DOCUMENT RESUME

ED 298 663 EA 020 354

TITLE Report to the Legislature on Controlling School Employee Health Care Costs (Chapter 303, Laws of 1986).
INSTITUTION Washington Office of the State Superintendent of Public Instruction, Olympia.
PUB DATE Jan 88
NOTE 49p.; Some pages of Appendixes contain small, light type.
PUB TYPE Legal/Legislative/Regulatory Materials (090)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Costs; *Educational Policy; Elementary Secondary Education; *Expenditures; *Health Insurance; State Legislation; State Norms; Tables (Data); *Teacher Employment Benefits; Workers Compensation
IDENTIFIERS *Washington

ABSTRACT

This document comprises the mandatory report of the Superintendent of Public Instruction to the Washington State legislature on proposed methods of controlling health care costs for school employees. It focuses on the costs to Washington's 296 school districts of providing health care coverage for approximately 80,000 employees. The introduction outlines four types of health care containment strategies, which, respectively, affect the providers, the benefits themselves, those who seek services and treatment, or the system as a whole. The second section lists many of the reasons for the increasing costs of health care. This is followed by discussions of state law governing school district insurance benefits and of the role of the superintendent of public instruction. A detailed review follows of legislatively authorized benefit levels and of the data on employee benefits. The report concludes with a set of specific policy recommendations. Appended are statistical tables and other pertinent documents pertaining to health insurance costs for school employees. (TE)

DR. FRANK B. BROUILLET Superintendent of Public Instruction

TO: Members of the Washington State Legislature

FROM: Dr. Frank B. Brouillet

RE: A Report on Controlling School Employee Health Care Costs

In 1986 the legislature passed ESHB 2021, an act relating to managed health care. Among the provisions of this act, a number of state agencies were directed to work with the Office of Financial Management in the study of health care cost containment policies. Section 12, Chapter 303, Laws of 1986 directed the Superintendent of Public Instruction to complete a study for school employees. The following is therefore submitted as required.

For additional copies of this report or further information, please contact:

Judy Hartmann
Administrative Assistant for Governmental Liaison
Old Capitol Building, FG-11
Olympia, WA 98504
(206) 586-6906, SCAN 321-6906

INTRODUCTION

This report is submitted pursuant to Section 12, Chapter 303, Laws of 1986, which states:

> Not later than January 1, 1988, the superintendent of public instruction shall report to the legislature on proposed methods of controlling school employee health care costs....

The report is confined to employer (i.e., school district) costs to provide health care coverage for approximately 80,000 individual employees in the state's 296 school districts. There are other school health costs which could be included in a review of health care costs, among which are the following: health instruction, the screening of all 760,000 students for up-to-date immunizations, scoliosis testing, instruction in physical education, nutrition related to the school food service program, and student health services (e.g., school nurses, counselors, physical therapists, etc.). Determining costs of these types of activities would be difficult. Since earlier efforts have concentrated on employee health care costs, this report is similarly targeted.

Concern for containing health care costs dates back at least twenty years, but the issue of health care cost containment hit its stride within the last ten years. The 1969 Legislature created a state employees' insurance and health care advisory committee to study the provision of adequate health care with concern for the welfare of both the employees and the state. In the early 1980s, numerous publications and articles in journals, magazines and newspapers gave wide coverage to the topic. Two state reports provide good background information on this topic. The Final Report on the Six-Year State Health Care Purchasing Plan was prepared in December 1984 by the Governor's Steering Committee on the Six-Year Health Care

Purchasing Plan. Health Care Cost Containment: A Background Paper was prepared in January 1984 by the House of Representatives, Office of Program Research.

Containment strategies can be divided into four types. One type impacts providers and the manner in which they are organized to provide services. The following are examples: health maintenance organizations, preferred providers, self insuring of plans, maximizing out-of-hospital services, hospital specializing, free standing clinics, tighter licensing requirements for health care practitioners, designating approved providers, etc.

The second type of strategy impacts the benefits themselves: utilization review, second opinion on surgery, coverage exclusions or ceilings on service, claims audits, coordination of benefits where more than one family member carries insurance, administered price systems, fixed reimbursement rates for specific services or treatment, use of generic drugs, mail order prescriptions, catastrophic coverage, etc.

The third type of strategy impacts those who seek services and treatment. Included in this group are advent or expansion of deductibles and/or co-payments, wellness programs, comprehensive employee information programs, employee assistance programs (e.g., alcohol or drug rehabiliation), routine employee health screening, employer provision of facilities for exercise, consumer information regarding types and costs of various health coverages, incentive programs designed to encourage only necessary use of services, etc.

And, the fourth type of strategy relates to the system as a whole. For example, employers have formed health care coalitions to share information on the changing world of health care, costs, quality, trends, etc. Also

included in this category is the recommended formation of a health care data base on local, regional, state and national levels.

The containment strategies listed above are representative of efforts in the area, but are not all-inclusive. Some of them have been in operation for years. Others are recent developments.

RISING HEALTH CARE COST

In spite of widespread recognition of the rising cost of health care and innovative attempts to stop or curb the rate of increase, the upward trend continues. In the five-year period from December 1981 until December 1986, for example, the consumer price index rose 17.6 percent. During that same period, the medical cost index rose 44 percent and the cost of prescription drugs rose 59 percent.

Another way to portray the medical cost increase is as a percentage of the gross national product (GNP). In the 1950s, it was 4 percent of the GNP; today it is about 11 percent of the GNP. There are predictions that it will rise to 14 or 15 percent of the GNP by the end of the next decade.

According to Dr. Uwe Reinhardt, James Madison Professor of Political Economy at Princeton University, inflation in health care really took off after 1980. The percentage of the GNP spent on health care between 1975 and 1980 rose only 9.6 percent compared with a 16.5 percent increase between 1980 and 1985, measured in constant dollars.

Here are a few quotes from recent articles on the continuing rise in costs:

> "...claims costs since 1985 have been climbing faster than insurance rates. The gap...widened significantly at the end of last year and seems to be getting bigger

as efforts to hold down medical costs have run out of steam."

Wall Street Journal, May 15, 1987

"By the year 2000, we'll probably be devoting 14 to 15 percent of GNP to health care. Physicians will still be the central decision-makers in health-care spending, and will still be very well off. I hope that at least one of my children will be among them."

Dr. Uwe E. Rinhart
"The Real Numbers Don't Add Up to Health-Cost Savings"
Medical Economics, August 24, 1987

"Health care has become one of the powerhouses of the American service economy. Confounding all efforts at cost containment, spending on health has passed $500-billion for the first time this year and is expected to reach 11.4 percent of the gross national product."

New York Times, September 8, 1987

"Health care inflation has proved as stubborn as the common cold. Despite touted remedies and precautions, it strikes every year and no cure is in sight."

Wall Street Journal, September 29, 1987

"The nation spent 10.9 percent of the gross national product on health last year, up from 8.5 percent in 1976. Despite Federal efforts to control costs, Dr. Roper (Head of Federal Health Care Financing Administration) predicted, 'We are going to be spending more of our gross national product on health.'"

New York Times, November 23, 1987

There are several reasons advanced for the increasing cost of health care, among which are the following:

* General inflation on goods and services
* More people insured and broader coverage offered (e.g., mental health, changing legal requirements)
* Aging population
* More aware and more demanding consumers

* New technology: equipment and medicines, e.g., organ transplants and related anti-rejection drugs, CAT scanners, magnetic resonance imagers, lithotripters

* Labor shortage in general and nursing shortage, specifically

* Cost shifting caused by treatment of the indigent

* Changing practices of hospitals and physicians (billing practices, number of treatments prescribed)

* New treatments for Alzheimer's disease and acquired immune deficiency syndrome (AIDS)

* Malpractice insurance costs

* Increased use of medical tests as precautionary measures for potential malpractice claims (defensive medicine)

* An increasingly litigious society

* Decentralized delivery system with many small or independent providers (inefficiencies)

* Impact of medical costs being paid by third parties, i.e., insurance companies, health care organizations and governments. (Individuals therefore do not feel the impact of rising costs on a day-to-day basis.)

None of the above should be singled out, but each contributes to rising health care cost. Some have direct impact on costs while others have indirect impact. Some experts argue that new developments in medicine will have a salutary impact on costs in the long run, while other observers say that these advancements will contribute to higher survival rates which, in turn, will increase the demand for other types of treatments. At any rate, a review of the list of causes indicates the breadth, complexity and depth of this situation.

STATE LAW GOVERNING SCHOOL DISTRICT INSURANCE BENEFITS

School districts are municipal corporations and therefore have only those powers expressly granted by the legislature or those powers which are necessary in order to carry out the expressly granted powers. There are

several sections of law which govern the provision of health care for employees of school districts. Health insurance for common school employees is authorized in RCW 28A.58.420:

> (1) The board of directors of any of the state's school districts may make available...health, health care...insurance...for...employees of the school district, and their dependents. Such coverage may be provided by contracts with private carriers, self-insurance, or self-funding pursuant to chapter 48.62 RCW, or in any other manner provided by law. (2) Whenever funds shall be available for these purposes, the board of directors may contribute all or a part of the cost of such protection or insurance for the employees of their respective districts and their dependents. ...All contracts for insurance...written to take advantage of the provisions of this section shall provide that the beneficiaries of such contracts may utilize on an equal participation basis the services of those practitioners licensed pursuant to chapters 18.22, 18.25, 18.53, 18.57 and 18.71 RCW.

The equal participation basis practitioners referenced in the above cite are podiatrists, chiropracters, optometrists, osteopaths, and physicians.

