Appendix C

Review of Other States' Public Employee and Retiree Health Benefit Plans

STATE	DESCRIPTION
Arizona	**BACKGROUND** **State Agency:** Arizona's employee health benefits program for active employees is administered by the Department of Administration (ADOA) through its Human Resources Division. The administration department is directly responsible to the governor and the legislature. Health benefit coverage for most of the retirees is available through a separate state agency, the Arizona State Retirement System (ASRS), which also administers the pension benefit program for the state and other government agencies in Arizona. **Established by Statute:** Yes. **GOVERNANCE PRACTICES** **Board Composition:** Only the ASRS is governed by a Board of Trustees. The board is composed of nine members. Five of the members must include an educator, an employee of one of the political subdivisions participating in the program, a retiree in the program, a state employee and an at-large member. The other four members must be individuals with at least ten years of experience with investments/securities and economic theory such as a certified financial analyst, a professor of economics or investments at a university, or an economist with at least five years of management experience. **Authority of Board:** The board has broad authority over the program. **FUNDING** **Contribution Formula:** The employer contribution for active employees and their dependents is determined as part of each year's budgeting process. The employer subsidy is a maximum of $95 per month for retirees not yet eligible for Medicare and $80 for dependent coverage. For those eligible for Medicare, the subsidy is $65 for the retirees and $50 for dependent coverage. Only those retirees with at least ten years of service are eligible for the maximum subsidies. Those with less than five years of service receive no subsidy. **Funding Method:** The health maintenance organization (HMO) and other prepaid coverages are fully insured with no experience rating. The Preferred Provider Organization (PPO) and indemnity coverages are also fully insured but involve prospective experience rating. **Practice of Porting to Union or Other Competing Plans:** No. There are no union or other competing public employee health benefit plans.

STATE	DESCRIPTION
Arizona – cont.	**Reserves:** No. The rate renewal process uses prior year excess contributions in renewal rates negotiations with the indemnity or PPO carriers. The HMO plans are community rated each year and therefore have no "excess" contributions by definition.

ADMINISTRATION

Organizational Structure: The ADOA's Human Resources Division administers the active state (and other) government employee benefit program and reports directly to the governor's office and the state legislature.

The ASRS administers most of the state (and other) government retiree benefit programs and reports to the governor's office and the state legislature.

Contribution/Premium Collection: The contributions are directed to the agencies that administer the two health benefit programs. These agencies submit premiums to the insurance carriers or HMOs. The ASRS also administers the government employee/retiree pension program. It therefore is able to deduct the retiree contributions for health and dental coverage from the monthly pension benefits, adds the amount of government/employer subsidy and submits premiums to the carriers.

Eligibility Determination: The ADOA and ASRS determine eligibility. For retirees, the ASRS also administers the pension program, which can be very helpful in determining eligibility for the health and dental benefits as well.

Claims Administration: This is performed by the insurance carriers and HMOs.

Customer Service: This is performed by the insurance carriers and HMOs.

Financial Reporting: Not readily available for ADOA and active employees.

The ASRS gathers the financial information from carriers and with the help of outside actuarial consultants provides annual reports to its board, along with its recommendations for renewal rates and possible benefit changes.

Rate/Benefit Negotiation with Carriers: Performed by the respective agencies for renewals. For any new plans to be offered, the negotiations are with the State Procurement Office.

Benefits Eligibility: All full-time state employees, long term disability participants, and their eligible dependents. Retirees of Arizona's state agencies and universities and their eligible dependents.

Benefit Options: Indemnity, PPO and HMO medical plans are available for active employees. Indemnity, PPO and Medicare HMO medical plans are available for retirees.

