

TEACHERS' RETIREMENT BOARD
BENEFITS AND SERVICES COMMITTEE

SUBJECT: 2009 District Health Benefits Survey

ITEM NUMBER: 4

CONSENT:

ATTACHMENT(S): 1

ACTION:

DATE OF MEETING: February 3, 2010 / 30 mins.

INFORMATION: X

PRESENTER(S): Ed Derman

PURPOSE OF THE ITEM

This is the report of CalSTRS' third triennial district health benefits survey. The first and second surveys were conducted in October 2003 and 2006 and reported to the Committee at their February meeting in 2004 and 2007 respectively.

RELATIONSHIP TO THE BOARD'S STRATEGIC PLAN

Goal 2	Proactively develop benefits and products that meet customer needs.
Objective D	Explore alternative ways to assist active and retired educators in obtaining affordable health care.

BACKGROUND

CalSTRS' primary focus is the pensions of California educators, but the availability of affordable health care can have a tremendous impact on the ability of members to maintain their standard of living in retirement. Historically CalSTRS has played a very modest role in providing health benefits for retired members and plays no role in providing health benefits to active members. Instead, provision of health insurance is a collective bargaining issue addressed at the local district level. However, CalSTRS has studied health care benefits provided to its members. It has conducted surveys of both districts and teachers and has established task forces to study the issue. The most recent task force report, *Health Care Have and Have Nots: A Crisis for California's Retired Educator*, was published in May 2008.

METHODOLOGY

In November and December 2009, the districts were asked to complete the survey about their health insurance coverage and health benefit costs that were in effect at the time of the survey or would be in effect as of January 1, 2010. For the first time, CalSTRS districts were asked to electronically complete the survey about the health benefits they offer.

The questionnaire covered the following major components:

- Active member health care coverage and costs
- Retired members health care coverage and costs

- Co-payment and deductible increases over the last three years
- Districts handling of postretirement benefit obligations imposed by the Governmental Accounting Standards Board (GASB)
- Payment and reimbursement for Medicare and health care coverage for disabled CalSTRS members
- Anticipated changes in the future

The survey was e-mailed to 1,096 districts. However, because of incorrect e-mail addresses or some other problem, only 969 (88.4 percent) were received by districts. Some districts' information technology system apparently blocked the e-mail in which the survey was sent because a Zoomerang e-mail, the system used for the survey, was viewed as "spam." A small number of districts chose to mail a paper copy of the results. CalSTRS had a response rate of 38.5 percent rate of the surveys successfully sent (34 percent of all districts). This compares to a return rate of 35 percent in 2006 and 42 percent in 2003.

Because a broad range of districts returned the survey, it is reasonable to make generalizations and suggest trends based on the results. However, care must be taken because this is not a longitudinal study. We contact all districts, but the same districts do not necessarily reply each time. Further, a change of a few percentage points in a particular response from one survey to the next probably is not significant. The percentage of survey responses for each type of district (County Offices of Education, Community Colleges and K-12 districts) is similar. In addition, we received surveys from 50 of the 58 counties and there was only one county with more than one K-12 school from which we did not receive a response. We also received responses from districts of all sizes, ranging from four districts that cover one member with health insurance to the Los Angeles Unified School District (LAUSD), which covers 40,000 active and 36,000 retired members.

Sending the survey to districts via e-mail resulted in a comparable response rate as sending it via the mail. It may have helped that districts were expecting the survey because most had been contacted via phone ahead of time to determine the e-mail address of the proper person to whom to send the survey. On the other hand, because of budgetary constraints some districts have less staffing available to complete a survey.

SUMMARY OF FINDINGS

There were no major surprises in the data provided in this survey.

- Virtually all full-time active members continue to have district-supported health care coverage.
- Forty percent of the districts offer health insurance to part-time educators. Most require that the educator work at least one-half time. Further, when part-time members retire, they typically must have 10 or 15 years of full time service with the district to receive any support for health care from the district.
- The percentage of districts that provide no support to members at retirement grew to 29 percent from the 19 percent that was reported in 2006.
- The percentage of retired members who receive no financial support for health insurance at age 65 is essentially the same as reported in 2006 (61 percent in 2009 versus 62 percent in 2006).