Self-funded plans are authorized in RCW 48.62.035 which states as follows:

> School districts and educational service districts may either individually or in combination with other such districts, self-fund their employees'...health benefit plans if...the plan is fully covered by an excess loss insurance policy... Self-funded plans shall also comply with the mandatory coverage provisions of chapter 48.44 RCW.

Among mandatory coverage treatments or services in self-funded plans are the following:

Alcoholism/chemical dependency

Podiatrists

Continuing coverage into adulthood for disabled dependents

Registered nurses

Chiropractors

Care for newborn infants and congenital abnormalities from moment of birth

Reconstructive breast surgery and single breast reduction

Continuous coverage for former family members

Non-termination for change in health status of covered person

Parity of reimbursement for the same health care services provided by appropriately licensed practitioners

Optional coverage for home health care, hospice care, and supplemental mental health treatment for insured and dependents

Conversion rights upon termination of group coverage

In addition, RCW 48.46.180 requires that "state government or any political subdivision thereof, which offers its employees a health benefits plan, shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization which provides health care services in the geographic areas in which the employees reside."

RCW 41.04.020 permits school districts to authorize deductions from employee salaries or wages for payment or contribution to "a person, firm or corporation administering, furnishing, or providing...medical, surgical and hospital care or either of them..." if the school board approves of it and such approved authorization is filed with the county auditor or the person authorized by law to draw warrants against school district funds. The cost of any such group policy or plan is not to be considered as additional compensation to the employees (RCW 41.04.190).

School districts are also authorized to make deductions from employee salary or wages for capitation payments to any duly authorized health maintenance organization (RCW 48.46.180). A capitation payment is a fixed amount per capita for an agreed upon set of health services.

While school districts are authorized to use the services of the state's Division of General Administration to procure health benefit programs

(RCW 41.04.220), they are not authorized to participate in any of the programs or plans offered by the State Employees' Insurance Board (RCW 41.04.205). No school districts are currently using the General Administration option.

Another important variable in the consideration of school employee health care is the certificated and classified employees' authority to bargain for such benefits. Certificated employees are those with professional certificates including teachers, counselors, principals, etc. Classified employees include secretaries, custodians, bus drivers, cooks, accountants, data processors, etc.

Classified employees' bargaining is governed by Chapter 41.56 RCW and certificated employees' bargaining is governed by Chapter 41.59 RCW. Classified employees' scope of bargaining includes "personnel matters, including wages, hours and working conditions,..." (RCW 41.56.030(4)). In addition, RCW 41.56.950 states, "Whenever a collective bargaining agreement...is concluded after the termination date of the previous collective bargaining agreement...all benefits included in the new...agreement including wage increases may accrue beginning with such effective date as established by this section."

Certificated employees scope of bargining includes "...wages, hours, and terms and conditions of employment..." (RCW 41.59.020(2)). In addition, RCW 41.59.790 includes the following language:

> (1) Whenever a collective bargaining agreement...is concluded after the termination date of the previous collective bargaining agreement...all benefits included in the new collective bargaining agreement, including wage or salary increases, may accrue beginning with such effective date as established by this subsection, and may also accrue beginning with the effective date of any individual

> employee contracts affected thereby. (2) Any collective bargaining agreement may provide for the increase of any wages, salaries and other benefits during the term of such agreement or the term of any individual employee contracts concerned, in the event that employer receives by increased appropriation or from other sources, additional moneys for such purposes.

Employer provision of insurance benefits, including health benefits, has historically been included in the scope of bargaining.

As was mentioned earlier in this report, school districts are municipal corporations and therefore not state agencies. Local school districts are individual employers--296 of them--covering the entire state. Among those districts are hundreds of bargaining agreements, some for certificated employees and others for classified employees. The three largest school districts alone have over 50 different bargaining agreements with various groups of their employees.

ROLE OF SUPERINTENDENT OF PUBLIC INSTRUCTION (SPI)

The State Constitution designates the superintendent of public instruction as one of the state's elected officials, and states that the superintendent "...shall have supervision over all matters pertaining to public schools..." This has not been interpreted to authorize the superintendent of public instruction to operate school districts on a day-to-day basis.

According to our State Supreme Court, the term "supervision" in the Constitution means more than "to advise" but less than "to control." Pursuant to law, the superintendent may require school districts to formulate their own policies on certain matters, but the superintendent should stop short of prescribing specifics (unless required to do so by statute) or of operating local school districts under normal circumstances.

School districts are creatures of the legislature, and the delivery of education is a responsibility shared by the state and local school districts. General standards are promulgated by the superintendent of public instruction pursuant to law and school districts have received a broad delegation of authority from the legislature to operate the schools. The superintendent of public instruction has steadfastly supported the sharing of responsibility and the maintenance of maximum local control of schools.

Nonetheless, state law relating to the schools has become more detailed and prescriptive in recent years. An example is the limitation on salary and benefits districts may pay their employees. Nowhere in existing law or past law, however, has the superintendent of public instruction been given the authority to define health care, regulate health benefits themselves, or supervise the health care providers or the insurance industry. The superintendent of public instruction has had the responsibility for making budget requests to the governor and legislature, to promulgate rules and apportion and distribute state funds, and to develop school district budget and financial reporting standards and forms (a shared responsibility with the state auditor), among many other duties.

LEGISLATIVELY AUTHORIZED BENEFIT LEVELS

As early as 1969, the legislature earmarked an appropriation to the public schools for the purpose of funding employee health benefits (Chapter 282, Laws of 1969, 1st Extraordinary Session). At that time, the employer contribution for health benefits was statutorily limited to a maximum of $10 per month per employee. During the 1969-70 school year, the appropriation was sufficient for the state to allocate $6 per month per employee to school districts.

Since that initial action, the state appropriation for school employee health benefits has been broadened to cover insurance benefits. Concurrently, the amounts appropriated and the authorized rates per month per employee have increased. More specifically, in 1971, the maximum monthly rate was increased from $10 to $15. In 1973, it was increased to $20. See Appendix 1 for a recent history of legislatively authorized rates. In 1975, allowable coverage was expanded from health benefit to the more general insurance benefits.

Prior to 1979, school employees and state employees generally received different treatment from the legislature in the areas of salaries and benefits. Since 1979, however, the appropriated benefit rate for school employees has been identical to that of state employees. At the present time, the school district appropriation for insurance benefits authorizes a rate of $167 per month per full-time equivalent employee. That same rate is authorized for state employees.

School districts differ in several respects from the state in the manner in which they are authorized to compensate employees. In addition to the authority granted to school employees to bargain for salaries and benefits, the legislature imposed controls on such payments. The salary and benefit controls first were imposed on school districts in the 1981-82 school year. During the prior year some school districts were contributing substantially more than $167 per month for health benefits. Since the controls applied only to increases granted, those higher paying districts have been allowed to continue the higher contribution rate to the present.

Legislative treatment of school employees' salaries and benefits has departed from that of state employees in at least three other respects. In 1984,

the legislature permitted school districts to pay employees at the maximum average rate of $179 per month for insurance benefits, which was $12 per month more than the $167 authorized for state employees and funded for school districts in the appropriations act (Section 505(7)(d) of Chapter 285, Laws of 1984). The additional $12 per month was to come from local school district funds.

Districts which were not already paying above $167 per month, and some districts which were paying at $167 per month or below, exercised the option to pay up to $179 per month. Districts that did not take advantage of the increase to $179 during the 1984-85 school year were not authorized subsequently to increase their insurance benefit level above the greater of their 1984-85 actual level or $167 per month. To the present day, this set of districts is still limited to $167 per month. Salary and benefit limitations for the 1987-88 school year apply only to certificated instructional staff. They no longer apply to certificated administrators or classified employees.

The second departure--an allowed trade-off between authorized salary and benefit increases--was contained in the salary limitation laws first enacted in 1981 to control salaries and benefits paid by school districts to their employees. The 1981 appropriations act contained the following language:

> Insurance benefit increases granted employees shall constitute a portion of the salary increase...whenever a district's contribution to employee insurance benefits will exceed, by virtue of increases provided in 1981-82 or 1982-83, $121 per full time equivalent staff unit in 1981-82 and $137 per full time equivalent staff unit in 1982-83.
>
> Section 92(7)(b) of Chapter 340, Laws of 1981

Paralleling that appropriations act language was the following provision

in substantive law:

> Increases in school district employee fringe benefit contributions by school districts shall be included for purposes of determining salary and compensation increases ...if contributions to fringe benefits provided by a district or, by virtue of the increase, will exceed the amount provided for fringe benefits in the state operating appropriations act in effect at the time the compensation is payable.
>
> Section 2 of Chapter 16, Laws of 1981
> codified as RCW 28A.58.095

RCW 28A.58.095 was repealed by the 1987 Legislature, but a variation on the above theme exists today:

> Fringe benefit contributions for basic education certificated instructional staff shall be included as salary... to the extent that the district's actual average benefit contribution exceeds the greater of: (i) the formula amount for insurance benefits...; or (ii) the actual average amount provided by the school district in the 1986-87 school year ...fringe benefits shall not include payment for unused sick leave..., or employer contributions for old age survivors insurance, workers' compensation, unemployment compensation, and retirement benefits...
>
> Subsection 3(a) of Section 205 of
> Chapter 2, Laws of 1987, 1st Ex. Sess.
> codified as RCW 28A.58.0951

This allowance of a salary-benefit trade-off has provided more flexibility to school employees than is available to state employees in deciding upon the extent of health coverage and other insurance benefits.

The third departure was authorized in the 1987 legislative session. School districts are now authorized to exceed certificated instructional staff salary and benefit limitations by separate contract for additional time, additional responsibilities or incentives. Such separate contracts are called supplemental contracts, provisions of which are bargainable (RCW 28A.58.0951(4)).