STATE	DESCRIPTION
Arizona – cont.	**Benefit Determination:** State statutes mandate that state government employee, retiree and dependent health benefits be made available, but do not define the coverage. Benefit changes are not subject to legislative approval but are part of the renewal negotiation process with the carriers and HMOs. Benefits for retirees are determined by the ASRS and approved by its board.
California	**BACKGROUND** The California Public Employees Retirement System (CalPERS) Health Benefits Program is a state agency. Its Board of Administration administers the state employee health benefit program. It has over one million members and is the second largest purchaser of health care in the nation, second only to the Federal Employees' Health Benefit Program. **Established by Statute:** Yes. **GOVERNANCE** **Board Composition:** CalPERS is administered by a 13 member Board of Administration consisting of elected, appointed, and ex officio members. It consists of five for active employees, one for retirees, one from a public agency, one official of a life insurer, one jointly appointed by the house and senate, and four ex officio members (state treasurer, state controller, personnel director, and a state personnel board member). **Authority of Board:** Constitutional and statutory authority over the system's administration and investment decisions. It has over 1,000 professional employees. The board has exclusive control of administration, investment of retirement fund assets, membership and benefit issues, and all powers reasonably necessary to carry out the health benefits program. Its authority includes setting employer contribution rates, determining asset allocations, and providing actuarial valuations. **FUNDING** **Contribution Formula:** Funded by a combination of employer and employee contributions. For active employees, the amount of employer contributions is subject to collective bargaining agreements. Retirees' contributions are based on a statutory requirement of the average of the three largest CalPERS health plans. **Funding Method:** The PPO is self-funded and administered by Blue Cross of California. HMO coverage is fully insured and the coverage is provided through about 20 HMOs, which must negotiate with CalPERS for each year's renewal. **Practice of Porting Funds to Union Benefit Plans:** No. There are no union or other competing health benefit plans for public employees. **Reserves:** There are no "excess contributions" with HMO coverage, because of the very stringent rate renewal negotiations involved. The PPO plans are self-funded. If there are excess funds, these would belong to the CalPERS benefit program.

STATE	DESCRIPTION
California – cont.	**ADMINISTRATION** **Organizational Structure:** CalPERS' organizational structure consists of many divisions and offices including actuarial and employer services, benefits services, fiscal services, health program development, long-term care, information technology, investment, and audit services, and planning and research. **Contribution/Premium Collection:** Handled by CalPERS' actuarial & employer services. **Eligibility Determination:** Handled by CalPERS' health benefit services. **Claims Administration:** CalPERS' health benefit services provides assistance with claims, however claims processing is done by the respective health plan and not by the CalPERS agency itself. **Customer Service:** CalPERS' health benefit services provides assistance, however customer service for members is done by the respective health plans and not by CalPERS. CalPERS' actuarial & employer services handles the employer as the customer. **Financial Reporting:** Handled by CalPERS. **Information Technology:** CalPERS' Information Technology Services Division utilizes the following technologies in providing services to CalPERS: Server Technologies - client/server technology strategy is based on the use of "open" systems (nonproprietary) using the UNIX operating system. CalPERS has an extensive investment in departmental servers running Novell Netware and Windows/NT. Database management and warehousing is based upon relational technology from Oracle. Client Technologies - The standard client workstations are Intel-based Pentium computers running Windows 3.11, Windows 95, or Windows NT Workstation from Microsoft. Network Technologies - Novell Netware is used as the standard local area network operating system and is being integrated with additional open systems networking protocols like TCP/IP to provide the inter-enterprise networking capability. Applications Development Technologies - Enterprise-wide application development standards include programming tools from Forte. Non-enterprise-wide application standards include Powerbuilder from Powersoft Corporation and Visual Objects from Computer Associates. End-user analysis and data access tools include Impromptu and Powerplay. Foundation application technologies - groupware, using Microsoft Exchange/Schedule+ , provides e-mail, calendar & scheduling, public folders, and the infrastructure for their Internet/Intranet applications. Microsoft internet information server hosts the CalPERS On-line Home Page (http://www.calpers.ca.gov) while Netscape Navigator is their standard browser.

