purchased from existing health plans and carriers, and would be

designed for maximum cost effectiveness, stability, service and access. Increasing health quality would be a high priority, and the program would be designed to take advantage of CalSTRS members' expressed interest in health education and self-management of care. Retirees would be included in this program, and there would not be a requirement that the same level of district subsidy be paid for retirees as for actives. However, rules would have to be established to avoid adverse selection.

**Enablers** – The prime enablers of this program would be aggregating purchasing power, providing sufficient choice (to both members and districts), reduction in administrative costs, and increased focus on quality and self-management of care. In the short run purchasing power and administrative efficiencies would be the prime cost savers. In the longer run, the key to this program is higher quality of care and greater self-management of care. Our research and experience indicates that this is the most promising way to achieve better member and provider satisfaction, better health status for the CalSTRS population, and substantial and sustainable cost reductions.

**Barriers** – Several prime barriers to a successful program exist. There has been a substantial consolidation of carriers in the market – so much so that they may not be willing to negotiate sufficient savings. There are key transition issues, such as how does CalSTRS get the participation of sufficient districts to gather substantial purchasing power, when districts may only join if there is already a sufficient number of participants? There are a number of important technical issues as well, such as determining the right mix of choice and simplicity, determining how rates will be set (e.g., with geographic variants? separate for actives and retirees?). Finally, in the current market it may be difficult to achieve a 7% cost savings, if that indeed is the critical target.

**Design elements** – The report below discusses design elements (“architect’s renderings”), including the type of plan and benefit level choice that seems to be needed based on the survey data. It also discusses funding issues, cost and pricing issues, and vendor issues. One important issue is whether districts would be allowed to obtain health coverage from CalSTRS for both certificated and classified employees. The data from the survey makes clear that districts would like to do this; the reason is clear – if they cannot, then they will not be able to eliminate much of their administrative cost and will lose bargaining power in the market for the classified employees.

**Pilot potential** – Establishing a statewide medical plan is a major undertaking. Therefore, for each approach discussed we evaluate the possibility of a pilot. A pilot clearly is appropriate for this approach, although the risk exists that insufficient participation will occur to establish the quality improvements that we believe are available with a broad based program.

### *Approach 2 – Statewide Medical Benefits Program Contracting Directly With Providers*

**Concept** – This concept is the same as that under Approach 1, except that health care coverage would be purchased by CalSTRS directly from providers (physicians, hospitals, laboratories, etc.) and not from health plans.

**Enablers** – The prime enablers for Approach 1 generally apply to this approach as well. In addition, there are also the following prime enablers. There appears to be a strong desire by physicians and perhaps hospitals to limit their contracting with health plans. Many health plans are for profit, and it may be possible to eliminate this profit with direct contracting. The likelihood of success depends on concentrating a sufficient number of members, and this may require partnering with other (non-school) employers; preliminary indications are that this may be feasible.

**Barriers** – The special barriers for direct contracting include the following. Start up costs can be significant, although there are strategies to deal with this. Cost savings from reducing profits may be difficult to achieve in the current California market, although this can change with the consolidation of health plans. Providers may also want to capture some of the potential savings from direct contracting. Health plans and carriers may try to create strong incentives for providers not to directly contract. Liability issues can sometimes be greater under a direct contracting approach than through contracting with vendors.

**Design elements** – Direct contracting changes the process in many ways. Buyers and providers of health care talk directly to one another; the focus becomes what the buyer is interested in, not what the health plan wants to sell; there can be a greater focus on incentives to providers with less focus on control and penalties. However, administrative costs are not eliminated; there are a number of administrative services that must be provided, including eligibility processing, data tracking, and communications. CalSTRS can contract for these services or the providers could subcontract with health plans/carriers to provide services (turning the tables so the health plans are contracted to the providers).

There are a number of factors that affect direct contracting, including the structure of medical groups in any particular area, the size and geographic reach of those groups, and the way that are hospitals are organized.

The best financial results are obtained with focused use of provider networks. However, as the network is limited, members may not be able to continue to use their existing physician. Our experience is that if limited networks are used the transition is difficult, but after the transition there is greater member and patient satisfaction.

An important issue involves Kaiser-Permanente. Kaiser provides care to just under 40% of the districts, based on the district survey. It is unlikely that the Permanente Medical Groups or Kaiser Hospitals would enter into direct contracting relations with CalSTRS because of the way that the Kaiser program operates. However, Kaiser will be a critical part of any medical program established by CalSTRS. As discussed below, we believe that an opportunity exists to establish a long-term partnership with Kaiser. Partnership does not mean acquiescence, however. We also believe that there are a number of financial and operational issues that Kaiser can address to provide lower costs and higher quality to a CalSTRS sponsored program.

An alternative model is the Minneapolis program, with a number of attractive elements discussed later in this report. However, as stated by the Minneapolis program leaders, this model has a significant ramp up time because of data requirements and the need to establish strong buy-in by the employers and providers. Therefore, this may be a later stage effort for a CalSTRS direct contracting effort.

**Pilot potential** – We believe that this approach, if chosen by CalSTRS, should be tested on a pilot basis because of the required up front commitment and the need for member concentration. Examples of possible locations for a pilot might include Sacramento or similar types of areas with well-established group based physician provider organizations, and where partner-employers may be willing to join a pilot.

### *Approach 3 – Statewide Program for Retirees and / or Part Time Employees*

**Concept** – CalSTRS would become a reliable source of access for retiree and / or part-time employee health care, and would develop a medical program for these individuals. The program would provide a source of coverage to individuals who find access restricted or who now purchase coverage individually. It could be a stand-alone program or could be part of Approach 1 or 2 as well as other Approaches described below.

**Enablers** – A prime enabler is the desire of actives and retirees to have a trusted, stable retiree health care program. Other enablers would include a program subsidy that reduces the cost of coverage, and the districts’ desire for options to help provide coverage.

**Barriers** – The key barrier is adverse selection risk from coverage purchased by individual buyers and the resulting difficulty of providing a stable and cost effective program. This is closely tied to the survey results that indicate a limited ability for non-covered individuals to pay for coverage. A further barrier is that retirees are somewhat more likely to reside in rural areas, with a limited number of health care providers and therefore a more limited ability to influence both cost and the model of care.

**Design elements** – Program design would be based on a number of factors, including the extent of district subsidy of costs, district or individual purchase, age of the member (under 65 or not), and Medicare eligibility. A key issue is balancing benefits coverage and cost while avoiding adverse selection. To achieve the latter, ground rules such as the following may be needed: CalSTRS subsidy of benefits (e.g., a CalSTRS match of district contributions but including a maintenance of effort requirement), limitations on certain benefits, a “continuous enrollment” requirement, and pre-existing condition requirements to the extent not prohibited by law. Further, the program must be made attractive to participants; packaging benefits such as health club enrollments or discounts, and possibly life insurance benefits might help accomplish this.

A major challenge will be to design a program that fits with the pocketbook of CalSTRS retirees and / or part-time employees who currently do not have health care coverage. About half of the retired survey respondents in this situation said that they would be willing to pay \$50 per month or more for coverage; however, coverage typically runs between approximately \$350 and \$450 per month for retirees. The only way to address this issue is to provide a subsidy – either a direct subsidy from, e.g., CalSTRS or an indirect subsidy from the pricing of a program for active CalSTRS members. As noted above, a subsidy might take the form of, e.g., 10% of premium if the district pays for at least 20% of the premium, but no less than is being paid by the district today.

**Pilot potential** – A pilot may be appropriate here, although this may be more difficult if the pilot involves a CalSTRS subsidy.

#### *Approach 4 – Pharmacy/ Prescription Drug Benefit Program*

**Concept** – CalSTRS would be the purchaser of pharmacy benefit management (PBM) services for all districts that opt to participate in the program. Also, CalSTRS would provide individual coverage options. As with the medical programs, CalSTRS would establish the benefits, negotiate the financial arrangements and arrange for needed administration. The program would be designed for optimal quality of care, cost effectiveness and service. Quality of care would be a critical element of the program, through education, drug utilization review, and minimizing negative drug effects and inappropriate under-utilization and over-utilization of drugs. This approach could be integrated with any of the other approaches described.

**Enablers** – A major enabler is the current high cost trend for prescription drugs. Based on Health Benefits Task Force input and Mercer’s experience, districts and members are quite concerned about controlling this trend. Another enabler is the opportunity to establish a partnership with PBM providers to develop effective long-term care management, improve quality of care and better manage costs.

**Barriers** – Variations in existing coverage are likely to be significant, making it difficult to design one program that meets everyone’s needs. Kaiser provides in-house pharmacies, making a drug carve-out problematic for Kaiser. Retirees’ needed coverage will change if drug coverage is provided through Medicare at some point in the future. Subsidies may also be needed for an effective retiree program.

**Design elements** – Uniform program design is the most effective way to achieve success. Drug benefits carved out to a single PBM also provide the best foundation for a high quality program. There will be tension in determining the pharmacy network, with more financial leverage with a limited network, but creating the potential of more difficult access for members. An open formulary likely would work best for both members and physicians, although with financial incentives to encourage use of formulary drugs. The

precise incentives for employees should be designed specifically for the CalSTRS population. Effectively integrating prescription drug with medical care management should be a key goal. If the CalSTRS population that joins this program is sufficiently large, there may be opportunities for creative financial arrangements.

**Pilot potential** – A pilot may be effective here. As a separate program, there may be sufficient interest due to current cost trends. As a result, a statewide, or regional, drug program could also be developed as a first step in a more comprehensive CalSTRS health care program.

#### *Approach 5 – Statewide Dental / Vision Program*

**Concept** – CalSTRS would be a purchaser of dental and / or vision care coverage for all districts that opt to join the purchasing pool. CalSTRS would establish coverage options, negotiate the costs and arrange for needed administration. The program would be designed for maximum cost effectiveness, stability, service and access. Health care would be purchased from existing health plans and carriers.

**Enablers** – Some vendors of coverage have already indicated a desire to work with CalSTRS in this area. Further, the aggregation of purchasing power and added convenience may be of substantial interest to districts and members.

**Barriers** – As a stand-alone program this approach may not be sufficiently attractive because of the limited total dollar savings that it will produce. Further, there will be transition issues for this program similar to those for the medical programs. Also, uniformity in program will be important to obtain material savings, and this may be difficult to develop while keeping the program sufficiently attractive to a large number of districts. Moreover, a number of districts may now have generous plan designs that, if matched by a CalSTRS program, could limit cost savings.

**Design elements** – As with medical plans, critical design elements include having a small number of plans (as few as one dental and one vision), range of plan types (PPO and HMO) and benefit levels. The program would again focus on maximizing quality.

**Pilot potential** – If a medical program is piloted, this could be added with little additional risk and possibly material benefit. Further, if there is sufficient district interest it might be worthwhile developing this program on a statewide, or regional, basis as a first step in a more comprehensive CalSTRS health care program.

### *Approach 6 – Dental/Vision Plan – Voluntary Individual Enrollment Only*

**Concept** – Under this approach, CalSTRS would develop a program to meet the dental and vision care needs of members and retirees who are not currently covered for these benefits, who may find access restricted, or who purchase this coverage individually and therefore can benefit from CalSTRS’ combined purchasing power. Programs would be designed to meet individuals’ expressed ability to pay.

**Enablers** – In both the current study and a 1998 study performed by Mercer for CalSTRS, there was interest in voluntary, individual purchase dental / vision plans. Further, vendors have expressed interest in offering this coverage, at prices that seem to fit with what has been indicated as appropriate by survey respondents.

**Barriers** – Possible barriers include adverse selection issues, potential underwriting restrictions, and the cost of providing sufficiently generous plan designs.

**Design elements** – Voluntary dental and vision programs are part of a growing market, so the number of plans has increased in the past few years. There are two general designs: discount purchasing arrangements and insurance style programs. The first involves minimal cost because no insurance protection is offered. The second has the possibility of adverse selection and therefore a potential need for limitations on benefits. In our discussions with vendors, we sought sample plan designs. These sample designs included: very low co-pay or co-insurance requirements for preventive services; moderate co-pay or co-insurance for basic dental services and substantial co-pay or co-insurance for major services; deductibles for PPO plans; and maximum benefit limits per year.

**Pilot potential** – A pilot would reduce CalSTRS’ risks and initial investment, but it may be as useful to negotiate a statewide program at the outset.

### *Approach 7 – Medicare Part A Funding*

**Concept** – CalSTRS would provide, in whole or in part, funding for Medicare Part A premiums for retirees over age 65 who are not eligible for premium-free Medicare Part A.

**Enablers** – CalSTRS investment earnings can be used, indirectly, to fund this type of program if desired. There are a limited number of retirees who do not have this coverage; extrapolating from the survey data, it appears that there are about 23,000 retirees in this situation. This will be a limited group because Medicare covers every CalSTRS member first hired on and after April 1, 1986.

**Barriers** – The estimated potential cost of this option is over \$85,000,000 for 1999 alone. This is not a one time cost and it could increase over a number of years while pre-1986 hired members continue to retire. To fully understand the cost, an actuarial study must be done. Further, this option might be seen as providing a discriminatory benefit or a reward for failing to elect into Medicare when that was available.

**Design elements** – A subsidy can be for all or part of the premium. A subsidy can be structured in a number of ways, such as capping it to limit inflation effects, setting a uniform percentage for each retiree, providing the subsidy only if the district also pays a subsidy, or limiting the benefit to career teachers. If CalSTRS pays a subsidy, it can be done indirectly from earnings on the CalSTRS investment portfolio.

**Pilot potential** – It would seem inappropriate to pilot this program, providing a subsidy for only a limited group.

#### *Approach 8 – Individual Member Tax Advantaged Savings for Retiree Health Care*

**Concept** – CalSTRS would make available a tax-free savings program so active members could save to pay for their, and their dependents', retiree health care needs. Member savings would be credited to accounts and would be used to pay for items such as retiree health premiums, co-pays, deductibles, and Medicare. Savings would be invested under the program, with the cash balance plan being used for these savings.

**Enablers** – About half of the active survey respondents said that they would be very interested in such a program. Savings would be through payroll deduction, and credited to an account maintained by CalSTRS. Under current tax laws, savings, earnings on the savings and payment of the savings would be tax-free as long as the monies are restricted to retiree health care.

**Barriers** – It is hard to save, therefore a CalSTRS program might be little used. Further, there is limited flexibility in year to year choice of savings. Also, when monies are committed to health care it is difficult to use them for another purpose, even in cases of hardship. Further, this program does not assist members who are already retired.

**Design elements** – Active members would choose the amount of savings that they wish to make, and contributions would be to a “401(h)” account under CalSTRS. Savings would be on a payroll deduction basis and would be under a “one-time irrevocable election.” However, there are several ways to make such an election and this can provide a degree of flexibility in the program, as described later in this report. Districts and unions could bargain to establish the program and could bargain for a district contribution to the account. Annual account statements would be provided to members. For ease of administration, the current CalSTRS cash balance plan administrative arrangements could be used, although this program would not technically be a part of the cash balance



program but would be part of the larger CalSTRS retirement program. Assets would be invested with all CalSTRS assets, and would be paid out for medical benefits after the member's retirement. Assets also could be paid for dependents' health benefits.

**Pilot potential** – This program could be piloted if desired.

## 4. Next Steps

It appears that the next steps could include the following:

1. The CalSTRS Board reviews this report and gathers input from stakeholders.
2. With such input, CalSTRS decides which, if any, of the approaches described in this report to consider pursuing.
3. CalSTRS might wish to consider setting an initial direction but also obtain additional information before making a final decision. For example, CalSTRS might want to obtain further information about how and where a direct contracting pilot would be implemented, or may wish to hold focus groups on such issues as plan designs.
4. CalSTRS might wish to consider pursuing limited approaches at the outset, which would fit into an overall larger program and which would serve, e.g., to develop infrastructure and experience for operating a statewide medical program.
5. The prior two steps could be done simultaneously.
6. CalSTRS might wish to consider starting work on implementing one or several of the approaches described, including investigating and evaluating possible methods of administration.

# Section II. Evaluation of Alternative Approaches for CalSTRS Health Care Program

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# Section II. Evaluation of Alternative Approaches for CalSTRS Health Care Program

## OVERVIEW AND KEY INFORMATION

### 1. Introduction

The primary goals of this study are to:

- Identify potential health care coverage needs of active teachers, retirees, and school districts as employers
- Develop and evaluate possible approaches that CalSTRS might use to help meet those needs

The primary needs that were identified by the surveys and as discussed with the CalSTRS Health Benefits Task Force, are the following:

- Ensure that retiree health care coverage is stable and available for CalSTRS members and their dependents
- Provide coverage for all California teachers at lower cost, while preserving or improving access and quality of care

Additional identified needs are to:

- Provide dental and vision coverage for retirees
- Provide a tax free method for members to save to pay for their retiree health care

The CalSTRS Health Benefits Task Force has discussed these needs and also has focused on the “Three C’s” of

- Cost – Achieve cost containment or reduction for any health program established by CalSTRS
- Choice – Provide sufficient choice to members so the program fits well with what is currently provided and therefore is sufficiently attractive to members

- Control – Provide sufficient responsiveness to members and districts to resolve problems that arise in providing care for their members. In addition, provide a program that enables and encourages members to exercise increased control over their own care so they receive the highest quality care possible in a cost-effective manner.

The Health Benefits Task Force believes that if these three elements can be achieved, with an emphasis throughout on providing very high quality healthcare, the likelihood of a successful STRS program will be substantially improved.

Mercer has identified eight different approaches CalSTRS may wish to consider to meet these needs, listed below. These approaches to a CalSTRS health care program were evaluated in light of the needs identified in the survey and by the Health Benefits Task Force. Each of these approaches deals with the identified needs in different ways. Approaches 1 and 2 would establish and make available a statewide health benefits program for all active and retired CalSTRS members and retirees (and their dependents), to provide lower cost and high quality medical care, and stable retiree health care. Approach 3 would establish a health benefits program only for retirees, with the goal of establishing a stable program for this group. Approaches 4, 5, 6, 7, and 8 would establish more focused programs, based on needs and interests identified in the surveys. Note that these approaches are not intended to be in order of priority, but rather build upon one another to provide a basis for understanding the issues involved.

- Medical Benefits Program Using Existing Vendors of Coverage
- Medical Benefits Program Using Direct Contracting with the Provider Community
- Voluntary Medical Benefits Program for Retirees and / or Part-time Employees
- Pharmacy/Prescription Drug Benefit Program
- Dental/Vision Plans – Program for School Districts Using Existing Vendors of Coverage
- Dental/Vision Plans – Individual Voluntary Enrollment Only
- Medicare Part A Funding
- Advanced Funding/Tax Deferred Savings

This section of the report describes the eight approaches listed, and for each approach addresses:

- The concept and how the approach meets the needs established by the surveys and the Health Benefits Task Force.
- “Enablers” and “Barriers” to each approach, from the data in the surveys and input from the Health Benefits Task Force, and from Mercer’s knowledge of the health care market.
- Design elements for each approach.

Based on the concept, enablers and barriers, we set out our initial recommendations for a design for each approach, if that particular approach is chosen by CalSTRS. As agreed, our recommendations are sketches of the suggested approach (“architect’s renderings”). This is done of necessity because substantial additional information is needed to develop detailed designs, and because the health care market changes so rapidly. Our initial recommendations discuss the following elements for each of the approaches:

- Design Elements
- Funding Approach
- Cost/Pricing Issues
- Vendor Issues
- Program Participation
- Pilot Potential

Additional issues are discussed as appropriate.

These initial recommendations present an outline of how each approach might be structured, and issues surrounding each option. They are not intended to provide operation details, specific price modeling, or final recommendations on whether the approach should be implemented. Rather, this report provides CalSTRS with the basis for evaluating whether or not it is worthwhile to move forward on one or a combination of the alternatives discussed. Further, we suggest next steps, which have as one key focus how CalSTRS might structure a program (pilot or otherwise) at the lowest reasonable entry cost and therefore risk. We wish to point out that in each situation, detailed design elements must be developed in order to seek appropriate bids from providers of services, and proceed with implementation.

Finally, we must note that there is no “magic bullet” to solve the problem of health care coverage and costs in California. The health care market is difficult. There are fewer health plans, economic distress of a number of providers, physicians and others who are unhappy about the organization of health care, and fewer government resources such as Medicare, Medi-Cal, and teaching hospital subsidies. Nevertheless, there are clearly available strategies that CalSTRS can follow to meet the needs of its members and school districts. Each strategy has strengths and risks, which the Board will want to consider carefully.

## 2. Key Information from the Member and Retiree Surveys

The following summarizes some of the key information from the member and retiree surveys. Detailed survey methodology and results are included in Appendices A and B respectively. As discussed in Appendices A and B, it should be noted that some issues

occurred in the sampling process. However, based on our review of the data, we do not believe that these issues create any material differences in the results or recommendations contained in this report.

The survey data shows that most of active member respondents have insurance coverage for themselves for medical expenses, including almost all full-time teachers. The survey data further shows that about two-thirds of active members who have insurance indicate that they pay nothing for the coverage.

Active respondents who do not have medical insurance tend to have lower family incomes. The top 4 reasons indicated for not having coverage are:

| Reason - in order of importance                |
|--|
| Not enough income to pay for coverage          |
| Planning to get coverage soon                  |
| Coverage not available                         |
| Coverage seems overpriced relative to benefits |

Active respondents currently express a great deal of concern regarding their continuing ability to obtain adequate retiree medical insurance after their retirement, with over 70% indicating that they are very concerned. In addition, a substantial number (about half) are very interested in a program that would allow them to use personal savings to pay for some of the cost of retiree medical coverage, on a tax-free basis.

Slightly over 90% of retiree respondents have insurance coverage other than Medicare for themselves for medical expenses. This includes service retirees, surviving spouses, and disabled benefit recipients. In each of these categories, the large majority of respondents reported that they have coverage.

However, these retiree data do not fit with the experience of the Health Benefits Task Force members. Their experience is that a substantial number of retirees do not have coverage. There are several ways to reconcile the differences between the survey data and the Health Benefits Task Force members' experience. For example, the survey looks at a point in time and the Health Benefits Task Force members are aware of the changing nature of retiree coverage, such as the plans of school districts and the districts' future finances. Also, Health Benefits Task Force members may hear many situations of no coverage because of their professional roles. In

addition, the survey information does not identify the level of coverage available to retirees – some of this coverage may be quite limited, or represents only supplemental coverage (e.g., for covering Medicare deductibles or coinsurance). Finally, of course, the survey data may not accurately reflect reality notwithstanding the use of accepted statistical methods.

In any event, we believe that in assessing member needs it is clear that providing secure and stable retiree health care coverage is very important. This conclusion is based on the strong concern expressed by active members about their ability to have retiree coverage, the strong concern among Health Benefits Task Force members about providing such coverage, the changing health care market in California, limited school district finances, and the survey data from retirees.

Current retirees obtain coverage through a number of different sources, depending primarily on age, and whether or not they are Medicare eligible. Seventy-nine percent of respondents age 65 and over are enrolled in Medicare Part A. Most of these respondents receive Medicare Part A at no cost because they or their spouses have a sufficient number of Medicare quarters. About 6% of respondents pay for Part A coverage, which currently costs \$309/month/person. About the same number do not have Part A and are enrolled in Part B only, which currently costs \$45.50/month/person.

For those retiree survey respondents (all retirees combined) indicating that they had coverage other than Medicare, the following indicates the source of that coverage (although not necessarily who pays for coverage). Note: for simplicity of presentation, all percentages in this chart have been rounded to the nearest 5%.

| SOURCE OF COVERAGE | Former educational employer | Spouse's current or former employer | Individual coverage |
|--------------------|-----------------------------|-------------------------------------|---------------------|
| Less than age 65   | 60%                         | 25%                                 | 15%                 |
| Age 65 & over      | 35%                         | 15%                                 | 35%                 |

Therefore, at age 65 there is a marked shift to individual coverage and away from school district coverage. Individual coverage can be expensive and rates have recently increased significantly. These facts may be an important basis for the large concern among actives about retiree coverage.