EMPLOYEE BENEFIT DATA

The Superintendent of Public Instruction does not receive any data from school districts specifically related to employee health care expenditures. The Accounting Manual for School Districts in Washington State and corresponding standardized school budget and financial reporting forms provide for reporting of the overall expenditures for employee benefits as a single object of expenditure. This has been the case since the 1967-68 school year. Included in this object of expenditure are both certificated and classified employee benefit expenditures in the following two general categories: (1) mandatory benefits including employer retirement contributions, old age and survivors insurance, employer contributions for workmen's compensation (industrial insurance, medical aid and supplemental pension) and unemployment compensation; and (2) permissive benefits (also referred to as insurance benefits) including health, health care, hospitalization, dental care, vision care, salary protection, life insurance, accidental death and dismemberment insurance, disability insurance, cancer insurance, cafeteria plans, contributions to variable employee benefit association (VEBA) plans, etc.

In 1986-87, on a statewide basis, the average full-time certificated school employee received an employer contribution toward insurance benefits of about $175 per month. Because districts have local flexibility within the limitations described earlier, the average amount individual school districts contributed to certificated employees' insurance benefit plans in 1986-87 ranged from a high of $234 per month per full-time equivalent employee to a low of $103. Eighty-eight districts paid under $167 per month, sixty paid $167 per month and 149 districts paid over $167 per month on average. Within districts, insurance benefit amounts vary among

employees and employee groups. Unlike state employees who never see employer paid benefit dollars on their payroll stubs or choose how much of the authorized benefit level to use, school employees have individual choice of how much of their benefits to use, and the amounts and providers or insurers are indicated on their individual payroll stubs.

In 1986-87, on a statewide basis, the average school district classified employee received an employer contribution toward insurance benefits of about $156 per month. The monthly average contribution rate for classified employees in individual school districts ranged from a high of $215 to a low of $34 per month. Two very small districts, each with less than one full-time classified employee, reported no monthly benefit contribution. For that year, 56 districts paid over $167 per month per classified employee, 12 districts paid $167 and 229 districts paid less than $167 on average.

The annual school personnel reporting system (Forms S-275 and S-277) provides an item in which the school districts report the mandatory fringe benefit contributions for each employee and a separate item in which is reported the permissive or insurance benefit contribution for each employee. This report does not provide for reporting a separate amount contributed by the district specifically for health care coverage.

Using the available data, the financial magnitude and expenditure trends for employee benefits in the public schools, in general, can be seen by looking at Appendix 2. Even with the shift of the employer contribution to the Teachers' Retirement System from the state to local school districts beginning in the 1986-87 school year, the proportion of expenditures for benefits has remained reasonably constant.

While it is not possible at the state level to isolate exact cost breakdowns

among specific types of benefits, estimates can be made. Mandatory benefits comprised about two-thirds of the benefit expenditures based on 1986-87 school district budget estimates and annual personnel report data. If one assumes that most but not all of the permissive benefit expenditures are spent for health care, employer health care costs for schools approximated one-third of the benefit expenditures or about 5 percent of all operating expenditures in 1986-87. These health care costs are employer costs only and do not include any additional premium payments made by employees in some districts.

A study of school district group insurance programs was completed in 1980 by William M. Mercer, Inc. for the State Employees' Insurance Board pursuant to Section 24(4) of Chapter 270, Laws of 1979, 1st Extraordinary Session. The 1979 Legislature appropriated $38,000 for the study. Mercer found there were thirty-two carriers providing medical coverage to approximately 69,200 school district employees. At that time, the percent of employees covered by the major providers was as follows:

Blue Cross	45.8%
13 county medical plans	32.2%
5 health maintenance organizations	19.0%
11 insurance companies	2.9%

The Mercer report contained extensive comparisons between school district group insurance programs and their costs, and those offered state employees through the State Employees' Insurance Board. Comparable data have not been collected since that study was performed.

CURRENT SITUATION

Among the major health care providers in school districts today are Blue Cross, Washington Dental Service, Group Health Cooperative, other health maintenance organizations, the thirteen county medical plans (10 affiliated

with Blue Shield), and the Employee Benefits Cooperative (sponsored by Educational Service District No. 101 and coordinated throughout the state by the eight other educational service districts).

During the last few years, these health care providers have incorporated various cost containment measures. Appendix 3 presents a brief outline of changes in the Blue Cross program offered to school district employees through the Washington Education Association (WEA). Appendix 4 presents a brief outline of similar changes made in the ESD 101 Employee Benefits Cooperative since its inception. Appendix 5 contains a brief outline of current plans offered by the Employee Benefits Cooperative and corresponding plan costs.

As in the state employees' insurance plans and many of those across the country, costs have increased. Education employees' costs have increased as well. According to information provided to the Washington Education Association Board of Directors in May 1987, their Blue Cross traditional health care plan increased its rate 20 percent over the prior year and reduced some of the benefits. WEA's Blue Cross Preferred Provider Plan increased its rate for 1987-88 by 32.8 percent and reduced some benefits. The WEA Retiree Under 65 Plan rate increased 14.4 percent and the Retiree Over 65 Plan rose 10 percent, both with some benefit reductions. The WEA Dental Plan rate increase was 6 percent with an additional 5 percent taken from the rate stabilization fund with no benefit changes. The WEA vision plan contemplates neither rate nor benefit changes for 1987-88. The WEA plans have not been singled out for a particular reason. These plans cover the largest number of school district employees in the state and the data were in readily available form.

Since there are so many variables and changes in plans and coverages from year to year, comparisons among providers and plans are difficult to make. See Appendix 6 for a representative school district's health care options and employer contributions for the 1987-88 school year. This is provided to indicate the current rates among plans available in a typical school district. Of course, comparisons among rates are meaningless without a detailed knowledge of the corresponding benefits, deductibles, etc.

Health care premiums for federal employees are also rising. According to the September 21, 1987 issue of Business Insurance, the nation's largest group health insurance program (in excess of 9 million participants) will experience an average cost increase of 32 percent. The increases are attributed to sharp increases in health care costs and health care utilization. Next year there will be 488 health care plans available to federal employees. Plans sponsored by Blue Cross/Blue Shield, which cover about 3 million federal employees and dependents, will experience premium increases ranging between 40 percent and 60 percent.

It is apparent that the issue of health care cost containment is complicated, is of national scope and is a continuing concern. Health care costs have been likened to the proverbial balloon which, when squeezed in one place, pops out in another. Obviously it is not limited to Washington's school employees who comprise about 3 percent of the state's adult population and about 30 percent of state and local public employees. The following recommendations are made recognizing that (1) many of the forces at work are beyond the state's control, (2) this topic is highly technical, and (3) the agency's background in this area and resources under the current structure are very limited.

RECOMMENDATIONS

*Establish an office of health care benefits in SPI with the following duties at a minimum:

Develop uniform definitions and standards to be used to review and analyze health care plans, specific benefits, extent of coverage, etc.

Collect statewide data on health benefit providers, insurers, coverages, costs and cost containment activities and serve as a health care information clearinghouse.

Analyze the extent of double coverage of employees (coordination of benefits) and propose a solution, if needed.

*Establish an employee health care advisory committee to the superintendent of public instruction with representation from management, employees, providers, insurers, etc.

*Encourage or provide incentives to school districts to offer employee wellness programs. Included would be information on such preventive measures as the following:

Routine physical exams

Alcohol and drug control

Smoking cessation

Stress management

Physical fitness

Weight control

Hypertension control

Immunizations

Diet/nutrition programs

Safety awareness, e.g., using seat belts, accident prevention, defensive driving, etc.

Use of sunscreen and protective clothing

Awareness of environmental carcinogens

Use of counseling/psychological assistance

Maternal health and well-child care

*Amend state laws to permit authorization of a health care plan with incentives for employees to make prudent use of medical services. (See Appendix 7 for information on the "Mendocino Plan.")

*Provide comparisons among providers and insurers accompanied by specific related benefits, costs of treatments, frequency of service and cost per unit using established standards for comparison. The health care industry is changing rapidly, which makes such comparisons difficult, but an effort must be made by an objective entity to develop a common basis for comparison. There is need for a law that requires a standard basis for disclosure and comparison, similar to the national "truth in lending law" in the consumer credit industry. A major hurdle is that the health care delivery system is many times more complex than is the loan business. In addition to comparing costs and benefits in a standard way, the quality care issue must also be addressed. Just as quality is demanded of the schools, those who need health care and those who purchase health care have a legitimate interest in the quality of their health care. Indeed, it is the public's top concern, according to numerous opinion surveys concerning health care. In addition, uniform cost comparisons and cost trends among providers and insurers should include data

over at least five years. Given the changes made from year to year, it would be inappropriate to base policy decisions in this area on changes among plan costs over one two-year period.

*Consider the feasibility of establishing an optional, self-funded health care program with adequate, quality coverage available to all state and local public employees in the State of Washington with stop-loss insurance to protect the plan and its subscribers against claims in excess of (1) a defined expenditure threshold per specific claim and (2) a defined aggregate plan expenditure threshold. At a minimum, coverage should include basic and major medical, hospital, vision and dental care.

*Limit school district contributions for health benefits to coverage by group insurance plans.

*Condition receipt of state dollars for insurance benefits on timely submittal of reports requested by the agency.

Consideration was given to requiring districts to offer a high deductible plan with a sliding sc[illegible] for those not able to afford a large payment, similar to Medicare legislation currently before both houses of Congress wh[illegible] would provide protection against health care cost for catastrophic illness. Both House and Senate bills contain a two-tiered premium--one a basic premium and the other an income related supplemental premium. Any plan which requires individuals to make large payments before insurance proceeds are triggered should contain consideration for those not able to pay for such costs. There are several drawbacks to providing such a plan for employees. In the first place, it is designed for Medicare participants, and most employees are younger with families. The health care use patterns are no doubt different. Second, a bureaucracy would

have to be established to keep track of income eligibility standards. Third, the only way such a plan would receive any support from employees is if it were the only plan available. In practice, people generally seek the best coverage obtainable.