STATE	DESCRIPTION
California – cont.	Applications Strategy phases out all legacy applications. Key operational components include baseline analysis and business process re-engineering, integrated corporate database, the CalPERS online member and employer transaction system, and Year 2000 compliance. **Benefit Determination:** Benefits cannot be added, changed, or deleted without the concurrence of the State Legislature. **Rate/Benefit Negotiation with Carriers:** Handled by CalPERS. **Management Controls:** The Board of Administration has established several committees to review and report on specific programs, projects, and issues and make recommendations to the board. The full board and standing committees typically meet once each month. There are a number of committees including: Finance This committee provides financial oversight on all budget matters, evaluates funding alternatives, oversees preparation and recommends approval of the CalPERS budget, and oversees the CalPERS annual and periodic audits. Benefits and Program Administration This committee reviews all matters related to benefit program structure, actuarial studies and rate setting, retirement program policy, and administrative issues. Strategic Planning This committee oversees the strategic planning process, including selection of consultants, defining process direction and monitoring development of the CalPERS Strategic Plan. **BENEFITS** **Eligibility:** Active and disabled employees must be appointed to a state, public agency, or school district job that will last at least six months and one day, and is at least half-time or more. State limited-term employees (seasonal, temporary) are not eligible. Retirees must have been enrolled in a CalPERS health plan at the time they separated from employment. **Benefit Options:** Active/Disabled Employees can choose PPO or HMO benefit options. Benefits are standardized across all carriers. Retirees can choose Medicare Supplement and Medicare HMO benefit options. Early retirees receive the same benefit options as the active employees. Benefit negotiation process involves a very rigorous exercise where each HMO must justify its rates (including components of its total rates) by providing CalPERS with detailed utilization and unit cost information. This utilization data can be periodically audited by CalPERS.

STATE	DESCRIPTION
Colorado	**BACKGROUND** **State Agency:** Public Employees Retirement Association. **Established by Statute:** Yes. **GOVERNANCE PRACTICES** **Board Composition:** Information on the board of trustees was not available. **FUNDING** **Reserves:** A group benefit plans reserve fund is established by state statutes. Expenditures are made from the group benefit plans reserve fund, upon certification by the director, for the payment to the carriers of premiums, claims costs and administrative fees and costs associated with the group benefit plans. A premium stabilization fund is established within the group benefit plans reserve fund for the purpose of offsetting unexpected year-end deficits and extraordinary fluctuations in annual premiums. The director certifies in writing to the state treasurer which portion of the funds shall be invested that are in the director's judgment not needed for the payment of premiums and claims costs to the carriers. Investments are limited to securities authorized by the board of trustees of the public employees retirement association. **Contribution/Premium Collection:** The director remits to the treasurer for deposit in the fund all payments received by the director for group benefit plans premium costs from employees and the state as employer. The director also remits to the treasurer for deposit any payments received for the carriers of group benefit plans. **Practice of Porting Funds to Union Benefit Plans:** No. There are no union or other competing health benefit plans for public employees.
Connecticut	**BACKGROUND** **State Agency:** State Employees Retirement System. **Established by Statute:** Yes. **GOVERNANCE PRACTICES** **Board Composition:** The State Employees Retirement Commission. The State Comptroller is Secretary Ex Officio. Other board information was not readily available. **ADMINISTRATION** **Organizational Structure:** The plan is administered by the state comptroller's Retirement and Benefit Services Division. The division administers state employee health benefits, and manages the state deferred compensation plan. It directs plan design, benefit administration, and policy for all state insurance benefits including medical, surgical, hospital, and life insurance. It negotiates with insurance carriers, monitors providers, and reviews health care utilization and cost reports. **Contribution/Premium Collection:** The comptroller's retirement and benefit services division.