For those retirees that did not have other coverage, the primary reasons tended to be cost related:

| Reason – in order of importance                |
|--|
| Not enough income to pay for coverage          |
| Coverage seems overpriced relative to benefits |
| Do not need medical coverage                   |
| Available benefits not attractive              |

Sixty-five percent of retiree respondents without medical coverage think it is very important to obtain such coverage.

- About half indicate that they can pay \$50 a month or more for medical coverage for themselves
- About the same percentage can pay an additional \$50 a month or more for medical coverage for family members

Respondents that have coverage (both active teachers and retirees) are generally satisfied with their health care benefits.

The top three decision factors (besides cost) in selecting medical insurance are the same for actives and retirees:

- Trust in the organization sponsoring the plan
- Ease of getting referrals to specialists
- Coverage for prescription drugs

The top three features in making a medical plan substantially more attractive are also the same for actives and retirees:

- Disease management program
- Coverage for alternative medicine
- Ability to be rewarded for taking good care of one’s health



### 3. Key Information from the District Sponsor Survey

#### a. Purchase of Health Care by School Districts

Based on the district survey data, districts currently purchase medical coverage in a variety of ways. For simplicity of presentation, all percentages have been rounded to the nearest 5%.

| WHERE COVERAGE IS OBTAINED | 50 or Fewer Employees | 51 to 250 Employees | 251 or More Employees | Combined |
|----------------------------|-----------------------|---------------------|-----------------------|----------|
| Purchase Independently     | 20%                   | 30%                 | 55%                   | 35%      |
| JPA/Trust                  | 80%                   | 70%                 | 35%                   | 60%      |
| Other                      | 5%                    | 5%                  | 10%                   | 5%       |

In addition, 9% of district respondents indicated that they currently obtain medical coverage through CalPERS, with Districts having more than 250 employees representing the majority of these responses. Per information provided by CalSTRS, a total of 98 districts cover certificated employees under the PERS program (representing approximately 9% of districts statewide, consistent with the survey results).

#### b. Willingness of Districts to Change Source of Coverage

Most districts express satisfaction with current medical coverage arrangements, however they also express interest in changing coverage if sufficient cost savings can be achieved, and in stabilizing the cost of coverage through multi-year rate guarantees. Twenty-five percent of districts are very interested in a CalSTRS sponsored statewide health benefits program, while another 45% are somewhat interested.

As can be seen in the following table, about 70% of districts that reported their size (as measured by number of certificated employees) indicated that they would be very likely to change coverage for a cost savings of 8% or more. About 45% indicated that such a change was very likely at 7%. At any given level of cost savings, smaller districts were more likely to indicate an interest in changing coverage than were large districts.

These data are very important for understanding the cost parameters of a program that likely must be provided by CalSTRS if it is to be successful. However, these data must be viewed cautiously because of several limitations, including:

- They represent the views of the individual(s) who completed the survey, not necessarily those of all critical decision-makers.
- They represent views under the assumption that “all else is equal” (e.g., plan offerings and designs) – this may or may not be achievable.

Therefore, while these data are important, we caution that it is best viewed as giving orders of magnitude results. Again, for simplicity of presentation we have rounded all percentages to the nearest 5%.

| % VERY LIKELY TO CHANGE | 50 or Fewer Employees | 51 to 250 Employees | 251 or More Employees | Combined |
|-------------------------|-----------------------|---------------------|-----------------------|----------|
| 2% Savings              | 5%                    | 5%                  | 5%                    | 5%       |
| 3% Savings              | 10%                   | 5%                  | 5%                    | 5%       |
| 5% Savings              | 30%                   | 20%                 | 20%                   | 20%      |
| 7% Savings              | 55%                   | 45%                 | 35%                   | 45%      |
| 8% or More Savings      | 80%                   | 65%                 | 60%                   | 70%      |

### c. Current Program Designs Available to Members and/or Retirees

Current program designs offered through the Districts vary substantially. These variations include, but are not limited to:

- Types of plans offered (Indemnity, PPO, POS, HMO)
- Number of options available within a particular type of plan (e.g., 2 HMO options versus 3)
- Number of options available across plan types (e.g., 1 PPO, 1 POS, and 2 HMOs offered through the same district)
- Eligibility criteria (e.g., number of hours worked to be considered full-time, student age limitations, etc.)

As an example, the following table identifies the number of plans of various types made available through the districts to active, certificated members (for simplicity of presentation, percentages in excess of 2% have been rounded to the nearest 5%):

| NUMBER OF PLANS BY TYPE | One | Two  | Three | Four or More | Do Not Offer This Type of Plan |
|-------------------------|-----|------|-------|--------------|--------------------------------|
| Indemnity               | 15% | 5%   | 1%    | 1%           | 80%                            |
| PPO                     | 60% | 10%  | 5%    | 5%           | 20%                            |
| HMO                     | 25% | 25%  | 10%   | 5%           | 35%                            |
| POS                     | 15% | 2%   | 0%    | 1%           | 85%                            |
| Triple Option           | 5%  | 0.5% | 1%    | 0%           | 95%                            |

Not surprisingly, rural districts were more likely to indicate offering PPO plans, while urban districts were more likely to indicate offering HMOs or POS plans.

The District surveys included a number of questions on the major benefit design components of currently offered plans, including:

- Eligibility
- Deductibles
- Coinsurance
- Copayments
- Maximum out of pocket limitations
- How prescription drugs are covered (e.g., separate copay versus being subject to deductible and coinsurance)

This information was used as a basis for developing plan design options, which are summarized in Appendix C.

#### d. Vendors Currently Used

The district survey requested that districts identify administrators that they currently use for medical coverage. Districts identified administrators from a list of choices, or indicated “other” (multiple responses were received). The following were the top four administrators based on the number of Districts that indicated use of that administrator:

|            |     |
|------------|-----|
| Blue Cross | 55% |
| Kaiser     | 40% |
| HealthNet  | 14% |
| PacifiCare | 13% |

California Care (the Blue Cross HMO) was also indicated by 6% of the districts, however some or all of these could overlap with the 55% of districts that also indicated Blue Cross. In addition, Blue Shield non-HMO coverage was indicated by 9% of the districts, and Blue Shield HMO by 6% of the districts, again with the possibility of overlap. No other carrier was identified by more than 10% of the responding districts, although the “other” category was indicated by 17% of the districts.

#### 4. Medical Benefits – Costs and Contributions

The cost information was separated into two types of plans (HMO and non-HMO), and three different risk pools (active, retiree without Medicare, and retiree with Medicare). In many cases, the district’s active rate is the same as its retiree without Medicare rate (i.e., the early retirees are combined with the active pool). The districts reported premium rates based on their own rating tier structure. We reviewed the rates in the most common tier structures reported, which were a single tier (composite rate), and three-tiers. The following table provides a general summary of the average premium rates reported by the categories we reviewed:

|                         | <b>Monthly Premium</b> |                   |                |               |
|-------------------------|------------------------|-------------------|----------------|---------------|
|                         | <u>Single tier</u>     | <u>Three tier</u> |                |               |
|                         |                        | <u>1-party</u>    | <u>2-party</u> | <u>family</u> |
| <i>Active Employees</i> |                        |                   |                |               |
| Average Non-HMO premium | \$413                  | \$235             | \$455          | \$606         |
| Average HMO premium     | \$352                  | \$175             | \$336          | \$461         |

#### *Non-Medicare Retirees*

|                         |       |       |       |       |
|-------------------------|-------|-------|-------|-------|
| Average Non-HMO premium | \$392 | \$275 | \$538 | \$638 |
| Average HMO premium     | \$360 | \$192 | \$399 | \$512 |

### *Medicare Retirees*

|                         |       |       |       |       |
|-------------------------|-------|-------|-------|-------|
| Average Non-HMO premium | \$347 | \$201 | \$371 | \$523 |
| Average HMO premium     | \$228 | \$103 | \$199 | \$351 |

Note: The 2-party and family rates shown for Non-Medicare assume that both adult parties are not covered by Medicare, and the 2-party and family rates shown for Medicare assume that both adult parties are covered by Medicare.

### HMO versus Non-HMO

Based on the average single tier rates, the average HMO premium for actives is approximately 15% lower than the average non-HMO premium. The Non-Medicare rate differential is not as large, and the Medicare rate differential is much larger (approximately 35%).

### Rural versus Non-Rural

We also saw variations in the rates by rural versus non-rural. On average the active rates and non-Medicare retiree rates for rural counties were approximately 10% higher than the corresponding rates for urban counties. The Medicare retiree rates were slightly lower for rural than for urban.

### Large counties versus Small counties

On average, the districts with over 1,000 employees had lower premium rates than the districts with under 1,000 employees, for both HMO and non-HMO plans. The premium rates for districts under 1,000 employees varied by population size. It was difficult to make comparisons of premium rates by population size because there was a significant variation in plan design from district to district.

### Comparison to CalPERS Premiums and Mercer/Foster Higgins survey data

When we compare the average monthly premium rates shown above to CalPERS rates, we find that they are in the same range. For example, the average 1-party rate for the CalPERS plans for calendar year 2000 is \$201 per month. If this is adjusted downward by

10% to reflect CalPERS premium rate increases from 1999 to 2000, it is \$183 per month, which is in the middle of the HMO 1-party rate for actives (\$176) and the non-HMO 1-party rate for actives (\$235) shown above for CalSTRS.

The 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicated that the 1998 average PPO cost per employee for the West region was \$326 per month, and the 1998 average HMO cost per employee was \$275 per month. Adjusting these rates upward 10% to reflect average premium increases from 1998 to 1999, the PPO cost per employee would be \$359 (versus a \$413 single tier rate for CalSTRS non-HMO). The HMO cost per employee with a similar adjustment would be \$303 (versus a \$352 single tier composite rate for CalSTRS HMOs).

Based on the above comparisons, the premiums reported in the district survey may be over 15% higher than the companies in the West region of the Mercer/Foster Higgins survey and appear to be about the same as the CalPERS premiums. The survey rates are probably more directly comparable with the CalPERS rates because they are likely to represent more similar plan designs, similar type of entities, and similar geographic locations. Comparison to the CalPERS rate indicates that the responding districts may currently be achieving reasonable rates on average for the plan designs that they offer.

### Contributions

Approximately 80% of the districts using a one premium rate tier structure required no medical premium contribution for actives and non-Medicare retirees, and 60% of those districts required no premium contributions for Medicare retirees. For districts using three premium tiers, less than 80% required no medical premium contribution for 1-party actives, less than 60% required no premium contribution for 1-party non-Medicare retirees and less than 40% required no contribution for 1-party Medicare retirees. Both the numbers of districts requiring contributions and the amount of the contributions increased for 2-party and family coverage.

For those districts that required contributions, average active contributions ranged from 20-40% of premium, non-Medicare retiree contributions ranged from approximately 30-70% of premium, and Medicare retiree contributions ranged from 90-95% of premium.

## 5. Dental and Vision Benefits – Costs and Contributions

The cost information for dental and vision benefits was not separated by type of plan (i.e., managed care versus indemnity). The majority of the dental coverage is provided through Delta Dental and the majority of the districts use VSP for vision benefits coverage. Each district reported premium rates by their own rating tier structure – we reviewed the rates in the most common tier structures reported, which were a single tier (composite rate), and three-tiers (similar to the medical). The following table provides a general summary of the average premium rates reported by the categories we reviewed:

|                         | Monthly Premium |                |                |               |
|-------------------------|-----------------|----------------|----------------|---------------|
|                         | Single tier     | Three tier     |                |               |
|                         |                 | <u>1-party</u> | <u>2-party</u> | <u>family</u> |
| <i>Active Employees</i> |                 |                |                |               |
| Average dental premium  | \$75            | \$43           | \$78           | \$105         |
| Average vision premium  | \$17            | \$11           | \$18           | \$26          |
| <i>Retirees</i>         |                 |                |                |               |
| Average dental premium  | \$83            | \$42           | \$83           | \$106         |
| Average vision premium  | \$17            | \$11           | \$18           | \$24          |

### Rural versus Non-rural

The dental and vision rates were reviewed for rural versus non-rural differences. The active dental rates were 5-10% lower for urban than for rural districts on average. The active vision rates for the districts with three tiered rates were also lower for urban than for rural, but the districts with a single tier had higher vision rates for urban than for rural. The retiree rates for urban versus rural did not show any consistent patterns.

### Contributions

Over 90% of the districts with one premium tier required no premium contribution for dental and vision coverage. Almost 80% of the districts with three-tiers required no premium contribution for 1-party dental and vision coverage. However, more than half of the districts required premium contributions for 2-party and family coverage, and those contributions ranged from 50-100%.

## 6. Comments on Survey Data

The survey results must be evaluated carefully. As an example, respondents to the district survey may represent the views of only one (or a very few) individuals that completed the survey, and may not reflect the realities of the decision making process when a district

is offered an actual CalSTRS sponsored health care option. Another example includes how an active or retired employee might view the issue of “satisfaction” with current coverage – with satisfaction potentially interpreted as the amount they pay, the benefit they receive, the doctor they use, or some combination of these and other factors.

With this caution, these various data collection components create a basis for structuring alternative approaches for a potential CalSTRS sponsored health program. The following portions of this section of the report provide a number of approaches based on a combination of survey results, input from the CalSTRS Health Benefits Task Force, and Mercer’s experience in designing and structuring health care offerings for active employees and retirees in California and nationally.

## 7. Notes on the Approaches Set Out Below

- The Approaches set out below are not in order of preference but ordered as “building blocks” for understanding.
- Medical programs are described first because they are of most interest, with the more familiar group purchasing described (Approach 1) and then direct contracting (Approach 2). Medical programs also include a retiree-only program, with elements that can be adapted to address part-time employees (Approach 3).
- Prescription drugs are discussed next (Approach 4), because this component of medical programs is of such concern to many given the high rate of cost increases, and because coverage for prescription drugs was identified in the surveys as a top concern for both actives and retirees.
- Dental and vision is discussed (Approaches 5 and 6) because they are clearly of interest to CalSTRS retirees and actives, either combined with medical and Rx or as stand alone programs. This interest was also established in STRS’ prior (1998) survey.
- Finally, financing issues are discussed, including financing Medicare Part A for retirees who do not have it and providing the opportunity for tax free savings by members for their future retiree health care. (Approaches 7 and 8)

While CalPERS (PEMHCA) clearly is an option for health care coverage, we do not describe PEMHCA in this report because it is currently available to districts and therefore no action by CalSTRS is necessary for this coverage to occur.



# Approach 1: Statewide Medical Benefits Program Contracting with Existing Health Plans and Carriers

## 1. Concept

CalSTRS would be a purchaser of health care for any and all school districts that opt to join in the CalSTRS purchasing pool. CalSTRS would establish the health care coverage options available to the districts, would negotiate the costs, and would arrange for the needed administration, including premium collection and payment, claims payment, ombudsman, etc. Healthcare would be purchased from existing health plans and carriers. CalSTRS would design the program for maximum cost effectiveness, stability, service and access. CalSTRS also would design the program with a maximum use of member education, and incentives to improve self-management of their healthcare. Benefits would be designed to be attractive to members, through the inclusion of disease management programs, coverage of alternative medicine, and rewards for taking good care of one's health. Finally, an emphasis on continuous improvement in quality would represent an underlying foundation for the overall program.

This approach would include retirees as well as actives. There would not be a requirement for the same level of school district subsidy for retirees as for actives. Nevertheless, some ground rules may be required to avoid adverse selection with respect to retirees.

Responding to the “cost, choice and control” issues of the Health Benefits Task Force:

- One goal of this program would be to reduce or limit cost increases to the extent possible in the California marketplace and dependent on the purchasing power that the program could attract.
- Another goal would be to provide choice of a number of types of coverage (PPO, HMO, etc.) and benefit levels.
- A third goal would be to provide rapid response to local problems with carriers and providers, developing a quick response team within STRS to deal with local issues.

Under this approach, CalSTRS would purchase coverage from existing carriers. Under Approach 2 (described below), CalSTRS would be a direct purchaser of health care from the providers – physicians groups, hospitals, laboratories, etc.

## 2. Enablers

The following are the fundamental elements of this approach that would help enable success.

- Aggregate purchasing power through consolidation of coverage
- Provide sufficient choice to avoid major changes in current types of coverage
- Reduce administrative and other costs, through aggregation of districts
- Increase focus on quality, defined as better outcomes, by designing incentives in partnership with the health plans and providers, thereby achieving reduced costs
- Reduce medical claims through self empowerment of CalSTRS members using education and incentives
- Include benefits that will be attractive to CalSTRS members, such as alternative care, wellness programs, and other quality based differentiators
- To the extent possible, work with health plans and providers on a long-term partnership basis avoiding an adversarial relationship
- Provide administrative arrangements (such as one or more assigned ombudspersons) so that members and districts are assured that coverage and care issues are resolved quickly and reasonably, and that program administration requirements are made as easy as possible for the districts.

## 3. Barriers

The following are the fundamental issues that cause concern about the likelihood of success of this alternative.

- The uncertain state of the California health care market—have health plans consolidated so much that they will not negotiate sufficient savings with a new large purchasing coalition? Are plans and providers in such real financial distress that they will not be able to negotiate additional savings even if they were willing to do so?
- Key transition issues:
  - The “chicken and egg” issue—how does CalSTRS get the participation of districts in sufficient degree that it can gather sufficient purchasing power to drive desirable pricing terms?
  - If sufficient savings were obtained, can districts and their unions agree in the needed time frame to participate in the CalSTRS program in order to generate sufficient purchasing group size?
- Currently districts have very different programs; how can they be given sufficient choice so moving to a CalSTRS program would not unduly disrupt the current situation?

- Independence—will districts be willing to forgo their current “independence” in designing and administering health care coverage for their employees?
- Reliability of the district survey data— key information from the survey is the level of interest in the districts in moving source of coverage based on rate reductions. The survey responses are ordinarily from one knowledgeable individual, but that person cannot speak for the district. The only real way to test the accuracy of this data is to actually provide a market choice to the districts; this action, of course, requires some up front expenditure and risk.
- Cost and pricing issues—there are a number of cost and pricing issues that generally can only be resolved with substantially more information about the districts and members who would participate in a CalSTRS program, along with the specific plan designs and structures that would be offered.
- Current cost levels do not appear unreasonably high. Therefore, achieving savings of 7% or more may require aggressive efforts in all areas.

## 4. Design Elements

### a. Choice and Cost

The most important elements for a successful CalSTRS program appear to be to provide reduced net cost, improve the quality of healthcare, and establish a significant degree of choice among plan types and benefit levels for districts and members. Our recommendations for the best reasonable way to achieve these goals are to concentrate purchasing power and provide choice, as described below, while building in a significant emphasis on providing high quality healthcare.

- Small number of health plans—Provide health care coverage and administrative services through a small number of carriers/health plans
- Full range of plan types—Provide a full range of plan types (Indemnity, PPO, POS, and HMO) for purchase by all Districts and their members. (As presently occurs, the district and unions would bargain the options that would be provided, from the menu of choices offered.)
- Choice of benefit level—Provide ranges of options within each plan type (an indemnity option, high/medium/low options for PPO and HMO, high/medium options for POS, and one out of area plan option).
- Selection through bargaining—Districts and their unions could bargain to select one or more of the plan options to offer to employees, and would not be required to offer all plans. Some limitations on the number and types of plans offered for a particular District may be required, based on appropriate underwriting/risk considerations, and in conjunction with any carrier restrictions that might be required.

- Quality— Partner with health plans, providers and CalSTRS members to focus on quality, and establish incentives for better outcomes, lower costs, and a higher level of member-control of their own health care.

## b. Limitations on design — indemnity, triple option, POS

- Possible indemnity plan limitation – An Out of Area (indemnity) plan option would clearly need to be available to those employees residing outside the service area of any network based plans offered by CalSTRS. In addition, an indemnity plan option is also included in this approach as an option for members residing within the service area of a network based plan offered by a CalSTRS program. However, in order to maximize the leverage and cost effectiveness available through contracted healthcare arrangements, eliminating an indemnity option for districts that lie within the network areas of CalSTRS offered plans could improve program financial performance. The importance of an indemnity plan option should be further explored with districts and members to determine whether or not this type of limitation would have a significant effect on expected participation.
- Triple Option—Due to the relatively small number of districts that currently offer triple option medical plans, no such program is included in this structure. However, it is important to note that the districts that offered such a plan tended to be larger (e.g., over 1,000 certificated employees). Since volume purchasing is an important aspect of this approach, we recommend additional discussion with some of these districts to determine whether or not a triple option alternative is essential to their participation in a CalSTRS sponsored program.
- POS—We have included two POS options, since approximately 17% of the districts indicate that they currently offer this type of plan. However, in order to minimize complexity of the program, it may be desirable to eliminate POS options entirely. Offering only PPO and HMO options limits the types of program choices available to members, but continues to allow districts the opportunity to offer a plan that allows full access to out of network providers. As part of future efforts to refine program design, it may be appropriate to re-visit this issue, however we currently suggest including POS options until further feedback can be obtained from districts and members regarding the importance of the inclusion of such plans.

## 5. Funding Approach

### a. Existing Funding Sources

- Funding is expected to come from district and member contributions currently being paid to other sources of coverage.

- Savings are anticipated as a result of the leveraged purchasing power and efforts to focus on quality of care. However, given the state of the health care market it is not clear the extent of the savings available. Other California purchasing coalitions have achieved substantial cost reductions in their early years. This even was the case for PBGH, which is a coalition of large sophisticated employers, each of which had substantial purchasing power on its own. However we are reluctant to predict the effects of purchasing coalitions in the current health care market, which is quite different from that of prior years. Further, to the extent that cost savings are to come from quality improvement and educated member control of their care, it may take several years to implement these programs and see the resulting savings.
- In initial years there will be an added expense from start up costs. To the extent that these costs partially or fully offset early years' savings, and are paid out of current premiums instead of being amortized over a longer period, they could have a negative impact on program costs in the short term.

## b. New Funding Sources

If the CalSTRS Board wishes to, and has the money to do so, it can use the current high level of earnings to partly subsidize health care premiums for members in districts that participate in the CalSTRS health care program.

Here are some order of magnitudes for consideration:

- We estimate that the current total annual health care premiums paid for all CalSTRS members and retirees is approximately \$1.5 billion to \$2 billion (or \$2.5 billion to \$3 billion including classifieds).
- Using \$2 billion, 10% of this amount is \$200 million per year.
- If only 10% of CalSTRS members and retirees were to participate in a CalSTRS health care program, a 5% subsidy would represent approximately \$10 million per year. With 25% participation, this figure rises to approximately \$50.0 million and with 50% participation to \$100.0 million.

Using the survey data, with a 5% reduction in health care costs, about 20% of the districts indicate that they would be likely to change source of coverage. If another 3% of costs were reduced through administrative savings, purchasing power, and increased quality (including member education and empowerment), this would bring an 8% reduction in costs. With an 8% or greater reduction, about 65% of districts indicated that they would be very likely to change. Discounting this (for conservatism) by 25% would give about a 50% shift of districts to a CalSTRS program with an 8% or greater rate reduction.

These numbers need additional discussion, since it is difficult to predict how many districts might actually participate, and when they would choose to do so. However, it appears that some “pump priming” by CalSTRS would substantially increase the chance of success of a CalSTRS sponsored health care program.

One prime issue is how CalSTRS can use its pension assets to subsidize health care. The short answer is that CalSTRS cannot directly use its pension assets to do this. However, existing CalSTRS assets can be substituted for current employer (and member) contributions to CalSTRS, which in turn can be contributed to a health care program for those districts that choose to participate. This type of substitution is common for retiree health care funding; however, it also should be available for active health care funding. Counsel for CalSTRS should carefully review this issue.

