

# **JOINT INSURANCE COMMITTEE**

## **H A N D B O O K**

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The Joint Insurance Committee (JIC), the Thompson Education Association (TEA) and the Board of Education have established Thompson School District's philosophy of its insurance coverage through discussions and decisions that have taken place over the last 20 years.

## **Components of the District Insurance Philosophy**

Comprehensive Coverage (medical, dental, and life insurance)

Competitive Premium

Choice of Medical Plans (since 1991)

Four-tier Rate Structure (employee, employee + spouse, employee + child(ren), or family)

100% Participation of Full-Time Employees

Eligibility for Part-time Employees (must work at least a 50% assignment)

Eligibility for Retirees (must be at least 50 years of age, have either 10 years of current district insurance coverage or 15 years current service, and be insured at the time of retirement)

Self-Insurance Funding

Shared or Pooled Risk

Long-term Stability and Continuity in Benefit Programs

## **JIC Mandate**

The JIC, as required by board policy GCBD/GDBD Professional and Classified Staff Insurance and Benefits and Article 10 of the Memorandum of Understanding, is a group of individuals who represent licensed, classified, and administrative staff.

Members are appointed by the Thompson Education Association, the Classified Advisory Council, or the superintendent, depending on their employee group affiliation. The membership consists of four teachers, three classified staff employees, and two administrators, one of which is to be a principal. Ex-officio, non-voting members include a board member, the Executive Director of Human Resources, the TEA President or designee, the Benefits and Risk Manager, the Benefits Secretary, and a representative from Willis HRH, Plan Administrator of the CEBT. The terms of committee members are for up to three years and staggered to assure continuity. There is no limit on the number of terms that may be served. The superintendent or his designee serves as co-chairman of the committee. The other co-chairman is selected from teacher representatives. A secretary shall be elected from the membership.

The JIC is required to meet at least quarterly. The committee usually meets at least six times a year to evaluate current insurance issues and concerns and to discuss insurance trends and market developments. After thorough review and thoughtful consideration of all the issues and related consequences, the JIC makes an annual recommendation to the Board of Education regarding insurance specifications (i.e., deductible amount and other coverage limitations), funding options, benefit changes, alternative insurance financing plans (i.e., self-funding, self-insurance and trusts) and/or broker/consultant qualifications. At the conclusion of each meeting, the secretary shall issue a written report to all employees regarding any action taken by the committee.

The JIC is also responsible for working jointly with the Insurance Benefit Negotiations Subcommittee on improving communications and education related to health care costs, wellness and alternative benefit structures. It is also to examine changes in the policy coverage period and to examine life insurance coverage to assure compliance with applicable I.R.S. regulations.

The insurance program offered by the district is based on employment standards, employee negotiations and requests and funding levels.

The Board of Education makes the final decision regarding the selection of the insurance carriers. All rights and privileges as owner of the policies shall be reserved by the District.

## **CEBT**

Established in 1980, CEBT is a non-profit trust consisting of over 140 public sector employers (of which about 85 are educational institutions) and 17,000 employees. Including dependents, there are close to 30,000 members covered for medical, dental, vision and life insurance benefits. CEBT is the largest trust of its kind in Colorado and one of the largest in the western United States. Annual premium deposits should total approximately \$95,000,000 for the July 1, 2004-June 30, 2005 fiscal year with an additional \$290,000,000 available for reserves.

CEBT employer members must offer at least one of the medical plans and life insurance coverage, but may also select additional lines of coverage, for their employees. Available CEBT coverage selections include five medical plans (three PPO's and two EPO plans and a choice between two managed care networks), employer sponsored dental and vision plans, voluntary dental and vision plans and life insurance.

In 1989, the CEBT became a self-funded, multi-employer trust. At present, approximately 90% of the premium deposits are available for claims and 10% are used to pay fixed expenses (administration expenses such as claims handling, legal services, production and distribution of plan documents [i.e., certificate booklets, information updates, I.D. cards, etc.] phones, postage, etc.) The industry's average cost of administration is 15%, which includes profit margin.