STATE	DESCRIPTION
Connecticut – cont.	**Eligibility Determination:** The comptroller's retirement and benefit services division. **Information Technology:** The comptroller's information technology division provides network support; mainframe support including production and input/output control and disaster recovery; personal computer technical support; local area network administration, infrastructure and helpdesk support; personal computer application development and support; Internet/Intranet application development and support; data and system security, and inter-division project management. **Benefit Determination:** The comptroller's retirement and benefit services division. **Rate/Benefit Negotiation with Carriers:** The comptroller's retirement and benefit services division. **Management Controls:** The comptroller's retirement and benefit services division monitors providers, and analyzes reports on health care utilization and costs. **Practice of Porting Funds to Union Benefit Plans:** No. There are no union or other competing health benefit plans for public employees.
Michigan	**BACKGROUND** **State Agency:** The Michigan State Employees Retirement System (SERS) enrolls retirees and beneficiaries for health, dental, and vision insurance, the Michigan Department of Management and Budget's Office of the State Employer administers the health insurance programs. **Established by Statute:** Yes. **GOVERNANCE PRACTICES** **Board Composition:** The SERS is governed by a nine member board composed of two employee and two retiree members, all appointed by the governor, and five ex-officio members. The ex-officio members include the attorney general, state treasurer, acting insurance commissioner, state personnel director, and deputy auditor general. **ADMINISTRATION** **Organizational Structure:** SERS enrolls retirees and beneficiaries for health, dental, and vision insurance. The department's management and budget office administers the health insurance programs, and also administers employee benefits programs for classified and unclassified state employees and retirees, including administration of life, health, vision, and dental insurance plans; flexible spending accounts; and continuation of insurance coverage.
Missouri	**BACKGROUND** **State Agency:** The Missouri Consolidated Health Care Plan (MCHCP), administers health benefits for state employees and retirees. It is a non-profit entity which has the responsibility of administering the law and bears a fiduciary obligation to the State of Missouri, the taxpayers and its members.

STATE	DESCRIPTION
Missouri – cont.	**Established by Statute:** Yes. **GOVERNANCE PRACTICES** **Board of Composition:** The Board of Trustees has 11 members. The board is comprised of one member of the Senate, one member of the House, three citizens of the State of Missouri who are not members of the plan, but who are familiar with medical issues, three members of the board shall be members of the plan, and three *ex officio* members (health director, insurance director and the administration commissioner). **Authority of Board:** The board has the authority to operate the benefit program. **ADMINISTRATION** **Organizational Structure:** The executive director, who is appointed by the board, is responsible for managing the plan. The director advises the board on all matters pertaining to the plan and, with the approval of the board, contracts for professional services and employs the staff needed to operate the plan. The plan's organization structure consists of the following departments: fiscal affairs, membership services, customer support, research and compliance, data management systems, human resources, and marketing. **Management Controls:** The assistant director is responsible for monitoring health care trends and determining how they may impact the plan, and ensuring that the plan is in compliance with new state and federal regulations. The assistant director also coordinates the development, evaluation, and award of requests for proposals, and assists in the negotiation and execution of contracts. Research and compliance provides collection, analysis and reporting of various statistical health related data, including Group Health Association of America reports, and the Health Plan Employer Data and Information Set (HEDIS). The department evaluates and monitors HMO, PPO, purchase of service plans (POS), and indemnity plan vendors who are awarded contracts by the plan. It maintains data on network development, provider turnover and other factors affecting performance of the contractors. The department is also responsible for conducting audits, performing customer satisfaction surveys, and serving as a patient advocate when necessary. **Practice of Porting Funds to Union Benefit Plans:** No. There are no union or other competing health benefit plans for public employees.
New York	**BACKGROUND** **State Agency:** The Governor's Office of Employee Relations (GOER) is the management representative at collective bargaining negotiations with the eight unions representing 93 percent of the state executive branch employees. **Established by Statute:** Yes. Employee health benefits are a mandatory subject of collective bargaining. **GOVERNANCE PRACTICES** Information Not Readily Available