### c. Self Funded Program

We anticipate that coverage would be self-funded (self-insured) to the extent possible. With substantial portions of members currently covered under HMOs, we would expect that a significant portion of the CalSTRS program would be under insured/capitated arrangements.

## 6. Cost and Pricing Issues

There are a number of cost and pricing issues that generally can only be resolved with more information about who would participate in a CalSTRS program (districts and members). These include:

Claims cost is a function of price and volume:

- Price will depend upon a combination of provider discounts, negotiated capitation rates, and administrative efficiency, which are related to program size (the larger the number of members, the greater the likelihood of good discounts).
- Price will vary by geographic location. Therefore, it is likely that geographic rating will be needed to provide the needed incentives for districts and members to join.
- Volume, or utilization of services, will depend upon the health status of the participants. Without sufficient incentives to join, there may be substantial concerns about anti-selection. Districts with higher average utilization of health services will be more likely to sign up. Although their higher costs may be justified by claims experience, this might mean that underwriting and rate differentials should be considered.

- Utilization of services is also affected by the specific practice patterns of the providers, and can vary by geographic location; another reason why geographic rating may be required.
- Volume will be affected by the precise incentives that are used to empower employees to change their behavior. These incentives must be designed to match the demographic characteristics of the CalSTRS population.

Pricing is a function of plan design and program structure:

- Voluntary district participation creates opportunities for adverse selection. Program structure will need to address this potential problem.
- If a district can offer the CalSTRS plan as one of many options, this may lead to higher costs than requiring that the CalSTRS plan be the only health plan option.
- Accepting all districts (without any underwriting guidelines) could also lead to higher cost levels.
- Type of plans (i.e., an HMO with a limited provider network or a PPO with a very inclusive provider network) and the ability to manage care through providers will affect the pricing of the plans.
- Plan incentives – are there specific unique features of the plan/program that will attract healthy (or unhealthy) enrollees?
- Risk adjustment – does the program pay the plans based upon the health status of the population they serve?

## 7. Vendor Issues

To better control costs and maximize purchasing power under this alternative, the number of health plans/administrators offered should be limited – potentially only two or three carriers capable of supplying all needed services. This structure maximizes the pool of participants covered by any one carrier, and should maximize the competition among administrators bidding to supply services to CalSTRS program participants. In addition, this structure allows CalSTRS to concentrate its efforts with those vendors having the strongest ability to effectively manage health care costs, and that are willing to work towards effective integration of quality improvements to meet CalSTRS’ needs.

One key issue of concern is the willingness of vendors to participate in the process. As an example, we understand that many districts currently face the problem referred to as “Blue on Blue”. Blue Cross currently provides coverage to a substantial proportion of the teachers in districts throughout California, and does so through many different avenues – direct with the districts, through JPAs, and through Trust arrangements. In an effort to avoid competing with itself (among other potential issues), we understand that Blue Cross’ policy is to decline to quote on business for which Blue Cross already provides coverage. As an example, if a district currently obtains coverage directly from Blue Cross, and wishes to enter a JPA arrangement that also uses Blue Cross (but possibly at a lower premium

rate), Blue Cross may decline to cover that district through the JPA. CalSTRS would have to explore this issue carefully with Blue Cross and potential substitute carriers.

In addition, if CalSTRS has large-scale success it might affect other arrangements currently in existence. Since many districts and members currently obtain coverage through JPAs and Trusts, a substantial movement to CalSTRS away from those organizations could impact the remaining districts' costs. However, the CalSTRS program might be able to work with existing JPAs and Trusts as partners for administrative and other resources, which may mitigate some of the potential issues in this area.

## 8. Program Participation

The effectiveness of this alternative is dependent upon the ability to bring together a sufficiently large number of members into the program. We have the following comments on this issue:

- There is no “right” number of participants to achieve the benefits of leveraged purchasing power – larger is better, but even a relatively small program could be helpful for some districts.
- However, other large purchasing options already exist for many districts (JPAs, Trusts, CalPERS), and in fact 80% of Districts with 50 or fewer employees indicated that they currently purchase coverage through a JPA or Trust. An important question then is how much savings (if any) would occur relative to these entities.
- The presence of unique features can play a large role in attracting participants.
- To have a significant impact on quality, thus improving value and outcomes on the more significant portion of healthcare costs, also requires substantial consolidated purchasing. To maximize the opportunities in this area, CalSTRS may wish to partner with other large purchasers, such as CalPERS, PBGH, the University of California, or others.

Other factors are important, as follows:

- The number and variety of designs available will have an impact on both the premium rates and administration costs. Increasing the number of benefit designs and/or carriers offered increases the administrative complexity of the program, and decreases the concentration of members (and therefore the leverage available) with any one carrier. However, reducing the number of benefit designs and/or carriers offered is likely to reduce the attractiveness of the program to both districts and members. We have recommended a balance between these two factors, suggesting a reduction in the number of plans/carriers and a number of designs that generally fit with what we understand is currently provided.
- While districts indicated an interest in changing coverage if offered certain levels of cost savings, the actual decision making process would be subject to collective bargaining. Further, local issues may influence any particular district's decision to join a



CalSTRS program. Therefore, while the price sensitivity shown in the data appears to be a reasonable indication of the market, without more information, the district survey data probably should be used cautiously. The actual result could be less (or greater) than that implied by the survey results.

- Transition issues are of importance. For example, not all districts that wish to participate will be able to do so at the first available opportunity. Their timing of participation in the program may depend on when their next negotiation opportunity is available, how recently they last changed medical coverage, their current rates and rate guarantees, and other factors.
- The most important transition issue may be “chicken and egg”. Many districts may wish to participate, but only with a high likelihood of cost savings. Yet, cost savings may be dependent on their participation. There are a variety of ways to deal with this concern, with different attendant issues.
- Some districts may choose to take a “wait and see” attitude towards participation. Minimizing this effect will require that any CalSTRS-sponsored program be well thought out, well structured, well communicated, and well implemented.

Of course, participation can be guaranteed, technically, if all school districts are required to participate. We do not understand this to be a realistic alternative.

## 9. Additional Critical Success Factor – Classified Employee Coverage

The program described above is focused on CalSTRS members – certificated employees. However, the plan sponsor survey made clear that the districts want a program that is for both certificated and classified employees.

The ability for Districts to include classified employees in the program was the third most important factor to districts in finding a CalSTRS sponsored program attractive. The reason is simple. If districts had to split the health program between classified and certificated employees, they would not be able to eliminate much of their internal administrative cost, and they would lose bargaining power in the market for the classified employees for whom they would retain responsibility. Further, it would be difficult as an HR matter for the districts because they would have to consider duplicating the benefit structure under the CalSTRS program for their classified employees. Eighty percent of districts indicate that they offer classified employees the same benefit plan design and contribution structure as that offered to certificated employees. Classified retirees, while not addressed as part of this survey, are likely to create similar types of concerns for districts.

For all these reasons, if CalSTRS offered a health care program for both actives and retirees that was limited to certificated employees the chance of success would be significantly reduced. (However, other alternatives might not create this problem, such as a program to subsidize Medicare premiums or to help CalSTRS members save for their retiree health care. These approaches are discussed later in this report.)

It should be noted that the surveys did not include the views of classified employees or retirees, and only limited data were collected from districts regarding issues associated with this population.

## 10. Pilot Potential

There are plus and minus considerations for a pilot. On the positive side, a pilot may reduce start up costs and allow CalSTRS to test concepts in a lower risk environment. Such a program might focus on a particular county or counties determined to be suitable based on teaching population, current access (or lack of access) to appropriate medical care, and other factors.

However, a pilot approach may not result in sufficient participation to establish the types of quality improvements and incentives that we believe are available with a broader based program. As a result, in a pilot program it would be more important to attempt to achieve greater levels of district and member participation.

## Approach 2: Statewide Medical Benefits Program Contracting Directly with Providers

### 1. Concept

This concept is the same as that discussed under Approach 1, except that health care coverage would be purchased directly from providers, not health plans.

STRS would be a purchaser of health care for any school districts that opted to join in the CalSTRS purchasing pool. CalSTRS would establish the health care coverage options available to the districts, would negotiate the costs, and would arrange for the needed administration, including premium collection and payment, claims payment, ombudspersons, etc. CalSTRS would design the program for maximum cost effectiveness, stability, service and access, once again with an underlying foundation and focus on quality of care. CalSTRS also would design the program with a maximum use of member education, and incentives to improve self-management of their healthcare.

Health care would be purchased directly from physician groups, hospitals and other health care providers. CalSTRS would effectively establish its own network of health care providers and ancillary service providers (such as claims payers). An alternative model that might be further considered would be the Minneapolis model, discussed below.

The “cost, choice and control” issues would be addressed in ways similar to Approach 1 above.

### 2. Enablers

The same enablers and barriers to large group purchasing discussed for Approach 1 generally apply here. Enablers and barriers that are described under this approach are focused on the special issues of direct contracting, and include the following:

- There is a strong desire by many physicians and hospitals to no longer contract with health plans and carriers.
- There is a need for many health plans and carriers to “show a profit” for various financial reasons (stock price, loan rates, etc.).  
Bypassing the plans/carriers may eliminate this profit component and thus reduce cost.

- The likelihood of success increases with the ability to concentrate a substantial number of members with a limited number of providers. (While this enabler applies also to Approach 1, we have included it here because it is usually a critical element in negotiating provider contracts.)
- To obtain the needed concentration of members, especially with a pilot program, it may be best to partner with other programs or employers.

### 3. Barriers

- Start-up costs include negotiating provider contracts. These costs can be significant, though there are strategies to deal with this.
- To the extent that cost savings are to come from cutting out plans/carriers' profits, there may currently be limited opportunity in the California market. However, with concentration of health plans this could change rapidly.
- Providers may wish to capture some of the potential savings achieved through bypassing the plans/carriers. This may be particularly true given recent concerns expressed in the public media regarding provider group bankruptcies, and that providers have been under tremendous financial pressures.
- Health plans and carriers may be threatened by a direct contracting program and may try to create strong incentives for providers (such as hospitals that are members of large chains) not to directly contract.

### 4. Discussion of Direct Contracting

This alternative represents an extension of the previously described statewide purchasing structure, focused on maximizing potential cost savings by contracting directly with health care providers.

For many years, buyers and sellers of health care have not talked with one another directly. Taking advantage of this void, health plans stepped into the picture and took control of most interactions. As a matter of market analysis, the health plans purchased health care services “at wholesale” and sold them to employers and employees “at retail”. They also added value through providing administrative services. However, with a large enough group of employees, there are substantial questions about whether health plans bring sufficient value to pay their increasingly higher rates. Large groups can also buy “at wholesale” and can provide the administrative services or can contract them out. However, this is not often done in the U.S. health care market place; in fact, this is one marketplace where buyers and sellers are isolated from one another. The fact that buyers and sellers of healthcare are isolated from one another also reduces the likelihood of being able to understand and address each other’s needs.

Direct contracting also can change the overall focus of the process onto what the employer wants to buy, not what the vendor wants to sell. This can be a substantial advantage in health care because what the vendors want to sell has become less flexible as vendors have increased in size and concentration. Simultaneously, direct contracting allows a greater focus on incentives to providers, and a lesser focus on controls and penalties as part of the structure of delivering care. Generally, this seems to fit better with what providers want.

The direct contracting process generally involves the employer (or in this instance CalSTRS), working directly with providers (hospitals, physician groups and others such as laboratories and home health care providers) in a local community to establish agreements for the provision of care to the employer's members in that community. These agreements are intended to bypass the health plans and eliminate their profit margin and other unwanted costs, and shift the medical care management decisions, (as well as the risk associated with that care, when possible in the regulatory environment), directly to the providers. As a result, it is expected that providers in many instances will have greater control than under standard managed care arrangements in healthcare decision-making (e.g., when a referral will or will not be made for a patient). With this change, another goal is to increase both provider and patient satisfaction.

However, direct contracting does not eliminate all of the administrative costs of providing health care. Many of the services provided by HMOs, insurance carriers and TPAs are essential to the process of managing the health care system. These include such areas as eligibility processing, data tracking and analysis, communications, and the like. In many cases, providers may not wish to take on these responsibilities, or may not be able to do so. As a result, providers would need to subcontract for those needed services directly from an outside vendor. Alternatively, CalSTRS might subcontract needed services on a centralized basis. Some of the administrative costs should be eliminated, however, to the extent that physicians are responsible for more of their actions and there is less "over the shoulder" administration required. There also may be cost efficiencies in administration if the work is done more efficiently.

The number and types of contractual arrangements that must be established in order to provide the full range of services to members will vary by location throughout the State. A few of the factors involved include:

- How medical groups are structured to provide services (e.g., breadth and depth) in a specific location
- How large those medical groups are (it is generally financially and administratively prohibitive to attempt to contract on a physician by physician basis)
- The geographic reach of those medical groups
- The number of overlapping medical groups within a given area, and how many groups must be contracted
- How hospitals are organized within a given area, and types of hospitals and services available (general, tertiary, teaching, etc.)

Conceptually, the savings associated with this approach are based on reducing certain elements of insurance vendor overhead and profit charges. As a hypothetical example, if we assume that 80% of a premium dollar currently pays for actual care, the remaining 20% is maintained by the insurance carrier for administration, overhead, marketing and advertising, profit, and the like. Further assume that ½ of the 20% is spent on issues directly relevant to the provision of coverage. Under these assumptions, approximately 10% would be used for costs that could potentially be eliminated from the process (e.g., marketing and advertising expenses, vendor profit, etc.), resulting in a 10% cost reduction. This savings would then be partially offset by the additional tasks undertaken by CalSTRS (or its designated sub-contractor) to maintain the direct contracting arrangements and manage the program over time. If these added costs represented the equivalent of 5% of current premiums, the end result would be savings of approximately 5%.

Savings can also be achieved through “smart” contracting. By contracting with the highest quality, and most effective providers of service, and potentially de-selecting lesser quality or less effective providers, smart contracting maximizes the opportunity to achieve cost savings while improving quality.

Please note that the above is only a hypothetical description of how costs might be developed – it is not intended as an actual estimate of potential savings. Actual results would differ significantly depending on such factors as geographic location, the actual administrative and other cost components that could be saved (which would vary both by carrier and by type of coverage), and the contractual arrangements that are actually negotiated with the providers. This latter issue is of substantial importance, and is further discussed below.

Experience with direct contracting is increasing. For example, Mercer has successfully contracted for large employers in a number of states, in many instances producing substantial savings. However, it should be noted that the greatest recent cost savings opportunities have often come in health care markets that are quite different from that in California. Even so, the California market continues to see rapid change, and therefore until a CalSTRS based direct contracting project is attempted (even if just on an informal inquiry basis), it is difficult to predict the outcome.

## 5. Design Elements

Design elements for this program would be similar in nature to those discussed in Approach 1. In addition, there are the following considerations.

- The best financial arrangements will be obtained with focused use of network providers. In the best case (financially) this requires a limited network of providers, and incentives for members to use the network. A limited network is best because better pricing can be obtained if more “volume” is directed to providers. Also, a limited network reduces administrative costs and increases the

accountability and therefore effectiveness of provider-controlled medical management. A plan under both Approach 1 and this Approach can be designed to include deductible and coinsurance incentives; with direct contracting, it may be appropriate to expand these incentives.

- Using a limited network has downsides. The most important issue is that by limiting the physician network, members may not be able to continue to use their existing physician. (Of course, transition plans for medical care in process would be an essential element of any program.) Our general experience is that the transition to a limited network can be difficult, but that after the transition there often is greater member and physician satisfaction. One point to keep clear, however, is that a limited network is not critical for direct contracting. It generally will, however, substantially lower start up costs (because fewer contracts are required), lower ongoing administrative costs (because the complexity is reduced), provide strong incentives to the physicians which can increase member satisfaction, and reduce negotiated contract costs for medical care.
- Separately, as discussed under Approach 1 and based on the survey data, providing several plan designs (HMO, PPO, POS) and several different levels of coverage (high, medium and low) is important to attract participants. However, as part of a pilot, and to make direct contracting attractive to providers as an administrative matter, it may be appropriate to limit benefit design variations to reduce complexity. For example, it may be possible in a pilot market to meet the needs of all participating districts with a smaller number of design options. This will be dependent on the current program designs that districts maintain in the pilot market, and the districts' and members' willingness to participate in the program with more limited options.

## 6. Funding Approach

Funding elements for this program would be similar to those discussed in Approach 1. However, Knox Keene licensing limits the ability of medical groups and hospitals to negotiate capitated arrangements on a direct contracting basis. Although capitated arrangements may not be feasible under this approach (or only to a more limited extent), Mercer has successfully negotiated other financial reimbursement arrangements that capture much of the desired risk controls associated with capitation. An example would be the use of budget corridors with risk targets that share the risks and financial responsibility for managing care between the provider and CalSTRS. The actual elements of risk sharing and program funding will depend on a number of different factors including the nature of the specific services being contracted, and the local nature of the provider marketplace.

## 7. Cost and Pricing Issues

Most of the cost and pricing issues mentioned in Approach 1 also apply to Approach 2. Additional cost and pricing issues that are unique to direct contracting are discussed below:

- As mentioned previously, the start-up administrative costs for this option may be greater because CalSTRS would be responsible for additional tasks, such as provider contracting.
- Ultimately, the total plan cost with direct contracting could be lower than purchasing from a health plan because there would be no profit margin built into the pricing (also discussed previously).
- In addition to regulatory restrictions on capitation, providers may be less willing to accept any risk in the way they are paid. At least in the beginning, due to the uncertainty of the CalSTRS plan population size and health status, providers may insist on fee-for-service, unless the risk arrangement is upside only for the providers.
- Uncertainty may also cause providers to negotiate elevated fee-for-service levels. However, providers may be inclined to negotiate reasonable contracts due to the desirability of eliminating the health plan.
- Health plans may have an easier time negotiating by combining the CalSTRS program with contractual arrangements with other groups.
- Although a unique plan design may be an advantage for attracting new enrollees, it will also be more difficult to price unique plan design features. Therefore, additional margin may need to be included in the initial plan pricing.
- If the program is designed to pay for itself, sufficient contingency reserves will need to be included in the pricing (e.g., established health plans may be more willing and able to take risks that their premium rates will be sufficient).

## 8. Vendor Issues

The vendor issues with direct contracting are quite different from those under Approach 1. (In health care purchasing, the terminology is important. “Vendors” are usually referred to as intermediaries such as health plans and insurance carriers. “Providers” are physicians, hospitals, and others who actually provide health care to members.)

### a. Service Providers and Vendors

In this program, for the most part, vendors of insurance (HMOs and insurance carriers) are removed from the process. To the extent that they have a role, they may become contract (or subcontract) administrators who provide support services to provider groups and/or CalSTRS. CalSTRS would identify which services are needed, and then determine if it is more efficient to have them provided



by the providers or a direct contract with CalSTRS. If by the providers, these services would be part of the overall provider contract. If by another contractor, CalSTRS would seek competitive bids as appropriate. In either event, vendors could compete to provide administration and other support services. (In some circumstances, they would be contractors to the medical groups, turning upside down the current relation between vendors and medical groups).

## b. Provider Contracting Issues

A number of factors will affect any particular provider's willingness to directly contract with CalSTRS, including:

- Some providers are likely to be interested in reducing the carriers' participation in the process, and may well be willing to offer comparable cost arrangements on a direct contracted basis to do so
- Some providers will not wish to compete against the carriers
- Carriers may pressure providers not to participate, using their book of business as leverage

## c. Kaiser-Permanente

One of the more important vendor issues involves the Kaiser Permanente Health Care Program. Kaiser provides health care to 40% of districts, based on the district survey. Without a significant change in the Kaiser contractual relationships, it is unlikely that CalSTRS will be able to contract directly with Kaiser hospitals and the two California Permanente Medical Groups. Kaiser owns most of the California hospitals it uses, and we understand that for many years the Medical Groups have contracted to provide services exclusively to Kaiser, except for limited situations. This is not to say that CalSTRS should not consider direct contracting here; it is to say that the likelihood of success would depend on major changes in internal Kaiser relationships.

Based on current member and District use, Kaiser would be an important part of any CalSTRS health care program, and it may well not fit a direct contracting approach. Therefore, we suggest a different approach with Kaiser (for both this approach and Approach 1).

The following factors are important to a Kaiser strategy:

- Recent events such as the sale of money losing eastern Kaiser plans indicate that Kaiser is becoming more focused on its core California strengths.
- Kaiser has been extraordinarily insulated from the "outside". This is changing, we believe.

- With the recent history of pricing battles in the California market, Kaiser and large buyers have often been adversaries, not partners. However, with a health care program, CalSTRS will necessarily become a long-term partner of Kaiser, and will be a new kid on the block. There may be new opportunities to work with Kaiser by establishing new relationships.
- Partnership does not mean acquiescence. We believe that there are a number of financial and operational issues that Kaiser can address to provide lower costs and higher quality to a CalSTRS sponsored program.

We recommend that under any alternative that involves medical care, CalSTRS develop a partnership strategy for working together with Kaiser. To be successful, this will take skill, imagination and some luck on both sides. However, we believe that it can be done.

## 9. Program Participation

Participation issues for this program would be similar to those discussed in Approach 1. In addition, there are the following considerations.

Consolidating districts for purchasing with existing insurance vendors, under Approach 1, involves maximizing competition between vendors. However, using existing vendors offers the opportunity to access their negotiating leverage for their entire book of business. Obtaining the necessary concentration of members to offer comparable negotiating leverage in direct contracting with providers will require substantial participation on the part of districts and members; this makes partnership arrangements with other large employers an important option to pursue. (We understand from informal conversations with at least one other large California group purchaser that there may be opportunities to do this on a pilot basis.)

Direct contracting works differently in different health care markets, and the strategy and outcomes depend very much on the environment in the particular market. It appears that a key element in California may be a strong desire on the part of physicians to bypass the existing medical decision making issues involving referrals, etc. If, in fact, physicians are willing to contract to avoid what they clearly and strongly denounce, then there may be an ability to obtain contract arrangements that are at least as favorable as the health plans now get. This can only be determined by market testing, however.

## 10. Additional Success Factors – Network Limitation

The most successful direct contracting efforts are often selective in choosing providers to participate in the contracted arrangements. This aids the program in several ways:

- Allows CalSTRS to establish a higher level of quality and service expectations by selecting only those provider groups that meet select standards
- Increases the concentration of membership within a provider group or groups
- Decreases the financial risk to the provider group by spreading that risk over an increased membership base
- Provides the opportunity to select only those physician groups and hospital systems that are sufficiently sophisticated and financially sound to effectively manage health care risk
- Decreases start-up costs, as well as the cost of administering and maintaining the program over time

The problem with limiting network size relates to the disruption of member relationships with their existing physicians. To the extent that a large network with a broad choice among physicians and hospitals is important, this may become a barrier to program success. However, there is substantial evidence that effectively structured networks with fewer providers can significantly improve satisfaction levels. The question then becomes, can the barriers be overcome in order to achieve improvements in the longer term. This can only be determined by actual experience with the particular group.

Finally, the greatest success is anticipated through the achievement of a true working partnership between providers, employers, and members. Meeting the needs of both sides involves controlling claim costs, obtaining higher levels of satisfaction and perceptions of quality, and eliminating marginal value services offered by middlemen by bringing together buyers and sellers. This will be essential in establishing a stable, cost effective long-term structure for the program, and represents value added to all participants.

## 11. Pilot Potential

Given the increased up-front commitment necessary to start this type of program, and the greater need to bring together concentrations of members, we believe that this approach should be tested on a pilot basis. The best opportunity for a pilot program would be in areas that currently have well established physician provider organizations, and in which a large number of districts/members could be brought together within a relatively concentrated geographic region. In addition, the opportunity to partner with other large public or private sector employers within the area would also be of value. Examples of potential locations might include Sacramento or similar types of areas with well-established group based physician provider organizations and where partner-employers may be willing to join a pilot.