Based on the self-funded financial structure, the CEBT is subject to Department of Labor regulations. As a governmental employer trust fund, the CEBT is not subject to the Colorado Division of Insurance. The CEBT has, however, added the same state-mandated benefits, i.e., mammography, prostate exams, and standard coverage for biologically based mental illnesses, as if it was subject to the jurisdiction of the Colorado Division of Insurance.

The Trust is structured with a governing board of trustees, an administrator and third party vendors that are contracted by the board of trustees to provide specific services to the CEBT. The CEBT is one of the largest and most financially successful trust funds in the country. During the course of the past few years, numerous plans of this type have failed primarily due to financial insolvency. The primary reasons for the CEBT success are two essential elements, pooling risk and self-funding.

### Participation Requirements

Since the establishment of the CEBT, the board of trustees has supported a long-term vision of balancing reasonable benefits and stable costs. As a result of this long-term philosophical approach, some primary underwriting guidelines have been established (consistent enrollment practices, mandatory medical and life insurance coverage, 100% participation of all full-time eligible employees, restrictions on late entrants, established, written claims appeal process etc.). The most important benefit of the established guidelines is actuarial predictability.

## 100% Participation Agreement

In order to predict future claims and costs, the trust has required that all eligible full-time employees enroll in the employee package. The actuarial results of this participation requirement have allowed for a 90 - 95% credibility factor in projecting future costs. In addition, rates reflect an approximate 8 - 10% discount as a result of these underwriting requirements. This single factor has contributed more to the success of the CEBT over the long term than any other factor.

The district has had a 100% participation agreement since its enrollment with the CEBT in 1981. In 1994, the 100% participation agreement was waived; following the annual review and the loss of about a 10% rate credit. The 100% participation agreement was reinstated in the following year. If the district eliminated the 100% participation agreement clause there would be an immediate increase to premiums due to the loss of an 8-10% rate credit.

## Cost of Insurance

Plan design, utilization, fixed expenses, and medical trend (inflation) contribute to the cost of insurance.

The one factor of insurance cost that employers can affect is plan design, which affects utilization. The rising cost of premiums may be minimized by plan design changes. However, any changes to the plan design that result in the employee paying more out of his or her pocket is a benefit cost shift. It's difficult to find a balance between premium cost containment and benefit cost shift. Ideally, this cost shift would be tempered by salary increases or premium deductions, both which are very difficult to achieve in the current climate.

## Benefits of CEBT Participation

The CEBT has, through its funding, plan design, size-based purchasing power, and cost containment philosophies, been able to provide comprehensive coverage at a competitive cost over the last 21 years. CEBT membership benefits, for Thompson School District and its employees, include excellent customer service and advocacy, continuity of coverage and service personnel, competitive premiums, premium stability, customized plan design, ownership and control of plan and claims management, and representation on the Board of Trustees.

The financial benefits of membership include reduction of administrative costs, elimination of insurance company profits (typically 5% of total premium), elimination of state premium tax (2.2% of total premium collected) and interest earnings, which average \$1,185,000 annually.

## Rate History

YEAR	EXCLUSIVE PROVIDER ORGANIZATION (EPO)	PREFERRED PROVIDER ORGANIZATION (PPO)
7/1/2011		PPO IV 15% PPO V 15%
7/1/2010	EPO III Disc	PPO III Disc PPO IV 8.5% PPO V 8.5% Intro
7/1/2009	6.5%	PPO III 6.5% PPO IV 6.5%
7/1/2008	5%	PPO III 5% PPO IV 5%
7/1/2007 Intro HRP	5% Intro EPO III, Disc EPO II	PPO III 5% PPO IV 5%
7/1/2006	5.50%	PPO III 5.5% PPO IV 5.5%
7/1/2005	2.40%	PPO III 2.3% PPO IV 0%
7/1/2004	15%	PPO III 2% PPO IV 2%
7/1/2003	14%	PPO II 33% Disc PPO III 11% PPO IV 2.7% Intro
7/1/2002	34%	PPO II 34% PPO III 25%
7/1/2001	27.50%	PPO I 43% Disc PPO II 27.5% PPO III 19% Intro
7/1/2000	9.50%	PPO I 25.5% PPO II 9.5%
7/1/1999	7.50%	PPO I 13.5% PPO II 7.5% Intro