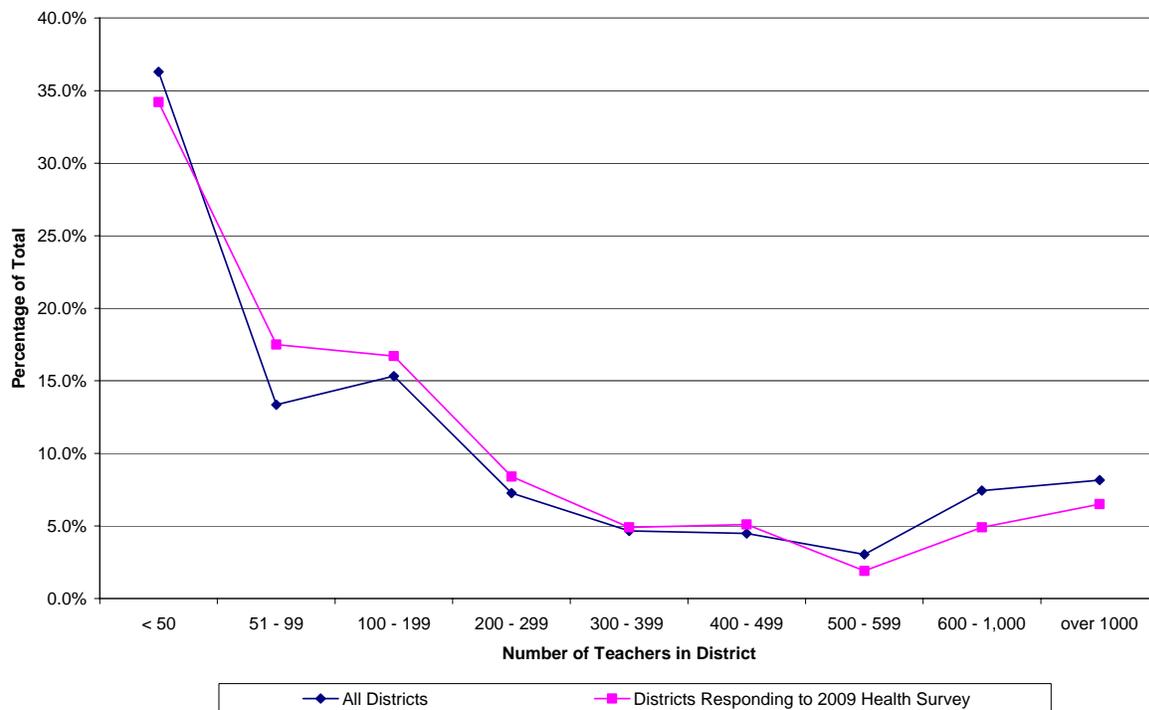
Also, rather than include definitions in this item, we have provided a glossary of terms that may be unfamiliar to those not immersed in the study of health as attachment one.

ACTIVE MEMBERS

Size of Reporting Districts

Districts representing 128,000 employees, or 28 percent of the total active CalSTRS membership responded to the survey. The range is from four districts that cover one teacher each to LAUSD that covers 40,000. The next largest district covers 2,724 educators. Excluding the LAUSD, which accounts for 31 percent of the active employees reported in the questionnaire, the average size of districts that responded to the questionnaire was 238 members, but the median is only 95 members. The distribution of districts is representative of all school districts because the percentage of districts by numbers of teachers that responded to the survey corresponds to all districts by number of teachers. For example approximately 34 percent of the districts that responded to the survey have fewer than 50 teachers. Thirty-three percent of all districts in the state are the same size. The chart below shows the distribution of all districts and responding districts by number of teachers. The distribution of responses by size of districts in the 2003 and 2006 surveys were similar.

Districts by Number of Teachers



Types of Health Care Offered by Districts

As reported in CalSTRS' earlier district health surveys, virtually all of the reporting districts either provide or coordinate medical and dental coverage for their educators and 94 percent of

districts provide vision care benefits. Further, the insurance is effective either upon hire or on the first of the month following the members’ employment date. Approximately 35 percent of the districts offer a cafeteria plan, and 19 percent have a Health Savings Account plan feature. It appears that these latter two approaches may be increasing in popularity. In 2006, 25 percent of the districts offered cafeteria plans and eight percent had Health Savings Account plan feature.