## 12. Minneapolis Model

An alternative model would be similar to the Minneapolis model. Here, generally, providers newly organize themselves in accordance with rules established by the health purchasing coalition (e.g., CalSTRS) to provide care to employees who choose their plans. The price for services is essentially a “global” rate that is established by the newly organized health programs, but with retrospective risk adjustment. Employees choose among the health plans offered by their employers, and their employers establish the amount of monthly contribution that each employer will pay per employee.

This is a model with attractive elements. Specifically, it puts the providers and the members in direct contact with each other on care and economics. It also gives direct economic, professional and social encouragement to the providers to “do the right thing” instead of having a set of rules imposed on the providers by a managed care company. Self-interest and therefore self-regulation may be a much more powerful way to achieve results than is outside regulation.

According to the Minneapolis program leader who spoke to CalSTRS, however, this model has a significant ramp up time because of data requirements and the need to establish strong buy-in by the employers and providers. In California, there may be two other issues, one practical and one legal. The practical problem may be to convince providers to become organized according to the bidding rules because CalSTRS might not have a sufficient market presence. (The Minneapolis program leader indicated that they believe about 8% of the relevant market was probably needed.) The legal problem may be that the newly organized programs might have to obtain Knox-Keene licenses to bid at a global “capitation” rate (even one that is risk adjusted). There may well be ways to solve each of these issues. In these circumstances, CalSTRS may wish to consider this type of a program as a second stage type of direct contracting.

## Approach 3: Statewide Program for Retirees and/or Part Time Employees

### 1. Concept

STRS would develop a program designed to meet the medical care needs of retired teachers and/or part time employees. This program would be intended to offer a source of coverage to those individuals who may currently find access restricted, or who purchase coverage individually and therefore might benefit from a combined purchasing arrangement through CalSTRS. In addition, the program could also be designed to meet the needs of district-sponsored retiree and/or part time employee medical benefits. The district level program could operate either as a stand-alone option for the purchase of such coverage, or in conjunction with a broader statewide program that includes active employees under Approach 1 or Approach 2. In either instance, CalSTRS becomes a reliable source of access to future retiree medical coverage and to part-time employee coverage as appropriate. Finally, a well constructed and managed prescription drug program, as further described under Approach 4, could be a key differentiation for this approach.

Due in part to the reduced availability of data on part time employee needs, the balance of this approach description focuses largely on retirees. However, most of the elements associated with retiree programs (either at the district level, or offered as individually purchased benefits) are similarly applicable to part time employees. The most significant distinction would be focused on plan designs, since the needs of the part time employee population would be expected to differ from those of retirees.

### 2. Enablers

- The desire of current retirees to have a secure program
- Districts' desire for available options to help provide coverage to retirees and part time employees
- A program subsidy that allows individuals purchasing directly from CalSTRS to buy coverage cost effectively
- An effective communications program to non-covered individuals that helps them understand their options
- The fact that this type of program is expected to support the goal (as identified by the Health Benefits Task Force) of enhancing attraction and retention of teachers

### 3. Barriers

- Adverse selection risks associated with coverage purchased by individual purchasers
- Non-covered individuals' ability to pay
- Districts' that don't wish to split coverage for actives and retirees
- Current district pricing structures that may make a CalSTRS sponsored program less attractive
- Difficulty of providing a stable, cost effective retiree only program because the population is more limited and therefore the purchasing power more limited, and because of the greater chance of adverse selection
- Some concentration of retirees in rural areas, with potentially a limited number of health care providers and therefore a limited ability to affect both costs and the model of care

### 4. Design

Program design under this approach would be based on whether or not the costs of coverage are being subsidized by the district versus individual purchase, whether or not the individual is under 65 or 65 and older, and whether or not the individual is Medicare eligible. For part time employees the latter two items would not be relevant. Similar to Approach 1, this program would be designed to work with a minimum number of vendors in order to maximize the aggregation of members for each vendor.

It may or may not be appropriate to develop this program on a direct contracted basis. If the plan were made available only to retirees and/or part time employees (i.e., not in conjunction with a statewide active program), it becomes less likely that a sufficient number of participants could be aggregated to produce the needed purchasing volumes. In addition, since retirees will often move out of urban areas in retirement, the ability to obtain adequate numbers of participants within a direct contracting program is further diminished.

#### a. Plans Purchased and Subsidized by Districts

For plans purchased and partially funded by the districts, retirees under age 65 and part-time employees would be offered the same plans as those described under Approaches 1 and 2 (with plan offerings selected by the districts). Districts could select a more limited number of options, or could offer the same options as those offered to active employees. Retirees over age 65 would be eligible to participate in Medicare + Choice options, or a Medicare supplemental PPO/out of area plan. The PPO/out of area plans would be designed to pay as a regular plan with deductibles and appropriate coinsurance, offset by the amount that Medicare actually pays (or would have paid had the Medicare claim been submitted). Total payments received from Medicare and from the CalSTRS program

would not exceed the amount that would have been paid by the plan in the absence of Medicare coverage. An out of area plan would also be available, with comparable Medicare integration requirements.

For those individuals not eligible for Medicare, the under age 65 programs would continue to be made available, again assuming district subsidization.

## b. Retirees Under age 65 and/or Part Time Employees Purchasing Coverage Directly from CalSTRS

It is generally more difficult to develop medical programs on a voluntary basis. This is primarily due to the problems of maintaining a viable mix of risks in the pool of individuals that choose to purchase coverage. Typically, at any given cost level, individuals who are relatively less healthy are more likely to purchase coverage than are relatively healthier individuals. This process, known as “adverse selection”, can cause total program costs to exceed the amount of collected revenues over time, thus causing the program to operate at a loss. In order to protect against this occurrence, it is necessary to ensure that as many healthy individuals as possible also choose to enter the pool, or to place limitations on the ability of relatively unhealthy individuals to enter.

The most direct way of encouraging participation is to subsidize program costs. This can be done either by direct subsidy from CalSTRS, or by allocating excess revenues from another source to subsidize individuals paying directly (e.g., excess money from a district-based statewide active and retiree system used to offset costs for individual purchasers). Incentive approaches could also be arranged for this group. An example would be for CalSTRS to provide a matching subsidy for districts that choose to contribute to the cost of this group. However, direct subsidy approaches may work to discourage districts from expanding retiree coverage, since it would be less expensive for Districts (and possibly members) to simply purchase coverage directly from CalSTRS. This could result in an excessive subsidy burden for CalSTRS over time, since those who already have effective coverage might enter the CalSTRS program due to the subsidy.

Regardless of whether or not a direct subsidy approach is used, the following types of incentives/restrictions are likely to be needed in order for the program to be fully self-supporting and sustainable over time:

- **Limitations/Incentives on Certain Benefits** – Since participants are generally expected to be greater users of services, it may be appropriate to limit plan benefits in order to avoid substantial financial losses over time. Typically this is done by establishing significant cost-sharing requirements for all benefits, so that the individual has an ongoing, and substantial financial incentive not to overuse care. In addition, establishing incentive arrangements to encourage individuals to follow appropriate treatment requirements and to pursue ongoing improvements in their health can make a substantial impact on the long-term costs of care.

- Enrollment Should be Continuous – In order to maintain financial viability, a CalSTRS program should not be seen as the health plan provider of last resort. To the extent that retirees are permitted to enter the program at any time during retirement, healthy individuals would be more likely to wait (and save on premium costs), and might choose to enroll at a later date when they need medical care. In order to avoid this, we recommend requiring that retirees participate in the program immediately upon retirement. Alternatively, since some retirees may have other coverage (e.g., through a spouse), they would be permitted to delay coverage under a CalSTRS sponsored program until such time as their other coverage was terminated. Regardless, continuous enrollment in a health care program would be required to receive coverage on an individual basis under the CalSTRS plan. This requirement would be waived for existing retirees on a one-time-only basis, allowing them to enter at the program's inception.
- Pre-Existing Condition Requirements – For those individuals not currently covered for medical insurance, it may be necessary to establish pre-existing condition limitations for certain benefits. An example might include reduced total dollar limitations for some programs (e.g., out of area or PPO plans) for a fixed period of time, or might limit the types of plan options that the individual may choose (e.g., HMO only).

The above represent examples of the types of program design provisions that may be needed to control selection under the program. Not all elements would be the same for retirees versus part time employees, but similar types of restrictions would need to be applied. Which design elements should be included will depend on a variety of factors, such as:

- The total cost of the program to participants (if the cost is viewed as relatively inexpensive given the benefits received, the plan will be more widely accepted by an appropriate mix of healthy and relatively less healthy individuals).
- STRS willingness/ability to absorb program losses should they occur (the fewer the restrictions placed on the program, the more attractive and valuable is the plan to CalSTRS members, but at the risk of greater financial loss).
- The ability to combine total program costs with other programs (e.g., district supported active and retiree coverage) in order to stabilize the overall costs of the programs.

In addition, depending on the final structure of the program, any limitations imposed may need to be effectively structured to comply with all regulatory requirements applicable to group health plans (e.g., HIPAA).



### c. Retirees Age 65 and Over Purchasing Coverage Directly from CalSTRS

Individuals eligible for Medicare would be offered the ability to participate in available Medicare + Choice options, as well as the out of area/PPO plan discussed under the district-subsidized arrangement above. In this instance, selection problems are reduced by the fact that Medicare would cover the majority of the cost of the benefits. Individuals who are not eligible for Medicare would be offered the opportunity to participate in plans similar to those offered to voluntarily enrolled retirees under age 65. Similar restrictions and issues relative to adverse selection would apply to this group as well.

### d. Additional Design Comments

Regardless of the program's orientation based on age and funding source, it will be important to maximize the program's attractiveness to participants. As such, we recommend including appropriately designed benefit components that address particular retiree needs, such as prescription drug coverage and hearing benefits. In addition, other benefits might be attractive as part of a package of this type, such as health club enrollment/discounts, and possibly life insurance benefits. However, because of the highly selective nature of some of these items, we recommend that they only be included as part of a package of health care benefits, not as separately purchased options.

Based on Mercer's experience, individual purchasers will balance the benefits of the program against the cost of coverage, and will decide the program's value and attractiveness on that basis. The most important question is whether or not the design restrictions that may be required in order to ensure financial viability of the program will substantially reduce the likelihood of participation. To pursue further guidance on detailed plan design, we recommend the use of focus groups to test reactions to possible designs.

## 5. Funding

Current funding of retiree coverage comes from a variety of sources, which may or may not be sources of funding for a CalSTRS sponsored program. Although we do not currently have detailed information on the sources of coverage for part time employees, with the exception of Medicare these sources are almost certainly similar to those discussed below for retirees. However, it is likely that the proportion of part time employees receiving coverage will be different by source.

#### a. District Subsidized Retirees

If the goal of this design is focused on improving cost factors for existing retiree coverage (e.g., giving District subsidized retirees access to less expensive plan alternatives) it is reasonable to believe that this can be accomplished without new sources of funds. Existing district and retiree contributions would support coverage in a manner similar to that discussed under Approaches 1 and 2, with CalSTRS' efforts emphasizing volume purchasing with a focus on improving quality.

#### b. Retirees that currently have coverage through their spouse's or former employer's plans

These individuals may or may not currently be eligible to participate in a district sponsored program, but regardless have chosen to participate in their spouse's plan or their former employer's plans (likely due to cost or benefit design differences, however this survey project did not explore that issue). A CalSTRS sponsored program might be attractive to these individuals, but in many instances funding could not be transferred to the CalSTRS program, so that these individuals would be unlikely to purchase a CalSTRS program at full cost. On the other hand, if any significant subsidy were to be offered by CalSTRS as part of an individual purchasing option, many of these individuals might well terminate existing coverage in order to take advantage of the CalSTRS subsidy.

#### c. Retirees that currently obtain individual coverage

Persons purchasing coverage individually (either in addition to other coverage, or as their only coverage) are likely to be paying directly for the cost of that coverage. To the extent that a CalSTRS sponsored program is made available to these individuals, some of these individuals would choose to change coverage to the CalSTRS plan, and funds currently being paid to other plans would shift to CalSTRS.

#### d. Currently Uncovered Retirees under age 65

In order for more non-covered retirees to become covered in a cost-effective manner, some level of new funding will probably be necessary, either from districts, CalSTRS, or some other source. As indicated in the retiree survey results, approximately half of currently uncovered retirees are willing to pay \$50 or more per month for coverage. This amount (while possibly understated by survey respondents due to typical survey bias issues) is well below the cost of coverage for individuals in their retirement years. Actual costs can range from \$350 to \$450 per month, or more. As a result, a typical plan structure will be unlikely to be appealing to these individuals.

Several approaches present themselves to address this issue:

- Provide only catastrophic benefit levels in order to reduce program costs – This approach minimizes program costs by minimizing benefit design, but would likely be unattractive to many retirees due to the relatively low level of benefits available. We do not view this as a viable option.
- Directly subsidize the cost of coverage – This approach could be quite costly, due to the substantial difference between cost and affordability mentioned above, and would also attract individuals who are already covered elsewhere (due to the significant subsidy being provided). In addition, it discourages districts from expanding retiree coverage, since it would be less expensive (at the district level) to allow individuals to simply purchase directly from CalSTRS. At a \$4,000 per year subsidy, every 10,000 retirees that choose to join the program would cost CalSTRS \$40,000,000 per year. In reality, this type of approach might well attract many more than 10,000 retirees.
- Incentive structure – This approach would be designed to use CalSTRS funding to encourage districts to subsidize retiree coverage. As an example, CalSTRS might provide a 10% coverage subsidy for districts that provide a minimum of a 20% subsidy for retirees. Such an approach would cost substantially less, and would encourage districts to further subsidize retiree coverage. In addition, it could be used as an encouragement for districts that currently provide retiree coverage to join a statewide active/retiree plan through CalSTRS, since the 10% subsidy would effectively be “found money” for the districts. Furthermore, “maintenance of effort” rules may be needed for districts that already provide a subsidy that is greater than, e.g., 20%. However, this structure does not guarantee that all currently non-covered retirees would be financially able to obtain coverage.

#### e. Retirees Age 65 and Over who are not Medicare Eligible

Persons in this category could be dealt with similarly to uncovered individuals under age 65. However, since Medicare eligibility could be used as the criteria for availability of the benefit, a directly subsidized approach becomes more feasible. With 79% of current retiree respondents age 65 and over covered by Medicare Part A at no charge, on an extrapolated basis this would leave an estimated 23,000 retirees without Medicare coverage. In addition, this may be a decreasing population, as more post-1986 retirees should have Medicare coverage as time goes on. By subsidizing this coverage only for non-Medicare-eligible retirees, total subsidy costs can be better defined.

However, for this group it may be more effective to simply assist in subsidizing the cost of Medicare Part A (see Approach 7 later in this report). Actual medical care costs for an age 70 individual not covered by Medicare are likely over \$500 per month, making a Medicare buy-in approach (Approach 7) a potentially better option for consideration.

## 6. Cost/Pricing

For district based purchasing, cost and pricing would have similar issues to those discussed under Approach 1 for actives. In addition, it may be necessary to establish separate pricing structures for actives and retirees if this approach is implemented in conjunction with an active program. This will allow the flexibility to compare favorably against existing district pricing structures that have separate rates for actives and retirees. However, it may also be necessary to be able to provide a combined (composite) pricing structure to meet the needs of those districts that currently use a combined rating approach in their benefit programs. While adding to the administration needs of the program, this flexibility may add substantially to the ability to attract districts to participate.

A retiree only program would also allow the option of implementing other plan design factors to differentiate it from a plan that includes actives. As an example, this might include a disease management program that focuses on diseases of the elderly, contributions based on choice of quality providers (such as providers that specialize in geriatrics), and a communications program directed at the specific needs of retirees. All of these features will make the plan more attractive to the elderly population, but probably not financially attractive to individual retirees purchasing coverage unless offered together with a subsidy.

The voluntary nature of the individual purchasing option of this proposed approach means that the plan would first need to compete with the programs that are available to the individual who does not have coverage through the district, whether part time employee or retiree. The plan price would need to be more attractive than other options available to the individual, which could probably only be accomplished with a CalSTRS funded subsidy. Otherwise, only the least healthy members who have limited or no other options will join, and the plan will experience adverse selection.

A subsidy would also be necessary to attract early retirees who currently have coverage through their district at the same level and with the same contributions as active employees. In our experience, early retirees can be twice as expensive as actives. Assuming this to be the case, then separating the retiree and active member costs would result in a reduction of the active member premium rate. As an example, if early retirees represent 10% of the combined active/early retiree population, then separating this group for rating purposes would result in a reduction in the active member premium of approximately 9% (while the now separated retiree rates would approximately double). By keeping these groups combined for rating purposes, the districts effectively provide an indirect subsidy to the retirees. The districts that do provide this indirect subsidy would have an incentive to move all early retirees to a CalSTRS retiree only program if they are looking for ways to reduce the premium for active employees.

## 7. Vendor Issues

Vendors would be contracted in a similar way to that proposed in Approach 1. However, for the age 65 and over retiree population it would be important that vendors have well-established Medicare + Choice programs available, and be committed to maintaining those programs over time. In addition, the ability to provide coverage for out-of-state retirees (through national HMO, PPO, and other structures) would become an important selection factor.

## 8. Program Participation

Program participation will depend on a combination of district interest, and individual interest/willingness to pay. These issues then depend on the ability to reduce costs and aggregate purchasing power. In addition, participation will be directly impacted by the ability to provide new funding to support certain aspects of the program as discussed above.

As a stand-alone statewide program, the plan offers districts and individuals the advantages of increased purchasing power, although for uncovered individuals this may not be sufficient incentive to participate without some form of financial subsidy. At the same time, if a statewide active program is established it may be essential to include a structure to support retirees and part time employees as well. Although somewhat less than half of retiree survey respondents currently obtain coverage through a district sponsored plan, districts may be less willing to participate in a statewide active plan unless a retiree program is also available (although under potentially differing district subsidy levels from that of actives). This is likely to also be true for districts that currently provide coverage for part time employees.

## 9. Pilot Potential

Similar to Approaches 1 and 2, piloting this approach may be desirable. Whether coverage is offered to districts, individuals, or both, an initial effort for a particular geographic area (e.g., a county) could be effective in confirming interest, program effectiveness, cost and selection issues, etc. If developed in conjunction with Approach 1 or 2, this should be piloted concurrently with those pilots.

## Approach 4: Pharmacy/Prescription Drug Benefit Program

### 1. Concept

CalSTRS would develop a program designed to meet the prescription drug benefit needs of active and retired teachers. Essentially, CalSTRS would be the purchaser of pharmacy benefit management (PBM) services for any and all school districts that opted to join in the CalSTRS developed program. In addition, CalSTRS could also develop individual coverage options to address the needs of the uncovered, or under-covered, population. CalSTRS would establish the prescription drug coverage provisions available to districts and/or the individual member, would negotiate the financial arrangements, and would arrange for the needed administration. The program would be designed for optimal quality of care, cost effectiveness, and service, taking advantage of extensive member education and appropriate drug usage incentives. The program would be designed to enhance medical care through effective quality control, drug utilization review, controlling and reducing negative drug interaction effects, and minimizing inappropriate under-utilization and over-utilization of drugs. Finally, the program would be integrated with Approaches 1, 2, or 3, if any of these approaches were also implemented.

### 2. Enablers

Several fundamental elements that are expected to enable success for other options also apply to the Rx program, and were discussed under earlier approach descriptions. There are also key elements related specifically to prescription drug coverage that reinforce the likelihood of success:

- Individual respondents, especially retired members, indicate that prescription drug benefit coverage is an important aspect of their benefit plans
- Districts that provide Rx coverage are likely interested in effectively controlling Rx costs given the recent cost trends
- Current prescription drug use offers many opportunities for effective member education to increase the wise and effective use of prescriptions
- PBM providers and CalSTRS would need to work together to create a true partnership to develop effective long term care management, improve quality of care, and contain rapidly rising prescription drug costs

### 3. Barriers

Several fundamental issues that may represent barriers to success for Approaches 1, 2, and 3 also apply to the Rx program. In addition, there are key issues specifically related to prescription drug coverage that could impact the likelihood of success:

- Variations in current Rx coverage are likely to be significant, with differences in copays, formularies, drug management programs, and the like. Will a uniform program be sufficiently attractive to encourage participation? Currently districts may have various levels of Rx coverage; how can each district be satisfied by uniform Rx coverage such that implementing the CalSTRS program would not unduly disrupt the current situation?
- Since Kaiser provides in-house pharmacies integrated with its management initiative and incentives directed at their physicians, a prescription drug benefit carve-out will likely be problematic with Kaiser; since a large percentage of CalSTRS members are enrolled with Kaiser, this could limit the scope of an Rx program.
- Rx coverage designed to satisfy the needs of retired members could change if Medicare coverage is modified to include prescription drug benefits
- Prescription drug costs represent a significant portion of health care expenditures for retired members. Current Medicare Supplement coverage and Medicare + Choice plans can result in somewhat prohibitive out-of-pocket expense to many retirees given deductibles, coinsurance, and annual benefit caps. CalSTRS may need to consider some level of subsidy in order to provide a more attractive, comprehensive, yet affordable Rx coverage alternative.

### 4. Design Elements

The CalSTRS pharmacy/prescription drug program would be intended to offer a source of coverage to districts and/or individual members that currently find Rx benefits inadequate or restricted. The Rx program would be most effective if designed to work with a single PBM. However, if CalSTRS implements Approach 1, 2, or 3, the selected vendors for medical care could instead coordinate the Rx benefits. In either event, a successful program would likely be one focused on improving quality and containing costs, while providing access to needed pharmacy providers and appropriate medications.

## a. Rx Coverage - Basic Structure

There are several Rx program models that exist in the marketplace, including:

- Access to Discount Prices and Education – This type of arrangement is comparable to the offering from the AARP, and to some extent the independent Internet pharmacies recently appearing. Members who use these programs can buy drugs at discounted prices and may receive information about specific drugs or medical conditions, but nothing is really managed.
- Traditional Card/Mail Order Rx Plan – This type of arrangement is the most widely utilized and appears to be currently in use by a substantial number of districts. Various levels of discounts and various approaches to providing information likely exist. If pharmacy management is taking place, it likely varies in scope and intensity.
- Supplemental Rx Coverage – The need for this type of arrangement has emerged due to the limitations imposed by Medicare Supplement options and the Medicare +Choice plans that are available. Many such plans leave members facing prohibitive out-of-pocket expenditures for prescription drugs. A supplemental program adds an additional layer of Rx benefit to other Rx coverage available to the district or individual. Even if Rx coverage were added to Medicare, the currently proposed Medicare Rx design would have limits that may make supplemental Rx coverage attractive.

Under a CalSTRS sponsored program, a unique model would emerge – the next generation Rx program. We envision that the program will be some combination of the existing models, providing a platform upon which improvements can be made. Improvements would be heavily focused on quality management and long-term cost containment.

## b. Rx Coverage – Program Design Elements

The following represent initial recommendations for key program design elements, or identify decisions that would need to be made in finalizing program design.

- Uniform program design – The most effective way to achieve success with the Rx program is to concentrate the purchasing power and leverage offered by a consistent, uniform program – for design, administration, and quality management efforts.
- Rx benefits carved-out to specialty PBM – Specialty PBM providers currently demonstrate the most effective management of prescription drug utilization (although Kaiser also does very well in many instances). As a result, we believe that working with an effective PBM represents the best foundation for establishing a high quality Rx program. True integrated care management will also require that information flow efficiently between the PBM and the patients’ medical carriers in order to maximize the effectiveness of drug management processes.