## **Stop Loss Insurance**

Stop loss insurance is established to protect a group from a single, large loss or from a large volume of aggregate claims. This coverage allows the group to establish appropriate and acceptable financial risks based on its financial strength, i.e., assets or reserves.

### Specific Stop Loss

The Trust purchases specific stop loss insurance for any large individual claim that exceeds \$400,000. CEBT is governed by a Board of Trustees representative of the employer groups participating in the Trust.

## **Reserves**

Effective February 16, 2001, the CEBT reserves will be reduced from 28.5% to 15% (of collected premium). The reserves are to cover the Aggregate Stop Loss and Incurred but not reported (IBNR) exposures as well as to provide plan stabilization. The goal is to eventually have reserves at 22% of annual premium deposits with 2% allocated to pay final run-out expenses, in the event the Trust would cease operations.

Current reserves approved by the Board of Trustees are: IBNR @ 15%; plan stabilization reserve (PSR) @ 10%; and final expense reserve for winding down the Trust in its entirety @ 2%.

## **Utilization**

Utilization is the ratio between premiums collected and claims paid. For example, if a plan has 85% utilization it means that for every \$1.00 collected in premium, 85¢ was paid out in claims.

Utilization is only one of the factors that drive premium costs. However, if utilization is less than 85% then typically, any premium increase to the plan will be slight.

## **Insurance Premium Structure Options**

Over the years there has been much discussion recently about what type of premium structure is the most fair to employees. Should an employee and spouse be charged the same for coverage as a family of four or five? Should a healthy family be charged the same as an employee with one very ill dependent? Who should subsidize whom? In reality, whether you look at single or family rates, the healthy subsidize the ill. If a truly fair and equitable method were to be used to determine the cost of coverage, it would be

based on actual utilization. This method would defeat the group philosophy to spread the risk of adverse claims over a larger base of insureds, to reduce administrative costs and to assure long-term premium, and ultimately, financial stability.

### Tiered Rating Structure

The district offered a two-tier premium structure through CEBT from 1981 - 2006.

The two-tier premium structure rates coverage as either single or family, regardless of the number of dependents in the family.

The district changed its rating structure for family coverage from a 2-tier rate structure, i.e., single or family premium to a 4-tier rate structure, i.e., employee, employee + spouse, employee + child(ren) or employee + family, effective July 1, 2006.

The change to a 4-tier rate structure had been requested a number of times over the years but was not recommended in the past, due to the significant rate adjustment of between 5 – 10% that would have been added to the family premium (which made up the majority of our family units). Given the district's positive paid claims ratio and credibility of the loss history, the plan administrator was able to negotiate and deliver a 4-tier rate structure, in which the proposed premium increase to the employee + family would only reflect current paid claims ratio and trend (without the additional rate adjustment).

In the early 1980's, multi-tier groups were offered in many cases, because premiums were much lower and the additional cost to families wasn't as great as it would be today.

About 25% of the district's insured population carries family insurance, which is lower than the expected family participation in a group plan.

Of the district's family units population, about 22% of them would be categorized as employee and spouse, 4% would be categorized as employee and children, and 74% of them would be categorized as employee, spouse and children. Based on actuarial data, the district's percentages of family units are very consistent with industry norms.