STATE	DESCRIPTION
New York – cont.	**ADMINISTRATION** **Organizational Structure:** The state's health insurance plan is regulated and administered by the civil service department. Employer-Union Trust Approach: A joint committee on health benefits was established with the unions to cooperatively develop and oversee administration of health care programs for represented employees. The committee process has facilitated many effective program changes or modifications outside of regularly scheduled labor negotiations. These modifications and program improvements would not have occurred as readily without this joint labor-management forum. **Management Controls:** In addition to having a benefit planning and oversight role for employees represented by unions, the office of employee relations is also responsible for benefit program development on behalf of management and legislative employees, and represents the State on various health benefit coalitions. In addition, the office analyzes the impact of proposed health care legislation, researches health care trends, and provides assistance on emerging developments in the health care field. GOER staff are co-responsible with civil service and the state public employee unions to provide oversight to the various health plan contracts. GOER conducts an annual HMO review process, and trains agency health benefit administrators. **Benefit Eligibility:** The plan is available to all state active and retired employees and employees of state and local governments that elect to participate and their dependents. **Practice of Porting Funds to Union Benefit Plans:** No. There are no union or other competing health benefit plans for public employees.
Oregon	**BACKGROUND** **State Agency:** In Oregon, there is a health benefit plan for active employees and a separate plan for retirees' health benefits. The Oregon Public Employees Benefit Board (PEBB) was established in May 1997, and became active on January 1, 1998. The single board replaces two union boards that covered state employees represented by Oregon's largest public employee union, and the other board which covered unrepresented, management and employees represented by 12 smaller labor unions. The PEBB board is under the state's Department of Administrative Services. The Oregon Public Employees Retirement System (PERS) sponsors a group health insurance program for its retired and disabled employees. PERS contracts with different health care plans that offer comprehensive benefits. Almost 900 public employers participate, including all state agencies, public school districts, cities, and counties in Oregon. PERS is the retirement program for about 95 percent of state and local government employees in Oregon. This program offers coverage for both non-Medicare and Medicare PERS retirees and dependents. PERS offers three health plans through competitive bidding. **Established by Statute:** Yes.

STATE	DESCRIPTION
Oregon – cont.	**GOVERNANCE PRACTICES** **Board Composition:** The PEBB Board consists of ten members: two ex-officio members from the legislature, four state employees, four union representatives and one representing classified, unrepresented state employees. Trustees for PERS are appointed by the governor and ratified by the senate for three-year terms. Four trustees are selected from management and four trustees must be members of collective bargaining units. One of the eight trustees described above must be a retired member of the system. **Authority of Board:** The PEBB Board functions as an employer-union trust governance system. It determines health policy, but does not to get involved in day-to-day health benefit issues. It negotiates and renews health plan contracts and rates annually. The board determines benefits and plans that are best designed to meet the needs and provide for the welfare of eligible employees and the state. Emphasis is placed on: (1) employee choice among high quality plans; (2) a competitive marketplace; (3) plan performance and information; (4) employer flexibility in plan design and contracting; (5) quality customer service; (6) creativity and innovation; (7) plan benefits as part of the total employee compensation; and (8) improvement of health of members. **FUNDING** **Contribution Formula:** The state pays 100 percent of the PEBB premiums for active employees. Oregon's statutes authorize payments from PERS toward the monthly cost of health insurance sponsored by the system. Currently, the law provides up to $60 per month contribution toward premium cost for eligible PERS members. The payments are from the PERS Retirement Health Insurance Account (RHIA). PERS pays the lesser of the monthly premium cost or $60. Premium payments exceeding that amount can be deducted from your monthly benefit checks. **Funding Method:** PEBB offers a variety of options to employees, including PPO, HMO and POS plans. These will tend be fully insured. **Practice of Porting Funds to Union Benefit Plans:** No. Oregon's union health benefit plans combined to create a single health benefit program for Oregon's public employees in January 1998. **BENEFITS** **Benefit Eligibility:** Active employees are eligible for health care coverage under the PEBB program. Retired members of PERS enrolled in Medicare receive a retirement allowance under the system. A legal spouse, dependent child(ren), and the surviving spouse of a PERS retiree are also eligible for PERS health benefits. Non-Medicare retirees can enroll in the PERS plans, but are not eligible for the monthly premium contribution until enrolled in Medicare. Upon enrollment in Medicare, retirees can receive payments.