- Pharmacy Network – More aggressive financial arrangements can be obtained through a select or exclusive network of retail pharmacy providers, but using a limited network has downsides. Ultimately, it will be important to balance convenient access with the ability to contract with the best performing pharmacies, and those pharmacies able to offer the best contractual relationships.
- Mail Order Option – Mail order should be included in the program on a cost-effective basis for both the plan and the member. Appropriate quality measures should be reviewed and should reflect the inherent advantages of mail order – convenience and efficiency – and providers should utilize technological approaches such as touch tone telephone and Internet based drug information and prescription refills. The mail order option should also be designed to take advantage of utilization management opportunities. These efforts should be clinically sound, cost effective, and focused on achieving high-quality outcomes.
- Open Formulary – Formularies currently represent a substantial opportunity to control prescription drug costs. However, it is important to note that restricting access to certain medications may cause disruption with members, and can cause increases in other medical costs. Given this, and the variety of designs that are currently being used by CalSTRS members, we suggest an open and voluntary formulary, under which members would not be denied coverage of any medically necessary prescription. However, reasonable financial incentives would be designed to encourage use of formulary drugs.
- Consumer-Focused Cost Sharing – The plan would include cost sharing provisions that are designed to help participants become more knowledgeable consumers, and to avoid situations that might produce a prohibitive expense for any individual. Appropriate limits to overall plan benefits would be structured to avoid program financial losses over time, while avoiding arbitrary limitations that may cause a member to forego purchasing needed prescription drugs due to expense considerations.
- Generic Drug Substitution – Generic drug substitution usually results in the most cost effective alternative, when available. We suggest that any Rx program include ongoing communication about generic drug substitution as well as some financial incentive for members to use generic drug substitutes when medically appropriate.
- Rx Utilization Controls – The appropriate level of intervention should include efforts that address all areas of inappropriate prescribing, especially problems that have the potential to be dangerous for the patient or more costly than necessary. Limitations should not be arbitrary, and should be well supported by nationally accepted prescribing guidelines and published clinical literature.
- Integrated HealthCare Management – We believe a key goal for CalSTRS should be to partner with health plans, PBM provider(s), and CalSTRS members to focus on quality, and establish incentives for better outcomes, lower costs, and a higher level of member-control over their own health care. If part of CalSTRS' mission is to improve the overall quality of care, this integration will be vital, since effective disease management requires integrated information on drugs and healthcare services.

### c. Rx Coverage - Program Eligibility

- Rx Coverage Purchased and Subsidized by the Districts – For plans purchased and partially funded by the Districts, actives and retirees under age 65 would be offered a single Rx program intended to provide full Rx coverage (i.e., replace any existing Rx coverage). Many retirees over age 65 are eligible to participate in Medicare Supplement plans or Medicare + Choice options. In this instance, a modified Rx would be designed to supplement existing benefits.
- Individual Member Availability – Similar to medical coverage, “adverse selection” could occur with the pharmacy/prescription drug program. Appropriate controls would limit adverse selection for benefits purchased on an individual basis. Similar to Approach 3, some combination of design restrictions, continuous enrollment requirements, and program subsidy will likely be required to create an effective individual option.

### d. Rx Coverage – Additional Design Comments

Regardless of the program’s orientation, it will be important to optimize the program’s attractiveness to targeted members. Based on our experience, retirees will balance the benefits of an Rx program against the cost of Rx coverage, and will decide the program’s value and attractiveness on that basis. To pursue further guidance on program design decisions, use of focus groups specifically targeted at prescription drug coverage should provide valuable input regarding the attractiveness, and eventual acceptance, of Rx program design alternatives.

## 5. Funding Approach

### a. Existing Funding Sources

- Funding is expected to come from district and member contributions that may currently be paid for other sources of coverage and/or that may be additional for the Rx program. To the extent that the program focuses on those members with existing coverage (either through districts or individually), no additional funding should be necessary.

- Individuals that are currently covered through their spouse's or former employer's plans may or may not currently be eligible to participate in a district-sponsored program. A CalSTRS sponsored Rx program might be attractive to these individuals, but in many instances funding could not be transferred to the CalSTRS program, so that these individuals would be unlikely to purchase a CalSTRS program at full cost.
- Savings are anticipated as a result of leveraged purchasing power and efforts to focus on quality of care. Given the highly competitive state of the PBM marketplace, if the Rx program design can attract a large enough number of covered lives, savings should be available.
- In the initial years there could be added expense from start up costs. Depending on participation, eventual savings should partially or fully offset start-up costs.

## b. New Funding Sources

If the STRS Board wishes to, and has the money to do so, it can use the current high level of earnings to partly subsidize pharmacy premiums for members in districts that participate in the STRS health care program. The funding issues associated with this are discussed under Approach 1.

Here are some orders of magnitude for consideration:

- We estimate that the current annual prescription drug costs for all STRS members and retirees are about \$350 to \$400 million (or \$550 to 600 million including classifieds.)
- Using \$400 million, 5% of this amount is \$20 million per year.
- If only 10% of the STRS members and retirees were to participate in a STRS prescription drug program, a 5% subsidy would be approximately \$2.0 million annually. If 25% participate, the subsidy would increase to approximately \$5.0 million, and at 50% participation would be \$10 million.

## 6. Cost and Pricing Issues

As with the medical plan options, there are a number of cost and pricing issues that generally can only be resolved with more information about who would participate in a CalSTRS program (districts and members). These include:

- Drug cost trend has been very high in recent years. Increasing utilization is the largest component of prescription drug cost trend, and is a difficult component to predict given the various factors influencing prescription drug use (e.g., new products, new uses for existing products, direct-to-consumer advertising, etc.).
- The precise incentives used to empower employees and encourage changes in their prescription drug utilization decisions will have to be specifically designed for the CalSTRS population. Factors that influence current prescription drug use must be considered when designing the CalSTRS Rx program. These factors include sources of Rx coverage, incumbent PBM provider management efforts, and incentives offered to physicians for certain prescribing results.
- Similar to the medical plan approaches discussed earlier, adverse selection is an important issue. Districts with higher costs will be more likely to implement the CalSTRS Rx program, although their higher costs may be justified by claims experience. Individuals with “known” prescription drug costs will be more apt to join if more generous Rx coverage is available or supplemental Rx coverage eases the cost burden from existing limits.
- If the CalSTRS Rx program is sufficiently “unique” and attracts a “large enough” number of participating members, the possibility may exist to negotiate a unique financial arrangement. This could incorporate some type of risk-sharing or profit limitation agreement with the PBM provider(s). While these types of agreements are not commonplace, they are ideas that the specialty PBM providers have suggested from time-to-time for distinctive programs in the marketplace.

## 7. Vendor Issues

To most effectively control prescription drug costs, and to maximize purchasing power, the number of PBM providers should be limited (probably to a single PBM). This approach should maximize the pool of participants covered by any one provider, and should maximize the competition among managers/administrators bidding to supply PBM services to CalSTRS program participants.

### PBM Provider Contracting Issues

A number of factors will affect any specific PBM provider’s willingness to contract with CalSTRS, including:

- Some PBM providers will likely be interested in reducing medical plan carrier participation in prescription drug management, and may well be willing to offer more aggressive financial arrangements to do so.
- Some PBM providers may be prohibited from competing against the medical plan carriers due to outsourcing PBM arrangements that include non-compete clauses.
- Medical plan carriers may pressure PBM providers not to participate, using their book of business as leverage

- One of the more important vendor issues involves Kaiser, which provides health care to about 40% of districts, based on the survey. As with the medical plan options, CalSTRS will need to develop a partnership strategy for working with Kaiser in this area.

## 8. Program Participation

Program participation will depend on a combination of district interest, the appeal of the program to individual members, and the willingness/ability of both groups to pay for coverage. These issues then depend on the ability to control costs and aggregate purchasing power, while maintaining and improving on the quality of the Rx healthcare being provided. In addition, participation may be further impacted by subsidized support for a more generous, and flexible, Rx program.

Consolidating prescription drug coverage with a single PBM provider would maximize the competitive outcome between PBM vendors. Obtaining the necessary concentration of members to maximize negotiating leverage with PBM providers will require substantial participation on the part of both districts and individual members. This makes partnership arrangements with other large employers or purchasing groups a potentially valuable option to pursue, although not essential to the success of this approach.

Through a stand-alone statewide Rx program, CalSTRS can offer districts and individual members the advantages of increased purchasing power, although for uncovered individuals this may not be sufficient incentive to participate without some form of financial subsidy. Districts may be less willing to participate in a statewide Rx program unless coverage is provided for actives and retirees. In addition, in order to attract as many individual members as possible, districts should probably be permitted to purchase coverage for retirees only, even if active employees are not joining the CalSTRS program.

The ultimate success of this alternative is dependent upon the ability to bring a sufficiently large number of members into the Rx program. With a pool size of 50,000+ members (100,000+ individuals, including family members), administrative/other savings might range from 5% to 10%. With 100,000+ members (200,000+ individuals, including family members), based on Mercer's general experience, savings might be as high as 15%. As the number of districts and individual members increases beyond this point, continuing cost savings can be achieved, but at a potentially decreasing rate of improvement. It should be noted that these savings percentages represent estimates based on Mercer's general experience and knowledge of broad based purchasing environments – they are not intended to be actual projections of savings that will be achieved under a CalSTRS program.

Other participation issues are similar to those described under the medical options, including limitations imposed by district level decision making processes, transition timing issues, etc.

## 9. Pilot Potential

Because prescription drugs are typically used by a high percentage of people in any covered population, the CalSTRS designed program offers an excellent opportunity for piloting in select areas without substantial concern that interest or participation will be too low. This expectation holds with respect to specific districts, geography, or other variables. We believe the pilot approach would be effective in gauging results such as:

- Level of individual member interest and willingness to participate
- Member acceptance of pharmacy management efforts and controls
- Cost effectiveness of Rx program financial arrangement and plan design
- Identification of transition issues to address when the Rx program is expanded
- Testing of progressive utilization management programs or value added services

Separately, there may be sufficient interest in an Rx program because of current cost trends that a statewide (or regional) Rx program could be developed as a first step in a comprehensive STRS health care program.

# Approach 5: Dental/Vision Plans – Statewide Program for School Districts and Individuals

## 1. Concept

STRS would be a purchaser of dental and/or vision care coverage for any and all school districts that opted to join in the CalSTRS purchasing pool. CalSTRS would establish coverage options available to the districts, would negotiate the costs, and would arrange for the needed administration, including premium collection and payment, claims payment, etc. CalSTRS would design the program for maximum cost effectiveness, stability, service and access. Health care would be purchased from existing health plans and carriers.

## 2. Enablers

The following are the fundamental elements of this alternative that would enable success.

- Added convenience for districts, members and retirees by purchasing through CalSTRS
- Aggregation of purchasing power through consolidation of coverage
- Provide sufficient choice to avoid major changes in current types of coverage.
- Reduced administrative and other costs, through aggregation of districts and associated economies of scale
- Some vendors of coverage have already indicated a willingness/desire to work with CalSTRS in this area

## 3. Barriers

The following are the fundamental issues that cause concern about the likelihood of success of this alternative.

- As a stand-alone option focused on aggregating purchasing power, this program may be insufficiently attractive. Districts and members may not wish to move to a CalSTRS-sponsored program for the relatively small savings (versus medical care savings opportunities) that might be available under such a plan
- Will savings be sufficient to be worth the initial investment if done as a stand-alone option?
- Transition timing issues would be similar to those identified in Approach 1
- Districts currently have very different programs; can CalSTRS provide sufficient choice so that the program is attractive?

- Independence – will districts be willing to forgo their current “independence” in designing and administering dental and vision care coverage for their employees?
- Survey data – Similar to the medical options, the only real way to test the district and member interest in this benefit is to actually provide a market choice to the districts. This action, of course, requires some up front expenditure and risk.
- Cost and pricing issues – there are a number of cost and pricing issues that generally can only be resolved with substantially more information about the districts and members who would participate in a CalSTRS program.

## 4. Design Elements

### Choice and Cost

Similar to the medical options, the most important elements for a successful program will probably be to provide reduced net cost and a reasonable degree of choice for districts and members.

- Small number of dental or vision plans – Provide coverage and administrative services through a small number of carriers/health plans (as few as 1 dental and 1 vision carrier).
- A range of plan types – Provide PPO and prepaid plan options for purchase by all Districts and their members, thus enhancing the attractiveness of participation
- Choice of plan level – Provide ranges of options within each plan type (high and low options for PPO and prepaid, and one out of area plan option).
- Selection through bargaining – Districts and their unions could bargain to select one or more of the plan options to offer to employees, and would not be required to offer all plans. Some limitations on the number and types of plans offered for a particular district may be required, based on appropriate underwriting/risk considerations, and in conjunction with any carrier restrictions that might be required.
- Quality – Partner with dental and vision plans, providers, and CalSTRS members to focus on maximizing quality.



## 5. Funding Approach

### a. Existing Funding Sources

- Funding is expected to come from district and member contributions currently being paid to other sources of coverage.
- Savings are anticipated as a result of leveraged purchasing power. However, similar to vendors of medical coverage, dental and vision vendors in California are highly concentrated. Also, as discussed below, existing plans may provide generous benefits, making savings more difficult to achieve. As a result, the extent of any savings that might be achieved is not clear.
- In initial years there will be an added expense from start up costs. To the extent that a dental/vision approach is combined with a similar effort for medical plans, the cost for implementing dental and vision plans will be significantly lower. However, if these costs partially or fully offset early years' savings, and are paid out of current premiums instead of being amortized over a longer period, they could have a negative impact on program costs in the short term.

### b. New Funding Sources

If the STRS Board wishes to, and has the money to do so, it can use the current high level of earnings to partly subsidize dental and vision care premiums for members in districts that participate in the STRS health care program. The funding issues associated with this are discussed under Approach 1.

Here are some orders of magnitude for consideration:

- We estimate that the current total annual dental and vision care premiums paid for all STRS members and retirees are about \$450 to \$500 million (or \$650 to 700 million including classifieds.)
- Using \$500 million, 5% of this amount is \$25 million per year.
- If only 10% of the STRS members and retirees were to participate in a STRS dental / vision care program, a 5% subsidy would be approximately \$2.5 million. If 25% participate, the subsidy would increase to approximately \$6.25 million, and at 50% participation would be \$12.5 million.

### c. Self Funded Program

We anticipate that coverage would be self-funded (self-insured) to the extent possible, with insured/capitated arrangements for the prepaid dental programs.

## 6. Cost and Pricing Issues

There are a couple of factors that affect the cost of the CalSTRS districts' dental plans:

- **Generous plan design.** The survey indicates that, on average, current dental benefits are more generous than the typical dental benefits program made available in the general employer community. For example, in many cases the district provides 100% coverage for diagnostic, preventive, and basic restorative services, whereas a more typical plan would provide 100% on diagnostic and preventive services and pay only 80% on basic restorative services. Most districts had individual deductibles of \$10 or less, which is lower than the typical dental indemnity deductible (ranges from \$25 to \$75), and most districts include coverage for orthodontia. These more generous benefits tend to drive up utilization and plan cost.
- **High utilization assumptions.** The dental premiums reported on the district surveys reflect higher than average costs when compared to the general population, but are in line with costs expected for teachers. Teachers tend to be high utilizers of dental services, and dental insurers generally price them accordingly, even with an average plan design.

Because of these factors, we expect that a statewide program for school districts and individuals would not achieve significant savings without a change in plan design or through the addition of other managed care elements. There may be some savings in administrative costs, but administrative costs are a small percentage of the total premium

## 7. Vendor Issues

To most effectively control costs and maximize purchasing power under this alternative, the number of plans/administrators offered should be limited – potentially only one carrier for dental coverage and one carrier for vision coverage. This structure maximizes the pool of participants covered by any one carrier, and should maximize the competition among administrators bidding to supply services to CalSTRS program participants.

For dental and vision coverage, the vendors' willingness to participate in the process is of some concern, but possibly to a lesser extent than that for medical coverage. Several carriers have already expressed interest in participation, and have provided some preliminary input on plan design and pricing components for Approach 6 (voluntary dental and vision programs). However, since a disproportionate number of teachers with dental and vision coverage are currently covered by Delta Dental or Vision Service Plan, these organizations may ultimately have concerns in this area similar to those of Blue Cross for medical.

As with medical coverage, large-scale success by CalSTRS in providing these benefits might affect other arrangements currently in existence. Since many districts and members currently obtain coverage through JPAs and Trusts, a substantial movement to CalSTRS away from those organizations could negatively impact the remaining districts' costs. Again, CalSTRS could work with existing JPAs and Trusts as partners and administrative resources, which may mitigate some of the potential issues in this area.

## 8. Program Participation

The effectiveness of this alternative is dependent upon the ability to bring a sufficiently large number of members into the program. As with medical coverage under Approach 1, there is no “right” number of participants to achieve increased purchasing power. In addition, increased purchasing power may translate into reasonable percentage cost savings, but may not produce significant dollar savings to sufficiently encourage districts and members to participate. In any event, program costs would have to be compared to costs of other large purchasing options that already exist for some districts through JPAs, Trusts, etc.

Other factors influencing a decision to participate in a CalSTRS sponsored program include:

- Number and variety of designs available
- The collective bargaining decision making process
- Transition issues and timing
- Expectations about future costs
- The ability to cover both certificated and classified employees under a CalSTRS-sponsored plan

These issues are described in more detail under Approach 1, but apply similarly to this approach.

## 9. Pilot Potential

This approach adds relatively little additional risk when implemented as a supplement to Approach 1 for medical coverage. As a result, to the extent that a pilot is performed for medical coverage, it may also be appropriate to incorporate dental and vision coverage into the program.

As a stand-alone concept (focused on district level purchasing as opposed to individual purchasing under Approach 6), if there is sufficient district interest, it might be worthwhile to develop this program on a statewide (or regional) basis as a first step in a comprehensive STRS health care program.

## Approach 6: Dental/Vision Plans – Individual Voluntary Enrollment Only

### 1. Concept

Mercer previously explored voluntary dental and vision programs in a 1998 study for CalSTRS. At that time Mercer recommended that CalSTRS consider the implementation of such programs for CalSTRS members and retirees. The current survey that is the basis of this report confirms a continued need in this area, and the marketplace continues to make such programs available as the basis for a CalSTRS sponsored program. Under this approach, CalSTRS would develop a program designed to meet the dental and vision care needs of members and retirees who are not currently covered for these benefits, may currently find access restricted, or who purchase coverage individually and therefore might benefit from a combined purchasing arrangement through CalSTRS. Program options would be specifically designed to meet individuals' expressed ability to pay, or could be enhanced to provide improved benefits through use of a CalSTRS subsidy. Options could be either PPO or prepaid (HMO style) plans, or both.

The following are the fundamental enablers and barriers to making such a program successful:

### 2. Enablers

- Vendors expressed interest in offering this coverage through a CalSTRS-sponsored arrangement
- Ability to design program options that match individuals' willingness/ability to pay
- A network-based approach minimizes costs in line with individuals' ability to pay
- Effective communications to encourage/promote participation

### 3. Barriers

- Adverse selection risks associated with coverage purchased by individual purchasers
- Non-covered individuals' ability to pay – although the survey indicates that willingness/ability to pay matches the costs of some individual programs that could be made available, not all individuals indicated the same willingness/ability to pay
- Underwriting restrictions that may limit the attractiveness to some individuals (e.g., coverage levels that increase based on number of years of participation)

## 4. Design

Voluntary dental and vision programs are currently part of a growing market. As a result, the number of available plans has increased in the past few years. Several plan designs are currently available from vendors, and can be effectively offered under a group-purchasing environment. These designs are generally categorized in two ways:

- Discount purchasing arrangements – these allow individuals the opportunity to use specified service providers at discounted costs. Several vendors for these programs exist, and costs are minimal since no insurance protection is being provided.
- Insurance style programs – these offer benefits with a more traditional insurance approach, usually based on some form of managed care structure (PPO or prepaid HMO styles of network arrangements). While benefits are typically better than those offered by a discount plan, premium costs are also greater.

However, for insurance-style programs, adverse selection results in the need for a variety of limitations on benefits offered. Adverse selection occurs when people who are most likely to use a service or have claims under an insurance policy sign-up for that program. For example, dental expenses tend to be predictable for most people over a 12-month period. Thus, those most likely to enroll in dental insurance at the beginning of a year are people who are likely to have claims that exceed their premiums. This makes the program unstable because costs will increase each year, and soon only the worst risks will remain in the dental program, which has become financially unattractive to everyone else. The same adverse selection dynamic applies to all potential programs in which there is risk pooling accompanied by some predictability of utilization and individual selection of program participation.

Based on our discussions with vendors, a number of program designs are available that can be offered to CalSTRS on a completely voluntary (non-CalSTRS-subsidized) basis. Based on a target price per person of \$15 per month (the approximate median response in the survey data for willingness/ability to pay), we sought sample dental plan designs from several potential vendors of coverage. In general, these benefit designs:

- Offer very low co-payment or coinsurance requirements for preventive services (or no co-payment at all)
- Have moderate co-payment or coinsurance requirements for basic dental services
- Have substantial co-payment or coinsurance requirements for major services
- PPO plans also include deductibles (e.g., \$50 per person), and maximum benefit limitations of approximately \$750 per year
- Have anti-selection requirements, such as waiting periods, increasing benefit levels over time, minimum participation, or enrollment lock-ins

To the extent that a CalSTRS subsidy is included in the program, more substantial dental benefits are available and can be offered. Such a subsidy would also increase the overall attractiveness of the plan to individuals, promoting increased participation, thus reducing the impact of adverse selection.

## 5. Funding

Program funding would come from contributions made by individual participants. Additional funding (if any) might also be made available from CalSTRS, either to enhance benefits and/or increase participation. In order to reduce program risks, CalSTRS should consider insuring the program during the initial few years.

## 6. Cost/Pricing

For the moderate insurance benefit levels described above, current costs would be expected to fall into the following ranges:

- Dental PPO designs – \$11 to \$20 per single employee per month
- Dental prepaid HMO designs – \$8 to \$14 per single employee per month
- Vision plan designs – \$5.50 to \$6.00 per single employee per month

Please note that the examples above are based on plan design features specifically targeted to the voluntary market because individuals purchasing dental coverage voluntarily tend to be very price sensitive. The plan is designed so that the premium cost is low and there are special limits (mentioned previously) to avoid anti-selection. In all instances, the per employee costs would vary based on a variety of factors, such as the proportion of cost paid by the individual (e.g., versus a partial CalSTRS subsidy), whether dental and vision were packaged versus offered separately, retiree status, and the like. However, these preliminary plan costs appear to be in line with survey respondents indicated willingness / ability to pay for such coverage.

## 7. Vendor Issues

Voluntary dental (and to some extent vision) programs have been targeted by the insurance industry as a high growth market, and are available from several large, national vendors. In addition, vendors with whom we have had discussions have expressed interest in working with CalSTRS to develop a program focused on individuals who are not currently covered.

Since this program is targeted towards individuals who are not currently covered, concerns about which vendors currently provide services to districts, members and retirees throughout the state may have less importance. However, there may also be some value to establishing a relationship with a vendor that currently provides coverage to districts, since those future retirees (whose coverage is not continued by the district) could move directly into a CalSTRS plan on an individual basis while maintaining their provider relationship.

## 8. Program Participation

Program participation will depend on a combination of individual interest/willingness to pay. In turn, these will be based on the ability to achieve the right balance between product design, price, and ease of use. Subsidizing costs, while not an essential part of this option, could improve participation substantially.

Actual participation is difficult to predict, however some vendors have participation requirements (minimum number of covered persons, or minimum percentage enrollment of eligible persons) in order to underwrite the product. Participation requirements (often between 25% and 50% of eligible enrollees) might create the need for some level of rate subsidy to encourage enrollment. Alternatively, CalSTRS could self-fund the program in order to avoid minimum participation requirements – however, this places CalSTRS at risk for adverse selection under the plans (which is the major reason that the vendors include such requirements in the first place).