Consideration was also given to authorizing school districts to provide employee benefits under plans administered by the State Employees' Insurance Board (SEIB), as is the case for other municipal corporations in this state. This was not recommended for the following reasons: The SEIB programs are experiencing cost increases at least comparable to other plans. Therefore, such a change would have questionable impact on health care costs. Nothing new would be provided to schools by making such a change. In addition, with another in a growing list of health care options for school employees, it is possible people would move from plan to plan from year to year, depending on which plan is the best plan of the moment. This would create underwriting and administrative problems for both systems and contribute additional cost to the program.

Finally, since health care costs affect literally everyone, these recommendations should be considered in the context of the needs for all of our state and local public employees.

APPENDIXES

NINE-YEAR HISTORY OF LEGISLATIVELY AUTHORIZED INSURANCE BENEFIT LEVELS FOR K-12 PER MONTH PER FTE STAFF

1979-80	$85
1980-81	$95
1981-82*	$121
1982-83	$137
1983-84	$159
1984-85**	$167 state + $12 local = $179
1985-86	$167 state + $12 local = $179
1986-87	$167 state + $12 local = $179
1987-88	$167 state + $12 local = $179

*First year of salary compliance. In addition, the legislature allowed school employees a trade-off between increases in district contributions to insurance benefits greater than authorized in the appropriations act so long as that greater increase was counted as part of the salary increase granted for that year.

**Legislature allowed districts to pay up to $179 this year. The trade-off between the increase in employee benefit contribution and the salary increase remained in effect. In addition, the Legislature authorized full-time nine-month classified employees to receive insurance benefit contributions for 12 months which increased this outlay by approximately 15% for basic education employees and 30% for transportation employees.

TOTAL EXPENDITURES AND EXPENDITURES FOR SALARIES
AND EMPLOYEE BENEFITS IN THE PUBLIC SCHOOLS
FOR YEARS INDICATED--GENERAL FUND*
(In millions)

Year	Total	Salary	Benefits	Benefits as Percent of Total Expenditures	Benefits as Percent of Salary	Salary and Benefits as Percent of Total Expenditures
1979-80	$1,739.6	$1,209.6	$176.0	10.1%	14.6%	79.7%
1980-81	1,921.7	1,356.0	199.8	10.4%	14.7%	81.0%
1981-82	1,959.9	1,390.8	210.3	10.7%	15.1%	81.7%
1982-83	1,998.5	1,386.7	221.2	11.1%	16.0%	80.5%
1983-84	2,213.9	1,506.4	256.6	11.6%	17.3%	79.6%
1984-85	2,395.4	1,621.0	284.9	11.9%	17.6%	79.6%
1985-86	2,515.9	1,704.0	305.2	12.1%	17.9%	79.9%
1986-87**	2,875.6	1,816.5	491.5	17.1%	27.1%	80.3%
1987-88**	3,061.8	1,929.7	516.1	16.9%	26.7%	79.9%

*Data for 1979-80 through 1985-86 are actuals from year-end financial reports (F-196). The 1986-87 and 1987-88 figures are from school district budgets (F-195).

**1986-87 is the first year school districts paid the employer contribution to the Teachers' Retirement System. This change is reflected in the large increase in benefit expenditures in 1986-87 and 1987-88 over prior years.

319 Seventh Avenue
Olympia, Washington 98501
206 943 3150

Washington Education Association

Changes made in WEA Medical Plan

1982

Alternative Plan C offered at lower rates
Professional Review Organization (PRO) contracted
Rate increase on 365 Plan - 51%
HealthPlus available in major areas

1983

Medical Plan bid procedure completed - Blue Cross retained
RX copayment increased to $3 from $1
$25 emergency room copayment added
100% coverage for pre-admission testig, skilled nursing facility, home health care, and second opinion surgical consultation.
Hospital benefits changed to 80%/100% from 100%.
Rate increase - 7.5%

1984

10% discount to groups offering only WEA plans (+ one HMO)
Medicare "carveout" for retirees
Rate decrease - 6%

1985

Stop-smoking benefit added
Audio/Hearing benefit added
No rate change

1986

Surgical treatment for morbid obesity added
Surgical treatment for sexual disfuncation
Community Health Agencies added as providers
Preferred Provider plan offered in place of Select Plan II with rates 30% lower than Traditional Plan.
Hospital Utilization Management system added
Traditional Plan (365) rates increased 7.6%

1987

Traditional Plan rates increased 22%
Preferred Plan rates increased 31%
Rx copayment changed to $5 non-generic, $3 generic
Spinal manipulation benefit limited
Co-insurance changed from 80% of first $1250 to 80% of first $2000 for Traditional Plan.
Alconolism/drug dependency benefit modified to comply with state law.

ESD 101 - Employee Benefits Cooperative

Overview of Rate and Plan Changes: 1983-84 through 1987-88

YEAR	RATE	PLAN	BENEFITS/CHANGES	DEDUCT/CO-PAY	MBRS
1983-84	$159 00	'Health Plan'	Medical/Dental/Vision Launched SEIB Plan	$75 00 Deductible $300 00 Co-Pay	5,459
1984-85	$167 00	Plan A/Dental/Vision	Surgical Pre-Authorization Required	$75 00 Deductible $300 00 Co-Pay	
	$162.26	Plan B	Medical Only	- 0.00 - Deductible $250 00 Co-Pay	9,460
1985-86	$167 00	Plan D (167 Plan)	Medical/Dental/Vision Reduced. Dental Benefits Increased. Deductible and Co-Pay	$150 00 Deductible $1,000.00 Co-Pay	232
	$179 00	Plan 179	Medical/Dental/Vision Reduced. Dental Benefits	$75.00 Deductible $300.00 Co-Pay	3,266
	$199 69	Plan A/Dental/Vision	Reduced. Alcoholism/Drug Abuse	$75.00 Deductible $300.00 Co-Pay	2,510
	$162.26	Plan B	Medical Only Reduced: Alcoholism/Drug Abuse	- 0.00 - Deductible $250 00 Co-Pay	2,473
	$163 85	Plan C	Preferred Provider Medical Only King, Pierce & Snohomish Area	$50.00 Deductible - 0.00 - Co-Pay	39
	$39 25 $9 81	Dental Vision	Dental/Vision Benefits Only		3,150
				TOTAL	11,700
1986-87	$179 00	Plan 179	Increased: Preferred Hospital Co-Pay Waiver, Preventive Care Reduced. Dental Coverage	$75.00 Deductible $300 00 Co-Pay	1,541
	$207 98	Plan A/Dental/Vision		$75 00 Deductible $300 00 Co-Pay	1,508
	$181 73	Plan B	Reduced Surgical Pre-Authorization Required	- 0 00 - Deductible $250 00 Co-Pay	1,842
	$148 77	Plan C - Preferred Provider	King, Pierce & Snohomish Area	-$50 00 Deductible - 0 00 - Co-Pay	81
	$148.77	Plan C - Preferred Hospital	Washington State except for King, Pierce & Snohomish Area	0 00 - to $75.00 Deductible - 0 00 - to $300 00 Co-Pay	1,359
	$41 75 $9 81	Dental Vision	Dental/Vision Benefits Only		3,604
				TOTAL	9,965
1987-88	$179 00	Plan 179	Reduced. Dental to Preventive Care Only, Spinal Manipulations Increased. Prescription Co-Pay for Non-Generic Drugs, Alcoholism Treatments, Deductible and Co-Pay	$250.00 Deductible $500 00 to $1,000 00 Co-Pay	N/A *
	$220 42	Preferred (Plans A & C)/Dental/Vision	Reduced. Dental Increased. Preferred Provider and Preferred Hospital Plans Combined	- 0 00 - to $75.00 Deductible - 0 00 - to $300 00 Co-Pay	N/A *
	$221.27	Choice (Plan B)	Reduced Spinal Manipulations Increased: Prescription Co-Pay for Non-Generic Drugs, Alcoholism Treatments, Co-Pay	- 0.00 - Deductible $400 00 Co-Pay	N/A *
	$32.53 $9 32	Dental Vision	Reduced: Dental Benefits. Vision and A, D & D Rates Reduced With No reduction in Coverage.		N/A *

EBC Employee Benefits Cooperative

"Providing the best coverage for the lowest cost"

EBC announces benefit changes for 1987-88

The following is an outline of benefit and rate changes for the Employee Benefits Cooperative Plans for 1987-1988.

The benefits for **Plan A** have been combined with **Plan C** benefits. The newly combined plan is the **PREFERRED PLAN**.

Plan B is now the **CHOICE PLAN**.

In order to maintain a $179 rate for the **$179 PACKAGE PLAN**, deductibles and co-payments have been increased, and dental benefits have been reduced.

The **DENTAL PLAN** rate has been modified to a basic plan for a lower rate.

The **VISION PLAN** rate has been decreased by 5%.

The Cooperative is committed to providing the best medical care possible at the lowest cost to the employee. This year's renewal actions have resulted in sound, basic, health care plans at very competitive rates.