STATE	DESCRIPTION
Oregon – cont.	**Benefit Options:** Active employees can select PPO, HMO or POS plans and can make use of a Section 125 cafeteria approach. Retirees can select from three different health care plans, an indemnity, fee-for-service insurance plan, a non-Medicare plan and a Medicare Companion plan to Medicare and non–Medicare retirees, and a Kaiser HMO plan, through its group insurance program. Insurance is provided by five licensed insurance carriers, through contracts approved by the PERS Board.
Pennsylvania	**BACKGROUND** **State Agency:** Pennsylvania's public employee health benefits are provided by the Pennsylvania Employees Benefit Trust Fund (PEBTF). The Commonwealth of Pennsylvania entered into an Agreement and Declaration of Trust (Agreement) with Council 13, American Federation of State, County and Municipal Employees, AFL-CIO (AFSCME) to form Pennsylvania Employees Benefit Trust Fund (the trust fund). The purpose of the trust fund is to provide hospital, medical/surgical and supplemental benefits under a jointly administered, multi-union health and welfare fund. In accordance with the terms of the respective collective bargaining agreements between the commonwealth and AFSCME, the Pennsylvania Social Services Union and the Independent State Stores Union, the separate union health benefit trust funds were merged into the trust effective January 1, 1993. Additional collective bargaining units were merged into the trust effective April 1994. In July 1997, another trust agreement incorporated management employees into the health benefits program. The trust fund is a qualified trust under the Internal Revenue Code and is exempt from federal income taxes under provisions of Section 501(c)(9). **Established by Statute:** No. **GOVERNANCE PRACTICES** **Board composition:** The PEBTF board is established as an employer-union trust. The board has 14 members, in which seven are affiliated with the commonwealth and seven are affiliated with the unions. **Authority of Board:** The Board of Trustees has the right to modify the benefits provided to active employees. The plan may be terminated only by the agreement of the Commonwealth, AFSCME, and the trustees subject to the provisions set forth in ERISA. **FUNDING** **Contribution Formula:** The commonwealth's collective bargaining agreements obligate it to provide certain contributions on behalf of all bargaining unit employees. The commonwealth submits contractually established contributions on behalf of active managerial employees and union employees, and also on behalf of retired employees. The trust receives approximately 94 percent of its contributions from the commonwealth.

STATE	DESCRIPTION
Pennsylvania – cont.	Active Employees Contributions are recorded when due based on rates established through agreements between the commonwealth, the trust fund and the unions. The rate effective for the fiscal years ended June 30, 1998 and 1997 was $4.94 annually per active full-time employee. This rate is not necessarily indicative of the contribution rate for future fiscal years. Retirees Contributions are recorded when due. At fiscal year end, if contributions exceed the annuitant's incurred expenses, the trust fund is obligated to refund to the commonwealth the excess of the year's contributions over the incurred expenses. If expenses exceed contributions for the fiscal year, the commonwealth is obligated to fund the deficit. **Practice of Porting Funds to Union Benefit Plans:** No. Pennsylvania consolidated its separate union health plans into a single health benefit program for all public employees in 1988. **Reserves:** No. Excess funds in the trust are refunded to the commonwealth at the end of each year. If there is a deficit, the commonwealth must fund that deficit each year. **ADMINISTRATION** **Organizational Structure:** Pennsylvania has a private industry third-party administrator (TPA) called the Pennsylvania Employees Benefit Trust Fund (PEBTF) for active employees which processes claims, provides customer service, and conducts internal audits. The PEBTF was established in 1988 and is *not* part of the state government. The TPA does its own contracting and bidding. The trust fund and the commonwealth entered into an administrative agreement that defines the rights and obligations of the commonwealth and the trust fund as they relate solely to the administration of medical benefits for individuals enrolled in Pennsylvania retired employee annuitants health plan. Under this agreement, the trust serves as the administrator of benefits and provides administrative services for the annuitants plan. In addition, the trust fund is not an insurer, underwriter or guarantor of any benefits for the annuitants plan. Under the retiree agreements, the commonwealth is responsible for the costs of claims paid, including retention costs and claims incurred but not reported, and direct and indirect administrative. Under the current administration agreement, the indirect costs incurred are allocated based on factors developed by the trust and agreed to by the commonwealth. The trust and the commonwealth review these factors every six months for reasonableness. The TPA handles contributions and premium collection, claims administration, financial reporting, rate/benefit negotiations with insurance carriers, and management controls. **Customer Service:** Customer service is handled by both the TPA and the insurance carriers.