## 9. Pilot Potential

Given the need to reduce adverse selection, in part by obtaining sufficient enrollment, this option may also represent an opportunity for a pilot approach. Selecting a geographic area in which to offer such a program, and limiting enrollment to a specific category (such as retirees), allows the ability to test the need for a subsidized approach. If insufficient enrollment levels are achieved, consideration can then be given to program changes. A pilot will reduce risks to CalSTRS relative to initial investments, and allows CalSTRS to develop knowledge and capabilities before expanding coverage.

## Approach 7: Medicare Part A Funding

### 1. Concept

STRS would provide funding, in whole or in part, for Medicare Part A premiums for retirees over age 65 who are not eligible for premium free Part A Medicare.

### 2. Enablers

- Under the current federal tax laws, it is possible to indirectly use a portion of STRS investment earnings to fund a retiree health program, including payment of Medicare premiums.
- The survey data shows that about 80% of CalSTRS retiree respondents over age 65 have Medicare Part A at no additional cost to the retiree, and the remaining 20% do not. Extrapolating from the survey data, this would mean that about 23,000 CalSTRS retirees over age 65 do not have Medicare Part A at no cost. The data does not provide the source of Part A coverage, which could be self or spouse.
- About 5% of retiree respondents pay for Medicare Part A themselves.
- The cost of Medicare Part A, when purchased individually, is \$309/month for 1999. Additionally, Part B must be purchased if Part A is purchased individually.
- Every CalSTRS member who was first hired by a district on or after April 1, 1986, is required to pay Medicare taxes and therefore is earning quarters toward coverage.
- This option would provide essential help for a limited group of retirees.

### 3. Barriers

- The potential cost of this option is over \$85,000,000 for 1999.
- This is not a one time cost; it will continue over a number of years while pre-1986 teachers retire. Eventually all teachers will be covered by Medicare because of the now mandatory taxation.
- To understand the full potential cost and the number of years that the subsidy will likely be needed, an actuarial study should be done, taking into account future and current retirees.
- This option can be viewed as providing a discriminatory benefit in favor of a limited group.



- This option can be viewed as providing a reward for failing to elect into Medicare when that choice was available and failing to pay Medicare taxes as did many teachers.
- Under the new “84-month” buy-in rule, a teacher who buys Medicare Part A for her/himself for 84 months then is entitled to Medicare Part A on a premium free basis. However, under current interpretation CalSTRS cannot provide the funds for this buy-in; if CalSTRS provides the funds, the 84-month rule does not apply.

## 4. Design Elements

The basic design issues for a CalSTRS subsidy of Medicare Part A premiums are the following:

- A subsidy can be for all or part of the premium.
- If a subsidy is for part of the premium, there are several ways to structure it, including (but not limited to) the following:
  - capping the amount paid to limit the effects of inflation
  - setting a uniform percentage of subsidy for each affected retiree
  - setting a subsidy percentage designed to provide a higher subsidy to the retirees that are most needy (e.g., a subsidy could be higher for older retirees or for retirees with lower CalSTRS pension benefits)
- A minimum length of service under CalSTRS might be required to qualify for the subsidy, so it is limited to “career” teachers.
- To deal with the possibility that CalSTRS investment earnings might not be as high in the future as in the past, the benefit could be subject to a minimum stated level of earnings.
- To encourage more rapid elimination of the problem, subsidies might be tied to the active pre-1986 members of the relevant district electing into Medicare.
- This benefit can be structured so it is tax free to the recipients.

## 5. Funding Approach

This benefit could be funded indirectly from earnings on the CalSTRS investment portfolio. These earnings would be used indirectly to fund a “401(h) account” from which premiums would be paid.

## 6. Cost and Pricing Issues

- It is estimated that the cost for 1999 of this benefit would be over \$85,000,000.
- This amount does not take into account administrative costs.
- An actuarial study is needed to estimate the costs over time and the length of time that this benefit would be paid.

## 7. Vendor Issues

It is not likely that a vendor would be used for this option.

## 8. Program Participation

The vast majority of eligible retirees who are offered this subsidy would most likely accept.

## 9. Pilot Potential

It does not seem appropriate to pilot this program. Piloting would provide funding only for a subgroup of CalSTRS retirees in a situation where there would seem to be very little to be learned or gained from a pilot.

## Approach 8: Advanced Funding/Tax Free Savings

### 1. Concept

STRS would make available a tax-free savings program so members could save to pay for their, and their dependents, retiree health needs. Member savings would be credited to accounts and could be used to pay for retiree health care premiums, co-pays, deductibles, and Medicare Part A or B premiums. Savings would be invested under the program; one likely option would be to use the CalSTRS cash balance plan for these savings.

### 2. Enablers

- About half of active member survey respondents stated that they would be very interested in a program that allowed them to pre-fund the cost of medical insurance after they retire. Another approximately 40% indicated that they would be somewhat interested in such a program.
- Savings should be through payroll deduction.
- Savings should be credited to an individual account program that is already established and maintained by CalSTRS, to reduce the administrative costs. The likely program is the cash balance plan.
- The tax laws allow such a program to be tax-free: no taxes would apply to the contributions, account earnings, or distributions from the accounts. This is an unusually generous treatment and comes from the aggregation of several tax laws.
- Employers could bargain to match (on whatever basis they agreed on) employee contributions. This could be as minimal as “pump priming” of \$100 per year, or as much as a dollar for dollar match or more.
- Additional market information would increase the likelihood of success; again we recommend focus groups because they are low cost, can be done quickly, and often provide quite useful information.

### 3. Barriers

- Regardless of expressed desire, it is not easy for people to save. Therefore, CalSTRS could “build it” and “they may not come”.
- For this program to be wholly tax-free there is limited year to year flexibility in electing the amount of savings. The amount of flexibility available may depend on the degree of tax risk that CalSTRS is willing to take.

- When savings are committed to retiree health care, it may be difficult to use them for another purpose even if there are fundamental changes in the way that health care is provided to retirees.

## 4. Design Elements

The basic design elements for a tax-free savings program are as follows:

- Members choose the amount of savings that they wish, and contributions are made to a “401(h) account” within CalSTRS.
- Savings would be on a payroll deduction basis.
- Districts and unions would bargain for establishing and maintaining the program, district by district.
- Member contributions are made on a tax pickup basis under section 414(h)(2) of the Internal Revenue Code.
- Employer contributions, if any, also would be made to a 401(h) account.
- Contributions are credited to individual member accounts. Earnings are credited to these accounts, as designated by CalSTRS.
- Annual account balance statements are provided to members.
- For ease of administration, the current cash balance plan administrative structure should be considered for record keeping and interest crediting. However, because of the limits under section 401(h), the accounts should be held under CalSTRS and not the cash balance plan. (Annual contributions to a section 401(h) account cannot exceed 25% of the total of “current service” pension contributions and retiree medical contributions.)
- Assets are invested along with all other CalSTRS assets, as a part of the CalSTRS investment pool.
- On retirement, account balances can be used to pay for health care for retirees and their dependents. Account balances can be used for, e.g., the following: health insurance premiums, Medicare premiums, co-payments, deductibles, and expenses not covered by insurance. Tax limitations require that the expenses must be otherwise deductible under section 213 of the Internal Revenue Code.
- On a member’s death, account assets can be used to provide health benefits for the surviving spouse and dependents. If there are none, it is possible to structure the program to provide a refund to the estate. However, this amount would be taxable.
- STRS may wish to consider engaging a TPA to administer payments. It also may wish to limit what benefits will be paid for because of administrative considerations. However, CalSTRS also may wish to charge a small administrative fee to all account members for administration (similar to the member charges that are common in many defined contribution retirement plans).
- STRS would want to provide clear communications about the program, including its options and limitations.

One key issue is the amount of flexibility available to members in choosing the level of savings and then changing the level of savings. Section 414(h)(2) limits the degree of that flexibility. However, we believe that the following types of choices can be made.

1. A one-time choice of a stated percentage of pay or a level dollar amount of savings for the member's working lifetime.
2. Same as 1, but stated percentage of pay or level dollar amount is limited to a set number of years. (Similar to purchase of service; this is the purchase of retiree health benefits.) Separately, at a later time, it should be possible to have another election to do the same thing.
3. Same as 1, with "layering", so if a member is comfortable with, e.g., 1% of compensation savings at an early age, she/he can layer another percent (or portion of a percent) on top of the original savings election.
4. Same as 1, but with a substantial "catch-up" feature. For example, a teacher may save nothing for retiree health until 5 years before retirement, and then she/he elects to save 30% of salary every year for the next 5 years. (There are no section 415 or 402(g) or 457 or other restrictions on the percentage of compensation that is saved – except that it cannot exceed 100% of taxable compensation. There also are no section 415 limits on the amounts payable.)

Choices 2, 3 and 4 involve different degrees of tax risk and should be reviewed by your counsel.

## 5. Funding Approach

Contributions would be voluntary, by members. Unions and districts could bargain for the employer to provide additional funding as discussed above. Additionally, if CalSTRS has sufficient assets it could add to these accounts on an indirect basis.

## 6. Cost and Pricing Issues

The costs of administering this program are:

- Set up costs. These include administrative (account balance program, etc.), legal (document drafting), comfort if desired (IRS letter perhaps, or legal opinion probably), and communications (quite important). CalSTRS may be able to amortize these costs from charges on the account balances.
- Ongoing administration. These include administrative (receiving money, accounting for it, investing it), communications (answering questions from members), and payment (STRS may wish to consider engaging a TPA for this work).

## 7. Vendor Issues

The vendor CalSTRS may wish to consider using would be a TPA for claims payment. There should be a number of available vendors for this type of work.

## 8. Program Participation

STRS may wish to perform some test marketing to determine the reality of the level of interest expressed in the survey. CalSTRS may further wish to do some modest economic modeling to determine the “break even” point where administrative costs can be spread among sufficient accounts to make them reasonable.

## 9. Pilot Potential

A pilot probably is not worthwhile here, because the startup costs should as easily cover a small number as a larger number of participants. However, a “rolling rollout” through the state may have the best chance of success because communications can be focused. Further, the point of a pilot is to determine what will work and what will not work. CalSTRS should be able to get substantial information on these issues with focus groups. These are low cost, quick and easy to do. We recommend focus groups before CalSTRS decides to implement this type of program.

# Appendices

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# Appendix A. Data Collection Methodology

## Overview

This section of the report describes the methodology for each of the following data collection components of the health benefits feasibility study:

- Surveys
  - Active teacher survey
  - Retired and disabled teacher survey
  - District survey
  - Trust/JPA survey
- Other structured input
  - Constituent group input
  - State interviews
- GeoAccess analysis

For each component the following topics are included as applicable:

- Selecting individuals/organizations from which to obtain input
- Description of the data collection instrument
- Description of the data collection process
- Response rate or degree of cooperation



## Statistical Analysis

Statistical analysis is applicable to structured questions on all the surveys and on the state interviews. This analysis was performed as follows:

- Mercer checked each completed survey for usability (performed by CalSTRS for state interviews)
- Mercer supervised data entry of structured survey results by an organization specializing in data entry; the organization performed “double data entry” to check for data that had been input incorrectly (data entered by CalSTRS for state interviews)
- A database containing all responses was sent to CalSTRS
- CalSTRS ran statistics requested by Mercer using SPSS, a powerful statistical analysis software program
- CalSTRS sent statistics to Mercer to analyze

CalSTRS supplied the following statistics as requested:

- Frequency – the number of respondents who gave each response
- Mean – the average of all responses to a given item. Because the mean includes all responses, it summarizes in one measure how all respondents reply to a given question. In calculating the means (and percentages) in all charts shown in this report, we exclude missing data and respondents who did not have an opinion (that is, who checked “not applicable” or a similar reply as their response).
- Cross tabulation – frequencies and means contrasted for various subgroups of respondents (for example, retirees with Medicare vs. retirees without Medicare, urban school districts vs. rural school districts).

## Urban/Rural Classification

One of the issues addressed by the study is to determine the differences, if any, between rural and urban health care needs in California. Therefore, a method is needed to classify individual and district respondents as “urban” or “rural”.

For sample selection, as described below, rural active teachers were moderately over-sampled (a greater proportion of this population was surveyed) to ensure an adequate number of respondents in this category for valid statistical analysis. For this purpose, a potential respondent was considered “rural” if the person lived in a county identified as “rural” by one or more of the following California organizations:

- California State Association of Counties (CSAC);
- Regional Council of Rural Counties; or
- Rural Health Policy Council.

The distinction between urban and rural was refined for data analysis of member and district surveys using listings derived from GeoNetworks, a software system used to calculate accessibility to health plan providers, which was created by a company called GeoAccess, Incorporated. Each ZIP code is classified as urban, suburban, or rural by GeoAccess using the following criteria:

- Urban – a ZIP code for which the population density is greater than 3,000 persons per square mile.
- Suburban – a ZIP code for which the population density is between 1,000 and 3,000 persons per square mile.
- Rural – a ZIP code for which the population density is less than 1,000 persons per square mile.

For purposes of this analysis, the suburban ZIP codes were combined with the urban ZIP codes in the urban category. The reason for this reclassification is that, in terms of access to health care plans and providers, we expect few differences between urban and suburban residents or districts.

Individual respondents living in California were classified as “urban” or “rural” based on the ZIP code of their primary residence, as indicated by each respondent on the completed survey. Respondents living outside California were not included in the geographical analysis, but were included on all other analyses. District respondents were classified as “urban” or “rural” based on the ZIP code of their mailing address.

# Active Teacher Survey

## Sample Selection

The sample was drawn from the following groups of active members:

- Part time community college
- Part time K-12
- Full time

Teachers not members of any CalSTRS retirement plan were eligible to be included in the sample.

The hypothesis used to select the active sample, based on Mercer experience with similar surveys and methods anticipated to boost response, was a 25% response rate. A group of at least 100 respondents was desired in each of the major three categories of teachers in order to allow for statistical analyses of each group.

Based on the above considerations, it was planned to moderately over-sample part-time community college faculty and rural teachers in each group. Within each category (for example, rural community college) the sample was to be selected randomly from all teachers in that category to total the desired sample size. Planned sample sizes were quite adequate for purposes of a statistical sampling survey.

The samples selected by STRS did not conform to the planned sampling methodology because of a programming error that was not discovered until completed surveys had been received back from respondents. About half the teachers included in the file used to select the part-time sample were actually full-time teachers. For that reason, we have not considered data from the “part-time” group of respondents in this report. For the full-time sample, some districts were over-sampled and some were under-sampled relative to the mean percentage of teachers sampled across all districts.

- Over-sampled districts are predominantly in small, rural counties. Since rural counties were over-sampled by design, this is not a concern.
- Under-sampled counties include some large districts in the Central Valley, Southern California and Northern California.

Thus, under-sampled counties are geographically distributed across urban areas of California. The programming error which caused the skewed sampling did not result in specific categories of teachers within a district– such as longer service teachers – being more or less likely to be included in the sample than other categories.

To be sure the analysis accounts for any demographic skewing of full-time respondents that might have resulted from the sampling problems, all cross-tabulations of demographic variables, such as age, sex, health, and income, with the survey opinion questions were analyzed. As detailed in Appendix B, no substantive, operationally meaningful differences among demographic groups are indicated by the data. That is, no recommendation in this report would be affected if one demographic group (for example, women, or older respondents) were over-represented among respondents.

Based on our review, we believe it is likely that survey respondents do reflect a representative cross-section of full-time active teachers. Since even if the demographics of respondents were somewhat skewed it would not substantively affect the results and recommendations, the full-time active survey continues to be useful in understanding the health care needs and desires of California teachers.

## Survey Instrument

The survey instrument for active teachers consisted of 40 structured questions in the following major categories:

- Current insurance coverage (questions 1-22)
- Insurance coverage selection (questions 23-28)
- Demographics (questions 29-40)

Respondents were given definitions of the following terms:

- Insurance coverage
- HMO
- Dependent parent
- Dependent child
- Educational employer

Respondents were asked to use the terms as defined in answering the questions in order to maximize comparability of data among respondents.

## Survey Process

Surveys were pre-coded to identify part time community college, part time K-12, and full time teacher respondents.

CalSTRS supervised survey printing and mailing. Surveys were mailed to home addresses, and the number of surveys returned as undeliverable was tracked. Two reminder postcards were sent to each person in the sample to urge survey completion.

Another incentive for survey completion was a drawing each survey respondent could enter to win \$100 for the school of his or her choice. To maintain confidentiality of responses, the drawing entry form was separate from the survey. There were three \$100 drawings. The winning schools were:

- Chico High School
- Herman Intermediate School (San Jose)
- Tracy High School

The \$300 given to these schools was donated by William M. Mercer, Incorporated.

Respondents were instructed to return their completed survey in a postage-paid envelope addressed to William M. Mercer, Incorporated. Surveys were returned to Mercer to preserve the confidentiality of the survey process. All completed surveys are held by Mercer, and will not be shared with any other entity, other than for data entry purposes.

## Response Rate

The overall response rate on the full-time active teacher survey was an excellent 39.1%, as summarized below.

|                              |       |
|------------------------------|-------|
| Surveys mailed:              | 4,270 |
| Surveys delivered:           | 4,138 |
| Surveys received by cut-off: | 1,617 |
| Response rate:               | 39.1% |

## Retired and Disabled Teacher Survey

### Sample Selection

The sample was drawn from the following groups of CalSTRS members receiving retirement benefits:

- Disabled benefit recipients
- Service retirees
- Spouses receiving benefits

The hypothesis used to select the retiree sample, based on Mercer experience with similar surveys and anticipated reminders, was a 40% response rate. A group of at least 100 respondents was desired in each of the major three categories of retirees in order to allow for statistical analysis of each group.

Based on the above considerations, it was necessary to over-sample disabled benefit recipients, but not necessary to over-sample rural retirees. Within each of the three categories, the sample was selected randomly from all retirees in that category to total the desired sample size.

| Category                    | Number of Retirees | Sample Size  | Sample Percentage |
|-----------------------------|--------------------|--------------|-------------------|
| Disabled benefit recipients | 3,328              | 301          | 9.0%              |
| Service retirees            | 141,094            | 3,401        | 2.4%              |
| Spouses receiving benefits  | 12,166             | 301          | 2.5%              |
| <b>Total</b>                | <b>156,588</b>     | <b>4,003</b> | <b>2.6%</b>       |

## Survey Instrument

The survey instrument consisted of 40 structured questions in the following major categories:

- Current insurance coverage (questions 1–24)
- Insurance coverage selection (questions 25–29)
- Demographics (questions 30–40)

To the extent compatible with obtaining the needed data, the questions on the active teacher and retired teacher surveys were identical. Retired respondents were given the same definitions to use in completing the survey as were active respondents.

## Survey Process

Surveys were pre-coded to identify disabled retirees, service retirees, and spouses receiving benefits.

CalSTRS supervised survey printing and mailing. Surveys were mailed to home addresses, and the number of surveys returned as undeliverable was tracked. One reminder postcard was sent to each person in the sample to urge survey completion.

As for active respondents, retirees were instructed to return their completed surveys in a postage-paid envelope addressed to Mercer, and the confidentiality of the survey process has been maintained.

## Response Rate

The overall response rate on the retired and disabled teacher survey was an excellent 60.1%, as summarized below. Response rates for all subcategories would also be considered excellent.

| Category                    | Surveys Mailed | Surveys Delivered | Surveys Received by Cut-off | Response Rate |
|-----------------------------|----------------|-------------------|-----------------------------|---------------|
| Disabled benefit recipients | 301            | 301               | 164                         | 54.5%         |
| Service retirees            | 3,401          | 3,398             | 2,107                       | 62.0%         |
| Spouses receiving benefits  | 301            | 287               | 125                         | 43.6%         |
| <b>Total</b>                | <b>4,003</b>   | <b>3,986</b>      | <b>2,396</b>                | <b>60.1%</b>  |

## District Survey

### Sample Selection

All K-12 school districts, community college districts, and County Offices of Education in California received the survey. This totaled 1,117 survey recipients.

### Survey Instrument

The survey instrument consisted of 47 structured questions in the following major categories:

- Program overview (questions 1-11)
- Medical benefits (questions 12-32)
- Dental and vision benefits (questions 33-47)



Respondents were given definitions of the following terms:

- Medical indemnity plan
- Health maintenance organization (HMO)
- Medicare risk HMO
- Medicare supplement plan
- Point of Service (POS) plan
- Preferred provider organization (PPO) medical plan
- Triple option medical plan
- Dental indemnity plan
- Preferred provider organization (PPO) dental plan
- Prepaid dental plan
- Triple option or other hybrid dental plan
- Vision plan
- Fully-insured plan
- Self-funded plan
- Dependent parent
- Domestic partner
- Educational entity
- Health care benefits plan

Respondents were asked to use the terms as defined in answering the questions in order to maximize comparability of data among respondents.

## Survey Process

CalSTRS supervised survey printing and mailing. Surveys were mailed to the superintendent of each district. A reminder letter was sent to each district to urge survey completion, and CalSTRS followed up the letter with telephone calls to large districts (those with 1,800 or more certificated employees).

## Response Rate

The response rate was an excellent 29.6%, with 331 surveys received by the cut-off date. Approximately 65 surveys, which could not be included in the analysis, were received after the cut-off date. (CalSTRS staff has subsequently entered the data from late respondents for reference purposes.)

Response rates for urban versus rural districts varied as follows:

| Category        | Surveys Mailed | Surveys Received by Cut-off | Response Rate |
|-----------------|----------------|-----------------------------|---------------|
| Urban Districts | 351            | 116                         | 33.0%         |
| Rural Districts | 766            | 215                         | 28.1%         |
| <b>Total</b>    | <b>1117</b>    | <b>331</b>                  | <b>29.6%</b>  |

## Trust/JPA Survey

### Sample Selection

All 12 employer/employee trusts providing health benefits to California teachers received the survey. Nineteen JPAs for which CalSTRS was able to obtain contact information also received the survey.

### Survey Instrument

The survey instrument consisted of 38 structured questions in the following major categories:

- Program overview (questions 1–7)
- Medical benefits (questions 8–23)
- Dental and vision benefits (questions 24–38)

To the extent compatible with getting the data needed, the questions on the trust/JPA survey and district survey were identical. Trust/JPA respondents were given the same definitions to use in completing the survey as were district respondents.

## Survey Process

CalSTRS supervised survey printing and mailing. Surveys were mailed to a contact identified in each trust or JPA. A reminder letter was sent to each contact to urge survey completion, and CalSTRS followed up the letter with telephone calls to large trusts.

## Response Rate

Only 3 surveys were returned by the cut-off date, for a low response rate of 9.7%. Because of the low response rate and number of returned surveys, data from respondents cannot be generalized to the larger group of Trusts and JPAs in California. For this reason, results of this data collection component were not closely analyzed or included in formulating recommendations.

## Constituent Group Input

CalSTRS and/or Mercer received important input used to formulate recommendations from the following two sources:

- Health Benefits Task Force
- Health Executive Advisory Review Team (HEART)

## Health Benefits Task Force Member Selection

The Health Benefits Task Force is comprised of representatives from various school districts, community college districts, unions, trusts, the State of California, and other constituency groups. CalSTRS selected Health Benefits Task Force members based on expressed interest in the health benefits project, expertise in health benefits, availability, geographic representation, leadership position, and similar related factors.

## Health Benefits Task Force Meetings

Input from Health Benefits Task Force members was obtained at monthly or bi-monthly Health Benefits Task Force meetings, which covered a wide range of issues. Typically, members were presented information on a topic, such as the operation of an existing trust providing benefits to teachers, draft data collection instruments, or preliminary results of data collection. Then, members would discuss the information and provide guidance for recommendations and actions.

The Health Benefits Task Force also provided critical guidance on the diverse points of view and priorities of different constituent groups, and methods for reaching consensus.