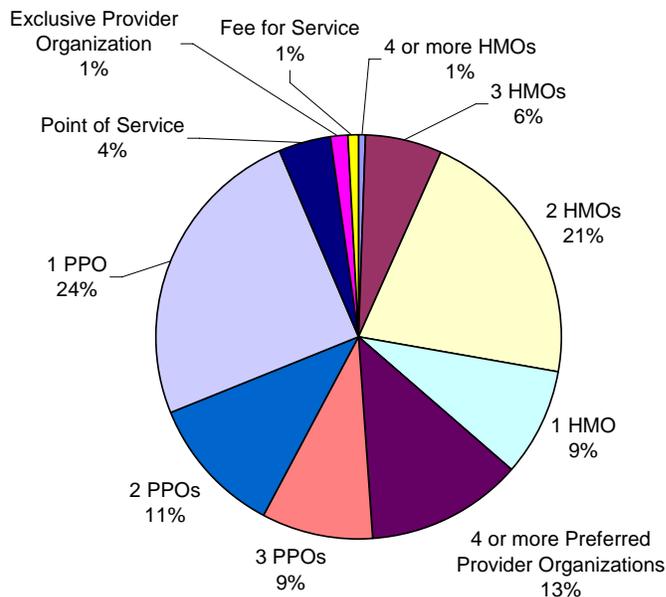
More California Educators Have Health Coverage than Private Sector Employees

No matter the size of the district, virtually all California educators are covered by district health insurance. This is not the case in the private sector, particularly for smaller firms. The California Health Care Foundation reported in its December 2009 *California Employer Health Benefits Survey* that only 65 percent of California firms with three to nine employees offer health insurance coverage. Of the private firms with 10 to 49 employees, 81 percent offer health coverage. Nationally the corresponding figures are 46 percent of firms with three to nine employees and 76 percent of firms with 10-49 employees offer health coverage.

Health Insurance Options

Almost 84 percent of districts offer more than one health insurance option to their teachers. Overwhelmingly, districts offer Preferred Provider Organizations (PPO) or Health Maintenance Organizations (HMO). Approximately five percent offer Point of Service (POS), while less than 2 percent offer Exclusive Provider Organization (EPO) and Traditional Fee-for Service Plans. The chart below shows the distribution of these plans, and number of such plans made available by districts. With the multiple options, there are a total of 1,232 options offered.

Health Plan Options Offered by Districts



The following table shows the same data for the 2009 and 2006 surveys. CalSTRS did not collect this data in 2003.

Percentage of Districts that Offer Health Plan Options

Plans Offered	2006 Survey	2009 Survey
Offers 1 HMO	8%	9%
Offers 2 HMOs	21%	21%
Offers 3 HMOs	1%	6%
Offers 4 HMOs	2%	1%
Offers 1 PPO	30%	24%
Offers 2 PPOs	9%	11%
Offers 3 PPOs	6%	9%
Offers 4 PPOs	14%	13%
Offers POS	6%	4%
Offers Other Plan Options	2%	2%

Reimbursement of Employees – Additional Salary in Lieu of District Provided Health Care

Eighty-four percent of reporting districts do not reimburse members who opt not to have the health plans offered by the district. Sixty-one districts reported some form of reimbursement for medical care cost including dental and vision. Reimbursements for employee-only coverage ranged from \$100 to \$750 per month. The average reimbursement is approximately \$305 per month. Some districts provide reimbursement on an annual basis, with the highest amount reported as \$3,000. The data from the 2006 survey is similar. Eighty-four percent of the districts did not reimburse if the employee opted not to have health plans while 56 districts reported some form of reimbursements. These ranged from \$91 per month to \$5000 per year with an average of \$200 per month.

Contract Health Insurance Providers

Districts contract with a variety of sources to secure health insurance for members. Districts reported that 59 percent belong to a joint powers authority (JPA) or trust. Twenty-four percent of the districts contract directly with health insurance care providers, while 10 percent contract with CalPERS' health benefits program, Public Employees Medical and Hospital Care Act or PEMHCA. Seven percent of the districts contract directly with a health insurance provider and also receive health benefits through a JPA. The percentage of districts reporting that they directly contract with a provider increased significantly from the 2006 survey, with a corresponding reduction in the use of JPAs or trusts, as indicated in the table below. The reasons that the data from this year's survey are significantly different from the information in the previous surveys are unclear. Staff have some concern that districts may have misinterpreted the question and therefore answered it incorrectly.