ALL MEDICAL PLANS

- Alcoholism and drug addiction treatment changed to:
  - ✔ alcoholism treatment; $5,000 during any 24-month period, $10,000 lifetime maximum
  - ✔ drug addiction treatment; $1,000 during each contract period
- Chiropractic coverage modified
  - ✔ spinal manipulations limited to 15 per calendar year
  - ✔ all other chiropractic services covered as any other benefit
- Prescription drug benefit modified
  - ✔ $3 co-payment for generic drugs
  - ✔ $5 co-payment for non-generic drugs

CONTINUING SPECIAL BENEFITS

- Experimental organ transplant coverage
- Preventive care - preferred provider plans
  - ✔ annual physical examinations for employee and spouse
  - ✔ well baby care to age one
  - ✔ immunizations through age six
- Only one year required for retirement plan elegibility

CHOICE PLAN (formerly Plan B)

- Co-insurance increased to 80% of first $2,000.

PREFERRED PLAN (formerly Plans A and C)

- Options for choice between the preferred and non-preferred providers:
  - ✔ preferred provider physician - no deductible, 85% of first $2,000 co-payment
  - ✔ preferred provider hospital - 100% coverage after $75 annual deductible
  - ✔ non-preferred physician and hospital - $75 annual deductible and 85% of first $2,000 co-payment
- Preventive care covered with preferred physicians
- Immunizations covered through age six

$179 PACKAGE PLAN

- **Medical** - Deductible and co-payment increased:
  Options for choice of preferred or non-preferred providers:
  - ✔ preferred provider physician; $250 deductible per person with $750 family maximum and 90% of the first $5,000 co-payment
  - ✔ preferred provider hospital; 100% of coverage after deductible
  - ✔ non-preferred physicians and hospitals; $250 deductible per person with $750 family maximum and 80% of the first $5,000 co-payment
  - ✔ preventive care covered with preferred physicians
- **Dental** - Coverage modified to preventive care only: Routine examinations, x-rays, cleaning, flouride treatment
- **Vision** - Removal of the restriction on frame replacement of "only to accomodate replaced lenses"

RETIREMENT PLAN

- Incorporated into the Preferred Plan
- Supplementary Medicare plans available

(over)

DENTAL PLAN BENEFITS MODIFIED

- Maximum benefit has increased to $1,500 (from $1,250)
- Previous dental coverage is no longer required
- Diagnostic and preventive care (routine exams, x-rays, cleaning, flouride treatment and sealants):
  - ✔ incentive level increased to a contstant 100% for all subscribers
  - ✔ no yearly exam requirement
- Basic care
  - ✔ fillings, oral surgery, peridontics and endodontics at a constant 70% co-payment
- Major care
  - ✔ crowns, inlays, onlays, bridges and dentures at a constant 50% co-payment
- Annual deductible on basic and major care
  - ✔ $25 with a $75 family maximum
- Orthodontia for dependents available as a group option
  - ✔ $1,500 maximum
  - ✔ $100 deductible

VISION PLAN

- Reduced rates
- Increase in frame replacement benefit
  - ✔ no longer restricted to "only to accomodate replaced lenses"

These are the official changes to the existing plans for the 1987-1988 year.

If you would like further information, would like to schedule a presentation for your district or have questions regarding the changes, please contact Gwen Hershiser, EBC Coordinator or Pat Harkins at ESD 101, (509) 456-6320 or SCAN 545-6320.

EMPLOYEE BENEFITS COOPERATIVE MEDICAL PLANS
October 1, 1987 - September 30, 1988

	CHOICE PLAN (formerly B)	PREFERRED PLAN (formerly A & C)			$179 PACKAGE PLAN		
		Preferred		Non-preferred	Preferred		Non-preferred
Benefits		Physician	Hospital	Provider	Physician	Hospital	Provider
Revolving 5-year maximum	$1,000,000	Same			Same		
Annual deductible	None	None	$75/225	$75/225	$250/750	$250/750	$250/750
Co-payments	80% of $2000	85% of $2000	100% coverage	85% of $2000	90% of $5000	100% coverage	80% of $5000
Preventive Care (annual physical exam, well baby, immunizations)	Not covered	Covered	Covered	Not covered	Covered	Covered	Not covered
Prescriptions	$3 generic $5 non-generic	Same Same		Same Same	Same Same		Same Same
Organ Transplants	Covered	Covered		Covered	Covered		Covered
Life & Accidental Death & Dismemberment	$10,000 (level term)	Same		Same	Same		Same
Retirement Eligibility	One year	Same		Same	Same		Same
Rates:	Full / Discount	Full / Discount					
Employee	$112.74 / $101.47	$ 91.43 / $ 82.29					
Employee + spouse	223.13 / 200.82	180.01 / 162.01					
Employ+spouse+children	269.83 / 242.85	217.65 / 195.89					
Employee + children	159.44 / 143.50	128.60 / 115.74					
Composite	By group	By group			(Includes vision and preventive dental coverage) $179.00		

Dental Plan Rates	32.53	(Dental and Vision Plans are available either
Dependent orothodontia	5.62	with EBC Medical Plans or separately)
Vision Plan Rates	9.32	

SAMPLE SCHOOL DISTRICT

1987-88 INSURANCE RATES

OPEN ENROLLMENT: September 1 through October 10 for all employees.

NEW EMPLOYEES: Must enroll for optional benefits within 30 days of employment.

CHANGES: Must be made by tenth of month to be effective the first day of following month.

ENROLLMENT: Brochures and enrollment forms available through the Personnel Office.

QUESTIONS: Please direct any questions regarding coverage to that particular insurance company.

XXX County Medical

Employee Only	$88.20	(w/ 1 child $131.50)	(w/ 2 children $174.80*)
Employee & Spouse	176.40	(w/ 1 child $219.70)	(w/ 2 children $263.00*)

*First and second child are $43.30 each. No additional charge for more than two children.

Blue Cross Medical

	Traditional	Preferred	Health Plus w/ Vision
Employee	$113.60	$ 96.65	$ 88.79
Employee & Spouse	222.50	188.85	186.35
Employee, Spouse & Children	268.50	227.85	257.87
Employee & Children*	159.60	135.65	152.47

*Any number of children. Group term Life and Accidental Death and Dismemberment premiums are included in health insurance coverage.

Group Health Medical

Employee Only	$85.91	(w/ 1 child $133.66)	(w/ 2 children $181.41*)
Employee & Spouse	171.82	(w/ 1 child $219 57)	(w/ 2 children $267.32*)
Dependent Child over 21 yrs.	85.91		

*First and second child are $47.75 each. No additional charge for more than two children.

Mandatory Life Insurance w/ Group Health Medical: $1.63/month for employee only. $2.13/month for employee and dependents. Subscribers can choose which plan desired. (No. Amer. Life)

Dental

Dental coverage is mandatory for all employees eligible for medical benefits.

Certificated Dental	$46.35	(Family - with orthodontia)
Secretaries (XAEOP)	39.65	(Family - no orthodontia)
Educational Assistants	22.05	(Employee only - no orthodontia)
Teamsters Dental	21.55	(Family - with orthodontia)
Food Service	22.05	(Employee only - no orthodontia)

Salary Insurance

Brochures on coverage and rates available at the Personnel Office.

XEA members have a mandatory long-term disability salary insurance (Mutual Benefit Life Insurance Co.) which is $7.60 per month. Optional short-term disability salary insurance is available to XEA members. Brochures and rates for this are available at the Personnel Office.

Life Insurance

TransAmerican Occidental Life Insurance coverage is mandatory for all XEA members. Monthly premium is $1.75 and is deducted from district contribution.

1987-88 District Benefit Contribution by Bargaining Unit

Amount indicated in brackets "( )" is amount remaining that district will contribute for medical and/or salary insurance after the mandatory coverage noted is deducted.

Classified:

Secretaries: Mandatory coverage is $39.65 for dental insurance.

$179.00	($139.35)	12-month, middle and high school secretaries
$150.00	($110.35)	9-month and elementary school secretaries
$120.00	($ 80.35)	9-month/6 hours per day - pod secretaries
$ 89.50	($ 49.85)	9-month/half-time secretaries

Educational Assistants: Mandatory coverage is $22.05 for dental insurance.

$117.00	($ 94.95)	6 1/2 + hours
$101.00	($ 78.95)	5 1/2 - 6 hours
$ 83.00	($ 60.95)	4 1/2 - 5 hours
$ 67.00	($ 44.95)	4 hours

Food Service: Mandatory coverage is $22.05 for dental insurance.

$138.00	($115.95)	7 + hours
$111.50	($ 89.45)	4 - 6 1/2 hours
$ 55.00	($ 32.95)	3 - 3 1/4 hours
$ 45.00	($ 22.95)	2 - 2 1/4 hours

Teamsters: Mandatory coverage is $21.55 for dental insurance.

$219.00	($197.45)	12-month
$160.00	($138.45)	9-month
$ 60.00	($ 38.45)	substitutes (eligible after working three (3) consecutive months of sixty (60) hours per month.)

Unrepresented:

$179.00

(1987-88 District Benefit Contribution by Bargaining Unit, Continued)

Certificated:

XEA Members: Mandatory coverage is $55.70. (Dental, $46.35; Life, $1.75 and Long-term Disability insurance, $7.60)

$179.00	($123.30)	1.00 FTE or 12-month
$148.60	($ 92.30)	.83 FTE
$125.00	($69.30)	.66 FTE
$ 89.50	($ 33.80)	.50 FTE

Administrators and Principals: Mandatory coverage is $46.35 for dental insurance.