## Input Level

Health Benefits Task Force members were eager to provide input, and discussed open issues in-depth. Members worked with Mercer and CalSTRS between meetings as necessary to provide information and assistance. Union representatives worked with CalSTRS to encourage survey response from union members included in survey samples.

## HEART Member Selection

HEART is composed of physicians, researchers, and other policy leaders and experts on specific medical conditions likely to be of interest to CalSTRS members. Dr. Kathleen Connell, Chair, TRB Health Benefits Committee, selected HEART members based on their expertise, expressed interest in the project, and availability.

## HEART Meetings

Input from HEART was obtained at a May meeting. Additional meetings will be held, as the future direction of CalSTRS on health care issues is determined.

At the May meeting, subject matter experts made presentations on heart disease, osteoporosis, Alzheimer's disease, and health care purchasing alliances.

## Input Level

HEART members were eager to provide input, and presented on key topics as requested by Dr. Connell.

## State Interviews

### Sample Selection

CalSTRS sent a prescreening instrument to all other states to determine which states would be most helpful to interview. The prescreening instrument included questions on:

- Whether a statewide health care benefits program for teachers exists
- Inclusion of other public employees in the health benefits program for teachers
- Whether the teachers program is voluntary or mandatory for districts
- Whether actives, retirees, or both are covered
- Number of employees and retirees covered under the program
- Year the program was established
- Whether health benefits are subject to collective bargaining

CalSTRS received responses from 42 state plans. On the basis of answers to the prescreening questions, CalSTRS targeted nine states with a voluntary plan and one state with a mandatory plan to interview.

### Interview Instrument

The interview was structured using an interview guide with 20 structured and 15 open-ended questions in the following major categories:

- Background information (questions 1-10)
- Plan design (questions 11-14)
- Administration (questions 15-21)
- Implementation/transition (questions 22-25)
- Financing (questions 26-34)
- Closing thoughts/advice (question 35)

## Interview Process

CalSTRS sent the interview instrument to all respondents in advance of the interview to allow time for preparation. Some states responded to the questionnaire in writing, while others completed the interview with a representative of CalSTRS over the telephone.

## Response Rate

All ten states approached responded to the interview request, and were cooperative in providing both factual information and thoughts concerning their statewide health plan for teachers.

The following states completed interviews:

- Arizona
- Colorado
- Louisiana
- New Jersey
- Ohio
- Oklahoma
- Tennessee
- Virginia
- Washington
- Wisconsin

## GeoAccess Analysis

### Plan Selection

This analysis consisted of a geographic matching process to determine what percentages of California active and retired teachers live in the service areas of certain health plans and networks, including Health Maintenance Organizations (HMOs), Medicare risk HMOs (for retirees enrolled in Medicare), and Preferred Provider Organizations (PPOs)

Mercer used a proprietary database called Mercer Value Process (MVP) to select plans and networks to include in the analysis. Criteria used for selection were as follows:

- All HMOs with enrollment of 85,000 or more (17 HMOs)
- All Medicare +Choice (Medicare risk) HMOs with enrollment of 10,000 or more (9 HMOs)
- Eight PPOs which, in Mercer's experience have high enrollment and work with large groups (PPO enrollment was not available)

## Matching Process

Mercer requested an electronic file from each selected health plan and network, to include all ZIP codes in the service area of the identified plan or network. Mercer obtained from CalSTRS an electronic file with the residence ZIP code of all active and retired CalSTRS members. Mercer screened the files received from health plans and networks, and excluded data from analysis that appeared inaccurate (for example, showed HMO coverage in rural counties which, based on Mercer's experience, have no HMO access).

Mercer combined valid data on plan/network service areas by plan/network type to generate a list of all ZIP codes in California in the service area of at least one plan or network of that type (for example, in the service area of at least one HMO). Mercer used FoxPRO database software to match the number of active employees and retirees under 65 to the service areas of combined HMOs and combined PPOs and the number of retirees 65 and older to the service areas of combined HMOs, and combined PPOs.

## Response Rate

Mercer received usable ZIP code data from 6 HMOs and 1 PPO.

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# Appendix B. Research Findings

## Overview

This section of the report provides an overview of the major findings from the following data collection components.

- Surveys
  - Active full-time teacher survey
  - Retired and disabled teacher survey
  - District survey
- State interviews
- GeoAccess analysis

Detailed results are shown in the Exhibits in Section VIII.

## Active Full-Time Teacher Survey

### Current Insurance Coverage – Medical

Over ninety-nine percent of full-time respondents have insurance coverage for themselves for medical expenses.



For dependent medical coverage:

- 71% of married respondents say their spouse has medical coverage
- 66% of respondents with dependent children state those children have medical coverage
- 88% of respondents with a dependent parent say that parent has medical coverage

The above percentages for spouse and children medical coverage for active full-time employees were further discussed with the Health Benefits Task Force. Based on Health Benefits Task Force input it is believed that these figures are less than the actual proportion of active dependents (both spouse and children) that are covered for medical coverage, and that the survey response to this question was anomalous.

Since virtually all respondents have medical insurance for themselves, answers to the questions on reasons for not having such coverage are not meaningful.

Respondents who have medical coverage for themselves were asked to indicate all sources of that coverage. The top four sources are:

| Source                       | Percent Indicating Source |
|------------------------------|---------------------------|
| Current educational employer | 94%                       |
| Spouse's employer            | 15%                       |
| Individual coverage          | 2%                        |
| Other employer               | 1%                        |

The total exceeds 100% because respondents were permitted to check multiple answers.

Sixty-nine percent of those with insurance pay nothing for the coverage. Respondents are generally satisfied with their medical benefits:

- 46% are very satisfied
- 38% are somewhat satisfied

## Current Insurance Coverage – Dental

Ninety-nine percent of respondents have insurance coverage for themselves for dental expenses. Again, reasons for not having coverage could not be meaningfully analyzed because of the small number of respondents in this category.

Respondents who have dental coverage for themselves were asked to indicate all sources of that coverage. The top four sources are:

| Source                       | Percent Indicating Source |
|------------------------------|---------------------------|
| Current educational employer | 95%                       |
| Spouse's employer            | 13%                       |
| Individual coverage          | 2%                        |
| Other employer               | 1%                        |

The total exceeds 100% because respondents were permitted to check multiple answers.

Eighty-three percent of those with insurance pay nothing for the coverage. Respondents are generally satisfied with their dental benefits:

- 58% are very satisfied
- 27% are somewhat satisfied

## Current Insurance Coverage – Vision

Ninety-two percent of respondents have insurance coverage for themselves for vision care expenses.

Respondents who do not have vision insurance for themselves were asked to indicate all reasons they do not have such coverage. The top four reasons are:

| Reason   | Percent Indicating Reason |
|--|---------------------------|
| Coverage not available                         | 42%                       |
| Coverage seems overpriced relative to benefits | 25%                       |
| Do not need vision care coverage               | 13%                       |
| Available coverage not attractive              | 11%                       |

The total exceeds 100% because respondents were permitted to check multiple answers.

Forty-seven percent of respondents without vision coverage say it is very important to obtain such coverage.

Respondents who have vision coverage for themselves were asked to indicate all sources of that coverage. The top four sources are:

| Source                       | Percent Indicating Source |
|------------------------------|---------------------------|
| Current educational employer | 88%                       |
| Spouse's employer            | 10%                       |
| Individual coverage          | 1%                        |
| Other employer               | 1%                        |

The total exceeds 100% because respondents were permitted to check multiple answers.

Respondents are generally satisfied with their vision benefits:

- 48% are very satisfied
- 32% are somewhat satisfied

## Factors in Selecting Medical Insurance

Respondents were asked to indicate the importance to them of thirteen factors in deciding which medical insurance to buy. Respondents answered using a four point scale ranging from “Very important” (scored as a “1”) to “Not at all important” (scored as a “4”). Thus, a lower score indicates higher importance for a given factor. We can use the mean score and the percentage who answered “Very important” to rank the factors as follows (from most to least important):

| Decision Factor                               | Mean Importance Score | Percent Who Score the Factor as “Very Important” |
|---|-----------------------|--|
| Ease of getting referrals to specialists      | 1.16                  | 85%  |
| Coverage for prescription drugs               | 1.18                  | 84%  |
| Trust in the organization sponsoring the plan | 1.22                  | 81%  |
| Premium for coverage                          | 1.24                  | 80%  |
| Wide choice of doctors                        | 1.26                  | 78%  |
| Easy-to-use claims payment process            | 1.29                  | 76%  |
| Coverage when traveling                       | 1.36                  | 68%  |
| Specific doctor in the network                | 1.41                  | 68%  |
| Copayment or deductible for services          | 1.42                  | 64%  |
| Coverage for any doctor                       | 1.46                  | 66%  |
| Specific hospital in the network              | 1.53                  | 58%  |
| Recommendation                                | 2.03                  | 27%  |
| Ability to coordinate with spouse             | 2.11                  | 45%  |

## Attractive Plan Features

Respondents were asked which plan features would make a specific medical plan substantially more attractive. Respondents could indicate as many of the seven choices as they wanted. Results are as follows, ranked from most to least attractive:

| Plan Feature  | Percent Selecting Feature |
|---|---------------------------|
| Disease management program  | 61%                       |
| Coverage for alternative medicine   | 59%                       |
| Ability to be rewarded for taking good care of one's health               | 56%                       |
| Ability to get lower costs for using designated highest quality providers | 47%                       |
| Ability to enroll a dependent parent                                      | 20%                       |
| Ability to enroll a domestic partner                                      | 18%                       |
| Lower premiums in exchange for a higher deductible                        | 11%                       |

## Plan Choices

Respondents were asked about their willingness to join an HMO. While 54% say they are very or somewhat willing to join an HMO, 46% indicate that they are not too willing or not at all willing to enroll in this type of medical plan.

Respondents were asked about the trade off between plan choice and employee cost to purchase coverage.

- 19% say having a choice of several medical plans with different doctor networks is more important than cost
- 72% say choice and cost are equally important
- 9% say cost is more important than plan choice

## Concerns about Future Medical Care in Retirement

Seventy-two percent of respondents are very concerned about their ability to secure adequate medical coverage after retirement, and another 21% are somewhat concerned.

Forty-seven percent are very interested in a program that would allow them to pre-fund some of the cost of retiree medical coverage on a tax-favored basis, and another 39% are somewhat interested.

## Cross-Tabulation Analysis

As discussed in Appendix A, a programming error at STRS resulted in some districts being over-sampled and others being under-sampled relative to the mean percentage of full-time teachers in all districts. In order to assess whether any potential skewing in the demographics of respondents resulting from this error would bias survey results, all cross-tabulations between demographic variables and opinion questions were analyzed to see if substantial differences that would be operationally significant existed between demographic groups. The differences identified met the following criteria:

- Difference of at least 15 percentage points from the mean for that question for the demographic group (for example, the response for respondents age 65 and older differs from the average response for the question by at least 15 percent).
- At least 20 people in the demographic group gave the response.

The following differences meet the specified criteria:

1. Respondents over 65 are less likely to have dependent children coverage and are less likely to say the ability to enroll a dependent parent would make a plan more attractive to them. Respondents age 34 and under are less likely to be very concerned about their ability to secure adequate medical coverage after retirement.
2. Respondents who rate their health as "fair" are more likely to say that ability to use a disease management program will make a plan substantially more attractive to them.
3. Respondents who are single with no dependent children are more likely to say that ability to enroll a domestic partner will make a plan substantially more attractive to them.
4. Respondents with a family income under \$35,000 are less likely to have a spouse or dependent children enrolled in their plan, while those who have a family income over \$75,000 are more likely to have a spouse enrolled.

5. Respondents with a family income under \$35,000 are more likely to say that a recommendation from a family member, friend, or co-worker is "very important" in selecting a health plan. These same respondents are less likely to say that ability to coordinate coverage with the coverage of their spouse is "very important." These respondents are more likely to say abilities to enroll a dependent parent or a domestic partner would make a plan substantially more attractive to them.

Because these differences would not impact the selection of approaches for a CalSTRS health benefits program, results from the full-time teacher survey are useful for planning purposes without any adjustments for sampling issues.

## Retired and Disabled Teacher Survey

### Current Insurance Coverage - Medical

Ninety-two percent of respondents have insurance coverage other than Medicare for themselves for medical expenses, including:

- 87% of disabled benefit recipients
- 93% of service retirees
- 90% of surviving spouses

Most respondents age 65 and over are enrolled in Medicare:

| Currently Enrolled in Medicare Parts A and B? | Under Age 65 | Age 65 and Over |
|---|--------------|-----------------|
| Yes, with Part A at no cost                   | 4%           | 79%             |
| Yes, but pay an added amount for Part A       | 0%           | 6%              |
| Enrolled in Part B only                       | 3%           | 7%              |
| Not enrolled in Medicare at all               | 89%          | 4%              |
| Not sure                                      | 5%           | 4%              |

For dependent medical coverage:

- 91% of married respondents say their spouse has medical coverage
- 63% of respondents with dependent children state those children have medical coverage
- 73% of respondents with a dependent parent say that parent has medical coverage

Respondents who do not have medical insurance for themselves were asked to indicate all reasons they do not have coverage. The top four reasons are:

| Reason   | Percent Indicating Reason |
|--|---------------------------|
| Not enough income to pay for coverage          | 37%                       |
| Coverage seems overpriced relative to benefits | 35%                       |
| Do not need medical coverage                   | 16%                       |
| Available benefits not attractive              | 13%                       |

Sixty-five percent of respondents without medical coverage think it is very important to obtain such coverage.

- 53% can pay \$50 a month or more for medical coverage for themselves
- 47% can pay an additional \$50 a month or more for medical coverage for family members

Respondents who have medical coverage for themselves were asked to indicate all sources of that coverage. The top four sources are:

| Source                      | Percent Indicating Source |
|-----------------------------|---------------------------|
| Former educational employer | 46%                       |
| Individual coverage         | 33%                       |
| Spouse's employer           | 19%                       |
| Other employer              | 3%                        |



Thirty nine percent of those with insurance pay nothing for the coverage. Respondents are generally satisfied with their medical benefits:

- 55% are very satisfied
- 32% are somewhat satisfied

## Current Insurance Coverage – Dental

Fifty-nine percent of respondents have insurance coverage for themselves for dental expenses.

Respondents who do not have dental insurance for themselves were asked to indicate all reasons they do not have such coverage. The top four reasons are:

| Reason   | Percent Indicating Reason |
|--|---------------------------|
| Coverage seems overpriced relative to benefits   | 42%                       |
| Not enough income to pay for coverage            | 20%                       |
| Coverage not available                           | 17%                       |
| Dentists in plan’s network not attractive choice | 15%                       |

Thirty-one percent of respondents without dental coverage think it is very important to obtain such coverage.

- 35% can pay \$20 a month or more for dental coverage for themselves
- 32% can pay an additional \$20 a month or more for dental coverage for family members

Respondents who have dental coverage for themselves were asked to indicate all sources of that coverage. The top four sources are:

| Source                      | Percent Indicating Source |
|-----------------------------|---------------------------|
| Former educational employer | 50%                       |
| Individual coverage         | 22%                       |
| Spouse's employer           | 20%                       |
| Other employer              | 4%                        |

Sixty four percent of those with insurance pay nothing for the coverage. Respondents are generally satisfied with their dental benefits:

- 43% are very satisfied
- 32% are somewhat satisfied

### Current Insurance Coverage – Vision

Sixty-two percent of respondents have insurance coverage for themselves for vision care expenses.

Respondents who do not have vision insurance for themselves were asked to indicate all reasons they do not have such coverage. The top four reasons are:

| Reason   | Percent Indicating Reason |
|--|---------------------------|
| Coverage seems overpriced relative to benefits | 30%                       |
| Coverage not available                         | 30%                       |
| Not enough income to pay for coverage          | 20%                       |
| Do not need vision care coverage               | 15%                       |

Thirty-two percent of respondents without vision coverage say this is very important to obtain such coverage.

Respondents who have vision coverage for themselves were asked to indicate all sources of that coverage. The top four sources are:

| Source                      | Percent Indicating Source |
|-----------------------------|---------------------------|
| Former educational employer | 48%                       |
| Individual coverage         | 18%                       |
| Spouse's employer           | 16%                       |
| Other employer              | 4%                        |

Respondents are generally satisfied with their vision benefits:

- 47% are very satisfied
- 34% are somewhat satisfied

## Factors in Selecting Medical Insurance

Respondents were asked to indicate the importance to them of thirteen factors in deciding which medical insurance to buy. Respondents answered using a four point scale ranging from “Very important” (scored as a “1”) to “Not at all important” (scored as a “4”). Thus, a lower score indicates higher importance for a given factor. We can use the mean score and the percentage who answered “Very important” to rank the factors as follows (from most to least important):

| Decision Factor                               | Mean Importance Score | Percent Who Score the Factor as “Very Important” |
|---|-----------------------|--|
| Trust in the organization sponsoring the plan | 1.11                  | 91%  |
| Ease of getting referrals to specialists      | 1.14                  | 88%  |
| Coverage for prescription drugs               | 1.22                  | 82%  |
| Premium for coverage                          | 1.23                  | 81%  |
| Easy-to-use claims payment process            | 1.26                  | 80%  |
| Wide choice of doctors                        | 1.28                  | 77%  |
| Coverage when traveling                       | 1.40                  | 69%  |
| Copayment or deductible for services          | 1.42                  | 66%  |
| Specific doctor in the network                | 1.43                  | 68%  |
| Coverage for any doctor                       | 1.44                  | 68%  |
| Specific hospital in the network              | 1.53                  | 60%  |
| Recommendation                                | 2.04                  | 29%  |
| Ability to coordinate with spouse             | 2.09                  | 52%  |

## Attractive Plan Features

Respondents were asked which plan features would make a specific medical plan substantially more attractive to enroll in. Respondents could indicate as many of the seven choices as they wanted. Results are as follows, ranked from most to least attractive:

| Plan Feature  | Percent Selecting Feature |
|---|---------------------------|
| Disease management program  | 61%                       |
| Ability to be rewarded for taking good care of one's health               | 47%                       |
| Coverage for alternative medicine   | 46%                       |
| Ability to get lower costs for using designated highest quality providers | 44%                       |
| Lower premiums in exchange for a higher deductible                        | 17%                       |
| Ability to enroll a domestic partner                                      | 13%                       |
| Ability to enroll a dependent parent                                      | 4%                        |

## Plan Choices

Respondents were asked about their willingness to join an HMO. While 51% say they are very or somewhat willing to join an HMO, 49% are not too willing or not at all willing to enroll in this type of medical plan.

Respondents were asked about the trade off between plan choice and retiree cost to purchase coverage.

- 16% say having a choice of several medical plans with different doctor networks is more important than cost
- 73% say choice and cost are equally important
- 11% say cost is more important than plan choice

The survey also asked about dental plan choices. Twenty-three percent of respondents are very interested in joining a dental discount plan, assuming the cost to join is about \$5 per month. Another 26% are somewhat interested in joining such a plan.

# District Survey

## Program Overview

Respondents are one of the following types of educational entities:

- School districts (K-12) – 88%
- Community college districts – 6%
- County Offices of Education – 6%

The organizations range in size from 1 to 43,000 certificated employees and from 1 to 21,000 classified employees. However, it should be noted that throughout this district survey analysis, large and small district responses are weighted equally. No adjustment is made to weight responses to reflect the number of employees covered by a particular district.

Based on CalSTRS input, 228 districts (out of 1,117 total districts) have not yet offered employees hired prior to April 1, 1986 the opportunity to elect participation in Medicare based on their teaching employment.

Respondents currently obtain coverage from differing sources, and these sources vary substantially by district size (as measured by the number of certificated employees indicated in the survey response). For comparison purposes, CalSTRS has provided the following information regarding the total number of districts (combined for school districts, community college districts, and county offices of education) in each of the size ranges shown below:

| District Size (# of Certificated Employees) | Number of Districts as Reported By CalSTRS |
|---|--|
| 1 to 10                                     | 70   |
| 11 to 50                                    | 243  |
| 51 to 100                                   | 145  |
| 101 to 250                                  | 218  |
| 250 to 1,000                                | 341  |
| Greater than 1,000                          | 138  |
| All district's combined                     | 1,155                                      |

The following charts provide a breakdown of the source of medical, dental or vision coverage by district size as reported by survey respondents. Note that percentages do not sum to 100% – districts were permitted multiple responses since some may currently purchase coverage from more than one source. In addition, not all districts responded to every question (e.g., a district does not offer vision coverage, and therefore no response was given for this benefit).

**MEDICAL BENEFITS**

| District Size (# of Certificated Employees) | Independently Purchase | Purchase through JPA/Trust | Other |
|---|------------------------|----------------------------|-------|
| 1 to 10                                     | 19%                    | 81%                        | 3%    |
| 11 to 50                                    | 17%                    | 81%                        | 3%    |
| 51 to 100                                   | 21%                    | 79%                        | 8%    |
| 101 to 250                                  | 34%                    | 67%                        | 2%    |
| 250 to 1,000                                | 59%                    | 38%                        | 10%   |
| Greater than 1,000                          | 67%                    | 30%                        | 10%   |
| All district's combined                     | 36%                    | 64%                        | 6%    |

**DENTAL BENEFITS**

| District Size (# of Certificated Employees) | Independently Purchase | Purchase through JPA/Trust | Other |
|---|------------------------|----------------------------|-------|
| 1 to 10                                     | 19%                    | 78%                        | 6%    |
| 11 to 50                                    | 14%                    | 86%                        | 1%    |
| 51 to 100                                   | 21%                    | 82%                        | 5%    |
| 101 to 250                                  | 20%                    | 81%                        | 3%    |
| 250 to 1,000                                | 41%                    | 60%                        | 4%    |
| Greater than 1,000                          | 60%                    | 43%                        | 3%    |
| All district's combined                     | 27%                    | 74%                        | 4%    |



**VISION BENEFITS**

| District Size (# of Certificated Employees) | Independently Purchase | Purchase through JPA/Trust | Other |
|---|------------------------|----------------------------|-------|
| 1 to 10                                     | 19%                    | 69%                        | 3%    |
| 11 to 50                                    | 21%                    | 79%                        | 1%    |
| 51 to 100                                   | 23%                    | 79%                        | 5%    |
| 101 to 250                                  | 23%                    | 61%                        | 6%    |
| 250 to 1,000                                | 46%                    | 47%                        | 4%    |
| Greater than 1,000                          | 67%                    | 27%                        | 3%    |
| All district's combined                     | 32%                    | 62%                        | 4%    |

Most respondents believe the cost of their organization's current health care plans is reasonable, as the following chart shows.

|  | Medical Plan | Dental Plan | Vision Plan |
|--|--------------|-------------|-------------|
| Percent responding that cost is low        | 6%           | 6%          | 18%         |
| Percent responding that cost is reasonable | 69%          | 74%         | 67%         |
| Percent responding that cost is high       | 19%          | 14%         | 9%          |
| Percent not sure                           | 6%           | 6%          | 6%          |

Most respondents with medical, dental or vision plans indicate that they are generally satisfied with health care coverage offered to active and retired certificated employees.

|   | Medical Plan | Dental Plan | Vision Plan |
|---|--------------|-------------|-------------|
| Percent “Very satisfied” – actives      | 59%          | 65%         | 66%         |
| Percent “Somewhat satisfied” – actives  | 37%          | 30%         | 31%         |
| Percent “Very satisfied” – retirees     | 54%          | 58%         | 57%         |
| Percent “Somewhat satisfied” – retirees | 35%          | 31%         | 32%         |

Respondents were asked how classified employees are generally covered for health care benefits.