The actuaries determine that based on the demographics of a group, a specific total number of dollars will be necessary to pay claims and administer the plan. Therefore, if a group was to offer a multi-tier premium structure, it would have to increase the cost to the employee, spouse and children tier in order to provide a lower cost to the employee plus one or employee and children tiers.

Changing the two-tier premium structure to a multi-tier structure would adversely affect the majority of District employees who carry family coverage.

## **Open Enrollment**

Part-time employees, who are working at least 50%, and/or employees who wish to add family coverage, may enroll in the insurance plan during the open enrollment period.

Coverage added during the open enrollment period is effective July 1.

## **Health Insurance Portability and Accountability Act**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes important protections for working Americans and their families who have pre-existing medical conditions or might suffer discrimination in health coverage. The HIPAA limits exclusions for pre-existing conditions; prohibits discrimination against employees and dependents based on health status; guarantees renewability and availability of health coverage to certain employers and individuals; and protects many workers who lose health coverage by providing better access to individual or group health insurance coverage.

Employees and/or their dependents may become eligible for Special Enrollment Rights under the HIPAA if the employee or dependents loses other coverage or if there's a change in family coverage, i.e., marriage, birth, adoption or placement for adoption. Special Enrollment Rights allow mid-year enrollment in the group plan, in accordance with the date of the qualifying event i.e., loss of coverage or change in family status.

## **Pros and Cons of Bidding Insurance**

How often should insurance programs be bid? Are there any real advantages to bidding? Is there something better out there? How do the District premiums compare with other districts in our area? What is happening in the market place?

### Reasons to bid

- \* May be able to obtain better coverage and/or lower premium (be aware of the lowball bid, which is where companies may be buying market share or may be attempting to shore up a struggling profit/loss report - new business provides new money and a claim lag)
- \* Test the market
- \* Improve service from your broker or insurer
- \* Define service and coverage requirements
- \* Learn something about the current insurance program and policy details
- \* Examine insurance alternatives (coverages, exclusions, funding, and costs)

### Reasons not to bid

- \* Current broker assesses various insurers on an on-going basis, provides regular information of the market conditions, forecasts insurance and premium changes and shifts
- \* The least expensive policy may not provide adequate services; insureds are better off with current program

- \* Coverages were bid recently
- \* The bidding process is too time consuming given current priorities
- \* Insurers are reluctant to quote if it appears the policyholder is only looking at price or frequently shops insurance
- \* Rigid bid specifications can limit broker creativity
- \* Periodic changes of agents and insurers does not typically foster loyalty or support strong partnerships

### **Pre-tax Premium and Flexible Spending Accounts**

These programs are operated in accordance with and as defined by current Internal Revenue Service regulations and the Thompson School District board policy.

New employees are eligible to enroll in the pre-tax premium option and/or the flexible spending accounts at the time of hire; the eligible payroll deductions begin with their first paycheck.

A representative from American Fidelity visits all district locations during the spring to discuss the pre-tax premium option, flexible spending accounts, and other pre-tax options with employees. It is during this meeting that the enrollment or waiver form for participation in the pre-tax premium, flexible spending accounts and other pre-tax benefit options will be completed.

All employees must complete an annual election form, either enrolling or waiving participation in the programs. In order to continue participation in any of these pre-tax programs, an annual election form must be completed and submitted to the District Insurance Department by June 30. Any changes made during this open enrollment will be effective on the July paycheck.

Responsibility for monitoring the Flexible Spending Accounts is vested in the Joint Insurance Committee.

A summary of third party administrator activity and financial reports to the District, as well as pertinent District records shall be reviewed by the Committee semiannually. The Committee will review documents presenting the net cost advantage or deficit derived from administration of the plans annually.

Any money forfeited under the plans which remain following offset of any deficit incurred for administration of the plans shall be used for employee related activities and expenditures. If the forfeited funds or the accumulation of the forfeited funds are greater than \$5,000, the Committee shall request approval for specific use(s) of these funds from the Board of Education.