$179.00	($132.65)	1.00 FTE or 12-month
$148.60	($101.65)	.83 FTE
$125.00	($ 78.65)	.66 FTE
$ 89.50	($ 43.15)	.50 FTE

PUBLIC SCHOOLS
COMPARISON OF MEDICAL BENEFITS
1987/1988 SCHOOL YEAR

COVERAGE	COUNTY MEDICAL	GROUP HEALTH COOPERATIVE OF PUGET SOUND	WEA-BLUE CROSS HEALTHPLUS	WASHINGTON EDUCATION ASSOCIATION PLANS WEA-BLUE CROSS PREFERRED PROVIDER PLAN	WEA-BLUE CROSS TRADITIONAL PLAN
		The following benefits will be provided for covered conditions and procedures. Except as noted, all care and services must be approved by and provided thru GHC staff and facilities to be covered.	Each family chooses one Participating Provider within 20 miles of home and then chooses a Personal Care Physician from their Provider Group. All health care services must be provided or authorized by the Personal Care physician, including specialist referrals.		
PHYSICIAN SERVICES		At GHC or GHC designated facility:		Preferred / Non-preferred	
Office Calls	35 outpatient calls/year	Provided in Full	Paid in Full-Partic. Provider only	Paid in Full / 80% of UCR*	Covered under Major Medical
Hospital Visits	Inpatient covered for 365 days/yr.	Provided in Full	Paid in Full-Partic. Provider only	Paid in Full / 80% of UCR*	Covered under Major Medical
Home Calls	Counted in the 35 calls/year	Provided in Full by GHC when medically necessary & within GHC service area.	Paid in Full after $15 copay	Paid in Full / 80% of UCR*	Covered under Major Medical
Surgery	Paid in Full	Provided in Full	Paid in Full-Partic. Provider only	Paid in Full / 80% of UCR*	Paid at 80% of UCR*
				Mandatory Second Surgical Opinion paid in full in both Preferred and Non-Preferred plans - same as Traditional Plan.	Mandatory Second Surgical Opinion required on certain procedures. Surgeon will not be paid if requirement not satisfied (see booklet for list of procedures).
Preadmission Testing	Paid in Full	Provided in Full	Paid in Full-Partic. Provider only	Paid in Full / Paid in Full	Paid in full if within 72 hours of admission
Assistant Surgeon	Paid in Full	Provided in Full	Paid in Full-Partic. Provider only	Paid in Full / 80% of UCR*	Paid at 80% of UCR*
Anesthesia	Paid in Full	Provided in Full	Paid in Full-Partic. Provider only	Paid in Full / 80% of UCR*	Paid at 80% of UCR*
Diagnostic X-ray/Lab	Paid in Full	Provided in Full	Paid in Full-Partic. Provider only	Paid in Full / 80% of UCR*	Paid at 80% of UCR*
Radiation Therapy	Paid in Full	Provided in Full	Paid in Full-Partic. Provider only	Paid in Full / 80% of UCR*	Paid at 80% of UCR*
Physical Therapy	Paid under Major Medical at 80% for 10 visits. Additional benefits will be approved if prescribed by attending physician.	Provided in Full	Paid in full up to 25 visits each condition-Partic. Provider only	Paid in Full / 80% of UCR*	Paid at 80% of UCR*
Ambulance	$80 one way/condition, balance at 80% under Major Medical	Allowance up to $1000/emergency. $50 deductible per emergency for transportation to non-GHC designated facility.	Paid in full after $25 copayment (50% copayment for air ambulance).	Paid in Full / 80% of UCR*	Paid at 80% of UCR*
Maternity	Paid in Full	Provided in Full	Paid in Full-Partic. Provider only	Paid in Full / 80% of UCR*	Paid at 80% of UCR*
Well Child Care	Not Covered	Provided in Full	Paid in Full-Partic. Provider only	Not covered except for routine infant nursery care while mother is hospitalized	Not covered
Routine Physicals	Not Covered	Provided in Full	Paid in Full-Partic. Provider only	Not covered	Not covered
Eye Exam	1 eye exam each two years paid in full	Provided in full, except for cosmetic contact lenses. Contact lenses provided in full for eye pathology.	One every 2 years paid in full. Frames & lenses or contact lenses-once every 24 month period up to $140. Partic. Provider only	Not covered	Not covered
Podiatry	Counted in 35 calls/year by participating practitioner.	Provided up to $200 per contract year for services of licensed chiropractors, podiatrists, & osteopaths for covered services not available at GHC. Costs over $200 covered when referred by a GHC physician prior to treatment.	Not covered	Not covered	Paid at 80% of UCR*
Audio (Hearing Care)	Not Covered	Diagnostic hearing exams provided in full.	Hearing screening paid in full. Participating Provider only.	80% to a maximum of $400 during 3 consecutive years.	80% to a maximum of $400 during 3 consecutive years.
Stop Smoking Benefit	Not Covered	Smoking withdrawal program provided at GHC for minimal fee.	No benefit	Employee/spouse only: 50% of actual expenses to $250 lifetime maximum.	Employee/spouse only: 50% of actual expenses to $250 lifetime maximum.

*Blue Cross determines UCR (usual, customary & reasonable)

COVERAGE	PUBLIC SCHOOLS: COUNTY MEDICAL	PUBLIC SCHOOLS: GROUP HEALTH COOPERATIVE OF PUGET SOUND	WASHINGTON EDUCATION ASSOCIATION PLANS: MEA-BLUE CROSS HEALTHPLUS	WASHINGTON EDUCATION ASSOCIATION PLANS: MEA-BLUE CROSS PREFERRED PROVIDER PLAN	WASHINGTON EDUCATION ASSOCIATION PLANS: MEA-BLUE CROSS TRADITIONAL PLAN
HOSPITAL				Preadmission Review: Enrollee must have his/her physician or hospital contact the Plan to determine if an inpatient admission is necessary. If not requested, a $100 hospital inpatient copayment penalty will be imposed.	All hospital admissions must be authorized by Blue Cross. If an emergency admission, Blue Cross must be notified within 48 hours of admission. $100 copayment will be assessed prior to benefit payment for non-compliance.
Room & Board	Semi-private t $200/day for 365 days per year. Balance up to $210 covered under Major Medical.	At GHC or GHC designated facility: Provided in full including private room when prescribed by GHC physician.	Paid in full-Partic. Provider only	Paid in full 80% of UCR*	80% of average semi-private rate for 365 days/year.
Intensive Care	Semi-private plus add'l $200/day	Provided in full	Paid in full-Partic. Provider only	Paid in full 80% of UCR*	Paid at 80% of UCR*
Ancillary Charges	Paid in full	Provided in full	Paid in full-Partic. Provider only	Paid in full 80% of UCR*	Paid at 80% of UCR*
Outpatient Accident	Paid in full if treated within 72 hours for 60 days, balance under Major Medical	Provided in full. (Emergency care at non-GHC designated facility is subject to $10 deductible.)	Surgery paid in full; emergency room charges paid in full after $25 copayment (waived if admitted to hospital)-Participating Provider only.	Paid in full 80% of UCR*	$25 deductible per visit; treatment must begin within 30 days. Paid in full if hospitalized. Certain elective procedures must be performed on outpatient basis. Approval for inpatient must be obtained or surgeon benefits will not be provided.
Emergency Illness	Paid in full	Provided in full (Emergency care at non-GHC designated facility is subject to $100 deductible.) $25.00 copayment/ visit for use of emergency room at GHC or GHC designated facility.	Participating Physician only-paid in full; emergency room paid in full after $25 copayment (waived if admitted to hospital)	$25 deductible per visit; Paid in full if hospitalized.	$25 deductible per visit; Paid in full if hospitalized.
Durable Medical Equipment	80%	Ostomy supplies, temporary orthopedic appliances for up to 6 months; oxygen and oxygen equipment when ordered by GHC physician; other durable medical equipment not covered. Prosthetic devices provided in full when authorized & listed as covered in GHC Prosthetic Device Formulary.	For purchase or rental as authorized by HealthPlus, member pays 20% of charges for equipment prescribed by HealthPlus physician.	Paid in full 80% of UCR*	Paid at 80% of UCR*
Neuropsychiatric	In-and Outpatient Combined: Paid in full to $500 for M.D., Ph.D., mental health center and outpatient state state mental hospital.	Inpatient - Not covered. Outpatient - 10 calls in full, next 10 50/50. After total of 20 visits per calendar year, enrollee pays all charges.	Member pays 20% of charges, including professional visits, to a maximum of 30 days per calendar year and 100% thereafter. Participating Provider only.	Inpatient - same as any other but paid at 80% of UCR* Outpatient - constant 50% to 50 visits/calendar year	Inpatient - same as any other condition. Outpatient - 50% to annual maximum of 50 calls
Alcoholism/Drug Abuse Treatment	Paid at 80% to $5,000 maximum in any 24 consecutive month period; lifetime maximum of $10,000. Applicable to alcoholism treatment only; no drug abuse treatment covered.	Paid to $5,000 in any 24 consecutive month period; lifetime maximum of $10,000.	Paid in full up to $5,000 maximum in any 24 consecutive month period; lifetime maximum $20,000 Detoxification treatment for alcoholism or drug abuse covered same as any other condition. Participating Provider only.	Limited to treatment in a hospital or alcohol treatment facility to $5,000 during any 24 consecutive month period for treatment of alcohol dependency, to $20,000 lifetime maximum.	Limited to treatment in a hospital or alcohol treatment facility to $5,000 during any 24 consecutive month period for treatment of alcohol dependency, to $20,000 lifetime maximum.
Chiropractic Service	Counted in the 35 calls/year. Reimbursement not to exceed the amount which would have been paid to a participating physician.	Same as Podiatry, except services of designated providers must be used when available in the GHC service area.	50% of charges, including X-rays, to $250 maximum per calendar year. Member pays 100% thereafter. Participating Provider only.	Paid at 80% up to $1,250 in charges per calendar year.	Paid at 80% up to $1,250 in charges per calendar year.
Prescription Drugs	$3.00 deductible per prescription or refill.	Inpatient - Provided in full. Outpatient - most drugs are covered in full when prescribed by a GHC physician and obtained at a GHC pharmacy.	$3 copayment per 34-day or 100 doses. Oral contraceptives limited to 30-day supply. Prescription must be from a HealthPlus physician and dispensed at a participating pharmacy.	Covered in full after: $5 copayment for non-generic drugs, or $3 copayment for generic drugs when dispensed by a Blue Cross participating pharmacy.	Covered in full after: $5 copayment for non-generic drugs, or $3 copayment for generic drugs when dispensed by a Blue Cross participating pharmacy.