STATE	DESCRIPTION
Pennsylvania – cont.	**BENEFITS** **Benefit Options:** Active or disabled employees can select from four geographically separate Blue Cross/Blue Shield plans, 13 HMO plans, five POS plans and one PPO plan. The health program covers hospital, medical/surgical, prescription drug, dental, vision and hearing aid benefits. The retirees health program covers hospital, medical/surgical, prescription drug, dental, vision and hearing aid benefits. **Benefit Determination:** Benefits are determined by the Board of Trustees.
South Dakota	**BACKGROUND** **State Agency:** South Dakota's Bureau of Personnel administers its state employee health plan. The plan's intent is to prudently use available resources to fix true medical problems and to help employees and their covered dependents avoid the serious financial consequences that could result from catastrophic illnesses or injuries. It is not intended to provide first dollar coverage for every health care service or treatment. The bureau is responsible for designing and administering the plan, and paying claims. The administrator can change the plan's design, modify coverages, and change premiums or funding mechanisms at any time with or without notice. **Established by Statute:** Yes. **FUNDING** **Contribution Formula:** South Dakota's state employee health plan is funded through a combination of state dollars and employee contributions. **Funding Method:** The state employee health plan became self insured in 1991. **Practice of Porting Funds to Union Benefit Plans:** No. There are no union or other competing health benefit plans for public employees. **ADMINISTRATION** **Organizational Structure:** At present, the health plan uses three companies that are identified as "third party administrators. The first, Dakota Care, has the responsibility for re-pricing claims and managing health care utilization. The second, PAID Prescription Network, helps employees save dollars through prescription discounts. The third, Wellmark Blue Cross Blue Shield of South Dakota, processes and pays claims. The plan administrator can hire companies with the expertise, manpower, and computer systems to do tasks that the bureau is unable to do. **BENEFITS** **Benefit Eligibility:** All full-time employees and dependents, and COBRA participants.

STATE	DESCRIPTION
South Dakota – cont.	**Funding:** Employees pay the full cost of all dependent coverage under all four plans. The amount of the contribution is established by the bureau at its discretion. The State pays the full cost of coverage for active "nonsmoking" employees under the $500 deductible, $1,000 deductible and provider network plans. The cost for employee and spouse coverage increases by $25 a month per person if either smoke tobacco. The plan administrator reserves the right to adjust contribution rates during the plan year. Employees can choose to opt out of health coverage or to enroll in the $1,000 deductible plan, in those cases the state will provide the employee $300 per plan year in flex credits. Employees can use the flex dollar credits to reduce the cost of dependent health plan, dental, vision, major injury, hospital, or toward a medical expense reimbursement account. **Retirees:** All retired employees, as determined by the State. **Benefit Options:** Active and disabled employees have a PPO plan. Retirees have a PPO plan and a Medicare supplement plan.
Texas	**BACKGROUND** **State Agency:** The Texas Employees Retirement System (ERS). In 1975, the Legislature created the Texas Employees Uniform Group Insurance Program to provide high quality health insurance and other optional coverages for employees, retirees and their eligible dependents. **Established by Statute:** Yes. **GOVERNANCE PRACTICES** **Board Composition:** The ERS Board of Trustees has six members. The governor, chief justice of the Texas supreme court and speaker of the House each appoint a member, and three members are state employees elected by the ERS members. **FUNDING** **Contribution Formula:** The state pays the cost of health and basic term life coverage, not to exceed the cost of the basic plan for full-time employees working 20 hours a week or more. Full-time employees also receive up to one half the cost of health coverage for eligible dependents, not to exceed one half the cost of dependent coverages provided by the carrier for the basic plan. Part-time employees are eligible for one half the contributions that full-time employees receive for their health, life insurance, and dependent health coverages. The state pays 100 percent of the cost of health coverage, not to exceed the cost of the basic plan for retirees. The state pays up to 50 percent of the cost of health coverage for eligible dependents, not to exceed 50 percent of the cost for dependent coverages provided by the carrier for the basic plan. The retiree is responsible for paying the remaining cost of health coverage for dependents and for other coverages selected.