The TEA agrees to hold the Board of Education and administration harmless from any action, by any teacher, growing out of the operation of the Flexible Spending Accounts and assumes full responsibility for its operation.

#### Pre-tax Premium

Employees, who are enrolled the district insurance plan, VSP (the voluntary vision insurance plan) and/or the American Fidelity Insurance cancer and intensive care plan, are eligible to participate in

the pre-tax premium program. Employees may elect to have their portion of premiums (for single part-time insurance and/or family coverage) deducted from their paycheck before taxes are calculated.

All elections (pre-tax premium and/or flexible spending accounts) are generally irrevocable during the plan year, which runs from July to June. However, there are a few, very restrictive qualifying events which allow for a mid-year change. Qualifying events differ among the various pre-tax options.

Individuals with dependent coverage, or who are part-time paying a portion of the individual premium, on a pre-tax basis option may not drop the coverage during the plan year, unless one of the few and very restrictive I.R.S. qualifying events applies.

### Flexible Spending Accounts

All employees are eligible to participate in flexible spending accounts. Employees may elect to have miscellaneous medical, dental and vision expenses (the cost for treatment or service) and/or dependent daycare expenses deducted from their paycheck before taxes are withheld.

All elections (pre-tax premium and/or flexible spending accounts) are generally irrevocable during the plan year, which runs from July to June. However, there are a few, very restrictive qualifying events which allow for a mid-year change. Qualifying events differ among the various pre-tax options. For example, a participant in the Dependent Day Care program may increase or decrease the contribution based on the cost of care or a change in the number of day care hours. This qualifying event is not extended to participants whose day care provider is also a relative. Conversely, a participant in the Miscellaneous Medical Expense program may not change the contribution based on an increase or decrease in expected expenses.

## **Long Term Disability Insurance**

The district provides long term disability (LTD) insurance to all full-time employees at no cost and at a minimal cost to part-time employees who work at least half time (3 ¾ hours per day) or who are on a 50% contract.

In the event an employee becomes disabled, and is covered by the plan, he or she may be eligible to receive up to 66 2/3% of gross earnings. The benefit waiting period is 60 calendar days or full use of available paid leave, whichever is greatest. The maximum monthly benefit is \$6,000 per month. If other deductible income is received or payable, then the LTD benefit will be reduced by that amount. The minimum monthly LTD benefit is the greater of either \$100 or 10% of the 66 2/3% LTD benefit.

Long-term disability benefits may continue up to age 65. However, if the disability begins at, or after, age 61 the benefits are limited to a specific number of months or years, based on the age at the

time the disability begins.

## **List of Acronyms and Abbreviations**

ASO -Administrative Services Only  
ASR -Aggregate Stop Loss Reserve  
CEBT -Colorado Employer Benefit Trust  
COBRA – Consolidated Omnibus Budget Reconciliation Act  
CSR- Customer Service Representative  
EE's- employees  
EOB -Explanation of Benefits  
EAP -Employee Assistance Plan  
EPO -Exclusive Provider Organization (HMO)  
ERISA -Employee Retirement Income Security Act  
ER's- employers  
FSA -Flexible Spending Account  
HMO -Health Maintenance Organization  
IBNR- Incurred But Not Reported  
IPA- Independent Physician Association  
LTD- Long Term Disability  
MEWA- Multiple Employer Welfare Association  
MMI -Maximum Medical Improvement  
MTL -Maximum Terminal Liability  
PD -Permanent Disability  
PDL -Preferred Drug List  
PFPL -Pre-paid Funding Account for Plan Liability  
PHO -Physician Hospital Organization  
PBM -Pharmacy Benefit Manager  
PPO -Preferred Provider Organization  
R&C -Reasonable and Customary  
STD- Short Term Disability  
TD -Total Disability  
TPA -Third Party Administrator  
TUC -The Urman Company