*Blue Cross determines UCR (usual, customary & reasonable)

COVERAGE	PUBLIC SCHOOLS: COUNTY MEDICAL	PUBLIC SCHOOLS: GROUP HEALTH COOPERATIVE OF PUGET SOUND	WASHINGTON EDUCATION ASSOCIATION PLANS: WEA-BLUE CROSS HEALTHPLUS	WASHINGTON EDUCATION ASSOCIATION PLANS: WEA-BLUE CROSS PREFERRED PROVIDER PLAN	WASHINGTON EDUCATION ASSOCIATION PLANS: WEA-BLUE CROSS TRADITIONAL PLAN
Home Health Care	130 visits for approved nurses & therapists. $5,000 maximum per year.	Provided in full for services of health care professionals when authorized.	Paid in full-Partic. Provider only	Paid in full following hospitalization.	Paid in full following hospitalization.
Hospice	6 months - $5,000 maximum per year.	Provided in full	Paid in full-Partic. Provider only	Individual case management	Individual case management
Major Medical	$300,000; no limit on Basic Benefits	N/A	N/A	$1,000,000	$1,000,000
Medical Deductible	None	None - unless specifically noted.	N/A	None	None
Restoration	Full basic benefits renew automatically. Basic benefits consist of doctor, hospital, X-ray & lab and accidents.	N/A	N/A	N/A	N/A
Stop Loss	80% to $2,500; 100% thereafter.	Not applicable - most items are fully covered. Refer to benefit brochure for limits.	N/A	Preferred: Plan pays 100% except as specified. Non-preferred: Plan pays 80% of first $5,000 in charges; 100% thereafter.	80% of the first $2,000 of covered charges each calendar year; 100% thereafter.
Pre-existing Conditions	No benefits paid for 6 months after coverage begins for any condition which existed within the 6 months prior to effective date of coverage. Waiting period waived during open enrollment in September and October each year.	Covered in full Note: Group Health Cooperative of Puget Sound is a non-profit health maintenance organization providing health care on a pre-payment basis. As a direct service program, the Cooperative is dedicated to bringing its subscribers and dependents quality medical and hospital care, including preventive medical services.	N/A	N/A	N/A

SUMMARY OF RATES

	COUNTY MEDICAL	GROUP HEALTH COOPERATIVE OF PUGET SOUND	WEA-BLUE CROSS HEALTHPLUS	WEA-BLUE CROSS PREFERRED PROVIDER PLAN	WEA-BLUE CROSS TRADITIONAL PLAN
Employee	$ 88.20	$ 85.91	$ 88.79	$ 96.65	$113.60
Employee + Spouse	176.40	171.82	186.35	188.85	222.50
Employee + Spouse + 1 Child	219.70	219.57	257.87	227.85	268.50
Employee + Spouse + 2+ Children	263.00	267.32	257.87	227.85	268.50
Employee + 1 Child	131.50	133.66	152.47	135.65	159.60
Employee + 2+ Children	174.80	181.41	152.47	135.65	159.60

Students age 19-23 each $43.30. Over age 20, adult rate applies.

NOTE:

This is our comparison of rates and benefits. The actual insurance company material will contain the contractual provisions and supersedes anything contained herein. The rates quotes are based upon the information furnished.

MENDOCINO COUNTY LOUIS DELSOL SUPERINTENDENT OF SCHOOLS
2240 EAST SIDE ROAD ■ UKIAH, CALIFORNIA 95482

1985

AN INTRODUCTORY MESSAGE FROM
LOUIS DELSOL, SUPERINTENDENT
MENDOCINO COUNTY SCHOOLS

Seven years ago the Mendocino Staywell health plan was put into place to provide health and hospitalization benefits to the 170 employees and their dependents at the Mendocino County Schools Office. Since that time this original plan has been expanded to cover not only a larger county schools staff but also the 800 plus employees of nine other school districts within Mendocino County.

This desire of others to be covered by the plan is, we believe, a sign of its success. And there is other evidence to indicate that the plan has yielded substantial benefits to those of us who pioneered Staywell. Those benefits have been both financial and attitudinal. Our office simply has more money available to it from interest earned on the way we handle health plan money. In addition, we feel there is evidence to show that Staywell has made enough of our employees "careful cost-incurrers" to keep our premiums lower than comparable coverages of other plans in other public agencies in California.

Also, there is a growing awareness of the wellness living, of incorporating fitness routines and improved diets in the life-styles of our employees. We attribute much of this attitudinal change to the incentive in the plan and to the health literature which is now an integral part of Staywell.

Perhaps the most far reaching effect to come out of our experience with the adaptable plan has been our other efforts at cost containment. Staywell now brings work forces from several school agencies together. Administrators, teachers and clerical persons all sit down to make health plan decisions together. This group is currently working on ways to make preferred providers and pre-hospitalization reviews integral parts of our plan. These efforts are succeeding.

In sum, Staywell has benefits in and of itself. But it gains real power as the cornerstone of a comprehensive effort that includes health education and cost containment efforts such as preferred providerships and pre-hospitalization review. And we feel there are still other ways to keep the cost of health care in check and we're determined to find them, develop them, and make them a part of our overall health plan effort.

LGD:mlh

707/462-2345

General Information

Employes Who Stay Healthy Save Money With This Self-Insurance Plan

BY LOUIS DELSOL

AS BOSTONIANS expect a parade on St. Patrick's Day, and New Orleanians prepare for revelry during Mardi Gras, we Californians brace for passage of spending and funding lids on Election Day. So, as a result of Propositions 13 and 4, Mendocino County (California) school officials have invented a way to save school dollars through a new approach to health insurance coverage. And any school system can do it—without adding a single staff member or spending one additional dollar.

Our self-insurance plan with its unique "stay well" incentive contains remarkable advantages for the school system, its employes, and the insurance company.

How the plan works: Under the standard health insurance coverage that Mendocino County schools previously purchased, we would have had to pay $203,000 for full, or "first-dollar," coverage for our 160 employes. That entire amount, of course, would have been paid to an insurance company. Under our new plan, we have budgeted the same $203,000 for health coverage, but we'll put $80,000 of that into a "local health account," keeping it under our control. We will pay the remaining $123,000 to an insurance carrier (Blue Shield), contracting for a $500-deductible group policy for major medical coverage. In other words, the schools will pay (from our local health account) the legitimate costs for the first $500 of an employe's yearly medical expenses. The insurance company will cover any costs in excess of that amount. So as not to be bogged down in paperwork, we've contracted with a local medical consulting agency to handle all claims, bill processing, and other administrative tasks.

How the employe wins: The key to the plan is its "stay well" incentive, a feature that seldom is part of conventional group health plans. The schools allocate $500 annually for each employe (a total of $80,000 in our case); this is deposited in a local health account. If the employe does not spend the entire amount during one year, the amount not used will be carried over to the following year. Because he need use only $500 from his account in any one year—Blue Shield covers anything above that amount—the employe carries ahead any unused amounts from previous years.

On leaving our employment, the employe may take as "severance pay" any unspent amount that has accrued to his name in the local health account, or he may buy into the program after leaving his job. So: If someone works for the Mendocino schools for five years and maintains a perfect bill of health, on leaving the schools he'll receive $2,500. (We do not officially call this money severance pay because the health insurance package is not legally considered salary. Of course, on leaving the schools and receiving the unspent health premiums, the employe is expected to report this income to the I.R.S.)

YOUR VERDICT, PLEASE

Here's an article you may find controversial. Let us—and your colleagues in school management—know whether you love it or loathe it. Turn to the postage-paid card facing page 42, and give us your verdict. We'll publish the results in a later issue of THE EXECUTIVE EDUCATOR

We believe employes will be careful not to incur frivolous medical expenses (because they stand to benefit from unspent funds). To allay criticism that the plan discourages sound practices of preventive medicine, we provide each employe with a booklet prepared by Blue Shield, which describes conditions under which people ought to seek medical care.

How the employer benefits: First, the employer gains the interest earned on the funds deposited annually in the local health account. And because we're assuming that *all* employes will not spend the *entire* $500 deposited in their names, we'll realize additional interest over the years from the unspent accumulations. This interest money will help us realize our major goal for the plan: to "reuse" dollars budgeted for health insurance so that money becomes available for educational programs and services. (We stand to earn from $500,000 to $750,000 over the next decade.)

An indirect savings will come from the "sheltering" feature made possible by the local health account. In our new plan, only the $123,000 that we pay to Blue Shield, which amounts to about 60 percent of our total health insurance bill, will be subject to inflation. Had we continued our old policy, the full $203,000 would have been affected. Our local health account, then, will shelter approximately 40 percent of our health insurance costs from inflation. And at the double-digit inflation rates currently being passed on to consumers by health insurance carriers, that savings can be substantial.

How the insurance carrier benefits: According to people who watch the industry, one of the main fears in the insurance business today is that it is going to price itself right out of the market, allowing the government to come in as the only health insurer. The self-insurance feature makes private insurance programs more affordable.

To the best of our knowledge, Mendocino County schools are the first in California to devise a self-insurance policy for its employes. One important tip for some schools: While talks were under way with Blue Shield, our central office kept employe representatives apprised of progress; other school systems that might want to consider similar self-insurance plans probably will have to negotiate with their teacher union because health insurance usually is a negotiable fringe benefit.

