SUMMARY OF ENGROSSED SUBSTITUTE SENATE BILL 5940
PUBLIC SCHOOL EMPLOYEES' INSURANCE BENEFITS

Brief Background

The Legislature found that each year, nearly one billion dollars in public funds are spent on the purchase of employee insurance benefits for more than 200,000 public school employees and their dependents, and that school districts and their employees need better information to improve current practices and inform future decisions with regard to health insurance benefits.

Through ESSB 5940, the Legislature established the following goals:

(1) Improve transparency of health benefit plan claims and financial data to assure prudent and efficient use of taxpayers' funds at the state and local level;

(2) Create greater affordability for full family coverage and greater equity between premium costs for full family coverage and for employee only coverage for the same health benefit plan;

(3) Promote healthcare innovations and cost savings, and significantly reduce administrative costs; and

(4) Provide greater parity in state allocations for state employee and K-12 health benefits.

In addition, ESSB 5940 makes clear that current collective bargaining is for benefits is retained, as is state, school district, and employee contributions to benefits.

ESSB 5940 Requirements

School districts must modify their benefits for employees to require every employee to pay a minimum premium for the medical benefit coverage, subject to collective bargaining, and ensure that employees selecting a richer benefit plan pay a higher premium. School districts offering medical, vision, and dental benefits must (1) offer a high deductible health plan option with a health savings account similar to that required for state employees; (2) make progress toward employee premiums for full family coverage, unless a different target is developed in future reports; and (3) offer employees at least on comprehensive health benefit plan in which the employee share of the premium for a full-time employee does not exceed the share of premiums paid by state employees (approximately 15 percent).

School districts and school district health benefit providers, which includes insurance carriers and third party administrators, are required to annually submit specified financial and enrollment information on the health benefit plans operated for district employees to the Office of the Insurance Commissioner (OIC), on a schedule determined by the OIC. If the district does not comply, the Superintendent of Public Instruction is required to limit the school district's authority to offer employee benefits to those offered through the Health Care Authority (HCA).

The specified financial and enrollment data includes, but is not limited to: progress by the district and its benefit providers toward greater affordability for full family coverage, health care cost savings, and significantly improved administrative costs; total premium expenses; total claims expenses; claims reserves; plan administrative expenses; data to provide an understanding of employee health benefit plan coverage and costs, including, the total number of employees, and for each employee, the employee's full-time equivalent status, types of coverage or benefits received including numbers of covered dependents, eligible dependents, the amount of the district's contribution to premium, additional premium costs paid by the employee through payroll deductions, and the age and sex of the employee and each dependent; a summary of benefit packages offered to each group of district employees; aggregated employee and dependent demographic information; total claims payment by benefit package; total premiums by benefit package; and a listing of large claims defined as annual amounts paid in excess of $100,000. The specified financial and enrollment data is protected from public disclosure, with all similarly reported data.

Beginning December 31, 2013, the OIC must submit an annual report to the Legislature containing specific information and analysis on school district benefit plans. By June 1, 2015, the HCA must submit a similar report to the Governor, Legislature, and the Joint Legislative Audit and Review Committee (JLARC) that must include the development of a specific target to realize the goal of greater equity between premium costs for full-family coverage, employee only coverage, and review of the three-to-one ratio of employee premium costs, which was retained. The HCA must also review the advantages and disadvantages to the state, school districts, and school employees of various approaches to consolidated purchasing of school employee health benefits and options to achieve the legislative goals outlined above. By December 31, 2015, the JLARC must submit a report to the Legislature indicating the progress by school districts and their benefit providers in achieving the list of established goals and performance objectives. Finally, if the JLARC determines that districts and their providers have not made adequate progress on the established goals, the report must include recommendations for any Legislative action necessary for implementation, and the Legislature must takes all steps necessary to implement the goals.