Comparison of Health Insurance Providers

Survey Year	Direct Contract with Provider	Joint Powers Agreement or Trust	CalPERS	Direct and JPA
2003	15%	66%	8%	8%
2006	16%	68%	7%	5%
2009	24%	59%	10%	7%

Certificated Part-Time Employees

CalSTRS also asked if districts provide health benefits to certificated part-time employees. Fifteen percent of the districts reported that they did not have part-time certificated employees, while another 45 percent indicated that they did not offer post retirement health care insurance benefits to their part-time employees. Of the 40 percent that do offer health benefits to part-time staff, most require that part-time employees work half time or more, have 10 to 15 years of service with the district, the district will pay a proportion of the premium based on the members' appointment, or the members pay proportionately to their appointments. In the 2006 survey, 38 percent of the districts had similar provisions for providing health care benefits to part-time staff.

Health Benefits are Similar for Classified staff

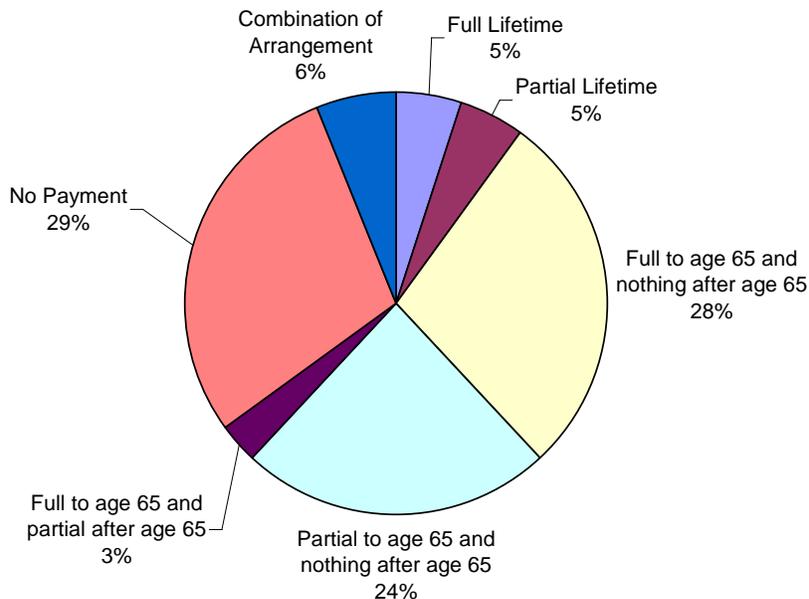
Almost three-quarters of the districts offer the same health benefits to classified staff as they offer to certificated staff. Provisions in bargaining agreements may require different contributions rates.

RETIRED CERTIFICATED MEMBERS

The provision of post-retirement health care is subject to collective bargaining agreements that are negotiated between employees and their employer. As stated in the CalPERS statewide health insurance pool study: "Compared to other large California employers, school districts do a good job of providing comprehensive medical coverage to early retirees to bridge the transition coverage under Medicare.... Once retirees reach Medicare age (age 65), they are much less likely to have district-provided coverage." Districts reported that they covered almost 56,000 retired members, but almost 65 percent of those covered were employed at LAUSD. Twenty-nine percent of the districts surveyed offer no district-paid health care for any retired employees. In these cases, coverage provided by the districts must be paid entirely by the retired employee. For the 71 percent that offer some financial support to retired members, many require employees to have achieved a specified age and/or years of service to qualify for post-retirement benefits. Successive contracts have required more service and provided less reimbursement. Many districts have monthly or annual maximum amounts or caps that they will pay for retired members' health insurance.

The following chart shows the results of the 2009 survey with the table following providing responses to these questions from the three CalSTRS district health surveys.

Postretirement Health Benefits Coverage



Districts Support of Retired Members Health Benefits

Post Retirement Health Care Paid by the District			
	2003 Survey	2006 Survey	2009 Survey
Full payment for health benefits for life	3%	1%	5%
Full payment to age 65, then partial payment	4%	7%	3%
Full payment to age 65, then no payment	36%	39%	28%
Partial payment for life	4%	6%	5%
Partial payment to age 65, then no payment	18%	28%	24%
No payment for health benefits	20%	19%	29%
Other types of agreements	12%	0%	6%
No health benefits provided	4%	0%	0%

As shown in the table below, 81 percent of districts now do not offer financial support when a retired member reaches age 65. Because the largest districts often offer full or partial reimbursement for the members' lives, the percentage of retired teachers who do not financially support such benefits is lower than the percentage of districts.