Any size school system ought to be able to adopt a health insurance plan like ours in Mendocino County. For more details, write to me at 589 Low Gap Road, Ukiah, Calif. 95482. Also, the Group Sales Division of Blue Shield in San Francisco can provide further information. ■

Louis Delsol is superintendent of schools in Mendocino County, Ukiah, Calif.

Here's Your Verdict

Opinions, some skepticism

Readers Applaud Superintendent's Stay-well Health Insurance Plan

COST-CONSCIOUS school executives (and what self-respecting administrator *isn't* cost-conscious, these days?) overwhelmingly approve of a stay-well health insurance plan now being used in Mendocino County (California) schools. (Superintendent Louis Delsol wrote about the plan in our February issue.)

Under the Mendocino medical insurance program, the amount of money paid to the school system's insurance carrier was slashed and the savings placed in a local account that pays the first $500 of any employe's legitimate medical costs. The school system then earns interest on the unspent balance, and employes who don't use their annual $500 allotment receive the accumulated money as a bonus when they leave the school system. Delsol says the cash bonus acts as an incentive for employes to stay healthy.

Ninety-three percent of readers responding to our call for "Your Verdict, Please" thought Delsol's stay-well insurance plan was a healthy idea for ailing school budgets. This comment from a superintendent in California is typical: "With [illegible] dollar cuts we face in California schools, this is a good way to reduce expenditures and make a few bucks at the same time. Also, it appears to be a way of recognizing those staff members who don't 'take advantage' of their fringe benefits."

Most school people who endorsed the Mendocino County plan cited financial advantages. "Schools have been paying for insurance of all kinds for far too long," says a Washington superintendent. "I'm for any innovation that allows schools to spend a greater portion of the budget on students." An Iowa reader agrees: "It's one way to break the cycle of constantly increasing medical insurance costs. And we should take advantage of any break we can find." From another reader: "The stay-well plan seems an excellent way to reapportion insurance dollars. In fact, I'd be in favor of examining a plan that allows a district to be totally self-insured." And from a former teacher: "I agree with the concept from the employe viewpoint. Personally, I would have liked receiving a lump-sum severance 'bonus.' As it turned out, I taught for ten years and never once used Blue Cross/Blue Shield or any other insurance. True, I *was* healthy; but I sure could have used the cash for other things when I changed jobs."

Besides financial considerations, readers also noted other pluses of the stay-well plan. "It should reduce abuse of sick leave," says a Utah reader. "Perhaps school people will learn to be more responsible for their own health," says an administrator in Indiana, who adds: "Industry already is beginning to pick up on this, maybe such an incentive is just the prod we need." From a Michigan administrator: "It sounds like a great way to help improve employe morale. One might even consider paying for sick days not taken at the end of the year."

One superintendent in Nebraska described a similar insurance plan his own school system devised: "The major differences," he says, "are (1) that accumulated savings in the local insurance account are used to improve benefits, and (2) that an insurance consultant handles the paperwork and periodically puts the major medical coverage out for bids to realize the best deal possible."

Opponents of the stay-well plan most often cited the possible adverse effects the plan could have on employes' health. "Frivolous medical expenses—is there such a thing?" asks one reader. A California administrator cautions: "Such a program will stop the use of preventive medicine because employes will hold back from proper care just to build a 'nest egg.'" Says a Kansas reader: "It's unfair to tempt employes into staying home and doctoring themselves just to save a part of their $500."

Other readers questioned the savings potential of the Mendocino plan because of the extra record keeping involved. Another complaint: "It is irresponsible to take a program covering only 160 employes and project savings for large districts. Increasing insurance costs—and increased record-keeping costs—undoubtedly will be higher than anticipated. Show me the results in three years."

Finally, this prediction from an Illinois superintendent: "I like the concept, but I see a bug: How long will you be able to *keep* the interest on those investments? I suspect the teacher union already is placing designs on the interest money to be given to those teachers who leave. 'After all,' they'll say, 'it's our money you're investing.'" ■

Not for it's their money only if they get sick, or when retire

How the savings would result:

From the Local Health Account, savings would derive from

1. INTEREST earned on the account held locally; and
2. UNSPENT amounts within this account. We are assuming that all employees will not spend the entire $500 held in their names. Thus any amount less than the budgeted $80,000 remaining in the account at the end of the year will be, in effect, "savings," and will be carried over to the following year.

From the $500 Major Medical Policy, indirect savings would derive as follows:

The cost of coverage will most probably increase over the next several years because of inflation. In our new plan $123,000 will be affected by inflationary increases. However, if we had maintained our original standard full coverage policy, $203,000 would have been subject to increase. So, by alloting a portion of the original cost amount to a locally administered account - an amount that will be held constant at $500 per employee - we will have sheltered that amount from inflation and will, in fact, reduce the cost of future full health insurance coverage.

How the Local Health Account is maintained

Each year $500 per employee will be budgeted to this account and will be held in the name of each employee. The employee may have that money used to pay legitimate* claims for his health costs. Any costs above $500 (up to one million) will be paid by the insurance company providing the Major Medical policy.

The employee may or may not use up his entire $500 amount. If he does not, the amount remaining in his account at the end of the year will be carried over to the following year, still held in his name. This means that, if he has $300 remaining, the following year he will have $800 in the account in his name, $500 of which he can use for medical expense. Since he can use only $500, he will always carry ahead the original or any previous year savings. If he uses less than the $500 in the second year, he will carry forward that savings also. A third $500 is then budgeted the third year and so it goes as long as he remains an employee.

*Allowable expenses will be determined by the local Medical Foundation which administers claims under policies of all major carriers. The same benefits will be allowable under the locally administered $500 first dollar coverage as are currently allowed under the $500 deductible policy of the insurance carrier.

Dated, but concept is clearly illustrated

The Mendocino County Superintendent of Schools

MENDOCINO COUNTY SCHOOLS HEALTH PLAN

INTRODUCTION

The following plan will work best if the employee group is fully covered (i.e., "first dollar" coverage).

The main intent of the plan is to reuse budgeted health insurance dollars so that money becomes available for program purposes. This is to be accomplished without loss of medical coverage to the employee. To achieve these ends, this plan is set up to

1) *create a partially self-insured program to provide medical coverage for employees and dependents;*
2) *keep a portion of the money previously paid out as premiums "at home" earning interest for the home agency or corporation;*
3) *introduce a "stay-well" incentive factor that will encourage employees to use as little of the "at home" portion as possible;*
4) *shelter a portion of current and future costs of health and medical insurance from inflation;*
5) *and by these means, contain the rising costs of the County Schools Office of health-medical insurance.*

MAIN FEATURES OF THE PLAN

Under the standard plan for full medical and health insurance coverage that we have purchased in the past, we would have budgeted for this current year

$ 203,000 -> to insurance company

all of which goes to the insurance company.

Under the new Mendocino Health Plan we will budget

to local health account for use for first $500 of employee medical expenses. It is administered by our office on presentation of allowable claims by employees and eligible dependents

<- $80,000 | $123,000 ->

to insurance company to provide $500 Deductible Group Major Medical Coverage

$203,000

Each year, our office would

1. set aside $500 per employee in the Local Health Account; and
2. secure a $500 Deductible Group Major Medical policy to cover employee health expenses after the first $500.

The cost to the office of both plans this first year is the same. But after the first year, we anticipate that a compounding of savings will result which may amount, in our case, to one-half million dollars over the next ten years.

The Stay - Well feature is this:

At the time the employee leaves the office, he may

1) take as "severance" pay any unspent amounts that have accrued to his name in the Local Health Account, or
2) have those remaining funds purchase continuing health insurance to the extent that his "savings" can cover the cost.

We believe that the employee knowing that he stands to benefit personally from any unspent allowances, will use more discretion in incurring future medical expenses. He may even choose to pay some medical costs himself, electing to gain income tax benefits instead of depleting the funds set aside in his name.

Important conditions:

__ At no point is the "savings" considered salary since it is unrelated to the work he does;

__ At no point is the "savings" or the $500 set-aside affected by retirement or pension plans since the amounts are unrelated to his salary.

__ The money in the Local Health Account does not "belong" to the employee at any time during his employment. Therefore

a) he gets no interest on it (he only benefits from "savings" from the $500 yearly allotment budgeted in his name).

b) he cannot borrow on or withdraw any part of the funds held in his name during his term of employment

__ He can not realize any "savings" until after he has been in the plan for a full year, nor can he benefit from any current $500 allotment during the year in which he ceases to be an employee of the Mendocino County Schools Office. He can only benefit from unspent amounts for previous full years of employment.

MENDOCINO COUNTY SCHOOLS
FINANCIAL REPORT
HEALTH INSURANCE SIDE ACCOUNT
June 30, 1986

EMPLOYEE TOTALS

1979-1985

PRIOR YEAR

Prior Year Balance Forward	$173,824.12		
Adj. Term. Emp. Trans. to Dist.	(9,258.05)		
Refunds to Terminated Emp.	(15,795.44)		
Prior Year Claims	(7,172.69)		
		$141,597.94	

1985-86

CURRENT YEAR

Employer Cost	$120,051.99		
Claims Processed	(85,021.19)		
Employee Refunds	(117.01)		
		$34,913.79	
Employee Cumulative Total			$176,511.73

DISTRICT TOTALS

Interest Balance Forward	$68,672.45		
Earned 85-86	12,646.98		
		$81,319.43	
Admin. Cost Balance Forward	$23,599.47		
Expenses 85-86	29,648.47		
		($53,247.94)	
Unvested Emp. Trans. to Dist.		9,258.05	
			$37,329.54
TOTAL FUND BALANCE			$213,841.27

TOTAL EMPLOYEE REFUNDS TO DATE $40,755.23