FINAL BILL REPORT
ESSB 5940

C 3 L 12 E 2
Synopsis as Enacted

Brief Description: Concerning public school employees' insurance benefits.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Hobbs, Ericksen, Keiser, Tom, Kastama and Zarelli).

Senate Committee on Ways & Means
House Committee on Ways & Means

Background: In 2010 the State Auditor's Office conducted a performance review of the public school employees' health benefits purchased by 295 school districts. The report became available to legislators during the 2011 legislative session and included three main recommendations: streamline the benefits array of school employees to improve efficiency, transparency, and stability; standardize coverage levels for more affordable and equitable health care benefits; and reduce costs by restructuring the health benefits array. Legislation passed in the 2011 special session (section 213 of the state budget) directed the Health Care Authority (HCA) to develop a proposal for consolidating the purchase of school district benefits to improve administrative efficiency, transparency, and equity. The HCA report, delivered in December 2011, identified that over $1 billion in public funds is spent each year on school employee benefits for 109,000 employees and the additional 94,000 dependents that are enrolled in benefits.

The state provides funding to school districts to support the purchase of health benefits for employees. For the 2011-13 fiscal biennium, the state provides $768 per full-time equivalent employee (FTE). The amount of the school funding rate is commonly passed through as an allocation to each school district employee through bargaining agreements. In addition, some school districts have, in some instances, bargained local funds that are added to the state allocation.

At the district level, the actual distribution of the health benefit allocation is determined through collective bargaining. There are no state mandated maximum or minimum amounts that a district must spend per employee or FTE. In many districts, the amount provided for health benefits is pro-rated based on the amount of time an employee works; in some districts employees may be eligible for benefits beginning at 10 percent of full-time employment; while in other districts, employees working at least half-time are provided the same benefit as a full-time employee.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

School district employee contributions vary by district, and often by bargaining unit within districts. Similarly, benefits may be purchased by bargaining unit or other groups of employees; each bargaining unit or group of bargaining units may receive funding in separate funding pools. Recent studies indicate more than 1,000 funding pools are operated in Washington's 295 school districts. Employee premiums may vary significantly among districts and funding pools. There is also substantial variation in the share of the costs employees pay between those insuring only themselves, and those insuring families. Full-time school district employees that are insuring only themselves on average pay about 4 percent of the cost of benefits, while those full-time school district employees that insure their families on average pay about 43 percent of the cost.

During study of the school district health benefit system in 2011, the HCA stated that it was unable to collect some of the needed demographic, payroll, and benefits data. The HCA identified a number of the obstacles to data collection that it found and would need to be dealt with to enable analysis of the effectiveness of the administration and purchasing systems employed by districts. Among the obstacles to data transparency identified were (1) variations in district budget practices; (2) contracts with third party administrators that made it difficult to assess administrative costs; and (3) contracts with benefits carriers which allow the carriers to withhold information about the make-up of premiums, including components of administrative fees, and claims information at the school district, employee bargaining group, or individual member level.

The Office of the Insurance Commissioner oversees Washington's insurance industry, ensuring that companies, agents, and brokers follow state law.

Summary: School districts must modify their benefits for employees to require every employee to pay a minimum premium for the medical benefit coverage, subject to collective bargaining, and ensure that employees selecting a richer benefit plan pay a higher premium. School districts offering medical, vision, and dental benefits must (1) offer a high deductible health plan option with a health savings account similar to that required for state employees; (2) make progress toward employee premiums for full family coverage that are not more than three times the premiums for employees purchasing single coverage, unless a different target is developed in future reports; and (3) offer employees at least one comprehensive health benefit plan in which the employee share of the premium for a full-time employee does not exceed the share of premiums paid by state employees (approximately 15 percent). All school district contracts must be held to responsible procurement or contracting standards, and school districts must make progress on promoting health care innovations, cost savings, and reduced administrative costs.

School districts and school district employee health benefit providers are required to annually submit specified financial and enrollment information on the health benefit plans operated for district employees to the Office of the Insurance Commissioner (OIC), on a schedule determined by the OIC. The information is protected from public disclosure, as with all other similarly reported data. If a school district does not comply with the reporting requirements for two reporting periods, the Superintendent of Public Instruction is required to limit the school district's authority to offer employee benefits to those offered through the state HCA.

School district benefit providers that do not comply with the data reporting requirements are subject to the enforcement actions of the OIC. Similarly, the authority to operate in the state is removed from any individual or joint local government self-insured health and welfare benefits plan formed by a school district that does not comply with the data reporting requirements contained in the act. The Attorney General must take all necessary action to terminate the operation of an out-of-compliance self-insured health and welfare benefits program.

Beginning December 1, 2013, the OIC must submit an annual report to the Legislature containing specific information and analysis on school district health benefit plans. The report must include information on detailed financial and performance data such as premium expenses, claims expenses, claim reserves, and administrative expenses including compensation paid to brokers, detailed enrollment data. The OIC may adopt rules for the data submission requirements, and may contract with a consultant to complete the analysis and reporting responsibilities. The commissioner must consult with school district representatives to ensure the data and reports from the benefit providers will give school districts sufficient information to enhance the district's ability to manage their benefit program and seek competitive alternatives for health insurance coverage.

By June 1, 2015, the HCA must submit a report to the Governor, Legislature, and the Joint Legislative Audit and Review Committee (JLARC), with analysis of the OIC reports, including the development of a specific target to realize the goal of greater equity between premium costs for full-family coverage and employee only coverage, and review of the appropriateness of the three-to-one ratio of employee premium costs. The HCA must also review the advantages and disadvantages to the state, school districts, and school employees of various approaches to consolidated purchasing of school employee health benefits, and options to achieve the legislative goals, with analysis of the costs for the state and school employees, impacts for existing purchasing programs, and a proposed timeline for any recommended actions.

By December 31, 2015, JLARC must submit a report to the Legislature indicating the progress by school districts and their benefit providers in achieving a list of established goals and performance expectations. The report must include a recommendation on the specific target to realize the goal for greater affordability for full family coverage and greater equity in premium costs, and the status of each school districts' progress in achieving the established goals. In the 2015-2016 school year, JLARC must determine which districts have met the requirements for the benefit offerings, premiums and competitive contracting standards, and must rank order the performance, and then provide performance grants to the highest performing districts to reduce employee health insurance co-payments and deductibles, from a future $5 million appropriation to be made by the Legislature.

If JLARC determines districts and their benefit providers have not made adequate progress on the established goals, JLARC must report to the Legislature with advantages, disadvantages, and recommendations on why progress has not been made and any reasons for insufficient progress; what remedies would help remove barriers to improvement; and whether purchasing of school district benefits should be consolidated through various approaches. The report must include recommendations for any Legislative action necessary for implementation, and the Legislature must take all steps necessary to implement the

recommendations unless an alternative strategy is adopted during the 2016 Legislative session.

Votes on Final Passage:

First Special Session
Senate 29 17

Second Special Session
Senate 25 20
House 53 45

Effective: July 11, 2012