Percentage of Districts that Do Not Provide Financial Support for Health Care to Retired Members at Age 65

	Percentage of Districts providing no financial support for health care to retired members after age 65	Represents percentage of retired teachers
2003 Survey	78	57
2006 Survey	86	62
2009 Survey	81	61

Change in District Health Care Coverage for Retired Employees

Only nine percent of the districts reported some change in coverage for retired employees over the last three years. The primary change reported was that districts that paid full health insurance to age 65 are now providing only partial health insurance to age 65. Other districts now limit reimbursements to a specified amount and a few others report that they no longer pay any amount toward retired members’ health insurance coverage. The same changes were reported in the 2006 survey.

Comparison to Private Employers

Even though the situation is not ideal, CalSTRS members are in somewhat better circumstances than facing employees in the private sector. In a recent Towers Perrin Retiree Health Care Cost Survey, it was found that only 22 percent of the surveyed companies provide new hires some subsidized coverage at retirement. Another 23 percent offer employees’ access, at their own cost, to the employee group plan. The picture is better for current retirees and employees already working; 45 percent of the private employers provide subsidized coverage for some with an additional 14 percent offering access to the group plan at the employees’ cost.

HEALTH CARE INCREASES

Health Benefit Premium Costs

CalSTRS asked districts about health benefit premium increases in the last three years and estimated future health care premium. The range of increases is very large, from zero to over 50 percent increases. A small group’s premiums can increase significantly if there are a few costly claims. Therefore, the median is a better indicator. The median increase in premiums for 2007, 2008, and 2009 is six to nine percent, with an estimated 10 to 19 percent change in the next two years.

The districts’ experience is similar to that of all California employers. Health insurance premiums in California increased 7.5 percent in 2009, according to the California Healthcare Foundation as reported in their December 2009 Employer Health Benefits Survey. Further, premiums continue to rise at much more than the overall California inflation rate. “Since 2002, health insurance premiums have increase by 117.5 percent, more than four times the 23.1 percent increase in California’s overall inflation rate.”

CalSTRS did not inquire about actual dollar amount of premiums because they vary depending on plan design, location and availability of plan options. In addition, “employee group size does not appear to be a significant factor in current plan costs. This may be, in part, because smaller districts are more likely to be participating in one of the existing pooling arrangements.” (CalPERS Statewide Health Care Pool Study)

Health Care Benefit Changes

Districts were asked to provide information regarding whether there had been any changes in the co-payments or deductibles employees pay as part of their plan benefit. These types of plan design changes typically do not take place annually. Only 29 percent of the districts reported one or more benefit changes regarding co-payments or deductibles, and most districts reported no increase in some years. Sixty-nine districts reported changes in co-payments ranging from zero in some years to more than 50 percent. For perspective, an increase from a \$10 co-payment to a \$15 co-payment for a doctor visit is an increase of 50 percent. Only 50 districts reported changes in deductibles. Again, the increases ranged from 0 to 50 percent with many districts reporting no change for some years. The table below shows the range and median increases in co-payments and deductibles.

Reported Increases in Co-payments and Deductibles

Benefit Changes	2007	2008	2009	Estimated for Next Two Years
Co-payment Increase Median	0%	0%	1 – 5%	0%
Deductible Increase Median	0%	0%	1-5%	1 – 5%

In 2006, the districts reported co-payment changes of five to eight percent and deductible changes of two to six percent in one of the three years. In 2003, most districts reported increases in both co-payments and deductibles, but CalSTRS did not collect data on the percentage of increases.

Reduction or Loss of Health Care Providers

Only 29 districts reported a reduction or loss of health insurance carriers over the last three years. The primary reason was that HMOs stopped offering service in the districts’ area or the district joined a JPA and there are fewer options. There were also a few districts that added an option for their teachers. The data from previous surveys is similar with most of the losses or reductions of providers occurring in 2004.

GOVERNMENTAL ACCOUNTING STANDARDS BOARD

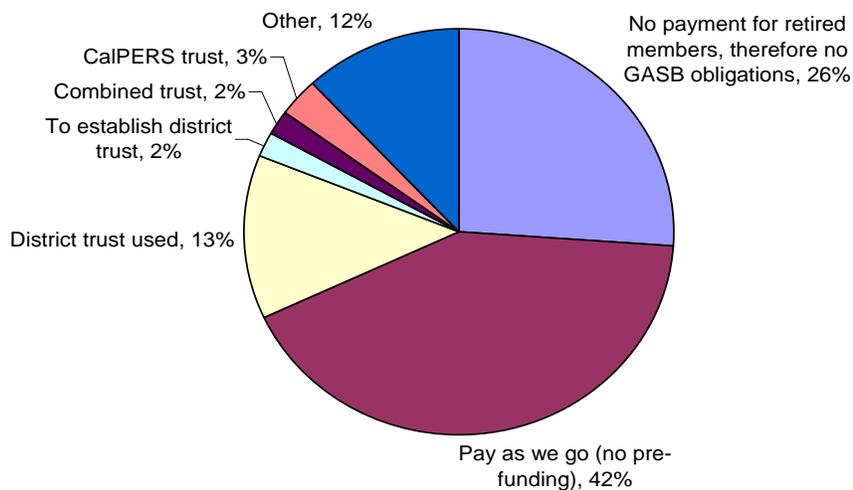
In 2004, the Governmental Accounting Standards Board (GASB) imposed two new standards: Statement 43 and Statement 45. These statements, which deal with accounting, reporting and disclosure requirements for post-employment benefits other than pensions, have had a significant