STATE	DESCRIPTION
Texas – cont.	**BENEFITS** **Eligibility:** Full or part-time employee of the state of Texas. Retired employees are eligible if they fulfill all of the certain requirements including ten years of service, age and service requirements for the retirement system. **Benefit Options:** Active and disabled employees can select from HealthSelect, HealthSelect Plus, and a number of approved HMOs. Blue Cross and Blue Shield of Texas, Inc. administers the HealthSelect plan for the ERS. Retirees have the same health options as active employees. **Practice of Porting Funds to Union Benefit Plans:** No. There are no union or other competing health benefit plans for public employees.
West Virginia	**BACKGROUND** **State Agency:** The Public Employees Insurance Agency (PEIA) administers the health benefit and the basic and supplemental life insurance plans for all state employees. **Established by Statute:** Yes. **GOVERNANCE PRACTICES** **Board Composition:** The agency is governed by a five-member finance board that includes a state employees' representative, a teachers' representative, two business representatives and an executive director. All board members are appointed by the governor. The executive director is the leading member of the board and is also responsible for the agency's administrative duties. **Authority of Board:** The finance board makes all decisions regarding benefits and contributions under the state employees life and health benefits plans. **FUNDING** **Contribution Formula:** The employer contribution is approximately 93 percent of premiums for active employees and their dependents, and approximately 70 percent of premiums for retirees and their dependents. **Funding Method:** The basic health plans for active and retirees are self funded. The HMO and other prepaid coverages are fully insured with no experience rating. **Practice of Porting Funds to /Union Benefit Plans:** No. There are no competing union health benefit plans. **Reserves:** There generally are no reserves to deal with, since the self funded plans are funded on a pay-as-you-go basis. The fully insured plans by definition do not involve any reserves to be held by the agency or the carriers. **ADMINISTRATION** **Organizational Structure:** The executive director reports directly to the secretary of administration.

STATE	DESCRIPTION
West Virginia – cont.	**Contribution/Premium Collection:** The PEIA invoices and collects the premiums from all public employers, retains the premiums under the self-funded plans and remits the applicable premiums to the appropriate carriers/HMOs. **Claims Administration:** The third party administrator (TPA) is responsible for administering claims for the self-funded plans. The carriers/HMOs for the fully insured plans. The agency monitors the performance of the TPAs and audits the carriers/HMOs. **Customer Service:** Customer service is performed by the TPAs/carriers/HMOs. Customer complaints can also be directed to the agency. **Financial Reporting:** The PEIA provides quarterly reports to its board. It also makes recommendations for renewal rates and possible benefit changes. PEIA also collects and analyzes quality of care data. **Benefit Determination:** Benefits are determined as part of the renewal process and negotiations with carriers/HMOs. The agency director recommends changes to the board. **Rate Setting/Benefit Negotiation with Carriers:** This is performed by the agency with assistance from outside consultants. **BENEFITS** **Benefit Options:** Active employees and retirees not eligible for Medicare can select from self-funded indemnity plans and six HMO or POS medical plans are available. **Medicare Eligible Retirees:** Only Medicare Supplement indemnity plans are available. **Practice of Porting to Union or Other Competing Plans:** No. There are no union or other competing public employee health benefit plans.