- 80% say classified employees generally receive the same benefit plan design and pay the same contributions for coverage as certificated employees
- 7% say classified employees generally receive the same benefit plan design as certificated employees, but the contributions required for coverage are higher for the classified group; another 3% say the plan design is the same, but contributions for coverage are lower for the classified group
- 7% say classified and certificated employees receive different benefits and pay different contributions
- 3% use some other methodology

### *Interest in a CalSTRS Program*

Respondents were asked to indicate their overall level of interest in a CalSTRS-sponsored statewide health benefits program.

|                                 | Rural | Urban | Combined |
|---------------------------------|-------|-------|----------|
| Percent “Very Interested”       | 28%   | 18%   | 25%      |
| Percent “Somewhat Interested”   | 46%   | 44%   | 45%      |
| Percent “Not Too Interested”    | 20%   | 28%   | 23%      |
| Percent “Not At All Interested” | 6%    | 11%   | 7%       |

Respondents were asked to indicate the importance to them of fifteen factors in deciding whether a CalSTRS-sponsored health benefits program would be an attractive choice. Respondents answered using a four point scale ranging from “Very important” (scored as a “1”) to “Not at all important” (scored as a “4”). Thus, a lower score indicates higher importance for a given factor. We can use the mean score and the percentage who answered “Very important” to rank the factors as follows (from most to least important):

| Decision Factor  | Mean Importance Score | Percent Who Score the Factor as “Very Important” |
|--|-----------------------|--|
| Lower Cost   | 1.20                  | 82%  |
| Multi-year rate guarantees                             | 1.37                  | 67%  |
| Coverage available on both certificated and classified | 1.42                  | 69%  |
| Dental plan coverage                                   | 1.46                  | 70%  |
| Vision plan coverage                                   | 1.51                  | 64%  |
| Coverage available for retirees                        | 1.55                  | 60%  |
| Plan that allows use of any licensed provider          | 1.62                  | 53%  |
| Easier administration                                  | 1.67                  | 52%  |
| Lower participant out-of-pocket costs                  | 1.70                  | 48%  |

| Decision Factor                                       | Mean Importance Score | Percent Who Score the Factor as "Very Important" |
|---|-----------------------|--|
| Broad managed care provider networks                  | 1.79                  | 45%  |
| More plan choices                                     | 1.85                  | 39%  |
| Coverage available for part-time employees            | 2.16                  | 29%  |
| Coverage available for domestic partners              | 2.53                  | 24%  |
| Request for CalSTRS coverage in collective bargaining | 2.57                  | 18%  |
| Coverage available for dependent parents              | 2.67                  | 11%  |

Respondents were asked to indicate the likelihood of switching from current health care coverage offerings to a CalSTRS-sponsored health benefits program for five levels of cost savings, assuming benefit coverage is similar. Respondents answered using a four point scale ranging from "Very likely" (scored as a "1") to "Not at all likely" (scored as a "4"). Thus, a lower score in the center column below indicates a greater likelihood of switching (e.g., a score of 1.00 would mean that every respondent indicated that they were very likely to switch). We can use the mean score and the percentage that answered "Very likely" to understand the approximate magnitude of cost savings needed to motivate districts that responded to the survey to select a CalSTRS-sponsored program.

| Cost Decrease for District | Mean Likelihood of Switching | Percent Who Responded "Very Likely" to Switch |
|----------------------------|------------------------------|---|
| 2%                         | 3.08                         | 5%  |
| 3%                         | 2.90                         | 5%  |
| 5%                         | 2.24                         | 22%   |
| 7%                         | 1.80                         | 45%   |
| 8% or more                 | 1.38                         | 67%   |

### *Participation in PERS Medical Program*

Twenty-nine (9%) of the 331 respondents purchase medical benefits for certificated employees through CalPERS (this medical benefits program is also frequently called PEMHCA after the Public Employees' Medical and Hospital Care Act from which it was created). Districts with more than 250 employees represented the majority of these responses. Per information provided by CalSTRS, a total of 98 districts cover certificated employees under the PERS program (representing approximately 9% of districts statewide, consistent with this survey's results).

*Medical Benefits — Administrators*

Respondents use the following administrators to pay medical claims and/or provide medical benefits for certificated employees and retirees. Note that many respondents use more than one administrator, so the total of responses is more than 331.

| Administrators              | Respondents Indicating Use |
|-----------------------------|----------------------------|
| Blue Cross                  | 167                        |
| Kaiser                      | 121                        |
| HealthNet                   | 43                         |
| PacifiCare                  | 38                         |
| Blue Shield (non-HMO)       | 27                         |
| California Care             | 19                         |
| Blue Shield HMO             | 18                         |
| Lifeguard                   | 11                         |
| Prudential HMO              | 10                         |
| Prudential (non-HMO)        | 8                          |
| Aetna HMO                   | 6                          |
| Health Plan of the Redwoods | 6                          |
| CIGNA HMO                   | 5                          |
| Maxicare                    | 3                          |
| Other                       | 57                         |

*Medical Benefits — Eligibility*

Districts have varied requirements on the number of hours per week a certificated employee must work to be eligible for medical benefits.

| Hours Per Week for Eligibility | Percent of Respondents |
|--------------------------------|------------------------|
| 20 hours                       | 36%                    |
| No minimum hours               | 17%                    |
| 35 hours                       | 10%                    |
| 32 hours                       | 6%                     |
| 40 hours                       | 4%                     |
| 16 hours                       | 2%                     |
| Other                          | 25%                    |

Respondents indicated that the following categories of people are eligible for some or all medical plans.

| Category                                  | Percent of Districts Indicating Eligibility |
|---|---|
| Retired teachers under 65                 | 90%   |
| Disabled teachers                         | 77%   |
| Retired teachers with Medicare            | 69%   |
| Retired teachers over 65 without Medicare | 60%   |
| Surviving spouses of teachers             | 52%   |
| Domestic partners — opposite sex          | 17%   |
| Domestic partners — same sex              | 12%   |
| Dependent parents                         | 4%  |

It is our understanding that districts are currently required by law to make available health benefits to retirees. In answering this question relative to retirees, we believe that respondents may have misinterpreted or misunderstood the question.

### *Medical Benefits — Types of Plans*

Respondents offer the following types of medical plans.

| Type of Plan        | Percent of Districts Offering at Least One Plan of this Type |
|---------------------|--|
| PPO                 | 78%  |
| HMO                 | 64%  |
| Medicare supplement | 46%  |
| Medicare Risk HMO   | 25%  |
| Indemnity           | 22%  |
| POS                 | 16%  |
| Triple Option       | 4%   |

Plans offered span a wide range of deductibles, coinsurance, co-payments, and annual limits. In most plans of all types, prescription drugs are covered with a fixed dollar co-payment that may vary by drug type.

### *Medical Benefits — Costs and Contributions*

The requested cost information was separated into two types of plans – HMO and non-HMO, and three employee risk pools – active, retiree without Medicare, and retiree with Medicare. In many cases, the district’s active rate is the same as its retiree without Medicare rate (i.e., the early retirees are combined with the active pool). The districts reported premium rates by their rating tier structure – we reviewed the rates in the most common tier structures reported, which were a single tier (composite rate), and three-tiers. The following table provides a general summary of the average premium rates reported by the categories we reviewed:



| <b>Monthly Premium</b> |            |         |        |  |
|------------------------|------------|---------|--------|--|
| Single tier            | Three tier |         |        |  |
|                        | 1-party    | 2-party | family |  |

*Active Employees*

|                         |       |       |       |       |
|-------------------------|-------|-------|-------|-------|
| Average Non-HMO premium | \$413 | \$235 | \$455 | \$606 |
| Average HMO premium     | \$352 | \$175 | \$336 | \$461 |

*Non-Medicare Retirees*

|                         |       |       |       |       |
|-------------------------|-------|-------|-------|-------|
| Average Non-HMO premium | \$392 | \$275 | \$538 | \$638 |
| Average HMO premium     | \$360 | \$192 | \$399 | \$512 |

*Medicare Retirees*

|                         |       |       |       |       |
|-------------------------|-------|-------|-------|-------|
| Average Non-HMO premium | \$347 | \$201 | \$371 | \$523 |
| Average HMO premium     | \$228 | \$103 | \$199 | \$351 |

Note: The 2-party and family rates shown for Non-Medicare assume that both adult parties are not covered by Medicare, and the 2-party and family rates shown for Medicare assume that both adult parties are covered by Medicare.

*HMO versus Non-HMO*

Based on the average single tier rates, the average HMO premium for actives is approximately 15% lower than the average non-HMO premium. The Non-Medicare rate differential is not as large, and the Medicare rate differential is much larger (approximately 35%).

*Rural versus Non-Rural*

We also saw variations in the rates by rural versus non-rural. On average, the Active rate and Non-Medicare retiree rate for rural counties was approximately 10% higher than the corresponding rate for non-rural counties. The Medicare retiree rates were slightly lower for rural than for urban.

## *Large counties versus Small counties*

On average, the districts with over 1,000 employees had lower premium rates than the districts with under 1,000 employees, for both HMO and non-HMO plans. The premium rates for districts under 1,000 employees varied by population size. It was difficult to make comparisons of premium rates by population size because there was a significant variation in plan design from district to district.

## *Comparison to CalPERS Premiums and Mercer/Foster Higgins survey data*

When we compare the average monthly premium rates shown above to CalPERS rates, we find that they are in the same range. For example, the average 1-party rate for the CalPERS plans for calendar year 2000 is \$201 per month. If this is adjusted downward by 10% to reflect CalPERS premium rate increases from 1999 to 2000, it is \$183 per month, which is between the HMO 1-party rate for Actives (\$176) and the non-HMO 1-party rate for Actives (\$235) shown above for CalSTRS.

The 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicated that the 1998 average PPO cost per employee for the West region was \$326 per month and the 1998 average HMO cost per employee was \$275 per month. If these rates were adjusted upward 10% to reflect average premium increases from 1998 to 1999, the PPO cost per employee would be \$359 (versus a \$413 single tier rate for CalSTRS non-HMO). The HMO cost per employee would be \$303 (versus a \$352 single tier composite rate for CalSTRS HMOs).

Based on the above comparisons, the CalSTRS premiums may be over 15% higher than the companies in the West region of the Mercer/Foster Higgins survey, and appear to be about the same as the CalPERS premiums. The CalSTRS rates are probably more directly comparable with the CalPERS rates because they are likely to represent more similar plan designs, similar types of entities, and similar geographic locations. Comparison to the CalPERS rate indicates that the CalSTRS districts may currently be achieving reasonable rates on average for the plan designs that they offer.

## *Contributions*

Approximately 80% of the districts using a one premium tier rate structure required no medical premium contribution for actives and non-Medicare retirees, and 60% of those districts required no premium contributions for Medicare retirees. For districts using three premium tiers, less than 80% required no medical premium contribution for 1-party actives, less than 60% required no premium contribution for 1-party non-Medicare retirees, and less than 40% required no contribution for 1-party Medicare retirees. Both the numbers of districts requiring contributions and the amount of the contributions increased for 2-party and family coverage.

For those districts that required contributions, average Active contributions ranged from 20-40% of premium, Non-Medicare retiree contributions ranged from approximately 30-70% of premium, and Medicare retiree contributions ranged from 90-95% of premium.

*Dental Benefits — Administrators*

Respondents use the following administrators to pay dental claims and/or provide dental benefits for certificated employees and retirees.

| Administrator                  | Respondents Indicating Use |
|--------------------------------|----------------------------|
| Delta Dental (not prepaid PMI) | 211                        |
| Delta Dental (prepaid PMI)     | 87                         |
| Safeguard                      | 11                         |
| United Concordia               | 5                          |
| Blue Shield                    | 2                          |
| CIGNA                          | 2                          |
| MetLife                        | 2                          |
| Blue Cross                     | 1                          |
| Prudential                     | 1                          |
| Western Dental                 | 1                          |
| Other                          | 55                         |

*Vision Benefits — Administrators*

Respondents use the following administrators to pay vision claims and/or provide vision benefit for certificated employees and retirees.

| Administrators                          | Respondents Indicating Use |
|---|----------------------------|
| Vision Service Plan (VSP)               | 248                        |
| Vision provided through medical plan(s) | 23                         |
| Medical Eye Plan                        | 17                         |
| AVP                                     | 5                          |
| Other                                   | 43                         |

*Dental Benefits — Eligibility*

Respondents indicated that the following categories of people are eligible for some or all dental plans.

| Category                                  | Percent of Districts Indicating Eligibility |
|---|---|
| Retired teachers under 65                 | 72%   |
| Disabled teachers                         | 65%   |
| Retired teachers with Medicare            | 59%   |
| Retired teachers over 65 without Medicare | 51%   |
| Surviving spouses of teachers             | 47%   |
| Domestic partners – opposite sex          | 13%   |
| Domestic partners – same sex              | 9%  |
| Dependent parents                         | 5%  |

### *Dental and Vision Benefits — Types of Plans*

Respondents offer the following types of plans.

| Type of Plan         | Percent of Districts Offering at Least One Plan of this Type |
|----------------------|--|
| Vision Plan          | 94%  |
| PPO dental           | 77%  |
| Indemnity dental     | 63%  |
| Prepaid dental       | 59%  |
| Triple option dental | 3%   |

The majority of dental and vision plans have individual deductibles of \$10 or less. Most dental plans cover in-network diagnostic/preventive and restorative services at 100%. The calendar year dental maximum does vary widely across respondents. Most respondents provide orthodontia coverage; this is especially the case for prepaid dental plans.

### *Dental and Vision Benefits — Costs and Contributions*

The cost information for dental and vision benefits was not separated by type of plan (i.e., managed care versus indemnity). As shown elsewhere in this report, the majority of the dental coverage is provided through Delta Dental and the majority of the districts use VSP for vision benefits coverage. The districts reported premium rates by their rating tier structure – we reviewed the rates in the most common tier structures reported, which were a single tier (composite rate), and three-tiers (similar to the medical). The following table provides a general summary of the average premium rates reported by the categories we reviewed:

|  | <b>Monthly Premium</b> |                   |                |               |
|--|------------------------|-------------------|----------------|---------------|
|  | <u>Single tier</u>     | <u>Three tier</u> |                |               |
|  |                        | <u>1-party</u>    | <u>2-party</u> | <u>family</u> |

*Active Employees*

|                        |       |      |      |       |
|------------------------|-------|------|------|-------|
| Average dental premium | \$86  | \$49 | \$89 | \$105 |
| Average vision premium | \$26* | \$11 | \$18 | \$26  |

*Retirees*

|                        |       |      |      |       |
|------------------------|-------|------|------|-------|
| Average dental premium | \$91  | \$42 | \$83 | \$106 |
| Average vision premium | \$36* | \$11 | \$18 | \$24  |

\* These numbers are likely overstated because of what appear to be incorrect rates reported by one district.

*Rural versus Non-rural*

The single and three-tiered rates were reviewed for rural versus non-rural differences. The single tier rates for actives and retirees, for dental and for vision, were higher for urban than for rural. For the three-tiered rates for actives and retirees, for dental and for vision, the opposite was true. The urban rates were lower than the rural rates. Part of the explanation for this may be that the large urban groups that are able to negotiate lower rates because of their size are all in the three-tiered comparison. There also may be differences in plan design.

*Contributions*

Over 90% of the districts using a one premium tier required no premium contribution for dental and vision coverage. Almost 80% of the districts using three-tiers required no premium contribution for 1-party dental and vision coverage. However, more than half of the districts required premium contributions for 2-party and family coverage, and those contributions ranged from 50-100%.

## State Interviews

### Prescreening Questions

Nine of the ten states interviewed include public employees (who are not school district employees) in their statewide health benefits program for school district employees. Eight respondents cover both actives and retirees, while two cover retirees only. Only one of the responding states has health benefits subject to collective bargaining.

### Background Questions

Three states require all certificated employees hired prior to April 1, 1986 to contribute to and participate in Medicare.

Only one state allows portions of school districts (for example, individual bargaining units) to elect participation in the statewide health benefits program if the entire district does not participate.

States give the following reasons that school districts choose to join the statewide plan.

| Reason                        | Number Giving Reason as Most Important |
|-------------------------------|--|
| Lower cost                    | 6                                      |
| Better choice of health plans | 2                                      |
| It's mandatory                | 1                                      |

Eight states include both classified and certificated employees in the statewide program, while two include certificated employees only. Six states mandate eligibility provisions rather than allowing school districts to determine their own eligibility rules for actives, retirees and part-timers.

### *Plan Design*

Respondents have a variety of observations on plan design, including:

- Having uniform benefits in all HMOs is helpful

- Generous benefits, such as a medical indemnity plan or unlimited drugs in HMOs, are popular
- Offering a variety of options is confusing to some retirees

Respondents use different strategies to deal with the issue of benefits for retirees over age 65 without Medicare:

- Two states require retirees to buy Parts A and B
- Two require purchase of Part B only
- Two continue to provide full benefits without requiring any Medicare purchase.

None of the respondents contributes towards the cost of Medicare Part A coverage for individuals age 65 and older who do not qualify for premium-free Part A coverage.

## Administration

Eight states perform tasks for the statewide program primarily on a centralized basis by a state agency, while two perform primarily on a centralized basis by the health plan claims administrator.

While three respondents are very satisfied with their current administrative set-up, five are somewhat satisfied. Respondents outlined several administrative challenges, including:

- Systems issues
- Adequate staffing
- Managing vendor relationships
- Participant communications



## Implementation/Transition

Respondents classify the ease of initial implementation of the statewide health care benefits program as follows:

- A few bumps along the way, but generally smooth implementation and transition — 4 states
- Difficult — 4 states
- Very difficult — 1 state

Respondents outline several implementation difficulties including:

- Finding and communicating with retirees
- Selecting satisfactory vendors
- High costs
- Inflexible legislation
- Systems problems
- Inadequate lead time
- Communicating with districts and unions

## Financing

Respondents use the following billing rate structures:

- Same rates for actives and retirees not eligible for Medicare; retirees with Medicare have different rates — 5 states
- Active employees, retirees not eligible for Medicare, and retirees with Medicare all have different rates — 4 states

Nine of the states allow individual school districts to decide how much to contribute toward the cost of a full-time active employee's coverage, but only four states allow this flexibility for retirees with Medicare and five for retirees without Medicare.

Most respondents subsidize retiree coverage:

- Five subsidize retirees both with and without Medicare
- One subsidizes retirees without Medicare only
- One lets the school district decide

For states that subsidize retirees, the subsidy is from the following sources:

- Active employee rates — 4 states
- Additional employer contributions or assessments — 4 states
- Plan assets and/or investment income — 2 states
- Other source — 4 states

Five states voice concerns over the rising cost of prescription drug benefits, and four over the cost of retiree benefits.

## GeoAccess Analysis

Only a limited number of vendors were able to provide us with accurate data in the necessary format within the time constraints of this project. Based on these vendor provided data files, the following represents the proportion of the CalSTRS active and retiree population that would have geographic access to at least 1 network provider within a maximum of a 10 mile radius of the individual’s residence zip code. This is further broken down for each vendor and type of plan shown.

| Vendor/Type of Plan           | % of Active Members with at Least 1 Provider within 10 miles of Residence Zip Code | % of Retirees with at Least 1 Provider within 10 Miles of Residence Zip Code |
|-------------------------------|--|--|
| Blue Cross PPO                | 94%  | 93%  |
| Blue Cross HMO                | 84%  | 82%  |
| Blue Shield HMO               | 83%  | 80%  |
| HealthNet HMO                 | 89%  | 86%  |
| Kaiser HMO                    | 79%  | 72%  |
| Pacificare HMO                | 98%  | 95%  |
| All Vendors/Networks Combined | 100%   | 100%   |

These figures, while believed accurate based on data provided by the vendors, are in some instances much greater than anticipated given the expected rural residence of many CalSTRS members and retirees.

As a result, we further evaluated the proportion of zip codes covered by the above combination of HMOs. Of 2,237 California zip codes in which CalSTRS members reside 1,889 (84%) are considered to be part of one or more of the above vendors' network areas. Of 1,643 zip codes in which retirees reside, 1,442 (88%) are considered to be part of one or more of the above vendors' network areas. This appears to be consistent with the above data, since a greater number of CalSTRS individual members and retirees would be expected to reside in zip codes that are in urban (and therefore network) areas.

However, the above information is based solely on the data provided by the vendors, and while reviewed with the carriers, it has not been audited. Given the importance of rural health care within the educational environment, further research may be needed to properly understand network coverage issues in rural areas.

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## Appendix C. Sample Plan Design Structure

The following plan designs represent sample structures that might apply for district sponsored health plans under approaches 1, 2, and 3 for medical plans. Retirees over age 65 would be offered a combination of Medicare +Choice plans or Medicare supplement plans, however insufficient information was available through the survey to adequately structure sample designs at this time.

It should be noted that these sample designs represent “averages” based on a general review of the plan designs currently in use by districts responding to the survey. Actual district designs varied extremely widely, so it is unlikely that the plans below will represent an exact match for most districts. In addition, since this data was gleaned from the district survey respondents, all districts (regardless of size) were given equal weighting in structuring these designs.

We consider these sample designs to represent an approximation of the types of options that would need to be made available under a CalSTRS sponsored program in order to be considered attractive to districts, members, and retirees. However, it will be important to perform additional research (e.g., through focus groups) to clarify and finalize plan details.

In each instance it is contemplated that the number of weekly working hours required for member eligibility would be flexible to meet the districts’ needs. Part-time employees could also be made eligible assuming some minimum level of district subsidy is applied. If no district subsidy is available for part-time employees, those individuals could still be eligible for an individually purchased plan through STRS under Approach 3, should that approach be implemented. Domestic partner coverage would be available should a particular district and its members wish to include this eligible classification.

Finally, all of these summary designs assume that prescription drugs will be carved out (under a copay prescription drug card style benefit) to a Pharmacy Benefit Manager, and that behavioral health and substance abuse benefits will be carved out to a Managed Behavioral Health vendor. Details of actual benefits in these areas were not included in this survey effort.

## HMO Design Options

|                      | <b>HMO High Benefit</b> | <b>HMO Moderate Benefit</b> | <b>HMO Low Benefit</b> |
|----------------------|-------------------------|-----------------------------|------------------------|
| Deductible           | None                    | None                        | None                   |
| Physician Copay      | \$0                     | \$5                         | \$10                   |
| Hospital Coinsurance | 100%                    | 100%                        | 100%                   |

## POS Design Options

|   | <b>POS High Benefit</b> | <b>POS Moderate Benefit</b> |
|---|-------------------------|-----------------------------|
| Deductible (In Network/Out of Network)            | \$0/\$300               | \$0/\$300                   |
| Physician Copay                                   | \$5                     | \$10                        |
| Hospital Coinsurance (In Network/Out of Network)  | 100%/80%                | 100%/70%                    |
| Maximum Out of Pocket (In Network/Out of Network) | \$500/\$1000            | \$1500/\$3000               |

## PPO and Indemnity Plan Options

|   | <b>PPO High Benefit</b> | <b>PPO Moderate Benefit</b> | <b>PPO Low Benefit</b> | <b>Indemnity / Out of Area Employees</b> |
|---|-------------------------|-----------------------------|------------------------|--|
| Deductible (In Network/Out of Network)            | \$0/\$150               | \$100/\$200                 | \$200/\$400            | \$250                                    |
| Physician Copay                                   | \$10                    | N/A                         | N/A                    | N/A                                      |
| Hospital Coinsurance                              | 100%/80%                | 90%/70%                     | 80%/60%                | 80%                                      |
| Maximum Out of Pocket (In Network/Out of Network) | \$500/\$1000            | \$1500/\$3000               | \$2500/\$5000          | \$1500/\$3000                            |

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## Appendix D. Summary Statistics for CalSTRS Benefits Survey

The following provides the summary statistical information produced by CalSTRS for each of the following survey components:

- Full-Time Active Employees Only
- Retired and Disabled Members Only
- Districts Only
- State Survey Interviews

This material, along with other data reports provided by CalSTRS, represent one basis of the information and recommendations presented in this report.