impact because districts must now report (though not necessarily fund) the expenses and liabilities for district paid retiree health care in their financial statements.

This year's survey focused on districts' GASB 43/45 obligations and how they were paying these costs. Many districts have not yet determined their GASB 43/45 obligations. Only 71 percent of the districts answered how they paid these costs and most districts did not include specifics about the percentage funded, total left to pay, and amount paid this or subsequent years.

There were 14 districts that reported that they are 100 percent funded while over 50 said that they have not pre-funded any health benefits. The average for the 76 districts reporting a funding percentage was 29 percent funded. The amount paid this year ranged from zero to \$9.8 million with a total of 76 districts reporting that they paid \$44.7 million this year. Fifty-three districts have or plan to establish a trust or are members of a joint trust. Nine districts reported that they were part of the CalPERS' California Employers' Retiree Benefit Trust. None of the responding districts have sold or plan to sell retired health obligation bonds. The following chart shows how districts pay GASB 43/45 costs.

Districts Pay GASB Costs Varied Ways



MEDICARE AND DISABILITY BENEFITS

Medicare Reimbursement

Only 15 districts pay the Medicare Part B (doctor visits) premiums for their retired members. Although reimbursing for Medicare Part B premiums is still rarely provided as a benefit, this does represent a slight increase from the districts that reported this in the earlier surveys (11 districts in 2003 and 13 districts in 2006).

Disabled Employees Health Insurance Options

Districts provide a variety of health care alternatives for members who become disabled while working for the district. Twenty-seven percent of the districts offer the same coverage to disabled members as offered to active employees. Just three percent provide either a full or partial health care package, unless the member is eligible to retire or meets the other district requirements for post-retirement health care. Fourteen percent of the districts will pay for the disabled member's health care until the member is eligible to retire, and then the member is subject to the same post-retirement coverage as other retired members. Disabled employees from 22 percent of the districts have the option to be covered by district health insurance while on disability but must pay all the premiums. Another 21 percent of districts offer health care for the period of time required by federal law and then require employees to secure health insurance individually. In some instances, members secure health care coverage while on disability through more than one alternative. For instance, the district may pay the member's health care until the member reaches retirement age. At this point, the member may opt for COBRA coverage or opt to be covered by the district plan, but pay all of the premium costs. Thirteen percent of the responding districts have not had disabled CalSTRS members or had alternative coverage generally involving time and age requirements and health care caps. The findings from the three surveys are presented in the table below.

Health Insurance Options Districts Provide to Members on CalSTRS Disability

	2003 Survey	2006 Survey	2009 survey
Same as for active employees	Not asked	Not asked	27%
Lifetime health insurance entirely paid by district	1%	1%	1%
Lifetime health insurance, but district pays only a portion of the premium	2%	1%	2%
District pays premium until member retires; then member under retired member provisions	18%	26%	14%
Member has option to be covered by district plan, but must pay all the premium	26%	30%	22%
Member offered COBRA coverage and then must secure health insurance individually	29%	28%	21%
Other	23%	15%	13%

Health Care Insurance Pool

In December 2007 CalPERS published its study of the feasibility of establishing a statewide health benefits pool for all school employees. It concluded that “properly structured, there is a viable opportunity for districts to benefit from being placed in a statewide health care coverage pool.” Further they believe that the pool should be mandatory. However, there are significant barriers to such a plan.

CalSTRS asked districts whether they were interested in joining such a statewide health care pool and to rank their reasons to participate in such a pool. Thirty percent of the responding districts indicated that they would be interested in participating in a statewide health insurance pool. In order of descending importance, as reported by districts, their responses were:

- Potential for lower district and employee costs;
- Possibility of lower co-payments or deductibles;
- More types of health plans or insurance carriers available;
- Elimination of administrative burden, and
- More potential vendors which would mean more options for employees.

