

Washington State Health Care Authority

THE K-12 PUBLIC SCHOOL EMPLOYEE HEALTH BENEFITS REPORT PURCHASING STRATEGY FOR A CONSOLIDATED BENEFITS SYSTEM

PROJECT TERMINOLOGY

KEY PROJECT TERMS

The K-12 Public School Employee Health Benefits Report — The name of the report, which the Health Care Authority has been tasked with writing by the Legislature, outlining a proposed purchasing strategy for a strengthened, consolidated public school employee health benefits system.

The K-12 Public School Employee Health Benefits Report project — The name of the overarching project to produce the report.

K-12 public school employee health benefits system — The system by which K-12 public school employees obtain health benefits.

Project Teams — The five established teams of participants and stakeholders involved in the project:

- Project Leadership and Support Team**
- Project Design Team**
- Inter-agency Authorization Executive Team**
- K-12 Project Advisory Team**
- Key Legislators and Staff**

See the full roster or project committee diagram for more details on each committee—available on the project website: <http://www.hca.wa.gov/k12report>

State Auditor’s Office Performance Review of K-12 Employee Health Benefits, which includes the HayGroup study — How we refer to the combined State Auditor’s Office report and HayGroup study; note: this performance review was delivered to the Legislature in February 2011.

GLOSSARY OF TERMS

Actuarial Value — A method for measuring the value to an average enrollee of the benefits provided by a health benefits plan. It represents the average percentage of allowed medical costs that would be paid by the plan, assuming a specified standard enrollee population. It does not include premium costs, and represents an average value; the percentage payout for any particular enrollee may be very different from the actuarial value of a plan.

Adverse Selection (Anti-Selection) — The tendency of individuals with a higher probability of incurring claims (high risk) to select the maximum amount of insurance protection, while those with lower probability elect lower levels of, or defer, coverage.

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

Hay Benefit Value Comparison (BVC) method — A proprietary method for comparing the value of compare the relative value of employee benefit packages by placing them on a “common cost” basis that assumes both a common enrollee population and a common funding method. This approach eliminates extraneous factors that complicate a direct comparison of premiums or plan costs, such as differences between funding methods, enrollee demographics and administrative overhead.

Carve-Out — Removing a specific benefit from the contract with the primary health plan and negotiating the coverage separately, usually with a specialty vendor or network. For instance, prescription drug coverage is often purchased separately on a self-funded basis from a specialized pharmacy benefit manager. It should not be confused with the term “carveout” (defined below) which is sometimes used to describe the Washington State retiree remittance.

Carveout — A term sometimes used to describe the Washington State retiree remittance. It should not be confused with the term “carve-out” (defined above) which describes one approach for managing the cost of specific benefits.

Case Management — A process which focuses on coordinating a number of services required by severely ill or injured participants to ensure that provided services are appropriate, timely, thorough yet non-redundant and cost effective.

Centers of Excellence (COE) — Medical facilities that contract with a health plan to provide medical care for specific types of high cost services, such as transplants or cancer treatment. Centers of excellence are selected based on outcomes and cost effectiveness, and typically perform a large number of procedures with highly favorable outcomes and low incidents of adverse results.

COBRA — Combined Omnibus Budget Reconciliation Act of 1985

Coinsurance — A common provision of health care plans in which the covered individual and the insurer or plan sponsor share in a specified ratio of health care expenses (e.g., 80% paid by plan, 20% paid by participant). In a PPO or POS plan, the ratio usually favors the covered individual when the costs are incurred with providers who are part of the PPO or part of a specified network (e.g., 100% coverage within the PPO or network and 70% coinsurance ratio for providers outside the PPO or network).

Contributory Benefit Plan — A program in which the employee contributes part (or all) of the cost, and the employer covers any remainder.

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

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

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

Disease Management (DM) — Disease management refers to the process of identifying health plan enrollees with particular health conditions or risk factors, then assisting those enrollees in managing their conditions to delay the onset or slow the progression of disease.

Durable Medical Equipment (DME) — Medical equipment, such as a hospital bed, wheelchair, or oxygen equipment that may be prescribed by a physician and that has an extended useful life.

ESD — Educational Service Districts are regional administrative units created by statute that evolved from county superintendents. There are currently nine ESDs in Washington.

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

FEHB — Federal Employee Health Benefits (FEHB) Program. This is the health benefits program for federal workers.

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

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

FTE — Full Time Equivalents.

Funding Pool — A mechanism mandated by Revised Code of Washington (RCW) 28A.400.280 for redistributing at the local school district level any unused State allocations for employee benefits among the district's employees.

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

HBPR — Hay Benefits Prevalence Report.

Hay Health Care Benefit Value Comparison (HCBVC) model — A proprietary actuarial model used to estimate the relative value of health benefit packages. It is one of the primary tools used by Hay Group in applying the Benefit Value Comparison (BVC) method to health benefit programs.

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

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

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

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

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

Levy Lid — A statutory limit on the local levy, expressed as a percentage, for a school district. The levy lid effectively caps the amount of revenue a local district can raise to supplement State and federal funds.

Managed Care — Control of utilization, costs, quality and claims, using a variety of cost containment methods, including pre-certification and case management. The primary goal is to deliver cost-effective health care without sacrificing quality or access.

Maximum Benefit — The maximum amount that a health care plan will pay on behalf of a covered participant during that individual's lifetime.

National Committee for Quality Assurance (NCQA) — A non-profit organization that accredits managed care organizations. The accrediting process evaluates organizations against a specific set of standards.

OFM — Office of Financial Management.

OIC — Office of Insurance Commissioner.

Out-of-Pocket Limit — The maximum amount of out-of-pocket health care expenses that a participant is responsible for during a plan year. Every dollar spent on health care after this amount is generally reimbursed in full.

PEBB — Public Employees' Benefits Board.

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

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

PPACA — Patient Protection and Affordable Care Act.

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

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

Provider Network — Health care providers that have a contractual relationship with a health plan to provide care to the plan's enrollees. Network contracts define the payments the health plan will make to the providers for services rendered to enrollees. They also typically include provisions designed to ensure the quality and cost-effectiveness of care.

RCW — Revised Code of Washington.

SAO — State Auditor's Office (of Washington State).

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

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

SERS — School Employees' Retirement System.

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

TRS — Teachers' Retirement System.

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

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

WAC — Washington Administrative Code.

WEA — Washington Education Association.

WSIPC — Washington School Information Processing Cooperative.