In contrast, 44 percent of the responding districts indicated that they were not interested in participating in a statewide pool primarily because they either are already in a pool (such as a trust) or they did not want to give up control over the benefit structure. Twenty-six percent either did not respond to the health care question or were not sure if they would be willing to participate in a pool. Many mentioned that because health benefits were negotiable, it would require union approval. Lower cost and availability of plan options would be critical as well.

The 2006 survey was distributed before the CalPERS study was complete, but the level of interest in joining a pool seems to have declined since the 2006 survey. At that time, 51 percent of the districts indicated that they would be interested in joining the pool and 37 percent said they were not interested. Thirteen percent did not respond to the inquiry.

FUTURE CHANGES

The answer to the question about any other anticipated major or significant changes in the future can be best summed up in one district's answer, "costs up, options down" with the emphasis on the costs increasing. Specifically, districts expect health care premiums to rise and that employees will be asked to pay a higher share of the overall costs. A few districts also mentioned that the national health reform may affect their district's health benefits.

National Health Plan

Although both houses of Congress have passed health care reform, they have yet to come together for the conference committee to agree upon a final plan. Therefore, it is still too early to tell how the establishment of a national health plan will affect the health care benefits offered by the districts. However, a major provision of the legislation is that employers are expected to continue to offer health care insurance to their employees. Health insurance for retired members may not change significantly because Medicare will essentially remain the same. There are provisions which "close the donut hole" in Medicare Part D, the drug coverage. Medicare supplemental plans may vary because the Medicare Advantage plans reimbursement rates will be the same as other Medicare supplement plans. Allowing retired individuals ages 55 through 64 who do not have other health insurance to enroll in Medicare was eliminated from the Senate bill. Staff will report on the legislation's affect on California districts after it passes and is signed by the President.

CONCLUSION

There were no major surprises in the data provided in this survey. All active members continue to have district supported health care coverage, but the picture changes for part-time educators and retired members. Forty percent of the districts offer health insurance to part-time educators and most require that the educator work at least one-half time. Further, when members retire, they typically must have 10 or 15 years of full time service with the district to receive any support for health care from the district. The 61 percent of retired members who get no financial support for health insurance at age 65 is essentially the same as reported in 2006.

There are many terms used in the report on the 2009 District Health Benefits Survey that might be considered health care jargon and may be unfamiliar to those who are not immersed in the study of health care. Rather than include the definitions in the report, we have included this glossary as an attachment. The terms are listed alphabetically.

AB 528 benefits are named after the bill passed in 1985. Under California Government Code Sections 7000-7008, districts must offer retiring members and their spouses the opportunity to enroll in health and dental insurance. The district may charge the retiring member the full cost of benefits. Further, the plan for retired members may be underwritten separately.

CalPERS Statewide Health Insurance Pool Study required CalPERS to conduct a study to examine the feasibility and cost-effectiveness of a single statewide health care pool that would all public school employees. The study, published in December 2007, was required by AB 265, passed in 2005.

COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1985. It is the federal law that obligates employers to offer continued health insurance coverage to terminated employees and their dependants for designated periods of time. The former employee or dependent typically pays the premium plus an administrative cost.

Co-payments is a cost-sharing arrangement of a health plan in which the individual pays a fixed fee for a specific service (such as \$10 for an office visit) in addition to deductibles and coinsurance, often on a per service basis. Co-payments are used to discourage inappropriate use of benefits and to help finance health benefit plans.

Deductible is an amount that the individual must pay prior to receiving any reimbursement from insurance. Some deductibles are per service while other deductibles are computed annually.

ERISA refers to the Employee Retirement Income Security Act of 1974, a federal law governing pensions and other employee benefits offered by private employers and unions. Federal law does not regulate public sector employee programs including pensions. ERISA contains a “preemption clause” providing that it supersedes all state laws that relate to private-sector employee pension and benefits programs.

Exclusive Provider Organization (EPO) is a type of managed health care organization in which no coverage is typically provided for services received outside of the EPO. However, some EPOs incorporate the primary care physician gate keeping concept along with the prospective approval of referrals to specialists providers outside of the EPO.

Fee-for-Service Plans are the traditional kind of health care policy. Insurance companies pay fees for the services provided to the insured people covered by the policy. This type of health insurance offers the most choices of doctors and hospitals. A member can

choose any doctor and change doctors any time. The insurer only pays for part of the doctor and hospital bills. Members pay a monthly fee or premiums and typically have a deductible and may have co-payments when they receive service.

Flexible benefit plan is a plan in which participants may choose among two or more benefits containing taxable or nontaxable compensation elements, i.e., cash or “qualified benefits.” Participants may choose qualified benefits by electing not to receive taxable cash compensation or currently taxable benefits treated as cash.

Governmental Accounting Standards Board (GASB) is the independent, not-for-profit organization formed to establish and improve financial accounting and reporting standards for state and local government.

Health Insurance Portability and Accountability Act (HIPAA) is the law passed in 1996 that expands health care coverage for individuals who have lost their jobs or have moved from one job to another. HIPAA protects people who have pre-existing medical conditions or problems getting health coverage. HIPAA also:

- limits how companies can use pre-existing medical conditions to keep an individual from getting health insurance coverage;
- usually gives people credit for health coverage they have had in the past;
- may give people special help with group health coverage when they lose coverage or have a new dependent; and
- generally, guarantees the right to renew health coverage.

Health Maintenance Organizations (HMO) are health plans, paid for through a prepaid premium, which offer individuals a range of health benefits, including preventative care, for a monthly fee and a range of co-payments. Members of an HMO must use the designated physicians and providers, other than with the referral of members’ primary care physician or in an emergency.

Joint Powers Authority (JPA) is an entity formed and operated by one or more public agencies to spread risk among them for the purpose of establishing, operating and maintaining a joint program for employee benefits.

Medi-Cal (in other states Medicaid) is a federal and state health insurance program designed to provide access to health services for persons below a certain income level, including elderly persons who are poor.

Medicare is the federal health insurance program for citizens and permanent residents age 65 or more. In addition, individuals who are judged to be disabled and received Social Security disability for 24 or more months may also receive Medicare as will people with other specific disabilities such as End-Stage Renal disease.

Medicare Advantage Plans (Medicare Part C) provide Medicare Parts A and B plus additional benefits. Often prescription drug benefits are included. These can be offered as private-fee-for-service, preferred provider organizations, or health maintenance organizations. These plans were offered a higher reimbursement rate than Medicare fee-

for-service plans in the 2003 Medicare Modernization Act. However, this advantage is being eliminated.

Medicare Premium Payment Program was established in 2000 with the first payments made in July 2001. CalSTRS pays the Medicare Part A premiums for eligible retired Defined Benefit Program members who do not receive Medicare Part A premium-free from another source. CalSTRS also pays Medicare Parts A and B surcharges assessed by Centers for Medicare and Medicaid (CMS), the federal agency that administers Medicaid, for eligible DB members who enrolled in Medicare prior to July 1, 2001, and for whom CalSTRS is paying the Medicare Part A premium.

Medi-gap Policy is a Medicare supplemental policy, sold by private insurance companies, designed to pay for services not covered by Medicare. In most states, there are standard plans, labeled A through J. With the implementation of Medicare Part D, the design of these some of these plans changed because prescription drug benefits are no longer part of Medi-gap policies.

Out-Of-Pocket are the funds, including deductibles, co-payments, or coinsurance, that individuals must pay for their health care.

Point of Service (POS) is a health care insurance plan that allows enrollees to seek care from a physician affiliated with the service provider at a fixed co-payment or to choose a nonaffiliated physician and pay a larger share of the cost.

Preferred Provider Organizations (PPO) are managed care plans in which individuals use doctors, hospitals, and providers that belong to the network. Individuals can use providers outside the network for an additional cost. Members of a PPO can generally choose their own physician and do not need a referral from their primary care physician to see a specialist.

Premium is the amount of money an employer or individual pays for insurance coverage.

Primary Care Physician is a doctor who is trained to provide basic care and is the first physician people see for most health care. In many HMOs, individuals must see or get a referral from their primary care doctor before seeing any other health care provider.

Public Employees Medical and Hospital Care Act (PEMHCA) is CalPERS' statewide health care program. Approximately 115 school districts contract with the CalPERS for their health care. All premiums are paid by the participants and their employers; CalPERS does not subsidize the premiums in any way.

Trust is a joint effort of labor and management to pool resources to provide a variety of health and welfare benefits to school employees.

Voluntary Employee Beneficiary Association (VEBA) is a tax-exempt welfare benefit fund, regulated by the Internal Revenue Code, which pays death, sickness, accident or other benefits to members, dependents or beneficiaries.